COMPANION GUIDE

JULY 2004

HEALTH CARE CLAIM STATUS REQUEST
VERSION 4010A1

HEALTH PLAN SYSTEMS INC (HPS)
ANSI ASC X12N 276 Version 4010A1
HEALTH CARE CLAIM STATUS REQUEST

Health Plan Systems is a pioneer in the development of administrative software for the health care industry and, after ten years of extensive research and development, presents a product portfolio designed to help clients achieve Health Insurance Portability and Accountability Act (HIPAA) compliance with unprecedented benefits of efficiency, flexibility and functionality.

As one of the elite group of companies to have its software certified by ***Claredi***, a national third-party organization accrediting entities that send or receive HIPAA-regulated transactions, Health Plan System's proven software makes HIPAA compliance a simple and easy part of everyday business.

HPS Clearinghouse EDI Enrollment Procedure

The first step in becoming electronic billers is to complete an Electronic Data Interchange (EDI) Enrollment registration. We process your registration and assign an electronic Submitter Number and Login ID to you, which identify you as an electronic claim submitter.

If you have any question you can contact your software vendor or HPS Clearinghouse Support Team. Our support team will be happy to assist you at any business time.

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ANSI ASC X12N 276 (004010X093A1)

HEALTH PLAN SYSTEMS INC (HPS)
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Disclaimer

Purpose of the ANSI ASC X12N 276 Claim Status Request - Companion Guide

This companion guide for the ANSI ASC X12N 276 transactions has been created for use in conjunction with the standard implementation guide. It is not a replacement for the implementation guide, but rather used as an additional source of information. The companion guide contains data clarifications derived from specific business rules that apply exclusively to Claim Status Requests processing for the providers who have enrolled with Health Plan Systems.

The guide also includes the testing procedure required by the Health Plan Systems EDI Department. Before sending the Claim Status Request, the providers can also test their Claim Status Request with HPS Clearinghouse. The submitters are therefore encouraged to often check the website of Health Plan Systems for updates to the companion guides at the following web site:

http://hpsch.2hps.com

We will provide an electronic mail access to submitters that are willing to communicate with Health Plan Systems. HPS will provide an email alert whenever there is an update or change of business rules or technical modifications.

Business Requirements

The Health Insurance Portability and Accountability Act (HIPAA) require that HPS Clearinghouse, and all other health insurance payers and clearinghouse in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI ASC X12N 276 implementation guides have been established as the standards of compliance for Claim Status Request transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI ASC X12N 276 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the HPS Clearinghouse service number ***024272739***. The information in this document is subject to change. Changes will be communicated via e-mail and on HPS Clearinghouse web site: http://hpsch.2hps.com

This companion document supplements, but does not contradict any requirements in the ANSI ASC X12N 276 implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

- HPS will only process one transaction type (records group) per interchange (transmission); a submitter can submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).

- HPS is required to create a TA1 Interchange Acknowledgement to report the results of the standard ANSI ASC X12N syntax editing. The TA1 will be available while submitting Claim Status Request to Clearinghouse. HPS provides a way for retrieving and translating the TA1 acknowledgement in an extensive way which is new in the market. Transactions with errors must be corrected and resubmitted.

- HPS is required to create a 997 Functional Acknowledgement to report the results of the standard ANSI ASC X12N syntax editing. The 997 will be available within one (1) business day. The 997 will report standard ANSI X12N syntax errors. HPS provides a way for retrieving and translating the 997 acknowledgements. Transactions with errors must be corrected and resubmitted.

- All dates that are submitted on an incoming 276 transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejections of the Claim Status Request or the applicable interchange (transmission).

- HPS will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic Claim Status Request submission.

- HPS will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receiver's Code) based on the carrier definition.

- Only valid qualifiers for HPS must be submitted on incoming 276 transactions.

- Retrieval of the ANSI ASC X12N 997 functional acknowledgment files can be done on or before the first business day after the Claim Status Request file is submitted, but not less than one day after the file submission.

