Medical Care Collection Fund (MCCF) eBilling Compliance Phase 4

Interface Control Document

Patch IB\*2\*576

Health Care Claims (837)

Logo for the Department of Veterans Affairs, Office of Information and Technology, Product Development, including the official seal of the Department of Veterans Affairs


Department of Veterans Affairs

January 2017

Version 10.0

Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Version | Description | Author |
| 6/10 | 1.0 | Existing 837 mapping document placed in ICD format | M. Simons OED  M. Wilbanks FSC |
| 6/18 | 1.1 | Modified | M. Wilbanks FSC |
| 8/2/10 | 1.2 | Modified: 5.3.1 CL1-10; 5.3.1 CL1-28 to 30; 5.3.9 PC-04; 5.3.13; 5.4.1 OI-23 ; 5.4.1 OI-21 and 22; 5.4.21 PRF21 deleted.; 5.3.4 SUB 12 | M. Wilbanks FSC |
| 8/5/10 | 1.3 | Modified: 5.4.2 OI-7; 5.4.21 PRF-5; 5.4.21 PRF-8 ; 5.4.21 PRF-24; 5.4.21 PRF-30; 5.4.23 RX1-7; 5.4.23 RX1-8; 6.5 TOS conversion will be removed with 5010. | M. Wilbanks FSC |
| 10/06/10 | 1.4 | Modified: 5.2.10 PT2-5,6; 5.4.23 RX1-7; 5.3.1 CL1-5; 5.3.6 UB1-20  Deleted: OP6 | M. Wilbanks FSC |
| 10/08/10 | 1.5 | Modified: 5.2.3 CI1-14; 5.2.7 CI5-8; 5.3.2 CL1A -17,19; 5.3.2 CL1A-23; 5.4.1 OI1-12; 5.4.24 LOPE-16,17; 5.4.25 LOP1-16,17; 5.2.26 LREN-16,17; 5.2.28 LSUP-16,17 | M. Wilbanks FSC |
| 10/29/10 | 1.6 | Modified: 5.3.1 CL1 CLM05-2 | M. Wilbanks FSC |
| 11/29/10 | 1.7 | Added: Max length of all fields  Modified: 5.2.3 CI1-14; 5.2.4 CI1A-4; 5.2.5 CI2 -10; 5.2.9 PT1-11; 5.3.1 CL1-22; 5.3.1 CL1-23; 5.3.4 SUB-6; 5.3.18 OPR-11; 5.4.20 PRF-5; 5.4.21 INS-9; 5.4.30 LCOB-6 | M. Wilbanks FSC |
| 1/31/11 | 1.8 | Added: 5.2.2 PRV1-12  Modified: CL1-15,17 | M. Wilbanks FSC |
| 3/11 | 2.0 | Modified for Patch IB\*2\*447 | T. Zimmer PD  M. Simons PD  M. Wilbanks FSC |
| 12/13 | 3.0 | Modified for Patch IB\*2\*488 | M. Simons  M. Wilbanks FSC  A. Sharma FSC |
| 1/27/14 | 4.0 | Updated following review (488) by CBO/PMO | M. Simons  A. Sharma FSC |
| 3/14 | 5.0 | Modified for Patch IB\*2\*516  Data mapping information added | M. Simons  M. Wilbanks FSC  A. Sharma FSC |
| 4/14 | 6.0 | Updated following review (516) by CBO/PMO | M. Simons |
| 5/15 | 7.0 | Modified for Patch IB\*2\*547 | M. Simons  C. Minch |
| 6/15 | 8.0 | Updated for Patch IB\*2\*547 after decision to only lengthen longer insurance fields – CR 002 | M. Simons |
| 4/16 | 9.0 | Changes from Active state: Gave BLANK length = 1 | M.Simons |
| 1/17 | 10.0 | Updated for Patch IB\*2\*576 | M. Simons |

Table of Contents

1 Introduction 1

1.1 Purpose 1

1.2 Scope 1

1.3 System Identification 1

1.3.1 Current Claims Process 2

1.3.2 VistA Integrated Billing Module 3

1.3.3 FSC – Gentran Basic 3

1.3.4 FSC – Instream (HIPAA Validation Software) 3

1.4 Operational Agreement 3

2 Interface Definition 3

2.1 System Overview 3

2.2 Interface Overview 4

2.3 Operations 4

2.4 Data Transfer 4

2.5 Transaction Types 4

2.6 Data Exchanges 4

2.7 Communications Methods 4

2.8 Performance Requirements 4

2.9 Security 5

3 Interface Requirements 5

4 Interface Verification 5

5 Appendix A – Data Elements 1

5.1 Section 1 – General Information 1

5.1.1 GEN - General ID Data [SEQ 5] 2

5.2 Section 2 – Per Claim Data 3

5.2.1 PRV - Loop 2010AA (Billing Provider Data) [SEQ 15] 3

5.2.2 PRV1 - Loop 2010AB (Pay-To Provider (Parent VAMC) Data) [SEQ 16] 6

5.2.3 CI1 - Loop 2010BB/BC (Current Payer Data) [SEQ 20] 8

5.2.4 CI1A - Loop 2010AA (Billing Provider Secondary ID Data) [SEQ 28] 11

*5.2.5* *CI2 - Loop 2000B/2010BA (Subscriber Data) [SEQ 30]* 13

*5.2.6* *CI2A - Loop 2000B/2010BA (Subscriber Data)* 15

*5.2.7* *CI3 - Loop 2000B (Subscriber Group/Employment Data) [SEQ 35]* 17

*5.2.8* *CI3A - Loop 2000B (Subscriber Group/Employment Data)* 18

5.2.9 CI5 - Loop 2010BB/BC (Payer ID Data) [SEQ 37] 20

5.2.10 CI6 - Loop 2010BA (Subscriber ID Data) [SEQ 38] 22

5.2.11 PT1 - Loop 2000B/C 2010BA/CA (Patient Data) [SEQ 40] 24

5.2.12 PT2 - Loop 2000B/C 2010CA (Patient Data) [SEQ45] 27

5.3 Section 3 – Claim Level Data 29

5.3.1 CL1 - Loop 2300 (Claim Level Data) [SEQ 50] 29

5.3.2 CL1A - Loop 2300 (Claim Level Data) [SEQ 51] 37

5.3.3 CL1B – Loop 2300 (Claim Level Data) [SEQ 52] 41

5.3.4 SUB - Loop 2310C/D/E 2300 (Service Facility Data) [SEQ 55] 42

5.3.5 SUB2 - Loop 2310C/E (Service Facility Data) [SEQ 57] 45

5.3.6 UB1 - Loop 2300 (Claim Level Form Data) [SEQ 60] 48

5.3.7 OC1-OC12 - Loop 2300 (Occurrence Code Data) [SEQ 65] 50

5.3.8 OS1-OS12 - Loop 2300 (Occurrence Span Code Data) [SEQ 70] 50

5.3.9 PC1-PC12 - Loop 2300 (Procedure Code Data) [SEQ 75] 52

5.3.10 SPC- Loop 2300 (Surgical Procedure Code Data) [SEQ 77] 53

5.3.11 VC1-VC12 - Loop 2300 (Value Code Data) [SEQ 80] 54

5.3.12 CC1-CC12 - Loop 2300 (Condition Code Data) [SEQ 85] 54

5.3.13 DC1-DC12 - Loop 2300 (Diagnosis Code Data) [SEQ 90] 55

5.3.14 OPR - Loop 2310A/B/C (Att/Other Oper/Oper Physician/Provider Data) [SEQ 96] 56

5.3.15 OPR1 - Loop 2310A/B (Att/Other Oper/Oper Physician/Provider Data) [SEQ 97] 59

5.3.16 OPR2 - Loop 2310A (Attending Provider Secondary ID Data) [SEQ 98] 62

5.3.17 OPR3 - Loop 2310B (Operating Physician Secondary ID Data) [SEQ 99] 64

5.3.18 OPR4 - Loop 2310C (Other Operating Provider Secondary ID Data) [SEQ 100] 66

5.3.19 OPR5 - Loop 2310A (Referring Provider Secondary ID Data) [SEQ 101] 70

5.3.20 OPR7 - Loop 2310E (Supervising Provider Data) [SEQ 103] 73

5.3.21 OPR8 - Loop 2310E (Supervising Provider Secondary ID Data) [SEQ 104] 75

5.3.22 OPR9 – Loop 2310B/2310D (Rendering Provider Data) [SEQ 104.5] 79

5.3.23 OPRA – Loop 2310B/2310D (Rendering Provider Secondary ID) [SEQ 104.4] 81

5.3.24 AMB - Loop 2310E/F (Ambulance Pick-up / Drop-off) [SEQ 104.8] 85

5.3.25 AMB1 - Loop 2310E/F (Ambulance Pick-up / Drop-off) [SEQ 104.9] 87

5.3.26 AMB2 - Loop 2300 (Ambulance Certification Data) [SEQ 104.91] 88

5.4 Section 4 – Other Insurance Data 90

*5.4.1* *OI1 - Loop 2320/2330B (Other Subscriber and Other Payer Data) [SEQ 105]* 90

*5.4.2* *OI1A - Loop 2320/2330B (Other Subscriber and Other Payer Data)* 93

5.4.3 OI2 - Loop 2330A (Other Payer Subscriber Data) [SEQ 110] 95

5.4.4 OI4 - Loop 2330B (Other Payer Data) [SEQ 112] 97

5.4.5 OI5 - Loop 2330A (Other Payer Subscriber Data) [SEQ 113] 100

5.4.6 OI6 - Loop 2330B (Other Payer ID Data) [SEQ 114] 103

5.4.7 COB1 - Loop 2320 (Claim Level COB Amounts) [SEQ 115] 106

5.4.8 MOA1 - Loop 2320 (Medicare Outpatient Adjudication COB Data) [SEQ 120] 107

5.4.9 MIA1 - Loop 2320 (Medicare Inpatient Adjudication COB Data) [SEQ 125] 109

5.4.10 MIA2 - Loop 2320 (Medicare Inpatient Adjudication COB Data) [SEQ 130] 112

5.4.11 CCAS - Loop 2320 (COB Claim Level Adjustments) [SEQ 135] 115

5.4.12 OP1 - Loop 2330C/D (Other Payer Rendering Provider Data) [SEQ 170] 120

5.4.13 OP1A - Loop 2330C/D (Other Payer Attending Physician Data) [SEQ 170.5] 124

5.4.14 OP2 - Loop 2330D (Other Payer Operating Physician Data) [SEQ 171] 127

5.4.15 OP3 - Loop 2330F (Other Payer Service Facility Data) [SEQ 172] 131

5.4.16 OP4 - Loop 2330C (Other Payer Referring Provider Data) [SEQ 173] 134

5.4.17 OP7 - Loop 2330E (Other Payer Service Facility Data) [SEQ 176] 138

5.4.18 OP8 - Loop 2330F (Other Payer Supervising Provider Data) [SEQ 177] 141

5.4.19 OP9 - Loop 2330E (Other Payer Other Operating Provider Data) [SEQ 178] 145

5.5 Section 5 – Line Level Data 149

5.5.1 PRF - Loop 2400 (Professional Service Line Data) [SEQ 180] 149

5.5.2 RX1 - Loop 2400/2410 (Drug Service Line Data) [SEQ 190] 157

5.5.3 LDAT – Loop 2400 Supplemental line information [SEQ 191] 159

5.5.4 LOPE - Loop 2420A (Line Operating Physician Data) [SEQ 192] 161

5.5.5 LOP1 - Loop 2420B (Line Other Operating Physician Data) [SEQ 193] 166

5.5.6 LREN - Loop 2420A/C (Line Rendering Provider Data) [SEQ 193.3] 171

5.5.7 LPUR - Loop 2420B (Line Purchase Service Provider Data) [SEQ 193.6] 176

5.5.8 LSUP - Loop 2420D (Line Supervising Provider Data) [SEQ 194] 178

5.5.9 LREF - Loop 2420F/D (Line Referring Provider Data) [SEQ 194.3] 183

5.6 Section 6 – Other Insurance Line Level Data 188

5.6.1 LCOB - Loop 2430 (COB Service Line Adjudication Data) [SEQ 195] 188

5.6.3 LCAS - Loop 2430 (COB Line Level Adjustments) [SEQ 200] 192

6 Appendix B – FSC Mapping Rules 1

6.1 TPA Clearinghouse ID 1

6.2 Site Focus Testing 2

6.3 Payer ID Switch 3

6.4 Set X12 Outbound Claim Version 6

6.5 Remove NPI from Medicare claims 7

6.6 Remove AB3 8

6.7 Remove LQ 9

6.8 Remove AAA 9

6.9 Remove 2U 10

6.10 Default Service Facility Address 11

6.11 Default Billing Address 13

6.12 Modify secondary IDs for Medicare Claims 14

6.13 Remove Other Payer Information from Claim 16

6.14 Remove Secondary IDs from Claims 17

6.15 Compare Subscriber and Patient 18

6.16 Swap Address Lines 19

7 Appendix C – FSC Default Values 1

# Introduction

This document describes the interface between a VistA system at a VA Medical Center and the Gentran system at the VA Financial Services Center in Austin, TX.

## Purpose

The purpose of this Interface Control Document (ICD) is to define the message structure and protocols which govern the interchange of data between the Integrated Billing (IB) module within a VistA system and the VA Financial Services Center (FSC) related to the electronic processing of ASC X12N/005010 Health Care Claims (837).

## Scope

This Interface Control Document specifies the interface between VistA IB and FSC. This document provides details on the functional, performance, operational and design requirements for the interface between VistA IB and FSC. This document defines the record layouts for the data that the FSC receives from VistA IB. This document is intended for all parties requiring such information, including business stakeholders, end-users, software developers, system designers, testers and anyone else responsible for implementing this interface.

## System Identification

This Interface Control Document describes the interface between VistA IB and the Gentran system at FSC.

VistA is health care system installed at VA Medical Centers. The IB module is software designed to support the creation of health care claims. This interface supports the electronic third party billing process which involves the electronic transmission of 837 Health Care claims to Emdeon, the VA’s clearinghouse, where claims are either transmitted to the insurance company or sent to a printing facility.

The Gentran system at FSC, receives the data from a VistA system at a VA Medical Center, translates the data into a standard ASC X12N/005010 Health Care Claims (837) transmission, validates whether or not the data complies with HIPAA standards and then forwards the claim data to Emdeon.

### Current Claims Process



### VistA Integrated Billing Module

|  |  |
| --- | --- |
| System | Details |
| Title | VistA Integrated Billing Module |
| Abbreviation | IB |
| Version number | 2 |
| Release number | *576* |
| Point of Contact | *Toby Rudik* |
| Vendor [optional] | n/a |

### FSC – Gentran Basic

|  |  |
| --- | --- |
| System | Details |
| Title | Gentran Basic |
| Abbreviation | n/a |
| Version number | 6.5.10 |
| Point of Contact | Jaime Manzano |
| Vendor [optional] | Sterling Commerce |

### FSC – Instream (HIPAA Validation Software)

|  |  |
| --- | --- |
| System | Details |
| Title | Instream |
| Abbreviation | n/a |
| Version number | 7.5.0 |
| Point of Contact | Jaime Manzano |
| Vendor [optional] | TIBCO Software |

## Operational Agreement

This Interface Control Document provides the specification for an interface between VistA IB and FSC regarding health care claims data. The Chief Business Office (CBO) is responsible for notifying FSC personnel of any potential or planned changes to data feeds once these changes are known in order to minimize adverse impacts.

# Interface Definition

Health care claims data is transmitted from a VistA system at a VA Medical Center to the FSC in flat files via VistA Mailman messages.

Data is also returned to the sending VistA system from the FSC in Mailman messages. Refer to the ICD document *X12 835 formats for EFT, ERA and MRA* dated May 2010.

## System Overview

The VistA IB module is designed to create claims for reimbursement from third party payers for health care services rendered to the patient by the Department of Vetren’s Affairs when the patient has private insurance or is eligible for Medicare. The IB software is part of VistA, an integrated health care system, and is able to create claims based on data received from the patient’s inpatient and/or outpatient patient record. VistA is a M system with VMS running on Windows.

Gentran is a COBOL system. It is design to receive data from a VistA IB system and to translate that data into a HIPAA compliant 837 Health Care Claim transmission.

## Interface Overview

The messages exchanged between VistA and FSC use existing VistA Mailman software which relies on existing TCP/IP connections between the two systems.

## Operations

Once an IB user authorizes a third party health care claim to a payer who is able to receive either an electronic or printed claim submission, the VistA IB module will extract the claim data and create a message that will be transmitted at a predetermined time based upon site definable parameters. The transmission times are defined in the IB Site Parameters, [IBJ MCCR SITE PARAMETERS].

A Billing Clerk can force a claims transmission if necessary by using the IB option, [IBCE 837 MANUAL TRANSMIT] though this is not normal procedure.

Whether or not a payer is able to receive claims from a HCCH is based upon the company’s agreement with the HCCH and electronic payers are defined as such in the VistA IB option, [IBCN INSURANCE CO EDIT].

Claims that cannot be transmitted to FSC are printed at the VAMC and mailed to the payer.

Claims are transmitted to FSC in batches.

## Data Transfer

Data is transferred to and from FSC using the VistA Mailman messaging system.

FSC maintains both a test queue and a production queue. These queues are defined in the IB Site Parameters, [IBJ MCCR SITE PARAMETERS].

## Transaction Types

VistA transmits an 837 Heath Care Claims transaction type. Though the messages transmitted to FSC still contain some proprietary elements which are needed by Emdeon to print claims, the message content is modeled on the ASC X12 5010 standard and contains the data elements necessary for FSC to created compliant claims transmissions to electronic payers.

## Data Exchanges

VistA transmits an 837 Health Care Claims transaction type. Refer to Section Appendix A.

Each line in the Mailman message will correspond to a record in the 837 map.

Each record will begin with the record name. Each data piece within a record will be delimited by an up caret (^). Each record will be terminated with a tilde (~).

Example:

PRV ^^CHEYENNE VAMC^2360 E PERSHING BLVD^CHEYENNE^WY^820015356^3333333333^830168494~

Each 837 Health Care Claims transmission contains a value in the GEN – General ID Data record equivalent to the IB Patch version. This value allows FSC to route incoming 837 Health Care Claim transmission through the correct translation map at FSC. This allows FSC to support VistA sites who have different versions of IB\*2 installed to operate simultaneously.

## Communications Methods

Both the FSC and the VistA VAMC systems are configured to exchange Mailman messages using TCP/IP communication.

## Performance Requirements

No performance requirements exist for the transmission of 837 Health Care Claim transmissions for VistA.

## Security

MailMan transmission between VistA sites and FSC is within the VA firewall.

# Interface Requirements

Upon authorization of a claim to an electronically active payer (Bill/Claim File #399), the VistA system shall extract the claim data and transmit it to FSC in an 837 Health Care Claim transmission, at site defined times, for processing by FSC. Refer to Section 2.3.

# Interface Verification

The data transmitted to FSC from VistA is validated in several ways:

1. Testing data will be validated by comparing what data is transmitted to FSC with what data is received by FSC
2. Testing data will be validated by comparing what data is transmitted to FSC with what data is received by Emdeon
3. Testing and Production data will be validated for HIPAA compliance by the Instream application at FSC
4. Testing and Production data will be validated for completeness before being accepted into the FSC preprocessing software.

# Appendix A – Data Elements

This is the *576* version of this document. Changes are in italicized, red text.

Fields in this document that are specified as “BLANK” will have a length of 1 leaving VistA (i.e. the nil string). However, all of this data is converted into a fixed-width file by FSC.

*A = Alpha A/N = Alpha Numeric N = Number 2 Decimals = FSC will interpret the number as having 2 implied decimal points*

## Section 1 – General Information

Section 1 occurs once per batch. This information is not repeated for each claim.

BGN - Control Data [SEQ 1]

(REQUIRED – Max length 6 bytes)

| Piece | Description | Max Length/Type | Print/VPE | FSC Processing Comments |
| --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘BGN ’ | 4 A | N/A |  |
| 2 | RECORD DELIMITER | 1 A | N/A |  |

### GEN - General ID Data [SEQ 5]

(REQUIRED – Max length 84 bytes )

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘GEN ’ | 4 A |  |  |  |
| 2 | VISTA INTERNAL CONTROL NUMBER | 10 NUM |  |  |  |
| 3 | DATE | 8 NUM CCYYMMDD | BHT04 |  |  |
| 4 | REFERENCE # | 10 NUM | BHT03 |  |  |
| 5 | SITE ID | 3 A/N |  |  |  |
| 6 | RECEIVER ID #  ENVOYH (Envoy hospital)  ENVOYP (Envoy Professional)  CHAMVA (ChampVA bills)  PARTA (MEDICARE PART A) (Institutional)  PARTB (MEDICARE PART B) (Professional) | 30 A/N | ID’s ENVOYH, ENVOYP and CHAMVH, CHAMVP |  |  |
| 7 | VERSION IDENTIFIER | 13 A/N |  |  | *576*  For testing purposes, the 11th character is “D” |

## Section 2 – Per Claim Data

Section 2 occurs once per claim.

### PRV - Loop 2010AA (Billing Provider Data) [SEQ 15]

5010: The Billing Provider Loop must be a provider facility and also the lowest enumerated NPI of the provider. Billing Provider identifiers have changed. The NPI is now the only allowed identifier in the 2010AA NM109 data element.

(REQUIRED – Max length *206*  bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PRV ’ | 4 A |  |  |  |
| *2* | *BLANK* | *1* |  |  |  |
| 3 | Billing Prov Organization Name | 30 A | 837: 2010AA NM103  Print:  CMS 1500 – Box 33 – Line 1  UB04 – FL1 – Line 1 | Biller Input: N/A  *Screen 10, Section 5 or 7*  The Billing Provider is calculated based on the division. If the division has no NPI then the parent division is used. For RX claims, the dispensing pharmacy is used.  Storage:  File – Institution (#4)  Field – BILLING FACILITY NAME (# 200) else NAME (#.01) | Maximum HIPAA length is 60.  Set NM101 = 85  NM102 =2 |
| 4 | Billing Prov Address 1 | 35 A/N | 837: 2010AA N301  Print:  CMS 1500 – Box 33 – Line 2  UB04 – FL1 – Line 2 | Biller Input: N/A  Storage: File – Institution (#4)  Field – 1.01  Field 1.01 – STREET ADDR. 1 |  |
| 5 | Billing Prov City Name | 30 A/N | 837: 2010AA N401  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL1 – Line 3 | Biller Input: N/A  Storage:  File – Institution (#4)  Field – CITY (#1.03) |  |
| 6 | Billing Prov State Code | 2 A/N | 837: 2010AA N402  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL1 – Line 3 | Biller Input: N/A  Storage:  File – Institution (#4)  Field – STATE (#.02) | Required when in US or territories. |
| 7 | Billing Prov ZIP Code | 9 N | 837: 2010AA N403  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL1 – Line 3 | Biller Input: N/A  Storage:  File – Institution (#4)  Field – ZIP (# 1.04) | Required when in US or territories. |
| 8 | Communication Number (Phone) | 20 A?N | 837: 2010AA PER04  Print:  CMS 1500 – Box 33 - Top  UB04 – FL1 – Line 4 | Biller Input: N/A  *IB Site Parameters Section 10*  The telephone number is the number defined in Section 10 of the IB Site Parameters for the Pay-to Provider for the division used for the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field - TELEPHONE NUMBER (#.04) | Set PER01 = 1C  PER03 = TE  Maximum HIPAA length is 256. |
| 9 | Billing Prov Primary ID | 17 A/N | 837: 2010AA NM109  Print:  CMS 1500 – Box 33a  UB04 – FL56 - NPI | Biller Input: N/A  This is the Billing Provider’s NPI.  Storage:  File – INSTITUTION (#4)  Field – NPI (#41.99) |  |
| *10* | *BLANK* | *1* |  |  |  |
| 11 | Billing Prov Address 2 | 30 A/N | 837: 2010AA N302  Print:  UB04 - FL1 – Line 2 | Biller Input: N/A.  Storage:  File – INSTITUTION (#4)  Field – STREET ADDR. 2 (#1.02) | .  Maximum HIPAA length increased to 55. |
| 12 | Billing Provider Primary ID Qualifier | 2 A | 837: 2010AA NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 13 | Billing Prov Taxonomy Code Qualifier | 2 A | 837: 2000A PRV01  Print:  CMS 1500 – Box 33b – Other IDs may take precedence | Biller Input: N/A  Storage: N/A  Note: Always BI |  |
| 14 | Billing Prov Taxonomy Code | 10 A/N | 837: 2000A PRV03  Print: N/A | Biller Input:  *Screen 10, Section 5* or 7  The Billing Provider Taxonomy Code will be automatically populated but a user may override the default value.  Storage:  File – INSTITUTION (#4)  Subfile: TAXONOMY (#43)  Field – TAXONONY CODE (#.01) | Set PRV02 = PXC |

### PRV1 - Loop 2010AB (Pay-To Provider (Parent VAMC) Data) [SEQ 16]

(REQUIRED – Max length *138* bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PRV1' | 4 A |  |  | . |
| 2 | Entity ID Code "87" | 2 N | 837: 2010AB NM101  Print: N/A | Biller Input: N/A  Storage: N/A | . |
| 3 | Entity Type Qualifier "2" | 1 N | 837: 2010AB NM102  Print: N/A | Biller Input: N/A  Storage: N/A | . |
| 4 | BLANK | 1 |  |  |  |
| 5 | BLANK | 1 |  |  |  |
| 6 | BLANK | 1 |  |  |  |
| 7 | Pay-To Prov Address 1 | 35 A/N | 837: 2010AB N301  Print:  CMS 1500 – Box 33 – Line 2  UB04 – FL2 - Line 2  Note: FL2 will not be populated if the Pay-to Provider information is exactly the same as the Billing Provider. | Biller Input: N/A  *Section 10*  The Pay-to Provider Address is defined in Section 10/11 of the IB Site Parameters for the Pay-to Provider for the division used as the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field – STREET ADDRESS 1 (#1.01) |  |
| 8 | Pay-To Prov Address 2 | 35 A/N | 837: 2010AB N302  Print:  CMS 1500 – Box 33 – Line 2  UB04 – FL 2 – Line 2  Note: FL2 will not be populated if the Pay-to Provider information is exactly the same as the Billing Provider. | Biller Input: N/A  *Section 10*  The Pay-to Provider Address is defined in Section 10/11 of the IB Site Parameters for the Pay-to Provider for the division used as the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field – STREET ADDRESS 2 (#1.02) | Maximum HIPAA length is 55. |
| 9 | Pay-To Prov City Name | 30 A/N | 837: 2010AB N401  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL2 – Line 3  Note: FL2 will not be populated if the Pay-to Provider information is *exactly* the same as the Billing Provider. | Biller Input: N/A  *Section 10*  The Pay-to Provider Address is defined in Section 10/11 of the IB Site Parameters for the Pay-to Provider for the division used as the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field – CITY (#1.03) |  |
| 10 | Pay-To Prov State Code | 2 A/N | 837: 2010AB N402  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL2 – Line 3  Note: FL2 will not be populated if the Pay-to Provider information is exactly the same as the Billing Provider. | Biller Input: N/A  *Section 10*  The Pay-to Provider Address is defined in Section 10/11 of the IB Site Parameters for the Pay-to Provider for the division used as the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field – STATE (#1.04) |  |
| 11 | Pay-To Prov ZIP Code | 15 N | 837: 2010AB N403  Print:  CMS 1500 – Box 33 – Line 3  UB04 – FL2 – Line 3  Note: FL2 will not be populated if the Pay-to Provider information is exactly the same as the Billing Provider. | Biller Input: N/A  *Section 10*  The Pay-to Provider Address is defined in Section 10/11 of the IB Site Parameters for the Pay-to Provider for the division used as the Billing Provider.  Storage:  File - IB SITE PARAMETERS (#350.9)  Sub-file – Pay-to Providers  Field – ZIP (#1.05) |  |

