837 Health Care Claim Companion Guides

Version 2.8

January, 2024

For use with ASC X12N 837 Health Care Professional and Institutional Transactions Set Implementation Guides and Addenda (Version HIPAA 5010)

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www.carelonbehavioralhealth.com

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VERSION	CHANGES	DATE
Version 1.0	DRAFT	Sept. 2016
Version 1.1-1.5	Format changes and Final Version	Sept. 2016
Version 1.6	Format changes and Final Version	March 2017
Version 1.7	Add Instructions for Atypical Providers	April 2017
Version 1.8	Format changes and corrections	April 2017
Version 1.9	Format changes and corrections	May 2017
Version 2.0	Added Section 4.5 - Character Sets Supported (Page 3) Removed hard-coded GS03 value from Section 6.3 – Functional Group Header Specifications (Page 24) Added Code “U” and “W” as valid values for HI01-9 (Page 59)	July 2017
Version 2.1	Format changes and corrections	July 2017
Version 2.2	Correction to the description of 999 and 277CA generation by SNIP level.	February 2018
Version 2.3	Section 5.6: Updated Passing Specifications	May 2018
Version 2.4	Section 4.4 Updated to include business rules Section 5.4 Updated to exclude Snip 7 edits	June 2018
Version 2.5	Updated Character Sets Supported	June 2018
Version 2.6	Add Custom report response file details	May 2021
Version 2.7	Add Custom report response file details	November 2022

Chapter 1

Introduction

1.1. Introduction

1.2. What is HIPAA?

1.3. Purpose

1.1. Introduction

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

1.2. 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 healthcare transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in health care.

1.3. Purpose

The purpose of this document is to provide the information necessary to submit claims/encounters electronically to Carelon Behavioral Health, Inc. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer's system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com.

Other important websites:

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

This Document has been prepared as the Carelon Behavioral Health (Carelon) specific Companion Guide to the ASC X12 Implementation Guide(s).

The objectives of the Carelon Companion Guide are:

- To describe the process to become an EDI Trading partner with Carelon Behavioral Health
- To describe the processes to set up, test, and make operational a trading partner with Carelon Behavioral Health

- To identify codes and data elements that are applicable to Carelon Behavioral Health.

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.

Chapter 2

Audience and Contact Information

2.1. Intended Audience

The intended audience for this document is the technical department/team responsible for submitting electronic claims transactions to Carelon Behavioral Health. 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.

2.2. Contact Information

For HIPAA, 837 transactions, EDI, EDI Gateway, documentation and testing questions relating to Carelon, you can get answers by contacting any one of the following:

- EDI Helpdesk
  - Contact with EDI-related questions
  - 888-247-9311
  - BH_EDI.Operations@carelon.com

- Compliance Department
  - Contact for compliance/legal concerns 781-994-7500
  - BH_Compliance@carelon.com

Chapter 3

Set-Up Process Information

3.1. Trading Partner Submitter Forms

3.2. Submitter Form Information

3.1. Trading Partner Submitter Forms

Providers/trading partners interested in submitting electronic claim transactions must complete one of the following forms supplied by Carelon:

a) Provider Connect Online Services Account Request Form

b) Billing Agent Online Services Request Form (Clearinghouse Form)

These forms can be downloaded from Carelon's website at www.carelonbehavioralhealth.com or can be requested by contacting EDI Helpdesk at:

- Phone: 888-247-9311
- Email: BH_EDI.Operations@carelon.com

3.2. Submitter Form Information

- The Online Services Intermediary Authorization Form has to be completed by every provider who will be submitting via a clearinghouse.
- The Billing Agent Online Services Request Form would be completed by the clearinghouse on behalf of the healthcare provider(s).
- Complete the applicable form and return by FAX to 866-698-6032 or send by email to BH_EDI.Operations@carelon.com
- When Carelon EDI receives the form, we will send you an email acknowledgement that indicates your setup has been completed with Carelon Helpdesk. This email will include the Carelon Submitter ID. A second email will be sent with the password attached.
- A submitter ID is assigned to each trading partner. You will utilize the submitter ID to access FileConnect, ProviderConnect, or SFTP for file transmission.

Chapter 4

Supported Transactions and Limitations

4.1. Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 837 Health Care Claim transactions that Carelon will accept.

X12 FILE TYPE	FILE NAME	PURPOSE	SOURCE
837P	837 Professional Health Care Claim **ASC X12N 837 (005010X222A1)**	837 Professional Health Care Claim	Trading Partner
837I	837 Institutional Health Care Claim **ASC X12N 837 (005010X223A2)**	837 Institutional Health Care Claim	Trading Partner

4.2. Response Transactions Supported

This section is intended to identify the response transactions supported by Carelon.

X12 FILE TYPE	FILE NAME	PURPOSE	SOURCE	TURNAROUND FROM TIME OF SUBMISSION
TA1	Interchange Acknowledgement	Acknowledgement to verify transmission has been received	Carelon	Day of Submission
999	Functional Acknowledgement	Acknowledgement to verify the syntactical accuracy of the file (accept, reject, or accepted with errors)	Carelon	Day of Submission
277CA	Claims Acknowledgement	Provides a claim level acknowledgement for all claims received	Carelon	4 Business days
Report/ Text file	Custom Report/Text file	Only when invalid interchange ISA/GS header segments are sent and HIPAA compliant TA1 file is not possible	Carelon	Day of Submission

4.3. 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.

Carelon requires utilizing the following default delimiters:

DESCRIPTION	DEFAULT DELIMITER
Data element separator	* (Asterisk)
Sub-element separator	: (Colon)
Segment Terminator	~ (Tilde)
Repetition Separator	^ (Carat)

4.4. Specific Business Rules and Limitations

The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the ASC X12 standard implementation guides. Some of these limitations are explicit, such as:

- The Claim Information loop (2300) is limited to 100 claims per patient.
- The system allows a maximum of one ISA/IEA envelope per 837 file.
- The Service Line loop (2400) is limited to 50 service lines per professional claim or 50 service lines per institutional claim.
- The ST/SE envelope can be a maximum of 5000 claims per transaction as long as the file does not exceed the maximum file size of 8MB.
- Atypical Providers – This refers to providers who are not traditional health care providers, and therefore, do not have an NPI number assigned. Any claims submitted for services provided by atypical providers must have their Tax ID Number in 2010AA REF02 (REF01=”EI” or “SY”), and their Medicaid or State assigned provider identifier in 2010BB REF02 (REF01 = “G2”) in lieu of a Billing Provider NPI or 2310A REF02 (REF01= “G2”) in lieu of the Attending Provider NPI.
- Member and Provider Validation – Review of member data to ensure the member is covered by a Carelon policy. Review of provider data to ensure the correct provider record in our database is used for claims adjudication
- Duplicate Claim Check – When reviewing an Institutional claim, the following data elements are reviewed against claims received in the last 12 days: Patient control number, Member first and last name, Member address, Claim frequency code, Line level date of service, Revenue code, Procedure code, Total charge amount, and Billing provider NPI. When all data elements match the

claim will be rejected as an exact duplicate. When reviewing a Professional claim, the following data elements are reviewed against claims received in the last 12 days: Patient control number, Member first and last name, Member address, Claim frequency code, Line level data of service, Place of service, Procedure code, Total charge amount, and Billing provider NPI.