- Only loops, segment and data elements valid for the HIPAA Claim Status Request Implementation Guide will be translated. Non-implementation guide data may not be sent for processing consideration.

- The incoming 276 transactions must utilize delimiters from the following list:

  Data Element separator : - * (asterisk)
  Loop Segment Separator : - ~ (tilde)
  Component Separator : - : (colon)

  The usage of these characters within the text data elements in the incoming 276 transaction may cause problems with creation of subsequent transactions and hence it is not allowed.

- Currency code (CUR02) must equal 'USA'.

  You must submit incoming 276 data using the basic character set as defined in Appendix A of the 276 Implementation Guide. In addition to the basic character set, you may use characters from the extended character set. Using any characters from the extended character set which is not acceptable by payer will be rejected through functional acknowledgment (997).

- HPS recommends posting files with file name below 45 characters and it should be in windows standard file format.

- Date and time must be mentioned in HIPAA standard and Time zone and date must be in United States graphical format.

- HPS requires following standards for identifiers :

  Payer ID - Should be used as HPS listed (Provided in HPS Participated Payer List)

  Zip code - Should be either 5 or 9 digit numeric value (Special characters not allowed)

  SSN, EIN, Federal Tax ID - Should be 9 digit numeric value (Special characters not allowed)

  Phone, Fax - Should be 10 digit alphanumeric (Special characters not allowed)

  Extension - Should be 1 to 6 alphanumeric (Special characters not allowed)

276 Claim Status Request – Data Clarification

Level: Header

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
Header	**ISA**		**M**	**ID**	**3/3**	**R-1**	**Interchange Control Header**	
Header	ISA01	I01	M	ID	2/2	R	Authorization Information Qualifier	Must contain **'00'**
Header	ISA02	I02	M	AN	10/10	R	Authorization Information	Must contain 10 spaces
Header	ISA03	I03	M	ID	2/2	R	Security Information Qualifier	Must contain '**00**'
Header	ISA04	I04	M	AN	10/10	R	Security Information	Must contain 10 spaces
Header	ISA05	I05	M	ID	2/2	R	Interchange ID Qualifier	Must contain '**ZZ**'
Header	ISA06	I06	M	AN	15/15	R	Interchange Sender ID	Must contain ID assigned by HPS
Header	ISA07	I05	M	ID	2/2	R	Interchange ID Qualifier	Must contain '**ZZ**'
Header	ISA08	I07	M	AN	15/15	R	Interchange Receiver ID	Must contain '**024272739**' plus six Trailing spaces.
Header	ISA09	I08	M	DT	6/6	R	Interchange Date	**YYMMDD**
Header	ISA10	I09	M	TM	4/4	R	Interchange Time	**HHMM**
Header	ISA11	I10	M	ID	1/1	R	Interchange Control Standards Identifier	**U**(U.S. EDI Community of ASC X12, TDCC, and UCS)
Header	ISA12	I11	M	ID	5/5	R	Interchange Control Version	**00401**

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
							Number	
Header	ISA13	I12	M	NO	9/9	R	Interchange Control Number	The Interchange Control Number, ISA13, must be identical to the Associated Interchange Trailer IEA02.
Header	ISA14	I13	M	ID	1/1	R	Acknowledgment Requested	Must contain '**1**'
Header	ISA15	I14	M	ID	1/1	R	Usage Indicator	Must contain '**P**' or '**T**'
Header	ISA16	I15	M		1/1	R	Component Sub element Separator	Must contain '**:**'
Header	**GS**		**M**	**ID**	**2/2**	**R-1**	**Functional Group Header**	
Header	GS01	479	M	ID	2/2	R	Functional Identifier code	**HR**-Health Care Claim Status Request (276)
Header	GS02	142	M	AN	2/15	R	Application Sender's Code	Submitter's Tax ID
Header	GS03	124	M	AN	2/15	R	Receiver ID	Must contain '**024272739**'
Header	GS04	373	M	DT	8/8	R	Creation Date	Date expressed as **CCYYMMDD**
Header	GS05	337	M	TM	4/8	R	Creation Time	The recommended format is **HHMM**
Header	GS06	028	M	N0	1/9	R	Group Control Number	Must begin with 1 and increment by 1 for each subsequent GS with in a