### CI1 - Loop 2010BB/BC (Current Payer Data) [SEQ 20]

(REQUIRED – Max length *174*  bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI1 ’ | 4 A |  |  |  |
| 2 | Payer Name | 30 A/N | 837:  (I) 2010BB NM103  (P) 2010BB NM103  Print:  CMS 1500 – Top of form – Line 2  UB04 – FL38 – Line 1  UB04 – FL50 | Biller Input: *Screen 3 Section 1*  The payer is added to a bill on screen 3 but the payer must already exist.  Payers are defined in Insurance Company Entry/Edit. Insurance is entered for a specific patient in Patient Insurance Info Add/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows to which insurance company the patient’s policy belongs..  Storage:  File - Insurance Company (#36)  Field – Name (#.01) | Maximum HIPAA length is 60.  Set NM101 = PR  NM102 = 2  837I Loop change from 2010BC to 2010BB |
| 3 | Payer Address 1 | 35 A/N | 837:  (I) 2010BB N301  (P) 2010BB N301  Print:  CMS 1500 – Top of form – Line 3  UB04 – FL38 – Line 2  Note: Medicare (WNR) requires no Mailing Address on Screen 3 or in the 837 | Biller Input: Screen 3 Section 3  The payer address will be pulled automatically from the Insurance Company File but a user may override the default answer. There are addresses for Mailing/Inpt/Outpt/RX/Inquiry and Appeals claims. The claim type and/or the availability of the different addresses will affect the default value.  Storage:  File - Insurance Company (#36)  Field – Address Line 1 (#.111, .121, .141, .151, .161, .181) | 837I Loop change from 2010BC to 2010BB |
| 4 | Payer City Name | 30 A/N | 837:  (I) 2010BB N301  (P) 2010BB N301  Print:  CMS 1500 – Top of form – Line 5  UB04 – FL38 – Line 3 | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – CITY (#.114, .124, .144, .154, .164, .184) | 837I Loop change from 2010BC to 2010BB |
| 5 | Payer State Code | 2 A/N | 837:  (I) 2010BB N301  (P) 2010BB N301  Print:  CMS 1500 – Top of form – Line 5  UB04 – FL38 – Line 3 | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – STATE (#.115, .125, .145, .155, .165, .185) | Required when in US or territories.  837I Loop change from 2010BC to 2010BB |
| 6 | Payer ZIP Code | 15 NUM | 837:  (I) 2010BB N301  (P) 2010BB N301  Print:  CMS 1500 – Top of form – Line 5  UB04 – FL38 – Line 3 | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – ZIP (#.116, .126, .146, .156, .166, .186) | Required when in US or territories.  837I Loop change from 2010BC to 2010BB |
| 7 | BLANK | 1 |  |  |  |
| 8 | BLANK | 1 |  |  |  |
| 9 | BLANK | 1 |  |  |  |
| 10 | Payer Address 2 | 35 A/N | 837:  (I) 2010BB N301  (P) 2010BB N301  Print:  CMS 1500 – Top of form – Line 4  UB04 – FL38 – Line 2 | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – City (#.112, .122, .142, .152, .162, .182) | 837I Loop change from 2010BC to 2010BB |
| 11 | BLANK | 1 |  |  |  |
| 12 | Insurance Type Code | 2 A/N | 837: (P) 2000B SBR05  Print:  CMS 1500 – Box 1 – Check Box  Note: VistA looks at the Electronic Plan Type of the Group Insurance Plan file (#355.3) and checks Medicare, Medicaid or TRICARE if appropriate. If not it, VistA checks the bill to see if it is reimbursable and if the rate type (#399.3) is CHAMPVA, checks the CHAMPVA box. If not, it checks the Insurance Company file (#36) to see if the Electronic Insurance Type is Group Policy and checks the Group box. VistA never checks the FECA BLK Lung box, and if none of the above conditions exist, VistA checks the Other box. | Biller Input: N/A  VistA looks at the Electronic Plan Type of the Group Insurance Plan.  Storage:  File: GROUP INSURANCE PLAN (#355.3)  Field: ELECTRONIC PLAN TYPE (#.15) |  |
| 13 | BLANK | 1 |  |  |  |
| 14 | BLANK | 1 |  |  |  |
| 15 | MRA Secondary Indicator | 1 A | 837: N/A  Print: N/A  Note: M - MRA secondary N - non-MRA secondary Blank - primary claim. | Biller Input: N/A  Storage:  File: BILL/CLAIM (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) |  |

### CI1A - Loop 2010AA (Billing Provider Secondary ID Data) [SEQ 28]

(REQUIRED – Max length *92* bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI1A ’ | 4 A |  |  |  |
| 2 | Billing Prov Sec ID Qualifier(1) | 2 A/N | 837: 2010AA REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always G5 | Non-HIPAA Emdeon requirement. |
| 3 | Billing Prov Sec ID(1)  (4 character Site/Div ID for report sorting) | 20 A/N | 837: 2010AA REF02  Print: N/A  Emdeon uses this ID to sort reports to the sites. | Biller Input: N/A  Storage:  File: INSTITUTION (#4)  Field: NAME (#.01) | See note above. Emdeon site ID |
| 4 | Billing Prov Sec ID Qualifier(2) | 2 A/N | 837: 2010AA REF01  Print:  CMS 1500 – Box 33b | Biller Input: *Screen 3 Section 2*  Biller’s may override the default value on Screen 3 Section 2  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | 837I Must be EI  837P MUST EI |
| 5 | Billing Prov Sec ID(2) | 20 A/N | 837: 2010AA REF02  Print:  CMS 1500 – Box 33b  UB04 – FL57  Note: If no Billing Provider Secondary ID is defined, VistA will use the site’s Tax ID. | Biller Input: *Screen 3 Section 2*  Billing Provider Secondary IDs are defined in Insurance Company Entry/Edit🡪Provider IDs/ID Param. They are defined by Division and Form Type. The main division can act as the default for all divisions. The qualifiers can be specifically define (i.e. 1B for BS) or set to Electronic Plan Type and the patient’s Plan Type will determine the qualifier.  The Billing Provider Secondary ID may also be setup in Insurance Company Entry/Edit to use the Attending/Rendering provider’s ID as the Billing Provider Secondary ID.  Biller’s may override the default value on Screen 3 Section 2.  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | Must be EIN for Institutional.  Must be EIN for Professional. |
| 6 | Billing Prov Sec ID Qualifier(3) | 2 A/N | 837:  (P) 2010AA REF01  (P and I) 2010BB REF01  Print: N/A | Biller Input: *Screen 3 Section 2*  Biller’s may override the default value on Screen 3 Section 2  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | 2010AA Must be 0B State license number or 1G UPIN number  2010BB Must be G2 or LU use only if PRV9 (Billing provider NPI) is null |
| 7 | Billing Prov Sec ID(3) | 20 A/N | 837: 2010AA REF02  Print:  UB04 – FL57 | Biller Input: *Screen 3 Section 2*  Additional Billing Provider Secondary IDs are defined in Insurance Company Entry/Edit🡪Provider IDs/ID Param🡪Additional IDs  Biller’s may override the default value on Screen 3 Section 2.  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | 2010BB use only if PRV9 (Billing provider NPI) is null |
| 8 | Billing Prov Sec ID Qualifier(4) | 2 A/N | 837: 2010AA REF01  Print: N/A | Biller Input: *Screen 3 Section 2*  Biller’s may override the default value on Screen 3 Section 2  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | Must be 0B State license number or 1G UPIN number  837I element deleted |
| 9 | Billing Prov Sec ID(4) | 20 A/N | 837: 2010AA REF02  Print:  UB04 – FL57 | Biller Input: *Screen 3 Section 2*  Additional Billing Provider Secondary IDs are defined in Insurance Company Entry/Edit🡪Provider IDs/ID Param🡪Additional IDs  Biller’s may override the default value on Screen 3 Section 2.  Storage:  File: FACILITY BILLING ID (#355.92)  Field: PROVIDER ID (#.07) | 837I element deleted |

### CI2 - Loop 2000B/2010BA (Subscriber Data) [SEQ 30]

(REQUIRED – Max length 151 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI2 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence | 1 A | 837: 2000B SBR01  Print: N/A | Biller Input: Screen 3 Section 1  Storage:  File: BILL/CLAIM (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Codes added to indicate sequence out to 11 payers. VHA will only use up to three payers by VHA. |
| 3 | Subscriber Last Name | 60 A/N | 837: 2010BA NM103  Print:  CMS 1500 – Box 4  Box 13 – Signature Block  UB04 – FL58 by Payer | Biller Input: N/A  Screen 3 Section 1  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) | Maximum HIPAA length is 60.  Set NM101 = IL  NM102 = 1 |
| 4 | Subscriber First Name | 35 A/N | 837: 2010BA NM104  Print:  CMS 1500 – Box 4  Box 13 – Signature Block  UB04 – FL58 by Payer | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) | Maximum HIPAA length is 35. |
| 5 | Subscriber Middle Name | 25 A/N | 837: 2010BA NM105  Print:  CMS 1500 – Box 4  Box 13 – Signature Block  UB04 – FL58 by Payer | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) |  |
| 6 | Subscriber Name Suffix | 10 A/N | 837: 2010BA NM107  Print:  CMS 1500 – Box 4  Box 13 – Signature Block  UB04 – FL58 by Payer | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#1)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) |  |
| 7 | Subscriber Birth Date | 8 N CCYYMMDD | 837: 2010BA DMG02 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 11a | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S DOB (#3.01) | If 2000B SBR02 <>18 then ignore. |
| 8 | Subscriber Gender Code | 1 A | 837: 2010BA DMG03 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 11a | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S SEX (#3.12) | If 2000B SBR02 <>18 then ignore |

### CI2A - Loop 2000B/2010BA (Subscriber Data)

(REQUIRED – Max length 183 bytes)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| 1 | RECORD ID = ‘CI2A ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence | 1 A | 837: 2000B SBR01  Print: N/A | Biller Input: Screen 3 Section 1  Storage:  File: BILL/CLAIM (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Codes added to indicate sequence out to 11 payers. VHA will only use up to three payers by VHA. |
| 3 | Subscriber Address 1 | 55 A/N | 837: 2010BA N301 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STREET 1 (#3.06) | If 2000B SBR02 <>18 then ignore |
| 4 | Subscriber Address 2 | 55 A/N | 837: 2010BA N302 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STREET 2 (#3.07) | None. If 2000B SBR02 <>18 then ignore |
| 5 | Subscriber City Name | 30 A/N | 837: 2010BA N401 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S CITY (#3.08) | If 2000B SBR02 <>18 then ignore. |
| 6 | Subscriber State Code | 2 A/N | 837: 2010BA N402 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STATE (#3.09) | If 2000B SBR02 <>18 then ignore  Required when in US or territories. |
| 7 | Subscriber ZIP Code | 9 NUM | 837: 2010BA N403 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S ZIP (#3.1) | If 2000B SBR02 <>18 then ignore  Required when in US or territories. |
| 8 | Subscriber Telephone Number | 20 A/N | 837: 2010BA PER04 If 2000B SBR02 = 18  Print:  CMS 1500 – Box 7 | Biller Input: N/A  Screen 3 Section 1  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S PHONE (#3.11) | Set PER01 = IC PER03 = TE If 2000B SBR02 <>18 then ignore  If PT2 piece 5 is not null then ignore. |

### CI3 - Loop 2000B (Subscriber Group/Employment Data) [SEQ 35]

(OPTIONAL – Max length 116 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI3 ’ | 4 A |  |  |  |
| 2 | Insured Group or Policy # | 50 A/N | 837: 2000B SBR03  Print:  CMS 1500 – Box 11  UB04 – FL62 by Payer | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  Insurance is entered for a specific patient in Patient Insurance Info View/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows the policy name and number.  Storage:  File - Insurance Company (#36)  Subfile – GROUP INSURANCE PLAN (#355.3)  Field – GROUP NAME (#.03) |  |
| 3 | Insured Group Name | 60 A/N | 837: 2000B SBR04  Print:  CMS 1500 – Box 11c  UB04 – FL61 by Payer | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  Insurance is entered for a specific patient in Patient Insurance Info Add/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows the policy name and number.  Storage:  File – GROUP INSURANCE PLAN (#355.3)  Field – GROUP NUMBER (#.04) |  |

### CI3A - Loop 2000B (Subscriber Group/Employment Data)

(OPTIONAL – Max length 155 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI3A ’ | 4 A |  |  |  |
| 2 | INSURED EMPLOYER NAME | 30 A/N | 837: 2010BE NM103  Print:  UB04 – FL65 by Payer | Biller Input: N/A  The subscriber’s employment information is added via Patient Insurance Info Add/Edit🡪Add Policy or Policy Edit/View🡪Employer Info  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER”S EMPLOYER NAME (#2.015) | Not a HIPAA data element.  HCCH UB04 printing requirement  Set NM101 = 84  NM102 = 2 |
| 3 | Claim Filing Indicator Code  (Type of Payer/Source of Pay) | 2 A | 837: 2000B SBR09  Print:  CMS 1500 – Box 1  Note: CI will be used as a default when there is no value in File 355.3. | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  Insurance is entered for a specific patient in Patient Insurance Info Add/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows the electronic type. The plan may be edited in Insurance Company Entry/Edit🡪View Plans.  Storage:  File – GROUP INSURANCE PLAN (#355.3)  Field – ELECTRONIC PLAN TYPE (#.15) | Code set update. |
| 4 | Prior Authorization # | 35 A/N | 837: 2300 REF02  Print:  CMS 1500 – Box 23  UB04 – FL63 by payer  Note: System keeps track of the payer sequence. | Biller Input: Screen 10 Section 1/2  Storage:  File: BILL/CLAIM (#399)  Field: TREATMENT AUTHORIZATION CODE (#163)  Field: SECONDARY AUTHORIZATION CODE (#230)  Field: TERTIARY AUTHORIZATION CODE (#231) | Max length is 50 |
| 5 | Payer Claim Control Number Qualifier | 2 A/N | 837: 2300 REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always F8 |  |
| 6 | Payer Claim Control Number | 50 A/N | 837: 2300 REF02  Print:  UB04 – FL64 by payer | Biller Input: Screen 10 Section 1/2  This is the ICN/DCN received in an 835 and is used with replacement claims. On secondary and tertiary claims, the number(s) will be automatically populated.  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: ICN (#.14) |  |
| 7 | Prior Authorization Qualifier | 2 A/N | 837: 2300 REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always G1 |  |
| 8 | Referral Number Qualifier | 2 A/N | 837: 2300 REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 9F |  |
| 9 | Referral Number | 20 A/N | 837: 2300 REF02  Print: N/A | Biller Input: Screen 10 Section 1/2  Storage:  File: BILL/CLAIM (#399)  Field: PRIMARY REFERRAL CODE (#253) | Max length is 50 |

### CI5 - Loop 2010BB/BC (Payer ID Data) [SEQ 37]

(REQUIRED – Max length 237 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI5 ’ | 4 A | N/A |  |  |
| 2 | Payer Primary ID Qualifier | 3 A/N | 837: 2010BB NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PI | 837I: Loop changed to 2010BB |
| 3 | Payer Primary ID (Emdeon Payer ID) | 20 A/N | 837: 2010BB NM109  Print:  UB04 – FL51 by payer  Note: This is the legacy Primary ID. \*\*It will only print if there is no HPID.*\*\** | Biller Input: N/A  *Screen 3 Section 3*  The Payer IDs are automatically entered on a bill when the user adds the insurance to the claim. Payer IDs are enter in Insurance Company Entry/Edit🡪Billing/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI ID NUMBER – PROF (#3.02)  Field: EDI ID NUMBER – INST (#3.04) | 837I: Loop changed to 2010BB. |
| 4 | Payer Secondary ID Qualifier (1) | 3 A/N | 837: 2010BB REF01  Print: N/A | Biller Input: N/A  *Screen 3 Section 3*  The Payer IDs are automatically entered on a bill when the user adds the insurance to the claim. Payer IDs are enter in Insurance Company Entry/Edit🡪Billing/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID QUAL (1) (#6.01)  Field: EDI PROF SECONDARY ID QUAL (1) (#6.05) | 837I: Loop changed to 2010BB.  Code Set Change: Allowed Values - 2U, EI, FY, NF. |
| 5 | Payer Secondary ID (1) | 30 A/N | 837: 2010BB REF02  Print: N/A | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID (1) (#6.02)  Field: EDI PROF SECONDARY ID (1) (#6.06) | 837I: Loop changed to 2010BB. |
| 6 | Payer Secondary ID Qualifier (2) | 3 A/N | 2010BB REF01 | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID QUAL (2) (#6.03)  Field: EDI PROF SECONDARY ID QUAL (2) (#6.07) | 837I: Loop changed to 2010BB.  Code Set Change: Allowed Values - 2U, EI, FY, NF. |
| 7 | Payer Secondary ID (2) | 30 A/N | 837: 2010BB REF02  Print: N/A | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID (2) (#6.04)  Field: EDI PROF SECONDARY ID (2) (#6.08) | 837I: Loop changed to 2010BB. |
| 8 | Payer ID Qualifier | 2 A/N | 837: 2010BB NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XV |  |
| 9 | Payer Primary ID (HPID) | 80 A/N | 837: 2010BB NM109  Print:  UB04 – FL51 by payer | Biller Input: N/A  Screen 3 Section 3  The Payer IDs are automatically entered on a bill when the user adds the insurance to the claim. Payer IDs are entered in Insurance Company Entry/Edit🡪Billing/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Field: TBD |  |

### CI6 - Loop 2010BA (Subscriber ID Data) [SEQ 38]

(REQUIRED – Max length 144 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CI6 ’ | 4 A |  |  |  |
| 2 | Subscriber Primary ID Qualifier | 3 A/N | 837: 2010BA NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always MI. | Usage changed to required |
| 3 | Subscriber Primary ID | 80 A/N | 837: 2010BA NM109  Print:  CMS 1500 – Box 1a  UB04 – FL60 by payer | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER ID (#11) | Usage changed to required |
| 4 | Subscriber Secondary Qualifier (1) | 3 A/N | 837: 2010BA REF01  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER’s SEC QUALIFIER(1) ID (#5.02) |  |
| 5 | Subscriber Secondary ID(1) | 50 A/N | 837: 2010BA REF02 | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER’S SEC ID(1) (#5.03) |  |

### PT1 - Loop 2000B/C 2010BA/CA (Patient Data) [SEQ 40]

If the patient has been issued a unique identification number by the payer then they are considered the subscriber and the 2010CA loop is not submitted.

(REQUIRED – Max length 255 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA/Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PT1 ’ | 4 A |  |  |  |
| 2 | Pt Relationship to Insured | 2 A/N | 837:  2000B SBR02 if equal to 18  or  2000C PAT01 if not equal to 18  Print:  CMS 1500 – Box 6  UB04 – FL59 by payer | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: PT. RELATIONSHIP - HIPAA (#4.03) | None |
| 3 | BLANK | 1 |  |  |  |
| 4 | Pt Last Name | 30 A/N | 837: 2010CA NM104  Print:  CMS 1500 – Box 2  Box 12 as signature  UB04 – FL8b | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: NAME (#.01) | Maximum HIPAA length is 60.  Set NM101 = QC  NM102 = 1 |
| 5 | Pt First Name | 20 A/N | 837: 2010CA NM104  Print:  CMS 1500 – Box 2  Box 12 as signature  UB04 – FL8b | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: NAME (#.01) | Maximum HIPAA length is 35 |
| 6 | Pt Middle Name | 25 A/N | 837: 2010CA NM104  Print:  CMS 1500 – Box 2  Box 12 as signature  UB04 – FL8b | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: NAME (#.01) |  |
| 7 | Pt Address 1 | 35 A/N | 837: 2010CA N301  Print:  CMS 1500 – Box 5  UB04 – FL9a | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: STREET ADDRESS [LINE 1] (#.111) |  |
| 8 | Pt Address 2 | 35 A/N | 837: 2010CA N302  Print:  CMS 1500 – Box 5 | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: STREET ADDRESS [LINE 2] (#.112) |  |
| 9 | Pt City Name | 30 A/N | 837: 2010CA N401  Print:  CMS 1500 – Box 5  UB04 – FL9b | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: CITY (#.114) |  |
| 10 | Pt State Code | 2 A/N | 837: 2010CA N402  Print:  CMS 1500 – Box 5  UB04 – FL9c | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: STATE (#.115) | Required when in US or territories. |
| 11 | Pt ZIP Code | 9 NUM | 837: 2010CA N403  Print:  CMS 1500 – Box 5  UB04 – FL9d | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: ZIP CODE (#.116) | Required when in  US or territories. |
| 12 | Pt Birth DT | 8 NUM CCYYMMDD | 837: 2010CA DMG02  Print:  CMS 1500 – Box 3  UB04 – FL10 | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: DATE OF BIRTH (#.03) | Set DMG01 =D8 |
| 13 | Pt Gender Code | 1 A/N | 837: 2010CA DMG03  Print:  CMS 1500 – Box 3  UB04 – FL11 | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: SEX (#.02) |  |
| 14 | BLANK | 1 |  |  |  |
| 15 | BLANK | 1 |  |  |  |
| 16 | Medical Record Number | 20 A/N | 837:  (I) 2300 REF02  Print:  CMS 1500 – N/A  UB04 – FL3b | Biller Input: N/A  This is the patient’s SSN.  Storage:  File: PATIENT (#2)  Field: SSN (#.09) | Maximum size is 50  Set REF01 = EA |
| 17 | BLANK | 1 |  |  |  |
| 18 | BLANK | 1 |  |  |  |
| 19 | BLANK | 1 |  |  |  |
| 20 | Pt Name Suffix | 10 A | 837: 2010CA NM104  Print:  CMS 1500 – Box 2  Box 12 as signature  UB04 – FL8b | Biller Input: N/A  The patient is selected by a user from the Patient file  File: PATIENT (#2)  Field: NAME (#.01) | None |

### PT2 - Loop 2000B/C 2010CA (Patient Data) [SEQ45]

The information from this segment will be mapped to the subscriber loop if the relationship is 18 otherwise it will be mapped to the patient loop.

(OPTIONAL – Max length 163 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PT2 ’ | 4 A |  |  |  |
| 2 | BLANK | 1 |  |  |  |
| 3 | Patient Telephone Number | 20 A/N | 837: 2010CA PER04  Print:  CMS 1500 – Box 5 | Biller Input: N/A  The patient is selected by a user from the Patient file  Storage:  File: PATIENT (#2)  Field: PHONE NUMBER [RESIDENCE] (#.131) | Set PER01 = IC  Set PER03 = TE  Only map if the PT2 piece 5 is null. |
| 4 | Insured or Pt Death Date | 8 NUM CCYYMMDD | 837:  (P) 2000B PAT06 or  (P) 2000C PAT06  Print: N/A | Biller Input: N/A  The patient is selected by a user from the Patient file  Storage:  File: PATIENT (#2)  Field: DATE OF DEATH(#.351) | Map to 2000B if SBR02 is 18 otherwise map to 2000C |
| 5 | Property/Casualty Claim Number Qualifier | 3 A/N | 837:  2010BA REF01 or  2010CA REF01  Print:  CMS 1500 Box 11b | Biller Input: N/A  *Screen 8 Section 2*  The qualifier Y4 is automatically added by the output formatter when a P&C number is present. | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA  Must by Y4 |
| 6 | Property/Casualty Claim Number | 30 A/N | 837:  2010BA REF02 or  2010CA REF02  Print:  CMS 1500 Box 11b | Biller Input: *Screen 8 Section 2*  Storage:  File: BILL/CLAIM (#399)  Field: PROPERTY/CASUALTY CLAIM NUMBER (#261) | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA  Max length 50. |
| 7 | Property and Casualty Contact Qualifier | 2 A | 837:  (P)2010BA PER01 or (P)2010CA PER01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always IC | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA |
| 8 | Property and Casualty Contact Name | 60 A | 837:  (P)2010BA PER02 or (P)2010CA PER02  Print: N/A | Biller Input: *Screen 8 Section 2*  *Storage:*  File: BILL/CLAIM (#399)  Field: PROPERTY/CASUALTY CONTACT NAME (#268) | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA  None |
| 9 | Property and Casualty Telephone Qualifier | 2 A | 837:  (P)2010BA PER03 or  (P)2010CA PER03  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always TE | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA |
| 10 | Property and Casualty Telephone Number | 10 N | 837:  (P)2010BA PER04 or  (P)2010CA PER04  Print: N/A | Biller Input: *Screen 8 Section 2*  Storage:  File: BILL/CLAIM (#399)  Field: PROPERTY/CASUALTY CLAIM NUMBER (#261) | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA |
| 11 | Property and Casualty Extension Qualifier | 2 A | 837:  (P)2010BA PER05 or  (P)2010CA PER05  Print: N/A | Biller Input: *N/A*  Storage: N/A  Note: Always EX | Map to 2010BA if SBR09 is 18 otherwise map to 2010CA |
| 12 | Property and Casualty Extension Number | 10 N | 837:  (P)2010BA PER06 or  (P)2010CA PER06  Print: N/A | Biller Input: *Screen 8 Section 2*  Storage:  File: BILL/CLAIM (#399)  Field: PROP/CAS EXTENSION NUMBER (#269) | Map to 2010BA if SBR02 is 18 otherwise map to 2010CA  None |

## Section 3 – Claim Level Data

Claim Level data occurs once per insurance company/claim combination. Record ID = CL1 must be present for any of the other record types to be valid.

