ELECTRONIC MEDIA CLAIMS TECHNICAL LETTER NO. 28H

TO: All Electronic Media Claims Submitters
FROM: William Longenbaker, Bureau Chief
Bureau of Information Systems Support
DATE: June 28, 2006
SUBJECT: NATIONAL STANDARD FORMAT CARTRIDGE SPECIFICATIONS

TECHNICAL LETTER NUMBER (NO) 28H is being issued to notify all submitters of electronic media claims of a revision to the NATIONAL STANDARD FORMAT (NSF) for the submission of a Date of Discharge Field beginning July 1, 2006.

APPLICABLE OHIO ADMINISTRATIVE CODE (OAC) RULES CAN BE VIEWED ON THE ODJFS WEBSITE http://emanuals.odjfs.state.oh.us/emanuals FOR HOME HEALTH AND PRIVATE DUTY NURSING. THE RULES ARE FROM 5101:3-12-01 TO 5101:3-12-06 OF THE ADMINISTRATIVE CODE.

For the NSF format, the location of the field for the Date of Discharge is in the CA0 record, field location is 6.0, and this detail line is left justified in position 55-60 for 6 positions. Home Health and Private Duty Nursing services for up to 60 days after a post hospital stay requires the date of discharge to be present when the level of services exceeds the current state plan levels. The new specifications are also located at http://hipaa.oh.gov/odjfs/.

ODJFS encourages you to test this new date of discharge status field before submitting these claims to the Production environment. Please send all correspondence, production/test cartridges to the Data Scheduling Unit at the following address:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
Data Scheduling Unit
4200 East Fifth Ave. 1st Fl.
Columbus, Ohio 43219

06/06
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       Technical Cartridge Specifications
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       Instructions for completing ODJFS 06312 Letter of Certification/Batch Recap Form
       Letter of Certification/Batch Recap Form
       Health Insurance Claim Form HCFA-1500
Attached are specifications for the submission of electronic media claim billing cartridges for the National Standard Format to the Ohio Medicaid Program. Please review these instructions and familiarize yourself with the various issues before you attempt to submit a cartridge.

If you have any questions regarding billing instructions or policies, please contact:

Ohio Department of Job and Family Services
Bureau of Plan Operations/Provider Relations Section
P.O. Box 1461
Columbus, Ohio 43216-1461
VOICE RESPONSE UNIT: 1-800-686-1516, operational 24 hours per day, 7 days a week
TELEPHONE: 1-800-686-1516
FAX: 1-614-728-3264
686-1516 Operational 24 hours per day, 7 days a week.

To obtain a hardcopy of specific billing instructions, contact:

Ohio Department of Job and Family Services
Warehousing Service/Forms Distribution Section
2098 Integrity Drive, North
Columbus, Ohio 43209
FAX: 1-614-728-7724

To request provider training:

Ohio Department of Job and Family Services
Bureau of Plan Operations/Provider Network Management
Provider Training Unit
P.O. Box 1461
Columbus, Ohio 43266-0161
TELEPHONE: 1-614-752-9551

If you have any technical questions regarding cartridge submission or the specifications, please contact:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
MIS EDI Support
4200 East Fifth Avenue 1st Floor
Columbus, Ohio 43219
TELEPHONE: 1-614-387-1212
Data_Scheduling_Unit@ODJFS.state.oh.us

The attached specifications are the technical specifications. In order to submit claims on magnetic cartridge you must know how to bill on hardcopy. Hardcopy billing for the HCFA-1500 claim form instructions can be found in Chapter 3334, of the General Information Handbook.
GENERAL INFORMATION

Authorized providers and electronic media claim submitters can submit Clinic, Medicare Cross-Over, Dental, Independent Laboratory, Medical Supply, Physician/Podiatrist/Limited Practitioner/Waiver Service, Transportation and Vision Care claims in machine readable (magnetic cartridge) format.

A provider or electronic media claim submitter will become authorized to submit claims electronically (magnetic cartridge) only after a submitted cartridge has passed the acceptance testing procedures and all enrollment forms have been completed and returned to the Data Scheduling Unit and updated on the file.

Each submission must be accompanied by an ODJFS 06312 Letter of Certification/Batch Recap form, and signed by the electronic media claim submitter.

Electronic media claim submitters may submit claims as often as once per week, however, these submissions must have a minimum count of 250 Claims. Different types of claim submissions (National Standard Format) will be consolidated to reach the 250 submission. There is no minimum requirement for monthly submissions. All claims submitted must be received within 365 days from the actual date-of-service for all claims.

The Medicaid provider is ultimately responsible for the accuracy and validity reporting of all Medicaid claims submitted for payment. A provider using an electronic media claim submitter should ensure through a legal contract that the electronic media claim submitter reports claim information only as directed by the provider. A copy of all contracts between the provider and electronic media claim submitter must be made available to ODJFS upon request. Both the individual provider and the electronic media claim submitter must maintain a record of all Medicaid claims submitted for payment.

The electronic media claim submitter must abide by the provisions of 45 CFR 205.50 which states the requirements for the safeguarding of recipient information. All information pertaining to an individual recipient, supplied by ODJFS or collected internally within the computing and accounting systems for an electronic media claim submitter, can only be used in the accurate billing and accounting of claims or the for purposes of obtaining reimbursement.

Submission must be received by the Unit no later than 1:00 p.m. every Wednesday. The creation date on the file processor data record, record type (AA0) (processing date) must be the Wednesday the submission is received and any cartridges received after the date entered on the file header record will be returned unprocessed.

The system cannot handle multiple volume files. For multi cartridge submissions, each file must contain one header record and one trailer record.

Production cartridges should be sent to:
Ohio Department of Job and Family Services
Bureau of Information Systems Support
MMIS-EDI-Support
4200 East Fifth Avenue 1st Floor
Columbus, Ohio  43219
DEFINITIONS RELATED TO ELECTRONIC MEDIA CLAIM SUBMISSION

**Provider** Any individual or institution licensed or approved for participation in the Medicaid program by ODJFS.

**Provider Agreement** Is a contrast between ODJFS and a provider of MEDICAL ASSISTANCE services in which the provider agrees to comply with the terms of the “Provider Agreement,” state statutes and ODJFS administrative code rules, and federal statutes and rules.

**Electronic Media Claim Submitter** An individual or company who prepares invoices or receives payments on behalf of the provider. A provider who prepares electronic media claim submissions is also considered to be an electronic media claim submitter.

**Electronic Media Claims Submission** A complete electronic media claims submission consists of cartridges prepared as described in the electronic media claim specification publication appropriate to each provider type, and a hard copy of the “Letter of Certification/Batch Recap” form signed by the electronic media claim submitters.

**Billing Date** Date of invoice preparation.

**Service Date** Date service was provided to recipient.
The National Standard Format will accommodate the following providers:

(1) Clinic
   (a) Comprehensive - (Fee for service)
   (b) Diagnostic
   (c) Dialysis
   (d) Family Planning (Planned Parenthood)
   (e) Federally Qualified Health Center (FQHC)
   (f) Outpatient Health Facility (OHF)
   (g) Public Health Departments
   (h) Rehabilitation (Physical, Speech and Hearing Therapy)
   (i) Rural Health Facility (RHF)
   (j) Mental, Drug and Alcohol Clinic

(2) Cross-Over

(3) Dental
   Dentist (Individual/Group)

(4) Independent Laboratory
   (a) Independent Laboratory
   (b) Physiology Laboratory
   (c) X-Ray Laboratory

(5) Medical Supply
   (a) Durable Equipment
   (b) Medical Equipment
   (c) Orthotic Equipment
   (d) Prosthetic Equipment
   (e) Supplies

(6) Physician/Podiatrists/Limited Practitioners
   (a) Ambulatory Surgery Center
   (b) Chiropractor (Individual/Group)
   (c) Hospital Based Physician (Individual/Group)
   (d) Midwife Nurse
   (e) Osteopath Physicians (Individual/Group)
   (f) Physical Therapy
   (g) Physician (Individual/Group)
   (h) Podiatrist (Individual/Group)
   (i) Private Nurse
   (j) Psychologist (Individual/Group)
   (k) Home and Community Based Waivers Services
TECHNICAL SPECIFICATIONS FOR CARTRIDGES

Specifications for submission of Clinic, Medicare Cross-Over, Dental, Independent Laboratory, Medical Supply, Physician/Podiatrist/Limited Practitioner/Waiver Service, Transportation and Vision Care claims on magnetic cartridge follow:

(l) Compatible with IBM 3090 system/3480 or 3490E cartridge.

(m) Recording Density – 3800 characters per inch.

(n) Recording Code for Claims - Extended Binary Coded Decimal Interchange Code (EBCDIC, 18 Track or 36 track).

(o) File labels - None.

(p) Logical Record Length - 320 characters.

(q) Physical Record Length - 32000 characters, i.e., a blocking factor of 100.

(r) The outside surface of the cartridge must be clearly labeled with the provider’s/agent’s name, agent’s address, agent’s ID and the Julian submission day.

(s) DO NOT PAD THE END OF THE FILE WITH NINES OR BLANKS, INSTEAD, USE A SHORT BLOCK

(t) Standard IBM CARTRIDGE.

The vendor shall use chromium dioxide as the active recording element in the cartridges.

The oxide coating strength shall meet or exceed the IBM specification of 0.7 foot-pounds per square inch.
ELECTRONIC MEDIA CLAIM CARTRIDGE REJECTION CRITERIA

The following errors will cause your entire Cartridge submission to be rejected. To prevent your submission from being rejected, we recommend that the electronic media claim submitter subject their file to these edits.

(A) Rejections common to all invoices:

(1) Agent’s number is incorrect.

(2) Batch number is incorrect or out of sequence.

(3) File claim count in file trailer record does not match number of claims in file.

(4) Claim count in any batch trailer record does not match number of claims in batch.

(5) Provider number is invalid or missing.

(6) File claim count in file trailer record does not equal the amount stated on the ODJFS 06312 Letter of Certification/Batch Recap form.

(7) Any violation of the National Standard Format record ID and/or record ID sequence.

(8) Line items for a claim exceeds limit of 21.