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								file. Reset back to 1 for new file.
Header	GS07	455	M	ID	1/2	R	Responsible Agency Code	**X**- Accredited Standards Committee
Header	GS08	480	M	AN	1/12	R	Version / Release Industry ID Code	**004010X093A1**
Header	**ST**		**M**	**ID**	**2/2**	**R**	**Transaction Set Header**	
Header	ST01	143	M	AN	3/3	R	Transaction Set Identifier Code	**276** (Health Care Claim Status Request)
Header	ST02	329	M	AN	4/9	R	Transaction Set Control Number	Originators could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.
Header	**BHT**		**M**		**3/3**	**R-1**		**To define the business hierarchical structure of the**

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								transaction set and identify the business application purpose and reference data, i.e., number, date, and time
Header	BHT01	1005	M	ID	4/4	R	Hierarchical Structure Code	**0010** (Information Source, Information Receiver, Provider of Service, Subscriber, Dependent)
Header	BHT02	353	M	ID	2/2	R	Transaction Set Purpose Code	**13**(Request)
Header	BHT03					N/U		
Header	BHT04	373	O	DT	8/8	R	Transaction Set Creation Date	Date expressed as **CCYYMMDD**
Header	BHT05-06					N/U		

LEVEL : DETAIL, INFORMATION SOURCE LEVEL

LOOP ID - 2000A PAYER IDENTIFICATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
2000A	**HL**	**010**	**M**		**2/2**	**R>1**	**INFORMATION SOURCE LEVEL**	

2000A	HL01	628	M	AN	1/12	R	Hierarchical ID Number	The value of HL01 Should be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
2000A	HL02					N/U		
2000A	HL03	735	M	ID	1/2	R	Hierarchical Level Code	**20** (Information Source)
2000A	HL04	736	O	ID	1/1	R	Hierarchical Child Code	**1** (Additional Subordinate HL Data Segment in This Hierarchical Structure.)

LOOP ID – 2100A PAYER NAME

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
2100A	**LOOP-2100A**					**R>1**	**PAYER NAME**	
2100A	**NM1**		**O**		**3/3**	**O-1**	**PAYER NAME**	
2100A	NM101	98	M	ID	2/3	R	Entity Identifier Code	**PR** (Payer)
2100A	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**2** (Non-Person Entity)
2100A	NM103	1035	O	AN	1/35	R	Payer Name	
2100A	NM104-07					N/U		
2100A	NM108	66	X	ID	1/2	R	Identification Code Qualifier	Composite Medical Procedure Identifier

2100A	NM109	67	X	AN	2/80	R	Payer Identifier	Use this code for the reference number as qualified by the preceding data element (NM108).
2100A	**PER**		**O**	**ID**	**3/3**	**R-1**	**Payer Contact Information**	
2100A	PER01	366	M	ID	2/2	R	Contact Function Code	IC (Information Contact)
2100A	PER02	93	O	AN	1/60	S	Payer Contact Name	
2100A	PER03	365	X	ID	2/2	R	Communication Number Qualifier	**ED** (Electronic Data Interchange Access Number) **EM** (Electronic Mail) **TE** (Telephone)
2100A	PER04	364	X	AN	1/80	R	Communication Number	
2100A	PER05	365	X	ID	2/2	S	Communication Number Qualifier	**EX** (Telephone Extension)
2100A	PER06	364	X	AN	1/80	S	Communication Number	
2100A	PER07	365	X	ID	2/2	S	Communication Number Qualifier	**EX** (Telephone Extension), **FX** (Facsimile)
2100A	PER08	364	X	AN	1/80	S	Communication Number	