### CL1 - Loop 2300 (Claim Level Data) [SEQ 50]

(REQUIRED – Max length 236 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CL1 ’ | 4 A |  |  |  |
| 2 | Pt Control #  (Claim Number) | 38 A/N | 837: 2300 CLM01  Print:  CMS 1500 – Box 26  UB04 – FL3a | Biller Input: N/A  The claim number is system generated when a claim is created.  Storage:  File: BILL/CLAIM (#399)  Field: BILL NUMBER (#.01) |  |
| 3 | Facility Type Code  (Location of Care - Type of Bill) | 1 A/N | 837: (I) 2300 CLM05 - 1  Print:  UB04 – FL4 | Biller Input: *Screen 6 Section 1*  The Type of Bill is made up of 3 parts: Location of Care, Bill Classification and Timeframe of Bill. Users may change this information in Section 1.  *Screen 7 Section 1*  Only the Timeframe of Bill may be changed in Section 1.  Storage:  File: BILL/CLAIM (#399)  Field: UB-04 LOCATION OF CARE (#.24) | 837I piece 3 and 4 are combined to form the CLM05-1  Set CLM05-2 to A |
| 4 | Type of Bill Classification  (Bill Classification - Type of Bill) | 1 A/N | 837: (I) 2300 CLM05 - 1  Print:  UB04 – FL4 | Biller Input: *Screen 6 Section 1*  The Type of Bill is made up of 3 parts: Location of Care, Bill Classification and Timeframe of Bill. Users may change this information in Section 1.  *Screen 7 Section 1*  Only the Timeframe of Bill may be changed in Section 1.  Storage:  File: BILL/CLAIM (#399)  Field: UB-04 BILL CLASSIFICATION (#.25) | See above |
| 5 | Claim Frequency Code  (Timeframe of Bill - Type of Bill) | 1 A/N | 837: 2300 CLM05 - 3  Print:  UB04 – FL 4 | Biller Input: *Screen 6 Section 1*  The Type of Bill is made up of 3 parts: Location of Care, Bill Classification and Timeframe of Bill. Users may change this information in Section 1.  *Screen 7 Section 1*  Only the Timeframe of Bill may be changed in Section 1.  Storage:  File: BILL/CLAIM (#399)  Field: UB-04 TIMEFRAME OF BILL (#.26) | Sent on 837P and 837I for 5010 |
| 6 | CLAIM TYPE | 2 A | 837: N/A  Print: N/A  Note: RX for CMS -1500 RX claims and MD for CMS – 1500 500 non-RX claims | Biller Input: N/A  Storage: N/A |  |
| 7 | Release of Information Code | 1 A | 837:  2300 CLM09  2320 OI06  Print:  CMS 1500 – Box 12  UB04 – FL 52 | Biller Input: *Screen 6/7 Section 2*  A biller can designate a claim as sensitive on Screen 6/7 and indicate that an ROI has been completed. Regardless, the 837 value will always = Y for Yes  Storage:  File: BILL/CLAIM (#399)  Field: R.O.I. FORM(S) COMPLETED (#157) | Add to 2320 for 837P |
| 8 | Assignment of Benefits Indicator | 1 A | 837:  2300 CLM08  2320 OI03  Print:  CMS 1500 – Box 27  UB04 – FL53 by payer | Biller Input: *Screen 6/7 Section 2*  A biller can answer YES or NO to the Assignment of Benefits prompt in Section 2 if the Assignment of Benefits is not set when the Pt’s policy is created.  Storage:  File: GROUP INSURANCE PLAN (#355.3)  Field: BENEFITS ASSIGNABLE? (#.08)  File: BILL/CLAIM (#399)  Field: ASSIGNMENT OF BENEFITS (#156) | Either Y or N |
| 9 | Bill Status | 2 A/N | 837: N/A  Print: N/A | Biller Input: N/A  If CLAIM MRA STATUS (File #399, Field 24) = 0, then 00 is sent.  If the DATE FIRST PRINTED (File 399, Field 12) is populated, then 00 is sent.  If neither of the above, then 15 is sent | N/A |
| 10 | Statement From DT | 8 N CCYYMMDD | 837:  (P) 2300 DTP03  (I) 2300 DTP03 (2)  Print:  CMS 1500 – Box 18  UB04 – FL6 | Biller Input: *Screen 6/7 Section 3*  The statement to and from dates are initially created when the bill is being created, prior to Screen 1. Users may edit the dates on Screens 6/7 Section 3.  Storage:  File: BILL/CLAIM (#399)  Field: STATEMENT COVERS FROM (#151) | 837P set DTP01 = 141 DTP 02 = D8 Non-HIPAA field HCCH print requirement  Piece 10 and 11 should be combined into one DTP with DTP01 = 434 and DTP02 = RD8 |
| 11 | Statement To DT | 8 N CCYYMMDD | 837: (I) 2300 DTP03 (2)  Print:  CMS 1500 – Box 18  UB04 – FL6 | Biller Input: *Screen 6/7 Section 3*  The statement to and from dates are initially created when the bill is being created, prior to Screen 1. Users may edit the dates on Screens 6/7 Section 3.  Storage:  File: BILL/CLAIM (#399)  Field: STATEMENT COVERS TO (#152) | See note above |
| 12 | Estimated Claim Due Amt | 18 N  2 Decimals | 837:  (I) 2300 AMT02  (P) 2300 AMT02  Print:  UB04 – FL55 | Biller Input: N/A (Calculated)  TOTAL CHARGES (File 399, Field 201) minus OFFSET AMOUNT (File 399, Field 202) = Estimated Amount Due  Storage: N/A | Non-HIPAA field  HCCH UB04 print requirements  Set AMT01 = C5 |
| 13 | Total Claim Charge Amt | 18 N  2 Decimals | 837: 2300 CLM02  Print:  CMS 1500 – Box 28  UB04 – FL47 Line 23 TOTALS | Biller Input: N/A (Calculated)  *Screen 6/7 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Field: TOTAL CHARGES (#201) |  |
| 14 | Admission/Start or Care DT | 8 N CCYYMMDD | 837:  (I) 2300 DTP03 (3)  (P) 2300 DTP03 (12)  Print:  CMS 1500 – Box 18  UB04 – FL12 | Biller Input: N/A  *Screen 4 Section 1*  Users can view the Admission Date/Time on Screen 4 but they cannot change it.  Inpatient: Admission Date (else EVENT DATE)  Storage:  File: PTF (#45)  Field: ADMISSION DATE (#2) else  Non-PTF Admission: Admission Date  Storage:  File: BILL/CLAIM (#399)  Field: NON-PTF ADMISSION DATE (#159.5)  Outpatient: Statement Covers From Date  Storage:  File: BILL/CLAIMS (#399)  Field: STATEMENT COVERS FROM (#151) | Set DTP01 = 435  DTP02 = D8 |
| 15 | Admission Time | 4 N (HHMM) | 837: (I) 2300 DTP03  Print:  UB04 – FL13 | Biller Input: N/A  *Screen 4 Section 1*  Users can view the Admission Date/Time on Screen 4 but they cannot change it  This information is extracted by the code from the information retrieved for Piece 14.  For Bill Types equal to 11X and 18X, 00 is transmitted. | If sent then combine data element with piece 14 and set DTP02 = DT. Final format of combined data element is CCYYMMDDHHMM |
| 16 | Discharge DT | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (13)  Print:  CMS 1500 – Box 18 | Biller Input: N/A  *Screen 4 Section 1*  Users can view the Discharge Date/Time on Screen 4 but they cannot change it  Inpatient: Discharge Date  Storage:  File: PTF (#45)  Field: DISCHARGE DATE (#70) else  Non-PTF Admission: Non-VA Discharge Date  Storage:  File: BILL/CLAIM (#399)  Field: NON-VA DISCHARGE DATE (#.16)  Outpatient: DISCHARGE/CHECK-OUT MOVEMENT  Storage:  File: PATIENT MOVEMENT (#405)  Field: DISCHARGE/CHECK-OUT MOVEMENT (#17) else  State Covers To Date  Storage:  File: BILL/CLAIM (#399)  Field: STATEMENT COVERS TO (#152) | Set DTP01=096  DTP02 = D8 |
| 17 | Discharge Time | 4 N (HHMM) | 837: (I) 2300 DTP03 (1)  Print:  UB04 – FL 16 | Biller Input: N/A  *Screen 4 Section 2*  Users can view the Discharge Date/Time on Screen 4 but they cannot change it  This information is extracted by the code from the information retrieved for Piece 16. Default value is 0000. | Set DTP01=096  DTP02 = TM. |
| 18 | Onset of Current Illness/Symptom DT | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (1)  Print:  CMS 1500 – Box 14 | Biller Input: *Occurrence Code*  *Screen 4 Section 6*  *Screen 5 Section 7*  *If the ONSET OF SYMPTOMS/ILLNESS occurrence code (11) and date are on claim, that date is used.*  *If the LAST MENSTRUAL PERIOD occurance code (10) and date are on the claim, that date is used.*  *If no occurrence code on the claim, then the date will not be populated.*  Storage:  File: BILL/CLAIMS (#399)  Field: EVENT DATE (#.03) | Set DTP01=431  DTP02 = D8. |
| 19 | BLANK | 1 |  |  |  |
| 20 | Last Worked DT | 8 N CCYYMMDD | 837:  (P) 2300 DTP03 (10)  Print:  CMS 1500 – Box 16 | Biller Input: *Screen 10 Section 1 (CMS 1500 Only)*  Storage:  File: BILL/CLAIM (#399)  Field: UNABLE TO WORK FROM (#166) | Set DTP01 = 297  DTP02 = D8 |
| 21 | Work Return DT | 8 N CCYYMMDD | 837:  (P) 2300 DTP03 (11)  Print:  CMS 1500 – Box 16 | Biller Input: *Screen 10 Section 1 (CMS 1500 Only)*  Storage:  File: BILL/CLAIM (#399)  Field: UNABLE TO WORK TO (#167) | DTP01 = 296  DTP02 = D8 |
| 22 | Point of origin for ADM or visit | 1 A/N | 837: (I) 2300 CL102  Print:  UB04 – FL15 | Biller Input:  *Screen 4 Section 1* (Inpatient UB04)  *Screen 10 Section 1* (UB04)  File: BILL/CLAIM (#399)  Field: SOURCE OF ADMISSION (#159) |  |
| 23 | Priority type of ADM or visit | 1 A/N | 837: (I) 2300 CL101  Print:  UB04 – FL14 | Biller Input:  *Screen 4 Section 1 (Inpatient UB04)*  *Screen 5 Section 3*  File: BILL/CLAIM (#399)  Field: TYPE OF ADMISSION (#158) |  |
| 24 | Patient Status Code | 2 A/N | 837: (I) 2300 CL103  Print:  UB04 – FL17 | Biller Input: *Screen 7 Section 1*  File: BILL/CLAIM (#399)  Field: DISCHARGE STATUS (#162) which points to:  File: MCCR UTILITY (#399.1)  Field: DISCHARGE STATUS (#.13) | Required segment for Institutional claims. Change to code value listing. |
| 25 | Last Menstrual Period DT | 8 N CCYYMMDD | 837: (P) 2300 DTP03(6)  Print:  CMS 1500 – Box 14 | Biller Input: *Occurrence Code*  *Screen 4 Section 6*  *Screen 5 Section 7*  *If the ONSET OF SYMPTOMS/ILLNESS occurrence code (11) and date are on claim, that date is used.*  *If the LAST MENSTRUAL PERIOD occurance code (10) and date are on the claim, that date is used.*  *If no occurrence code on the claim, then the date will not be populated.*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | DTP01 = 484  DTP02 = D8 |
| 26 | BLANK | 1 |  |  |  |
| 27 | BLANK | 1 |  |  |  |
| 28 | Accident/Employment/Related Causes  (Qualified by AA) | 2 A | 837: (P) 2300 CLM11 - 1  Print:  CMS 1500 – Box 10b  UB04 – FL31 - 34  Note: The qualifier is determined from the Occurrence Code | Biller Input:  *Screen 4 Section 6*  *Screen 5 Section 7*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | None |
| 29 | Accident/Employment/Related Causes  (Qualified by EM) | 2 A | 837: (P) 2300/CLM/11 - 1  Print:  CMS 1500 – Box 10a  UB04 – FL31 – 34  Note: The qualifier is determined from the Occurrence Code | Biller Input:  *Screen 4 Section 6*  *Screen 5 Section 7*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | Map to the CLM11-2 if piece 28 is not null. |
| 30 | Accident/Employment/Related Causes  (Qualified by OA) | 2 A | 837: (P) 2300 CLM11 - 1  Print:  CMS 1500 – Box 10c  UB04 – FL31 – 34  Note: The qualifier is determined from the Occurrence Code | Biller Input:  *Screen 4 Section 6*  *Screen 5 Section 7*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | Map to the CLM11-2 if piece 28 or 29 is not null. Map to CLM11-3 if piece 28 and 29 are not null. |
| 31 | Auto Accident State Code | 2 A/N | 837:  (P) 2300 CLM11 - 4  (I) 2300 REF  Print:  CMS 1500 – Box 10b  UB04 – FL29 | Biller Input:  *Screen 4 Section 6*  *Screen 5 Section 7*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: STATE (#.03) | (I)REF01 = LU |
| 32 | Provider Signature on File | 1 A | 837: 2300 CLM06  Print:  CMS 1500 – Box 31 as signature | Biller Input: N/A  Storage: N/A |  |
| 33 | Place of Service Code (Claim Level) | 10 A/N | 837: (P) 2300 CLM05-01  Print: N/A | Biller Input: *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIM (#399)  Subfile: PROCEDURES (#340)  Field: PLACE OF SERVICE (#9) | Set CLM05-02 equal to B |
| 34 | BLANK | 1 |  |  |  |
| 35 | BLANK | 1 |  |  |  |
| 36 | BLANK | 1 |  |  |  |
| 37 | BLANK | 1 |  |  |  |
| 38 | Accident DT | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (5)  Print:  CMS 1500 – Box 15 | Biller Input:  *Screen 4 Section 6*  *Screen 5 Section 7*  Storage:  File: BILL/CLAIM (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | Set DTP01 = 439  STP02 =D8 |

### CL1A - Loop 2300 (Claim Level Data) [SEQ 51]

(REQUIRED – Max length 218 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CL1A ’ | 4 A |  |  |  |
| 2 | Initial Treatment DT (Spinal) | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (2)  Print:  CMS 1500 – Box 15 | Biller Input: *Screen 10 Section 5*  *Storage:*  File: BILL/CLAIMS (#399)  Field: DATE OF INITIAL TREATMENT (#246) | Set DTP02 = D8.  DTP01 mapped from piece 10 |
| 3 | Last X-Ray DT (Spinal) | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (7)  Print:  CMS 1500 – Box 15 | Biller Input: *Screen 10 Section 5*  *Storage:*  File: BILL/CLAIMS (#399)  Field: LAST XRAY DATE (#245) | Set DTP02 = D8  DTP01 mapped from piece 11 |
| 4 | BLANK | 1 |  |  |  |
| 5 | Assignment code | 1 A | 837: 2300 CLM/07  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always A | Code list change  Applies to all payers not just Medicare |
| 6 | Mammography Certification # | 30 A/N | 837: (P) 2300 REF02 (6)  Print: N/A | Biller Input: *Screen 10 Section 4*  *Storage:*  File: BILL/CLAIMS (#399)  Field: MAMMOGRAPHY CERT NUMBER (#242) | Maximum HIPAA length is 50.  REF mapped from piece 9 |
| 7 | Patient Condition Description (Spinal) | 1 A | 837: (P) 2300 CR208  Print: N/A | Biller Input: *Screen 10 Section 5*  *Storage:*  File: BILL/CLAIMS (#399)  Field: PATIENT CONDITION CODE (#248) |  |
| 8 | Acute Manifestation DT (Spinal) | 8 N CCYYMMDD | 837: (P) 2300 DTP03 (4)  Print: N/A | Biller Input: *Screen 10 Section 5*  *Storage:*  File: BILL/CLAIMS (#399)  Field: DATE OF ACUTE MANIFESTATION (#247) | DTP01 = 453  DTP02 = D8 |
| 9 | Mammography Certification Qualifier | 2 A/N | 837: (P) 2300 REF01(6)  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always EW. |  |
| 10 | Initial Treatment DT Qualifier | 3 A/N | 837: (P) 2300 DTP01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 454. |  |
| 11 | Last X-Ray DT Qualifier | 3 A/N | 837: (P) 2300 DTP01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 455 |  |
| 12 | Acute Manifestation DT Qualifier (453) | 3 A/N | 837: (P) 2300 DTP01  Print: N/A | Biller Input: N/A  Storage: N/A |  |
| 13 | Code List Qualifier Code (DR) | 2 A/N | 837: (I) 2300 HI01 - 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DR |  |
| 14 | Industry Code  (Prospective Payment Sys. DRG)) | 10 A/N | 837: (I) 2300 HI01 – 2  Print:  UB04 – FL71 | Biller Input:  *Screen 4 Section 3*  *Screen 10 Section 1*  Storage:  File: BILL/CLAIMS (#399)  Field: PPS (#170) |  |
| 15 | Code List Qualifier Code – Admit DX | 3 A/N | 837: (I) 2300 HI02 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always BJ with ICD 9  Always ABJ with ICD 10 |  |
| 16 | Industry Code - (Admitting DX) | 10 A/N | 837: (I) 2300 HI02 – 2  Print: UB04 – FL69 | Biller Input:  *Screen 4 Section 3*  *Screen 10 Section 1*  Storage:  File: BILL/CLAIMS (#399)  Field: ADMITTING DIAGNOSIS (#215) |  |
| 17 | Code List Qualifier Code (Patient Reason for Visit) 01 | 3 A/N | 837: (I) 2300 HI02 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PR with ICD 9  Always APR with ICD 10 |  |
| 18 | Industry Code (Patient Reason for Visit 01) | 10 A/N | 837: (I) 2300 HI02 – 2  Print:  UB04 – FL70 (Box 1) | Biller Input: *Screen 10 Section 2*  Storage:  File: BILL/CLAIMS (#399)  Field: PRV DIAGNOSIS (1) (#249) | None |
| 19 | Code List Qualifier Code (Patient Reason for Visit) 02 | 3 A/N | 837: (I) 2300 HI02 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PR with ICD 9  Always APR with ICD 10 |  |
| 20 | Industry Code (Patient Reason for Visit) 02 | 10 A/N | 837: (I) 2300 HI02 – 2  Print:  UB04 – FL70 (Box 2) | Biller Input: *Screen 10 Section 2*  Storage:  File: BILL/CLAIMS (#399)  Field: PRV DIAGNOSIS (2) (#250) |  |
| 21 | Code List Qualifier Code (Patient Reason for Visit) 03 | 3 A/N | 837: (I) 2300 HI02 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PR with ICD 9  Always APR with ICD 10 |  |
| 22 | Industry Code  (Patient Reason for Visit) 03 | 10 A/N | 837: (I) 2300 HI02 – 2  Print:  UB04 – FL70 (Box 3) | Biller Input: *Screen 10 Section 2*  Storage:  File: BILL/CLAIMS (#399)  Field: PRV DIAGNOSIS (3) (#251) |  |
| 23 | Disability Date Qualifier | 3 A/N | 837: (P) 2300 DTP01(9)  Print: N/A | Biller Input: N/A  Storage: N/A | Qualifiers: 360 – Start date; 361 – End date; 314 – Disability span |
| 24 | Disability Dates | 17 A/N CCYYMMDD or CCYYMMDD-CCYYMMDD | 837: (P) 2300 DTP03(9)  Print: N/A | Biller Input: *Screen 8 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Field: DISABILITY START DATE (#263)  Field: DISABILITY END DATE (#264) | If DTP01 = 360 or 361 then DTP02=D8 and format is CCYYMMDD  If DTP01 = 314 then DTP02 = RD8 and format is CCYYMMDD-CCYYMMDD |
| 25 | Assume Care Date Qualifier | 3 A/N | 837: (P) 2300 DTP01(14)  Print: N/A | Biller Input: N/A  Storage: N/A | 90 Assume Care |
| 26 | Assume Care Date | 8 N  CCYYMMDD | 837: (P) 2300 DTP03(14)  Print: N/A | Biller Input: *Screen 8 Section 6*  Storage:  File: BILL/CLAIMS (#399)  Field: ASSUMED CARE DATE (#282) | DTP02 = D8 |
| 27 | Relinquish Care Date Qualifier | 3 A/N | 837: (P) 2300 DTP01(14)  Print: N/A | Biller Input: N/A  Storage: N/A | 91 Relinquish care |
| 28 | Relinquish Care Date | 8 N  CCYYMMDD | 837: (P) 2300 DTP03(14)  Print: N/A | Biller Input: *Screen 8 Section 6*  Storage:  File: BILL/CLAIMS (#399)  Field: RELINQUISHED CAREDATE (#283) | DTP02 = D8 |
| 29 | Property and Casualty Date Qualifier | 3 N | 837: (P) DTP01(15)  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 444 |  |
| 30 | Property and Casualty Date of First Contact | 8 N CCYYMMDD | 837: (P) 2300 DTP03(15)  Print: N/A | Biller Input: *Screen 8 Section 2*  Storage:  File: BILL/CLAIMS (#399)  Field: RELINQUISHED CARE DATE (#283) | DTP02 = D8 |

### CL1B – Loop 2300 (Claim Level Data) [SEQ 52]

(OPTIONAL – Max length 44 bytes)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| 1 | RECORD ID = ‘CL1B ’ | 4 A |  |  |  |
| 2 | Attachment Report Type | 2 A | 837: 2300 PWK01  Print:  CMS 1500 – Box 19  Note: Prints only when Rate Type = Worker’s Comp. | Biller Input: *Screen 8 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Field: ATTACHMENT REPORT TYPE (#285) | None |
| 3 | Attachment Report Transmission Code | 2 A | 837: 2300 PWK02  Print: CMS 1500 – Box 19  Note: Prints only when Rate Type = Worker’s Comp. | Biller Input: *Screen 8 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Field: ATTACHMENT REPORT TRANS CODE (#286) | None |
| 4 | Attachment Control Qualifier | 2 A | 837: 2300 PWK05  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always AC |  |
| 5 | Attachment Control Number | 30 A/N | 837: 2300 PWK06  Print: CMS 1500 – Box 19  Note: Prints only when Rate Type = Worker’s Comp. | Biller Input: *Screen 8 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Field: ATTACHMENT CONTROL NUMBER (#284) | None |

### SUB - Loop 2310C/D/E 2300 (Service Facility Data) [SEQ 55]

(OPTIONAL – Max length 210 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘SUB ‘ | 4 A |  |  |  |
| 2 | Lab/Facility Name | 30 A/N | 837:  (I) 2310E NM103  (P) 2310C NM103  Print:  CMS 1500 – Box 32 – Line 1 | Biller Input:  *Non-fee*: If the division on a claim has no NPI (i.e. mobile unit), the Billing Provider will be the parent and the mobile unit will become the Service Facility. This information is taken from the Institution file.  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: NAME (#.01)  File: BILL/CLAIMS (#399)  Field: NON-VA FACILITY (#232) | 837P Loop Change to 2310C.  NM101 mapped from SUB2 piece 2  NM102 mapped from SUB2 piece 3  HIPAA maximum length increased to 60 in 5010. |
| 3 | Lab/Facility Address 1 | 35 A/N | 837:  (P) 2310C N301  (I) 2310E N301  Print:  CMS 1500 – Box 32 – Line 2 | Biller Input: *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: STREET ADDRESS (#.05) | 837P Loop Change to 2310C. |
| 4 | Lab/Facility City | 30 A/N | 837:  (P) 2310C N401  (I) 2310E N401  Print:  CMS 1500 – Box 32 – Line 3 | Biller Input: *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: CITY (#.06) | 837P Loop Change to 2310C Required when in US or territories. |
| 5 | Lab/Facility State | 2 A/N | 837:  P) 2310C N402  (I) 2310E/N4/02  Print:  CMS 1500 – Box 32 – Line 3 | Biller Input: *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: STATE (#.07) | 837P Loop Change to 2310C Required when in US or territories. |
| 6 | Lab/Facility ZIP Code | 15 N | 837:  (P) 2310C N403  (I) 2310E N403  Print:  CMS 1500 – Box 32 – Line 3 | Biller Input: *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: ZIP CODE (#.08) | 837P Loop Change to 2310C Required when in US or territories. |
| 7 | Total Purchased Service Amt | 15 N  2 Decimals | 837: Print only  Print:  CMS 1500 – Box 20 | Biller Input: N/A  This amount is calculated from the amounts entered for each purchased line item.  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PURCHASED COST (#19) | Element deleted. Print Field |
| 8 | CLIA #  (Clinical Laboratory Improvement Amendment Number) | 10 A/N | 837:  (P) 2300 REF02  Print:  CMS 1500 – BOX 23 | Biller Input: *Screen 10 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Field: LAB CLIA NUMBER (#235)  Note: The non-VA CLIA# is stored with the non-VA Facility – SYST🡪PROV🡪NF of Provider ID Maintenance. The VA CLIA# is stored in the Institution file. | Set REF01=X4 |
| 9 | BLANK | 1 |  |  |  |
| 10 | Purchased Serv Flag  1 = FEE,NON-LAB  2 = FEE, LAB | 1 N | Note: Used by FSC to determine where to output the rendering provider information if care was rendered at other than the main facility site. | Biller Input: *Screen 10 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Field: NON-VA CARE TYPE (#233) | None |
| 11 | BLANK | 1 |  |  |  |
| 12 | Lab/Facility Address 2 | 50 A/N | 837:  (I) 2310E N302  (P)2310C N302  Print: N/A | Biller Input: *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: STREET ADDRESS LINE 2 (#.1) | 837P: Loop change to 2310C. |

### SUB2 - Loop 2310C/E (Service Facility Data) [SEQ 57]

(OPTIONAL – Max length 178 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘SUB2 ‘ | 4 A | N/A |  |  |
| 2 | Lab/Facility Entity Code | 2 A | 837:  (I) 2310E NM101  (P) 2310C/NM101  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. No matter what value a user enters for X12 TYPE OF FACILITY, 77 will be transmitted.  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: X12 TYPE OF FACILITY (#.11) | 837P: Loop change to 2310C.  837I: Code change from FA to 77. |
| 3 | Lab/Facility Entity Type Qualifier  2 = Non-Person | 1 N | 837:  (I) 2310E NM102  (P) 2310C NM102  Print: N/A | Biller Input: N/A  Storage: N/A | 837P: Loop change to 2310C. |
| 4 | BLANK | 1 |  |  |  |
| 5 | Lab/Facility Primary ID Qualifier | 2 A/N | 837:  (P) 2310C NM108  (I) 2310E NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 6 | Lab/Facility Primary ID | 20 A/N | 837:  (P) 2310C NM109  (I) 2310E NM109  Print:  CMS 1500 – Box 32a | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. The NPI becomes the Primary ID.  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: NPI (#41.01) |  |
| 7 | Lab/Facility Secondary ID Qualifier (1) | 2 A/N | 837:  (I) 2310E REF01  (P) 2310C REF01  Print:  CMS 1500 – Box 32b | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop change to 2310C.  Code set change for both 837I and P - now only 0B, LU and G2 are allowed. |
| 8 | Lab/Facility Secondary ID (1) | 20 A/N | 837:  (I) 2310E REF02  (P) 2310C REF02  Print:  CMS 1500 – Box 32b | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837P: Loop change to 2310C. |
| 9 | Lab/Facility Secondary ID Qualifier (2) | 2 A/N | 837:  (I) 2310E REF01  (P) 2310C REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop change to 2310C.  Code set change for both 837I and P - now only 0B, LU and G2 are allowed. |
| 10 | Lab/Facility Secondary ID (2) | 20 A/N | 837:  (I) 2310E REF02  (P) 2310C REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837P: Loop change to 2310C. |
| 11 | Lab/Facility Secondary ID Qualifier (3) | 2 A/N | 837:  (I) 2310E REF01  (P) 2310C REF01  Print: N/A | Biller Input:  Fee: Screen 10 Section 4  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop change to 2310C.  Code set change for both 837I and P - now only 0B, LU and G2 are allowed. |
| 12 | Lab/Facility Secondary ID (3) | 20 A/N | 837:  (I) 2310E REF02  (P) 2310C REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837P: Loop change to 2310C. |

### UB1 - Loop 2300 (Claim Level Form Data) [SEQ 60]

(OPTIONAL – Max length 212 bytes

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘UB1 ’ | 4 A |  |  |  |
| 2 | Certification Condition Indicator (Homebound) | 1 A | 837: (P) 2300 CRC02  Print: N/A | Biller Input: *Screen 8 Section 7*  Storage:  File: BILL/CLAIMS (#399)  Field: HOMEBOUND (#236) | Set CRC01 = 75 |
| 3 | Special Program Indicator | 2 A/N | 837: (P) 2300 CLM12  Print: N/A | Biller Input: *Screen 8 Section 7*  Storage:  File: BILL/CLAIMS (#399)  Field: SPECIAL PROGRAM INDICATOR (#238)  Note: Always 31 for Medicare WNR | Only codes 02, 03, 05 and 09 allowed.  Codes 01, 07 and 08 have been deleted. |
| 4 | Last Seen DT | 8 N  CCYYMMDD | 837: (P) 2300 DTP03 (3)  Print: | Biller Input: *Screen 8 Section 7*  Storage:  File: BILL/CLAIMS (#399)  Field: DATE LAST SEEN (#237) | DTP01 = 304  DTP02 = D8 |
| 5 | BLANK | 1 |  |  |  |
| 6 | BLANK | 1 |  |  |  |
| 7 | BLANK | 1 |  |  |  |
| 8 | BLANK | 1 |  |  |  |
| 9 | BLANK | 1 |  |  |  |
| 10 | BLANK | 1 |  |  |  |
| 11 | BLANK | 1 |  |  |  |
| 12 | BLANK | 1 |  |  |  |
| 13 | BLANK | 1 |  |  |  |
| 14 | BLANK | 1 |  |  |  |
| 15 | BLANK | 1 |  |  |  |
| 16 | BLANK | 1 |  |  |  |
| 17 | BLANK | 1 |  |  |  |
| 18 | BLANK | 1 |  |  |  |
| 19 | Claim Note Text | 80 A/N | 837: (P) 2300 NTE02  Print:  CMS 1500 – Box 19 | Biller Input: *Screen 10 Section 6*  Storage:  File: BILL/CLAIMS (#399)  Field: FORM LOC 19-UNSPECIFIED DATA (#459) | Set NTE01 = ADD |
| 20 | Billing Note Text Qualifier | 3 A/N | 837: (I) 2300 NTE01  Print: N/A | Biller Input: N/A  Storage: N/A | Only codes ALG, DCP, DGN, DME, MED, NTR, ODT, RHB, RLH, RNH, SET, SFM, SPT, UPI |
| 21 | Billing Note Text | 80 A/N | 837: (I) 2300 NTE02  Print:  UB04 – FL 80 | Biller Input: *Screen 10 Section 1*  Storage:  File: BILL/CLAIMS (#399)  Field: BILL REMARKS (#402) |  |

### OC1-OC12 - Loop 2300 (Occurrence Code Data) [SEQ 65]

Inpatient only - one or more records per Claim Data record set - may repeat 1-12

(OPTIONAL – Max length 17 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OC1 ’ - ‘OC12’ | 4 A |  |  |  |
| 2 | Occurrence Code DT | 8 N CCYYMMDD | 837: (I) 2300 HI01 - 4  Print:  UB04 – FL31-34 | Biller Input: *Screen 4/5 Section 6/7*  Storage:  File: BILL/CLAIMS (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | Set HI01-3 = D8 |
| 3 | OCCURRENCE CODE | 3 A/N | 837: (I) 2300 HI01 - 2  Print:  UB04 – FL31-34 | Biller Input: *Screen 4/5 Section 6/7*  Storage:  File: BILL/CLAIMS (#399)  Subfile: OCCURRENCE CODE (#41)  Field: OCCURRENCE CODE (#.01) | Set HI01-1 = BH |

### OS1-OS12 - Loop 2300 (Occurrence Span Code Data) [SEQ 70]

Inpatient only - one or more records per Claim Data record - may repeat 1-12

(OPTIONAL – *Max length 26 bytes)*

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OS1 ’ - ‘OS12’ | 4 A |  |  |  |
| 2 | Occurrence Span Code DT (From) | 8 N  CCYYMMDD | 837: (I) 2300 HI01 - 4  Print:  UB04 – FL35-36 | Biller Input: *Screen 4/5 Section 6/7*  Storage:  File: BILL/CLAIMS (#399)  Subfile: OCCURRENCE CODE (#41)  Field: DATE (#.02) | Set HI03 = RD8. |
| 3 | Occurrence Span Code DT (Through) | 8 N  CCYYMMDD | 837: (I) 2300 HI01 – 4  Print:  UB04 – FL35-36 | Biller Input: *Screen 4/5 Section 6/7*  Storage:  File: BILL/CLAIMS (#399)  Subfile: OCCURRENCE CODE (#41)  Field: END DATE (#.04) |  |
| 4 | Occurrence Span Code | 3 A/N | 837: (I) 2300 HI01 - 2  Print:  UB04 – FL35-36 | Biller Input: *Screen 4/5 Section 6/7*  Storage:  File: BILL/CLAIMS (#399)  Subfile: OCCURRENCE CODE (#41)  Field: OCCURRENCE CODE (#.01) | Set HI02 = BI |

### PC1-PC12 - Loop 2300 (Procedure Code Data) [SEQ 75]

Inpatient Only - one or more records per Claim Data record - may repeat 1-25 (1 Principal and 24 Other)

(OPTIONAL – Max length 28 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PC1 ’ - ‘PC12’ | 4 A |  |  |  |
| 2 | Procedure DT | 8 N  CCYYMMDD | 837: (I) 2300 HI01 - 4  Print:  UB04 – FL74, 74a-e | Biller Input: *Screen 4 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURE DATES (#1) | Set HI01-3 = D8 |
| 3 | Procedure Code | 10 A/N | 837: (I) 2300 HI01 - 2  Print:  UB04 – FL74, 741-e | Biller Input: *Screen 4 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURE DATES (#1) |  |
| 4 | Procedure Code Qualifier | 3 A | 837: (I) 2300 HI01 – 1  Print: N/A | Biller Input: N/A  Whether a procedure is the Principal (BR or BBR) or Other (BQ or BBQ) is determined by the order in which they are added to the claim.  Storage: N/A  Note: Always BR or BQ for ICD 9  Always BBR or BBQ for ICD 10 |  |

### SPC- Loop 2300 (Surgical Procedure Code Data) [SEQ 77]

(OPTIONAL – Max length 34 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = SPC | 4 A |  |  |  |
| 2 | Primary Surgical Procedure Code Qualifier | 3 A | 837: (P) 2300 HI01 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always BP |  |
| 3 | Primary Surgical Procedure Code | 10 A/N | 837: (P) 2300 HI01 – 2  Print: N/A | Biller Input: *Screen 8 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Field: PRIMARY SURGICAL PROC CODE (#266) |  |
| 4 | Secondary Surgical Procedure Code Qualifier | 3 A | 837: (P) 2300 H201 – 1  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always BO |  |
| 5 | Secondary Surgical Procedure Code | 10 A/N | 837: (P) 2300 H201 – 2  Print: N/A | Biller Input: *Screen 8 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Field: SECONDARY SURGICAL PROC CODE (#267) |  |

### VC1-VC12 - Loop 2300 (Value Code Data) [SEQ 80]

Inpatient Only - one or more records per Claim Data record set - may repeat 1-12

(OPTIONAL – Max length 18 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘VC1 ’ - ‘VC12’ | 4 A |  |  |  |
| 2 | VALUE CODE | 3 A/N | 837: (I) 2300 HI01 - 2  Print:  UB04 – FL39-41a-d Section 1 | Biller Input: *Screen 4 Section 8*  Storage:  File: BILL/CLAIMS (#399)  Subfile: VALUE CODE (#47)  Field: VALUE CODE (#.01) | Set HI101 -1 = BE. |
| 3 | Value Code Associated Amt | 9 N  2 Decimals | 837: (I) 2300 HI01 - 5  Print:  UB04 – FL39-41a-d Section 2 | Biller Input: *Screen 4 Section 8*  Storage:  File: BILL/CLAIMS (#399)  Subfile: VALUE CODE (#47)  Field: VALUE (#.02) |  |

### CC1-CC12 - Loop 2300 (Condition Code Data) [SEQ 85]

(OPTIONAL – Max length *7* bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CC1 ’ - ‘CC12’ | 4 A |  |  |  |
| 2 | CONDITION CODE | 2 A/N | 837:  (I) 2300 HI01- 2  (P) 2300 HI01- 2  Print:  UB04 – FL 18-28 | Biller Input: Screen 4/5 Section 7/8  Storage:  File: BILL/CLAIMS (#399)  Subfile: CONDITION CODE (#40)  Field: CONDITION CODE (#.01) | Set HI01-1 to BG. |

### DC1-DC12 - Loop 2300 (Diagnosis Code Data) [SEQ 90]

One or more records per Claim Data record set

UB-04 claims can have 1 principle DX, 24 other DXs, and 12 External Cause of Injury DXs.