(9) File extends over one cartridge.
NATIONAL VERSION 001.03

OHIO MEDICAID
LOCAL VERSION 001.03

ISSUE DATE - 07/01/1993
IMPLEMENTATION DATE - 10/01/1993

LOCAL ISSUE DATE - 09/15/1993
LOCAL IMPLEMENTATION DATE - 02/01/94
### ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

#### RECORD DESCRIPTIONS

<table>
<thead>
<tr>
<th>Record Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA0 - File Header Record - Submitter</td>
<td>AA0.01</td>
</tr>
<tr>
<td>BA0 - Batch Header Record - Provider</td>
<td>BA0.01</td>
</tr>
<tr>
<td>CA0 - Claim Header Record - Patient</td>
<td>CA0.01</td>
</tr>
<tr>
<td>DA0 - Insurance Information Record - Payer</td>
<td>DA0.01</td>
</tr>
<tr>
<td>DA1 - Insurance Information Record - Payer</td>
<td>DA1.01</td>
</tr>
<tr>
<td>EA0 - Claim Detail Record - Claim Level</td>
<td>EA0.01</td>
</tr>
<tr>
<td>FA0 - Service Line Detail Record - Root</td>
<td>FA0.01</td>
</tr>
<tr>
<td>FB0 - Service Line Detail Record - Medical</td>
<td>FB0.01</td>
</tr>
<tr>
<td>FD0 - Service Line Detail Record - Dental</td>
<td>FD0.01</td>
</tr>
<tr>
<td>GA0 - Certification Record - Ambulance</td>
<td>GA0.01</td>
</tr>
<tr>
<td>HA0 - Cert. Record - Narrative Data</td>
<td>HA0.01</td>
</tr>
<tr>
<td>XA0 - Claim Trailer Record - Claim Totals</td>
<td>XA0.01</td>
</tr>
<tr>
<td>YA0 - Batch Trailer Record - Batch Totals</td>
<td>YA0.01</td>
</tr>
<tr>
<td>ZA0 - File Trailer Record - File Totals</td>
<td>ZA0.01</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

FILE LAYOUT

------------------AA0 - File Header Record ..........Submitter

| ----------------BA0 - Batch Header Record ..........Provider

| | --------------CA0 - Claim Header Record ..........Patient

| | | ------DA0 - Insurance Info Records ..........Payer(s)

| | | ------DA1 - Insurance Info Records ..........Payer(s)

| | | | -----EA0 - Claim Record

| | | | | -------FA0 - Service Line Detail Records

| | | | | -------FB0 - Service Line Detail Records

| | | | | -------FD0 - Service Line Detail Records

| | | | | | GA0 - Ambulance Certification Record

| | | | | | HA0 - Extra Narrative Record

| | | | | | | XA0 - Claim Trailer Record .......Claim Totals

| | | | | | | | YA0 - Batch Trailer Record .......Batch Totals

| | | | | | | | | ZA0 - File Trailer Record .......File Totals
GENERAL INSTRUCTIONS

The general instructions define the validation requirements for classes of fields as well as some standard abbreviations that are utilized.

ABBREVIATIONS:

Standard abbreviations used throughout the document:

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDR ........</td>
<td>Address (street address)</td>
</tr>
<tr>
<td>ANES ..........</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>APPL ..........</td>
<td>Appliance</td>
</tr>
<tr>
<td>ASSIGN .......</td>
<td>Assignment</td>
</tr>
<tr>
<td>CONT ..........</td>
<td>Containment</td>
</tr>
<tr>
<td>CUR ..........</td>
<td>Current</td>
</tr>
<tr>
<td>DT ...........</td>
<td>Date</td>
</tr>
<tr>
<td>EMPL ..........</td>
<td>Employment</td>
</tr>
<tr>
<td>EMPLR .........</td>
<td>Employer</td>
</tr>
<tr>
<td>FUNCTNL ........</td>
<td>Functional</td>
</tr>
<tr>
<td>ID ............</td>
<td>Identifier OR Identification</td>
</tr>
<tr>
<td>IMPRESS ........</td>
<td>Impression</td>
</tr>
<tr>
<td>IND ...........</td>
<td>Indicator</td>
</tr>
<tr>
<td>INFO ..........</td>
<td>Information</td>
</tr>
<tr>
<td>INSERT ........</td>
<td>Inserted</td>
</tr>
<tr>
<td>LOC ...........</td>
<td>Location</td>
</tr>
<tr>
<td>MEASURE .......</td>
<td>Measurement</td>
</tr>
<tr>
<td>MI ...........</td>
<td>Middle Initial</td>
</tr>
<tr>
<td>MIN ...........</td>
<td>Minutes</td>
</tr>
<tr>
<td>MOS ...........</td>
<td>Months</td>
</tr>
<tr>
<td>N/A ...........</td>
<td>Not Applicable OR None</td>
</tr>
<tr>
<td>NO ...........</td>
<td>Number</td>
</tr>
<tr>
<td>ORTHO ..........</td>
<td>Orthodontic</td>
</tr>
<tr>
<td>PAT ...........</td>
<td>Patient</td>
</tr>
<tr>
<td>PERM ..........</td>
<td>Permanent</td>
</tr>
<tr>
<td>PHONE ..........</td>
<td>Telephone</td>
</tr>
<tr>
<td>PLACE ..........</td>
<td>Placement</td>
</tr>
<tr>
<td>PRESCRIPT ........</td>
<td>Prescription</td>
</tr>
<tr>
<td>PROV ..........</td>
<td>Provider</td>
</tr>
<tr>
<td>PUR ...........</td>
<td>Purchased</td>
</tr>
<tr>
<td>REL ...........</td>
<td>Relationship</td>
</tr>
<tr>
<td>REP ...........</td>
<td>Representative</td>
</tr>
<tr>
<td>REPLACE .......</td>
<td>Replaced</td>
</tr>
<tr>
<td>REQ ...........</td>
<td>Requirement</td>
</tr>
<tr>
<td>RETIRE ..........</td>
<td>Retirement</td>
</tr>
<tr>
<td>SER ...........</td>
<td>Series</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

Standard abbreviations (continued):

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPNSR ........</td>
<td>Sponsor</td>
</tr>
<tr>
<td>SUB ..........</td>
<td>Submitter</td>
</tr>
<tr>
<td>SUPV ..........</td>
<td>Supervising</td>
</tr>
<tr>
<td>SVC ..........</td>
<td>Service</td>
</tr>
<tr>
<td>SYMP ..........</td>
<td>Symptom</td>
</tr>
<tr>
<td>TREAT ..........</td>
<td>Treatment</td>
</tr>
<tr>
<td>1ST ...........</td>
<td>First</td>
</tr>
</tbody>
</table>

DATA ELEMENT REQUIREMENT:

REQ codes:
R = required  O = optional  C = conditional

VALIDATION REQUIREMENTS:

Some Date Element description pages state:

"See GENERAL INSTRUCTIONS for 'xxxxxxxxxxxxxxxxxx' entry".

Where 'xxxxxxxxxxxxxxxxx' is one of the following data elements.

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>PAGE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>GI0.03</td>
</tr>
<tr>
<td>DATE</td>
<td>GI0.04</td>
</tr>
<tr>
<td>IDENTIFICATION NUMBERS</td>
<td>GI0.04</td>
</tr>
<tr>
<td>NAME 1 (INDIVIDUAL NAMES)</td>
<td>GI0.05</td>
</tr>
<tr>
<td>NAME 2 (COMPANY NAMES)</td>
<td>GI0.05</td>
</tr>
<tr>
<td>PATIENT CONTROL NUMBER</td>
<td>GI0.06</td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>GI0.07</td>
</tr>
</tbody>
</table>
GENERAL INSTRUCTIONS

ADDRESS:
---------------
ADDRESS-1 and ADDRESS-2:
   a) ADDRESS-1 may not contain a blank in the first position.
   b) If entered, ADDRESS-2 may not contain a blank in the first position.
   c) Must contain at least one embedded blank.
   d) May contain:
      A-Z
      0-9
      forward slash (/)
      period (.)
      comma (,)
      number sign (#)
      ampersand (&)
      parentheses '(())
      percent sign (%) - for: "in care of"
      blank ( )
   e) No other special characters are allowed.

CITY:
   a) First position must not be blank.
   b) May contain:
      A - Z
      period (.)
      comma (,)
      ampersand (&)
      blank ( )
   c) No other special characters are allowed.

STATE: Must be a valid code from EXHIBIT 1.

ZIP:
   a) Position 1-3 must be a code from EXHIBIT 1.
      Position 4-5 must be numeric.
      Position 6-9 is optional but must be numeric if entered.
   b) If the STATE code is a foreign country, ZIP is not required.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

DATE:
-------------
Format: CCYYMMDD

a) CC (century) must have a value of '19' or '20'. exception: may have a value of '18', '19' or '20' for birth dates.
b) YY (year) must have a value of '00' through '99'.
c) MM (month) must have a value of '01' through '12'.
d) DD (day) must have a value of '01' through '31'
dependent on MM.

<table>
<thead>
<tr>
<th>MM (month) value</th>
<th>DD (day) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01, 03, 05, 07,</td>
<td>01 through 31</td>
</tr>
<tr>
<td>08, 10, 12</td>
<td></td>
</tr>
<tr>
<td>04, 06, 09, 11</td>
<td>01 through 30</td>
</tr>
<tr>
<td>02</td>
<td>01 through 29</td>
</tr>
<tr>
<td></td>
<td>if YY is divisible by 4</td>
</tr>
<tr>
<td>02</td>
<td>01 through 28</td>
</tr>
<tr>
<td></td>
<td>if YY NOT divisible by 4</td>
</tr>
</tbody>
</table>

IDENTIFICATION NUMBERS:
-----------------------

a) If entered, first position may not be blank.
b) May contain: A - Z
            0 - 9
c) No embedded blanks are allowed.
d) Special characters may be used at the discretion of the receiver/payer.

MEDICAID NOTES: If special characters are allowed in a field, it will be specified in the instructions on that field.

GI0.4
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

NAME 1 (INDIVIDUAL NAMES):
--------------------------

LAST NAME and FIRST NAME

a) First position must be A-Z.

b) May contain: A-Z
   hyphen (-)
   blank ( )

c) No other special characters are allowed.

d) Titles such as 'Mr.', 'Dr.', 'Jr.' are not allowed.

e) Must be at least two (2) positions in length.

MIDDLE INITIAL

a) Must contain A-Z or blank.