LEVEL: DETAIL, INFORMATION RECEIVER LEVEL

LOOP ID – 2000B INFORMATION RECEIVER LEVEL

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000B			**M**		**2/2**	**R>1**	**INFORMATION RECEIVER LEVEL**	
2000B	HL01	628	M	AN	1/12	R	Hierarchical ID Number	The value of HL01 Should be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
2000B	HL02	734	O	AN	1/2	R	Hierarchical Parent ID Number	
2000B	HL03	735	M	ID	1/2	R	Hierarchical Level Code	**21** (Information Receiver)
2000B	HL04	736	O	ID	1/1	R	Hierarchical Child Code	**1** (Additional Subordinate HL Data Segment in This Hierarchical Structure.)

LOOP ID – 2100B INFORMATION RECEIVER NAME

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100B	**Loop:2100B**					**R->1**	**Information Receiver Name**	
2100B	**NM1**		**O**	**ID**	**3/3**	**R-1**	**Information Receiver or**	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
							Organization Name	
2100B	NM101	98	M	ID	2/3	R	Entity Identifier Code	**41** (Submitter)
2100B	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1** (Person) **2** (Non-Person Entity)
2100B	NM103	1035	O	AN	1/35	R	Information Receiver Last/Org Name	
2100B	NM104	1036	O	AN	1/25	S	Information Receiver First Name	
2100B	NM105	1037	O	AN	1/25	S	Information Receiver Middle Name	
2100B	NM106					N/U		
2100B	NM107	1039	O	AN	1/10	S	Information Receiver Name Suffix	
2100B	NM108	66	X	ID	1/2	R	Identification Code Qualifier	**46** (Electronic Transmitter Identification Number (ETIN)), **FI** (Federal Taxpayer's Identification Number), **XX** (Health Care Financing Administration National Provider Identifier)
2100B	NM109	67	X	AN	2/80	R	Information Receiver Identifier	Use this code for the reference number as qualified by the preceding data element

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								(NM108).

LEVEL : DETAIL, SERVICE PROVIDER LEVEL

LOOP ID – 2000C SERVICE PROVIDER LEVEL

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000C	**LOOP 2000C**					**R>1**	**SERVICE PROVIDER LEVEL**	
2000C	**HL**		**M**		**2/2**	**R>1**	**SERVICE PROVIDER LEVEL**	
2000C	HL01	628	M	AN	1/12	R	Hierarchical ID Number	The value of HL01 Should be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
2000C	HL02	734	O	AN	1/2	R	Hierarchical Parent ID Number	
2000C	HL03	735	M	ID	1/2	R	Hierarchical Level Code	**19** (Provider of Service)
2000C	HL04	736	O	ID	1/1	R	Hierarchical Child Code	**1** (Additional Subordinate HL Data Segment in This Hierarchical Structure.)

LOOP ID – 2100C PROVIDER NAME

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100C	**Loop-2100C**					**R->1**	**Provider Name**	
2100C	**NM1**		**O**	**ID**	**3/3**	**R-1**	**Provider Name**	
2100C	NM101	98	M	ID	2/3	R	Entity Identifier Code	**1P**(Provider)
2100C	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1** (Person) **2** (Non-Person Entity)
2100C	NM103	1035	O	AN	1/35	R	Provider Last/Org Name	
2100C	NM104	1036	O	AN	1/25	S	Provider First Name	
2100C	NM105	1037	O	AN	1/25	S	Provider Middle Name	
2100C	NM106	1038	O	AN	1/10	S	Provider Name Prefix	
2100C	NM107	1039	O	AN	1/10	S	Provider Name Suffix	
2100C	NM108	66	X	ID	1/2	R	Identification Code Qualifier	**FI** (Federal Taxpayer's Identification Number), **SV** (Service Provider Number), **XX** (Health Care Financing Administration National Provider Identifier)
2100C	NM109	67	X	AN	2/80	R	Provider Identifier	Use this code for the reference number as qualified by the preceding data element

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								(NM108).

