COMPANION GUIDE

JULY 2004

HEALTH CARE CLAIM: PAYMENT ADVICE
VERSION 4010A1

HEALTH PLAN SYSTEMS INC (HPS)
ANSI ASC X12N 835 Version 4010A1
HEALTH CARE CLAIM PAYMENT ADVICE

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.

835

ANSI ASC X12N 835 (004010X091A1)

HEALTH PLAN SYSTEMS INC (HPS)
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Disclaimer

Purpose of the ANSI ASC X12N 835 Payment Advice - Companion Guide

This companion guide for the ANSI ASC X12N 835 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 claims processing for the payers 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 Remittance Advice, the payers can also test their Remittance Advice 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 835 implementation guides have been established as the standards of compliance for claim 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 835 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 835 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 claims 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 835 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 payment advice 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 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 835 transactions.

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

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

- The incoming 835 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 835 transaction may cause problems with creation of subsequent transactions and hence it is not allowed.

  Note: Contact HPS Team for utilizing other delimiters which is not mentioned here.

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

- You must submit incoming 835 data using the basic character set as defined in Appendix A of the 835 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)

835 Electronic Payment Advice – 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 Number	**00401**
Header	ISA13	I12	M	NO	9/9	R	Interchange	The

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
							Control Number	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 '**:**'
	GS		**M**	**ID**	**2/2**	**R-1**	**Functional Group Header**	
Header	GS01	479	M	ID	2/2	R	Functional Identifier code	**HP**-Health Care Claim Payment/Advice (835)
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 file. Reset back to 1 for new file.
Header	GS07	455	M	ID	1/2	R	Responsible	**X**- Accredited

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
							Agency Code	Standards Committee **X12**(Code used in conjunction with Data Element 480 to identify the issuer of the Standard)
Header	GS08	480	M	AN	1/12	R	Version / Release Industry ID Code	**004010X09 1A1**
Header	**ST**		**M**	**ID**	**2/2**	**R**	**Transaction Set Header**	
Header	ST01	143	M	AN	3/3	R	Transaction Set Identifier Code	**835** (Health Care Claim Payment/Advi ce)
Header	ST02	329	M	ID	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	**BPR**		**M**		**3/3**	**R-1**	**Beginning Segment for Payment**	**To indicate the beginning**

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
							Order/Remittance Advice	**of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable the related transfer of funds and/or information from payer to payee to** occur
Header	BPR01	305	M	ID	1 / 2	R	Transaction Handle Code	'**C'**, '**D'**, '**H'**, '**I'**, '**P'**, '**U'**, '**X'** Either one will be applicable. Verify HIPAA implementation guide for code list details
Header	BPR02	782	M	R	1/18	R	Total Actual Provider Payment Amount	Cannot exceed eleven characters, including decimals ($99999999.99).
Header	BPR03	478	M	ID	1/1	R	Credit/Debit Flag Code	Debit NOT ADVISED
Header	BPRO4	591	M	ID	3/3	R	Payment Method Code	**ACH** – Automated Clearing House, **BOP** – Financial Institution

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								Option, **CHK** – Check, **FWT** – Federal Reverse Funds/Wire Transfer, **NON** – Non payment data.
Header	BPRO5	812	O	ID	1/10	S	Payment Format	1.**CCP** (Cash Concentration /Disbursement plus Addenda.(CCD+) (ACH) -Use the CCD+ format to move money and up to 80 Characters of data). 2.**CTX** Corporate Trade Exchange (CTX) (ACH) -The CTX format can contain up to 9, 999 addenda records of 80 characters each.
Header	BPR06	506	X	ID	2/2	S	Depository Financial Institution (DFI) Identification Number Qualifier	**01** (ABA Transit Routing Number Including Check Digits (9 digits)), **04**(Canadian Bank Branch and Institution

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								Number)
Header	BPR07	507	X	AN	3/12	S	Sender DFI Identifier	Use this number to identify the number of the financial institution that sends the transaction into the ACH network.
Header	BPR08	569	O	ID	1/3	S	Acct Number Qualifier	**DA**(Demand Deposit)
Header	BPR09	508	X	AN	1/35	S	Account Number	
Header	BPR10	509	O	AN	1O/1O	S	Payer Identifier	BPR10 must be the Federal Tax ID Number, preceded by a “1.” When BPR10 is used, it must be identical to TRN03. This element is required when BPR04 is ACH, BOP or FWT.
Header	BPR11	510	O	AN	9/9	S	Originating Company Supplemental Code	This element is required when BPR10 is used and additional information is necessary for the payee to identify the source of the Payment.
Header	BPR12	506	X	ID	2/2	S	Depository Financial Institution (DFI) Identification	This element is required when BPR04 is ACH, BOP or FWT.