NAME 2 (COMPANY NAMES):
--------------------------

a) First position must be A-Z.

b) May contain:
   A-Z
   period (.)
   comma (,)
   hyphen (-)
   ampersand (&)
   blank ( )

c) No other special characters are allowed.

d) Must be at least two (2) positions in length.

G10.5
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

PATIENT CONTROL NUMBER:
---------------------------------------

a) First position must not be blank.

b) May contain:
   A-Z
   0-9
   forward slash (/)
   period (.)
   comma (,)
   hyphen (-)
   number sign (#)
   blank ( )

c) No other special characters are allowed.

MEDICAID NOTES: This is a required field used to link all records for a single claim. The entire claim will be denied without this information.

Only the first nine digits of this field is used by the Medicaid payment system. These first nine digits of the Patient Control Number will be used as the Medical Record Number and will be reflected as such on the printed Remittance Advice and the electronic PAY/REJECT file.

If this number is not available on hardcopy claims, the Scanner/Data Entry departments will insert the last nine digits of the Billing Number.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

TELEPHONE:
----------------

a) Format: AAAXXSSSS
   AAA = area code
   XXX = exchange
   SSSS = station number

b) Must contain 0-9 only.

c) No special characters or blanks are allowed.

d) Valid area codes may be found in EXHIBIT 1.

MEDICAID
NOTES:

BATCH:
-------

Each submission is composed of multiple batches.
Each batch is composed of multiple claims.

With respect to electronic submissions coming from providers and
intermediaries, our use of the term "batch" relates to the entire
submission or file. The batches that exist within that submission
have individual batch numbers but they are not used by the
Medicaid payment system. Therefore, these submissions are
balanced in total by using the total number of claims in the file.

With respect to submission from internal departments, the batches
within the submission or file are used by the Medicaid payment
system for balancing. Therefore, individual batches within a
submission may be rejected.

MISCELLANEOUS (NOT OTHERWISE SPECIFIED) CATEGORIES
----------------------------------------------------------

The use of any code category that is considered miscellaneous or
not specific in description requires the provider to maintain
hardcopy documentation in the patient's file to support the
submission of that claim. When these types of codes are used, it
is advisable to use the Narrative (HA0) record for their
explanation.

GI0.7
MEDICAID NOTES (CONTINUED):

CLAIMS NOT TO BE BILLED ELECTRONICALLY
----------------------------------------

The following types of claims cannot be billed electronically. They must be billed on hardcopy and sent to the Ohio Department of Job and Family Services.

1) Abortion, sterilization and hysterectomy claims.

2) Service dates over 365 days old.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
RECORD TYPE: AA0

LEVEL: FILE

PURPOSE: The first record of any file submitted electronically, it contains information pertinent to the submitter of the claim file. A submitter could be a provider of medical services (i.e. physician, lab, clinic...) or a billing agency. The information contained in this record will be the determining factor in whether or not the file will be allowed system access.

REQUIREMENTS: A "AA0" record is required for every submission.

ORDER: Preceding Following
Record Type Record Type
-------------- --------------
NONE BA0

NOTES:

MEDICAID NOTES: Filler fields will not be read by the Medicaid processing system. Other information may be provided in these areas but they will not affect the processing of these claims.
# ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** FILE HEADER RECORD
"SUBMITTER DATA"

**RECORD TYPE:** AA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;AA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>02.0</td>
<td>SUBMITTER IDENTIFIER</td>
<td>16</td>
<td>X</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>9</td>
<td>X</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>04.0</td>
<td>SUBMISSION TYPE</td>
<td>6</td>
<td>X</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>178</td>
<td>X</td>
<td>35</td>
<td>212</td>
</tr>
<tr>
<td>15.0</td>
<td>CREATION DATE</td>
<td>8</td>
<td>X</td>
<td>213</td>
<td>220</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>33</td>
<td>X</td>
<td>221</td>
<td>253</td>
</tr>
<tr>
<td>21.0</td>
<td>TEST/PROD IND</td>
<td>4</td>
<td>X</td>
<td>254</td>
<td>257</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>63</td>
<td>X</td>
<td>258</td>
<td>320</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-01.0

DATA ELEMENT: Record Identifier
(RECORD ID "AA0")

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------- | ------------- | -------- | ------- |------ |------ |-------
01.0   | X(03)        | LEFT    | SPACES  | 01   | 03   | R

DEFINITION: Field used to identify the "Submitter Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "AA0".

FORM LOCATION: N/A

REMARKS: N/A

AA0.3
RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

DATA ELEMENT: Submitter Identifier (SUB ID)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
--------- ---------------------- ----------- ----------- -------- ------- -----
02.0 X(16) LEFT SPACES 04 19 R

DEFINITION: Identifies the submitter as defined by the receiver.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the SUBMITTER ID entered in the File Trailer Record (ZA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: May be a federally assigned Employer Identification Number (EIN). EIN is also referred to as a Tax Identification Number (TIN) depending on the receiver's requirements.

MEDICAID NOTES: This field is composed of the three-character alphabetic submitter ID (agent ID) number and the three digit numeric submitter number (agent's number).
(Example ABC123).
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

DATA ELEMENT: Submission Type

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
-------- | -------------- | -------- | -------- | ------ | ------ | -----
04.0    | X(06)          | LEFT     | SPACES   | 29    | 34    | R

DEFINITION: Identifies the input medium or method used to transmit the data to the receiver.

CODE VALUES: ASYNC  BISYNC  RJE  FAX  CARTRIDGE

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASY</td>
<td>BSY</td>
<td>RJE</td>
<td>FAX</td>
<td>TP</td>
</tr>
<tr>
<td>ASY003</td>
<td>BYS024</td>
<td>RJE024</td>
<td>TPCRTG</td>
<td></td>
</tr>
<tr>
<td>ASY012</td>
<td>BYS048</td>
<td>RJE048</td>
<td>TP0800</td>
<td></td>
</tr>
<tr>
<td>ASY024</td>
<td>BYS096</td>
<td>RJE096</td>
<td>TP1600</td>
<td></td>
</tr>
<tr>
<td>ASY048</td>
<td>BYS192</td>
<td>RJE192</td>
<td>TP6250</td>
<td></td>
</tr>
</tbody>
</table>

DISKETTE  SCANNER  CPU

<table>
<thead>
<tr>
<th>DSK8SS</th>
<th>DSK5SS</th>
<th>DSK3SS</th>
<th>SCN</th>
<th>CPU</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSK8SD</td>
<td>DSK5SD</td>
<td>DSK3SD</td>
<td>SCNOCR</td>
<td></td>
</tr>
<tr>
<td>DSK8DD</td>
<td>DSK5DD</td>
<td>DSK3DD</td>
<td>SCNICR</td>
<td></td>
</tr>
<tr>
<td>DSK5HD</td>
<td>DSK3HD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VALIDATION: At a minimum, must be a valid code from the above lists. At the receiver's option, there may be more specific code requirements.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES:

For providers and intermediaries who are submitting their claims on cartridges, use the "TP" code. Do not use the other codes under "Cartridge".

For hardcopy claims that are being scanned, use the "SCN" code.

For hardcopy claims that are being keyed by the Data Entry department, use the "KD" code.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

DATA ELEMENT: Creation Date

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
--------- --------------------- ----------- ---------- -------- ------- ------
15.0 X(08) LEFT SPACES 213 220 R

DEFINITION: Identifies the date the submitter created the file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

Must not be later than the date the file is received.

FORM LOCATION: N/A

REMARKS: N/A CCYYMMDD

MEDICAID NOTES:

Submission must be received by the Data Scheduling Unit no later than 1:00 p.m. every Wednesday. The date must be the Wednesday the submission is received and any cartridges received after the date entered on the file header record will be returned unprocessed.

Production cartridges should be sent to:

Ohio Department of Job and Family Services Bureau of Information Systems Support Data Scheduling Unit 4200 E. Fifth Avenue, 1st Floor Columbus, Ohio 43219
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

DATA ELEMENT: Test/Production Indicator (TEST/PROD IND)

DEFINITION: A code indicating whether the file is to be used for test or production purposes.

CODE VALUES: TEST = file should be run through a test system.

PROD = file should be run through a production system.

VALIDATION: Must be entered if required by receiver.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

BATCH HEADER RECORD

RECORD TYPE: BA0

"PROVIDER DATA 1"

NATIONAL VER. 001.03 - 07/01/1993
RECORD NAME: BATCH HEADER RECORD  
"PROVIDER DATA 1"  
RECORD TYPE: BA0

LEVEL: BATCH

PURPOSE: To identify and provide information regarding the provider of services indicated in this batch.

REQUIREMENTS: This record is required.  
A "BA0" record is required for every submission.

ORDER:  
<table>
<thead>
<tr>
<th>Preceding Record Type</th>
<th>Following Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA0 or YA0</td>
<td>BA1 or CA0</td>
</tr>
</tbody>
</table>

NOTES: Only one BA0 record is allowed for each batch.

MEDICAID NOTES: See GENERAL INSTRUCTIONS for "Batch" definition.
## ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** BATCH HEADER RECORD  
"PROVIDER DATA 1"  
**RECORD TYPE:** BA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;BA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>04.0</td>
<td>BATCH NUMBER</td>
<td>4</td>
<td>N</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>12.0</td>
<td>PROVIDER MEDICAID NUMBER</td>
<td>15</td>
<td>X</td>
<td>75</td>
<td>89</td>
</tr>
<tr>
<td>16.0</td>
<td>PROVIDER OTHER NUMBER 1</td>
<td>15</td>
<td>X</td>
<td>135</td>
<td>149</td>
</tr>
</tbody>
</table>

*FILLER* means that the field can be optionally repeated.

**BA0.2**
**RECORD NAME:** BATCH HEADER RECORD  
**RECORD/FIELD:** BA0-01.0  
**RECORD ID:** BA0

**DATA ELEMENT:** Record Type

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>X(03)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>1</td>
<td>3</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** This field is used to identify the "PROVIDER DATA 1" record.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.  
Must be BA0.

**FORM LOCATION:** N/A

**REMARKS:** N/A
**RECORD NAME:** BATCH HEADER RECORD  
"PROVIDER DATA 1"

**DATA ELEMENT:** Batch Number (BATCH NO)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.0</td>
<td>9(04)</td>
<td>RIGHT</td>
<td>ZEROS</td>
<td>22</td>
<td>25</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** This is a sequential number assigned by the submitter, to each batch of claims.