CMS-1500 claims can have 12 DXs.

(OPTIONAL – Max length 21 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘DC1 ’ - ‘DC12’ | 4 A |  |  |  |
| 2 | DIAGNOSIS CODE | 10 A/N | 837:  2300 HI01 – 2  (I) 2300 HI03 – 2  Print:  CMS 1500 – Box 21A-L  UB04 – FL 67, 67A-Q  UB04 – FL 72a-c | Biller Input: *Screen 4/5 Section 3/2*  Users may add diagnoses to a claim from Screen 4/5. The order of the diagnoses determines default value for Admission Dx.  Storage:  File: IB BILL/CLAIMS DIAGNOSIS (#362.3)  Field: DIAGNOSIS (#.01) |  |
| 3 | Code List Qualifier Code | 3 A/N | 837:  2300 HI01 – 1 (BK, BF)  (I) 2300 HI03 – 1 (BN)  Print: N/A | Biller Input: N/A  Users may add diagnoses to a claim from Screen 4/5. The qualifiers will be automatically assigned based on order and whether the code is an E-code.  Storage: N/A | May be BK, BF or BN for ICD -9  May be ABK, ABF, and ABN for ICD-10 |
| 4 | Present on Admission Indicator | 1 A/N | 837:  (I) 2300 HI01-9  Print:  UB04 – FL67A-Q  UB04 – FL72a-c | Biller Input: *Screen 4 Section 3*  Users enter the POA indicator for inpatient claims.  Storage:  File: IB BILL/CLAIMS DIAGNOSIS (#362.3)  Field: POA INDICATOR (#.04) | None |

### OPR - Loop 2310A/B/C (Att/Other Oper/Oper Physician/Provider Data) [SEQ 96]

One record per Claim Data record set

(OPTIONAL – Max length 234 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR ’ | 4 A |  |  |  |
| 2 | Attending Prov Last Name | 20 A/N | 837: (I) 2310A NM103  Print:  CMS 1500 – Box 31 as signature  UB04 – FL76 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length increased to 60.  (I)Set NM101 = 71 NM102 = 1  837P moved to OPR9 record |
| 3 | Attending Prov First Name | 20 A/N | 837: (I) 2310A NM104  Print:  CMS 1500 – Box 31 as signature  UB04 – FL76 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length increased to 35.  837P moved to OPR9 record |
| 4 | Attending Prov Name Suffix | 10 A/N | 837: (I) 2310A NM107  Print:  CMS 1500 – Box 31 as signature  UB04 – FL76 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | 837P moved to OPR9 record |
| 5 | BLANK | 1 |  |  | Moved to OPR piece 17 |
| 6 | Other Operating Prov Last Name | 20 A/N | 837: (I) 2310C NM103  Print:  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Set NM101 = ZZ  NM102 = 1 |
| 7 | Other Operating Prov First Name | 20 A/N | 837: (I) 2310C NM104  Print:  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 8 | Other Operating Prov Name Suffix | 10 A/N | 837: (I) 2310C NM107  Print:  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 9 | Operating Phy Last Name | 20 A/N | 837: (I) 2310B NM103  Print:  UB04 – FL77 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Set NM101 = 72  NM102 = 1 |
| 10 | Operating Phy First Name | 20 A/N | 837: (I) 2310B NM104  Print:  UB04 – FL77 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length increased to 35. |
| 11 | Operating Phy Name Suffix | 10 A/N | 837: (I) 2310B NM107  Print:  UB04 – FL77 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 12 | BLANK | 1 |  |  |  |
| 13 | Referring Prov Last Name | 20 A/N | 837:  (P) 2310A NM103  (I) 2310F NM103  Print:  CMS 1500 – Box 17  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length is 60.  Set NM101 = DN  NM102 = 1 |
| 14 | Referring Prov First Name | 20 A/N | 837:  (P) 2310A NM104  (I) 2310F NM104  Print:  CMS 1500 – Box 17  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length is 35. |
| 15 | Referring Prov Name Suffix | 10 A/N | 837:  (P) 2310A NM107  (I) 2310F NM107  Print:  CMS 1500 – Box 17  UB04 – FL78-79 | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 16 | Attending Prov Taxonomy Qualifier | 2 A/N | 837: (I)2310A PRV01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always AT | 837P moved to OPR9 record |
| 17 | Attending Prov Taxonomy | 10 A/N | 837: (I)2310A PRV03  Print: N/A | Biller Input: *Screen 10 Section 3*  The physician’s taxonomy code is defaulted from the New Person🡪Person Class file but may be overridden by the biller.  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: TAXONOMY (#.15) | Set PRV02 = PXC.  837P moved to OPR9 record |

### OPR1 - Loop 2310A/B (Att/Other Oper/Oper Physician/Provider Data) [SEQ 97]

One record per Claim Data record

(OPTIONAL – Max length 74 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR1’ | 4 A |  |  |  |
| 2 | Attending Prov Primary ID Qualifier | 2 A/N | 837: (I) 2310A NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX | 837P moved to OPR9 record |
| 3 | Attending Prov Primary ID | 10 A/N | 837: (I) 2310A NM109  Print:  UB04 – FL76 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) | 837P moved to OPR9 record |
| 4 | Attending Prov Entity Type Qualifier | 1 A/N | 837:  (I) 2310A NM102  (P) 2310B NM102  Print: N/A | Biller Input: N/A  Storage: N/A | 837I Code 2 deleted only 1 = Person allowed |
| 5 | Other Operating Prov Primary ID Qualifier | 2 A/N | 837: (I) 2310C NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX | Name changed from Other Provider to Other Operating Providers.  Usage only allowed when an Operating Provider is specified in 2310B. |
| 6 | Other Operating Provider Primary ID | 10 A/N | 837: (I) 2310C NM109  Print:  UB04 – FL78 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) | Name changed from Other Provider to Other Operating Providers.  Usage only allowed when an Operating Provider is specified in 2310B. |
| 7 | Other Operating Prov Entity Type Qualifier | 1 A/N | 837: (I) 2310C NM102  Print: N/A | Biller Input: N/A  Storage: N/A | Usage only allowed when an Operating Provider is specified in 2310B. 837I Code 2 deleted only 1 = Person allowed. Usage changed to situational. |
| 8 | Operating Phy Primary ID Qualifier | 2 A/N | 837: (I) 2310B NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Operating Phy Primary ID | 10 A/N | 837: (I) 2310B NM109  Print:  UB04 – FL77 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Rend Prov Credentials | 3 A/N | 837: (P) 2310B NM106  Print:  CMS 1500 – Box 31  Note: Used for printing if HCCH needs to drop the claim to print. | Biller Input: *Screen 10 Section 3*  The biller can add a provider to a claim but the provider’s credentials come from the New Person file🡪Provider Class. The biller can override the default credentials.  Storage:  File: BILL/CLAIM (#399)  Subfile: PROVIDER (#222)  Field: CREDENTIALS (#.03) | Not a HIPAA data element.  HCCH printing requirements. |
| 11 | Referring Prov Primary ID Qualifier | 2 A/N | 837:  (P)2310A NM108  (I)2310F NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 12 | Referring Provider Primary ID | 10 A/N | 837:  (P) 2310A NM109  (I) 2310F NM109  Print:  CMS 1500 – Box 17b  UB04 – FL78 - 79 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 13 | BLANK | 1 |  |  |  |
| 14 | Referring Prov Entity Type Qualifier | 1 A/N | 837:  (P) 2310A NM102  (I)2310F NM102  Print: N/A | Biller Input: N/A  Storage: N/A | None |
| 15 | Operating Phy Entity Type Qualifier | 1 A/N | 837: (I) 2310B NM102  Print: N/A | Biller Input: N/A  Storage: N/A | 837I Code 2 deleted only 1 = Person allowed. |

### OPR2 - Loop 2310A (Attending Provider Secondary ID Data) [SEQ 98]

One record per Claim Data record

(OPTIONAL – Max length 140 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR2 ’ | 4 A |  |  |  |
| 2 | Attending Prov Secondary ID Qualifier (1) | 2 A/N | 837: (I) 2310A REF01  Print:  UB04 – FL76  Note: G2 or 1G ID used if no ID provided by the Insurance Company is found | Biller Input: *Screen 10 Section 3*  When a user adds a provider to a claim, they will be given an opportunity to enter one secondary ID. The secondary IDs are defined in Provider ID Maintenance. An ID can belong to the provider or it can be assigned to the provider by the payer.  VistA will extract up to the maximum number of provider secondary IDs into the 837.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU.  Professional rendering information move to OPRA |
| 3 | Attending Prov Secondary ID (1) | 30 A/N | 837: (I) 2310A REF01  Print:  UB04 – FL76  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  When a user adds a provider to a claim, they will be given an opportunity to enter one secondary ID. The secondary IDs are defined in Provider ID Maintenance. An ID can belong to the provider or it can be assigned to the provider by the payer.  VistA will extract up to the maximum number of provider secondary IDs into the 837.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Professional rendering information move to OPRA |
| 4 | Attending Prov Sec ID Qualifier (2) | 2 A/N | 837: (I) 2310A REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU.  Professional rendering information move to OPRA |
| 5 | Attending Prov Sec ID (2) | 30 A/N | 837: (I) 2310A REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Professional rendering information move to OPRA |
| 6 | Attending Prov Sec ID Qualifier (3) | 2 A/N | 837: (I) 2310A REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU  Professional rendering information move to OPRA. |
| 7 | Attending Prov Sec ID (3) | 30 A/N | 837: (I) 2310A REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Professional rendering information move to OPRA |
| 8 | Attending Prov Sec ID Qualifier (4) | 2 A/N | 837: (I) 2310A REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU  Professional rendering information move to OPRA |
| 9 | Attending Prov Sec ID (4) | 30 A/N | 837:  (I) 2310A REF02  (P) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Professional Rendering information move to OPRA |

### OPR3 - Loop 2310B (Operating Physician Secondary ID Data) [SEQ 99]

One record per Claim Data record

(Optional – Max length 141 bytes)

| Piece | Description | Max Length Data Type | 835/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR3 ’ | 4 A |  |  |  |
| 2 | Operating Phy Sec ID Qualifier (1) | 2 A/N | 837: (I) 2310B REF01  Print:  UB04 – FL77  Note: G2 or 1G ID used if no ID provided by the Insurance Company is found | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 3 | Operating Phy Sec ID (1) | 30 A/N | 837: (I) 2310B REF02  Print:  UB04 – FL77  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  When a user adds a provider to a claim, they will be given an opportunity to enter one secondary ID. The secondary IDs are defined in Provider ID Maintenance. An ID can belong to the provider or it can be assigned to the provider by the payer.  VistA will extract up to the maximum number of provider secondary IDs into the 837.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) |  |
| 4 | Operating Phy Sec ID Qualifier (2) | 2 A/N | 837: (I) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 5 | Operating Phy Sec ID (2) | 30 A/N | 837: (I) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) |  |
| 6 | Operating Phy Sec ID Qualifier (3) | 2 A/N | 837: (I) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 7 | Operating Phy Sec ID (3) | 30 A/N | 837: (I) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) |  |
| 8 | Operating Phy Sec ID Qualifier (4) | 2 A/N | 837: (I) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 9 | Operating Phy Sec ID (4) | 30 A/N | 837: (I) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) |  |

### OPR4 - Loop 2310C (Other Operating Provider Secondary ID Data) [SEQ 100]

One record per Claim Data record

(Optional – Max length 141 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR4 ’ | 4 A |  |  |  |
| 2 | Other Operating Prov Sec ID Qualifier (1) | 2 A/N | 837: (I) 2310C REF01  Print:  UB04 – FL78  Note: G2 or 1G ID used if no ID provided by the Insurance Company is found | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 3 | Other Operating Prov Sec ID (1) | 30 A/N | 837: (I) 2310C REF02  Print:  UB04 – FL78  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |
| 4 | Other Operating Prov Sec ID Qualifier (2) | 2 A/N | 837: (I) 2310C REF01  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 5 | Other Operating Prov Sec ID (2) | 30 A/N | 837: (I) 2310C REF02  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |
| 6 | Other Operating Prov Sec ID Qualifier (3) | 2 A/N | 837: (I) 2310C REF01  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 7 | Other Operating Prov Sec ID (3) | 30 A/N | 837: (I) 2310C REF02  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |
| 8 | Other Operating Prov Sec ID Qualifier (4) | 2 A/N | 837: (I) 2310C REF01  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 9 | Other Operating Prov Sec ID (4) | 30 A/N | 837: (I) 2310C REF02  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in FL78. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |

### OPR5 - Loop 2310A (Referring Provider Secondary ID Data) [SEQ 101]

One record per Claim Data record

(OPTIONAL – Max length 107 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR5 ’ | 4 A |  |  |  |
| 2 | Referring Prov Sec ID Qualifier (1) | 2 A/N | 837:  (P) 2310A REF01  (I) 2310F REF01  Print:  CMS 1500 – Box 17a  UB04 – FL78/79 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G and G2. |
| 3 | Referring Prov Sec ID (1) | 30 A/N | 837:  (P) 2310A REF02  (I) 2310F REF02  Print:  CMS 1500 – Box 17a  UB04 – FL78/79  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in Box 19/FL78/79 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |
| 4 | Referring Prov Sec ID Qualifier (2) | 2 A/N | 837:  (P) 2310A REF01  (I) 2310F REF01  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in Box 19/FL78/79 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G and G2. |
| 5 | Referring Prov Sec ID (2) | 30 A/N | 837:  (P) 2310A REF02  (I) 2310F REF02  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in Box 19/FL78/79 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | None |
| 6 | Referring Prov Sec ID Qualifier (3) | 2 A/N |  | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G and G2. |
| 7 | Referring Prov Sec ID (3) | 30 A/N | 837:  (P) 2310A REF02  (I) 2310F REF01  Print: N/A  Note: The software looks for the first compliant secondary ID to print. Only one Secondary ID prints in Box 19/FL78/79 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

### OPR7 - Loop 2310E (Supervising Provider Data) [SEQ 103]

One record per Claim Data record

(OPTIONAL – Max length 137 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR7’ | 4 A | N/A |  |  |
| 2 | Supervising Prov Last Name | 35 A/N | 837: (P) 2310D NM103  Print: N/A | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | 837P: Loop Change to 2310D.  Maximum HIPAA length increased to 60  Set NM101 = DQ  NM102 = 1. |
| 3 | Supervising Prov First Name | 25 A/N | 837: (P) 2310D NM104  Print: N/A | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | 837P: Loop Change to 2310D.  Maximum HIPAA length increased to 35. |
| 4 | Supervising Prov Middle Name | 25 A/N | 837: (P) 2310D NM105  Print: N/A | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | 837P: Loop Change to 2310D. |
| 5 | Supervising Prov Name Suffix | 10 A/N | 837: (P) 2310D NM107  Print: N/A | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | 837P: Loop Change to 2310D. |
| 6 | Supervising Prov Primary ID Qualifier | 2 A | 837: (P) 2310D NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX | 837P: Loop Change from to 2310D. |
| 7 | Supervising Provider Primary ID | 30 A/N | 837: (P) 2310D NM109  Print: N/A | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) | 837P: Loop Change to 2310D. |

### OPR8 - Loop 2310E (Supervising Provider Secondary ID Data) [SEQ 104]

One record per Claim Data record

(OPTIONAL – Max length 104 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR8’ | 4 A | N/A |  |  |
| 2 | Supervising Prov Sec ID Qualifier (1) | 2 A/N | 837:  (P) 2310D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU.  837P: Loop Change to 2310D. |
| 3 | Supervising Prov Sec ID (1) | 30 A/N | 837: (P) 2310D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2310D. |
| 4 | Supervising Prov Sec ID Qualifier (2) | 2 A/N | 837: (P) 2310D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop Change to 2310D.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 5 | Supervising Prov Sec ID (2) | 30 A/N | 837: (P) 2310D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2310D. |
| 6 | Supervising Prov Sec ID Qualifier (3) | 2 A/N | 837: (P) 2310D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU.  837P: Loop Change to 2310D. |
| 7 | Supervising Prov Sec ID (3) | 30 A/N | 837: (P) 2310D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2310D. |
| 8 | Supervising Prov Sec ID Qualifier (4) | 2 A/N | 837: (P) 2310D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU.  837P: Loop Change to 2310D. |
| 9 | Supervising Prov Sec ID (4) | 30 A/N | 837: (P) 2310D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2310D. |

### OPR9 – Loop 2310B/2310D (Rendering Provider Data) [SEQ 104.5]

One record per Claim Data record

(OPTIONAL – Max length 156 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPR9’ | 4 A | N/A |  |  |
| 2 | Rendering Provider Qualifier | 2 N | 837:  (I) 2310D NM101  (P)2310B NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 82 |  |
| 3 | Rendering Provider Type | 1 N | 837:  (I) 2310D NM102  (P)2310B NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 |  |
| 4 | Rendering Provider Last Name | 35 A/N | 837:  (I) 2310D NM103  (P)2310B NM103  Print:  CMS 1500 – Box 31 as signature | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 5 | Rendering Provider First Name | 25 A/N | 837:  (I) 2310D NM104  (P) 2310B NM104  Print:  CMS 1500 – Box 31 as signature | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) | Maximum HIPAA length increased to 35. |
| 6 | Rendering Provider Middle Name | 25 A/N | 837:  (I) 2310D NM105  (P) 2310B NM105  Print:  CMS 1500 – Box 31 as signature | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 7 | Rendering Provider Name Suffix | 10 A/N | 837:  (I) 2310D NM107  (P) 2310B NM107  Print:  CMS 1500 – Box 31 as signature | Biller Input: *Screen 10 Section 3*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: PERFORMED BY (#.02) |  |
| 8 | Rendering Provider Primary ID Qualifier | 2 A | 837:  (I) 2310D NM108  (P) 2310B NM108  Print: Preprinted | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Rendering Provider Primary ID | 30 A/N | 837:  (I) 2310D NM109  (P) 2310B NM109  Print:  CMS 1500 – Box 24J  UB04 – FL78/79 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Rend Prov Taxonomy Qualifier | 2 A/N | 837: (P)2310B PRV01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PE | 837I not used for rendering provider |
| 11 | Rend Prov Taxonomy | 10 A/N | 837: (P)2310B PRV03  Print: N/A | Biller Input: *Screen 10 Section 3*  The physician’s taxonomy code is defaulted from the New Person file but may be overridden by the biller.  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: TAXONOMY (#.15) | Set PRV02 = PXC.  837I not used for rendering provider |

### OPRA – Loop 2310B/2310D (Rendering Provider Secondary ID) [SEQ 104.4]

One record per Claim Data record

(OPTIONAL – Max length 140 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OPRA’ | 4 A | N/A |  |  |
| 2 | Rendering Provider Sec ID Qualifier (1) | 2 A | 837:  (I) 2310D REF01  (P) 2310B REF01  Print:  CMS 1500 – Box 24I, 1-6  Note: The software looks for the first compliant secondary ID to print. | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) |  |
| 3 | Rendering Provider Sec ID (1) | 30 A/N | 837:  (I) 2310D REF02  (P) 2310B REF02  Print:  CMS 1500 – Box 24J, 1-6 | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 4 | Rendering Provider Sec ID Qualifier (2) | 2 A | 837:  (I) 2310D REF01  (P) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) |  |
| 5 | Rendering Provider Sec ID (2) | 30 A/N | 837:  (I) 2310D REF02  (P) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 6 | Rendering Provider Sec ID Qualifier (3) | 2 A | 837:  (I) 2310D REF01  (P) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) |  |
| 7 | Rendering Provider Sec ID (3) | 30 A/N | 837:  (I) 2310D REF02  (P) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 8 | Rendering Provider Sec ID Qualifier (4) | 2 A | 837:  (I) 2310D REF01  (P) 2310B REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) |  |
| 9 | Rendering Provider Sec ID (4) | 30 A/N | 837:  (I) 2310D REF02  (P) 2310B REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

### AMB - Loop 2310E/F (Ambulance Pick-up / Drop-off) [SEQ 104.8]

Repeat x 2: Ambulance pick-up is sent in the 2310E while drop-off is in the 2310F. When sending both data elements the pickup location should be first.

(Optional – Max length 190 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘AMB’ | 4 A |  |  |  |
| 2 | Address Type Qualifier | 2 A/N | 837:  P)2310E / 2310F NM101  Print: N/A | Biller Input: N/A  *Screen 9 Section 1*  The system adds the Qualifier automatically. | Equal to PW for pick up or  45 for Drop off  Set NM102 = 2 |
| 3 | Ambulance Address Line 1 | 40 A/N | 837:  (P)2310E /2310F N301  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U ADDRESS 1 (#271)  Field: AMBULANCE D/O ADDRESS 1 (#277) |  |
| 4 | Ambulance Address Line 2 | 30 A/N | 837:  (P) 2310E /2310F N302  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U ADDRESS 2 (#272)  Field: AMBULANCE D/O ADDRESS 2 (#278) |  |
| 5 | Ambulance City | 30 A/N | 837:  (P) 2310E 2310F N401  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U CITY (#273)  Field: AMBULANCE D/O CITY (#279) | None |
| 6 | Ambulance State | 2 A | 837:  (P) 2310E / 2310F N402  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U STATE (#274)  Field: AMBULANCE D/O STATE (#280) | None |
| 7 | Ambulance Zip | 15 A/N | 837: (P) 2310E / 2310F N403  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U ZIP (#275)  Field: AMBULANCE D/O ZIP (#281) | None |
| 8 | Ambulance Drop Off Location | 60 A/N | 837: (P) 2310F NM103  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE P/U D/O LOCATION (#276) | Only used when NM101 = 45 |

Note: Currently the pick-up record is sequence 104.8 and the drop-off record is sequence 104.9. The two AMB records will be merged into one and will be controlled by field 2.

### AMB1 - Loop 2310E/F (Ambulance Pick-up / Drop-off) [SEQ 104.9]

Repeat x 1

(Optional – Max length 194 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘AMB1’ | 4 A |  |  |  |
| 2 | Amb Patient Weight Units | 2 A | 837: (P) 2300 CR101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always LB |  |
| 3 | Amb Patient Weight | 3 N | 837: (P) 2300 CR102  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: PATIENT WEIGHT (#287) |  |
| 4 | Amb Transport Reason Code | 1 A/N | 837: (P) 2300 CR104  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: TRANSPORT REASON CODE (#288) |  |
| 5 | Amb Distance Units | 2 A | 837: (P) 2300 CR105  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DH |  |
| 6 | Amb Transport Distance | 15 N | 837: (P) 2300 CR106  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: AMBULANCE TRANSPORT DISTANCE (#289) |  |
| 7 | Amb Round Trip Purpose | 80 A/N | 837: (P) 2300 CR109  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: ROUND TRIP PURPOSE DESCRIPTION (#290) |  |
| 8 | Amb Stretcher Purpose | 80 A/N | 837: (P) 2300 CR110  Print: N/A | Biller Input: *Screen 9 Section 1*  Storage:  File: Bill/Claims (#399)  Field: STRETCHER PURPOSE DESCRIPTION (#291) |  |

### AMB2 - Loop 2300 (Ambulance Certification Data) [SEQ 104.91]

Repeat x 3

(Optional – Max length 36 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘AMB2’ | 4 A |  |  |  |
| 2 | Amb Code Category | 2 N | 837: (P) 2300 CRC01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 07 |  |
| 3 | Amb Certification Condition Indicator | 1 A | 837: (P) 2300 CRC02  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always Y for YES |  |
| 4 | Amb Condition Code [1] | 3 A/N | 837: (P) 2300 CRC03  Print: N/A | Biller Input: *Screen 9 Section 2*  Storage:  File: Bill/Claims (#399)  Subfile: AMBULANCE CONDITION INDICATOR (#292)  Field: AMBULANCE CONDITION INDICATOR (#.01) |  |
| 5 | Amb Condition Code [2] | 3 A/N | 837: (P) 2300 CRC04  Print: N/A | Biller Input: *Screen 9 Section 2*  Storage:  File: Bill/Claims (#399)  Subfile: AMBULANCE CONDITION INDICATOR (#292)  Field: AMBULANCE CONDITION INDICATOR (#.01) |  |
| 6 | Amb Condition Code [3] | 3 A/N | 837: (P) 2300 CRC05  Print: N/A | Biller Input: *Screen 9 Section 2*  Storage:  File: Bill/Claims (#399)  Subfile: AMBULANCE CONDITION INDICATOR (#292)  Field: AMBULANCE CONDITION INDICATOR (#.01) |  |
| 7 | Amb Condition Code [4] | 3 A/N | 837: (P) 2300 CRC06  Print: N/A | Biller Input: *Screen 9 Section 2*  Storage:  File: Bill/Claims (#399)  Subfile: AMBULANCE CONDITION INDICATOR (#292)  Field: AMBULANCE CONDITION INDICATOR (#.01) |  |
| 8 | Amb Condition Code [5] | 3 A/N | 837: (P) 2300 CRC07  Print: N/A | Biller Input: *Screen 9 Section 2*  Storage:  File: Bill/Claims (#399)  Subfile: AMBULANCE CONDITION INDICATOR (#292)  Field: AMBULANCE CONDITION INDICATOR (#.01) |  |

## Section 4 – Other Insurance Data

### OI1 - Loop 2320/2330B (Other Subscriber and Other Payer Data) [SEQ 105]

One or more records per Claim Data record set

(OPTIONAL – Max length 165 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI1 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: 2320 SBR01  Print: N/A | Biller Input: Screen 3 Section 1  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Codes added to indicate sequence out to 11 payers. VA will only use Primary (P), Secondary (S) ,Tertiary (T) |
| 3 | Individual Relationship Code | 2 A/N | 837: 2320 SBR02  Print:  CMS 1500 – Box 6  UB04 – FL59 | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  The Patient’s Relationship to Insured is selected when the patient’s insurance policy is enter in Patient Insurance Info View/Edit.  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: PT. RELATIONSHIP TO INSURED (#16) | Code list now only includes 01, 18, 19, 20, 21, 39, 40, 53 and G8. |
| 4 | Other Group or Policy # | 50 A/N | 837: 2320 SBR03  Print:  CMS 1500 – Box 9a  UB04 – FL62 | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  Insurance is entered for a specific patient in Patient Insurance Info View/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows the policy name and number.  Storage:  File – GROUP INSURANCE PLAN (#355.3)  Field – GROUP NUMBER (#.04) | Maximum HIPAA length increased to 50. |
| 5 | Other Group or Policy Name | 60 A/N | 837: 2320 SBR04  Print:  CMS 1500 – Box 9d  UB04 – FL61 | Biller Input: Screen 3 Section 1  The policy is added to a bill on screen 3 but the payer must already exist.  Insurance is entered for a specific patient in Patient Insurance Info View/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows the policy name and number.  Storage:  File - Insurance Company (#36)  Subfile – GROUP INSURANCE PLAN (#355.3)  Field – GROUP NAME (#.03) |  |
| 6 | Other Payer Last or Organization Name | 35 A/N | 837: 2330B NM103  Print:  CMS 1500 – Box 9d  UB04 – FL50 | Biller Input: Screen 3 Section 1  The payer is added to a bill on screen 3 but the payer must already exist.  Payers are defined in Insurance Company Entry/Edit. Insurance is entered for a specific patient in Patient Insurance Info View/Edit. Once the insurance policy exists for a patient, it may be added to a bill and the system knows to which insurance company the patient’s policy belongs..  Storage:  File - Insurance Company (#36)  Field – Name (#.01) | Maximum HIPAA length increased to 60.  Set NM101 = PR  NM102 =2 |
| 7 | Claim Filing Indicator (Type of Payer) | 2 A/N | 837: 2320 SBR09  Print: N/A | Biller Input: N/A  VistA looks at the Electronic Plan Type of the Group Insurance Plan.  If Medicare and CMS-1500 = MB  If Medicare and UB04 = MA  If Electronic Plan Type is blank = CI  If Electronic Plan Type is MX and Plan Category contains A = MA  If Electronic Plan Type is MX and Plan Category contains B = MB  If Electronic Plan Type is MX and Plan Category does not contain A or B = CI  Storage:  File: GROUP INSURANCE PLAN (#355.3)  File: PLAN CATEGORY (#.14)  Field: ELECTRONIC PLAN TYPE (#.15) | Added codes:  17 - Dental Management Org, FI - FEP, MA can now be used for P and I.  Removed Codes:  09 - Self Pay, 10 - Central Certification, LI - Liability. |
| 8 | Insurance Type Code | 2 A/N | 837: (P) 2320 SBR05  Print: N/A | Biller Input: N/A  VistA looks at the Electronic Plan Type of the Group Insurance Plan.  Storage:  File: GROUP INSURANCE PLAN (#355.3)  Field: ELECTRONIC PLAN TYPE (#.15) | Code list change. Usage changed to situational |
| 9 | Other Payer Pt Signature Source Code | 1 A/N | 837: (P) 2320 OI04  Print: N/A | Biller Input: N/A  Note: Always B  Storage: N/A | Only code now in 5010 P. |