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
							Number Qualifier	
Header	BPR13	507	X	AN	3/12	S	DFI ID Number	This element is required when BPR04 is ACH, BOP or FWT.
Header	BPR14	569	O	ID	1/3	S	Acct Number Qualifier	This element is required when BPR04 is ACH, BOP or FWT. The values must be: **DA** (Demand Deposit) **SG** (Savings)
Header	BPR15	508	X	AN	1/35	S	Account Number	This element is required when BPR04 is ACH, BOP or FWT.
Header	BPR16	373	O	DT	8/8	R	Check Issue or EFT Effective Date	Date expressed as CCYYMMDD
Header	BPR17-BPR21					N/U		
Header	**TRN**		**R**		**3/3**	**R-1**	**Resuscitation Trace Number**	
Header	TRN01	481	M	ID	½	R	Trace Type Code	**1** (Current Transaction Trace Numbers)
Header	TRN02	127	M	AN	1/30	R	Check or EFT Trace Number	This number must be unique within the sender/receiver relationship. If a payment is made by check, this

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								number must be the check number.
Header	TRN03	509	O	AN	10/10	R	Originating Company ID	TRN03 must contain the Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to TRN03.
Header	TRN04	127	O	AN	1/30	S	Reference Identification	If both TRN04 and BPR11 are used, they must be identical.
Header	**CUR**		**O**		**3/3**	**S-1**	**Foreign Currency Information**	
Header	CUR01	98	M	ID	2/3	R	Entity Identifier Code	**PR**(Payer)
Header	CUR02	100	M	ID	3/3	R	Currency Code	
Header	CUR03	280	O	R	4/10	S	Exchange Rate	
Header	CUR04-CUR21					N/U		
Header	**REF**		**O**		**3/3**	**S-1**	**Receiver Identification**	
Header	**REF01**	**128**	**M**	**ID**	**2/3**	**R**	**Reference Identification Qualifier**	**EV** (Receiver Identification Number)
Header	REF02	127	X	AN	1/30	R	Receiver Identifier	Use this reference number as qualified by the preceding data element (REF01).
Header	REF03-					N/U		

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
	REF04							
Header	**REF**		**O**		**3/3**	**S-1**	**Version Identification**	
Header	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	**F2**(Version Code – Local)
Header	REF02	127	X	AN	1/30	R	Version Identification Code	Use this reference number as qualified by the preceding data element (REF01).
Header	REF03-REF04					N/U		
Header	**DTM**		**O**		**3/3**	**S-1**	**Production Date**	Under most circumstances, this segment is expected to be sent.
Header	DTM01	374	M	ID	3/3	R	Date/Time Qualifier	**405**(Production)
Header	DTM02	373	X	DT	8/8	R	Production Date	Date expressed as **CCYYMMDD**
Header	DTM03-DTM06					N/U		

LOOP ID - 1000A PAYER IDENTIFICATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
1000A						**R-1**	**Payer Identification**	
1000A	**N1**		**O**		**2/2**	**R-1**	**Name**	
1000A	N101	98	M	Id	2/3	R	Entity Identifier Code	**PR** (Payer)
1000A	N102	93	X	AN	1/60	S	Payer Name	Required if the National Plan ID is not transmitted in

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								N104.
1000A	N103	66	X	ID	1 / 2	S	Identification Code Qualifier Code designating the system/method	Under most circumstances, this element is expected to be sent. The value is **XV** (Health Care Financing Administration National Plan ID)
1000A	N104	67	X	AN	2/80	S	Payer Identifier	Under most circumstances, this element is expected to be sent.
1000A	N105-N106					N/U		
1000A	**N3**		**O**		**2/2**	**R>1**	**Payer Address**	
1000A	N301	166	M	AN	1/55	R	Payer Address Line	
1000A	N302	166	O	AN	1/55	S	Payer Address Line	
1000A	**N4**		**O**		**2/2**	**R-1**	**Payer City, State, ZIP Code**	
1000A	N401	19	O	AN	2/30	R	Payer City Name	
1000A	N402	156	O	Id	2/2	R	State or Province Code	
1000A	N403	116	O	Id	3/15	R	Postal code	Sized to 9 bytes
1000A	N404-N406					N/U		
1000A	**REF**		**S**		**3/3**	**S-4**	**Payer Additional Identification**	Under most circumstances, this segment is not sent.
1000A	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	**2U** (Payer Identification Number) **EO** (Submitter Identification