- NCCI Edits – Using National Correct Coding Initiative guidelines we will review for the three possible edits: Procedure to procedure, Medically unlikely, and Add-on codes.

4.5. Character Sets Supported

Carelon supports the Basic X12 Character Set:

- Uppercase Letters from A to Z
- Digits from 0 to 9
- Special Characters:
  - !
  - “
  - &
  - ‘
  - (
  -)
  - *
  - +
  - ,
  - –
  - .
  - /
  - :
  - ;
  - ?
  - =
  - (space)

Chapter 5

Testing

5.1. Testing Workflow

5.2. Testing Intro

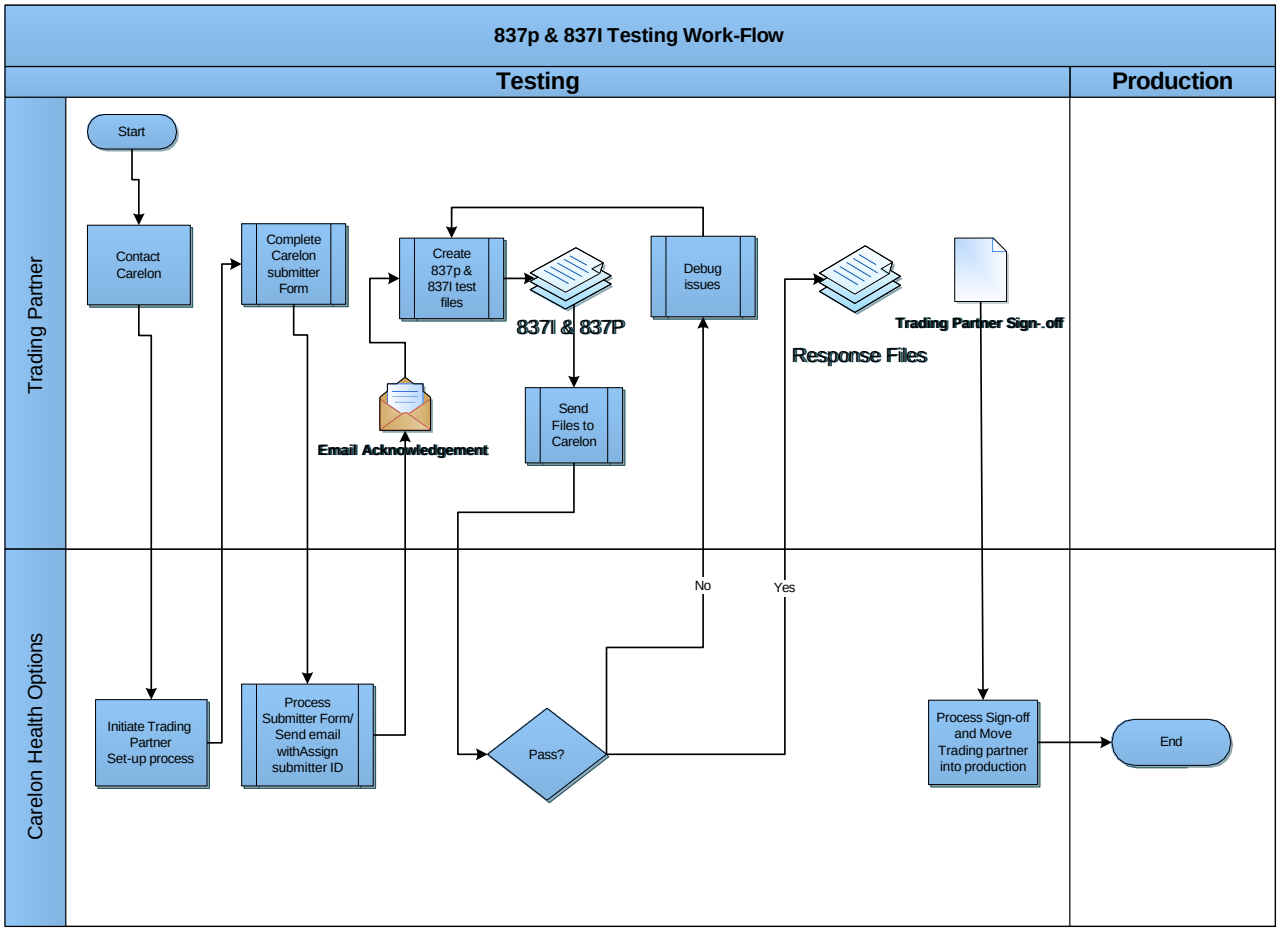
5.3. Validation Specifications

5.4. Compliance Testing Validation of Claims

5.5. National Provider Identifier Specifications

5.6. Trading Partner Acceptance Testing Specifications and Requirements

5.1. Testing Workflow



5.2. Testing Intro

Carelon requires testing for all direct submitters submitting 837P and 837I transactions. Please follow the appropriate format specifications listed in the specific data requirements and submission directions. Test files must be submitted using the secure protocols and submission methodology selected during the set-up process.

Once a test Submitter ID is set up for a trading partner, the submitter can begin to send claims transactions for testing. In order to test, it is imperative that a technical contact be established at the provider/ submitter organization. This contact must be able to monitor, change and submit the 837P and 837I transaction files to Carelon. This contact should be familiar with 837P, 837I, TA1, 277CA, and 999 X12 file transactions. During the testing process, Carelon will examine submitted transactions for required formats and elements, and will provide feedback during the testing process. This testing stage will continue until testing satisfaction is achieved on both sides and Carelon receives sign-off from the trading partner.

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

Upon the completion of successful testing, Carelon will move the trading partner into our production system. The ID number must be used in all files submitted for production claims processing communicated and coordinated with the provider's billing office in order to ensure the required billing information is provided to their billing agent/submitter.

5.3. Validation Specifications

Initial validation is conducted at a batch level. If the batch file is not syntactically valid, the submitter will need to resubmit the corrected batch in its entirety.

Secondary validation is conducted at a claim level. If claims are rejected on the claim level validation, the submitter will need to rebuild the corrected claims in a new batch and submit the new batch for validation.

Do not resubmit the same batch after making the claim level corrections as this will cause any claims that have passed validation from the previous submission to duplicate in the system.