### OI1A - Loop 2320/2330B (Other Subscriber and Other Payer Data)

One or more records per Claim Data record set

(OPTIONAL – Max length104 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI1A ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: 2320 SBR01  Print: N/A | Biller Input: Screen 3 Section 1  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Codes added to indicate sequence out to 11 payers. VA will only use Primary (P), Secondary (S) ,Tertiary (T) |
| 3 | Other Payer Paid Amt | 15 N  2 Decimals | 837: 2320 AMT02  Print:  CMS 1500 – Box 29  UB04 – FL54 | Biller Input: N/A  Medicare:  File: ACCOUNTS RECEIVABLE (#430)  Filed: TOTAL PAID PRINCIPAL (#77)  Non-Medicare:  File: BILL/CLAIM (#399)  Field: PRIMARY PRIOR PAYMENT (#218)  Field: SECONDARY PRIOR PAYMENT (#219)  Field: TERTIARY PRIOR PAYMENT (#220) | Set AMT01 = D. |
| 4 | COB Total non-Covered Amount | 18 N  2 Decimals | 837: 2320 AMT02  Print: N/A | Biller Input: N/A  System extracts this amount from the claim file.  Storage:  File: BILL/CLAIM (#399)  Field: COB NON-COVERED CHARGE AMOUNT (#260) | None |
| 5 | COB Total non-Covered Amount Qualifier | 2 A/N | 837: 2320 AMT01  Print: N/A | Biller Input: N/A  When OI4, Piece 12 is populated, the system populates this with A8.  Storage: N/A |  |
| 6 | Remaining Patient Liability Qualifier | 3 A/N | 837: 2320 AMT01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always EAF |  |
| 7 | Remaining Patient Liability | 15 N  2 Decimals | 837: 2320 AMT02  Print: N/A | Biller Input: N/A  This is the sum of the patient responsibility amounts in the EOB files for each payer.  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: PATIENT RESPONSIBILITY AMT (#1.02) | AMT01=EAF Will need to be track separately for each payer |
| 8 | Other Payer Prior Authorization Qualifier | 20 A/N | 837:  (I) 2330B REF01  (P) 2330B REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always G1 |  |
| 9 | Other Payer Prior Auth Number | 18 A/N | 837:  (I) 2330B REF02  (P) 2330B REF02  Print:  UB04 – FL63 by payer  Note: System keeps track of payer sequence. | Biller Input: Screen 10 Section 1/2  Storage:  File: BILL/CLAIM (#399)  Field: TREATMENT AUTHORIZATION CODE (#163)  Field: SECONDARY AUTHORIZATION CODE (#230)  Field: TERTIARY AUTHORIZATION CODE (#231) |  |

### OI2 - Loop 2330A (Other Payer Subscriber Data) [SEQ 110]

One record per 2320 record

(OPTIONAL – Max length 256 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI2 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: 2320 SBR01  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Subscriber Primary ID | 80 A/N | 837: 2330A NM109  Print:  UB04 – FL60 | Biller Input: N/A  Screen 3 Section 1  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER ID (#11) | Set NM108 = MI |
| 4 | Other Subscriber Last Name | 60 A/N | 837: 2330A NM103  Print:  CMS 1500 – Box 9  UB04 – FL58 | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) | Set NM101 = IL  NM102 = 1  Maximum HIPAA length increased to 60. |
| 5 | Other Subscriber First Name | 35 A/N | 837: 2330A NM104  Print:  CMS 1500 – Box 9  UB04 – FL 58 | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) | Maximum HIPAA length increased to 35. |
| 6 | Other Subscriber Middle Name | 25 A/N | 837: 2330A NM105  Print:  CMS 1500 – Box 9  UB04 – FL58 | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) |  |
| 7 | Other Subscriber Employer Name | 35 A/N | 837: 2330I NM103  Print:  UB04 - FL65 | Biller Input: N/A  The subscriber’s employment information is added via Patient Insurance Info Add/Edit🡪Add Policy or Policy Edit/View🡪Employer Info  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER”S EMPLOYER NAME (#2.015) | Non-HIPAA Field  HCCH printing requirements  Set NM101 = 84  NM102 = 1 |
| 8 | BLANK | 1 |  |  |  |
| 9 | BLANK | 1 |  |  |  |
| 10 | BLANK | 1 |  |  |  |
| 11 | Other Subscriber Primary ID Qualifier | 3 A/N | 837: 2330A NM108  Print: N/A | Biller Input: N/A  Screen 3 Section 1  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage: N/A  Note: Always MI. |  |

### OI4 - Loop 2330B (Other Payer Data) [SEQ 112]

One record per 2320 record

(OPTIONAL – Max length 208 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI4 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: Screen 3 Section 1  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers.  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance.. |
| 3 | Other Payer Address Line 1 | 55 A/N | 837: 2330B N301  Print: N/A | Biller Input: Screen 3 Section 3  The payer address will be pulled automatically from the Insurance Company File but a user may override the default answer. There are addresses for Mailing/Inpt/Outpt/RX/Inquiry and Appeals claims. The claim type and/or the availability of the different addresses will affect the default value.  Storage:  File - Insurance Company (#36)  Field – Address Line 1 (#.111, .121, .141, .151, .161, .181) | Added to 837P |
| 4 | Other Payer Address Line 2 | 55 A/N | 837: 2330B N302  Print: N/A | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – City (#.112, .122, .142, .152, .162, .182) | Added to 837P |
| 5 | Other Payer City Name | 30 A/N | 837: 2330B N401  Print: N/A | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – CITY (#.114, .124, .144, .154, .164, .184) | Added to 837P |
| 6 | Other Payer State Code | 2 A | 837: 2330B N402  Print: N/A | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – STATE (#.115, .125, .145, .155, .165, .185) | Added to 837P Required when in US or territories. |
| 7 | Other Payer Zip Code | 15 A/N | 837: 2330B N403  Print: N/A | Biller Input: Screen 3 Section 3  Storage:  File - Insurance Company (#36)  Field – ZIP (#.116, .126, .146, .156, .166, .186) | Added to 837P. Required when in US or territories. |
| 8 | Other Payer Check Qualifier | 3 N | 837: 2330B DTP01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 573 |  |
| 9 | Other Payer Check Date | 8 N CCYYMMDD | 837: 2330B DTP03  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: EOB PAID DATE (#.06) | DTP02 = D8 |
| 10 | Other Payer Claim Status | 2 A | 837: (I) 2300 REF02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: CLAIM STATUS (#.13) | Non HIPAA  HCCH print requirement  Set REF01 = SU Equal to the CLP02 on the 835 |
| 11 | Other Payer Referral Number Qualifier | 2 A/N | 837:  (I) 2330B REF01  (P) 2330B REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 9F |  |
| 12 | Other Payer Referral Number | 20 A/N | 837:  (I) 2330B REF02  (P) 2330B REF02  Print: N/A | Biller Input: Screen 10 Section ½  There can be a Primary, Secondary and Tertiary Referral Number. The system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers.  Storage: BILL/CLAIM (#399)  Field: PRIMARY REFERRAL NUMBER (#253)  Field: SECONDARY REFERRAL NUMBER (#254)  Field: PRIMARY REFERRAL NUMBER (#255) |  |

### OI5 - Loop 2330A (Other Payer Subscriber Data) [SEQ 113]

One record per 2320 record

(OPTIONAL – Max length 228 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI5 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance.. |
| 3 | Other Subscriber Name Suffix | 10 A/N | 837: 2330A NM107  Print:  UB04 – FL58 | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#1)  Subfile: INSURANCE TYPE (#.3121)  Field: NAME OF INSURED (#17) |  |
| 4 | Other Subscriber Address 1 | 55 A/N | 837: 2330A N301  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STREET 1 (#3.06) |  |
| 5 | Other Subscriber Address 2 | 55 A/N | 837: 2330A N302  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STREET 2 (#3.07) |  |
| 6 | Other Subscriber City Name | 30 A/N | 837: 2330A N401  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S CITY (#3.08) | 837P usage changed to required |
| 7 | Other Subscriber State Code | 2 A | 837: 2330A N402  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S STATE (#3.09) | Required when in US or territories. |
| 8 | Other Subscriber ZIP Code | 10 A/N | 837: 2330A N403  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: INSURED’S ZIP (#3.1) | Required when in US or territories. |
| 9 | Other Subscriber Sec ID Qualifier(1) | 2 A/N | 837: 2330A REF01  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER’s SEC QUALIFIER(1) ID (#5.02) |  |
| 10 | Other Subscriber Sec ID(1) | 50 A/N | 837: 2330A REF02  Print: N/A | Biller Input: N/A  *Screen 3 Section 1*  The biller can add the patient’s insurance policy to the bill on Screen 3 Section 1. The Subscriber information is maintained in Patient Insurance Info View/Edit🡪Add Policy or Policy View/Edit🡪Subscriber Updates  Storage:  File: PATIENT (#2)  Subfile: INSURANCE TYPE (#.3121)  Field: SUBSCRIBER’S SEC ID(1) (#5.03) | None |

### OI6 - Loop 2330B (Other Payer ID Data) [SEQ 114]

(OPTIONAL – Max length 145 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OI6 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance.. |
| 3 | Other Payer Primary ID Qualifier | 3 A/N | 837: 2330B NM108  Print: N/A | Biller Input: N/A  Storage: N/A |  |
| 4 | Other Payer Primary ID | 30 A/N | 837: 2330B NM109  Print:  UB04 – FL51 by payer  Note: This is the legacy Payer ID. \*\*It will only print if there is no HPID\*\* | Biller Input: N/A  Screen 3 Section 3  The Payer IDs are automatically entered on a bill when the user adds the insurance to the claim. Payer IDs are enter in Insurance Company Entry/EditBilling/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI ID NUMBER – PROF (#3.02)  Field: EDI ID NUMBER – INST (#3.04) |  |
| 5 | Other Payer Sec ID Qualifier (1) | 3 A/N | 837: 2330B REF01  Print: N/A | Biller Input: N/A  *Screen 3 Section 3*  Payer IDs are automatically entered on a bill when the user adds the insurance to the claim. Payer IDs are enter in Insurance Company Entry/Edit🡪Billing/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID QUAL (1) (#6.01)  Field: EDI PROF SECONDARY ID QUAL (1) (#6.05) | Code list includes 2U, EI, FY and NF.  TJ and F8 have been removed. |
| 6 | Other Payer Sec ID (1) | 30 A/N | 837: 2330B REF02  Print: N/A | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID (1) (#6.02)  Field: EDI PROF SECONDARY ID (1) (#6.06) |  |
| 7 | Other Payer Sec ID Qualifier (2) | 3 A/N | 837: 2330B REF01  Print: N/A  Note: This will not be used if the ICN/DCN number in COB1-7 exists. | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID QUAL (2) (#6.03)  Field: EDI PROF SECONDARY ID QUAL (2) (#6.07) | Code Set Change:  Allowed values are 2U, EI, FY and NF.  TJ has been removed. |
| 8 | Other Payer Sec ID (2) | 30 A/N | 837: 2330B REF02  Print: N/A  Note: This will not be used if the ICN/DCN number in COB1-7 exists. | Biller Input: N/A  *Screen 3 Section 3*  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI INST SECONDARY ID (2) (#6.04)  Field: EDI PROF SECONDARY ID (2) (#6.08) |  |
| 9 | Other Payer ID Qualifier | 2 A | 837: 2330BB NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XV |  |
| 10 | Other Payer Primary ID (HPID) | 30 A/N | 837: 2330BB NM109  Print:  UB04 – FL51 by payer | Biller Input: N/A  Screen 3 Section 3  Payer IDs are automatically enter on a bill when the user adds the insurance to the claim. Payer IDs are enter in Insurance Company Entry/Edit🡪Billing/EDI Param  Storage:  File: INSURANCE COMPANY (#36)  Subfile: HPID/OEID (#.08)  Field: HPID/OEID (#.01) |  |

### COB1 - Loop 2320 (Claim Level COB Amounts) [SEQ 115]

Maximum one record per OI1 record

(OPTIONAL – Max length 65 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘COB1’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: Screen 3 Section 1  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | BLANK | 1 |  |  | Element moved to OI1 piece 20. |
| 4 | BLANK | 1 |  |  |  |
| 5 | BLANK | 1 |  |  |  |
| 6 | BLANK | 1 |  |  |  |
| 7 | Other Payer Claim Control Number | 50 A/N | 837:  (I) 2330B REF02  (P) 2320B REF02  Print:  UB04 – FL64 by payer | Biller Input: *Screen 10 Section 1/2*  On a secondary or tertiary claim, the system will automatically populate the ICN from the electronic EOB. Users may manually enter one or more ICNs if necessary.  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: ICN (#.14) | Set REF01 = F8  Moved from OI1, Piece 10 |

Note: Do not delete this record without concurrence from FSC. FSC uses this record to identify the end of the OI segments.

### MOA1 - Loop 2320 (Medicare Outpatient Adjudication COB Data) [SEQ 120]

Maximum one record per OI1 record

(OPTIONAL – Max length 138 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘MOA1’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Outpatient Reimbursement Rate | 3 N | 837: 2320 MOA01  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REIMBURS. RATE (#3.01) |  |
| 4 | HCPCS Payable Amt | 15 N  2 Decimals | 837: 2320 MOA02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP HCPCS PAYMNT AMT (#3.02) |  |
| 5 | REMARKS CODE (1) | 15 A/N | 837: 2320 MOA03  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REMARKS CODE - 1 (#3.03) | Maximum HIPAA length increased to 50. |
| 6 | REMARKS CODE (2) | 15 A/N | 837: 2320 MOA04  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REMARKS CODE - 2 (#3.04) | Maximum HIPAA length increased to 50. |
| 7 | REMARKS CODE (3) | 15 A/N | 837: 2320 MOA05  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REMARKS CODE - 3 (#3.05) | Maximum HIPAA length increased to 50. |
| 8 | REMARKS CODE (4) | 15 A/N | 837: 2320 MOA06  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REMARKS CODE - 4 (#3.06) | Maximum HIPAA length increased to 50. |
| 9 | REMARKS CODE (5) | 15 A/N | 837: 2320 MOA07  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE OUTP REMARKS CODE - 5 (#3.07) | Maximum HIPAA length increased to 50. |
| 10 | ESRD Payment Amt | 15 N  2 Decimals | 837: 2320 MOA08  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE ESRD PAID AMT (#3.08) |  |
| 11 | Non-payable Prof Component Billed Amt | 15 N  2 Decimals | 837: 2320 MOA09  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-NON-PAYABLE PROF COMP (#3.09) |  |

### MIA1 - Loop 2320 (Medicare Inpatient Adjudication COB Data) [SEQ 125]

Maximum one record per OI1 record

(OPTIONAL – Max length 150 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘MIA1’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A |  | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Covered Days or Visits Amt | 4 N | 837: (I) 2320 MIA01  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP COV. DAYS/VISIT CT (#4.01) | Usage changed to situational |
| 4 | Claim DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA04  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP CLAIM DRG AMT (#4.03) |  |
| 5 | DRG Used | 10 A/N | 837: (I)2300 REF02 (2)  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: DRG Used (#.1) | Non-HIPAA field  HCCH UB04 printing requirement  Set REF01 = ZZ |
| 6 | Claim Disproportionate Share Amt | 15 N  2 Decimals | 837: (I) 2320 MIA06  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP DISPROP. SHARE AMT (#4.05) |  |
| 7 | Claim MSP Pass-through Amt | 15 N  2 Decimals | 837: (I) 2320 MIA07  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP MSP PASS THRU AMT (#4.06) |  |
| 8 | Claim PPS Capital Amt | 15 N  2 Decimals | 837: (I) 2320 MIA08  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAPITAL AMT (#4.07) |  |
| 9 | PPS-Capital FSP DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA09  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAP FSP-DRG AMT (#4.08) |  |
| 10 | PPS-Capital HSP DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA10  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAP HSP-DRG AMT (#4.09) |  |
| 11 | PPS-Capital DSH DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA11  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAP DSH-DRG AMT (#4.1) |  |
| 12 | Old Capital Amt | 15 N  2 Decimals | 837: (I) 2320 MA12  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP OLD CAPITAL AMT (#4.11) |  |

### MIA2 - Loop 2320 (Medicare Inpatient Adjudication COB Data) [SEQ 130]

Maximum one record per OI1 record

(OPTIONAL – Max length 167 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘MIA2’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A |  | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | PPS-Capital IME Amt | 4 N  2 Decimals | 837: (I) 2320 MIA13  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAPITAL IME AMT (#4.12) |  |
| 4 | PPS-Operating Hospital Specific DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA14  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS OP HOS DRG AMT (#4.13) |  |
| 5 | Cost Report Day Count | 4 N | 837: (I) 2320 MIA15  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP COST REPORT DAY CT (#4.14) |  |
| 6 | PPS-Operating Federal Specific DRG Amt | 15 N  2 Decimals | 837: (I) 2320 MIA16  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS OP FED DRG AMT (#4.15) |  |
| 7 | Claim PPS Capital Outlier Amt | 15 N  2 Decimals | 837: (I) 2320 MIA17  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PPS CAPITAL OUTLIER AMT (#4.16) |  |
| 8 | Claim Indirect Teaching Amt | 15 N  2 Decimals | 837: (I) 2320 MIA18  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP INDIRECT TEACH AMT (#4.17) |  |
| 9 | Non-Payable Prof Component Amt | 15 N  2 Decimals | 837: (I) 2320 MIA19  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP NON-PAY PROF COMP (#4.18) |  |
| 10 | Claim Payment Remark Code (1) | 10 A/N | 837: (I) 2320 MIA05  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PYMNT REMARK CODE-1 (#5.01) | Max HIPAA length increased to 50. |
| 11 | Claim Payment Remark Code (2) | 10 A/N | 837: (I) 2320 MIA20  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PYMNT REMARK CODE-2 (#5.02) | Max HIPAA length increased to 50. |
| 12 | Claim Payment Remark Code (3) | 10 A/N | 837: (I) 2320 MIA21  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PYMNT REMARK CODE-3 (#5.03) | Max HIPAA length increased to 50. |
| 13 | Claim Payment Remark Code (4) | 10 A/N | 837: (I) 2320 MIA22  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PYMNT REMARK CODE-4 (#5.04) | Max HIPAA length increased to 50. |
| 14 | Claim Payment Remark Code (5) | 10 A/N | 837: (I) 2320 MIA23  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP PYMNT REMARK CODE-5 (#5.05) | Max HIPAA length increased to 50. |
| 15 | PPS-Capital Exception Amt | 15 N  2 Decimals | 837: (I) 2320 MIA24  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: M-CARE INP CAP EXCEPTION AMT (#4.04) |  |

### CCAS - Loop 2320 (COB Claim Level Adjustments) [SEQ 135]

One or more records per OI1 record

(OPTIONAL – Max length 183 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘CCAS’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Adjustment Group Code | 2 A | 837: 2320 CAS01  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: ADJUSTMENT CATEGORY (GRP CODE) (#.01) |  |
| 4 | Adjustment Reason Code (1) | 5 A/N | 837: 2320 CAS02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 5 | Adjustment Amt (1) | 15 N  2 Decimals | 837: 2320 CAS03  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 6 | Adjustment Quantity (1) | 6 N | 837: 2320 CAS04  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |
| 7 | Adjustment Reason Code (2) | 5 A/N | 837: 2320 CAS05  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 8 | Adjustment Amt (2) | 15 N  2 Decimals | 837: 2320 CAS06  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 9 | Adjustment Quantity (2) | 6 N | 837: 2320 CAS07  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |
| 10 | Adjustment Reason Code (3) | 5 A/N | 837: 2320 CAS08  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 11 | Adjustment Amt (3) | 15 N  2 Decimals | 837: 2320 CAS09  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 12 | Adjustment Quantity (3) | 6 N | 837: 2320 CAS10  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |
| 13 | Adjustment Reason Code (4) | 5 A/N | 837: 2320 CAS11  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 14 | Adjustment Amt (4) | 15 N  2 Decimals | 837: 2320 CAS12  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 15 | Adjustment Quantity (4) | 6 N | 837: 2320 CAS13  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |
| 16 | Adjustment Reason Code (5) | 5 A/N | 837: 2320 CAS14  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 17 | Adjustment Amt (5) | 15 N  2 Decimals | 837: 2320 CAS15  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 18 | Adjustment Quantity (5) | 6 N | 837: 2320 CAS16  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |
| 19 | Adjustment Reason Code (6) | 5 A/N | 837: 2320 CAS17  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: REASON CODE (#.01) |  |
| 20 | Adjustment Amt (6) | 15 N  2 Decimals | 837: 2320 CAS18  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: AMOUNT (#.02) |  |
| 21 | Adjustment Quantity (6) | 6 N | 837: 2320 CAS19  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 CLAIM LEVEL ADJUSTMENTS (#10)  Subfield: REASON (#1)  Subfield: QUANTITY (#.03) |  |

### OP1 - Loop 2330C/D (Other Payer Rendering Provider Data) [SEQ 170]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP1 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance.. |
| 3 | Other Payer Rendering Entity ID | 2 A/N | 837:  (I) 2330G NM101  (P) 2330D NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 82 | 837I: Added loop.  837P: Loop has changed to 2330D. |
| 4 | Other Payer Rendering Entity Type Qualifier | 1 N | 837:  (I) 2330G NM102  (P) 2330D NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 - Person | 837I: Added loop.  837P: Loop has changed to 2330D. |
| 5 | Other Payer Rendering Sec ID Qualifier (1) | 2 A/N | 837:  (I) 2330G REF01  (P) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Added loop.  837P: Loop has changed to 2330D. |
| 6 | Other Payer Rendering Sec ID (1) | 30 A/N | 837:  (I) 2330G REF02  (P) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Added loop.  837P: Loop has changed to 2330D. |
| 7 | Other Payer Rendering Sec ID Qualifier (2) | 2 A/N | 837:  (I) 2330G REF01  (P) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Added loop.  837P: Loop has changed to 2330D. |
| 8 | Other Payer Rendering Sec ID (2) | 30 A/N | 837:  (I) 2330G REF02  (P) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Added loop.  837P: Loop has changed to 2330D. |
| 9 | Other Payer Rendering Sec ID Qualifier (3) | 2 A/N | 837:  (I) 2330G REF01  (P) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Added loop.  837P: Loop has changed to 2330D. |
| 10 | Other Payer Rendering Sec ID (3) | 30 A/N | 837:  (I) 2330G REF02  (P) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Added loop.  837P: Loop has changed to 2330D. |

### OP1A - Loop 2330C/D (Other Payer Attending Physician Data) [SEQ 170.5]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP1A ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Attending Entity ID | 2 A/N | 837: (I) 2330C NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 71 | 837I: Loop has changed to 2330C. |
| 4 | Other Payer Attending Entity Type Qualifier | 1 N | 837: (I) 2330C NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 – Person | 837I: Loop has changed to 2330C; Code 2 deleted only 1 allowed. |
| 5 | Other Payer Attending Sec ID Qualifier (1) | 2 A/N | 837: (I) 2330C REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  When a user adds a provider to a claim, they will be given an opportunity to enter one secondary ID. The secondary IDs are defined in Provider ID Maintenance. An ID can belong to the provider or it can be assigned to the provider by the payer.  VistA will extract up to the maximum number of provider secondary IDs into the 837.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Loop has changed to 2330C.  837P: Loop has changed to 2330D. |
| 6 | Other Payer Attending Sec ID (1) | 30 A/N | 837: (I) 2330C REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  When a user adds a provider to a claim, they will be given an opportunity to enter one secondary ID. The secondary IDs are defined in Provider ID Maintenance. An ID can belong to the provider or it can be assigned to the provider by the payer.  VistA will extract up to the maximum number of provider secondary IDs into the 837.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330C. |
| 7 | Other Payer Attending Sec ID Qualifier (2) | 2 A/N | 837: (I) 2330C REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Loop has changed to 2330C. |
| 8 | Other Payer Attending Sec ID (2) | 30 A/N | 837: (I) 2330C REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330C. |
| 9 | Other Payer Attending Sec ID Qualifier (3) | 2 A/N | 837: (I) 2330C REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Only 0B, 1G, G2, LU allowed.  837I: Loop has changed to 2330C. |
| 10 | Other Payer Attending Sec ID (3) | 30 A/N | 837: (I) 2330C REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Billers add the provider to the claim.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330C. |

### OP2 - Loop 2330D (Other Payer Operating Physician Data) [SEQ 171]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP2 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Operating Phy Entity ID | 2 A/N | 837: (I) 2330D NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 72 | 837I: Loop has changed to 2330D. |
| 4 | Other Payer Operating Phy Entity Qualifier | 1 N | 837: (I) 2330D NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 - Person | 837I: Loop has changed to 2330D.  Code set change:  ID qualifiers allowed are 0B, 1G, G2 and LU. |
| 5 | Other Payer Oper Phy Sec ID Qualifier (1) | 2 A/N | 837: (I) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330D.  Code set change:  ID qualifiers allowed are 0B, 1G, G2 and LU. |
| 6 | Other Payer Operating Phy Sec ID (1) | 30 A/N | 837: (I) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330D. |
| 7 | Other Payer Oper Phy Sec ID Qualifier (2) | 2 A/N | 837: (I) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330D.  Code set change:  ID qualifiers allowed are 0B, 1G, G2 and LU. |
| 8 | Other Payer Operating Phy Sec ID (2) | 30 A/N | 837: (I) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330D. |
| 9 | Other Payer Oper Phy Sec ID Qualifier (3) | 2 A/N | 837: (I) 2330D REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330D.  Code set change:  ID qualifiers allowed are 0B, 1G, G2 and LU. |
| 10 | Other Payer Operating Phy Sec ID (3) | 30 A/N | 837: (I) 2330D REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330D. |

### OP3 - Loop 2330F (Other Payer Service Facility Data) [SEQ 172]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP3 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Lab/Facility Entity ID | 2 A/N | 837: (I) 2330F NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 77 | 837I: Loop has changed to 2330F.  Code set change:  77 is not the only allowed code. |
| 4 | Other Payer Lab / Fac Entity Qualifier | 1 N | 837: (I) 2330F NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 2- Non-Person | 837I: Loop has changed to 2330F. |
| 5 | Other Payer Lab/Fac Sec ID Qualifier (1) | 2 A/N | 837: (I) 2330F REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330F.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 6 | Other Payer Lab/Facility Sec ID (1) | 30 A/N | 837: (I) 2330F REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330F. |
| 7 | Other Payer Lab/Fac Sec ID Qualifier (2) | 2 A/N | 837: (I) 2330F REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330F.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 8 | Other Payer Lab/Facility Sec ID (2) | 30 A/N | 837: (I) 2330F REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330F. |
| 9 | Other Payer Lab/Fac Sec ID Qualifier (3) | 2 A/N | 837: (I) 2330F REF01  Print: N/A | Biller Input:  Fee: Screen 10 Section 4  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop has changed to 2330F.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 10 | Other Payer Lab/Facility Sec ID (3) | 30 A/N | 837(I) 2330F REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | 837I: Loop has changed to 2330F. |

### OP4 - Loop 2330C (Other Payer Referring Provider Data) [SEQ 173]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP4 ’ | 4 A |  |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A |  | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Referring Prov Entity ID | 2 A/N | 837:  (P) 2330C NM101  (I) 2330H NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DN | 837P: Loop Change to 2330C. |
| 4 | Other Payer Referring Prov Entity Qualifier | 1 N | 837:  (P) 2330C NM102  (I) 2330H NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 - Person | 837P: Loop Change to 2330C. |
| 5 | Other Payer Refer Prov Sec ID Qualifier (1) | 2 A/N | 837:  (P) 2330C REF01  (I) 2330H REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop Change to 2330C.  Code set change:  ID qualifiers allowed are 0B, 1G and G2. |
| 6 | Other Payer Referring Prov Sec ID (1) | 30 A/N | 837:  (P) 2330C REF02  (I) 2330H REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2330C. |
| 7 | Other Payer Refer Prov Sec ID Qualifier (2) | 2 A/N | 837:  (P) 2330C REF01  (I) 2330H REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837P: Loop Change to 2330C.  Code set change:  ID qualifiers allowed are 0B, 1G and G2. |
| 8 | Other Payer Referring Prov Sec ID (2) | 30 A/N | 837:  (P) 2330C REF02  (I) 2330H REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2330C. |
| 9 | Other Payer Refer Prov Sec ID Qualifier (3) | 2 A/N | 837:  (P) 2330C REF01  (I) 2330H REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | ID qualifiers allowed are 0B, 1G and G2. |
| 10 | Other Payer Referring Prov Sec ID (3) | 30 A/N | 837:  (P) 2330C REF02  (I) 2330H REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837P: Loop Change to 2330C.  837I: Loop 2330F has been added for a Referring Provider. |

