



## **Beacon Health Strategies**

# **837 Health Care Claim Companion Guide**

**For use with  
ASC X12N 837 Health Care Professional and Institutional  
Transactions Set Implementation Guides and Addenda  
(Version 4010A1)**

July 1 2010  
Version 1.9

## Document Version History

---

Version	Date Published	Notes
0.9	July 21 2003	Beta testing version
0.9e	August 05 2003	Beta testing version <ul style="list-style-type: none"> <li>▪ Added Interchange Control Header and Trailer Information</li> <li>▪ Added Functional Group Header and Trailer Information</li> <li>▪ Added Service Facility data requirements in 837P data requirements</li> <li>▪ Added 837 Institutional data requirements</li> <li>▪ Added Original Reference data requirements in 837P &amp; 837I data requirements</li> </ul>
0.9f	September 05 2003	Beta testing version <ul style="list-style-type: none"> <li>▪ Text change in Setup/certification Process section</li> <li>▪ Added 'key points' in Considerations section</li> <li>▪ Set REF segment for Billing Provider as Required</li> <li>▪ Modified NM1 segment for Service Facility</li> <li>▪ Added REF segment for Service Facility</li> <li>▪ Added Appendix A - EDI Transactions/Billing Intermediary Form</li> <li>▪ Added Appendix B - Trading Partner/EDI Gateway Setup Form</li> </ul>
1.0	April 01 2004	<ul style="list-style-type: none"> <li>▪ Added clarification about Institutional Claims Processing (Pg 24)</li> </ul>
1.1	May 20 2005	<ul style="list-style-type: none"> <li>▪ Added details of a new report</li> <li>▪ Removed 'Electronic Media' submission method (for lack of interest from submitters)</li> <li>▪ Modified contact information</li> </ul>
1.2	Dec 30 2005	<ul style="list-style-type: none"> <li>▪ Included Plan ID for AHP</li> </ul>
1.3	Mar 15 2006	<ul style="list-style-type: none"> <li>▪ Included required segments for attending physician information for 837I</li> </ul>
1.4	April 05 2007	<ul style="list-style-type: none"> <li>▪ Included notes on NPI and Dual Submission till 05/22/07</li> </ul>
1.5	May 20 2007	<ul style="list-style-type: none"> <li>▪ Included segments for NPI in the Data Requirements section</li> <li>▪ Included and modified notes on NPI testing and Contingency Plan in the Key points section.</li> </ul>
1.6	May 12 2008	<ul style="list-style-type: none"> <li>▪ Included segments for Rendering Provider Name at the claim level and service line level.</li> <li>▪ Included Plan ID and Name for DC Chartered Health Plan.</li> <li>▪ Included Plan ID information at the Subscriber loop for providers submitting via EMDEON.</li> <li>▪ Included Payer ID in the payer segment for providers submitting via EMDEON.</li> <li>▪ Included notes on NPI under Loop Details.</li> </ul>
1.7	Dec 04 2008	<ul style="list-style-type: none"> <li>▪ Included Plan ID and Name for Health Right</li> <li>▪ Included Plan ID and Name for Neighborhood Health Partners</li> </ul>
1.8	Mar 01 2010	<ul style="list-style-type: none"> <li>▪ Included Plan ID and Name for Touch Stone</li> <li>▪ Included Plan ID and Name for BMC HealthNet Plan</li> </ul>
1.9	July 01 2010	<ul style="list-style-type: none"> <li>▪ Included Plan ID and Name for Abri Health Plan</li> <li>▪ Included Plan ID and Name for Orange County Mental Health Plan</li> </ul>

## Table of Contents

---

Table of Contents.....	3
Introduction .....	4
What is HIPAA?.....	4
Purpose .....	4
Intended Audience .....	4
Contact Information .....	5
Transaction Submission Procedures .....	6
Submission Methods.....	6
Setup/Certification Procedures .....	6
Testing .....	7
Technical Requirements .....	7
Reports .....	8
Considerations.....	9
Transactions Supported (inbound) .....	9
Delimiters Supported.....	9
Size/Maximum Limitations.....	9
Key Points – NPI Submission .....	9
Specific Data Requirements .....	11
Interchange Control and Functional Group Specifications .....	11
Professional Claims (837P) Data Requirements.....	12
Institutional Claims (837I) Data Requirements .....	19
Appendix A – EDI Transactions/Billing Intermediary Form	
Appendix B – Trading Partner/EDI Gateway Setup Form	

## Introduction

---

### ***What is HIPAA?***

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the establishment of national standards for electronic transmission of health data and ensuring privacy protection. The Administrative Simplification provisions of HIPAA, Title II require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Beacon Health Strategies, as a covered entity and health insurance payer will be accepting X12 837 Professional (837P) and Institutional (837I) Health Care Claims as mandated by the administration simplification provisions of HIPAA.

### ***Purpose***

This document has been prepared as a Beacon Health Strategies (Beacon) specific companion document to that implementation guide and to clarify when conditional data elements and segments must be used for Beacon reporting, and identify those codes and data elements that do not apply to Beacon. This companion guide document **supplements**, but does not contradict any requirements in the 837 version 4010a implementation guide. This companion is to be used in conjunction with the X12 implementation guide. The implementation guides for all HIPAA transactions are available from Washington Publishing Company and are available electronically to download at [www.wpc-edi.com/HIPAA](http://www.wpc-edi.com/HIPAA).

This document will be subject to revisions as new versions of the X12 837 Professional and Institutional Health Care Claim Transaction Set Implementation Guides are released.

### ***Intended Audience***

The intended audience for this document is the technical area which is responsible for submitting electronic claims transactions to Beacon Health Strategies. In addition, this information should be communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

## Contact Information

---

The purpose of this section is to provide contact information for any questions regarding HIPAA, 837 transactions, EDI, EDI Gateway, documentation and testing.

For General HIPAA questions relating to Beacon, you can get answers in one of the following ways:

1. From the Beacon website at **www.beaconhealthstrategies.com**. Go to the providers sections and click on 'resources' and then on 'HIPAA'.
2. By contacting any of the following staff listed here by responsibility.

Type of Contact	Contact	Telephone Number	Email Address
General TCS	Anup Vidyarthi	(781) 994-7524	anup.vidyarthi@beaconhs.com
Security	Anup Vidyarthi	(781) 994-7524	anup.vidyarthi@beaconhs.com
Privacy	Donna Zeh	(781) 994-7528	donna.zeh@beaconhs.com
Local codes	Beth Quinn	(781) 994-7508	Elizabeth.Quinn@beaconhs.com
Companion Documents	EDI Operations	(781) 994-7500	EDI.Operations@beaconhs.com
Trading Partner Setup	EDI Operations	(781) 994-7500	EDI.Operations@beaconhs.com
EDI Gateway	EDI Operations	(781) 994-7500	EDI.Operations@beaconhs.com
837 Transactions and Testing	EDI Operations	(781) 994-7500	EDI.Operations@beaconhs.com

## Transaction Submission Procedures

---

### *Submission Methods*

Providers/Trading partners will be able to submit 837 claim transactions utilizing any of the following methods:

1. Using Beacon's online secure EDI Gateway. To use this EDI gateway, you will need an Internet connection, a browser that supports 128-bit encryption, such as Internet Explorer 5.5 or higher.