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								Number) **HI** (Health Industry Number (HIN) **NF** (National Association of Insurance Commissioners (NAIC) Code) ADVISED
1000A	REF02	127	X	AN	1/30	R	Additional Payer Identifier	Use this reference number as qualified by the preceding data element (REF01).
1000A	REF03-REF04					N/U		
1000A	**PER**		**O**		**3/3**	**S-1**	**Administrative Communications Contact**	
1000A	PER01	366	M	ID	2/2	R	Contact Function Code	**CX** (Payers Claim Office)
1000A	PER02	93	O	AN	1/60	S	Payer Contact Name	
1000A	PER03	365	X	ID	2/2	S	Communication Number Qualifier	Verify Hipaa implementation guide for code list
1000A	PER04	364	X	AN	1/80	S	Payer Contact Communication Number	Use this Communication number as qualified by the preceding data element.
1000A	PER05	365	X	ID	2/2	S	Communication Number Qualifier	Verify Hipaa implementation guide for code list
1000A	PER06	364	X	AN	1/80	S	Payer Contact Communication Number	Use this Communication number as qualified by

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								the preceding data element.
1000A	PER07	365	X	ID	2/2	S	Communication Number Qualifier	EX (Telephone Extension)
1000A	PER08	364	X	AN	1/80	S	Payer Contact Communication Number	Use this Communication number as qualified by the preceding data element.
1000A	PER09					N/U		

LOOP ID - 1000B PAYEE IDENTIFICATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
1000B						**R**	**Payee Identification**	
1000B	**N1**		**O**		**1/1**	**R-1**	**Name**	
1000B	N101	98	M	ID	2/3	R	Entity Identifier Code	**PE**(Payee)
1000B	N102	93	X	AN	1/60	S	Payee Name	
1000B	N103	66	X	ID	½	R	Identification Code Qualifier	Verify HIPAA implementation guide for code list details
1000B	N104	67	X	AN	2/80	R	Payee Identification Code	
1000B	N105-N106					N/U		
1000B	**N3**		**O**		**2/2**	**S-1**	**Payee Address**	
1000B	N301	166	M	AN	1/55	R	Payee Address Line	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
1000B	N302	166	0	AN	1/55	S	Payee Address Line	
1000B	**N4**		**O**		**2/2**	**S-1**	**Payee City, State, ZIP Code**	
1000B	N401	19	O	AN	2/30	R	Payee City Name	
1000B	N402	156	O	Id	2/2	R	State or Province Code	
1000B	N403	116	O	Id	3/15	R	Postal code	Sized to 9 bytes
1000B	N4O4	26	O	ID	2/3	S	Country Code	
1000B	N405-N406					N/U		
1000B	**REF**		**O**		**3/3**	**S->1**	**Payee Additional Identification**	Under most circumstances, this segment is not sent.
1000B	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	Verify HIPAA implementation guide for code list details
1000B	REF02	127	X	AN	1/30	R	Additional Payee Identifier	Use this reference number as qualified by the preceding data element (REF01).
1000B	REF03-REF04					N/U		