LEVEL : DETAIL, SUBSCRIBER LEVEL

LOOP 2000D SUBSCRIBER LEVEL

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000D	**LOOP-2000D**					**R>1**	**SUBSCRIBER LEVEL**	
2000D	**HL**		**M**		**2/2**	**R>1**	**SUBSCRIBER LEVEL**	
2000D	HL01	628	M	AN	1/12	R	Hierarchical ID Number	The value of HL01 Should be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
2000D	HL02	734	O	AN	1/2	R	Hierarchical Parent ID Number	
2000D	HL03	735	M	ID	1/2	R	Hierarchical Level Code	**22** (Subscriber)
2000D	HL04	736	O	ID	1/1	R	Hierarchical Child Code	**0** *(*No Subordinate HL Segment in This Hierarchical Structure.), **1** (Additional Subordinate HL Data Segment in This Hierarchical Structure.)

2000D	DMG		O	ID	3/3	S-1	Subscriber Demographic Information	
2000D	DMG01	1250	X	ID	2/3	R	DTP Format Qualifier	**D8** (Date Expressed in Format CCYYMMDD)
2000D	DMG02	1251	X	AN	1/35	R	Subscriber Birth Date	
2000D	DMG03	1068	O	ID	1/1	R	Gender Code	**F** (Female) **M** (Male) **U** (Unknown)

LOOP 2100D SUBSCRIBER NAME

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100D	**Loop-2100D**					**R-1**	**Subscriber Name**	
2100D	**NM1**		**O**	**ID**	**3/3**	**R-1**	**Subscriber Name**	
2100D	NM101	98	M	ID	2/3	R	Entity Identifier Code	**IL** (Insured or Subscriber), **QC** (Patient)
2100D	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1** (Person) **2** (Non-Person Entity)
2100D	NM103	1035	O	AN	1/35	R	Subscriber Last/Org Name	
2100D	NM104	1036	O	AN	1/25	S	Subscriber First Name	
2100D	NM105	1037	O	AN	1/25	S	Subscriber Middle Name	
2100D	NM106	1038	O	AN	1/10	S	Subscriber Name Prefix	
2100D	NM107	1039	O	AN	1/10	S	Subscriber Name Suffix	
2100D	NM108	66	X	ID	1/2	R	Identification Code Qualifier	**24** (Employer's Identification Number), **MI** (Member Identification Number),

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								ZZ (Mutually Defined)
2100D	NM109	67	X	AN	2/80	R	Subscriber Identifier	Use this code for the reference number as qualified by the preceding data element (NM108).

LOOP 2200D CLAIM SUBMITTER TRACE NUMBER

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2200D	**LOOP 2200D**					**S>1**	**CLAIM SUBMITTER TRACE NUMBER**	**Use of this segment is required if the subscriber is the patient.**
2200D	**TRN**				**3/3**	**S-1**	**Trace Number**	
2200D	TRN01	481	M	ID	1/2	R	Trace Type code	**1** (Current Transaction Trace Numbers)
2200D	TRN02	127	M	AN	1/30	R	Trace Number	Should be unique within a transaction set
2200D	**REF**		**S**	**ID**	**3/3**	**S-1**	**Payer Claim Identification Number**	**This should be sent on claim inquiries when the Number is known.**
2200D	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**1K** (Payor's Claim Number)

2200D	REF02	127	X	AN	1/30	R	Payer Claim Control Number	Use this reference number as qualified by the preceding data element (REF01).
2200D	**REF**		**S**	**ID**	**3/3**	**S-1**	**Institutional Bill type Identification**	**Only use this segment if the subscriber is the patient and bill type is being sent in the inquiry request in connection with an institutional bill.**
2200D	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**BLT** (Billing Type)
2200D	REF02	127	X	AN	1/30	R	Bill Type Identifier	Use this reference number as qualified by the preceding data element (REF01).
2200D	**REF**		**S**	**ID**	**3/3**	**S-1**	**Medical Record Identification**	**This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim.**
2200D	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**EA** (Medical Record Identification Number)