### *Setup/Certification Process*

1. Providers/trading partners interested in submitting electronic claim transactions must complete the following forms supplied by Beacon:
  - a. EDI Transactions/Billing Intermediary Authorization Form (Appendix A)
  - b. Trading Partner/EDI Gateway Setup Form (Appendix B)
2. These forms can be downloaded from Beacon's website at [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com) or can be requested by contacting EDI Operations at Beacon.
3. The EDI Transactions/Billing Intermediary Authorization Form has to be completed by every provider who will be conducting EDI transactions with Beacon. This form is also utilized to authorize a billing intermediary if the provider utilizes one.
4. The Trading Partner/EDI Gateway Setup Form has to be completed by the technical person of the health care provider or the billing intermediary if applicable. This form is utilized to gather some trading partner technical information and to setup a Submitter ID on Beacon's EDI Gateway.
5. Complete both the forms and mail it to:  
EDI Operations  
Beacon Health Strategies  
500 Unicorn Park Drive  
Woburn, MA 01801
6. Upon receipt of the EDI Transactions/Billing Intermediary Authorization Form, you will receive an acknowledgement letter from Beacon which will also include the site identification numbers for the provider to be utilized when billing electronically in the service facility location segment.
7. Once the Trading Partner/EDI Gateway Setup Form is received, EDI Operations will establish a test submitter ID and a folder (mailbox) on our EDI Gateway and notify the technical contact via regular mail.
8. A submitter ID is assigned to each trading partner, provider or billing intermediary. You will utilize the submitter ID to create a login ID and password on the EDI Gateway. To access your folder (mailbox) to upload or download files, you have to login using the login ID. If there are multiple people who do the upload and download, you can create a login ID for each person utilizing the same submitter ID. This way there is a history of who uploaded or downloaded specific files. If a person with a login ID is no longer with the organization, the trading partner should notify EDI Operations at Beacon so we can deactivate that login ID.
9. Upon completion of successful testing, you will be notified of the same and you will be assigned a **new submitter ID for the production system** which should be used in all files submitted for production claims processing. The test Submitter ID should be used in all files submitted for testing.

### *Testing*

Beacon requires testing for all providers/trading partners/submitters submitting the 837P and 837I transactions. Please follow the appropriate format specifications listed in the specific data requirements

and submission directions. Test files have to be submitted utilizing the secure protocols and submission methodology selected.

Once a test Submitter ID is setup for a trading partner, the submitter can start sending claims transactions for testing. In order to test, it is imperative that a technical contact at the provider/submitter organization be established. This contact should have the ability to monitor, change and submit the 837P and 837I transaction files to Beacon. This contact should be familiar with 837P and 837I transaction as well as possess a solid understanding of the technology used to create these files. During the testing process, Beacon will examine submitted transactions for required formats and elements and will get responses during the testing process. A Beacon EDI Operations staff will contact you via telephone with results of the most recent test, generally within a week of submission. This testing stage will continue until testing satisfaction is achieved in both sides.

Beacon's testing procedures will validate the test file in its entirety. The entire file will either pass or fail validation. Beacon does not allow partial file submissions. If the file fails validation, a failure report will be provided explaining the failure messages.

Upon the completion of successful testing, you will be notified of the same and you will be assigned a new submitter ID for the production system which should be used in all files submitted for production claims processing. The test Submitter ID should be used in all files submitted for testing.

### ***Technical Requirements***

During testing of the 837P and 837I transactions, Beacon recommends that test claim files should contain a minimum of 25 claims and not exceed 100 claims in any one batch. File contents should simulate claims from normal business. Creating small files for testing provides for easier trouble shooting and recreation of the test file. Once your files have passed testing, you may send files of larger sizes.

## Reports

---

The following sections lists the reports that Beacon will provide and describes the process for retrieving these reports.

Report/File Number	Report/File Name	Purpose	Source	Turnaround from time of Submission
997	Functional Acknowledgement	This is a X12 file response report	Folder/Mailbox	Day of submission
Result*	Results Report file	To report claim level rejections and to report on total claims accepted along with their total claim amount	Folder/Mailbox	Day of submission

### **Functional Acknowledgment Report (997)**

File level summary indicating accepted and rejected transaction sets within a file. Please refer the Implementation Guide for Health Care Claims.

### **Results Report file**

When a file is uploaded from the EDI Gateway, the submitter is provided with a reference ID for the submission. The file name of the Results Report file will be <reference ID>\_results.txt

\* All files that are rejected at file level will not have a results file.

**Note:** All reports will be available to providers/trading partners via the EDI Gateway in the respective mailboxes. To access your mailbox, log in to the EDI Gateway and click on the 'download files' link. Providers/trading partners are responsible for downloading these reports when available.

## Considerations

---

### ***Transactions Supported (inbound)***

Beacon will support and accept the following inbound transactions:

- 837 Professional Health Care Claim – ASC X12N 837 (004010X098A1)
- 837 Institutional Health Care Claim – ASC X12N 837 (004010X096A1)

### ***Delimiters Supported***

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

Beacon recommends utilizing the following default delimiters:

<u>Description</u>	<u>Default Delimiter</u>
Data element separator	* (Asterisk)
Sub-element separator	: (Colon)
Segment Terminator	~ (Tilde)

Note: If the data contains any of the above delimiters, different delimiters can be utilized and specified in the ISA segment.

### ***Size/Maximum Limitations***

Claims files submitted in 'production' mode cannot exceed 5000 claims (CLM segments) in any one file as stated in the Implementation Guides.

### ***Key Points***

#### **National Provider Identifier**

Beacon is using dual use approach for claims submission, requiring legacy Beacon provider identification numbers to be submitted until the compliance date, but will afford providers the opportunity to also submit NPI. After May 23, 2007, providers are encouraged to submit NPI as long as they have provided the NPI number to Beacon in advance.

Providers who want to submit NPI on EDI transactions must test with Beacon prior to sending the transactions with NPI. Current submitters should test with Beacon before transitioning to the production systems. After successful testing, once the submitter has transitioned to NPI only, they cannot switch back to submitting with legacy ID. Please contact EDI operations at 781-994-7534 to test the transactions with NPI.

#### **Contingency Plan**

Based on CMS's contingency plan guidance, Beacon has implemented the ability to accept electronic transactions and paper claims with legacy ID only, legacy ID and NPI and NPI only. Testing is required for electronic transactions before submitting NPI. Along with this, Beacon's goal is to work with providers to transition to using NPI at the earliest.

## Loop Details

### For providers

- Loop 2010AA – NM1 segment should contain NPI for the Billing Provider
- Loop 2310B (837P) – NM1 segment should contain NPI for the Rendering Provider.
- Loop 2310A (837I) – NM1 segment should contain NPI for the Attending Provider.
- Loop 2310D (837P) – NM1 segment should contain NPI for the service facility location if it is different from the Billing Provider NPI.  
If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2310E (837I) – NM1 segment should contain NPI for the service facility location if it is different from the Billing Provider NPI.  
If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2420A (837P) – NM1 segment should contain NPI for the Rendering Provider if it is different from the Rendering Provider at the Claim level (2310B).
- Loop 2420A (837I) – NM1 segment should contain NPI for the Attending Provider if it is different from the Attending Provider at the Claim level (2310A).

### For billing agencies

- Loop 2010AA – NM1 segment should contain NPI for each of the provider they are billing for.
- Loop 2310B (837P) – NM1 segment should contain NPI for the Rendering Provider.
- Loop 2310A (837I) – NM1 segment should contain NPI for the Attending Provider.
- Loop 2310D (837P) – NM1 segment should contain NPI for the service facility location if it is different from the Billing Provider NPI.  
If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2310E (837I) – NM1 segment should contain NPI for the service facility location if it is different from the Billing Provider NPI.  
If there is more than one site with the same NPI, the claim will be processed using the first provider site. For all such cases, we recommend using provider site ID (supplied by Beacon) in the REF segment to identify the specific provider site.
- Loop 2420A (837P) – NM1 segment should contain NPI for the Rendering Provider if it is different from the Rendering Provider at the Claim level (2310B).
- Loop 2420A (837I) – NM1 segment should contain NPI for the Attending Provider if it is different from the Attending Provider at the Claim level (2310A).

## Specific Data Requirements

### Interchange Control and Functional Group Specifications

#### General

This section outlines the specifications for the Interchange Control and Functional Group header and trailer information.