5.4. Compliance Testing Validation of Claims

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing. Carelon will apply these validation edits during testing and production. Carelon applies the following edits to inbound HIPAA 837 files and claims:

1. SNIP Levels 1-6 Transaction Compliance Testing:

   SNIP-1: Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.

   SNIP-2: Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.

   SNIP-3: Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.

   SNIP-4: Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.

   SNIP-5: External Code Set Testing-This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.

   SNIP-6: Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

For more information on SNIP & front end edits, the following sites can be referenced:

- Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org/knowledge-center/health-it-compliance
- Centers for Medicare and Medicaid Services (CMS) – www.CMS.gov

5.5. National Provider Identifier Specifications

Carelon Behavioral Health, in accordance with the HIPAA mandate will require covered entities to submit electronic claims with the NPI and taxonomy codes in the appropriate locations. The NPI is a standard provider identifier that will replace the provider numbers used in standard electronic transactions today and was adopted as a provision of HIPAA. The NPI Final Rule was published on January 23, 2004 and applies to all health care providers.

Carelon Behavioral Health requires that all covered entities report their NPI prior to submitting electronic transactions containing an NPI. To update your provider NPI, please contact our National Provider Line at 800.397.1630.

All electronic transactions for covered entities should contain the provider NPI, taxonomy code, employee identification number and zip code + the 4-digit postal code in the appropriate loops.

Additional information on NPI including how to apply for a NPI can be found on the Centers for Medicare and Medicaid Services (CMS) website at: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply.html.

5.6. Trading Partner Acceptance Testing Specifications and Requirements

Trading partners are encouraged to submit a test file prior to submitting claims electronically to Carelon Behavioral Health.

To submit claims electronically, trading partners must obtain an ID & Password from the Carelon Behavioral Health EDI Helpdesk. Based on the types of services provided, a trading partner may receive multiple submitter IDs. Test files will need to be submitted under all assigned submitter IDs.

Trading partners who upgrade or change software are also encouraged to submit a test submission.

Submitters will be notified via e-mail as to the results of the file validation. If the file failed validation, the e-mail message will provide explanations for the failure. Any error message that is not understood can be explained thoroughly by a Carelon Behavioral Health EDI Coordinator.

After receiving notification that your test batch has passed validation, you will be asked to submit a sign-off document before submitting files to the “production” directories.

Test files will go through SNIP Levels 1-6 Transaction Compliance Testing only. SNIP Level 7 Front-End Validation will be performed in production.

Test sample:

- Provider and Member Data Samples
- 2 Files per Transaction Type (837I & 837P)
- 10 Claims Per File
- Submit with dates of service within the past month

Passing Specification:

- 2 Files per Transaction Type accepted (837I & 837P)
- 10 out of 10 Claims per file passed front-end edits
- **100% Claim acceptance rate**

Chapter 6

Implementation

6.1. Interchange Control Header Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
ISA		INTERCHANGE	R		
	ISA01	Authorization Information Qualifier	R	Valid values: '03' Additional Data Identification	Use '03' Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for authorization.	Use the Carelon Behavioral Health submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	Use '01' value to indicate that a password will be present in ISA04. Use '00' value to indicate that no password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use the Carelon Behavioral Health submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Use 'ZZ' or Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Usually Submitter ID out to 15 characters. Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use 'ZZ' Mutually Defined.
	ISA08	Interchange Receiver ID	R		Use "BEACON963116116"
	ISA09	Interchange Date	R	Date format YYMMDD.	The date (ISA09) is expected to be no more than seven days before the file is received. Any date that does not meet this criterion may cause the file to be rejected.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specifications.
	ISA11	Interchange Control Standards Identifier	R	Delimiter used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different than the data element separator, component element, and the segment terminator. Valid value: '^' Repetition Separator	Use the value specified in the implementation guide. '^'
	ISA12	Interchange Control Version Number	R	Use the current standard approved for the ISA/IEA envelope.	'00501'
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier, zero fill this element out to 9 Characters.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '1' Interchange Acknowledgement Requested	Use '1' Interchange Acknowledgement requested (TA1)
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	The Usage Indicator should be set appropriately. Either can be used.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	Carelon Behavioral Health will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified. ':' (colon) usually

6.2. Interchange Control Trailer Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups		Count the number of functional groups in the interchange	Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e.functional identifier code 'HC' Health Care Claim (837). Segregate professional and institutional functional groups into separate ISA/IEA envelopes.
	IEA02	Interchange Control Number		The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

6.3. Functional Group Header Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
GS		Functional Group Header	R		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HC' Health Care Claim (837)	Use 'HC' – Health Care Claim
	GS02	Application Sender's Code	R		Submitter ID Provided by Carelon
	GS03	Application Receiver's Code	R	This field will identify how the file is received by Carelon Behavioral Health.	Use "BEACON963116116"
	GS04	Date	R	Date format CCYYMMDD	Refer to the implementation guide for specifics.
	GS05	Time	R	Time format HHMM	Refer to the implementation guide for specifics.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	Assigned number originated and maintained by the sender. Recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' -Accredited Standards Committee X12	Use 'X' – Accredited Standards Committee X12

	GS08	Version/Release Industry ID Code	R	Professional Addenda Approved for Publication by ASC X12: '005010X222A1' Institutional Addenda Approved for Publication by ASCX12: '005010X223A2'	Use '005010X222A1' or '0051010X223A2' Other standards will not be accepted

6.4. Functional Group Trailer Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
GE		Functional Group Trailer	R		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group. Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

Chapter 7

Professional Claims Transaction Specifications

7.1. 837 Professional Claim Transaction Specifications

7.1. 837 Professional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
			HEADER		
ST		Transaction Set Header	R		
	ST01	Transaction Set Identifier Code	R		Use '837' Health Care Claim
	ST02	Transaction set control number	R	Assigned by sender. Must equal SE02	
	ST03	Transaction	R	Same as GS08	
BHT		Beginning of Hierarchical Transaction	R		
	BHT01	Hierarchical Structure Code	R	Valid values: '0019' Information Source, Subscriber, Dependent	Use '0019'
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18 Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT03	Reference Identification	R	BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.	Assigned by sender
	BHT04	Date	R	BHT04 is the date the transaction was created within the business application system.	CCYYMMDD
	BHT05	Time	R	BHT05 is the time the transaction was created within the business application system.	HHMMSSDD
	BHT06	Transaction Type Code	R	Separate claim and encounter data into two separate ISA/IEA envelopes (files).	'CH' is used for Claims 'RP' is used for Encounters