**CODE VALUES:** Must be equal to 0001 through 9999.

**VALIDATION:** Must be entered.
- Must be numeric.
- First occurrence must be 0001.

Whenever the "EMC Provider Identifier", BA0 - 02.0, or "Type of Batch", BA0 - 03.0, changes from those previously entered, the "Batch Number" must be reset to 01.

If the previous "EMC Provider Identifier", BA0 - 02.0 and "Type of Batch", BA0 - 03.0 are identical with those currently being processed, the "Batch Number" must be one greater that the previous "Batch Number".

**FORM LOCATION:** N/A

**REMARKS:** N/A

**MEDICAID NOTES:**
- For providers and intermediaries, this field identifies a batch for their own purposes but the Medicaid payment system does not use it.
- For Scanning and Data Entry departments, only three digits are accepted by the Medicaid payment system.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD/FIELD: BA0-12.0

DATA ELEMENT: Provider Medicaid Number (PROV MEDICAID NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- --------------------- ----------- ----------- --------- -------- -----
12.0       X(15)         LEFT       SPACES         75         89        C

DEFINITION: The number assigned to the Provider by a Medicaid State Agency for identification purposes.

CODE VALUES: N/A

VALIDATION: If entered:
This field must contain the Medicaid Provider Number as it appears on the Payer's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: HCFA-1500 Block 33

REMARKS: If the Medicaid Provider Number is not entered or entered incorrectly all Medicaid claims contained within the batch may be rejected.

REQUIREMENTS: The Medicaid Provider Number must be entered if the batch contains any claims that are to be processed by a Medicaid payer.

MEDICAID NOTES: This is the pay-to Medicaid provider number. This field MUST ALWAYS contain a seven digit provider number for the provider receiving payment.

In the case of a group practice or hospital, this is the group's number. In other instances, it is the rendering provider number.
MEDICAID NOTES: If the Medicaid Provider Number is not entered or entered incorrectly, all Medicaid claims contained within the batch may be deleted from the system or they may cause payment to the wrong provider.

Billing agencies should validate the digits of the provider number by using the following procedure:

The last digit is the "check" digit and is verified by a routine that takes the first six digits of the provider number and calculates a number that is compared to the seventh digit of the provider number.

The check digit is calculated as follows:

1) add together the first three odd position number digits and multiply the result by 2
2) add together the first three even position number digits
3) add together the results of step 1 and 2, then subtract from 100
4) the low order digit from the result of step 3 should be the check digit

For example:

Provider Number 8321597

1) \((8 + 2 + 5) \times 2 = 30\)
2) \(3 + 1 + 9 = 13\)
3) \(100 - (30 + 13) = 57\)
4) 7 should be the check digit
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** BATCH HEADER RECORD

"PROVIDER DATA 1"

**DATA ELEMENT:** Provider Other Number 1

(PROV NO 1)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.0</td>
<td>X(15)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>135</td>
<td>149</td>
<td>C</td>
</tr>
</tbody>
</table>

**DEFINITION:** The number assigned to the provider by the receiver for other identification purposes.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered as required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

**FORM LOCATION:** N/A

**REMARKS:** Example: Specific number assigned for Workmen's Compensation, Health Maintenance Organization (HMO) or Additional Commercial Number.

**MEDICAID NOTES:** In the case of a group practice, this field is the servicing provider's individual provider number. This field MUST ALWAYS contain the seven digit provider number of the servicing provider.

It can be found on the HCFA-1500 form in Block 33 as the "PIN#".

It has the same check digit routine as Provider Medicaid Number, Record BA0, Field 12.0.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

CLAIM HEADER RECORD

RECORD TYPE: CA0

"PATIENT DATA"
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the patient who received the services indicated in this claim.

REQUIREMENTS: A CA0 record is required for every claim.

ORDER: Preceding Following
Record Type Record Type
--------------- ----------------
BA0, BA1 or XA0 CB0 or DA0

NOTES: Only one CA0 record is allowed for each claim.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** CLAIM HEADER RECORD  
"PATIENT DATA"  
**RECORD TYPE:** CA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;CA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>2</td>
<td>X</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>04.0</td>
<td>PATIENT LAST NAME</td>
<td>20</td>
<td>X</td>
<td>23</td>
<td>42</td>
</tr>
<tr>
<td>05.0</td>
<td>PATIENT FIRST NAME</td>
<td>12</td>
<td>X</td>
<td>43</td>
<td>54</td>
</tr>
<tr>
<td>06.0</td>
<td>DATE OF DISCHARGE</td>
<td>6</td>
<td>X</td>
<td>55</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>121</td>
<td>X</td>
<td>61</td>
<td>181</td>
</tr>
<tr>
<td>22.0</td>
<td>OTHER INSURANCE INDICATOR</td>
<td>1</td>
<td>X</td>
<td>182</td>
<td>182</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>13</td>
<td>X</td>
<td>183</td>
<td>195</td>
</tr>
<tr>
<td>27.0</td>
<td>PAYER CLAIM CONTROL NO.</td>
<td>17</td>
<td>X</td>
<td>196</td>
<td>212</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>108</td>
<td>X</td>
<td>213</td>
<td>320</td>
</tr>
</tbody>
</table>
# ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** CLAIM HEADER RECORD  
"PATIENT DATA"

**RECORD/FIELD:** CA0-01.0

## DATA ELEMENT: Record Identifier

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>X(03)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>01</td>
<td>03</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** Code used to identify the "Patient Data" record.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.  
Must be "CA0".

**FORM LOCATION:** N/A

**REMARKS:** N/A
RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

DATA ELEMENT: Patient Control Number
(PAT CONTROL NO)

FIELD  COBOL PICTURE  JUSTIFY  INITIAL  FROM  THRU  REQ
--------  ------------------  -----------  -----------  ---------  --------
03.0      X(17)           LEFT       SPACES        06         22         R

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payers' systems will record and return seventeen characters on remittance advices or other documents. Consult the Matrix/Usage document supplied by the Payer/Receiver for additional information.

MEDICAID NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** CLAIM HEADER RECORD  
**"PATIENT DATA"**

**RECORD/FIELD:** CA0-04.0  
CA0-05.0

**DATA ELEMENT:**  
Patient Last Name  
(PAT LAST NAME)  
Patient First Name  
(PAT FIRST NAME)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.0</td>
<td>X(20)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>23</td>
<td>42</td>
<td>R</td>
</tr>
<tr>
<td>05.0</td>
<td>X(12)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>43</td>
<td>54</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** The name of the individual to whom the services were provided.

**CODE VALUES**  
N/A

**VALIDATION:** See GENERAL INSTRUCTIONS for "Name 1" entry.

**FORM LOCATION:** HCFA-1500 Block 2

**REMARKS:** N/A
RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-06.0

DATA ELEMENT: Date of Discharge (MMDDYY)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
-------|---------------|---------|---------|------|------|------
06.0   | 9(6)          | N/A     | ZEROS   | 55   | 60   | C

DEFINITION: Enter the six digit (MMDDYY) date of discharge when billing services provided for 60 days after a post-hospital stay for home health and private duty nursing services. The date of discharge can never be greater than 60 days from the date of service.

CODE VALUES N/A

VALIDATION: Must be in a valid date format.

FORM LOCATION: N/A

REMARKS: N/A
RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

DATA ELEMENT: Other Insurance Indicator
(OTHER INSURANCE IND)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------ | ------------- |--------- |--------- |------ |------ |------
22.0   | X(01)        | N/A     | SPACE   | 182  | 182  | C

DEFINITION: A code which indicates the patient has other insurance which may or may not be reflected on this claim.

CODE VALUES:
1 = Yes, patient has other insurance.
2 = Yes, patient has other insurance not reflected on this bill.
3 = No, patient does not have other insurance.

VALIDATION: Must be entered if required by payer/receiver.
If entered, must be a valid code from the above list.

FORM LOCATION: HCFA-1500 Block 11d

REMARKS:
1. Patient has declared that he/she has other insurance which may pay a portion of this claim and provided the necessary insurance information. (Not all insurance companies require the other insurance fields to be completed.)
2. Patient has declared that he/she has other insurance which may pay a portion of this claim but did not furnish the insurance information for this claim.
3. The provider has asked the patient if he/she has other insurance, and the patient has stated that they do not.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-22.0

DATA ELEMENT: Other Insurance Indicator
(OTHER INSURANCE IND)

(CONTINUED)

MEDICAID NOTES:
This field is required if other insurance is involved.
This is a one character field, either alphabetic or numeric which indicates if an insurance payment other than Medicare has been received or has not been received from the third party insurer. For Ohio Medicaid, the acceptable codes are as follows:

If you have received payment, please enter one of the following:

1 = Self/Family
2 = Blue Cross/Blue Shield
3 = Private Carrier
4 = Employer or Union
5 = Public Agency
6 = Other

If you have not received payment, please enter one of the following:

R = No Response From Carrier. Means no response from the insurance carrier for 90 days. A claim with this code may not be submitted until 91 days after the date of treatment.

P = No Coverage for This Recipient Number. Means that the provider has confirmed that there is health insurance for some members of the Medicaid case, but the particular patient is not covered.
MEDICAID NOTES:

F = No Coverage for All Recipient Numbers. Means that there is no health insurance for any member of the Medicaid case.

L = Disputed or Contested Liability. Means that the provider has confirmed that there is health insurance, but the coverage for the billed service is disputed or contested by the insurance carrier.

S = Non-Covered Services. Means that the provider has confirmed that there is health insurance, but that the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.

E = Insurance Benefits Exhausted. Means that the provider has confirmed that there is health insurance, but the policy benefits for the billed services have been exhausted.

X = Non-Cooperative Recipient. Means that the provider has confirmed that there is health insurance, but the patient refused to cooperate in collection effort.

8 = Other Insurance Indicator. Other source code of “8” Supplemental (wraparound) payment (for FQHCs or RHCs only). For FQHCs or RHCs, enter other source code of “8” if the provider is submitting for the managed care supplemental payment.

If you have not received payment from another source and there is no indication of health insurance coverage for the case, leave this item blank.

MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSOVERS:

Enter "M" if the Medicare Part C panel provider is not capitated.
Enter "H" if the Medicare Part C panel provider is capitated.