### OP7 - Loop 2330E (Other Payer Service Facility Data) [SEQ 176]

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP7 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Service Facility Entity ID | 2 A/N | 837: (P) 2330E NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 77 | Loop has changed to 2330E.  Code set change:  77 is now the only allowed code. |
| 4 | Other Payer Service Fac Entity Qualifier | 1 N | 837: (P) 2330E NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 2 – Non-Person | Loop has changed to 2330E. |
| 5 | Other Payer Service Fac Sec ID Qualifier (1) | 2 A/N | 837: (P) 2330E REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Loop has changed to 2330E.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 6 | Other Payer Service Facility Sec ID (1) | 30 A/N | 837: (P) 2330E REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Loop has changed to 2330E. |
| 7 | Other Payer Service Fac Sec ID Qualifier (2) | 2 A/N | 837: (P) 2330E REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Loop has changed to 2330E.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 8 | Other Payer Service Facility Sec ID (2) | 30 A/N | 837: (P) 2330E REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Loop has changed to 2330E. |
| 9 | Other Payer Service Fac Sec ID Qualifier (2) | 2 A/N | 837: (P) 2330E REF01  Print: N/A | Biller Input:  Fee: Screen 10 Section 4  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Loop has changed to 2330E.  Code set change:  ID qualifiers allowed are 0B, G2 and LU. |
| 10 | Other Payer Service Facility Sec ID (3) | 30 A/N | 837: (P) 2330E REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) | Loop has changed to 2330E. |

### OP8 - Loop 2330F (Other Payer Supervising Provider Data) [SEQ 177]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP8 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Supervising Prov Entity ID | 2 A/N | 837: (P) 2330F NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DQ | Loop changed to 2330F. |
| 4 | Other Payer Super Prov Entity Qualifier | 1 N | 837: (P) 2330F NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 - Person | Loop changed to 2330F. |
| 5 | Other Payer Supervising Prov Sec ID Qualifier (1) | 2 A/N | 837: (P) 2330F REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Loop change to 2330F.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 6 | Other Payer Supervising Prov Sec ID (1) | 30 A/N | 837: (P) 2330F REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | Loop change to 2330F. |
| 7 | Other Payer Supervising Prov Sec ID Qualifier (2) | 2 A/N | 837: (P) 2330F REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Loop change to 2330F.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 8 | Other Payer Supervising Prov Sec ID (2) | 30 A/N | 837: (P) 2330F REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | Loop change to 2330F. |
| 9 | Other Payer Supervising Prov Sec ID Qualifier (3) | 2 A/N | 837: (P) 2330F REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Loop change to 2330F.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 10 | Other Payer Supervising Prov Sec ID (3) | 30 A/N | 837: (P) 2330F REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | Loop change to 2330F. |

### OP9 - Loop 2330E (Other Payer Other Operating Provider Data) [SEQ 178]

One record per 2320 record

(OPTIONAL – Max length 113 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘OP9 ’ | 4 A | N/A |  |  |
| 2 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |
| 3 | Other Payer Other Operating Prov Entity ID Code | 2 A/N | 837: (I) 2330E NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always ZZ | 837I: Loop changed to 2330E. |
| 4 | Other Payer Other Operating Prov Entity Qualifier | 1 N | 837: (I) 2330E NM102  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 1 - Person | 837I: Loop changed to 2330E. |
| 5 | Other Payer Other Operating Prov Sec ID Qualifier (1) | 2 A/N | 837: N/A  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop changed to 2330E.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 6 | Other Payer Other Operating Prov Sec ID (1) | 30 A/N | 837: (I) 2330E RE02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop changed to 2330E. |
| 7 | Other Payer Other Prov Sec ID Qualifier (2) | 2 A/N | 837: (I) 2330E REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop changed to 2330E.    Name changed from Other Provider to Other Operating Provider. Usage only allowed when an Operating Provider is specified in 2310B.  Code Set Change:  Only codes now allowed are 0B, 1G, G2 and LU. |
| 8 | Other Payer Other Operating Prov Sec ID (2) | 30 A/N | 837: (I) 2330E REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop changed to 2330E. |
| 9 | Other Payer Other Operating Prov Sec ID Qualifier (3) | 2 A/N | 837: (I) 2330E REF01  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | 837I: Loop changed to 2330E.  Name changed from Other Provider to Other Operating Provider. Usage only allowed when an Operating Provider is specified in 2310B.  Code Set Change:  Only codes now allowed are 0B, 1G, G2, LU. |
| 10 | Other Payer Other Prov Sec ID (3) | 30 A/N | 837: (I) 2330E REF02  Print: N/A | Biller Input: *Screen 10 Section 3*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) | 837I: Loop changed to 2330E. |

### 

## Section 5 – Line Level Data

### PRF - Loop 2400 (Professional Service Line Data) [SEQ 180]

One or more records per Claim Data record

(OPTIONAL – Max length 212 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘PRF ’ | 4 A |  |  |  |
| 2 | Service Line # | 6 N | 837: (P) 2400 LX01  Print: N/A | Biller Input: *Screen 5 Section 4*  For each procedure on a claim, the biller can enter a Print Order. The Print Order determines the order in which the procedures are arranged.  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PRINT ORDER (3) |  |
| 3 | Service ID Qualifier | 2 A/N | 837: (P) 2400 SV101- 1  Print: N/A | Biller Input: *Screen 5 Section 4*  For each procedure on a claim, the biller can enter the coding method used. This qualifier is based on the coding method  Storage: N/A | Can only use ER, HC, IV, WK |
| 4 | Procedure Code | 10 A/N | 837: (P) 2400 SV101 - 2  Print:  CMS 1500 – Box 24d | Biller Input:  *Screen 4/5 Section 4*  *Screen 6/7 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURES (#.01) |  |
| 5 | Line Item Charge Amt | 9 N  2 Decimals | 837: (P) 2400 SV102  Print:  CMS 1500 – Box 24f | Biller Input: *Screen 7 Section 5*  The system calculates the charge amount based on Revenue Codes, Division and Reasonable Charges. A biller can override the system calculation if necessary.  Storage:  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODE (#42)  Field: CHARGES (#.02) |  |
| 6 | Service Unit Count | 6 N | 837: (P) 2400 SV104  Print:  CMS 1500 – Box 24g | Biller Input: *Screen 7 Section 5*  A biller can change the default value of 1 for the Units of Service. Charges.  Storage:  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODE (#42)  Field: UNITS OF SERVICE (#.03)  For Anesthesia:  Subfile: PROCEDURE (#304)  Field: MINUTES (#15) |  |
| 7 | Place of Service Code | 2 A/N | 837: (P) 2400 SV105  Print:  CMS 1500 – Box 24b | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PLACE OF SERVICE (#8) |  |
| 8 | BLANK | 1 |  |  |  |
| 9 | Service DT From | 8 N CCYYMMDD | 837: (P) 2400 DTP03 (1)  Print:  CMS 1500 – Box 24a | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURE DATE (#1) |  |
| 10 | Service DT To | 8 N  CCYYMMDD | 837: (P) 2400 DTP03 (1)  Print:  CMS 1500 – Box 24a |  |  |
| 11 | Diagnosis Code Pointer (1) | 2 A/N | 837: (P) 2400 SV107 - 1  Print:  CMS 1500 – Box 24e | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ASSOCIATED DIAGNOSIS (1) (#10) |  |
| 12 | Diagnosis Code Pointer (2) | 2 A/N | 837: (P) 2400 SV107 - 2  Print:  CMS 1500 – Box 24e | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ASSOCIATED DIAGNOSIS (2) (#11) |  |
| 13 | Diagnosis Code Pointer (3) | 2 A/N | 837: (P) 2400 SV107 - 3  Print:  CMS 1500 – Box 24e | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ASSOCIATED DIAGNOSIS (3) (#12) |  |
| 14 | Diagnosis Code Pointer (4) | 2 A/N | 837: (P) 2400 SV107 - 4  Print:  CMS 1500 – Box 24e | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ASSOCIATED DIAGNOSIS (4) (#13) |  |
| 15 | Procedure Modifier (1) | 2 N | 837: (P) 2400 SV101 - 3  Print:  CMS 1500 – Box 24d | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.01) |  |
| 16 | Procedure Modifier (2) | 2 N | Print: (P) 2400 SV101 - 4  Print:  CMS 1500 – Box 24d | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.01) |  |
| 17 | Procedure Modifier (3) | 2 N | 837: (P) 2400 SV101 - 5  Print:  CMS 1500 – Box 24d | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.01) |  |
| 18 | Procedure Modifier (4) | 2 N | 837: (P) 2400 SV101 - 6  Print:  CMS 1500 – Box 24d | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.01) |  |
| 19 | Emergency Indicator | 1 A | (P) 2400 SV109  CMS 1500 – Box 24c | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.01) |  |
| 20 | Units/Basis for Measurement Code | 2 A | 837: (P) 2400 SV103 | Biller Input: N/A  Storage: N/A  For Anesthesia – UN  All other service types - MJ | F2 Deleted / Only use MJ, UN |
| 21 | Service ID Qualifier | 2 A/N | 837: (P) 2410 LIN02  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always N4 |  |
| 22 | NDC | 48 A/N | 837: (P) 2410 LIN03  Print: Box 24 | Biller Input: Screen 5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: NDC (#53) |  |
| 23 | National Drug Unit Count | 15 N | 837: (P) 2410 CTP04  Print: Box 24 | Biller Input: Screen 5 Section 4  Storage:  File BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: UNITS (#54) |  |
| 24 | Hospice Employee Indicator | 1 A | 837: 2400 CRC02  Print: N/A | Biller Input: Screen 5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ATTENDING NOT HOSPICE EMPLOYEE (#50.03) | CRC01 = 70 CRC03 = 65 |
| 25 | Unit or Basis of Measurement Code | 2 A | 837: (P) 2410 CTP05-1  Print: Box 24 | Biller Input: Screen 5 Section 4  Storage: N/A  Note: Always UN |  |
| 26 | BLANK | 1 |  |  |  |
| 27 | BLANK | 1 |  |  |  |
| 28 | BLANK | 1 |  |  |  |
| 29 | EPSDT Indicator | 1 A | 837: (P) 2400 SV111  Print:  CMS 1500 – Box 24H | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: EPSDT FLAG (#50.07) |  |
| 30 | Line Note Text | 61 A/N | 837: (P) 2400 NTE02  Print:  CMS 1500 – Box 24 above procedure | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: SERVICE LINE COMMENT (#50.08)  Field: SERVICE LINE COMMENT QUALIFIER (#50.09) | NTE01 = ADD. |

INS - Loop 2400 (Institutional Service Line Data) [SEQ 185]

One or more records per Claim Data record

(OPTIONAL – Max length 152 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘INS ’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: (I) 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | REVENUE CODE | 10 A/N | 837: (I) 2400 SV201  Print:  UB04 – FL42 | Biller Input: Screen 6/7 Section 5  The system prepopulates the Revenue Codes based on Procedure Codes else users may enter Revenue Codes in Section 5.  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODES (#42)  Field: REVENUE CODE (#.01) |  |
| 4 | Procedure Code | 10 A/N | 837: (I) 2400 SV202 - 2  Print:  UB04 – FL 44 | Biller Input:  *Screen 4/5 Section 4*  *Screen 6/7 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURES (#.01) | Set SV202 – 1 = HC |
| 5 | Service Unit Count | 6 N | 837: (I) 2400 SV205  Print:  UB04 – FL 46 | Biller Input: *Screen 6/7 Section 5*  The system calculates the charge amount based on Revenue Codes, Division and Reasonable Charges. A biller can override the system calculation if necessary.  Storage:  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODE (#42)  Field: CHARGES (#.02) |  |
| 6 | BLANK | 1 |  |  |  |
| 7 | Procedure Modifier (1) | 2 A/N | 837: (I) 2400 SV202 – 3  Print:  UB04 – FL44 | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PPROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.02) |  |
| 8 | Procedure Modifier (2) | 2 A/N | 837: (I) 2400 SV202 – 4  Print:  UB04 – FL44 | Biller Input: *Screen 5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PPROCEDURES (#304)  Subfile: CPT MODIFIER SEQUENCE (#16)  Field: CPT MODIFIER (#.02) |  |
| 9 | Service Line Charge Amt | 18 N  2 Decimals | 837: (I) 2400 SV203  Print:  UB04 – FL 47 | Biller Input: *Screen 6/7 Section 5*  The system calculates the charge amount based on Revenue Codes, Division and Reasonable Charges. A biller can override the system calculation if necessary.  Storage:  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODE (#42)  Field: CHARGES (#.02) |  |
| 10 | Service Date From | 8 N CCYYMMDD | Print: (I) 2400 DTP03  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  *Screen 6/7 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURE DATE (#1) | Set DTP01 = 472  DTP02 = D8 |
| 11 | BLANK | 1 |  |  |  |
| 12 | Service Line Non-Covered Charge Amt | 18 N  2 Decimals | 837: (I) 2400 SV207  Print:  UB04 – FL48 | Biller Input: *Screen 6/7 Section 5*  Storage:  File: BILL/CLAIMS (#399)  Subfile: REVENUE CODE (#42)  Field: NON-COVERED CHARGE (#.09) |  |
| 13 | Units/Basis for Measurement Code | 2 A | 837: (I) 2400 SV204  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DA for 100-219  Always UN for all other Procedures | F2 Deleted / Only use DA, UN |
| 14 | Service ID Qualifier | 2 A/N | 837: (I) 2410 LIN02  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always N4 |  |
| 15 | NDC | 48 A/N | 837: (I) 2410 LIN03  Print: FL80 | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: NDC (#53) |  |
| 16 | National Drug Unit Count | 15 N | 837: (I) 2410 CTP04  Print: FL80 | Biller Input: Screen 5 Section 4  Storage:  File BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: UNITS (#54) |  |
| 17 | Unit or Basis of Measurement Code | 2 A | 837: (I) 2410 CTP05-1  Print: FL80 | Biller Input: Screen 5 Section 4  Storage: N/A  Note: Always UN |  |

### RX1 - Loop 2400/2410 (Drug Service Line Data) [SEQ 190]

One or more records per Claim Data record

(OPTIONAL – Max length 135 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘RX1 ’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: (P) 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Prescription # | 15 A/N | 837: (P) 2410 REF02  Print:  CMS 1500 – Box 24 | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: RX # (#.01) | VY code has been included in REF01 element.  Max HIPAA length increased to 50. |
| 4 | National Drug Code (1) | 11 A/N | 837: (P) 2410 LIN03 (1)  Print:  CMS 1500 – Box 24 | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: NDC # (#.08) |  |
| 5 | BLANK | 1 |  |  |  |
| 6 | Quantity, Days Supply | 55 A/N | 837: (P) 2400 SV101 – 7  Print:  CMS 1500 – Box 24 | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: DAYS SUPPLY (#.06) |  |
| 7 | Service Date (Refill) | 8 N CCYYMMDD | 837: (P) 2400 DTP03 (1)  Print: N/A | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: DATE (#.03) | Set DTP01 = 472 DTP02 = D8. |
| 8 | National Drug Unit Count | 10 N | 837: (P) 2410 CTP04  Print  CMS 1500 – Box 24 | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: QTY (#.07) | Set CTP05-1 = UN. |
| 9 | BLANK | 1 |  |  |  |
| 10 | Service ID Qualifier | 2 A/N | 837: (P) 2410 LIN02  Print:  CMS 1500 – Box 24 | Biller Input: N/A  Storage: N/A  Always: N4 - NDC in 5-4-2 Format |  |
| 11 | Prescription Date Qualifier | 3 N | 837: (P) DTP01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 471 |  |
| 12 | Prescription Date | 8 N CCYYMMDD | 837: (P) 2400 DTP03  Print: N/A | Biller Input: Screen 5 Section 5  Billers can add an RX to a claim. The actual RX comes from the Pharmacy software. Billers can override the data from the pharmacy.  Storage:  File: BILL/CLAIMS PRESCRIPTION REFILL (#362.4)  Field: ORDER DATE (#.11) | DTP02 = D8 |

### LDAT – Loop 2400 Supplemental line information [SEQ 191]

One per INS or PRF segment

(OPTIONAL – Max length 199 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LDAT ’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Attachment Report Type | 2 A | 837: 2400 PWK01  Print:  CMS 1500 – Box 19 (Worker’s Comp. claims) | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ATTACHMENT REPORT TYPE (#71) |  |
| 4 | Attachment Report Transmission Code | 2 A | 837: 2400 PWK02  Print:  CMS 1500 – Box 19 (Worker’s Comp. claims) | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ATTACHMENT REPORT TRANS CODE (#72) |  |
| 5 | Attachment Control Qualifier | 2 A | 837: 2400 PWK05  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always AC |  |
| 6 | Attachment Control Number | 30 A/N | 837: 2400 PWK06  Print:  CMS 1500 – Box 19 (Workman’s Comp. claims) | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ATTACHMENT CONTROL NUMBER (#70) |  |
| 7 | OB Anesthesia Additional Units Qualifier | 2 A | 837: (P)2400 QTY01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always FL |  |
| 8 | OB Anesthesia Additional Units | 5 N | 837: (P)2400 QTY02  Print: N/A | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: ADDITIONAL OB MINUTES (#74) |  |
| 9 | BLANK | 1 |  |  |  |
| 10 | BLANK | 1 |  |  |  |
| 11 | Line Item Control Number Qualifier | 2 A/N | 837: 2400 REF01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 6R |  |
| 12 | Line Item Control Number | 20 A/N | 837: 2400 REF02  Print: N/A | Biller Input: N/A  The system creates this number from the sequence of the line item and the claim number –Example: 1\_K101XXX  Storage: N/A | Value should be returned on 835 |
| 13 | Purchase Service Provider ID | 20 A/N | 837: 2400 PS101  Print: N/A | Biller Input: Screen 4/5 Section 4  Billers can add line level providers to a claim but the NPI comes from the New Person file or the IB Non-/Other VA Billing Provider file  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99)  File: IB NON/OTHER BILLING PROVIDER (#355.93)  Field: NPI (#41.01) | Should equal a provider from 2420 loop either NM109 or REF02 |
| 14 | Purchase Service Amount | 8 N  2 Decimals | 837: 2400 PS102  Print: N/A | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: PURCHASED COST (#19) |  |
| 15 | Description (NOC Procedure) | 80 A/N | 837:  (P) 2400 SV101-7  (I) 2400 SV202-7  Print: N/A | Biller Input: Screen 4/5 Section 4  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Field: PROCEDURE DESCRIPTION (#51) |  |

### LOPE - Loop 2420A (Line Operating Physician Data) [SEQ 192]

(Max one record per Line

(OPTIONAL – Max length 180 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LOPE’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: (I) 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Operating Physician Qualifier | 2 N | 837: (I)2420A NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 72 |  |
| 4 | Operating Physician Last Name | 60 A | 837: (I)2420A NM103  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) | NM102 = 1 |
| 5 | Operating Physician First Name | 35 A | 837: (I) 2420A NM104  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 6 | Operating Physician Middle | 1 A | 837: (I) 2420A NM105  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 7 | Operating Physician Name Suffix | 10 A | 837: (I) 2420A NM107  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 8 | Operating Physician Primary ID Qualifier | 2 A | 837: (I) 2420A NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Operating Physician Primary ID | 10 N | 837: (I) 2420A NM109  Print: N/A | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Operating Physician Secondary ID Qualifier (1) | 2 A/N | 837: (I) 2420A REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 11 | Operating Physician Secondary ID(1) | 10 A/N | 837: (I) 2420A REF02  Print: N/A | Biller Input: *Screen5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 12 | Operating Physician Secondary ID Qualifier (2) | 2 A/N | 837: (I) 2420A REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 13 | Operating Physician Secondary ID(2) | 10 A/N | 837: (I) 2420A REF02  Print: N/A | Biller Input: *Screen5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 14 | Operating Physician Secondary ID Qualifier (3) | 2 A/N | 837: (I) 2420A REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 15 | Operating Physician Secondary ID(3) | 10 A/N | 837: (I) 2420A REF02  Print: N/A | Biller Input: *Screen5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

### LOP1 - Loop 2420B (Line Other Operating Physician Data) [SEQ 193]

Maximum one record per Line

(OPTIONAL – Max length 180 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LOP1’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: (I) 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Other Operating Qualifier | 2 A | 837: (I)2420B NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always ZZ |  |
| 4 | Other Operating Provider Last Name | 60 A | 837: (I)2420B NM103  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) | NM102 = 1 |
| 5 | Other Operating Provider First Name | 35 A | 837: (I) 2420B NM104  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 6 | Other Operating Provider Middle | 1 A | 837: (I) 2420B NM105  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 7 | Other Operating Provider Name Suffix | 10 A | 837: (I) 2420B NM107  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 8 | Other Operating Provider Primary ID Qualifier | 2 A | 837: (I) 2420B NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Other Operating Provider Primary ID | 10 N | 837: (I) 2420B NM109  Print: N/A | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Other Operating Provider Secondary ID Qualifier (1) | 2 A/N | 837: (I) 2420B REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 11 | Other Operating Provider Secondary ID(1) | 10 A/N | 837: (I) 2420B REF02  Print: N/A | Biller Input: *Screen5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 12 | Other Operating Provider Secondary ID Qualifier (2) | 2 A/N | 837: (I) 2420B REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 13 | Other Operating Provider Secondary ID(2) | 10 A/N | 837: (I) 2420B REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 14 | Other Operating Provider Secondary ID Qualifier (3) | 2 A/N | 837: (I) 2420B REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 15 | Other Operating Provider Secondary ID(3) | 10 A/N | 837: (I) 2420B REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

### LREN - Loop 2420A/C (Line Rendering Provider Data) [SEQ 193.3]

Maximum one record per Line

(OPTIONAL – Max length 194 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LREN’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Rendering Provider Qualifier | 2 A/N | 837:  (P)2420A NM101  (I) 2420C NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always 82 |  |
| 4 | Rendering Provider Last Name | 60 A | 837:  (P)2420A NM103  (I) 2420C NM103  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) | NM102 = 1 |
| 5 | Rendering Provider First Name | 35 A | 837:  (P)2420A NM104  (I) 2420C NM104  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 6 | Rendering Provider Middle | 1 A | 837:  (P)2420A NM105  (I) 2420C NM105  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 7 | Rendering Provider Name Suffix | 10 A | 837:  (P)2420A NM107  (I) 2420C NM107  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 8 | Rendering provider Primary ID Qualifier | 2 A | 837:  (P)2420A NM108  (I) 2420C NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Rendering Provider Primary ID | 10 N | 837:  (P)2420A NM109  (I) 2420C NM109  Print: CMS 1500 - 24J | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Rendering Provider Secondary ID Qualifier (1) | 2 A/N | 837:  (P)2420A REF01  (I) 2420C REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 11 | Rendering Provider Secondary ID(1) | 10 A/N | 837:  (P)2420A REF02  (I) 2420C REF02  Print: | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 12 | Rendering Provider Secondary ID Qualifier (2) | 2 A/N | 837:  (P)2420A REF01  (I) 2420C REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set:0B, 1G, G2, LU |
| 13 | Rendering Provider Secondary ID(2) | 10 A/N | 837:  (P)2420A REF01  (I) 2420C REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 14 | Rendering Provider Secondary ID Qualifier (3) | 2 A/N | 837:  (P)2420A REF01  (I) 2420C REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 15 | Rendering Provider Secondary ID(3) | 10 A/N | 837:  (P)2420A REF02  (I) 2420C REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 16 | Rendering Provider Taxonomy Qualifier | 2 A | 837: (P)2420A PRV01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always PE |  |
| 17 | Rendering Provider Taxonomy Code | 10 A | 837: (P)2420A PRV03  Print: N/A | Biller Input: *Screen 10 Section 3*  The physician’s taxonomy code is defaulted from the New Person🡪Person Class file but may be overridden by the biller.  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROVIDER (#222)  Field: TAXONOMY (#.15) | PRV02 = PXC |

### LPUR - Loop 2420B (Line Purchase Service Provider Data) [SEQ 193.6]

Maximum one record per Line

(OPTIONAL – Max length 42 bytes)

| Piece | Description | Max Length Data Type | 837/VPE Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LPUR’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Purchase Service Provider Qualifier | 2 A | 837: (P)2420B NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always QB | Set NM102 = 1 |
| 4 | Purchase Service Provider Primary ID Qualifier | 2 A | 837: (P)2420B NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 5 | Purchase Service Provider Primary ID | 10 N | 837: (P)2420B NM109  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. The NPI becomes the Primary ID.  Storage:  File: IB NON/OTHER VA BILLING PROVIDER (#355.93)  Field: NPI (#41.01) |  |
| 6 | Purchase Service Provider Secondary ID Qualifier (1) | 2 A/N | 837: (P)2420B REF01  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Users may add an Outside Facility to a claim but the facility is defined in SYST🡪PROV🡪NF of Provider ID Maintenance. Secondary IDs can be the provider’s own ID or an ID assigned by a payer.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2 |
| 7 | Purchase Service Provider Secondary ID(1) | 10 A/N | 837: (P)REF02  Print: N/A | Biller Input:  *Fee: Screen 10 Section 4*  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Field: PROVIDER ID (#.07) |  |

### LSUP - Loop 2420D (Line Supervising Provider Data) [SEQ 194]

Maximum one record per Line

(OPTIONAL – Max length 180 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LSUP’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: (P) 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Supervising Provider Qualifier | 2 A | 837: (P)2420D NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DQ |  |
| 4 | Supervising Provider Last Name | 60 A | 837: (P)2420D NM103  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) | NM102 = 1 |
| 5 | Supervising Provider First Name | 35 A | 837: (P)2420D NM104  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 6 | Supervising Provider Middle | 1 A | 837: (P)2420D NM105  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 7 | Supervising Provider Name Suffix | 10 A | 837: (P)2420D NM107  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 8 | Supervising Provider Primary ID Qualifier | 2 A | 837: (P)2420D NM108  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Supervising Provider Primary ID | 10 N | 837: (P)2420D NM109  Print: N/A | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Supervising Provider Secondary ID Qualifier (1) | 2 A/N | 837: (P)2420D REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 11 | Supervising Provider Secondary ID(1) | 10 A/N | 837: (P)2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 12 | Supervising Provider Secondary ID Qualifier (2) | 2 A/N | 837: (P)2420D REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 13 | Supervising Provider Secondary ID(2) | 10 A/N | 837: (P)2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 14 | Supervising Provider Secondary ID Qualifier (3) | 2 A/N | 837: (P)2420D REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2, LU |
| 15 | Supervising Provider Secondary ID(3) | 10 A/N | 837: (P)2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

### LREF - Loop 2420F/D (Line Referring Provider Data) [SEQ 194.3]

Max two record per Line

(OPTIONAL – Max length 180 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LREF’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Referring Provider Qualifier | 2 A/N | 837:  (P)2420F NM101  (I)2420D NM101  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always DN |  |
| 4 | Referring Provider Last Name | 60 A | 837:  (P)2420F NM103  (I) 2420D NM103  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) | NM102 = 1 |
| 5 | Referring Provider First Name | 35 A | 837:  (P)2420F NM104  (I) 2420D NM104  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 6 | Referring Provider Middle | 1 A | 837:  (P)2420F NM105  (I) 2420D NM105  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 7 | Referring Provider Name Suffix | 10 A | 837:  (P)2420F NM107  (I) 2420D NM107  Print: N/A | Biller Input:  *Screen 4/5 Section 4*  Storage:  File: BILL/CLAIMS (#399)  Subfile: PROCEDURES (#304)  Subfile: LINE PROVIDER (#60)  Field: LINE PERFORMED BY (#.02) |  |
| 8 | Referring Provider Primary ID Qualifier | 2 A | 837:  (P)2420F NM108  (I) 2420D NM108 | Biller Input: N/A  Storage: N/A  Note: Always XX |  |
| 9 | Referring Provider Primary ID | 10 N | 837:  (P)2420F NM109  (I) 2420D NM109 | Biller Input: N/A  The biller can add a provider to a claim but the provider’s NPI comes from the New Person file.  Storage:  File: NEW PERSON (#200)  Field: NPI (#41.99) |  |
| 10 | Referring Provider Secondary ID Qualifier (1) | 2 A/N | 837:  (P)2420F REF01  (I) 2420D REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2 |
| 11 | Referring Provider Secondary ID(1) | 10 A/N | 837:  (P)2420F REF02  (I) 2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 12 | Referring Provider Secondary ID Qualifier (2) | 2 A/N | 837: (P)2420F REF01  (I) 2420D REF01 | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2 |
| 13 | Referring Provider Secondary ID(2) | 10 A/N | 837:  (P)2420F REF02  (I) 2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |
| 14 | Referring Provider Secondary ID Qualifier (3) | 2 A/N | 837:  (P)2420F REF01  (I) 2420D REF01  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID TYPE (#.06) | Code set: 0B, 1G, G2 |
| 15 | Referring Provider Secondary ID(3) | 10 A/N | 837:  (P)2420F REF02  (I) 2420D REF02  Print: N/A | Biller Input: *Screen 5 Section 4*  Users may add a one-time Secondary ID when they add the provider to a claim.  Provider Secondary IDs and Qualifiers are maintained in Provider ID Maintenance. Providers may have their own IDs or they may have IDs assigned to them by a payer.  The billing software will automatically pull a provider’s IDs from Provider ID Maintenance.  Storage:  File: IB BILLING PRACTITIONER ID (#355.9)  Or by Care Unit  File: IB INSURANCE CO LEVEL BILLING PROVIDER ID (#355.91)  Field: PROVIDER ID (#.07) |  |