LoopID/ Segment	Element / Description	Usage	RQD	Comments	Values
<b>Headers</b>					
<b>ISA</b>	<b>Interchange Control Header</b>			<b>Fixed record length segment</b>	
	ISA01 - Authorization Info Qualifier		R	No Authorization Info Present	00
	ISA02 - Authorization Information		R	10 spaces	
	ISA03 - Security Info Qualifier		R		00
	ISA04 - Security Information		R	10 spaces	
	ISA05 - Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA06 - Interchange Sender ID		R	Submitter ID Provided by Beacon	
	ISA07 - Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA08 - Interchange Receiver ID		R	Use "BHS-963116116"	
	ISA09 - Interchange Date		R	Format YYMMDD	
	ISA10 - Interchange Time		R	Format HHMM	
	ISA11 - Interchange Control Standards ID		R		U
	ISA12 - Interchange Version Number		R		00401
	ISA13 - Interchange Control Number		R	Assigned by sender. Must equal IEA02	
	ISA14 - Acknowledgement Required		R		0
	ISA15 - Usage Indicator		R	"T" for testing, "P" for production	
	ISA16 - Component Element Separator		R		:
<b>GS</b>	<b>Functional Group Header</b>				
	GS01 - Functional ID Code		R		HC
	GS02 - Application Sender's Code		R	Submitter ID Provided by Beacon	
	GS03 - Application Receiver's Code		R	Use "BHS-963116116"	
	GS04 - Date		R	Format "CCYYMMDD"	
	GS05 - Time		R	Format "HHMM"	
	GS06 - Group Control Number			Assigned by sender. Must equal GE02	
	GS07 - Responsible Agency Code		R		X
	GS08 - Version / Release		R	"004010X096A1" for 837 Institutional; "004010X098A1" for 837 Professional	

#### Trailers

<b>GE</b>	<b>Functional Group Trailer</b>				
	GE01 - Number of Transaction sets		R		
	GE02 - Group Control Number		R	Same as GS06	
<b>IEA</b>	<b>Interchange Control Trailer</b>				
	IEA01 - Number of Functional Groups		R		
	IEA02 - Interchange Control Number		R	Same as ISA13	

## Professional Claims (837P) Data Requirements

### General

The purpose of this section is to clarify the data elements and segments that must be used for professional claims transactions. The following information is designed to help you complete the 837P transaction. If you follow these guidelines, we'll be better able to process your claims accurately and efficiently.

### Detail Data

LoopID/ Segment	Element / Description	Usage	RQ D	Comments	Values
<b>ST</b>	<b>Transaction set Header</b>	<b>1</b>	<b>R</b>		
	<b>ST01</b> - Transaction set ID code		R	This element should be hard coded when submitting the claim.	837
	<b>ST02</b> - Transaction set control number		R	Assigned by Sender. Must equal SE02	
<b>BHT</b>	<b>Beginning of HL Transaction</b>	<b>1</b>	<b>R</b>		
	<b>BHT01</b> - Hierarchical Structure Code		R	This element should be hard coded when submitting the claim.	0019
	<b>BHT02</b> - Transaction set purpose code		R	Allowed values : "00", "18". Use "00"	00
	<b>BHT03</b> - Reference ID		R	Assigned by Sender.	
	<b>BHT04</b> - Date		R	Claim file creation date. Format CCYYMMDD	
	<b>BHT05</b> - Time		R	Claim file creation time. Format HHMM	
	<b>BHT06</b> - Transaction Type Code		R	Allowed Values : "CH", "RP". Use "CH"	CH
<b>REF</b>	<b>Transmission type Identification</b>	<b>1</b>	<b>R</b>		
	<b>REF01</b> - Reference ID qualifier		R		87
	<b>REF02</b> - Reference ID		R		004010X098A1
<b>LOOP 1000A</b>	<b>Submitter Name</b>	<b>1</b>			
<b>NM1</b>	<b>Submitter name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		41
	<b>NM102</b> - Entity Type Qualifier		R	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103</b> - Last Name / Org Name		R	Last name of physician or organization name	
	<b>NM104</b> - First Name		S	Required if NM102 = "1"	
	<b>NM105</b> - Middle Name		S	Required if NM102 = "1"	
	<b>NM107</b> - Name Suffix		S	Required if NM102 = "1"	
	<b>NM108</b> - ID Code qualifier		R		46
	<b>NM109</b> - ID Code		R		
<b>LOOP 1000B</b>	<b>Receiver Name</b>	<b>1</b>			
<b>NM1</b>	<b>Receiver name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		40
	<b>NM102</b> - Entity Type Qualifier		R		2
	<b>NM103</b> - Last Name / Org Name		R	Use "Beacon Health Strategies, LLC"	
	<b>NM108</b> - ID Code qualifier		R	ETIN	46
	<b>NM109</b> - ID Code		R	Use "BHS-963116116"	
<b>LOOP 2000A</b>	<b>Billing/ Pay to provider</b>	<b>&gt; 1</b>			
<b>HL</b>	<b>Billing/pay to provider HL</b>		<b>R</b>		
	<b>HL01</b> - Hierarchical ID Number		R	Sequence number incremented for each occurrence of HL.	
	<b>HL03</b> - Hierarchical Level Code		R		20
	<b>HL04</b> - Hierarchical Child Code		R		1

<b>PRV</b>	<b>Billing/pay to provider specialty information</b>		<b>S</b>		
	<b>PRV01</b>		R		BI or PT
	<b>PRV02</b>		R		ZZ
	<b>PRV03</b>		R		
<b>LOOP 2010AA</b>	<b>Billing provider</b>	<b>1</b>			
<b>NM1</b>	<b>Billing provider name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		85
	<b>NM102</b> - Entity Type Qualifier		R	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103</b> - Name Last or Organization Name		R		
	<b>NM104</b> - Name First		S	Required if NM102 = "1"	
	<b>NM105</b> - Name Middle		S	Required if NM102 = "1"	
	<b>NM107</b> - Name Suffix		S	Required if NM102 = "1"	
	<b>NM108</b> - ID Code qualifier		y	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109</b> - ID Code		y	National Provider ID / NPI	
<b>N3</b>	<b>Billing provider address</b>	<b>1</b>	<b>R</b>		
	<b>N301</b> - Address		R		
	<b>N302</b> - Address		S		
<b>N4</b>	<b>Billing provider city/state/zip</b>	<b>1</b>	<b>R</b>		
	<b>N401</b> - City		R		
	<b>N402</b> - State		R		
	<b>N403</b> - Zip		R		
	<b>N404</b> - Country		S	Required if billing address is outside of the US	
<b>REF</b>	<b>Billing Provider Secondary Identification</b>	<b>&gt;=1</b>	<b>R</b>		
	<b>REF01</b> - Reference ID Qualifier		R	BQ - Health Maintenance Organization Code Number EI - Employer's Identification Number SY - Social Security Number( cannot be used for Medicare members)	BQ,EI,SY
	<b>REF02</b> - Reference ID		R	Beacon Provider ID Provider Tax ID Social Security Number	
<b>PER</b>	<b>Billing Provider Contact Information</b>	<b>2</b>	<b>S</b>		
	<b>PER01</b> - Contact Function Code		R		IC
	<b>PER02</b> - Name		R		
	<b>PER03</b> - Comm Number Qualifier		R	Allowed Values: "EM, FX, or TE"	
	<b>PER04</b> - Communication Number		R		
<b>LOOP 2000B</b>	<b>Subscriber HL</b>	<b>&gt; 1</b>			
<b>HL</b>	<b>Subscriber HL</b>	<b>1</b>	<b>R</b>		
	<b>HL01</b> - Hierarchical ID Number		R	Assigned by sender	
	<b>HL02</b> - Hierarchical Parent ID Number		R	Assigned by sender	
	<b>HL03</b> - Hierarchical Level Code		R	Subscriber	22
	<b>HL04</b> - Hierarchical Child Code		R	"0" if Subscriber is the patient. "1" if subscriber is not the patient	
<b>SBR</b>	<b>Subscriber information</b>	<b>1</b>	<b>R</b>		
	<b>SBR01</b> - Payer Resp Seq No Code		R		
	<b>SBR02</b> - Individual Relationship code		S	Used if Subscriber is the Patient	18
	<b>SBR03</b> - Reference ID		S	Insured Group or Policy Number For Providers submitting via EMDEON – Use this to identify the Plan Allowed Values : "001" for Neighborhood	