When an "M" is entered in item CA0-22.0 the amount collected by the provider from all other insurance sources must be entered in item XA0-19.0.

When and "H" is entered in item CA0-22.0 the amount entered in item XA0-19.0 can be a zero. The Medicare Part C managed care plan copayment amount is entered in item DA1-13.0.
**RECORD NAME:** CLAIM HEADER RECORD

**DATA ELEMENT:** Payer Claim Control Number

**RECORD/FIELD:** CA0-27.0

**FIELD** | **COBOL PICTURE** | **JUSTIFY** | **INITIAL** | **FROM** | **THRU** | **REQ**
---|---|---|---|---|---|---
27.0 | X(17) | LEFT | SPACES | 196 | 212 | R

**DEFINITION:** A number assigned by the Payer/Receiver to identify the claim.

**CODE VALUES:** Blanks / Spaces are only valid values.

**VALIDATION:** Must be blank / space filled.

**FORM LOCATION:** N/A

**REMARKS:** For Payer/Receiver usage only.

For assignment of an Internal / Document / Claim Control Number (ICN/DCN/CCN) that the Payer/Receiver will pass to an adjudication system.

**MEDICAID NOTES:** This field should not be used by the provider or electronic submission intermediary. This field is for use by the Ohio Medicaid payment system only.

Known within the system as the Transaction Control Number, it has two versions, one for cartridge/computer submitted claims and one for OCR/Data Entry/Exam Entry claims. They are defined as follows:

CA0.10
RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

DATA ELEMENT: Payer Claim Control Number (PAYER CLM CONTROL NO)

OCR/DATA ENTRY/EXAM ENTRY FORMAT

abbbbcdeeefggghh

a = Input Medium Indicator

OLD FORMS (UB-82, 6780, ETC.):
   0 = Exam Entry
   1 = Keyed
   2 = Cartridge/Computer Billed
   3 = OCR
   4 = Computer Generated Credit or Adjustment

NEW FORMS (UB-92, HCFA-1500, ETC.):
   5 = Exam Entry
   6 = Keyed
   7 = Cartridge/Computer Billed
   8 = OCR
   9 = Computer Generated Credit or Adjustment

bbbb = Batch Date in Julian format (YYDDD)
c = Microfilm Machine Number
d = Microfilm Roll Number
eee = Batch Number
f = Claim Accounting Code
   0 = Original Claim
   1 = Credit Adjustment
   2 = Debit Adjustment
ggg = Document Number
hh = Document Line Number

CA0.11
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD "PATIENT DATA"
RECORD/FIELD: CA0-27.0
DATA ELEMENT: Payer Claim Control Number (PAYER CLM CONTROL NO)

(CONTINUED)

ELECTRONIC SUBMISSION FORMAT

abbbbcxcccdreeee

a = Input Medium Indicator

OLD FORMS (UB-82, 6780, ETC.):
  0 = Exam Entry
  1 = Keyed
  2 = Cartridge Billed
  3 = OCR
  4 = Computer Generated Credit or Adjustment

NEW FORMS (UB-92, HCFA-1500, ETC.):
  5 = Exam Entry
  6 = Keyed
  7 = Cartridge Billed
  8 = OCR
  9 = Computer Generated Credit or Adjustment

bbbbb = Batch Date in Julian format (YYDDD)
cccccc = Batch Number
d  = Claim Accounting Code
  0 = Original Claim
  1 = Credit Adjustment
  2 = Debit Adjustment
eeeeee = Document Number

For all claims except pharmacy, Document Number and Document Line Number are treated as a single field with each claim incrementing the number by one. For pharmacy claims, each form increments the document number by one and each line on the form increments the Document Line Number by one, up to a maximum of ten.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

INSURANCE INFORMATION RECORD

RECORD TYPE: DA0

NATIONAL VER. 001.03 - 07/01/1993
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD TYPE: DA0

LEVEL: CLAIM

PURPOSE: To identify the Payer(s) involved with and/or having liability for the resolution of this claim.

REQUIREMENTS: At least one DA0 record is required on every claim.

All known payers are to be identified by using this record.

ORDER: Preceding Following
Record Type Record Type
----------------- ------------------
CA0, CB0, DA0, DA0, DA1, DA2,
DA1 or DA2 or EA0

NOTES: When requesting payment from a secondary payer it is extremely important that the EOB/remittance information be provided from the primary payer(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

Multiple DA0 records should be sequenced according to national and state coordination of benefits rules. The primary payer should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be: PRIMARY followed by SECONDARY insurance (if applicable), and then TERTIARY insurance (if applicable). The CLAIM FILING INDICATOR (DA0-04.0) should be used to direct the claim to the appropriate payer(s).
### ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** INSURANCE INFORMATION  
**RECORD TYPE:** DA0  
"PAYER DATA 1"

<table>
<thead>
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<td>3</td>
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<td>X</td>
<td>4</td>
<td>5</td>
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<td>X</td>
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<td>22</td>
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<td>FILLER</td>
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<td>122</td>
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<td></td>
<td>FILLER</td>
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<td>X</td>
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<td>156</td>
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<td>181</td>
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<td>FILLER</td>
<td>106</td>
<td>X</td>
<td>215</td>
<td>320</td>
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</table>

DA0.2
RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

DATA ELEMENT: Record Identifier
(RECORD ID "DA0")

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- --------------------- ----------- ----------- --------- -------- -----
01.0 X(03) LEFT SPACES 01 03 R

DEFINITION: Field used to identify the "INSURANCE INFORMATION"- "PAYER DATA 1" record.

CODE VALUES: N/A

VALIDATION: A claim must have at least one "DA0" record and may have up to three.

Must be "DA0".

FORM LOCATION: N/A

REMARKS: N/A

DA0.3
**RECORD NAME:** INSURANCE INFORMATION

**RECORD/FIELD:** DA0-02.0

"PAYER DATA 1"

**DATA ELEMENT:** Sequence Number

(SEQUENCE NO)

**FIELD** | **COBOL PICTURE** | **JUSTIFY** | **INITIAL** | **FROM** | **THRU** | **REQ**
----------|------------------|-------------|-------------|---------|---------|------
02.0      | X(02)            | LEFT        | SPACES      | 04      | 05      | R    

**DEFINITION:** A numeric value from 01 through 03 used to sequence the "DA0" records and to associate "DA0" records with "DA1" and "DA2" records.

**CODE VALUES:**

- 01 - Identifies the primary payer record.
- 02 - Identifies the secondary payer record.
- 03 - Identifies the tertiary payer record.

**VALIDATION:** Must be entered.

Must be a valid code from the above list.

A claim must have at least one "DA0" record and may have up to three. All "Dan" records must be grouped as "DA0", "DA1", "DA2" by sequence number.

The first (or only) record must be identified by a sequence number of '01'.

**FORM LOCATION:** N/A

**REMARKS:** Multiple DA0 records should be sequenced according to national and state coordination of benefits rules. The primary payer should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be PRIMARY followed by SECONDARY insurance (if applicable) and then TERTIARY insurance (if applicable). The CLAIM FILING INDICATOR (DA0-04.0) should be used to direct the claim to the appropriate payer(s).
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-02.0

DATA ELEMENT: Sequence Number

(SEQUENCE NO)

(CONTINUED)

MEDICAID NOTES: Since Medicaid is the payer of last resort and that the records are submitted in sequence, it will be assumed that the last record in the sequence will relate to Medicaid information.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
----------------- | -------------- | ------- | ------- | -------- | ------- | -----
03.0     | X(17)          | LEFT    | SPACES  | 06     | 22     | R

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

MEDICAID NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

DA0.6
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION "PAYER DATA 1"
RECORD/FIELD: DA0-10.0

DATA ELEMENT: Group Number (GROUP NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
------- -------------------- ---------- ---------- -------- -------- ------
10.0            X(20)          LEFT        SPACES          69        88        C

DEFINITION: The identification number assigned by the payer to the group or plan through which insurance is provided.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

If entered, must only contain 0-9, A-Z, forward slash (/), period (.), comma (,), hyphen (-), number sign (#), ampersand (&) and blank ( ). No other characters are allowed.

Must NOT equal the PAYER ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ( ).

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces ( ). EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following laterals: "UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

DA0.7
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-10.0

DATA ELEMENT: Group Number
(GROUP NO)

(CONTINUED)

Must NOT equal the GROUP NAME (DA0-11.0).

FORM LOCATION: HCFA-1500 Blocks 9a, 11

REMARKS: Some payers require this information for all
claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payers since it's presence may expedite the
processing of the claim.

This information is required for processing a Medicare secondary claim.

MEDICAID NOTES: This field is required when other insurance is
involved. It contains the group number of the other insurance.
RECORD NAME: INSURANCE INFORMATION
RECORD/FIELD: DA0-11.0
"PAYER DATA 1"

DATA ELEMENT: Group Name

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- -------------------- ---------- ---------- -------- ------- ----- 11.0 X(33) LEFT SPACES 89 121 C

DEFINITION: The name of the group or plan through which insurance is being provided.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

See GENERAL INSTRUCTIONS for "Name 2" (company name) entry.

Must NOT equal the PAYER ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ( ).

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces ( ) EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following literals: "UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

Must NOT equal the GROUP NUMBER (DA0-10.0).
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-11.0

DATA ELEMENT: Group Name

(CONTINUED)

FORM LOCATION: HCFA-1500 Blocks 9d, 11

REMARKS: Some payers require this information for all claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payers since it's presence may expedite the processing of the claim.

This information is required for processing Medicare secondary claims.

MEDICAID NOTES: This field is required when other insurance is involved. It is the plan name or program name of the other insurance.

DA0.10
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
RECORD/FIELD: DA0-14.0
"PAYER DATA 1"

DATA ELEMENT: Prior Authorization Number (PRIOR AUTH NO)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.0</td>
<td>X(15)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>138</td>
<td>152</td>
<td>C</td>
</tr>
</tbody>
</table>

DEFINITION: A number, code or other indicator that the services provided on this claim have been authorized by the payer.

CODE VALUES: N/A

VALIDATION: Must be entered if required by the payer and prior approval has been obtained from the payer or his agent.