## Section 6 – Other Insurance Line Level Data

### LCOB - Loop 2430 (COB Service Line Adjudication Data) [SEQ 195]

Maximum one record per Line #/payer id on INS/PRF/RX1 record

(OPTIONAL – Max length 230 bytes)

| Piece | Description | Max Length Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LCOB’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Payer ID | 20 A/N | 837: 2430 SVD01  Print: N/A | Biller Input: N/A  Storage:  File: INSURANCE COMPANY (#36)  Field: EDI ID NUMBER – PROF (#3.02)  Field: EDI ID NUMBER – INST (#3.04)  Field: HPID (# TBD) |  |
| 4 | Service Line Paid Amt | 15 N  2 Decimals | 837: 2430 SVD02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: AMOUNT PAID (#.03) |  |
| 5 | Procedure Code | 20 A/N | 837: 2430 SVD03 – 2  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: PROCEDURE (#.04) | Set SVD03 – 1 = HC |
| 6 | Service Line Revenue Code | 10 A/N | 837: 2430 SVD04  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: REVENUE CODE (#.1) | Element removed in 5010 final rule and re-instated in the errata. |
| 7 | Procedure Modifier (1) | 2 A/N | 837: 2430 SVD03 - 3  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: PAID MODIFIERS (#2)  Field: PAID MODIFIERS (#.01) |  |
| 8 | Procedure Modifier (2) | 2 A/N | 837: 2430 SVD03 – 4  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: PAID MODIFIERS (#2)  Field: PAID MODIFIERS (#.01) |  |
| 9 | Procedure Modifier (3) | 2 A/N | 837: 2430 SVD03 – 5  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: PAID MODIFIERS (#2)  Field: PAID MODIFIERS (#.01) |  |
| 10 | Procedure Modifier (4) | 2 A/N | 837: 2430 SVD03 – 6  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: PAID MODIFIERS (#2)  Field: PAID MODIFIERS (#.01) |  |
| 11 | Procedure Code Description | 80 A/N | 837: 2430 SVD03 – 7  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: DESCRIPTION (#.09) |  |
| 12 | Paid Service Unit Count | 15 N | 837: (P) 2430 SVD05  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: PAID UNITS OF SERVICE (#.11) |  |
| 13 | Bundled Line Number | 6 N | 837: (P) 2430 SVD06  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Field: REFERENCED LINE # (#.12) |  |
| 14 | Adjudication or Payment DT | 8 N CCYYMMDD | 837: (P) 2430 DTP03  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Field: EOB PAID DATE (#.06) |  |
| 15 | Product or Service ID Qualifier | 2 A | 837: 2430 SVD03  Print: N/A | Biller Input: N/A  Storage: N/A |  |
| 16 | Remaining Liability Qualifier | 3 A | 837: 2430 AMT01  Print: N/A | Biller Input: N/A  Storage: N/A  Note: Always EAF |  |
| 17 | Remaining Liability | 15 N  2 Decimals | 837: 2430 AMT02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEIFITS (#361.1)  Field: PATIENT RESPONSIBILITY AMT (#1.02) |  |
| 18 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S) ,Tertiary (T) Must match value in OI1 piece 2 for insurance. |

### 

### LCAS - Loop 2430 (COB Line Level Adjustments) [SEQ 200]

One or more records per LCOB record

(OPTIONAL – Max length 190 bytes)

| Piece | Description | Max Length  Data Type | 837/Print Location | VistA Input/Storage | FSC Processing Comments |
| --- | --- | --- | --- | --- | --- |
| 1 | RECORD ID = ‘LCAS’ | 4 A |  |  |  |
| 2 | Service Line Counter | 6 N | 837: 2400 LX01  Print: N/A | Biller Input: N/A  The system will keep track of the order of Revenue Codes and procedures and keep the correct line level records together.  Storage: N/A |  |
| 3 | Claim Adjustment Group Code | 2 A | 837: 2430 CAS01  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Field: GROUP CODE (#.01) | LQ is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 4 | Adjustment Reason Code (1) | 5 A/N | 837: 2430 CAS02  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 5 | Adjustment Amt (1) | 15 N  2 Decimals | 837: 2430 CAS03  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ. |
| 6 | Adjustment Quantity (1) | 6 N | 837: 2430 CAS04  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is LQ. |
| 7 | Adjustment Reason Code (2) | 5 A/N | 837: 2430 CAS05  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 8 | Adjustment Amt (2) | 15 N  2 Decimals | 837: 2430 CAS06  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ |
| 9 | Adjustment Quantity (2) | 6 N | 837: 2430 CAS07  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is LQ |
| 10 | Adjustment Reason Code (3) | 5 A/N | 837: 2430 CAS08  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 11 | Adjustment Amt (3) | 15 N  2 Decimals | 837: 2430 CAS09  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ |
| 12 | Adjustment Quantity (3) | 6 N | 837: 2430 CAS10  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is LQ |
| 13 | Adjustment Reason Code (4) | 5 A/N | 837: 2430 CAS11  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 14 | Adjustment Amt (4) | 15 N  2 Decimals | 837: 2430 CAS12  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ |
| 15 | Adjustment Quantity(4) | 6 N | 837: 2430 CAS13  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is LQ |
| 16 | Adjustment Reason Code (5) | 5 A/N | 837: 2430 CAS14  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 17 | Adjustment Amt (5) | 15 N  2 Decimals | 837: 2430 CAS15  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ |
| 18 | Adjustment Quantity (5) | 6 N | 837: 2430 CAS16  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is LQ |
| 19 | Adjustment Reason Code (6) | 5 A/N | 837: 2430 CAS17  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: REASON CODE (#.01) | AAA is only valid for claims with CI5 piece 3 (destination payer ID) of IPRNT or PPRNT. |
| 20 | Adjustment Amt (6) | 15 N  2 Decimals | 837: 2430 CAS18  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: AMOUNT (#.02) | Zero is valid if LCAS piece 3 is LQ |
| 21 | Adjustment Quantity (6) | 6 N | 837: 2430 CAS19  Print: N/A | Biller Input: N/A  Storage:  File: EXPLANATION OF BENEFITS (#361.1)  Subfile: 835 LINE LEVEL ADJUSTMENTS (#15)  Subfile: ADJUSTMENTS (#1)  Subfile: REASONS (#1)  Field: QUANTITY (#.03) | Zero is valid if LCAS piece 3 is  LQ |
| 22 | Payer Responsibility Sequence # Code | 1 A | 837: N/A  Print: N/A | Biller Input: *Screen 3 Section 1*  Note: A biller can initially designate a claim as P/T/S but depending on the number of payers on a claim, the system will automatically keep track of the current Payer sequence and which payer(s) is the destination payer or the Other payers.  Storage:  File: BILL/CLAIMS (#399)  Field: CURRENT BILL PAYER SEQUENCE (#.21) | Primary (P), Secondary (S),Tertiary (T) Must match value in OI1 piece 2 for insurance. |

# Appendix B – FSC Mapping Rules

## TPA Clearinghouse ID

**Program Name:** TPA ClearinghouseID.exe

**Overview**

This preprocessor defines the claim office IDs which may be used with the secondary clearinghouse IDs. If a clearinghouse ID - defined on the Edit Clearinghouse ID page - is submitted on a claim, the claim office ID value must match one of the values in the table below.

If a valid combination of claim office ID and clearinghouse ID is not found, the clearinghouse ID and claim office ID values are removed from the claim and it is forwarded to the HCCH with a destination payer ID (CI5 -3 /2010BB NM109) of null.

**Business Case**

This preprocessor was implemented to allow HCCH to forward electronic secondary claims to additional payers by making the additional clearinghouse’s networks available to the VA. Under this process the VA would send the claim to HCCH. HCCH would then forward the claim to additional clearinghouse. The clearinghouse will submit the claim to the final payer.

**User Parameters**

**Preprocessor control page:** Configure Valid Clearinghouse IDs

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Clearinghouse ID | CI5 – 3 | 2010BB NM109 | TPA payer ID |
| Claim Office ID | N/A | N/A | Assigned by TPA |

**Functional Requirements**

**F REQ-1:** Remove the Clearinghouse ID if used on a Primary Claim

Determine whether the following statements are true:

* Payer ID (CI5 - 3 / 2010BB NM109) is equal to clearinghouse payer ID in the clearinghouse ID table
* Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is equal to P

If both statements are true, then perform the following steps:

* Delete Payer ID (CI5 - 3 / 2010BB NM109)
* Delete Payer ID qualifier (CI5 - 2 / 2010BB NM108)
* If the first secondary claim ID qualifier (CI5 - 4 / 2010BB REF01) is equal to FY, then delete the first secondary claim ID qualifier (CI5 - 4 / 2010BB REF01) and the first secondary ID (CI5 - 5 / 2010BB REF02)
* If the second secondary claim ID qualifier (CI5 - 6 / 2010BB REF01) is equal to FY, then delete the second secondary claim ID qualifier (CI5 - 6 / 2010BB REF01) and the second secondary ID (CI5 - 7 / 2010BB REF02)
* If the third secondary claim ID qualifier (CI5 - 8 / 2010BB REF01) is equal to FY, then delete the second secondary claim ID qualifier (CI5 - 8 / 2010BB REF01) and the second secondary ID (CI5 - 9 / 2010BB REF02)

**F REQ-2:** Validate the claim office ID for the Payer ID

Determine whether the following statement is true:

* Payer ID (CI5 - 3 / 2010BB NM109) is equal to clearinghouse payer ID in the clearinghouse table

If true, then do perform the following steps:

* If the claim office ID in the first secondary ID (CI5 - 5 / 2010BB REF02 where CI5-4 / 2010BB REF01 = FY) is not equal to one of the claim office IDs for the clearinghouse ID, then delete:
* Destination payer ID qualifier (CI5 - 2 / 2010BB NM108)
* Destination payer ID (CI5 - 3 / 2010BB NM109)
* First secondary claim ID qualifier (CI5 - 4 / 2010BB REF01)
* First secondary ID (CI5 - 5 / 2010BB REF02)

1. If the claim office ID in the second secondary ID qualifier (CI5 - 7 / 2010BB REF02 where CI5-4 / 2010 REF01 = FY) is not equal to one of the claim office IDs for the clearinghouse ID, then delete:

* Destination payer ID qualifier (CI5 - 2 / 2010BB NM108)
* Destination payer ID (CI5 - 3 / 2010BB NM109)
* Second secondary claim ID qualifier (CI5 - 6 / 2010BB REF01)
* Second secondary ID (CI5 - 7 / 2010BB REF02)

## Site Focus Testing

**Program Name:** EndToEndTestingID.exe

**Overview**

This page defines payers which are in focus testing. If a claim is submitted to a payer listed below from a site with the corresponding tax ID and is within the date span listed, the claim will be forwarded to the 5010 payer switch with the destination payer ID submitted by the site. If the claim is submitted from a site not listed on the table or is outside the date range, the destination payer ID will be changed to IPRNT for institutional claims or PPRNT for professional claims.

The payer ID must also be approved for secondary claims using the configure payer screen.

After focus test is complete, the payer ID should be removed from this table. If the test is unsuccessful, then it should also be removed from list of valid secondary IDs.

**Business Case**

When the VA sends a secondary claim to HCCH, HCCH either prints the claim on a paper claim form or transmits it electronically to the final payer. There are a limited number of payers that accept electronic secondary claims from the VA. If a secondary claim is submitted for one of the payers that is not designated as approved for the secondary claims, the FSC inserts a value (PPRNT or IPRNT) into the destination payer ID (CI5 – 3 / 2010BB NM109) which forces the claim to print on a paper claim form.

This preprocessor allows CBO to designate a limited number of sites that can submit electronic secondary claims to a specific payer while the rest of the sites continue to be processed on paper claims forms. This change is used to verify that the payer will correctly process electronic secondary claims where secondary claim testing was not completed satisfactorily. It creates an alpha and beta site testing for the payer and secondary claims.

**User Parameters**

**Preprocessor control page:** Configure Payer End to End Testing

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Payer Name | CI1-2 | 2010BB NM103 | This value is not referenced in the preprocessor logic |
| Payer ID | CI5-3 | 2010BB NM109 | HCCH payer ID |
| Insurance Sequence | CI2-2 | 2000B SBR01 | S – Secondary  T – Tertiary |
| Tax ID | CI1A-5 | 2010AA REF02 | Site tax ID |
| First Test Date | N/A | N/A | Date claim is sent to FSC |
| Last Test Date | N/A | N/A | Date claim is sent to FSC |
| Create By | N/A | N/A | User who created entry |

**Functional Requirements**

**F REQ-1:** Replace payer ID with PPRNT or IPRNT if not from test site

Determine if the following statements are true:

* The claim’s payer ID (CI5 - 3 / 2010BB NM109) is a payer ID on the table
* The billing provider tax ID (CI1A - 5 / 2010AA REF02) is not a tax ID listed for the payer ID
* The claim submission date is between the start and end date on the table
* The insurance sequence (CI2 – 2 / 2000B SBR01) is equal to insurance sequence value

If all statements are true, then:

* Change the (CI5 - 3 / 2010BB NM109) to IPRNT on institutional claims
* Change the (CI5 - 3 / 2010BB NM109) to PPRNT on professional claims

## Payer ID Switch

**Program Name:** PayerIDswitches.exe

**Overview**

This preprocessor changes the destination payer ID (CI5 – 3 / 2010BB NM109) if the claim is not a primary payer claim. The values for the destination payer ID can be configured differently if the previous payer ID is Medicare and also allows a Third Party Administrator (TPA) claim office ID to be submitted as a secondary payer ID number.

**Business Case**

This program addresses several business issues relating to payer ID:

Payers have established unique destination payer IDs that are different based on if the claim is primary or secondary.

Medicare secondary claims should be routed to a different location than non-Medicare secondary claims; this is done using the payer ID

Claims which are to be routed to Third Party Administered (TPA) Clearinghouses must include the TPA ID as the payer ID and a claim office ID number to identify the payer.

**User Parameters**

**Preprocessor control page:** Configure Payer

This page is also used by to set X12 outbound claim version. See 3.2.

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Payer Name | CI1-2 | 2010BB NM103 | This value is not referenced in the preprocessor logic |
| Primary ID | CI5- 3 | 2010BB NM109 | HCCH payer ID |
| Primary claims X12 Version | N/A | N/A | Used to set outbound claim version |
| 837 Claim Type | N/A | N/A | Professional  Institutional  Professional and Institutional  Unknown |
| Medicare secondary claims primary ID | CI5-3 | 2010BB NM109 | HCCH payer ID |
| Medicare secondary claims secondary ID | CI5-5 or CI5-7 | 2010BB REF02 | Value used by TPA to route claims. Can be sent in either the first or second instance of the REF |
| Non-Medicare secondary claims | CI5 – 3 | 2010BB NM109 | HCCH payer ID |

**Functional Requirements**

**F REQ-1:** Validate destination payer primary IDs on primary claims

If payer sequence (CI2 – 2 / 2000B SBR01) is “P,” then:

* If destination payer ID (CI5 - 3 / 2010BB NM109) is null, do nothing
* If destination payer ID (CI5 - 3 / 2010BB NM109) is in primary ID column, then do nothing
* If destination payer ID (CI5 - 3 / 2010BB NM109) is not in primary ID column, then set destination payer ID qualifier (CI5 - 2 / 2010BB NM108) and destination payer ID (CI5 - 3 / 2010BB NM109) to null

**F REQ-2:** Validate destination payer primary IDs on secondary professional claims where Medicare was the primary payer

If receiver ID (GEN – 6) is “ENVOYP” or “CHAMVP” and if (CI2 – 2 / 2000B SBR01) is “S” and other payer ID (OI6 – 4 / 2330B NM109) is “SMTX1” or “12M16” where other payer sequence (OI6 – 2) is “P”:

* If destination payer ID (CI5 - 3 / 2010BB NM109) is in the Medicare secondary ID column where the claim type is “P,” then do nothing
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “P” and the Medicare secondary column is not null and the TPA column is null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “P” and the Medicare secondary column is not null and the TPA column is not null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value and:
* If CI5 - 5 is null then set CI5 - 4 equal to “FY” and the CI5 - 5 equal to the TPA value
* If CI5 - 5 is not null then set CI5 - 6 to “FY” and the CI5 - 7 to the TPA value
* If none of the conditions are true, then set destination payer ID qualifier (CI5 – 2 / 2010BB NM108) to “PI” and destination payer ID (CI5 - 3 / 2010BB NM109) to “PPRNT”

**F REQ-3:** Validate destination payer primary IDs on tertiary professional claims where Medicare was the secondary payer

If receiver ID (GEN – 6) is “ENVOYP” or “CHAMVP” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “T” and other payer ID (OI6 – 4 / 2330B NM109) is “SMTX1” or “12M16” where other payer sequence (OI6 – 2) is “S,” then:

* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the Medicare secondary ID column where the claim type is “P” then do nothing
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “P” and the Medicare secondary column is not null and the TPA column is null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “P” and the Medicare secondary column is not null and the TPA column is not null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value and:
* If CI5 - 5 is null then set CI5 - 4 equal to “FY” and the CI5 - 5 equal to the TPA value
* If CI5 - 5 is not null then set CI5 - 6 to “FY” and the CI5 - 7 to the TPA value
* If none of the conditions are true then set destination payer ID qualifier (CI5 – 2 / 2010BB NM108) to “PI” and destination payer ID (CI5 - 3 / 2010BB NM109) to “PPRNT”

**F REQ-4:** Validate destination payer primary IDs on secondary institutional claims where Medicare was the primary payer

If receiver ID (GEN – 6) is “ENVOYH” or “CHAMVH” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “S” and other payer ID (OI6 – 4 / 2330B NM109) is “SMTX1” or “12M16” where other payer sequence (OI6 – 2) is “P”:

* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the Medicare secondary ID column where the claim type is “I” then do nothing
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “I” and the Medicare secondary column is not null and the TPA column is null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “I” and the Medicare secondary column is not null and the TPA column is not null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value and:
* If destination payer ID (CI5 - 3 / 2010BB NM109) is null then set CI5 - 4 equal to “FY” and the CI5 - 5 equal to the TPA value
* If destination payer ID (CI5 - 3 / 2010BB NM109) is not null then set CI5 - 6 to “FY” and the CI5 - 7 to the TPA value
* If none of the conditions are true then set destination payer ID qualifier (CI5 - 2 / 2010BB NM108) to “PI” and destination payer ID (CI5 - 3 / 2010BB NM109) to “IPRNT”

**F REQ-5:** Validate destination payer primary IDs on tertiary claims where Medicare was the secondary payer

If receiver ID (GEN – 6) is “ENVOYH” or “CHAMVH” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “T” and other payer ID (OI6 – 4 / 2330B NM109) is “SMTX1” or “12M16” where other payer sequence (OI6 – 2) is “S,” then:

* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the Medicare secondary ID column where the claim type is “I” then do nothing
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “I” and the Medicare secondary column is not null and the TPA column is null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value
* If the destination payer ID (CI5 - 3 / 2010BB NM109) is in the primary column where the claim type is “I” and the Medicare secondary column is not null and the TPA column is not null, then set destination payer ID (CI5 - 3 / 2010BB NM109) equal to the Medicare secondary value

and

* If CI5 - 5 is null then set CI5 - 4 equal to “FY” and the CI5 - 5 equal to the TPA value
* If CI5 - 5 is not null then set CI5 - 6 to “FY” and the CI5 - 7 to the TPA value
* If none of the conditions are true then set destination payer ID qualifier (CI5 - 2 / 2010BB NM108) to “PI” and destination payer ID (CI5 - 3 / 2010BB NM109) to “IPRNT”

**F REQ-6:** Do not act on destination payer IDs for non-primary claims if Medicare is not immediately secondary

* If receiver ID (GEN – 6) is “ENVOYH” or “CHAMVH” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “S” and OI6 - 4 is not “SMTX1” or “12M16” where OI6 - 2 is “P,” then do nothing
* If receiver ID (GEN – 6) is “ENVOYH” or “CHAMVH” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “T” and OI6 - 4 is not “SMTX1” or “12M16” where OI6 - 2 is “S,” then do nothing
* If receiver ID (GEN – 6) is “ENVOYP” or “CHAMVP” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “S” and OI6 - 4 is not “SMTX1” or “12M16” where OI6 - 2 is “P,” then do nothing
* If receiver ID (GEN – 6) is “ENVOYP” or “CHAMVP” and if Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is “T” and OI6 - 4 is not “SMTX1” or “12M16” where OI6 - 2 is “S,” then do nothing

## Set X12 Outbound Claim Version

**Program Name:** Version4010Splitter.exe, RemoveDowngradedRecords.exe

**Overview**

This preprocessor routes the claim data to 5010 Errata map based on the destination payer ID (CI5 -3 / 2010BB NM109). All preprocessors which alter the destination claim ID value must execute before this step.

**Business Case**

Allow the VA to send claims to the HCCH in the 5010 errata version of the X12 standard in order to manage the transition between the standards.

**User Parameters**

**Preprocessor control page:** Configure Payer

This page is also used to change payer IDs for non-primary claims. See 3.1

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Payer Name | CI1-2 | 2010BB NM103 | This value is not referenced in the preprocessor logic |
| Primary ID | CI5-3 | 2010BB NM109 | HCCH payer ID |
| Primary claims X12 version | N/A | N/A | Outbound claim version on primary claims |
| 837 Claim Type | N/A | N/A | Professional  Institutional  Professional and Institutional  Unknown |
| Secondary claims X12 version | N/A | N/A | Outbound claim version on secondary and tertiary claims |
| Medicare secondary claims primary ID | CI5-3 | 2010BB NM109 | HCCH payer ID See 3.1 |
| Medicare secondary claims secondary ID | CI5-5 or CI5-7 | 2010BB REF | Value used by TPA to route claims. See 3.1 |
| Non-Medicare secondary claims | CI5-3 | 2010BB NM109 | HCCH payer ID See 3.1 |

**Functional Requirements**

**F REQ-1:** Move primary claims into 5010 outbound file

If the Payer Responsibility Sequence (CI2 - 2 / 2000B SBR01) is equal to P, then determine if the following statement is true:

Is the value in the Payer Control table = 5010 where:

* The destination payer primary ID (CI5 – 3 / 2010BB NM109) is equals the value for in the primary ID column
* The value for Claim Type is equal to the claim:
* Claim Type is “Institutional” and receiver ID (GEN – 6) is “ENVOYH” or “PARTA” or “CHAMVH.”
* Claim Type is “Professional” and receiver ID (GEN – 6) is “ENVOYP”” or “PARTB” or “CHAMVP”
* If Claim Type is “Inst and Prof,” always return true for this condition

If true, then copy all records relating to the claim into a 5010 holding file including the BGN and GEN records.

**F REQ-2:** Move non-primary claims into the 5010 file

If the payer sequence value (CI2 - 2 / 2000B SBR01) is not equal to P, then determine if the following statement is true:

Is the value in the Payer Control table = 5010 where:

* The destination payer primary ID (CI5 – 3 / 2010BB NM109) is equal to a value in the secondary ID column. Column for Medicare or non-Medicare claims.
* The value for Claim Type is equal to the claim:
* Claim Type is “Institutional” and receiver ID (GEN – 6) is “ENVOYH” or “PARTA” or “CHAMVH”
* Claim Type is “Professional” and receiver ID (GEN – 6) is “ENVOYP”” or “PARTB” or “CHAMVP”
* If Claim Type is “Inst and Prof,” always return true for this condition

If true, then copy all records relating to the claim into a 5010 holding file including the BGN and GEN records.

**F REQ-3:** Move non-defined claims into the 5010 file

If the ID does not match a value in the table, then move it to the 5010 file.

## Remove NPI from Medicare claims

**Program Name:** RemoveNPI.exe

**Overview**

This program removes all National Provider ID numbers (NPI) from claims submitted to Medicare.

**Business Case**

Medicare Administrative Contractor cannot process VA claims when submitted with NPI number.

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** Remove NPI numbers from Medicare claims

If the destination payer ID (CI5 – 3 / 2010BB NM109) is equal to SMTX1 or 12M61 (Medicare), then delete the following records and fields:

* PRV - 9 and 12 Billing provider NPI (837P 2010AA; 837I 2010AA)
* PRV1 - 5 and 6 pay to provider NPI (4010 only)
* SUB2 - 5 and 6 Lab facility NPI (837P 2310C; 837I 2310E)
* OPR1 - 2 and 3 Attending provider NPI (837I 2310A)
* OPR1 - 5 and 6 Other operating provider NPI (837I 2310C)
* OPR1 - 8 and 9 Operating physician NPI (837I 2310B)
* OPR1 - 11 and 12 Referring provider NPI (837P 2310A; 837I 2310F)
* OPR7 - 6 and 7 Supervising provider NPI (837P 2310D)
* OPR9 - 8 and 9 Rendering provider NPI (837I 2310D; 837P 2310B)
* LOPE - 8 and 9 Line level operating physician NPI (837I 2420A)
* LOP1 - 8 and 9 Line level other operating physician NPI(837I 2420B)
* LREN - 8 and 9 Line level rendering provider NPI (837I 2420C; 837P 2420A)
* LPUR - 4 and 5 Line level purchase service provider NPI (837P 2420B)
* LSUP - 8 and 9 Line level supervising provider NPI (837P 2420D)
* LREF - 8 and 9 Line level referring provider NPI (837I 2420D; 837P 2420F)

## Remove AB3

**Program Name:** RemoveAB3.exe

**Overview**

This program removes the adjustment reason codes of AB3 and associated amounts when not submitted on a paper Medicare institutional secondary claims. (Payer ID is equal to IPRNT.)

**Business Case**

The AB3 value is used by HCCH for printing MRA files. It should only appear on claims with the IPRNT IDs.

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** If the destination payer ID (CI5 – 3 / 2010BB NM109) is equal to IPRNT, then do nothing.

**F REQ-2:** If the destination payer ID (CI5 – 3 / 2010BB NM109) is not equal to IPRNT then:

* If adjustment reason code 1 (CCAS – 4 / 2320 CAS02) is equal to AB3, then:
* Delete adjustment reason code 1 (CCAS – 4 / 2320 CAS02) adjustment amount 1 (CCAS – 5 / 2320 CAS03), and adjustment quantity 1 (CCAS – 6 / 2320 CAS04).
* If adjustment reason code 2 (CCAS – 7 / 2320 CAS05) then delete the entire CCAS record
* If adjustment reason 2 (CCAS – 7 / 2320 CAS05) is not null, then:
  + - Move adjustment 2 into adjustment 1
    - Move adjustment 3 into adjustment 2
    - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 2 (CCAS – 7 / 2320 CAS05) is equal to AB3, then:
* Delete adjustment reason code 2 (LCAS – 7 / 2320 CAS05) adjustment amount 2 (CCAS – 8 / 2320 CAS06), and adjustment quantity 2 (CCAS – 9 / 2320 CAS07).
* If adjustment reason 3 (CCAS – 10 / 2320 CAS08) is not null, then:
  + - Move adjustment 3 into adjustment 2
    - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 3 (CCAS – 10 / 2320 CAS08) is equal to AB3, then:
* Delete adjustment reason code 3 (CCAS – 10 / 2320 CAS08) adjustment amount 3 (CCAS – 11 / 2320 CAS09), and adjustment quantity 3 (CCAS – 12 / 2320 CAS10).
* If adjustment reason 4 (CCAS – 13 / 2320 CAS11) is not null, then:
  + - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 4 (CCAS – 13 / 2320 CAS11) is equal to AB3, then:
* Delete adjustment reason code 4 (CCAS – 13 / 2320 CAS11) adjustment amount 3 (CCAS – 14 / 2320 CAS12), and adjustment quantity 3 (CCAS - 15, 2320 CAS13).
* If adjustment reason 5 (CCAS – 16 / 2320 CAS14) is not null, then:
  + - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 5 (CCAS – 16 / 2320 CAS14) is equal to AB3, then:
* Delete adjustment reason code 5 (CCAS – 16 / 2320 CAS14) adjustment amount 5 (CCAS – 17 / 2320 CAS15), and adjustment quantity 5 (CCAS – 18 / 2320 CAS16).
* If adjustment reason 6 (LCAS – 19 / 2430 CAS17) is not null, then:
  + - Move adjustment 6 into adjustment 5
* If adjustment reason code 6 (LCAS – 19 / 2430 CAS17) is equal to AAA, then:
* Delete adjustment reason code 6 (LCAS – 19 / 2430 CAS17) adjustment amount 6 (LCAS – 20 / 2430 CAS18), and adjustment quantity 6 (LCAS – 21 / 2430 CAS19).