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 1000A – SUBMITTER					
NM1		Submitter Name	R		
	NM101	Entity Identifier Code	R	Code identifier Code	'41' is used for Submitter
	NM102	Entity Type Qualifier	R	'1'- Person '2'- Non-Person Entity	'1'- Person '2'- Non-Person Entity
	NM103	Last name of Physician or organization name	R	Name Last or Organization Name	Name Last or Organization Name
	NM104	First Name of Physician	S	Name First	Only used if NM102 = '1'
	NM105	Middle Name of Physician	S	Name Middle	Only used if NM102 = '1'
	NM108	ID code Qualifier	R	'46' Electronic Transmitter ID Number	'46' Electronic Transmitter ID Number
	NM109	Submitter Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the Carelon Behavioral Health assigned submitter ID Maximum 10 characters.
LOOP 1000B - RECEIVER					
NM1		Receiver Name	R		
	NM101	Entity ID Code	R		'40' Receiver
	NM102	Entity Type Qualifier	R		'2' Non-Person Entity
	NM103	Receiver Name	R	Name Last or Organization Name	Use 'CARELON BEHAVIORAL HEALTH, INC.'
	NM108	ID Code	R		'46' Identification Code Qualifier
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'BEACON963116116'

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2000A - BILLING PROVIDER					
HL		Billing Provider Level	R		
	HL01	Hierarchical ID Number	R	Sequence number incremented for each occurrence of HL	
	HL03	Level Code	R		Use ‘20’ information Source
	HL04	Hierarchical Child Code	R		Use ‘1’ Additional Subordinate
PRV		Billing Provider Specialty Information	S	Required for atypical providers	
	PRV01	Provider Code	R		‘BI’ Billing
	PRV02	Reference Identification Qualifier	R		‘PXC’ Health Care Provider Taxonomy Code
	PRV03	Reference Identification	R	Allowed value from External Code List 682.	
LOOP 2010AA – BILLING PROVIDER NAME					
NM1		Billing Provider Name	R		
	NM101	Entity ID Code	R		Use ‘85’ billing provider
	NM102	Entity Type Qualifier	R	Allowed values: ‘1’ for person ‘2’ for non-person	Use ‘1’ for person Use ‘2’ for non-person

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM103	Last Name or Organization Name	R	Billing Provider Last or Organizational Name	
	NM104	Name First	S	Billing Provider First Name	
	NM105	Name Middle	S	Billing Provider Middle Name	
	NM107	Name Suffix	S	Billing Provider Name Suffix	
	NM108	Billing Provider Identification Code Qualifier	R	Required for ALL NPI submitters, with the exception of atypical providers who have not been issued an NPI Number. For those atypical providers, The Billing Provider Secondary Identification (REF*G2) must be provided in Loop 2010BB. See Implementation Guide for additional information.	Use Value- 'XX'
	NM109	Billing Provider Identifier	R	Covered entities send the National Provider ID (NPI)	

Seg	Data Element	Name	Usage	Comments	Expected Value
N3		**Billing Provider Address**	**R**	**Must be a Physical Address, Not a P.O. Box. If the Pay-To Address is a P.O. Box, it must be sent in the Pay-To Address (Loop 2010AB).**	
	N301	Address Information	R	Billing Provider Address Line	
	N302	Address Information Second Address Line	S	Billing Provider Second Address Line	
N4		**Billing Provider City/State/Zip**	**R**		
	N401	City	R	Billing Provider City	
	N402	State	R	Billing Provider State	
	N403	Zip	R	Billing Provider Zip	

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Billing Provider Tax Identification**	**R**	**When NPI is submitted in the NM108/09 of this loop, either the EIN or SSN of the provider must be carried in this REF segment. The value that Carelon receives in this element will be returned on the 1099.**	
	REF01	Reference Identification Qualifier	R	Allowed values: 'EI' Employer's Identification Number 'SY' Social Security Number	Use 'EI' if the Provider ID is EIN Use 'SY' if Provider ID is SSN
	REF02	Billing Provider Additional Identifier	R	EIN or SSN of the billing provider.	
REF		**Billing Provider UPIN/License Info**	**S**		
	REF01	Reference ID Qualifier	R	Allowed values: '0B' State License Number '1G' Provider UPIN Number	Use '1G' for UPIN number (Medicaid Number)
	REF02	Reference ID	R	UPIN information	
LOOP 2010AB – PAY-TO ADDRESS NAME					
NM1		**Pay-To-Address Name**	**S**	**This must be sent if the Pay-To Address is a P.O. Box.**	
	NM101	Entity ID Code	R	'87' Pay-to Provider	
	NM102	Entity Type Qualifier	R	Allowed Values: '1' for person '2' for non-person	Use '1' for person Use '2' for non-person

Seg	Data Element	Name	Usage	Comments	Expected Value
N3		**Pay-To Address**	**R**		
	N301	Address Information	R	First Address Line	
	N302	Address Information	S	Second Address Line	
N4		**Pay-To City/State/Zip**	**R**		
	N401	City	R		
	N402	State	R		
	N403	Zip	R		

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2000B SUBSCRIBER HIERARCHICAL LEVEL					
HL		**Subscriber Hierarchical level**	**R**		
	HL01	Hierarchical Level	R	Assigned by sender	
	HL02	Hierarchical Parent ID Number	R	Assigned by sender	
	HL03	Hierarchical Level Code	R		Use '22' for subscriber
	HL04	Hierarchical Child Code	R		Use '0' if subscriber is the patient Use '1' if subscriber is not the patient
SBR		**Subscriber Information**	**R**		
	SBR01	Payer Responsibility Sequence Number code	R		Use 'P' for Primary Use 'S' for Secondary Use 'T' for Tertiary
	SBR02	Individual Relationship Code	S		Use '18' for Self
	SBR03	Subscriber Ref ID	S	Subscriber Group or Policy Number	"5" , "20" , "32" , "161", "MBHP" , "MAM" or "HEA" '5' for Fallon Health '20' for WellSense Health Plan – Massachusetts '32' for WellSense New Hampshire Medicaid '161' for WellSense Senior Care Options '183' for WellSense Medicare Advantage (HMO) 'MBHP' or 'MAM' for Massachusetts Behavioral Health Partnership 'HEA' for Health New England

Seg	Data Element	Name	Usage	Comments	Expected Value
	SBR04	Name	S	Required when SBR03 is not used and the group name is available.	"Fallon Health" or "WellSense Health Plan – Massachusetts" or "WellSense New Hampshire Medicaid" or "WellSense Senior Care Options" or "WellSense Medicare Advantage (HMO)" or "Massachusetts Behavioral Health Partnership" or "Health New England"
LOOP 2010BA – SUBSCRIBER NAME					
NM1		**Subscriber Name**	**R**		
	NM101	Entity Id Code	R		Use 'IL' Insured or Subscriber
	NM102	Entity Type Qualifier	R		Use '1' for person Use '2' for Non-Person Entity
	NM103	Name or organization name	R	Name Last or Organization Name	
	NM108	Identification Code Qualifier	R	An identifier must be present in the subscriber loop. Refer to Implementation Guide for further details.	Use 'MI' Member Identification Number.
	NM109	Subscriber Primary Identifier	R	Member ID from Membership card *Note: Medical Assistance Number can be used if applicable.	
LOOP 2010BB – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM101	Entity ID code	R		Use 'PR' Payer