FORM LOCATION: HCFA-1500 Block 23

REMARKS: N/A

MEDICAID NOTES: Complete this field only if prior/payment authorization is required for any of the services billed. Use the ODJFS assigned six (6) digit number from the approved "Prior Authorization" notification. Refer to the appropriate Medicaid Handbook to determine what services require prior authorization.
RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-18.0

DATA ELEMENT: Insured Identification Number (INSURED ID NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- --------------------- --------- ---------- -------- -------- ------
18.0     X(25)         LEFT        SPACES     157       181       R

DEFINITION: Insured's unique identification number, by the Third Party Payer.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for identification number entry. Must not contain all zeros or all nines (9's). May not contain any of the following literals: unknown", "individual", "self", "1234567890" or "none"

FORM LOCATION: HCFA-1500 Blocks 1a, 9a

REMARKS: Subscriber ID
Sponsor ID
HIC ID
SSN ID
Recipient ID
Employee ID (Group self administered)

MEDICAID NOTES: This is a required field and is an unique number assigned to each recipient.

This is the 12 digit billing number which is found in the column marked "Billing Number" on the Ohio Medical card (Medicaid, General Assistance, or Disability Assistance).
The tenth digit of the number is the "check" digit and is verified by a routine that takes the first nine digits of the Billing Number and calculates a number that is compared to the tenth digit of the Billing Number. If digits 11 and 12 are equal to 80, the routine is ignored.

The check digit is calculated as follows:

1) take the first five odd position number digits and treat it as a single number
2) multiply the result of step 1 by 2
3) add together each digit of the result of step 2 with the first four even position number digits
4) subtract the result of step 3 from 100
5) the low order digit from the result of step 4 should be the check digit

For example:

Billing Number 736285914701

1) (76894) X 2 = 153788
2) (1+5+3+7+8+8) + (3+2+5+1) = 43
3) 100 - (43) = 57
4) 7 should be the check digit
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

DATA ELEMENT: Insured Last Name
Insured First Name
Insured Middle Initial

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- --------------------- ----------- --------- -------- ----- -----
19.0 X(20) LEFT SPACES 182 201 C
20.0 X(12) LEFT SPACES 202 213 C
21.0 X(01) LEFT SPACES 214 214 C

DEFINITION: The last, first, middle name of the insured individual.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for Name 1 (individual names) entry.

FORM LOCATION: HCFA-1500 Blocks 4, 9

REMARKS: N/A

MEDICAID NOTES: This field is required when other insurance is involved. It is the Other Insured's Name from Block 9 of the HCFA-1500.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

INSURANCE INFORMATION RECORD

RECORD TYPE: DA1

NATIONAL VER. 001.03 - 07/01/1993
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 2"

RECORD TYPE: DA1

LEVEL: CLAIM

PURPOSE: To supply additional information for identifying the payer and/or to provide prior adjudication status information from primary payers.

REQUIREMENTS: When filing 'secondary' claims a "DA1" record is required for every payer who has received and/or processed the claim prior to this submission.

ORDER: Preceding Following
Record Type Record Type
--------- -----------
DA0 DA0, DA2 or EA0

NOTES: When requesting payment from a secondary payer it is extremely important that the EOB/remittance information be provided from the primary payer(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.
<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
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<td>62</td>
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DA1.2
**RECORD NAME:** INSURANCE INFORMATION

**RECORD/FIELD:** DA1-01.0

"PAYER DATA 2"

**DATA ELEMENT:** Record Identifier

(RECORD ID "DA1")

<table>
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<tr>
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<td>03</td>
<td>R</td>
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</table>

**DEFINITION:** Field used to identify the "INSURANCE INFORMATION" - "PAYER DATA 2" record.

**CODE VALUES:** N/A

**VALIDATION:** A claim may have up to three "DA1" records. Each must have a corresponding "DA0" record.

Must be "DA1".

**FORM LOCATION:** N/A

**REMARKS:** Multiple "DA1" records must have corresponding "DA0" records. The records are 'matched' by SEQUENCE NO (DA0-02.0 and DA1-02.0).
RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 2"

DATA ELEMENT: Sequence Number

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- ------------------ --------- ---------- ------- ------- ---
02.0 X(02) LEFT SPACES 04 05 R

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA1" records and to associate "DA1" records with "DA0" and "DA2" records.

CODE VALUES: 01 - Identifies the primary payer record.
02 - Identifies the secondary payer record.
03 - Identifies the tertiary payer record.

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (DA0-02.0) submitted in the preceding "DA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page DA0.04.
DATA ELEMENT: Patient Control Number  
(PAT CONTROL NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- ------------------- ---------- ------- -------- ----- ----- ----- 
03.0     X(17)            LEFT       SPACES  06    22    R

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

MEDICAID NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 2"

RECORD/FIELD: DA1-11.0

DATA ELEMENT: Allowed Amount

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- ------------------ ------- ------- ------- ------- -----
11.0 9(5)V99           RIGHT ZEROS 128 134     C

DEFINITION: The maximum amount determined by the payer as being "allowable" under the provisions of the contract prior to the determination of actual payment.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES: USE FOR MEDICARE CROSSOVER CLAIMS ONLY

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:
Enter the Medicare Part C managed care plan "approved/allowed/covered" amount found on the Medicare managed care plan's EOB remittance advice. The "approved/allowed/covered" amount is provided on the HIPAA compliant 835 Remittance Advance, as well as on many NSF and paper claims remittance advices; if the specific "approved/allowed/covered" amount is not given, then information is available on the remittance advice that providers can use in order to calculate this amount.

For example, if the Medicare managed care plan's EOB does not provide a place on the remittance for "allowed/approved/covered" amount, the provider will be able to calculate this amount by subtracting the "provider discount/contract adjustment" amount from the "charged/billed/claimed" amount.

(2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:
Enter the total dollar amount approved by Medicare indicated on the Summary Notice from Medicare.
DATA ELEMENT: Deductible Amount

FIELD  | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
-------|---------------|---------|---------|------|------|-----
12.0   | 9(5)V99      | RIGHT   | ZEROS   | 135  | 141  | C

DEFINITION: The amount deducted, by the payer, from the allowed amount. This amount will meet the contract "deductible" provisions.

The amount applied toward the deductible by this payer.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount of deductible on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:

Enter the Medicare Part C managed care plan deductible amount found on the Medicare managed care plan’s EOB remittance advice. If the Medicare managed care plan has bundled the deductible, coinsurance and copayment amounts enter the bundled amount in the DA1-13.0 field. If there is no amount listed leave this item blank.

Note: Providers paid under a capitation arrangement may submit the deductible amount set forth in their agreement with the Part C plan.

(2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:

Enter the dollar amount shown in the Deductible column on the Summary Notice from Medicare. If there is no deductible amount listed leave this item blank.
RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 2"

RECORD/FIELD: DA1-13.0

DATA ELEMENT: Coinsurance Amount

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- ------------------- ---------- ---------- ------- -------- -----
13.0 9(5)V99 RIGHT ZEROS 142 148 C

DEFINITION: The amount deducted, by the payer, from the allowed amount in order to meet the "coinsurance" provisions of the contract.

The amount applied toward the coinsurance by this payer.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount coinsurance on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) Crossovers:

Enter the Medicare Part C managed care plan coinsurance and/or copayment amount found on the Medicare managed care plan's EOB remittance advice. If the Medicare managed care plan has bundled the deductible, coinsurance and copayment amounts enter the bundled amount in this field. If there is no amount listed leave this item blank.

Note: Providers paid under a capitation arrangement may submit the coinsurance and/or copayment amounts set forth in their agreement with the Part C plan.

(2) TRADITIONAL MEDICARE PART A/B Crossovers:

Enter the dollar amount shown in the Co-insurance column on the Summary Notice from Medicare. If there is no coinsurance amount listed leave this item blank.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 2"

RECORD/FIELD: DA1-26.1

DATA ELEMENT: Date Paid by Medicare

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- ---------------------- ----------- ---------- ------- -------- -------
26.1 X(6) LEFT ZEROS 253 258 C

DEFINITION: This field is the date that this claim was paid by Medicare.

CODE VALUES: N/A

VALIDATION: Logical date edit: MMDDYY

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field is only used for Medicare Secondary Payer purposes.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSEOVERS:

For providers not paid under a capitation arrangement: Enter the date paid by the Medicare Part C managed care plan found on the Medicare managed care plan's EOB remittance advice.

For providers paid under a capitation arrangement: Enter the date of submission to Medicaid. This date may not be older than 365 days from the date of service.

(2) TRADITIONAL MEDICARE PART A/B CROSSEOVERS:

Enter the payment date shown in the upper right hand corner of the Summary Notice from Medicare.
CLAIM RECORD

RECORD TYPE: EA0

"CLAIM DATA"
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD
"CLAIM DATA"

LEVEL: CLAIM

PURPOSE: To identify claim level information.

REQUIREMENTS: One EA0 is required on every claim.

ORDER: Preceding
Record Type
----------
DA0, DA1 or DA2

Following
Record Type
----------
EA1 or FA0

NOTES: Only one EA0 record is allowed on each claim.
# ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** CLAIM RECORD  
**RECORD TYPE:** EA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
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<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>2</td>
<td>X</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>1</td>
<td>X</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>05.0</td>
<td>ACCIDENT INDICATOR</td>
<td>1</td>
<td>X</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>1</td>
<td>X</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>07.0</td>
<td>ACCIDENT/SYMPTOM DATE</td>
<td>8</td>
<td>X</td>
<td>26</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>46</td>
<td>X</td>
<td>34</td>
<td>79</td>
</tr>
<tr>
<td>20.0</td>
<td>REFERRING PROVIDER ID NUMBER</td>
<td>15</td>
<td>X</td>
<td>80</td>
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<tr>
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<td>FILLER</td>
<td>25</td>
<td>X</td>
<td>95</td>
<td>119</td>
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<td>22.0</td>
<td>REFER PROV LAST</td>
<td>20</td>
<td>X</td>
<td>120</td>
<td>139</td>
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<td>23.0</td>
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<td>X</td>
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<td>151</td>
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<tr>
<td>24.0</td>
<td>REFER PROV MI</td>
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<td>X</td>
<td>152</td>
<td>152</td>
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<td>FILLER</td>
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<td>X</td>
<td>153</td>
<td>178</td>
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<td>30.0</td>
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<td>5</td>
<td>X</td>
<td>179</td>
<td>183</td>
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<tr>
<td>31.0</td>
<td>DIAGNOSIS CODE-2 (SECONDARY)</td>
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<td>X</td>
<td>184</td>
<td>188</td>
</tr>
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<td></td>
<td>FILLER</td>
<td>132</td>
<td>X</td>
<td>189</td>
<td>320</td>
</tr>
</tbody>
</table>
RECORD NAME: CLAIM RECORD
"CLAIM DATA"

RECORD/FIELD: EA0-01.0

DATA ELEMENT: Record Identification (RECORD ID "EA0")

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------ | -------------- | -------- | -------- | ---- | ---- | ----
01.0   | X(03)          | LEFT    | SPACES  | 01   | 03   | R

DEFINITION: This is the record identifier for the Claim Detail Record - EA0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "EA0".