Level: Details

LOOP ID - 2000 HEADER NUMBER

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000	**Loop: 2000**					**S->1**	**Header Number**	
2000	**Lx**		**O**			**S-1**	**Assigned Number**	
2000	LX01	554	M	NO	1/6	R	Assigned Number	
2000	**TS3**		**O**		**3/3**	**S-1**	**Provider Summary Information**	
2000	TS301	127	M	AN	1/30	R	Provider Identifier	
2000	TS302	1331	M	AN	1 / 2	R	Facility Type Code	
2000	TS303	373	M	DT	8/8	R	Fiscal Period Date	Date expressed as **CCYYMMDD**
2000	TS304	380	M	R	1/15	R	Total Claim Count	
2000	TS305	782	M	R	1/18	R	Total Claim Charge Amount	
2000	TS306	782	O	R	1/18	S	Total Covered Charge Amount	
2000	TS307	782	O	R	1/18	S	Total Non covered Charge Amount	
2000	TS308	782	O	R	1/18	S	Total Denied Charge Amount	
2000	TS309	782	O	R	1/18	S	Total Provider Payment Amount	
2000	TS310	782	O	R	1/18	S	Total Interest Amount	
2000	TS311	782	O	R	1/18	S	Total Contractual Adjustment Amount	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000	TS312	782	O	R	1/18	S	Total Gramm-Rudman Reduction Amount	
2000	TS313	782	O	R	1/18	S	Total MSP Payer Amount	
2000	TS314	782	O	R	1/18	S	Total Blood Deductible Amount	
2000	TS315	782	O	R	1/18	S	Total Non-Lab Charge Amount	
2000	TS316	782	O	R	1/18	S	Total Coinsurance Amount	
2000	TS317	782	O	R	1/18	S	Total HCPCS Reported Charge Amount	
2000	TS318	782	O	R	1/18	S	Total HCPCS Payable Amount	
2000	TS319	782	O	R	1/18	S	Total Deductible Amount	
2000	TS320	782	O	R	1/18	S	Total Professional Component Amount	
2000	TS321	782	O	R	1/18	S	Total MSP Patient Liability Met Amount	
2000	TS322	782	O	R	1/18	S	Total Patient Reimbursement Amount	
2000	TS323	782	O	R	1/15	S	Total PIP Claim Count	
2000	TS324	782	O	R	1/18	S	Total PIP Adjustment Amount	
2000	**TS2**		**O**		**3/3**	**S-1**	**Provider Supplementary Information**	
2000	TS201	782	O	R	1/18	S	Total DRG Amount	
2000	TS202	782	O	R	1/18	S	Total Federal Specific Amount	
2000	TS203	782	O	R	1/18	S	Total Hospital Specific Amount	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2000	TS204	782	O	R	1/18	S	Total Disproportionate Share Amount	
2000	TS205	782	O	R	1/18	S	Total Capital Amount	
2000	TS206	782	O	R	1/18	S	Total Indirect Medical Education Amount	
2000	TS207	380	O	R	1/15	S	Total Outlier Day Count	
2000	TS208	782	O	R	1/18	S	Total Day Outlier Amount	
2000	TS209	782	O	R	1/18	S	Total Cost Outlier Amount	
2000	TS210	380	O	R	1/15	S	Average DRG Length of Stay	
2000	TS211	380	O	R	1/15	S	Total Discharge Count	
2000	TS212	380	O	R	1/15	S	Total Cost Report Day Count	
2000	TS213	380	O	R	1/15	S	Total Covered Day Count	
2000	TS214	380	O	R	1/15	S	Total Non covered Day Count	
2000	TS215	782	O	R	1/18	S	Total MSP Pass-Through Amount	
2000	TS216	380	O	R	1/15	S	Average DRG weight	
2000	TS217	782	O	R	1/18	S	Total PPS Capital FSP DRG Amount	
2000	TS218	782	O	R	1/18	S	Total PPS Capital HSP DRG Amount	
2000	TS219	782	O	R	1/18	S	Total PPS DSH DRG Amount	

LOOP ID - 2100 CLAIM PAYMENT INFORMATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100	**Loop:2100**					**R->1**	**Claim Payment Information**	
2100	**CLP**		**M**		**3/3**	**R-1**	**Claim Level Data**	
2100	CLP01	1028	M	AN	1/38	R	Patient Control Number	Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero.
2100	CLP02	1029	M	ID	1 / 2	R	Claim Status Code	Verify HIPAA implementation guide for code list details.
2100	CLP03	782	M	R	1/18	R	Total Claim Charge Amount	The amount can be zero or less, but the value in BPR02 may not be negative.
2100	CLP04	782	M	R	1/18	R	Claim Payment Amount	The amount can be zero or less, but the value in BPR02 may not be negative.
2100	CLP05	782	O	R	1/18	S	Patient Responsibility Amount	
2100	CLP06	1032	O	ID	1 / 2	R	Claim Filing Indicator Code	Verify HIPAA implementation guide for