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM102	Entity Type Qualifier	R		Use '2' Non-Person Entity
	NM103	Payer Name	R	Destination payer name	Use 'CARELON BEHAVIORAL HEALTH, INC.'
	NM108	Identification Code Qualifier	R	Valid values: 'PI' - Payer Identification 'XV' - HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier' until the National Plan ID is mandated.
	NM109	Payer Identifier	R	Destination payer identifier	Use 'BEACON963116116'
REF		**Billing Provider Secondary Identification**	**S**	**This information is required if the provider is an atypical provider, who does not have an NPI present in the Billing Provider Loop (2010AA).**	
	REF01	Reference ID Qualifier	R	Valid values: 'G2' – Provider Commercial Number 'LU' – Location Number	Use 'G2' Provider Commercial Number
	REF02	Reference ID	R	Medicaid or State assigned provider identifier.	
LOOP 2300 – CLAIM INFORMATION					
CLM		**Claim Information**	**R**		
	CLM01	Patient Account Number	R	Patient Control Number	Patient Control Number
	CLM02	Monetary Amount	R	Total Claim Charge Amount	Total Claim Charge Amount
	CLM05-1	Facility Code Value	R	Place of service	Place of service
	CLM05-2	Facility Code Qualifier	R	Use 'B' place of Service Codes for Professional	Use 'B' place of Service Codes for Professional

Seg	Data Element	Name	Usage	Comments	Expected Value
	CLM05-3	Claim Frequency Type Code	R	1 = Original 7 = Replacement 8 = Void/Cancel of Prior Claim	
REF		**Payer Claim Control Number**	**S**	**Required if Claim Frequency Type Code is 7, or 8**	
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number
	REF02	Original Reference Number	R		If this is a correction to a previously submitted claim use the Carelon Behavioral Health claim number. Enter the whole claim number without spaces or dashes. Include leading and trailing zeros.
REF		**Transmission Intermediaries ID**	**S**		
	REF01	Reference Identification Qualifier	R		Use 'D9' Claim Number
	REF02	Original Reference Number	R	Unique document control number	
NTE		**Claim Received Date**	**S**	**This segment is used only after accepted agreement between trading partners**	
	NTE01	Note Reference Code	R	The value must be 'ADD' for additional information	'ADD' – Additional Information

Seg	Data Element	Name	Usage	Comments	Expected Value
	NTE02	Date Note	R	Date Claim Received Must use format = CCYYMMDD (Pos. 1- 8)	CCYYMMDD- Claim Receive Date
HI		**Health Care Diagnosis Code**	**R**	**Do not include decimal point**	**Diagnoses submitted must include all characters out to the furthest position as defined by the diagnosis coding system.**
	HI01	Health Care Code Information	R		Principal Diagnosis
	HI01-1	Code List Qualifier Code	R		ABK- Principal Diagnosis- ICD10
	HI01-2	Industry Code	R	Use ABK for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BK for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI02	Health Care Code Information	S		Additional Diagnosis
	HI02-1	Code List Qualifier Code	R		ABF- Diagnosis- ICD10
	HI02-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI03	Code List Qualifier Code	S		Additional Diagnosis
	HI03-1	Code List Qualifier Code	R		ABF- Diagnosis- ICD10
	HI03-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI04	Code List Qualifier Code	S		Additional Diagnosis
	HI04-1	Code List Qualifier Code	R		ABF- Diagnosis- ICD10
	HI04-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	NM104	Name First	S	Referring Provider First Name	Referring Provider First Name
	NM105	Name Middle	S	Referring Provider Middle Name	Referring Provider Middle Name
	NM108	Identification Code Qualifier	S		Use Value – 'XX'
	NM109	Identification Code	S	This element contains the NPI for the Referring Provider.	Use the NPI of the Referring Provider.
LOOP 2310A – REFERRING PROVIDER NAME					
NM1		**Attending Provider Name**	**S**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM101	Entity Id Code	R		Use 'DN' for Referring Provider Use 'P3' for Primary Cary Provider
	NM102	Entity Type Qualifier	R		Use '1' for person
	NM103	Name or organization name	R	Referring Provider Last Name	
	NM104	Name First	S	Referring Provider First Name	
	NM105	Name Middle	S	Referring Provider Middle Name	
	NM108	Identification Code Qualifier	S		Use Value – 'XX'
	NM109	Identification Code	S	This element contains the NPI for the Referring Provider.	

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2310B – RENDERING PROVIDER NAME					
NM1		Rendering Provider Name	S		
	NM101	Entity Id Code	R		Use ‘82’ for Rendering Provider
	NM102	Entity Type Qualifier	R		Use ‘1’ for person Use ‘2’ for Non-Person Entity
	NM103	Name or organization name	R	Rendering Provider Last or Organization Name	
	NM104	Name First	S	Rendering Provider First Name	
	NM105	Name Middle	S	Rendering Provider Middle Name	
	NM108	Identification Code Qualifier	S		Use Value – ‘XX’
	NM109	Identification Code	S	The NPI of the Rendering Provider.	

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2310C – SERVICE FACILITY NAME					
NM1		**Service Location Name**	**S**	**This Segment should only be used when the Service Facility Address is different from the Billing Provider Address provided in Loop 2010AA.**	
	NM101	Entity Id Code	R		Use '77' for Service Location
	NM102	Entity Type Qualifier	R		Use '2' for Non-Person Entity
	NM103	Name or organization name	R	Service Location Organization Name	
	NM108	Identification Code Qualifier	S		Use Value – 'XX'
	NM109	Identification Code	S	Use the NPI of the Service Facility Location	
N3		**Address Information**	**S**		
	N301	Address Line 1	R		
	N302	Address Line 2	S		
N4		**Consumer City/State/Zip Code**	**R**		
	N401	City Name	R		
	N402	State	S		

Seg	Data Element	Name	Usage	Comments	Expected Value
	N403	Postal Code	S		
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION					
SBR		**Subscriber Information**	**S**		
	SBR01	Payer responsibility	R	**This loop is for OTHER PAYER ONLY. If there is another payer whose liability precedes Carelon Behavioral Health coverage, do not submit claim until you have received payment or denial from the other payer.**	Use 'P' - (Primary) Use 'S'- (Secondary) Use 'T'- (Tertiary) See Implementation Guide for additional Values
	SBR02	Individual Relationship Code	R	See Implementation Guide for other values	Use '18' - Self
	SBR03	Reference Identification	S		Group or Policy Number
	SBR04	Name	S		Other Insured Group Name
	SBR05	Insurance Type Code	S		See Implementation Guide for valid values
	SBR09	Claim Filing Indicator	S		See Implementation Guide for valid values
AMT		**COB Payer Paid Amount**	**R**		
	AMT01	Amount Qualifier	R	Payer Amount Paid	Use 'D' - Payer Amount Paid
	AMT02	Monetary Amount	R		Amount Paid by the Other Payer
AMT		**COB NON Covered Amount**			
	AMT01	Amount Qualifier Code	R	Non-covered charges -Actual	Use 'A8' - Non-covered charges -Actual
	AMT02	Monetary Amount	R	Non-covered charge amount	