				Health Plan of MA, "004" for HealthSource/Hudson Health Plan, "005" for Fallon Community Health Plan , "006" for Neighborhood Health Plan of RI, "009" for Affinity Health Plan, "013" for DC Chartered Health Plan "014" for Health Right "015" for Neighborhood Health Partners "018" for Touchstone Health "019" for Abri Health Plan "020" for BMC HealthNet Plan "021" for Orange County Mental Health Plan	
	<b>SBR04</b> - Name		<b>S</b>	Plan Name For Provider submitting via EMDEON – Allowed Values : Neighborhood Health Plan of MA, Health Source/Hudson Health Plan, Fallon Community Health Plan , Neighborhood Health Plan of RI, Affinity Health Plan, DC Chartered Health Plan, Health Right, Neighborhood Health Partners Touchstone Health Abri Health Plan BMC HealthNet Plan Orange County Mental Health Plan	
	<b>SBR05</b> - Insurance Type Code		<b>S</b>		
	<b>SBR09</b> - Claim File Indicator Code		<b>R</b>	Type Of Claim	
<b>LOOP 2010BA</b>	<b>Subscriber name</b>	<b>1</b>			
<b>NM1</b>	<b>Subscriber name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		<b>R</b>		IL
	<b>NM102</b> - Entity Type Qualifier		<b>R</b>	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103</b> - Name Last or Organization Name		<b>R</b>		
	<b>NM104</b> - Name First		<b>S</b>		
	<b>NM105</b> - Name Middle		<b>S</b>		
	<b>NM107</b> - Name Suffix		<b>S</b>		
	<b>NM108</b> - ID Code qualifier		<b>S</b>		MI
	<b>NM109</b> - ID Code			Use Member ID from membership card	
<b>N3</b>	<b>Subscriber's address</b>	<b>1</b>	<b>S</b>		
	<b>N301</b> - Address		<b>R</b>		
	<b>N302</b> - Address		<b>S</b>		
<b>N4</b>	<b>Subscriber's city/state/zip</b>	<b>1</b>	<b>S</b>		
	<b>N401</b> - City		<b>R</b>		
	<b>N402</b> - State		<b>R</b>		
	<b>N403</b> - Zip		<b>R</b>		
<b>DMG</b>	<b>Subscriber's demographic info</b>	<b>1</b>	<b>S</b>		
	<b>DMG01</b> - Date Time Format Qualifier		<b>R</b>		D8
	<b>DMG02</b> - Date Time Period		<b>R</b>	Date of Birth of subscriber (CCYYMMDD format)	
	<b>DMG03</b> - Gender Code		<b>R</b>	Allowed Values : "M", "F", "U"	
<b>LOOP 2010BB</b>	<b>Payer name</b>	<b>1</b>			
<b>NM1</b>	<b>Payer name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		<b>R</b>		PR
	<b>NM102</b> - Entity Type Qualifier		<b>R</b>		2
	<b>NM103</b> - Name Last or Organization Name		<b>R</b>	For Providers submitting via EMDEON - Allowed Values : Beacon Health Strategies,	

				LLC For all other Providers - Allowed Values : NHP-MA, HHP, FCHP, NHP-RI, Affinity, DCCHP, HealthRight, NHPNY, Touchstone, BMCHP, Abri, CalOptima	
	<b>NM108</b> - ID Code qualifier		R		PI
	<b>NM109</b> - ID Code		R	For Provider submitting via EMDEON – Allowed Values : 43324 For all other Providers - Allowed Values : "001" for Neighborhood Health Plan of MA, "004" for HealthSource/Hudson Health Plan, "005" for Fallon Community Health Plan , "006" for Neighborhood Health Plan of RI, "009" for Affinity Health Plan, "013" for DC Chartered Health Plan "014" for Health right "015" for Neighborhood Health Providers "018" for Touchstone Health "019" for Abri Health Plan "020" for BMC HealthNet Plan "021" for Orange County Mental Health Plan	
<b>LOOP 2000C</b>	<b>Patient HL</b>	<b>&gt; 1</b>	<b>S</b>	<b>Required when the Patient is different from the subscriber</b>	
<b>HL</b>	<b>Patient HL</b>	<b>1</b>	<b>S</b>		
	<b>HL01</b> - Hierarchical ID Number		R	Assigned by sender	
	<b>HL02</b> - Hierarchical Parent ID Number		R	Assigned by sender	
	<b>HL03</b> - Hierarchical Level Code		R		23
	<b>HL04</b> - Hierarchical Child Code		R		0
<b>PAT</b>	<b>Patient information</b>	<b>1</b>	<b>R</b>		
	<b>PAT01</b> - Individual relationship code		R		
<b>LOOP 2010CA</b>	<b>Patient name</b>	<b>1</b>			
<b>NM1</b>	<b>Patient name</b>		R		
	<b>NM101</b> - Entity ID Code		R		QC
	<b>NM102</b> - Entity Type Qualifier		R		1
	<b>NM103</b> - Name Last or Organization Name		R		
	<b>NM104</b> - Name First		R		
	<b>NM105</b> - Name Middle		S		
	<b>NM107</b> - Name Suffix		S		
	<b>NM108</b> - ID Code qualifier		R		MI
	<b>NM109</b> - ID Code		R	Use Member ID from membership card	
<b>N3</b>	<b>Patient address</b>	<b>1</b>	<b>R</b>		
	<b>N301</b> - Address		R		
	<b>N302</b> - Address		S		
<b>N4</b>	<b>Patient city/state/zip</b>	<b>1</b>	<b>R</b>		
	<b>N401</b> - City		R		
	<b>N402</b> - State		R		
	<b>N403</b> - Zip		R		
<b>DMG</b>	<b>Patient's demographic info</b>	<b>1</b>	<b>S</b>		
	<b>DMG01</b> - Date Time Format Qualifier		R		D8
	<b>DMG02</b> - Date Time Period		R	Date of Birth of Patient (CCYYMMDD format)	
	<b>DMG03</b> - Gender Code		R	Allowed Values : "M", "F", "U"	
<b>LOOP 2300</b>	<b>Claim information</b>	<b>100</b>			
<b>CLM</b>	<b>Claim information</b>	<b>1</b>	<b>R</b>		
	<b>CLM01</b> - Claim Submitters ID		R	Claim Number. Will be sent back in 835 & 277	

	<b>CLM02</b> - Monetary Amount		<b>R</b>	Total Claim Amount	
	<b>CLM05-1</b> - Facility Code Value		<b>R</b>	Place of Service	
	<b>CLM05-3</b> - Claim Frequency Type Code		<b>R</b>		
	<b>CLM06</b> - Yes/No Condition or Response Code		<b>R</b>		
	<b>CLM07</b> - Provider Accept Assignment Code		<b>S</b>		
	<b>CLM08</b> - Yes/No Condition or Response Code		<b>R</b>		
	<b>CLM09</b> - Release of Information Code		<b>R</b>		
	<b>CLM10</b> - Patient Signature Source Code		<b>S</b>		
	<b>CLM11</b>		<b>S</b>	CLM11 contains RELATED CAUSES INFORMATION and is only required when Accident or Employment Related Causes are indicated.	
	<b>CLM11-1</b> - Related Cause Code		<b>R</b>		
	<b>CLM11-2</b> - Related Cause Code				
	<b>CLM11-3</b> - Related Cause Code				
	<b>CLM11-4</b> - State				
	<b>CLM11-5</b> - Country				
	<b>CLM12</b> - Special Program Code				
	<b>CLM16</b> - Provider Agreement Code				
	<b>CLM20</b> - Delay Reason Code				
<b>DTP</b>	<b>Date - Admission</b>	<b>1</b>	<b>S</b>		
	<b>DTP01</b> - Date/Time qualifier		<b>R</b>		435
	<b>DTP02</b> - Date/Time Period Format Qualifier		<b>R</b>		D8
	<b>DTP03</b> - Date Time Period		<b>R</b>	In the format CCYYMMDD	
<b>DTP</b>	<b>Date - Discharge</b>	<b>1</b>	<b>S</b>		
	<b>DTP01</b> - Date/Time qualifier		<b>R</b>		96
	<b>DTP02</b> - Date/Time Period Format Qualifier		<b>R</b>		D8
	<b>DTP03</b> - Date Time Period		<b>R</b>	In the format CCYYMMDD	
<b>AMT</b>	<b>Patient Amount Paid</b>	<b>1</b>	<b>S</b>		
	<b>AMT01</b> - Amount Qualifier Code		<b>R</b>		F5
	<b>AMT02</b> - Monetary Amount		<b>R</b>		
<b>REF</b>	<b>Prior Authorization or Referral Number</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		<b>R</b>	Allowed Values: "9F" Referral, "G1" Authorization	
	<b>REF02</b> - Reference ID		<b>R</b>		
<b>REF</b>	<b>Original Reference Number</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		<b>R</b>		F8
	<b>REF02</b> - Reference ID		<b>R</b>		
<b>REF</b>	<b>Medical Record Number</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		<b>R</b>		EA
	<b>REF02</b> - Reference ID		<b>R</b>		
<b>HI</b>	<b>Health care diagnosis</b>	<b>1</b>	<b>S</b>		
	<b>HI01</b> - Healthcare Code Information		<b>R</b>		
	<b>HI01-1</b> - Code List qualifier code		<b>R</b>	Principal Diagnosis	BK
	<b>HI01-2</b> - Industry Code		<b>R</b>	ICD-9 Code	
	<b>HI02</b> - Healthcare Code Information		<b>R</b>		
	<b>HI02-1</b> - Code List qualifier code		<b>R</b>	Principal Diagnosis	BF