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								code list details.
2100	CLP07	127	O	AN	1/30	S	Payer Claim Control Number	
2100	CLP08	1331	O	AN	1 / 2	S	Facility Type Code	
2100	CLP09	1325	O	ID	1/1	S	Claim Frequency Code	
2100	CLP10					N/U		
2100	CLP11	1354	O	ID	1 / 4	S	Diagnosis Related Group (DRG) Code	
2100	CLP12	380	O	R	1/15	S	Diagnosis Related Group (DRG) Weight	
2100	CLP13	954	O	R	1/10	S	Discharge Fraction	
2100	**CAS**		**O**		**3/3**	**S-99**	**Claim Adjustment**	There can be no more than 99 claim adjustments, at the claim header level, per claim.
2100	CAS01	1033	M	ID	1 / 2	R	Claim Adjustment Group Code	Verify Hipaa implementation guide for code list
2100	CAS02	1034	M	ID	1 / 5	R	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS03	782	M	R	1/18	R	Adjustment Amount	Sized to 8 bytes.
2100	CAS04	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2100	CAS05	1034	X	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS06	782	X	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2100	CAS07	380	X	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
2100	CAS08	1034	X	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS09	782	X	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2100	CAS10	380	X	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2100	CAS11	1034	X	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS12	782	X	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2100	CAS13	380	X	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2100	CAS14	1034	X	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS15	782	X	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2100	CAS16	380	X	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2100	CAS17	1034	X	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2100	CAS18	782	X	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2100	CAS19	380	X	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2100	**NM1**		**M**	**ID**	**3/3**	**R-1**	**Patient Name**	
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**QC** (Patient)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1**(Person)
2100	NM103	1035	O	AN	1/35	R	Patient Last Name	
2100	NM104	1036	O	AN	1/25	R	Patient First Name	
2100	NM105	1037	O	AN	1/25	S	Patient Middle Name	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100	NM106					N/U		
2100	NM107	1039	O	AN	1/10	S	Patient Name Suffix	
2100	NM108	66	X	ID	1/2	S	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	S	Patient Identifier	
2100	NM110-NM111					N/U		
2100	**NM1**		**M**		**3/3**	**S-1**	**Insured Name**	
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**IL** (Insured or Subscriber)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1**(Person) **2**(Non-Person Entity)
2100	NM103	1035	O	AN	1/35	S	Subscriber Last Name	
2100	NM104	1036	O	AN	1/25	S	Subscriber First Name	
2100	NM105	1037	O	AN	1/25	S	Subscriber Middle Name	
2100	NM106					N/U		
2100	NM107	1039	O	AN	1/10	S	Subscriber Name Suffix	
2100	NM108	66	X	ID	1/2	R	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	R	Subscriber Identifier	
2100	NM110-NM111					N/U		
2100	**NM1**		**M**			**S-1**	Corrected Patient/Insured Name	Use this NM1 segment to identify the insured or subscriber whenever

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								the insured or subscriber is different from the patient.
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**74** (Corrected Insured)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1**(Person) **2**(Non-Person Entity)
2100	NM103	1035	O	AN	1/35	S	Corrected Patient or Insured Last Name	
2100	NM104	1036	O	AN	1/25	S	Corrected Patient or Insured First Name	
2100	NM105	1037	O	AN	1/25	S	Corrected Patient or Insured Middle Name	
2100	NM106					N/U		
2100	NM107	1039	O	AN	1/10	S	Corrected Patient or Insured Name Suffix	
2100	NM108	66	X	ID	1/2	S	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	S	Corrected Patient or Insured Identifier	
2100	NM110-NM111					N/U		
2100	**NM1**		**M**		**3/3**	**S-1**	**Service Provider Name**	
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**82** (Rendering Provider)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**1**(Person) **2**(Non-Person Entity)
2100	NM103	1035	O	AN	1/35	S	Rendering Provider Last Name	
2100	NM104	1036	O	AN	1/25	S	Rendering Provider	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
							First Name	
2100	NM105	1037	O	AN	1/25	S	Rendering Provider Middle Name	
2100	NM106					N/U		
2100	NM107	1039	O	AN	1/10	S	Rendering Provider Name Suffix	
2100	NM108	66	X	ID	1/2	R	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	R	Rendering Provider Identifier	
2100	NM110-NM111					N/U		
2100	**NM1**		**M**		**3/3**	**S-1**	**Crossover Carrier Name**	
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**TT** (Transfer To)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**2**(Non-Person Entity)
2100	NM103	1035	O	AN	1/35	R	Coordination of Benefits Carrier Name	
2100	NM104-NM107						N/U	
2100	NM108	66	X	ID	1/2	R	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	R	Coordination of Benefits Carrier Identifier	
2100	NM110-NM111					N/U		
2100	**NM1**		**M**		**3/3**	**S-2**	**Corrected Priority Payer Name**	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100	NM101	98	M	ID	2/3	R	Entity Identifier Code	**PR** (Payer)
2100	NM102	1065	M	ID	1/1	R	Entity Type Qualifier	**2**(Non-Person Entity)
2100	NM103	1035	O	AN	1/35	R	Corrected Priority Payer Name	
2100	NM104-NM107						N/U	
2100	NM108	66	X	ID	1/2	R	Identification Code Qualifier	Verify HIPAA implementation guide for code list details.
2100	NM109	67	X	AN	2/80	R	Corrected Priority Payer Identification Identifier	
2100	NM110-NM111					N/U		
2100	**MIA**	**O**			**3/3**	**S-1**	**Medical Inpatient Adjudication**	To provide claim-level data related to the adjudication of Medicare inpatient claims. Either MIA or MOA will appear, but not both.
2100	MIA01	380	M	R	1/15	R	Covered Days or Visits Count	
2100	MIA02	380	O	R	1/15	S	PPS Operating Outlier Amount	
2100	MIA03	380	O	R	1/15	S	Lifetime Psychiatric Days Count	
2100	MIA04	782	O	R	1/18	S	Claim DRG Amount	
2100	MIA05	782	O	R	1/18	S	Remark Code	
2100	MIA06	782	O	R	1/18	S	Claim Disproportionate	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
							Share Amount	
2100	MIA07	782	O	R	1/18	S	Claim Disproportionate Share Amount Claim MSP Pass-through Amount	
2100	MIA08	782	O	R	1/18	S	Claim PPS Capital Amount	
2100	MIA09	782	O	R	1/18	S	PPS-Capital FSP DRG Amount	
2100	MIA10	782	O	R	1/18	S	PPS-Capital HSP DRG Amount	
2100	MIA11	782	O	R	1/18	S	PPS-Capital DSH DRG Amount	
2100	MIA12	782	O	R	1/18	S	Old Capital Amount	
2100	MIA13	782	O	R	1/18	S	PPS-Capital IME amount	
2100	MIA14	782	O	R	1/18	S	PPS-Operating Hospital Specific DRG Amount	
2100	MIA15	782	O	R	1/18	S	Cost Report Day Count	
2100	MIA16	782	O	R	1/18	S	PPS-Operating Federal Specific DRG Amount	
2100	MIA17	782	O	R	1/18	S	Claim PPS Capital Outlier Amount	
2100	MIA18	782	O	R	1/18	S	Claim Indirect Teaching Amount	
2100	MIA19	782	O	R	1/18	S	No payable Professional Component Amount	
2100	MIA20	127	O	AN	1/30	S	Remark Code	
2100	MIA21	127	O	AN	1/30	S	Remark Code	
2100	MIA22	127	O	AN	1/30	S	Remark Code	
2100	MIA23	127	O	AN	1/30	S	PPS-Capital Exception Amount	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2100	MIA24	782	O	R	1/18	S	PPS-Capital Exception Amount	
2100	**MOA**		**O**		**3/3**	**S-1**	**Medicare Outpatient Adjudication**	To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting.
2100	MOA01	954	O	R	1/10	S	Reimbursement Rate	
2100	MOA02	782	O	R	1/18	S	Claim HCPCS Payable Amount	
2100	MOA03	127	O	AN	1/30	S	Remark Code	
2100	MOA04	127	O	AN	1/30	S	Remark Code	
2100	MOA05	127	O	AN	1/30	S	Remark Code	
2100	MOA06	127	O	AN	1/30	S	Remark Code	
2100	MOA07	127	O	AN	1/30	S	Remark Code	
2100	MOA08	782	O	R	1/18	S	Claim ESRD Payment Amount	
2100	MOA09	782	O	R	1/18	S	Non payable Professional Component Amount	
2100	**REF**		**O**		**3/3**	**S-5**	**Other Claim Related Identification**	
2100	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	Verify HIPAA implementation guide for code list details.
2100	REF02	127	X	AN	1/30	R	Other Claim Related Identifier	Use this reference number as qualified by the preceding