FORM LOCATION: N/A

REMARKS: N/A
RECORD NAME: CLAIM RECORD                           RECORD/FIELD: EA0-03.0
"CLAIM DATA"

DATA ELEMENT: Patient Control Number                   (PAT CONTROL NO)

FIELD     COBOL PICTURE     JUSTIFY     INITIAL     FROM    THRU    REQ
--------     --------------------     -----------     -----------    --------   ----- 
03.0            X(17)          LEFT        SPACES        06       22      R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
## ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** CLAIM RECORD

"CLAIM DATA"

**RECORD/FIELD:** EA0-05.0

**DATA ELEMENT:** Accident Indicator

**(ACCIDENT IND)**

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.0</td>
<td>X(01)</td>
<td>LEFT</td>
<td>SPACE</td>
<td>24</td>
<td>24</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** A code to indicate whether the patient's condition was the result of an accident.

**CODE VALUES:**

- A = Auto accident
- O = Other, non-auto accident
- N = No accident

**VALIDATION:**

- Must be entered.
- Must be a valid code from above list.
- If "A" or "O" is entered, EA0-07.0 thru EA0-11.0 must be completed according to payer requirements.

**FORM LOCATION:** HCFA-1500 Blocks 10b, 10c

**REMARKS:** N/A
RECORD NAME: CLAIM RECORD
"CLAIM DATA"

RECORD/FIELD: EA0-07.0

DATA ELEMENT: Accident/Symptom Date

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
07.0  | X(08)         | LEFT    | SPACES  | 26   | 33   | C

DEFINITION: The date of the accident or the date that patient first experienced symptoms of illness or the date of the last menstrual period (LMP).

CODE VALUES: N/A

VALIDATION: If "Symptom Indicator" (EA0-06.0) equals "1" or "2", this field must be completed according to payer requirements.

If "Accident Indicator" (EA0-05.0) equals "A" or "O", this field must be completed according to payer requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-1500 Block 14

REMARKS: N/A

MEDICAID NOTES: This field is only used for the Last Menstrual Period Date (LMP).
RECORD NAME: CLAIM RECORD
"CLAIM DATA"

RECORD/FIELD: EA0-20.0

DATA ELEMENT: Referring Provider Identification Number

(REFER PROV ID NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- ----- 20.0 X(15) LEFT SPACES 80 94 C

DEFINITION: The Identification Number assigned by the Payer to the Referring Physician.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: HCFA-1500 Block 17a

REMARKS: N/A

MEDICAID NOTES: For physicians, podiatrists, clinics and private duty nurses, if the patient was referred to you, enter the referring physician's provider number. If the referring physician's provider number is not available, enter 9111115 in this space and enter the referring physician's name and address (Record EA0, Fields 22, 23 and 24). This field must be completed when you are billing for consultative or referral services or billing for services provided to a Pact recipient for whom you are not the designated physician.
RECORD NAME: CLAIM RECORD
"CLAIM DATA"

DATA ELEMENT: Referring Provider Identification Number (REFER PROV ID NO)

MEDICAID NOTES:

For Medical Suppliers, enter the seven (7) digit Medicaid provider number of the prescribing physician or podiatrist. If the referring provider does not have a Medicaid provider number or you are unable to obtain the provider number, enter 9111115 in the space and the referring provider’s name and address.

For Laboratories, please leave blank unless the procedure code is one designated as code requiring a referring physician number.

For Transportation, except in instances of Ambulance Transportation to a hospital emergency room in an emergency situation; e.g., as a result of accident, injury or acute illness, all ambulance and ambulette services must be certified by a physician as medically necessary. Enter the Medicaid provider number of the attending or ordering physician.

Please refer to the check digit routine for the Provider Medicaid Number field (number 12.0) on Record BA0.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
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</thead>
<tbody>
<tr>
<td>22.0</td>
<td>X(20)</td>
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<td>SPACES</td>
<td>120</td>
<td>139</td>
<td>C</td>
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<tr>
<td>23.0</td>
<td>X(12)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>140</td>
<td>151</td>
<td>C</td>
</tr>
<tr>
<td>24.0</td>
<td>X(01)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>152</td>
<td>152</td>
<td>C</td>
</tr>
</tbody>
</table>

**DEFINITION:** Name of Provider who referred the patient to the provider of service on this claim.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered if required by payer.

See GENERAL INSTRUCTIONS for “Name 1” entry.

**FORM LOCATION:** HCFA-1500 Block 17

**REMARKS:** N/A

**MEDICAID NOTES:** These fields should be used if the Referring Provider Identification Number is equal to 9111115.

7/01/01 For FQHCs (type 12) or Rural Health Clinics (type 5), if the provider is billing for the managed care supplemental payment effective for dates of service, enter the seven digit Ohio Medicaid identification number of the Managed Care Plan (MCP) which paid the provider for managed care services. For a current list of Managed Health Care Provider numbers call the Bureau of Managed Health Care at 614-466-4693 and submit an information request.
**RECORD NAME:** CLAIM RECORD

**RECORD/FIELD:** EA0-30.0

**CLAIM DATA**

**DATA ELEMENT:** Diagnosis Code-1

**FIELD** | **COBOL PICTURE** | **JUSTIFY** | **INITIAL** | **FROM** | **THRU** | **REQ**
--- | --- | --- | --- | --- | --- | ---
30.0 | X(05) | LEFT | SPACES | 179 | 183 | R
31.0 | X(05) | LEFT | SPACES | 184 | 188 | C

**DEFINITION:** An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition resulting in a line item service.

**CODE VALUES:** ICD-9-CM Diagnosis Codes.

**VALIDATION:** Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

The submission of "V", "E" and/or "M" Diagnosis Codes may or may not be accepted by a payer.

**FORM LOCATION:** HCFA-1500 Block 21

**REMARKS:** The Diagnosis Code should correspond with the age and sex of the patient.

**MEDICAID NOTES:** Diagnosis Code-1 is considered the Primary Diagnosis.

Diagnosis Code-2 is considered the Secondary Diagnosis.

**PRIMARY DIAGNOSIS CODE:** For Physicians, Podiatrists, Vision, Ambulatory Surgical Centers, Clinics and Medical Suppliers, enter the appropriate diagnosis code from the Internal Classification of Diseases,
9th Edition, Clinical Modification (ICD-9-CM) for the primary diagnosis. Note: Some diagnosis codes in the ICD-9-CM are 3 or 4 digits. If the diagnosis is 5 digits, you must enter all 5 digits. "V" are acceptable. "E" and "M" codes are not acceptable as a primary diagnosis.

SECONDARY DIAGNOSIS CODE: Enter the 3, 4 or 5 digit ICD-9-CM code which corresponds to the secondary diagnosis for the patient. If there is no secondary diagnosis, leave this field blank. "V" and "M" codes are acceptable.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FA0

"CLAIM - ROOT SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD TYPE: FA0

LEVEL: CLAIM - ROOT SEGMENT

PURPOSE: To provide information related to the medical/dental services rendered to the patient by the provider.

REQUIREMENTS: This record is required on all claims.

ORDER:

<table>
<thead>
<tr>
<th>Preceding Record Type</th>
<th>Following Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>EA0, EA1, EA2, FA0,</td>
<td>FB0, FB1, FB2, FD0,</td>
</tr>
<tr>
<td>FB0, FB1, FB2,</td>
<td>CERT Records, HA0 or XA0</td>
</tr>
<tr>
<td>FD0, CERT Records,</td>
<td>or HA0</td>
</tr>
</tbody>
</table>

NOTES:

1. There must be at least 1 record type FA0 entered for a claim.
2. There may be up to 99 record type FA0's entered for a claim.

MEDICAID NOTES

There must be at least one but not more than twenty-one line items per document.

FA0.1
### ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** SERVICE LINE DETAIL  
**RECORD TYPE:** FA0  
**ROOT SEGMENT**

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;FA0&quot;</td>
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<td>1</td>
<td>3</td>
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<tr>
<td>02.0</td>
<td>SEQUENCE NUMBER</td>
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<td>X</td>
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<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
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<td>04.0</td>
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<td>X</td>
<td>23</td>
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**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** SERVICE LINE DETAIL  
**RECORD/FIELD:** FA0-01.0

**DATA ELEMENT:** Record Identifier  
(RECORD ID "FA0")

<table>
<thead>
<tr>
<th>FIELD</th>
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<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
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<td>X(03)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>01</td>
<td>03</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** This is the record identifier for the Service Line Detail Record - FA0.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

Must be 'FA0'.

**FORM LOCATION:** N/A

**REMARKS:** N/A
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Sequence Number

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- -----
02.0 X(02) LEFT SPACES 04 05 R

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

All Fxx records must be grouped as FA0, FB0, FB1 followed by any applicable CERT record(s) and/or Narrative record(s) (or for Dental claims, FA0, FD0) by Sequence Number.

FORM LOCATION: N/A

REMARKS: Consult the Matrix/User Guide document supplied by the payer/receiver to determine the maximum number (sequences) of "FA0" records allowed.

MEDICAID NOTES: There can be no duplicate line numbers for a document (claim or invoice). Line numbers must be in ascending sequence. There must be at least one but not more than twenty-one line items per document.

FA0.4
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Patient Control Number

(FAT CONTROL NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- -------- -----
03.0 X(17) LEFT SPACES 06 22 R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Line Item Control Number

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- -------- -----
04.0 X(17) LEFT SPACES 23 39 C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Service From Date

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- -----
05.0 X(08) LEFT SPACES 40 47 R

DEFINITION: The date the service was initiated.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-1500 Block 24a

REMARKS: N/A

MEDICAID NOTES: Enter the dates of service in chronological order (first to last). Each date of service must be a separate FA0 record. FAILURE TO ENTER A DATE WILL CAUSE THE CLAIM TO REJECT.