2200D	REF02	127	X	AN	1/30	R	Medical Record Number	Use this reference number as qualified by the preceding data element (REF01).
2200D	**REF**		**S**	**ID**	**3/3**	**S-1**	**Group Number**	**This REF segment is used to identify the location or Application System Number believed to contain the claim being inquired upon.**
2200D	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**LU** (Location Number)
2200D	REF02	127	X	AN	1/30	R	Group Number	Use this reference number as qualified by the preceding data element (REF01).
2200D	**AMT**		**O**	**ID**	**3/3**	**S-1**	**Claim Submitted Charges**	
2200D	AMT01	522	M	ID	1/3	R	Amount Qualifier Code	**T3** (Total Submitted Charges)
2200D	AMT02	782	M	R	1/18	R	Total Claim Charge Amount	Sized to 8 bytes. $999,999.99
2200D	**DTP**		**O**	**ID**	**3/3**	**S-1**	**Claim Service Date**	
2200D	DTP01	374	M	ID	3/3	R	DTP Qualifier	**232** (Claim Statement Period Start)

2200D	DTP02	1250	M	ID	2/3	R	DTP Format Qualifier	**RD8** (Date Expressed in Format CCYYMMDD-CCYYMMDD)
2200D	DTP03	1251	M	AN	1/35	R	Claim Service Period	

LOOP 2210D SERVICE LINE INFORMATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
2210D	**LOOP 2210D**				**R>1**		**SERVICE LINE INFORMATION**	
2210D	**SVC**				**3/3**	**R-1**	**Service Information**	
2210D	SVC01	C003	M			R	Composite Medical Procedure Identifier	
2210D	SVC01-1	235	M	ID	2/2	R	Product or service ID Qualifier	Verify Hipaa implementation guide for code list
2210D	SVC01-2	234	M	AN	1/48	S	Product /Service ID	
2210D	SVC01-3	1339	O	AN	2/2	S	Procedure Modifier	
2210D	SVC01-4	1339	O	AN	2/2	S	Procedure Modifier	
2210D	SVC01-5	1339	O	AN	2/2	S	Procedure Modifier	
2210D	SVC01-6	1339	O	AN	2/2	S	Procedure Modifier	
2210D	SVC01-7					N/U		
2210D	SVC02	782	M	R	1/18	R	Line Item Charge Amount	
2210D	SVC03	782	M	R	1/18	R	Line Item Provider Payment Amount	

2210D	SVC04	234	O	AN	1/48	O	Revenue code	
2210D	SVC05-06					N/U		
2210D	SVC07	380	O	R	1/15	S	Original Units of Service Count	The default is 1 unit. This element is required when the submitted units are greater than 1.
2210D	**REF**			**ID**	**3/3**	**S-1**	**Service Line Item Identification**	
2210D	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**FJ** (Line Item Control Number)
2210D	REF02	127	X	AN	1/30	R	Line Item Control Number	Use this reference number as qualified by the preceding data element (REF01).
2210D	**DTP**		**O**	**ID**	**3/3**	**R-1**	**Service Line date**	
2210D	DTP01	374	M	ID	3/3	R	DTP Qualifier	**472** (Service)
2210D	DTP02	1250	M	ID	2/3	R	DTP Format Qualifier	**RD8** (Date Expressed in Format CCYYMMDD-CCYYMMDD)
2210D	DTP03	1251	M	AN	1/35	R	Claim Service Period	