	<b>HI02-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI03</b> - Healthcare Code Information		R		
	<b>HI03-1</b> - Code List qualifier code		R	Principal Diagnosis	BF
	<b>HI03-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI04</b> - Healthcare Code Information		R		
	<b>HI04-1</b> - Code List qualifier code		R	Principal Diagnosis	BF
	<b>HI04-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI05</b> - Healthcare Code Information		R		
	<b>HI05-1</b> - Code List qualifier code		R	Principal Diagnosis	BK
	<b>HI05-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI06</b> - Healthcare Code Information		R		
	<b>HI06-1</b> - Code List qualifier code		R	Principal Diagnosis	BK
	<b>HI06-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI07</b> - Healthcare Code Information		R		
	<b>HI07-1</b> - Code List qualifier code		R	Principal Diagnosis	BK
	<b>HI07-2</b> - Industry Code		R	ICD-9 Code	
	<b>HI08</b> - Healthcare Code Information		R		
	<b>HI08-1</b> - Code List qualifier code		R	Principal Diagnosis	BK
	<b>HI08-2</b> - Industry Code		R	ICD-9 Code	
<b>LOOP 2310B</b>	<b>Rendering Provider</b>		<b>S</b>		
<b>NM1</b>	<b>Rendering Provider Name</b>	<b>1</b>	<b>S</b>		
	<b>NM101</b> - Entity ID Code		R		82
	<b>NM102</b> - Entity Type Qualifier		R		
	<b>NM103</b> - Name Last or Organization Name		R	Rendering Physician Last Name	
	<b>NM104</b> - Name First		S	Rendering Physician First Name	
	<b>NM105</b> - Name Middle		S		
	<b>NM108</b> - ID Code qualifier		R	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109</b> - ID Code		R	Rendering Provider National Provider ID / NPI	
<b>LOOP 2310D</b>	<b>Service Facility Location</b>		<b>S</b>		
<b>NM1</b>	<b>Service Facility Location</b>	<b>1</b>	<b>S</b>		
	<b>NM101</b> - Entity ID Code		R		77
	<b>NM102</b> - Entity Type Qualifier		R		
	<b>NM103</b> - Name Last or Organization Name		R	Provider Site Name.	
	<b>NM104</b> - Name First		S		
	<b>NM105</b> - Name Middle		S		
	<b>NM108</b> - ID Code qualifier		S	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109</b> - ID Code		S	National Provider ID / NPI	
<b>REF</b>	<b>Service Facility Location Secondary Identification</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		R		G5
	<b>REF02</b> - Reference ID		R	Provider Site ID Number( provided by Beacon)	
<b>LOOP 2400</b>	<b>Service Line</b>	<b>50</b>			
<b>LX</b>	<b>Service line</b>	<b>1</b>	<b>R</b>		
	<b>LX01</b> - Assigned Number		R	Counter. Assigned by sender	
<b>SV1</b>	<b>Professional service</b>	<b>1</b>	<b>R</b>		
	<b>SV101-1</b> - Product/Service ID Qualifier		R		
	<b>SV101-2</b> - Product/ Service ID		R	Procedure Code	

837 Health Care Claim Companion Guide v1.9  
July 1 2010

	<b>SV101-3</b> - Procedure Modifier		<b>S</b>	Modifier 1	
	<b>SV101-4</b> - Procedure Modifier		<b>S</b>	Modifier 2	
	<b>SV101-5</b> - Procedure Modifier		<b>S</b>	Modifier 3	
	<b>SV101-6</b> - Procedure Modifier		<b>S</b>	Modifier 4	
	<b>SV102</b> - Monetary Amount		<b>R</b>	Service line charge	
	<b>SV103</b> - Units or basis of measurement code		<b>R</b>		UN
	<b>SV104</b> - Quantity		<b>R</b>	Service Units	
	<b>SV105</b> - Facility Code value		<b>S</b>	Place of Service	
	<b>SV107-1</b> - Diagnosis Code Pointer		<b>S</b>		
	<b>SV107-2</b> - Diagnosis Code Pointer		<b>S</b>		
	<b>SV107-3</b> - Diagnosis Code Pointer		<b>S</b>		
	<b>SV107-4</b> - Diagnosis Code Pointer		<b>S</b>		
	<b>SV109</b> - Yes/No Condition or Response Code		<b>S</b>	Should be blank for Medicare claims	
<b>DTP</b>	<b>Service date</b>	<b>1</b>	<b>R</b>	<b>Service line Start/End</b>	
	DTP01 - Date/Time qualifier		<b>R</b>		472
	DTP02 - Date/Time Period Format Qualifier		<b>R</b>	Allowed Values : "D8" for Date, "R8" for Date Range	
	DTP03 - Date Time Period		<b>R</b>	Format "CCYYMMDD" for D8, "CCYYMMDD - CCYYMMDD" for R8	
<b>LOOP 2420A</b>	<b>Rendering Provider</b>		<b>S</b>		
<b>NM1</b>	<b>Rendering Provider Name</b>	<b>1</b>	<b>S</b>		
	<b>NM101</b> - Entity ID Code		<b>R</b>		82
	<b>NM102</b> - Entity Type Qualifier		<b>R</b>		
	<b>NM103</b> - Name Last or Organization Name		<b>R</b>	Rendering Physician Last Name	
	<b>NM104</b> - Name First		<b>S</b>	Rendering Physician First Name	
	<b>NM105</b> - Name Middle		<b>S</b>		
	<b>NM108</b> - ID Code qualifier		<b>R</b>	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109</b> - ID Code		<b>R</b>	Rendering Provider National Provider ID / NPI	
<b>SE</b>	<b>Transaction Set Trailer</b>	<b>1</b>	<b>R</b>		
	SE01 – Number of included segments		<b>R</b>		
	SE02 – Transaction Set Control Number		<b>R</b>	Assigned by Sender. Must equal SE02	

## Institutional Claims (837I) Data Requirements

### General

The purpose of this section is to clarify the data elements and segments that must be used for institutional claims transactions. The following information is designed to help you complete the 837I transaction. If you follow these guidelines, we'll be better able to process your claims accurately and efficiently.

### Detail Data

LoopID/ Segment	Element / Description	Usage	R Q D	Comments	Values
<b>ST</b>	<b>Transaction set Header</b>	<b>1</b>	<b>R</b>		
	<b>ST01</b> - Transaction set ID code		R	This element should be hard coded when submitting the claim.	837
	<b>ST02</b> - Transaction set control number		R	Assigned by Sender. Must equal SE02	
<b>BHT</b>	<b>Beginning of HL Transaction</b>	<b>1</b>	<b>R</b>		
	<b>BHT01</b> - Hierarchical Structure Code		R	This element should be hard coded when submitting the claim.	0019
	<b>BHT02</b> - Transaction set purpose code		R	Allowed values : "00", "18". Use "00"	00
	<b>BHT03</b> - Reference ID		R	Assigned by Sender.	
	<b>BHT04</b> - Date		R	Claim file creation date. Format CCYYMMDD	
	<b>BHT05</b> - Time		R	Claim file creation time. Format HHMM	
	<b>BHT06</b> - Transaction Type Code		R	Allowed Values : "CH", "RP". Use "CH"	CH
<b>REF</b>	<b>Transmission type Identification</b>	<b>1</b>	<b>R</b>		
	<b>REF01</b> - Reference ID qualifier		R		87
	<b>REF02</b> - Reference ID		R		004010X096A1
<b>LOOP 1000A</b>	<b>Submitter Name</b>	<b>1</b>			
<b>NM1</b>	<b>Submitter name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		41
	<b>NM102</b> - Entity Type Qualifier		R	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103</b> - Last Name / Org Name		R	Last name of physician or organization name	
	<b>NM104</b> - First Name		S	Required if NM102 = "1"	
	<b>NM105</b> - Middle Name		S	Required if NM102 = "1"	
	<b>NM107</b> - Name Suffix		S	Required if NM102 = "1"	
	<b>NM108</b> - ID Code qualifier		R		46
	<b>NM109</b> - ID Code		R		
<b>LOOP 1000B</b>	<b>Receiver Name</b>	<b>1</b>			
<b>NM1</b>	<b>Receiver name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		40
	<b>NM102</b> - Entity Type Qualifier		R		2
	<b>NM103</b> - Last Name / Org Name		R	Use "Beacon Health Strategies, LLC"	
	<b>NM108</b> - ID Code qualifier		R	ETIN	46
	<b>NM109</b> - ID Code		R	Use "BHS-963116116"	
<b>LOOP 2000A</b>	<b>Billing/ Pay to provider</b>	<b>&gt; 1</b>			
<b>HL</b>	<b>Billing/pay to provider HL</b>		<b>R</b>		
	<b>HL01</b> - Hierarchical ID Number		R	Sequence number incremented for each occurrence of HL.	