Seg	Data Element	Name	Usage	Comments	Expected Value
OI		**Other Insurance Coverage Information**	**R**		
	OI03	Benefits Assignment	R		Use 'N'- NO Use 'W'- not applicable Use 'Y'-YES
	OI04	Patient Signature Source	S	See Implementation Guide for valid values	
	OI06	Release of Information Code	R	See Implementation Guide for valid values	
LOOP 2330A – OTHER SUBSCRIBER NAME INFORMATION					
NM1			**S**	**Required if Loop 2320 is present**	
	NM101	Entity ID	R		Use 'IL' - Insured or Subscriber
	NM102	Entity Type	R		Use '1' – Person
	NM103	Last Name	R		
	NM104	First Name	S		
	NM105	Middle Name	S		
	NM107	Suffix	S		
	NM108	Identification Code	R		Use 'MI' - Member Identification Number
	NM109	Identification Number	R	Member Identification Number	
N3		**Other Subscriber Address**	**S**		
	N301	Address Information	R	Other Subscriber Address	
N4		**Other Subscriber City*State*ZIP**	**S**		
	N401	City Name	R	Other Subscriber City Name	
	N402	State	R	Other Subscriber State	
	N403	ZIP	R	Other Subscriber Zip	
LOOP 2330B – OTHER PAYER NAME INFORMATION					

Seg	Data Element	Name	Usage	Comments	Expected Value
NM1		**Other Payer Name**	**R**		
	NM101	Entity Identifier	R		Use 'PR' - Payer
	NM102	Entity Type	R		Use '2' -Non-Person Entity
	NM103	Organization Name	R	Name of Payer (Other Insurance Company)	
	NM108	ID Code Qualifier	R		Use 'PI' - Payer Identification
	NM109	Identification Code	R	Payer ID	
N3		Other Payer Address	**S**		
	N301	Address Information	R	Address Information	Address Information
N4		Other Payer City*State*ZIP	**R**		
	N401	City Name	R	City Name	
	N402	State Name	R	State Name	
	N403	Postal Code	R	ZIP Code	ZIP Code
DTP		Claim Adjudication Date	**R**		
	DTP01	Date/Time Qualifier	R		Use '573' Date Claim Paid
	DTP02	Format Qualifier	R		Use 'D8'
	DTP03	Adjudication Date	R		YYYYMMDD
LOOP 2400 – SERVICE LINE					
LX		**Service Line Number**	**R**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	LX01	Assigned Number	R	Number Assigned for differentiation within a transaction set	
SV1		**Professional Service**	**R**		
	SV101	Composite Medical Procedure Identifier	R		
	SV101-1	Product/Service ID Qualifier	R	Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	Use HC to identify health care financing administration. Use common procedural coding system (HCPCS) codes.
	SV101-2	Procedure Code	R	Procedure Code	Procedure Code
	SV101-3	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV101-4	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV101-5	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV101-6	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV104	Quantity	R		Use whole number unit values.
DTP		**Date – Service Date**	**R**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	DTP01	Date/Time Qualifier	R		Use '472' Service
	DTP02	Date Time Period Format Qualifier	R	Valid Values: 'D8' Date Expressed in Format CCYYMMDD 'RD8' Date Range Expressed in Format CCYYMMDD-CCYYMMDD	Use 'RD8' to specify a range of dates. The from and through service dates should be sent for each service line.
	DTP03	Date Time Period	R	Service Date	
LOOP 2430 – LINE ADJUDICATION INFORMATION					
SVD		**Professional Service**	**R**		
	SVD01	Payer ID	R	Payer Identification Code/Number	
	SVD02	Monetary Amount	R	Paid Amount	
	SVD03-1	Procedure Code/ID Qualifier	R		HC = HCPCS
	SVD03-2	Procedure Code/ID	R		
	SVD03-3	Modifiers	S		
	SVD03-4	Modifiers	S		
	SVD03-5	Modifiers	S		
	SVD03-6	Modifiers	S		

Chapter 8

Institutional Claim Transaction Specifications

8.1. 837 Institutional Claim Transaction Specifications

8.1. 837 Institutional Claim Transaction Specifications

Seg	Data Element	Name	Usage	Comments	Expected Value
			HEADER		
ST		Transaction Set Header	R		
	ST01	Transaction Set Identifier Code	R	Valid Value: '837' Health Care Claim	Use '837' Health Care Claim
	ST02	Transaction set control number	R	Assigned by sender. Must equal SE02	
	ST03	Transaction	R	Same as GS08	
BHT		Beginning of Hierarchal Transaction	R		
	BHT01	Hierarchical Structure Code	R		Use '0019'
	BHT02	Transaction Set Purpose Code	R	Valid Values: '00' Original '18' Reissue Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT03	Reference ID	R	Assigned by sender	
	BHT04	Date	R	Transaction Set creation date 'CCYYMMDD'	
	BHT05	Time	R	Transaction Set Creation Time 'HHMM'	

Seg	Data Element	Name	Usage	Comments	Expected Value
	BHT06	Transaction Type Code	R	Valid Values: ‘31’ Subrogation Demand ‘CH’ Chargeable ‘RP’ Reporting Separate claim and encounter data into separate ISA/IEA envelopes (files).	Use ‘CH’ for claims Use ‘RP’ for encounters.
LOOP 1000A – SUBMITTER NAME					
NM1		**Submitter Name**	**R**		
	NM101	Entity Identifier Code	R	‘41’ Submitter	
	NM102	Entity Type Qualifier	R	‘1’ person ‘2’ Non-Person Entity	
	NM103	Name Last or Organization Name	R	Name	
	NM104	Name First	S	Name First	Only if NM102 = ‘1’
	NM105	Name Middle	S	Name Middle	Only if NM102 = ‘1’
	NM108	ID code Qualifier	R	‘46’ Electronic Transmitter ID number	‘46’ ETIN
	NM109	Submitter Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the Carelon Behavioral Health assigned submitter ID. Maximum 10 characters.
LOOP 1000B – RECEIVER NAME					
NM1		**Receiver Name**	**R**		
	NM101	Entity ID Code	R	‘40’ Receiver	