LEVEL: DETAIL, DEPENDENT LEVEL

LOOP 2000E DEPENDENT LEVEL

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000E	**LOOP-200D**					**S>1**	**DEPENDENT LEVEL**	
2000E	**HL**		**M**		**2/2**	**S-1**	**DEPENDENT LEVEL**	
2000E	HL01	628	M	AN	1/12	R	Hierarchical ID Number	The value of HL01 Should be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
2000E	HL02	734	O	AN	1/2	R	Hierarchical Parent ID Number	
2000E	HL03	735	M	ID	1/2	R	Hierarchical Level Code	**23**(Dependent)
2000E	HL04					N/U	Hierarchical Child Code	
2000E	**DMG**		**O**	**ID**	**3/3**	**R-1**	**Dependent Demographic Information**	
2000E	DMG01	1250	X	ID	2/3	R	DTP Format Qualifier	**D8** (Date Expressed in Format CCYYMMDD)
2000E	DMG02	1251	X	AN	1/35	R	Dependent Birth Date	
2000E	DMG03	1068	O	ID	1/1	R	Gender Code	**F** (Female) **M** (Male) **U** (Unknown)

LOOP 2100D DEPENDENT NAME

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100E	**Loop-2100E**					**R-1**	**Dependent Name**	
2100E	**NM1**		**O**	**ID**	**3/3**	**R-1**	**Dependent Name**	
2100E	NM101	98	M	ID	2/3	R	Entity Identifier Code	**QC** (Patient)
2100E	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1** (Person)
2100E	NM103	1035	O	AN	1/35	R	Patient Last Name	
2100E	NM104	1036	O	AN	1/25	S	Patient First Name	
2100E	NM105	1037	O	AN	1/25	S	Patient Middle Name	
2100E	NM106	1038	O	AN	1/10	S	Patient Name Prefix	
2100E	NM107	1039	O	AN	1/10	S	Patient Name Suffix	
2100E	NM108	66	X	ID	1/2	R	Identification Code Qualifier	**MI** (Member Identification Number), **ZZ** (Mutually Defined)
2100E	NM109	67	X	AN	2/80	R	Patient Primary Identifier	Use this code for the reference number as qualified by the preceding data element (NM108).

LOOP 2200D CLAIM SUBMITTER TRACE NUMBER

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2200E	**LOOP 2200E**					**R>1**	**CLAIM SUBMITTER TRACE NUMBER**	**Use of this segment is required if the subscriber is the patient.**
2200E	**TRN**				**3/3**	**R-1**	**Trace Number**	
2200E	TRN01	481	M	ID	1/2	R	Trace Type code	**1** (Current Transaction Trace Numbers)
2200E	TRN02	127	M	AN	1/30	R	Trace Number	Should be unique within a transaction set
2200E	**REF**		**S**	**ID**	**3/3**	**S-1**	**Payer Claim Identification Number**	**This should be sent on claim inquiries when the Number is known.**
2200E	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**1K** (Payor's Claim Number)
2200E	REF02	127	X	AN	1/30	R	Payer Claim Control Number	Use this reference number as qualified by the preceding data element (REF01).

2200E	**REF**		**S**	**ID**	**3/3**	**S-1**	**Institutional Bill type Identification**	**Only use this segment if the subscriber is the patient and bill type is being sent in the inquiry request in connection with an institutional bill.**
2200E	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**BLT** (Billing Type)
2200E	REF02	127	X	AN	1/30	R	Bill Type Identifier	Use this reference number as qualified by the preceding data element (REF01).
2200E	**REF**		**S**	**ID**	**3/3**	**S-1**	**Medical Record Identification**	**This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim.**
2200E	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**EA** (Medical Record Identification Number)
2200E	REF02	127	X	AN	1/30	R	Medical Record Number	Use this reference number as qualified by the preceding data element (REF01).