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								data element (REF01).
2100	REF03-REF04					N/U		
2100	**REF**		**O**		**3/3**	**S-10**	**Rendering Provider Identification**	
2100	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	Verify HIPAA implementation guide for code list details.
2100	REF02	127	X	AN	1/30	R	Rendering Provider Secondary Identifier	Use this reference number as qualified by the preceding data element (REF01).
2100	REF03-REF04					N/U		
2100	**DTM**		**O**			**S-4**	**Claim Date**	Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim including all service lines. Dates at the service line level apply only to the service line where they appear.
2100	DTM01	374	M	ID	3/3	R	Date/Time Qualifier	Verify HIPAA implementation guide for

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								code list details.
2100	DTM02	373	X	DT	8/8	R	Production Date	Date expressed as **CCYYMMDD**
2100	DTM03-DTM06					N/U		
2100	**PER**		**O**		**3/3**	**S-3**	**Claim Contact Information**	This segment must only be used when there is a claim specific Communications contact instruction.
2100	PER01	366	M	ID	2/2	R	Contact Function Code	**CX** (Payers Claim Office)
2100	PER02	93	O	AN	1/60	S	Claim Contact Name	
2100	PER03	365	X	ID	2/2	S	Communication Number Qualifier	Verify Hipaa implementation guide for code list
2100	PER04	364	X	AN	1/80	S	Claim Contact Communication Number	Use this Communication number as qualified by the preceding data element.
2100	PER05	365	X	ID	2/2	S	Communication Number Qualifier	Verify Hipaa implementation guide for code list
2100	PER06	364	X	AN	1/80	S	Claim Contact Communication Number	Use this Communication number as qualified by the preceding data element.
2100	PER07	365	X	ID	2/2	S	Communication Number Qualifier	Verify Hipaa implementation guide for code list
2100	PER08	364	X	AN	1/80	S	Claim Contact Communication Number	Use this Communication number as