## Remove LQ

**Program Name:** RemoveLQ.exe

**Overview**

This program removes the adjustment reason codes of LQ and associated amounts when not submitted on a paper Medicare secondary claims. (Payer ID is equal to IPRNT or PPRNT.)

**Business Case**

The LQ value is used by HCCH for printing MRA files. It should only appear on claims with the IPRNT and PPRNT IDs.

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** If the destination payer ID (CI5 – 3 / 2010BB NM109) is equal to IPRNT or PPRNT, then do nothing.

**F REQ-2:** If the destination payer ID (CI5 – 3 / 2010BB NM109) is not equal to IPRNT or PPRNT and the Claim Adjustment Group Code (LCAS – 3 / 2320 CAS01) is equal to LQ, then delete the entire LCAS segment

## Remove AAA

**Program Name:** RemoveAAA.exe

**Overview**

This program removes the adjustment reason codes of AAA and associated amounts when not submitted on a paper Medicare secondary claims.

**Business Case**

The AAA value is used by HCCH for printing MRA files. It should only appear on claims with the IPRNT or PPRNT IDs.

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** If the destination payer ID (CI5 - 3, 2010BB NM109) is equal to IPRNT or PPRNT, then do nothing.

**F REQ-2:** If the destination payer ID (CI5 - 3, 2010BB NM109) is not equal to IPRNT or PPRNT, then:

* If adjustment reason code 1 (LCAS – 4 / 2430 CAS02) is equal to AAA, then:
* Delete adjustment reason code 1 (LCAS – 4 / 2430 CAS02) adjustment amount 1 (LCAS – 5 / 2430 CAS03), and adjustment quantity 1 (LCAS – 6 / 2430 CAS04).
* If adjustment reason code 2 (LCAS – 7 / 2430 CAS05) then delete the entire LCAS record
* If adjustment reason 2 (LCAS – 7 / 2430 CAS05) is not null, then:
  + - Move adjustment 2 into adjustment 1
    - Move adjustment 3 into adjustment 2
    - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 2 (LCAS – 7 / 2430 CAS05) is equal to AAA, then:
* Delete adjustment reason code 2 (LCAS – 7 / 2430 CAS05) adjustment amount 2 (LCAS – 8 / 2430 CAS06), and adjustment quantity 2 (LCAS - 9 / 2430 CAS07).
* If adjustment reason 3 (LCAS – 10 / 2430 CAS08) is not null, then:
  + - Move adjustment 3 into adjustment 2
    - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 3 (LCAS – 10 / 2430 CAS08) is equal to AAA, then:
* Delete adjustment reason code 3 (LCAS – 10 / 2430 CAS08) adjustment amount 3 (LCAS – 11 / 2430 CAS09), and adjustment quantity 3 (LCAS – 12 / 2430 CAS10).
* If adjustment reason 4 (LCAS – 13 / 2430 CAS11) is not null, then:
  + - Move adjustment 4 into adjustment 3
    - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 4 (LCAS – 13 / 2430 CAS11) is equal to AAA, then:
* Delete adjustment reason code 4 (LCAS – 13 / 2430 CAS11) adjustment amount 3 (LCAS – 14 / 2430 CAS12), and adjustment quantity 3 (LCAS – 15 / 2430 CAS13).
* If adjustment reason 5 (LCAS – 16 / 2430 CAS14) is not null, then:
  + - Move adjustment 5 into adjustment 4
    - Move adjustment 6 into adjustment 5
* If adjustment reason code 5 (LCAS – 16 / 2430 CAS14) is equal to AAA, then:
* Delete adjustment reason code 5 (LCAS – 16 / 2430 CAS14) adjustment amount 5 (LCAS – 17 / 2430 CAS15), and adjustment quantity 5 (LCAS – 18 / 2430 CAS16).
* If adjustment reason 6 (LCAS – 19 / 2430 CAS17) is not null, then:
  + - Move adjustment 6 into adjustment 5
* If adjustment reason code 6 (LCAS – 19 / 2430 CAS17) is equal to AAA, then:
* Delete adjustment reason code 6 (LCAS – 19 / 2430 CAS17) adjustment amount 6 (LCAS – 20 / 2430 CAS18), and adjustment quantity 6 (LCAS – 21 / 2430 CAS19)

## Remove 2U

**Program Name:** Remove2U.exe

**Overview**

If a secondary ID is sent in the other payer loop with the 2U qualifier where Medicare is the payer, this program removes both the ID and the qualifier.

**Business Case**

This preprocess was created to satisfy a payer requirement. The value 2U is not valid for the provider secondary ID type when submitting a Medicare primary claim per the HIPAA implementation guides. Some payers have added an edit to their system which will reject a claim if a 2U value is used as a provider secondary ID type on Medicare secondary claims. While this edit may not be in accordance with the HIPAA rules, it was decided to remove the 2U from Medicare secondary claims to reduce the overall rejection rate rather than attempt to convince payers to remove the edit.

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** Remove IDs submitted with 2U qualifier where Medicare Part A is the other payer

If the other insurance primary payer ID (OI6 – 4 / 2330B NM109) is equal to 12M61 (Medicare Part A), then:

* If the first secondary ID qualifier (OI6 record 5 / 2330B REF01) is equal to 2U, delete the first secondary ID qualifier (OI6 record 5 / 2330B REF01) and the first secondary ID (OI6 record 6 / 2330B REF02)
* If the second secondary ID qualifier (OI6 record 7 / 2330B REF01) is equal to 2U, delete the second secondary ID qualifier (OI6 record 7 / 2330B REF01) and the second secondary ID (OI6 record 8 / 2330B REF02)

**F REQ-2:** Remove IDs submitted with 2U qualifier where Medicare Part B is the other payer

If the other insurance primary payer ID (OI6 – 4 / 2330B NM109) is equal to SMTX1 (Medicare Part B), then:

* If the first secondary ID qualifier (OI6 record 5 / 2330B REF01) is equal to 2U, delete the first secondary ID qualifier (OI6 record 5 / 2330B REF01) and the first secondary ID (OI6 record 6 / 2330B REF02)
* If the second secondary ID qualifier (OI6 record 7 / 2330B REF01) is equal to 2U, delete the second secondary ID qualifier (OI6 record 7 / 2330B REF01) and the second secondary ID (OI6 record 8 / 2330B REF02)

## Default Service Facility Address

**Program Name:** SvcFacilityAddress.exe

**Overview**

If a claim is submitted to one of the destination payers in the user-defined list and no service facility information is submitted on the claim, then the billing provider information is duplicated in the service facility loop.

**Business Case**

Prior to patch 400, claims submitted from VAMC always contained a service facility address. With the implementation of patch 400, the VAMC won’t always be sending the service facility address. It was not known at the time of the implementation if there were any payers that require this information even though it is not HIPAA-compliant. It was decided that in order to mitigate the risk of claims receiving payer level claim rejects, FSC would implement code to default this value if the payer expressly requested this data item.

**User Parameters**

**Preprocessor control page:** Configure Service Facility Payer List

This page is also used to change payer IDs for non-primary claims. See 3.1.

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Payer ID | CI5 – 3 | 2010BB NM109 | HCCH payer ID |
| Payer name |  | 2010BB NM103 | Not used within the program |
| Payer flag | N/A | N/A | A – All claims  B – If place of service is not home or office |

**Functional Requirements**

**F REQ-1:**Copy the billing provider into the service facility loop when payer flag is A

Determine if the following statements are true:

* If the claim’s payer ID (CI5 – 3 / 2010BB NM109) is a payer ID listed on the control page
* The service facility name (SUB2 - 4/ 2310D NM103) is null
* The player flag is A

If all statements are true, then perform the following steps:

* Default value of 77 to record (SUB2 - 2 / 2310D NM101)
* Default value of 2 to record (SUB2 - 3 / 2310D NM102)
* Copy the billing provider name record (PRV - 3 / 2010AA NM103) to service facility name record (SUB - 2 / 2310D NM103)
* Copy the primary billing provider number (PRV - 9 / 2010AA NM109) to the primary service facility number (SUB2 - 6 / 2310D NM109) and set primary service ID qualifier (SUB2 – 5 / 2310D NM108) to XX
* Copy billing provider address line one record (PRV - 4 / 2010AA N301) to service facility provider address (SUB - 3 / 2310D N301)
* Copy billing provider address line two record PRV - 11 (2010AA N302) to service facility provider address line two (SUB – 12 / 2310D N302)
* Copy billing provider city (PRV - 5 / 2010AA N401) to service facility provider city (SUB – 4 / 2310D N401)
* Copy billing provider state (PRV - 6 / 2010AA N402) to service facility provider state (SUB – 5 / 2310D N402).
* Copy billing provider zip code (PRV - 7 / 2010AA N403) to service facility provider zip code (SUB – 6 / 2310D N403)
* Copy the second billing provider secondary ID qualifier record (CI1A - 4 / 2010AA REF01) to the first service facility qualifier record (SUB2 – 7 / 2310D REF01)
* Copy the second billing provider secondary ID record (CI1A - 5 / 2010AA REF02) to the first billing provider secondary ID record (SUB2 - 8 / 2310D REF02)
* Copy the third billing provider secondary ID qualifier record (CI1A - 6 / 2010AA REF01) to the second service facility qualifier record (SUB2 – 9 / 2310D REF01)
* Copy the third billing provider secondary ID record (CI1A - 7 / 2010AA REF02) to the second billing provider secondary ID record (SUB2 - 10 / 2310D REF02)
* Copy the fourth billing provider secondary ID qualifier record (CI1A - 8 / 2010AA REF01) to the third service facility qualifier record (SUB2 – 11 / 2310D REF01)
* Copy the fourth billing provider secondary ID record (CI1A - 9 / 2010AA REF02) to the third billing provider secondary ID record (SUB2 - 12 / 2310D REF02)

**F REQ-2:** Copy the billing provider into the service facility loop when payer flag is B

Determine if the following statements are true

* If the claim’s payer ID (CI5 – 3 / 2010BB NM109) is a payer ID listed on the control page
* The service facility name (SUB2 - 4/ 2310D NM103) is null
* The player flag is B
* The place of service (CL1 record 33) is not equal to 11 or 12

If all statements are true, then do the following:

* Default value of 77 to record (SUB2 - 2 / 2310D NM101)
* Default value of 2 to record (SUB2 - 3 / 2310D NM102)
* Copy the billing provider name record (PRV - 3 / 2010AA NM103) to service facility name record (SUB - 2 / 2310D NM103)
* Copy the primary billing provider number (PRV - 9 / 2010AA NM109) to the primary service facility number (SUB2 - 6 / 2310D NM109) and set primary service ID qualifier (SUB2 - 5 / 2310D NM108) to XX
* Copy billing provider address line one record (PRV - 4 / 2010AA N301) to service facility provider address (SUB – 3 / 2310D N301)
* Copy billing provider address line two record (PRV - 11 / 2010AA N302) to service facility provider address line two (SUB - 12 / 2310D N302)
* Copy billing provider city (PRV - 5 / 2010AA N401) to service facility provider city (SUB - 4 / 2310D N401)
* Copy billing provider state (PRV - 6 / 2010AA N402) to service facility provider state (SUB - 5 / 2310D N402)
* Copy billing provider zip code (PRV - 7 / 2010AA N403) maps to service facility provider zip code (SUB - 6 / 2310D N403)
* Copy the second billing provider secondary ID qualifier record (CI1A - 4 / 2010AA REF01) to the first service facility qualifier record (SUB2 - 7 / 2310D REF01)
* Copy the second billing provider secondary ID record (CI1A - 5 / 2010AA REF02) to the first billing provider secondary ID record (SUB2 - 8 / 2310D REF02)
* Copy the third billing provider secondary ID qualifier record (CI1A - 6 / 2010AA REF01) to the second service facility qualifier record (SUB2 - 9 / 2310D REF01)
* Copy the third billing provider secondary ID record (CI1A - 7 / 2010AA REF02) to the second billing provider secondary ID record (SUB2 - 10 / 2310D REF02)
* Copy the fourth billing provider secondary ID qualifier record (CI1A - 8 / 2010AA REF01) to the third service facility qualifier record (SUB2 - 11 / 2310D REF01)
* Copy the fourth billing provider secondary ID record (CI1A - 9 / 2010AA REF02) to the third billing provider secondary ID record (SUB2 - 12 / 2310D REF02)

## Default Billing Address

**Program Name:** DefaultBillingProviderAddress.exe

**Overview**

If a claim is submitted to a payer listed in the table below which includes a pay to address (2010AB N3 and 2010AB N4), then the pay to address replaces the billing address (2010AA N3 and 2010AA N4) in the outbound claim.

**Business Case**

This preprocessor was implemented to address issues within paper claims when sites use the pay to provider loop. The address information contained in this loop cannot be directly mapped to the paper claim form. FSC moves the pay to provider address to the billing address fields so that they will appear on the paper claim form.

**User Parameters**

**Preprocessor control page:** Configure Default Billing Provider

This page is also used to change payer IDs for non-primary claims. See 3.1.

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Primary ID | CI5 – 3 | 2010BB NM109 | HCCH payer ID |
| Claim Type | N/A | N/A | I – Institutional  P – Professional |

**Functional Requirements**

**F REQ-1:** Move the pay-to address information in the billing provider loop

Determine if the following statements are true for all claims:

* The pay to provider address (Record PRV1 – 7 / 2010AB N301) is not null
* The payer ID (CI5 – 3/ 2010BB NM109) is in the table

If both statements are true, then do the following:

* Copy the pay to provider address line one (Record PRV1 – 7 / 2010AB N301) to billing provider address line one (Record PRV – 4 / 2010AA N301)
* Copy the pay to provider address line two (Record PRV1 – 8 / 2010AB N302) to billing provider address line two (Record PRV – 11 / 2010AA N301)
* Copy the pay to provider city (Record PRV1 – 9 / 2010AB N401) to billing provider city (Record PRV – 5 / 2010AA N401)
* Copy the pay to provider state (Record PRV1 – 10 / 2010AB N402) to billing provider state (Record PRV – 6 / 2010AA N402)
* Copy the pay to provider zip (Record PRV1 – 11 / 2010AB N403) to billing provider zip (Record PRV – 7 / 2010AA N403)

## Modify secondary IDs for Medicare Claims

**Program Name:** ModifySecondaryIDsMedicare.exe

**Overview**

This preprocessor removes valid 5010 provider IDs that are not allowed by Medicare. If the provider ID type is not valid for 5010 it is removed within the map.

**Business Case**

Medicare has limited the secondary IDs that the VA may use

**User Parameters – N/A**

**Functional Requirements**

**F REQ-1:** Remove secondary IDs and qualifiers on Medicare Part A claims

If the destination payer ID (CI5 – 3 / 2010BB NM109) is 12M61 (Medicare Part A) then:

* Remove 2310A attending provider secondary ID if qualifier is not 1G
* If OPR2 - 2 is not 1G remove - 2 and 3
* If OPR2 - 4 is not 1G remove - 4 and 5
* If OPR2 - 6 is not 1G remove - 6 and 7
* If OPR2 - 8 is not 1G remove - 8 and 9
* Remove 2310B operating provider secondary ID if qualifier is not 1G
* If OPR3 - 2 is not 1G remove - 2 and 3
* If OPR3 - 4 is not 1G remove - 4 and 5
* If OPR3 - 6 is not 1G remove - 6 and 7
* If OPR3 - 8 is not 1G remove - 8 and 9
* Remove 2310C other operating provider secondary ID if qualifier is not 1G
* If OPR4 - 2 is not 1G remove - 2 and 3
* If OPR4 - 4 is not 1G remove - 4 and 5
* If OPR4 - 6 is not 1G remove - 6 and 7
* If OPR4 - 8 is not 1G remove - 8 and 9
* Remove 2310D rendering provider secondary ID if qualifier is not 1G
* If OPRA - 2 is not 1G remove - 2 and 3
* If OPRA - 4 is not 1G remove - 4 and 5
* If OPRA - 6 is not 1G remove - 6 and 7
* If OPRA - 8 is not 1G remove - 8 and 9
* Remove 2310F referring provider secondary ID if qualifier is not 1G
* If OPR5 - 2 is not 1G remove - 2 and 3
* If OPR5 - 4 is not 1G remove - 4 and 5
* If OPR5 - 6 is not 1G remove - 6 and 7
* Remove 2310E Service facility loop
* Remove SUB2 - 7, 8, 9, 10, 11, 12
* Remove 2420A line operating provider secondary ID if qualifier is not 1G
* If LOPE - 10 is not 1G remove - 10 and 11
* If LOPE - 12 is not 1G remove - 12 and 13
* If LOPE - 14 is not 1G remove - 14 and 15
* Remove 2420B line other operating provider secondary ID if qualifier is not 1G
* If LOP1 - 10 is not 1G remove - 10 and 11
* If LOP1 - 12 is not 1G remove - 12 and 13
* If LOP1 - 14 is not 1G remove - 14 and 15
* Remove 2420C line rendering provider secondary ID if qualifier is not 1G
* If LREN - 10 is not 1G remove - 10 and 11
* If LREN - 12 is not 1G remove - 12 and 13
* If LREN - 14 is not 1G remove - 14 and 15
* Remove 2420D line referring provider secondary ID if qualifier is not 1G
* If LREF - 10 is not 1G remove - 10 and 11
* If LREF - 12 is not 1G remove - 12 and 13
* If LREF - 14 is not 1G remove - 14 and 15

**F REQ-2:** Modify or remove secondary IDs and qualifiers on Medicare Part B claims

If the destination payer ID (CI5 – 3 / 2010BB NM109) is equal to SMTX1 (Medicare Part B) then:

* Change qualifier for location code in 2010AA from 1C to G2
* If CI1A – 6 is equal to 1C change it to G2
* Remove 2310A referring provider secondary ID if qualifier is not 1G or 0B
* OPR5 - 2 is not 1G or 0B remove - 2 and 3
* OPR5 - 4 is not 1G or 0B remove - 4 and 5
* OPR5 - 6 is not 1G or 0B remove - 6 and 7
* Change 2310B rendering provider qualifier to G2
* If OPRA - 2 is 1C change to G2
* If OPRA - 4 is 1C change to G2
* If OPRA - 6 is 1C change to G2
* If OPRA - 8 is 1C change to G2
* Remove all 2310C Service facility secondary IDs
* Remove SUB2 - 7, 8, 9, 10, 11, 12
* Change 2310D supervising provider qualifier to G2
* If OPR8 - 2 is EI change to G2
* If OPR8 - 4 is EI change to G2
* If OPR8 - 6 is EI change to G2
* If OPR8 - 8 is EI change to G2
* Remove 2420B Purchase Service secondary ID if qualifier is not 1G
* If LPUR - 6 is not 1G remove LPUR - 6 and 7
* Remove 2420D line supervising provider secondary ID if qualifier is G2
* LSUP - 10 is G2 remove - 10 and 11
* LSUP - 12 is G2 remove - 12 and 13
* LSUP - 14 is G2 remove - 14 and 15
* Remove 2420F line referring provider secondary ID if qualifier is not 1G
* LREF - 10 is not 1G remove - 10 and 11
* LREF - 12 is not 1G remove - 12 and 13
* LREF - 14 is not 1G remove - 14 and 15

## Remove Other Payer Information from Claim

**Program Name:** RemoveOtherPayerProviderInfromation.exe

**Overview**

This program removes all other payer provider information from a claim.

**Business Case**

According to the 5010 guide the other payer provider information is not required after the implementation of NPI. VA has given the sites the ability to submit this information if the payer requires it. The VA has learned that Medicare will reject claims submitted with this information. To reduce the risk of rejects from Medicare and payers that adopt Medicare edits FSC implemented this change to filter out the data even if submitted by the site unless the payer has requested the information be sent.

**User Parameters**

**Preprocessor control page:** Configure Remove other payer information

|  |  |  |  |
| --- | --- | --- | --- |
| Field name | VistA 432 | X12 location | Value |
| Primary ID | CI5 – 3 | 2010BB NM109 | HCCH payer ID |

**Functional Requirements**

**F REQ-1:** Remove other payer provider information from claims

If the destination payer ID (CI5 – 3 / 2010BB NM109) is in control table then remove the following records and all associated fields:

* OP1 - Other payer rendering provider (837I 2330G 837P 2330D)
* OP1A - Other payer attending physician data (837I 2330C)
* OP2 - Other payer operating physician data (837I 2330D)
* OP3 - Other payer service facility data (837I 2330F)
* OP4 - Other payer referring provider data (837P 2330C; 837I 2330H)
* OP7 - Other payer service facility data (837P 2330E)
* OP8 - Other payer supervising provider data (837P 2330F)
* OP9 - Other payer other operating provider data (837I 2330E)

## Remove Secondary IDs from Claims

**Program Name:** RemoveSecondaryIDsFromClaims.exe

**Overview**

This preprocessor removes all secondary provider ID numbers from a claim with the exception of the billing provider tax ID and the HCCH site ID unless the payer is authorized to receive additional payer IDs

**Business Case**

The 5010 standard does require secondary IDs to be submitted if a NPI is on the claim. At the time of implementation it was not known if payers would fully convert their systems to NPI. This process allows the data to continue to be submitted.

**User Parameters**

**Preprocessor control page:** Configure Remove Secondary ID from Claims

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Primary ID | CI5 – 3 | 2010BB NM109 | HCCH payer ID |

**Functional Requirements**

**F REQ-1:** Remove secondary provider IDs from claims

If the destination payer ID (CI5 – 3 / 2010BB NM109) is in control table, then remove data from the following records and fields:

* CI1A - 6, 7, 8, 9 Billing provider secondary IDs (837P 2010AA)
* SUB2 - 7, 8, 9, 10, 11, 12 Lab facility secondary IDs (837P 2310C; 837I 2310C)
* OPR2 all Attending provider secondary IDs (837I 2310A)
* OPR3 all Operating provider secondary IDs (837I 2330B)
* OPR4 all Other operating provider secondary IDs (837I 2330C)
* OPR5 all Referring provider secondary IDs (837P 2310A; 837I 2310F)
* OPR8 all Supervising provider secondary IDs (837P 2310D)
* OPRA all Rendering provider secondary IDs (837I 2310D; 837P 2310B)
* LOPE - 10, 11. 12, 13, 14 and 15 Line level operating physician secondary IDs (837I 2420A)
* LOP1 - 10, 11. 12, 13, 14 and 15 Line level other operating physician secondary IDs (837I 2420B)
* LREN - 10, 11. 12, 13, 14 and 15 Line level rendering provider secondary IDs (837I 2420C; 837P 2420A)
* LPUR - 6 and 7 Line level purchase service provider secondary IDs (837P 2420B)
* LSUP - 10, 11. 12, 13, 14 and 15 Line level supervising provider secondary IDs (837P 2420D)
* LREF - 10, 11. 12, 13, 14 and 15 Line level referring provider secondary IDs (837I 2420D; 837P 2420F)

## Compare Subscriber and Patient

**Program Name:** CompareSubscriberData.exe

**Overview**

The 5010 X12 standard only allows the patient loop (2010CA) to be submitted if the patient and subscriber share a common insurance member ID number. FSC enforces this rule by overwriting the subscriber information with the patient information if, on the inbound claim, the patient member ID number (PT3 - 3) is not equal to the subscriber member ID (CI6 - 3). FSC will not enforce this rule on the payers listed in the user-defined table.

**Business Case**

It is unknown at the time of implementation whether payers will be able to process claims without the patient loop.

**User Parameters**

**Preprocessor control page:** Configure Payers to Compare Subscriber

|  |  |  |  |
| --- | --- | --- | --- |
| Field Name | VistA 432 | X12 Location | Value |
| Primary ID | CI5 – 3 | 2010BB NM109 | HCCH payer ID |

**Functional Requirements**

**F REQ-1:** Move patient information into subscriber loop

If the destination payer ID (CI5 – 3 / 2010BB NM109) is **not** in control table then determine if the following statement is true:

* Is the patient primary ID (PT3 - 3 / No 5010 X12 field) not equal to the subscriber primary ID (CI6 – 3 / 2010BA NM109)?

If the statement is true, then perform the following steps:

* Set patient relationship to insured (PT2 – 3 / 2000B SBR08) equal to 18
* Set subscriber last name (CI2 – 3 / 2010BA NM103) equal to patient last name (PT1 – 4 / 2010CA NM103)
* Delete data element patient last name (PT1 – 4 / 2010CA NM103)
* Set subscriber first name (CI2 – 4 / 2010BA NM104) equal to patient first name (PT1 – 5 / 2010CA NM104)
* Delete data element patient first name (PT1 – 5 / 2010CA NM104)
* Set subscriber middle name (CI2 – 5 / 2010BA NM105) equal to patient middle name (PT1 – 6 / 2010CA NM105)
* Delete data element patient middle name (PT1 – 6 / 2010CA NM105)
* Set subscriber address (CI2 – 7 / 2010BA N301) equal to patient address (PT1 – 7 / 2010CA N301)
* Delete data element patient address (PT1 – 7 / 2010CA N301)
* Set subscriber city (CI2 – 8 / 2010BA N401) equal to patient city (PT1 – 9 / 2010CA N401)
* Delete data element patient city (PT1 – 9 / 2010CA N401)
* Set subscriber state (CI2 – 9 / 2010BA N402) equal to patient state (PT1 – 10 / 2010CA N402)
* Delete data element patient state (PT1 – 10 / 2010CA N402)
* Set subscriber zip code (CI2 – 10 / 2010 N403) equal to patient zip (PT1 – 11 / 2010CA N403)
* Delete data element patient zip (PT1 – 11 / 2010CA N403)
* Set subscriber birth date (CI2 – 11 / 2010BA DMG02) equal to patient birth date (PT1 – 12 / 2010CA DMG02)
* Delete data element patient birth date (PT1 – 12 / 2010CA DMG02)
* Set subscriber gender code (CI2 – 12 / 2010BA DMG03) equal to patient gender code (PT1 – 13 / 2010CA DMG03)
* Delete data element patient gender code (PT1 – 13 / 2010CA DMG03)
* Set subscriber telephone number (CI2 – 13 / 2010BA PER04) equal to patient telephone number (PT2 – 3 / 2010CA PER04)
* Delete data element patient telephone number (PT2 – 3 / 2010CA PER04)
* Set subscriber address line 2 (CI2 – 14 / 2010BA N302) equal to patient address line 2 (PT1 – 8 / 2010CA N302)
* Delete data element patient address line 2 (PT1 – 8 / 2010CA N302)
* Set subscriber name suffix (CI2 – 15 / 2010BA NM107) equal to patient name suffix (PT1 – 20 / 2010CA NM107)
* Delete patient name suffix (PT1 – 20 / 2010CA NM107)
* Set subscriber primary ID qualifier (CI6 - 2, 2010BA NM108) equal to patient primary ID qualifier (PT3 – 2 / 2010CA NM108)
* Delete patient primary ID qualifier (PT3 - 2, 2010CA NM108)
* Set subscriber primary ID (CI6 - 3, 2010BA NM109) equal to patient primary ID (PT3 – 3 / 2010CA NM109)
* Delete subscriber SSN qualifier (CI6 - 4)
* Delete subscriber SSN (CI6 - 5)

## Swap Address Lines

**Program Name:** SwapAddress.exe

**Overview**

If VistA submits a claim where the destination payer is AARP, this program switches address lines one and two within the billing provider and pay to provider loop.

**Business Case**

This preprocess was created to resolve a payer-specific requirement.

**User Parameters** – N/A

**Functional Requirements**

**F REQ-1:** Swap billing address lines one and two for AARP claims

If the destination payer ID (CI5 – 3 / 2010AA NM109) is equal to 36273 and the billing address line two (PRV - 11 / 2010AA N302) is not null, then:

* Move billing address line one (PRV – 4 / 2010AA N301) to billing address line two (PRV – 11 / 2010AA N302)
* Move billing address line two (PRV – 11 / 2010AA N302) to billing address line one (PRV – 3 / 2010AA N302)

**F REQ-2:** Swap pay to address one and two for AARP claims

If the destination payer ID (CI5 – 3 / 2010AA NM109) is equal to 36273 and the pay to address line two (PRV1 - 8 / 2010AB N302) is not null, then:

* Move pay to address line one (PRV1 – 7 / 2010AB N301) to pay to address line two (PRV1 – 8 / 2010AB N302)
* Move pay to address line two (PRV1 – 8 / 2010AB N302) to pay to address line one (PRV1 – 7 / 2010AB N302)

# Appendix C – FSC Default Values

| Field Name | Institutional Location | Professional Location | Value |
| --- | --- | --- | --- |
| Information source | BHT01 | BHT01 | 0019 |
| Original transaction | BHT02 | BHT02 | 00 |
| Transaction type | BHT06 | BHT06 | CH |
| Submitter name qualifier | NM101 | NM101 | 41 |
| Submitter name type | NM102 | NM102 | 2 |
| Submitter name | NM103 | NM103 | DEPT VETERANS AFFAIRS |
| Submitter ID qualifier | NM108 | NM108 | 46 |
| Submitter ID | NM109 | NM109 | 741612229 |
| Submitter contact qualifier | PER01 | PER01 | IC |
| Submitter contact name | PER02 | PER02 | ATTN EDI TEAM |
| Submitter contact number qualifier | PER03 | PER03 | TE |
| Submitter phone number | PER04 | PER04 | 5124605678 |
| Receiver name qualifier | NM101 | NM101 | 40 |
| Receiver name type | NM102 | NM102 | 2 |
| Receiver name | NM103 | NM103 | For 837-I  WEBMD  For 837-P  EMDEON |
| Receiver ID qualifier | NM108 | NM108 | 46 |
| Receiver ID | NM109 | NM109 | 133052274 |