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM102	Entity Type Qualifier	R		Use '2' Non-Person Entity
	NM103	Receiver Name	R		Use 'CARELON BEHAVIORAL HEALTH, INC.'
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'BEACON963116116'
LOOP 2010AA – BILLING PROVIDER NAME					
NM1		**Billing Provider Name**	**R**		
	NM101	Entity Identifier Code	R	'85' Billing Provider	
	NM102	Entity Type Qualifier	R	'2' Non-Person Entity	'2' Non-Person Entity
	NM103	Name Last or Organization Name	R	Name Last or Organization	
	NM108	Billing Provider Identification Code Qualifier	R	A business requirement by Carelon Behavioral Health.	Use 'XX' Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Billing Provider Identifier	R	This element contains the NPI for the Billing	
N3		**Billing Provider Address**	**R**	**Must be a Physical Address, Not a P.O. Box. If the Pay-To Address is a P.O. Box, it must be sent in the Pay-To Address (Loop 2010AB).**	
	N301	Address	R	Billing Provider Address	Billing Provider Address
N4		**Billing Provider City, State, ZIP**	**R**		
	N401	City Name	R	City Name	
	N402	State	R	State	

Seg	Data Element	Name	Usage	Comments	Expected Value
	N403	ZIP	R	ZIP	
REF		**Billing Provider Tax Identification**	**R**		
	REF01	Reference Identification Qualifier	R		Use 'EI'
	REF02	Billing Provider Additional Identifier	R	EIN of the billing provider.	
LOOP 2010AB – PAY-TO-ADDRESS NAME					
NM1		**Billing Provider Name**	**R**		
	NM101	Entity Identifier Code	R	'87' Pay-To Provider	
	NM102	Entity Type Qualifier	R	'2' Non-Person Entity	'2' Non-Person Entity

Seg	Data Element	Name	Usage	Comments	Expected Value
N3		**Pay-to Provider Address**	**R**		
	N301	Address	R	Pay-to Provider Address 1	
	N302	Address	R	Pay-to Provider Address 2	
N4		**Pay-to Provider City, State, ZIP**	**R**		
	N401	City Name	R	City Name	
	N402	State	R	State	
	N403	ZIP	R	ZIP	
LOOP 2000B SUBSCRIBER HIERARCHICAL LEVEL					
		Subscriber Hierarchical Level			
	HL01	Hierarchical ID number	R	Unique number assigned by sender	Unique number assigned by sender
	HL02	Hierarchical Parent ID number		Unique number assigned by sender	Unique number assigned by sender
	HL03	Hierarchical Level Code	R	'22' Subscriber	'22' Subscriber
	HL04	Child Code	R	Use '0' if subscriber is the patient Use '1' if subscriber is not the patient	Use '0' if subscriber is the patient Use '1' if subscriber is not the patient

Seg	Data Element	Name	Usage	Comments	Expected Value
		Subscriber Information	**R**		
	SBR01	Payer Responsibility Sequence Number code	R		Use 'P' for Primary Use 'S' for Secondary Use 'T' for Tertiary
	SBR02	Individual Relationship Code	S		Use '18' for Self
	SBR03	Subscriber Ref ID	S		"5" , "20" , "32" , "161", "MBHP" , "MAM" or "HEA" '5' for Fallon Health '20' for WellSense Health Plan – Massachusetts '32' for WellSense New Hampshire Medicaid '161' for WellSense Senior Care Options '183' for WellSense Medicare Advantage (HMO) 'MBHP' or 'MAM' for Massachusetts Behavioral Health Partnership 'HEA' for Health New England
	SBR04	Name	S		"Fallon Health" or "WellSense Health Plan – Massachusetts" or "WellSense New Hampshire Medicaid" or "WellSense Senior Care Options" or "WellSense Medicare Advantage (HMO)" or "Massachusetts Behavioral Health Partnership" or "Health New England"
LOOP 2010BB – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM101	Entity ID code	R	'PR' Payer	
	NM102	Entity Type Qualifier	R	'2' Non-Person Entity	
	NM103	Payer Name	R	Destination payer name.	Use 'CARELON BEHAVIORAL HEALTH, INC.'

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM108	Identification Code Qualifier	R	Valid values: 'PI' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier until the National Plan ID is mandated.
	NM109	Payer Identifier	R	Destination payer identifier	'Use "BEACON963116116"
LOOP 2300 – CLAIM INFORMATION					
CLM		**Claim Information**	**R**		
	CLM01	Claim Submitter ID	R	Claim Submitter's Patient Control Number	
	CLM02	Monetary Amount	R	Total Claim Charge Amount	
	CLM05-1	Facility Code Value	R	Facility Type Code	
	CLM05-2	Facility Code Qualifier	R	'A' Uniform Billing Claim Form	
	CLM05-3	Claim Frequency Type Code	R	1 = Original 7 = Replacement 8 = Void	
DTP		**Discharge Hour**	**S**		
	DTP01	Date/Time Qualifier	R		Use '096' - Discharge
	DTP02	Date Time Qualifier	R	'TM'	
	DTP03	Date Time Period	R	'HHMM'	
DTP		**Statement Date**	**S**		
	DTP01	Date/Time Qualifier	R		Use '434' -Statement

Seg	Data Element	Name	Usage	Comments	Expected Value
	DTP02	Date Time Period Format Qualifier	R		'RD8' Range of Dates Expressed in Format (CCYYMMDD-CCYYMMDD)
	DTP03	Date Time Period	R	Statement from and to Date	
DTP		**Admission Date/Hour**	**S**		
	DTP01	Date/Time Qualifier	R		Use '435' Admission
	DTP02	Date/Time Format Qualifier	R	Valid Values: 'D8' Date Expressed in Format CCYYMMDD. 'DT' Date and Time Expressed in Format CCYYMMDDHHMM	Use 'DT'- Date and Time Expressed in format (CCYYMMDDHHMM)
	DTP03	Date Time Period	R	Admission Date and Hour	
CL1		**Institutional Claim Code**	**R**		
	CL101	Admission Type Code	R	Code indicating the priority of this admission	From Code Source 231
	CL102	Admission Source Code	R	Code indicating the source of this admission	From Code Source 230
	CL103	Patient Status Code	R	Code indicating patient status as of the "statement covers through date"	From Code Source 239
PWK		**Claim Supplemental Information**	**S**		
	PWK02	Attachment Transmission Code	R	'AA' Available on Request at Provider Site.	Use 'AA' Available on Request at Provider Site.