2200E	**AMT**		**O**	**ID**	**3/3**	**S-1**	**Claim Submitted Charges**	**Use this segment if the service line SVC segment, loop 2210E is not used.**
2200E	AMT01	522	M	ID	1/3	R	Amount Qualifier Code	**T3** (Total Submitted Charges)
2200E	AMT02	782	M	R	1/18	R	Total Claim Charge Amount	Sized to 8 bytes. $999,999.99
2200E	**DTP**		**O**	**ID**	**3/3**	**S-1**	**Claim Service Date**	
2200E	DTP01	374	M	ID	3/3	R	DTP Qualifier	**232** (Claim Statement Period Start)
2200E	DTP02	1250	M	ID	2/3	R	DTP Format Qualifier	**RD8** (Date Expressed in Format CCYYMMDD-CCYYMMDD)
2200E	DTP03	1251	M	AN	1/35	R	Claim Service Period	

LOOP 2210E SERVICE LINE INFORMATION

Loop	**Segment**	**Data Element**	**Condition**	**Data Element Types**	**Min/ Max**	**Usage**	**Description**	**HPS**
2210E	**LOOP 2210E**				**R>1**		**SERVICE LINE INFORMATION**	
2210E	**SVC**				**3/3**	**R-1**	**Service Information**	
2210E	SVC01	C003	M			R	Composite Medical Procedure Identifier	
2210E	SVC01-1	235	M	ID	2/2	R	Product or service ID Qualifier	Verify Hipaa implementation guide for code list

2210E	SVC01-2	234	M	AN	1/48	S	Product /Service ID	
2210E	SVC01-3	1339	O	AN	2/2	S	Procedure Modifier	
2210E	SVC01-4	1339	O	AN	2/2	S	Procedure Modifier	
2210E	SVC01-5	1339	O	AN	2/2	S	Procedure Modifier	
2210E	SVC01-6	1339	O	AN	2/2	S	Procedure Modifier	
2210E	SVC01-7					N/U		
2210E	SVC02	782	M	R	1/18	R	Line Item Charge Amount	
2210E	SVC03					N/U		
2210E	SVC04	234	O	AN	1/48	O	Revenue code	
2210E	SVC05-06					N/U		
2210E	SVC07	380	O	R	1/15	S	Original Units of Service Count	The default is 1 unit. This element is required when the submitted units are greater than 1.
2210E	**REF**			**ID**	**3/3**	**S-1**	**Service Line Item Identification**	
2210E	REF01	128	M	ID	2/3	R	Reference Number Qualifier	**FJ** (Line Item Control Number)
2210E	REF02	127	X	AN	1/30	R	Line Item Control Number	Use this reference number as qualified by the preceding data element (REF01).

2210E	DTP		O	ID	3/3	R-1	Service Line date	
2210E	DTP01	374	M	ID	3/3	R	DTP Qualifier	**472** (Service)
2210E	DTP02	1250	M	ID	2/3	R	DTP Format Qualifier	**RD8** (Date Expressed in Format CCYYMMDD-CCYYMMDD)
2210E	DTP03	1251	M	AN	1/35	R	Claim Service Period	

Level: Trailer

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
Trailer	**TRANSACTION SET TRAILER**							
Trailer	**SE**		**M**	**ID**	**2/2**	**R-1**	**Transaction set trailer**	
Trailer	SE01	96	M	N0	1/10	R	Transaction Segment Count	Total number of segments included in a transaction set including ST and SE Segments.
Trailer	SE02	329	M	AN	4/9	R	Transaction Set Control Number	The Transaction Set Control Numbers in ST02 and SE02 must be Identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE)

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								and interchange (ISA-IEA).
Trailer	**GE**		**M**	**ID**	**2/2**	**R-1**	**Functional Group Trailer**	
Trailer	GE01	97	M	N0	1/6	R	Number Of Transactions Sets Included	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.
Trailer	GE02	28	M	N0	1/9	R	Group Control Number	The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Trailer	**IEA**		**M**	**ID**	**3/3**	**R-1**	**Interchange Control Identifier**	
Trailer	IEA01	I16	M	N0	1/5	R	Number Of Included Functional Groups	A count of the number of functional groups included in an interchange.

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
Trailer	IEA02	I12	M	N0	9/9	R	Interchange Control Number	A control number assigned by the interchange sender.