	<b>HL03 - Hierarchical Level Code</b>		R		20
	<b>HL04 - Hierarchical Child Code</b>		R		1
<b>PRV</b>	<b>Billing/pay to provider specialty information</b>		S		
	<b>PRV01 - Provider Code</b>		R		BI or PT
	<b>PRV02 - Reference ID Qualifier</b>		R		ZZ
	<b>PRV03 - Reference ID</b>		R		
<b>LOOP 2010AA</b>	<b>Billing provider</b>	<b>1</b>			
<b>NM1</b>	<b>Billing provider name</b>	<b>1</b>	R		
	<b>NM101 - Entity ID Code</b>		R		85
	<b>NM102 - Entity Type Qualifier</b>		R	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103 - Name Last or Organization Name</b>		R		
	<b>NM104 - Name First</b>		S	Required if NM102 = "1"	
	<b>NM105 - Name Middle</b>			Required if NM102 = "1"	
	<b>NM107 - Name Suffix</b>		S	Required if NM102 = "1"	
	<b>NM108 - ID Code qualifier</b>		y	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109 - ID Code</b>		y	Provider Tax ID / NPI	
<b>N3</b>	<b>Billing provider address</b>	<b>1</b>	R		
	<b>N301 - Address</b>		R		
	<b>N302 - Address</b>		S		
<b>N4</b>	<b>Billing provider city/state/zip</b>	<b>1</b>	R		
	<b>N401 - City</b>		R		
	<b>N402 - State</b>		R		
	<b>N403 - Zip</b>		R		
	<b>N404 - Country</b>		S	Required if billing address is outside of the US	
<b>REF</b>	<b>Billing Provider Secondary Identification</b>	<b>&gt;=1</b>	R		
	<b>REF01 - Reference ID Qualifier</b>		R	BQ - Health Maintenance Organization Code Number EI - Employer's Identification Number SY - Social Security Number( cannot be used for Medicare members)	BQ,EI,SY
	<b>REF02 - Reference ID</b>		R	Beacon Provider ID Provider Tax ID Social Security Number	
<b>PER</b>	<b>Billing Provider Contact Information</b>	<b>2</b>	S		
	<b>PER01 - Contact Function Code</b>		R		IC
	<b>PER02 - Name</b>		R		
	<b>PER03 - Comm Number Qualifier</b>		R	Allowed Values: "EM, FX, or TE"	
	<b>PER04 - Communication Number</b>		R		
<b>LOOP 2000B</b>	<b>Subscriber HL</b>	<b>&gt; 1</b>			
<b>HL</b>	<b>Subscriber HL</b>	<b>1</b>	R		
	<b>HL01 - Hierarchical ID Number</b>		R	Assigned by sender	
	<b>HL02 - Hierarchical Parent ID Number</b>		R	Assigned by sender	
	<b>HL03 - Hierarchical Level Code</b>		R	Subscriber	22
	<b>HL04 - Hierarchical Child Code</b>		R	"0" if Subscriber is the patient. "1" if subscriber is not the patient	
<b>SBR</b>	<b>Subscriber information</b>	<b>1</b>	R		
	<b>SBR01 - Payer Resp Seq No Code</b>		R		
	<b>SBR02 - Individual Relationship code</b>		S	Used if Subscriber is the Patient	18

	<b>SBR03</b> - Reference ID		<b>S</b>	Insured Group or Policy Number For Providers submitting via EMDEON – Use this to identify the Plan Allowed Values : "001" for Neighborhood Health Plan of MA, "004" for HealthSource/Hudson Health Plan, "005" for Fallon Community Health Plan , "006" for Neighborhood Health Plan of RI, "009" for Affinity Health Plan, "013" for DC Chartered Health Plan "014" for Health Right "015" for Neighborhood Health Partners "018" for Touchstone Health "019" for Abri Health Plan "020" for BMC HealthNet Plan "021" for Orange County Mental Health Plan	
	<b>SBR04</b> - Name		<b>S</b>	Plan Name For Provider submitting via EMDEON – Allowed Values : Neighborhood Health Plan of MA, Health Source/Hudson Health Plan, Fallon Community Health Plan , Neighborhood Health Plan of RI, Affinity Health Plan, DC Chartered Health Plan Health Right Neighborhood Health Partners Touchstone Health Abri Health Plan BMC HealthNet Plan Orange County Mental Health Plan	
	<b>SBR05</b> - Insurance Type Code		<b>S</b>		
	<b>SBR09</b> - Claim File Indicator Code		<b>R</b>	Type Of Claim	
<b>LOOP 2010BA</b>	<b>Subscriber name</b>	<b>1</b>			
<b>NM1</b>	<b>Subscriber name</b>	<b>1</b>	<b>R</b>		
	<b>NM101</b> - Entity ID Code		<b>R</b>		IL
	<b>NM102</b> - Entity Type Qualifier		<b>R</b>	Allowed Values : "1" for person, "2" for non-person.	
	<b>NM103</b> - Name Last or Organization Name		<b>R</b>		
	<b>NM104</b> - Name First		<b>S</b>		
	<b>NM105</b> - Name Middle		<b>S</b>		
	<b>NM107</b> - Name Suffix		<b>S</b>		
	<b>NM108</b> - ID Code qualifier		<b>S</b>		MI
	<b>NM109</b> - ID Code			Use Member ID from membership card	
<b>N3</b>	<b>Subscriber's address</b>	<b>1</b>	<b>S</b>		
	<b>N301</b> - Address		<b>R</b>		
	<b>N302</b> - Address		<b>S</b>		
<b>N4</b>	<b>Subscriber's city/state/zip</b>	<b>1</b>	<b>S</b>		
	<b>N401</b> - City		<b>R</b>		
	<b>N402</b> - State		<b>R</b>		
	<b>N403</b> - Zip		<b>R</b>		
<b>DMG</b>	<b>Subscriber's demographic info</b>	<b>1</b>	<b>S</b>		
	<b>DMG01</b> - Date Time Format Qualifier		<b>R</b>		D8
	<b>DMG02</b> - Date Time Period		<b>R</b>	Date of Birth of subscriber (CCYYMMDD format)	
	<b>DMG03</b> - Gender Code		<b>R</b>	Allowed Values : "M", "F", "U"	
<b>LOOP 2010BB</b>	<b>Payer name</b>	<b>1</b>			
<b>NM1</b>	<b>Payer name</b>	<b>1</b>	<b>R</b>		