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								qualified by the preceding data element.
2100	PER09					N/U		
2100	**AMT**		**O**		**3/3**	**S-14**	**Monetary Amount**	Use this segment to convey information only. It is not part of the Financial balancing of the 835.
2100	AMT01	522	M	ID	1/3	R	Amount Qualifier Code	Verify HIPAA implementation guide for code list details.
2100	AMT02	782	M	R	1/18	R	Claim Supplemental Information Amount	
2100	AMT03					N/U		
2100	**QTY**		**O**		**3/3**	**S-15**	**Quantity**	Use this segment to convey only information. It is not part of the financial balancing of the 835.
2100	QTY01	673	M	Id	2/2	R	Quantity Qualifier	Verify HIPAA implementation guide for code list details.
2100	QTY02	380	X	R	1/15	R	Claim Supplemental Information Quantity	
2100	QTY03-QTY04					N/U		

LOOP ID - 2110 SERVICE PAYMENT INFORMATION

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2110	**LOOP: 2110**					**S-999**	**Service Payment Information**	Under most circumstances, this segment is expected to be sent.
2110	**SVC**		**0**		**3/3**	**S-1**	**Service Information**	
2110	SVC01	COO3	M			R	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
2110	SVC01 - 1	235	M	ID	2/2	R	Product/Service ID Qualifier	Verify HIPAA implementation guide for code list details.
2110	SVC01 - 2	234	M	AN	1/48	R	Procedure Code	
2110	SVC01 - 3	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC01 - 4	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC01 - 5	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC01 - 6	1339	O	AN	2/2	S	Procedure Modifier	
2110	SCV01-7	352	S	AN	1/80	s	Procedure Code Description	
2110	SVC02	782	M	R	1/18	R	Line Item Charge Amount	
2110	SVC03	782	M	R	1/18	R	Line Item Provider Payment Amount	
2110	SVC04	234	O	AN	1/48	S	National Uniform Billing Committee Revenue Code	
2110	SVC05	380	O	R	1/15	S	Units of Service Paid Count	
2110	SVC06	C003	O			S	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
2110	SVC06-1	235	M	ID	2/2	R	Product or Service ID Qualifier	Verify HIPAA implementation guide for code list details.
2110	SVC06-2	234	M	AN	1/48	R	Procedure Code	
2110	SVC06-3	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC06-4	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC06-5	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC06-6	1339	O	AN	2/2	S	Procedure Modifier	
2110	SVC06-7	352	O	AN	1/80	S	Procedure Code Description	
2110	SVC07	380	O	R	1/15	S	Original units of Service Count	
2110	**DTM**		**O**			**S-3**	**Service Date**	Under most circumstances, this segment is expected to be sent.
2110	DTM01	374	M	ID	3/3	R	Date/Time Qualifier	Verify HIPAA implementation guide for code list details.
2110	DTM02	373	X	DT	8/8	R	Production Date	Date expressed as **CCYYMMDD**
2110	DTM03-DTM06					N/U		
2110	**CAS**		**O**		**3/3**	**S-99**	**Service Payment Information**	There can be no more than 99 claim adjustments, at the detail service line level, per service line.
2110	CAS01	1033	M	ID	1 / 2	R	Claim Adjustment Group Code	**CO-** Contractual Obligations **CR -**Correction

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								and Reversals **OA -**Other adjustments **PI-** Payer Initiated Reductions **PR-** Patient Responsibility.
2110	CAS02	1034	M	ID	1 / 5	R	Adjustment Reason Code	Claim Adjustment Reason Code
2110	CAS03	782	M	R	1/18	R	Adjustment Amount	When the submitted charges are paid in full, the value for this must be zero.
2110	CAS04	380	O	R	1/15	S	Adjustment Quantity	The units of service being adjusted.
2110	CAS05	1034	M	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2110	CAS06	782	M	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2110	CAS07	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2110	CAS08	1034	M	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2110	CAS09	782	M	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2110	CAS10	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2110	CAS11	1034	M	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2110	CAS12	782	M	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2110	CAS13	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2110	CAS14	1034	M	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementatio