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Payer Claim Control Number**	**S**	**Required if Claim Frequency Type Code is 7 or 8**	
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number
	REF02	Original Reference Number	R		If this is a correction to a previously submitted claim use the CarelonBehavioral Health claim number. Enter the whole clai number without spaces or dashes. Include leading and trailing zeros.
REF		**Transmission Intermediaries ID**	**S**	**This segment is used only after accepted agreement between trading partners**	
	REF01	Reference Identification Qualifier	R	The value must be 'D9' for Unique document control number	'D9' Unique document control number
	REF02	Original Reference Number	R	Unique document control number	Unique document control number
NTE		**Claim Received Date**	**S**	**This segment is used only after accepted agreement between trading partners**	
	NTE01	Note Reference Code	R	The value must be 'UPI' for additional information	'UPI' – Additional Information

Seg	Data Element	Name	Usage	Comments	Expected Value
	NTE02	Date Note	R	Date Claim Received Must use format = CCYYMMDD (Pos. 1- 8)	CCYYMMDD- Claim Receive Date
HI		**Principal Diagnosis**	**R**		
	HI01-1	Code List Qualifier Code	R		BK - Principal Diagnosis – ICD-9 ABK- Principal Diagnosis- ICD10
	HI01-2	Industry Code	R	Use 'ABK' for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use 'BK' for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI01-9	Yes/No Condition or Response Code	S	Present on Admission Indicator	'N' for No 'U' for Unknown 'W' for Not Applicable 'Y' for Yes
HI		**Admitting Diagnosis**	**S**		
	HI01-1	Code List Qualifier Code	R		BJ - Admitting Diagnosis – ICD-9 ABJ- Admitting Diagnosis- ICD10

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI01-2	Industry Code	R	Use 'ABJ' for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use 'BJ' for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
HI		**Patient's Reason for Visit**	**S**		
	HI01-1	Code List Qualifier Code	R		PR – Patient reason for visit – ICD-9 APR- Patient reason for visit - ICD10
	HI01-2	Industry Code	R	Use 'APR' for ICD-10 when service date is 10/01/2015 and after. Use 'PR' for ICD-9 when service date is 9/30/2015 and prior.	
HI		**External Cause of Injury**	**S**		
	HI01-1	Code List Qualifier Code	R		BN – External cause of injury – ICD-9 ABN- External cause of injury - ICD10
	HI01-2	Industry Code	R	Use 'ABN' for ICD-10 when service date is 10/01/2015 and after.	
HI		**Other Diagnosis Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BF - Other Diagnosis – ICD-9 ABF- Other Diagnosis- ICD10

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI01-2	Industry Code	R	Use 'ABF' for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use 'BF' for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
HI		**Principal Procedure Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BR - Principal Procedure – ICD-9 BBR- Principal Procedure- ICD10
	HI01-2	Industry Code	R	Use 'BBR' when service date is 10/01/2015 and after. Use 'BR' when service date is 9/30/2015 and prior.	
HI		**Other Procedure Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BQ - Other Procedure – ICD-9 BBQ- Other Procedure- ICD10
	HI01-2	Industry Code	R	Use BBQ when service date is 10/01/2015 and after. Use BQ when service date is 9/30/2015 and prior.	
LOOP 2310A – ATTENDING PROVIDER NAME					
NM1		**Attending Provider Name**	**S**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM101	Entity ID Code	R	'71' Attending Physician	'71' Attending Physician
	NM102	Entity Type Qualifier	R	'1' Person	'1' Person
	NM103	Name Last or Organization Name	R	Name Last or Organization Name	Name Last or Organization Name
	NM104	Name First	S	Attending Provider First Name	Attending Provider First Name
	NM105	Name MI	S	Attending Provider Middle Name	Attending Provider Middle Name
	NM108	ID Code Qualifier	R	Required for ALL NPI submitters, with the exceptions of atypical providers who have not been issued an NPI Number. For the atypical providers, the Attending Provider secondary Identification (REF*G2) must be provided in Loop 2310A. See Implementation Guide for additional information.	Use 'XX' – Centers for Medicare and Medicaid NPI
	NM109	ID Code	R	Attending Provider Primary Identifier	Attending Provider Primary Identifier
PRV		**Attending Provider Specialty Information**	**S**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	PRV01	Provider Code	R	Use 'AT' -Attending	Use 'AT' -Attending
	PRV02	Reference ID Qualifier	R	Use 'PXC'- Provider Taxonomy Code	Use 'PXC'- Provider Taxonomy Code
	PRV03	Reference ID	R	Provider Taxonomy Code	Provider Taxonomy Code
REF		**Attending Provider Secondary ID**	**S**		
	REF01	Reference ID Qualifier	R	'G2' Provider Commercial, Medicaid, Medicare Number '1G' UPIN number	'G2' Provider Commercial, Medicaid, Medicare Number '1G' UPIN number
	REF02	Reference ID	R		
LOOP 2310E- SERVICE FACILITY LOCATION NAME					
NM1		**Service Facility Location Name**	**S**		
	NM101	Entity ID code	R	Use '77' – Service Location	Use '77' – Service Location
	NM102	Entity Type Qualifier	R	'2' – Non-person Entity	'2' – Non-person Entity

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM103	Provider Site name	R	Provider Site Name	Provider Site Name
	NM108	ID Code Qualifier	R	'XX' Centers for Medicare and Medicaid NPI	'XX'
	NM109	ID Code	R	ID Code	ID Code
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION					
AMT		**COB Payer Paid Amount**	**R**		
	AMT01	Amount Qualifier Code	R		Use 'D' – Payer Amount Paid
	AMT02	Monetary Amount	R	When submitting claims with multiple claim lines where not all claim lines have a COB relationship; send separate claims.	Amount Paid by the Other Payer.
LOOP 2400 – SERVICE LINE NUMBER					
LX		**Service Line Number**	**R**		
	LX01	Assigned Number	R	Counter. Assigned by Sender	Counter. Assigned by Sender
SV2		**Institutional Service Line**	**R**		
	SV201	Product/Service ID	R	Service Line Revenue Code	Service Line Revenue Code
	SV202-1	Product/Service ID Qualifier	R	'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) codes	'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) codes
	SV202-2	Product/Service ID	R	Procedure Code	Procedure Code
	SV202-3	Product/Service Modifier	S	Modifier 1	Modifier 1

Seg	Data Element	Name	Usage	Comments	Expected Value
	SV202-4	Product/Service Modifier	S	Modifier 2	Modifier 2
	SV202-5	Product/Service Modifier	S	Modifier 3	Modifier 3
	SV205	Quantity	S	Service Units	Use whole number unit values.
DTP		**Service Date**	**S**		
	DTP01	Date/Time Qualifier	R	'472'- Service	'472'- Service
	DTP02	Date Time Period Qualifier	R	'D8'- CCYYMMDD 'RD8'- range of dates(CCYYMMDD-CCYYMMDD)	'D8'- CCYYMMDD 'RD8'- range of dates(CCYYMMDD-CCYYMMDD)
	DTP03	Date Time Period	R	Service Date	Service Date
LOOP 2430 – LINE ADJUDICATION INFORMATION					
SVD		**Professional Service**	**R**		
	SVD06	Assigned Number	R	Number of Units Paid for by Other Payer	Whole Units Only