	<b>NM101</b> - Entity ID Code		R		PR
	<b>NM102</b> - Entity Type Qualifier		R		2
	<b>NM103</b> - Name Last or Organization Name		R	For Providers submitting via EMDEON - Allowed Values : Beacon Health Strategies, LLC For all other Providers - Allowed Values : NHP-MA, HHP, FCHP, NHP-RI, DCCHP, HealthRight, NHPNY, TSH, BMCHP, Abri, CalOptima	
	<b>NM108</b> - ID Code qualifier		R		
	<b>NM109</b> - ID Code		R	For Provider submitting via EMDEON – Allowed Values : 43324 For all other Providers - Allowed Values : "001" for Neighborhood Health Plan of MA, "004" for HealthSource/Hudson Health Plan, "005" for Fallon Community Health Plan , "006" for Neighborhood Health Plan of RI, "009" for Affinity Health Plan, "013" for DC Chartered Health Plan "014" for Health Right "015" for Neighborhood Health Partners "018" for Touchstone Health "019" for Abri Health Plan "020" for BMC HealthNet Plan "021" for Orange County Mental Health Plan	
<b>LOOP 2000C</b>	<b>Patient HL</b>	<b>&gt; 1</b>	<b>S</b>	<b>Required when the Patient is different from the subscriber</b>	
<b>HL</b>	<b>Patient HL</b>	<b>1</b>	<b>S</b>		
	<b>HL01</b> - Hierarchical ID Number		R	Assigned by sender	
	<b>HL02</b> - Hierarchical Parent ID Number		R	Assigned by sender	
	<b>HL03</b> - Hierarchical Level Code		R		23
	<b>HL04</b> - Hierarchical Child Code		R		0
<b>PAT</b>	<b>Patient information</b>	<b>1</b>	<b>R</b>		
	<b>PAT01</b> - Individual relationship code		R		
<b>LOOP 2010CA</b>	<b>Patient name</b>	<b>1</b>			
<b>NM1</b>	<b>Patient name</b>		<b>R</b>		
	<b>NM101</b> - Entity ID Code		R		QC
	<b>NM102</b> - Entity Type Qualifier		R		1
	<b>NM103</b> - Name Last or Organization Name		R		
	<b>NM104</b> - Name First		R		
	<b>NM105</b> - Name Middle		S		
	<b>NM107</b> - Name Suffix		S		
	<b>NM108</b> - ID Code qualifier		R		MI
	<b>NM109</b> - ID Code		R	Use Member ID from membership card	
<b>N3</b>	<b>Patient address</b>	<b>1</b>	<b>R</b>		
	<b>N301</b> - Address		R		
	<b>N302</b> - Address		S		
<b>N4</b>	<b>Patient city/state/zip</b>	<b>1</b>	<b>R</b>		
	<b>N401</b> - City		R		
	<b>N402</b> - State		R		
	<b>N403</b> - Zip		R		
<b>DMG</b>	<b>Patient's demographic info</b>	<b>1</b>	<b>S</b>		
	<b>DMG01</b> - Date Time Format Qualifier		R		D8
	<b>DMG02</b> - Date Time Period		R	Date of Birth of Patient (CCYYMMDD format)	
	<b>DMG03</b> - Gender Code		R	Allowed Values : "M", "F", "U"	

LOOP 2300	Claim information	100			
<b>CLM</b>	<b>Claim information</b>	<b>1</b>	<b>R</b>		
	<b>CLM01</b> - Claim Submitters ID		R	Claim Number. Will be sent back in 835 & 277	
	<b>CLM02</b> - Monetary Amount		R	Total Claim Amount	
	<b>CLM05-1</b> - Facility Code Value		R	First two positions of Bill Type	
	<b>CLM05-3</b> - Claim Frequency Type Code		R	Third position of Bill Type	
	<b>CLM06</b> - Yes/No Condition or Response Code		R		
	<b>CLM07</b> - Provider Accept Assignment Code		S		
	<b>CLM08</b> - Yes/No Condition or Response Code		R		
	<b>CLM09</b> - Release of Information Code		R		
	<b>CLM10</b> - Patient Signature Source Code		S		
	<b>CLM11</b>		S	CLM11 contains RELATED CAUSES INFORMATION and is only required when Accident or Employment Related Causes are indicated.	
	<b>CLM11-1</b> - Related Cause Code		R		
	<b>CLM11-2</b> - Related Cause Code				
	<b>CLM11-3</b> - Related Cause Code				
	<b>CLM11-4</b> - State				
	<b>CLM11-5</b> - Country				
	<b>CLM12</b> - Special Program Code				
	<b>CLM16</b> - Provider Agreement Code				
	<b>CLM20</b> - Delay Reason Code				
<b>DTP</b>	<b>Discharge Hour</b>	<b>1</b>	<b>S</b>		
	<b>DTP01</b> - Date/Time qualifier		R		096
	<b>DTP02</b> - Date/Time Period Format Qualifier		R		TM
	<b>DTP03</b> - Date Time Period		R	In the format HHMM	
<b>DTP</b>	<b>Statement Dates</b>	<b>1</b>	<b>S</b>		
	<b>DTP01</b> - Date/Time qualifier		R		434
	<b>DTP02</b> - Date/Time Period Format Qualifier		R	Allowed Values : "D8" for Date, "R8" for Date Range	
	<b>DTP03</b> - Date Time Period		R	Format "CCYYMMDD" for D8, "CCYYMMDD - CCYYMMDD" for R8	
<b>DTP</b>	<b>Admission Date/ Hour</b>	<b>1</b>	<b>S</b>		
	<b>DTP01</b> - Date/Time qualifier		R		435
	<b>DTP02</b> - Date/Time Period Format Qualifier		R		TM
	<b>DTP03</b> - Date Time Period		R	In the format CCYYMMDDHHMM	
<b>CL1</b>	<b>Institutional Claim Code</b>	<b>1</b>	<b>S</b>		
	<b>CL101</b> - Admission Type Code		R	From Code Source 231	
	<b>CL102</b> - Admission Source Code		R	From Code Source 230	
	<b>CL103</b> - Patient Status Code		R	From Code Source 239	
<b>REF</b>	<b>Prior Authorization or Referral Number</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		R	Allowed Values: "9F" Referral, "G1" Authorization	
	<b>REF02</b> - Reference ID		R		
<b>REF</b>	<b>Original Reference Number</b>	<b>1</b>	<b>S</b>		
	<b>REF01</b> - Reference ID Qualifier		R		F8
	<b>REF02</b> - Reference ID		R		

REF	Medical Record Number	1	S		
	REF01 - Reference ID Qualifier		R		EA
	REF02 - Reference ID		R	Medical Record Number	
HI	Visit Diagnosis Information	1	S		
	HI01 - Healthcare Code Information		R	Principal Diagnosis	
	HI01-1 - Code List qualifier code		R		BK
	HI01-2 - Industry Code		R	ICD-9 Code	
	HI02 - Healthcare Code Information		R	Admitting Diagnosis	
	HI02-1 - Code List qualifier code		R		BJ
	HI02-2 - Industry Code		R	ICD-9 Code	
	HI03 - Healthcare Code Information		R	E-Code	
	HI03-1 - Code List qualifier code		R		BN
	HI03-2 - Industry Code		R	ICD-9 Code	
HI	Diagnosis Related Group (DRG) Info	1	S		
	HI01-1 - Code List qualifier code		R		DR
	HI02-2 - Industry Code		R	Diagnosis Related Group	
HI	Other Diagnosis Information	1	S	Diagnosis Codes	
	HI01 - Healthcare Code Information		R		
	HI01-1 - Code List qualifier code		R		BF
	HI01-2 - Industry Code		R	ICD-9 Code	
	HI02 - Healthcare Code Information		R		
	HI02-1 - Code List qualifier code		R		BF
	HI02-2 - Industry Code		R	ICD-9 Code	
	HI03 - Healthcare Code Information		R		
	HI03-1 - Code List qualifier code		R		BF
	HI03-2 - Industry Code		R	ICD-9 Code	
	HI04 - Healthcare Code Information		R		
	HI04-1 - Code List qualifier code		R		BF
	HI04-2 - Industry Code		R	ICD-9 Code	
	HI05 - Healthcare Code Information		R		
	HI05-1 - Code List qualifier code		R		BF
	HI05-2 - Industry Code		R	ICD-9 Code	
	HI06 - Healthcare Code Information		R		
	HI06-1 - Code List qualifier code		R		BF
	HI06-2 - Industry Code		R	ICD-9 Code	
	HI07 - Healthcare Code Information		R		
	HI07-1 - Code List qualifier code		R		BF
	HI07-2 - Industry Code		R	ICD-9 Code	
	HI08 - Healthcare Code Information		R		
	HI08-1 - Code List qualifier code		R		BF
	HI08-2 - Industry Code		R	ICD-9 Code	
	HI09 - Healthcare Code Information		R		
	HI09-1 - Code List qualifier code		R		BF
	HI09-2 - Industry Code		R	ICD-9 Code	
	HI10 - Healthcare Code Information		R		
	HI10-1 - Code List qualifier code		R		BF
	HI10-2 - Industry Code		R	ICD-9 Code	
	HI11 - Healthcare Code Information		R		
	HI11-1 - Code List qualifier code		R		BF
	HI11-2 - Industry Code		R	ICD-9 Code	