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								n guide for code list
2110	CAS15	782	M	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2110	CAS16	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2110	CAS17	1034	M	ID	1 / 5	S	Adjustment Reason Code	Verify Hipaa implementation guide for code list
2110	CAS18	782	M	R	1/18	S	Adjustment Amount	Sized to 8 bytes.
2110	CAS19	380	O	R	1/15	S	Adjustment Quantity	Sized to 14 bytes.
2110	**REF**		**O**		**3/3**	**S-7**	**Service Identification**	
2110	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	Verify HIPAA implementation guide for code list details.
2110	REF02	127	X	AN	1/30	R	Provider Identifier	Use this reference number as qualified by the preceding data element (REF01).
2100	REF03-REF04					N/U		
2110	**REF**		**O**		**3/3**	**S-10**	**Rendering Provider Information**	
2110	REF01	128	M	ID	2/3	R	Reference Identification Qualifier	Verify HIPAA implementation guide for code list details.
2110	REF02	127	X	AN	1/30	R	Rendering Provider Identifier	Use this reference number as qualified by the preceding data element

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
								(REF01).
2110	REF03-REF04					N/U		
2110	**AMT**		**O**			**S-12**	**Service Supplemental Amount**	
2110	AMT01	522	M	ID	1/3	R	Amount Qualifier Code	Verify HIPAA implementation guide for code list details.
2110	AMT02	782	M	R	1/18	R	Service Supplemental Amount	
2110	AMT03					N/U		
2110	**QTY**		**O**		**3/3**	**S-6**	**Quantity**	Service Supplemental Quantity.
2110	QTY01	673	M	Id	2/2	R	Quantity Qualifier	Verify HIPAA implementation guide for code list details.
2110	QTY02	380	X	R	1/15	R	Service Supplemental Quantity Count	
2110	QTY03-QTY04					N/U		
2110	**LQ**		**O**		**2/2**	**S-99**	**Health Care Remark Codes**	There can be no more than 99 remark codes per service line.
2110	LQ01	1270	O	ID	1/3	R	Code List Qualifier Code	**HE**(Claim Payment Remark Codes) **RX** (National Council for Prescription Drug Programs Reject/Payment Codes)
2110	LQ02	1271	X	AN	1/30	R	Remark Code	

Level: Summary

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
Summary	**PLB**		**O**		**3/3**	**S->1**	**Provider Adjustment**	
Summary	PLB01	127	M	AN	1/30	R	Provider Identifier	The provider number assigned by the payer.
Summary	PLB02	373	M	DT	8/8	R	Fiscal Period Date	Date expressed as **CCYYMMDD**
Summary	PLB03	CO42	M			R	Adjustment Identifier	
Summary	PLB03-1	426	M	ID	2/2	R	Adjustment Reason Code	Verify HIPAA implementation guide for code list details.
Summary	PLB03-2	127	O	AN	1/30	s	Provider Adjustment Identifier	
Summary	PLB04	782	M	R	1/18	R	Provider Adjustment Amount	
Summary	PLB05	CO42	X			S	Adjustment Identifier	
Summary	PLB05-1	426	M	ID	2/2	R	Adjustment Reason Code	
Summary	PLB05-2	127	O	AN	1/30	S	Reference Identification	
Summary	PLB06	782	X	R	1/18	S	Provider Adjustment Amount	
Summary	PLB07	CO42	X			S	Adjustment Identifier	
Summary	PLB07-1	426	M	ID	2/2	R	Adjustment Reason Code	
Summary	PLB07-2	127	O	AN	1/30	S	Reference Identification	
Summary	PLB08	782	X	R	1/18	S	Provider Adjustment Amount	
Summary	PLB09	CO42	X			S	ADJUSTMENT IDENTIFIER	
Summary	PLB09-1	426	M	ID	2/2	R	Adjustment Reason Code	

Loop	Segment	Data Element	Condition	Data Element Types	Min/Max	Usage	Description	HPS
Summary	PLB09-2	127	O	AN	1/30	S	Reference Identification	
Summary	PLB10	782	X	R	1/18	S	Provider Adjustment Amount	
Summary	PLB11	CO42	X			S	Adjustment Identifier	
Summary	PLB11-1	426	M	ID	2/2	R	Adjustment Reason Code	
Summary	PLB11-2	127	O	AN	1/30	S	Reference Identification	
Summary	PLB12	782	X	R	1/18	S	Provider Adjustment Amount	
Summary	PLB13	CO42	X			S	Adjustment Identifier	
Summary	PLB13-1	426	M	ID	2/2	R	Adjustment Reason Code	
Summary	PLB13-2	127	O	AN	1/30	S	Reference Identification	
Summary	PLB14	782	X	R	1/18	S	Provider Adjustment Amount	

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

Loop	Segment	Data Element	Condition	Data Element Types	Min/ Max	Usage	Description	HPS
								SE02 must be Identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) 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

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