	<b>HI12 - Healthcare Code Information</b>		R		
	<b>HI12-1 - Code List qualifier code</b>		R		BF
	<b>HI12-2 - Industry Code</b>		R	ICD-9 Code	
<b>HI</b>	<b>Principal Procedure Information</b>	<b>1</b>	<b>S</b>		
	<b>HI01 - Healthcare Code Information</b>		R		
	<b>HI01-1 - Code List qualifier code</b>		R	BR is for ICD-9 Code	BP/BR
	<b>HI01-2 - Industry Code</b>		R	ICD-9 Code	
	<b>HI01-3 -Date Time Period Format Qualifier</b>		R	Use if HI01 is Principal Procedure Code	D8
	<b>HI01-4 -Date Time Period</b>		R		CCYYMMDD
<b>HI</b>	<b>Other Procedure Information</b>	<b>2</b>	<b>S</b>		
	<b>HI01 - Healthcare Code Information</b>		R		
	<b>HI01-1 - Code List qualifier code</b>		R	BQ is ICD-9, BO is from code source 130	BO/BQ
	<b>HI01-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI01-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI01-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI02 - Healthcare Code Information</b>		R		
	<b>HI02-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI02-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI02-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI02-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI03 - Healthcare Code Information</b>		R		
	<b>HI03-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI03-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI03-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI03-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI04 - Healthcare Code Information</b>		R		
	<b>HI04-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI04-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI04-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI04-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI05 - Healthcare Code Information</b>		R		
	<b>HI05-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI05-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI05-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI05-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI06 - Healthcare Code Information</b>		R		
	<b>HI06-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI06-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI06-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI06-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI07 - Healthcare Code Information</b>		R		
	<b>HI07-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI07-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI07-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI07-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI08 - Healthcare Code Information</b>		R		
	<b>HI08-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI08-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI08-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI08-4 -Date Time Period</b>		R		CCYYMMDD

	<b>HI09 - Healthcare Code Information</b>		R		
	<b>HI09-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI09-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI09-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI09-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI10 - Healthcare Code Information</b>		R		
	<b>HI10-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI10-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI10-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI10-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI11 - Healthcare Code Information</b>		R		
	<b>HI11-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI11-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI11-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI11-4 -Date Time Period</b>		R		CCYYMMDD
	<b>HI12 - Healthcare Code Information</b>		R		
	<b>HI12-1 - Code List qualifier code</b>		R		BO/BQ
	<b>HI12-2 - Industry Code</b>		R	Standard Procedure Code	
	<b>HI12-3 -Date Time Period Format Qualifier</b>		R		D8
	<b>HI12-4 -Date Time Period</b>		R		CCYYMMDD
<b>QTY</b>	<b>Claim Quantity</b>	<b>4</b>	<b>S</b>		
	<b>QTY01 - Quantity Qualifier</b>		R		CA/CD/LA/NA
	<b>QTY02 - Quantity</b>		R	Days	
	<b>QTY03 - 1 - Unit or Basis for Measurement Code</b>		R		DA
<b>LOOP 2310A</b>	<b>Attending Physician</b>		<b>R</b>		
<b>NM1</b>	<b>Attending Physician Name</b>	<b>1</b>	<b>S</b>		
	<b>NM101 - Entity ID Code</b>		R		71
	<b>NM102 - Entity Type Qualifier</b>		R		
	<b>NM103 - Name Last or Organization Name</b>		R	Attending Physician Last Name	
	<b>NM104 - Name First</b>		R	Attending Physician First Name	
	<b>NM105 - Name Middle</b>		S		
	<b>NM108 - ID Code qualifier</b>		S	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109 - ID Code</b>		S	National Provider ID / NPI	
<b>REF</b>	<b>Attending Physician Secondary Identification</b>	<b>1</b>	<b>R</b>		
	<b>REF01 - Reference ID Qualifier</b>		R		
	<b>REF02 - Reference ID</b>		R		
<b>LOOP 2310E</b>	<b>Service Facility Location</b>		<b>S</b>		
<b>NM1</b>	<b>Service Facility Location</b>	<b>1</b>	<b>S</b>		
	<b>NM101 - Entity ID Code</b>		R		77
	<b>NM102 - Entity Type Qualifier</b>		R		
	<b>NM103 - Name Last or Organization Name</b>		R	Provider Site Name.	
	<b>NM104 - Name First</b>		S		
	<b>NM105 - Name Middle</b>		S		
	<b>NM108 - ID Code qualifier</b>		S	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109 - ID Code</b>		S	National Provider ID / NPI	
<b>REF</b>	<b>Service Facility Location Secondary Identification</b>	<b>1</b>	<b>S</b>		

	<b>REF01</b> - Reference ID Qualifier		R		G5
	<b>REF02</b> - Reference ID		R	Provider Site ID Number provided by Beacon	
<b>LOOP 2400</b>	<b>Service Line (Refer Notes Below)</b>	<b>50</b>			
<b>LX</b>	<b>Service line</b>	<b>1</b>	R		
	<b>LX01</b> - Assigned Number		R	Counter. Assigned by sender	
<b>SV2</b>	<b>Institutional service</b>	<b>1</b>	R		
	<b>SV201</b> - Product/Service ID		R	UB92 Rev Code	
	<b>SV202</b> -Composite Medical Procedure ID		S		
	<b>SV202-1</b> - Product/Service ID Qualifier		R		HC
	<b>SV202-2</b> - Product/ Service ID		R	Procedure Code	
	<b>SV202-3</b> - Procedure Modifier		S	Modifier 1	
	<b>SV202-4</b> - Procedure Modifier		S	Modifier 2	
	<b>SV202-5</b> - Procedure Modifier		S	Modifier 3	
	<b>SV202-6</b> - Procedure Modifier		S	Modifier 4	
	<b>SV203</b> - Monetary Amount		R	Service line charge	
	<b>SV204</b> - Units or basis of measurement code		R		DA / UN
	<b>SV205</b> – Quantity		R	Service Units	
	<b>SV206</b> - Unit Rate		S	For Inpatient Claim, Service Line Accommodation rate amount	
	<b>SV207</b> - Monetary Amount		S	Non covered charge amount	
<b>DTP</b>	<b>Service date</b>	<b>1</b>	R	<b>Service line Start/End</b>	
	<b>DTP01</b> - Date/Time qualifier		R		472
	<b>DTP02</b> - Date/Time Period Format Qualifier		R	Allowed Values : "D8" for Date, "R8" for Date Range	
	<b>DTP03</b> - Date Time Period		R	Format "CCYYMMDD" for D8, "CCYYMMDD - CCYYMMDD" for R8	
<b>LOOP 2420A</b>	<b>Attending Physician</b>		R		
<b>NM1</b>	<b>Attending Physician Name</b>	<b>1</b>	S		
	<b>NM101</b> - Entity ID Code		R		71
	<b>NM102</b> - Entity Type Qualifier		R		
	<b>NM103</b> - Name Last or Organization Name		R	Attending Physician Last Name	
	<b>NM104</b> - Name First		R	Attending Physician First Name	
	<b>NM105</b> - Name Middle		S		
	<b>NM108</b> - ID Code qualifier		S	"XX" - Health Care Financing Administration National Provider Identifier	XX
	<b>NM109</b> - ID Code		S	National Provider ID / NPI	
<b>SE</b>	<b>Transaction Set Trailer</b>	<b>1</b>	R		
	<b>SE01</b> – Number of included segments		R		
	<b>SE02</b> – Transaction Set Control Number		R	Assigned by Sender. Must equal SE02	

**Notes:** For Institutional claims the first claim line is treated as the primary claim line and the rest are treated as ancillary claim lines. The claim is paid based on the units and revenue/procedure code of the primary claim line.