Since Medicaid does not pay for spanned billing dates, the Service To Date should be left blank.

Note: All services must be billed to Medicaid within 365 days of the date of service.

01/01/2002 Order Received Date for eye glass orders denotes date the Optical laboratory received the eyeglass order for processing.

FA0.7
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FA0-07.0

DATA ELEMENT: Place of Service (PLACE OF SVC)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.0</td>
<td>X(02)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>56</td>
<td>57</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION: The code that identifies where the service was performed.

CODE VALUES:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-09</td>
<td>Unassigned</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>10, 13-19</td>
<td>Unassigned</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room - Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>20, 27-29</td>
<td>Unassigned</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>30, 35-39</td>
<td>Unassigned</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance - Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance - Air or Water</td>
</tr>
<tr>
<td>40, 43-49</td>
<td>Unassigned</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>50, 57-59</td>
<td>Unassigned</td>
</tr>
</tbody>
</table>

FA0.8
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Place of Service (PLACE OF SVC)

(CONTINUED)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>65</td>
<td>End Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>60, 63, 64</td>
<td>Unassigned</td>
</tr>
<tr>
<td>66-69</td>
<td>Unassigned</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>70, 73-79</td>
<td>Unassigned</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
<tr>
<td>80, 82-89</td>
<td>Unassigned</td>
</tr>
<tr>
<td>99</td>
<td>Other Unlisted Facility</td>
</tr>
<tr>
<td>90-98</td>
<td>Unassigned</td>
</tr>
</tbody>
</table>

VALIDATION: Must be entered

Must be a valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24b

REMARKS: N/A

MEDICAID NOTES: An additional code is available:

73 Clinic NOS

All claims, other than those submitted by independent laboratories, portable x-ray suppliers and independent physiological laboratories, require a place of service. Please check your Billing Instructions for details.

FAO.9
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FA0-09.0

DATA ELEMENT: HCPCS Procedure Code

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -----
09.0 X(05) LEFT SPACES 60 64 R

DEFINITION: This is the HCPCS/CPT-4 code that describes the service.

CODE VALUES: HCPCS/CPT-4 code set.

VALIDATION: Must be entered.

Must be a valid HCPCS/CPT-4 procedure code.

FORM LOCATION: HCFA-1500 Block 24d

REMARKS: N/A

MEDICAID NOTES: Enter the 5 character/digit Health Care Financing Administration Common Procedure Coding System (HCPCS) code which corresponds to the service being rendered.

Encounter/Procedure Codes - ONLY provider types (04) OHF, (05) RHF, and (12) FQHC must bill the appropriate five (5) digit encounter code followed immediately on the next record by the HCPCS code(s) that corresponds to the services rendered. HCPCS CODES MUST FOLLOW THE ENCOUNTER CODE TO WHICH THEY RELATE.

FA0.10
Modifiers (all providers) - In certain instances, a 2 character/digit modifier will be required depending on the service. When entering a code with the modifier, enter the 2 character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes. The following services must always be billed using a modifier:

- Healthcheck evaluation and management codes (99381-99395)
- Anesthesia
- Assistant at Surgery
- Ambulance/Ambulette
- Oxygen

Other services may require a modifier based on the type and/or place of service. The appropriate Medicaid Handbook should be referenced for further details regarding the use of modifiers.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
DATA ELEMENT: HCPCS Modifier 1

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.0</td>
<td>X(02)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>65</td>
<td>66</td>
<td>C</td>
</tr>
</tbody>
</table>

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID

NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at surgery, laboratory, transportation, radiology, durable medical equipment, etc.).

Please refer to the Medicaid Handbook for proper usage.

Please refer to the ODJFS web site Electronic Manuals http://emanuals.odjfs.state.oh.us/emanuals
Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E-Collection. Look for the services your billing, e.g. physicians, or FQHC's, or transportation. Find the approved modifiers for the services you need to use in your program.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME:    SERVICE LINE DETAIL
RECORD/FIELD: FA0-13.0

DATA ELEMENT:    Line Charges

FIELD            COBOL PICTURE   JUSTIFY   INITIAL   FROM   THRU   REQ
--------            --------------------   -----------   -----------   -----------   ------
13.0               9(05)V99          RIGHT       ZEROS         71          77        R

DEFINITION:    The charges related to this service.

CODE VALUES: N/A

VALIDATION:    Must be positive unsigned numeric value.

FORM LOCATION:    HCFA-1500 Block 24f

REMARKS: N/A

MEDICAID
NOTES: This field is the usual and customary fee for the service listed on this record.

FA0.13
RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Units Of Service

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
--- | -------------- | ------- | ------- | ----- | ----- | ----
18.0 | 9(03)V9       | RIGHT  | ZEROS   | 82    | 85    | C

DEFINITION: The number of services rendered in days or units.

CODE VALUES: N/A

VALIDATION: Must be Positive unsigned numeric value.

FORM LOCATION: HCFA-1500 Block 24g

REMARKS: In order to capture fractional services, the fourth position with an assumed decimal position.

MEDICAID NOTES: This field contains the number of units of service if more than one. Only numbers 1 to 999 are accepted. The digit to the right of the decimal must be zero (0).

NOTE: Multiple units of service on a single record is limited to anesthesia time, allergy services, transportation (number of loaded miles), medical supplies (number of items dispensed), private duty nursing (hours of personal care) and waiver services.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME:   ERVICE LINE DETAIL
CORD/FIELD: FA0-19.0

DATA ELEMENT:  Anesthesia/Oxygen Minutes
ANESTHESIA/OXYGEN MIN)

FIELD    COBOL PICTURE    JUSTIFY    INITIAL    FROM    THRU    REQ
--------    --------------------    -----------    -----------    -----------    -------
19.0        9(04)            RIGHT       ZEROS            86        89         C

DEFINITION:   The actual number of minutes patient was anesthetized or number of minutes of oxygen.

CODE VALUES:  N/A

VALIDATION:   When required by Payer, must be positive unsigned numeric value.

FORM LOCATION: HCFA-1500 Block 24G

REMARKS:       N/A

MEDICAID
NOTES:       This field is valid for anesthesia minutes only.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FA0-39.1

DATA ELEMENT: Eyeglass Order Shipping Date
(EG ORDER SHIPPING DATE)

FIELD: 39.1
COBOL PICTURE: X(08)
JUSTIFY: LEFT
INITIAL: SPACES
FROM: 231
THRU: 238
REQ: C

DEFINITION: The date the eyeglasses were shipped.

CODE VALUES: N/A

VALIDATION: Must be entered for eyeglass orders.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field only applies to Medicaid vision contractors.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME:    SERVICE LINE DETAIL
DATA ELEMENT:    HCPCS Modifier 2

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- -------- -----
39.2 X(02) LEFT SPACES 242 243 C

DEFINITION:  These codes identify special circumstances related to the performance of the service.

CODE VALUES:  See current HCPCS Modifier codes.

VALIDATION:  Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

Please refer to the ODJFS web site Electronic Manuals http://emanuals.odjfs.state.oh.us/emanuals Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E-Collection. Look for the services your billing, e.g. physicians, or FQHC’s, or transportation. Find the approved modifiers for the services you need to use in your program.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
DATA ELEMENT: HCPCS Modifier 3

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
------- -------------------- ----------- ----------- ------- -------- ----
39.3 X(02) LEFT SPACES 244 245 C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper usage of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID
NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at-surgery, laboratory, transportation, radiology, durable medical equipment, etc.). Please refer to the Medicaid Handbook for proper usage.

Please refer to the ODJFS web site Electronic Manuals http://emannuals.odjfs.state.oh.us/emanuals Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E-Collection. Look for the services your billing, e.g. physicians, or FQHC’s , or transportation. Find the approved modifiers for the services you need to use in your program.

FA0.18
RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FA0-39.4

DATA ELEMENT: HCPCS Modifier 4

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -----
39.4 X(02) LEFT SPACES 246 247 C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID

NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at-surgery, laboratory, transportation, radiology, durable medical equipment, etc.).

Please refer to the Medicaid Handbook for proper usage.

Please refer to the ODJFS web site Electronic Manuals http://emanuals.odjfs.state.oh.us/emanuals
Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E-Collection. Look for the services your billing, e.g. physicians, or FQHC’s, or transportation. Find the approved modifiers for the services you need to use in your program.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FB0

"MEDICAL SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993
RECORD NAME: SERVICE LINE DETAIL  
RECORD TYPE: FB0

LEVEL: CLAIM - MEDICAL SEGMENT

PURPOSE: To provide information related to the medical services rendered to the patient by the provider.

REQUIREMENTS: If required by the payer, this record must be submitted.

ORDER: Preceding Following
Record Type Record Type
---------- ------------
FA0 FA0, FB1, CERT records, HA0 or XA0

NOTES: There may be up to 99 record type FB0's entered for a claim.

MEDICAID
NOTES: There must be at least one but not more than twenty-one line items per document.
## ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** SERVICE LINE DETAIL  
**MEDICAL SEGMENT**  

**RECORD TYPE:** FB0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;FB0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>02.0</td>
<td>SEQUENCE NUMBER</td>
<td>2</td>
<td>X</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>04.0</td>
<td>LINE ITEM CONTROL NO</td>
<td>17</td>
<td>X</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>88</td>
<td>X</td>
<td>40</td>
<td>127</td>
</tr>
<tr>
<td>17.0</td>
<td>PRESCRIPTION NUMBER</td>
<td>15</td>
<td>X</td>
<td>128</td>
<td>142</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>12</td>
<td>X</td>
<td>143</td>
<td>154</td>
</tr>
<tr>
<td>22.0</td>
<td>EPSDT INDICATOR</td>
<td>1</td>
<td>X</td>
<td>155</td>
<td>155</td>
</tr>
<tr>
<td>23.0</td>
<td>FAMILY PLANNING INDICATOR</td>
<td>1</td>
<td>X</td>
<td>156</td>
<td>156</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>164</td>
<td>X</td>
<td>157</td>
<td>320</td>
</tr>
</tbody>
</table>

FB0.2
RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Record Identifier

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- ------
01.0     X(03)          LEFT       SPACES 01         03        R

DEFINITION: This is the record identifier for the Service Line Detail Record - FB0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be 'FB0'.

FORM LOCATION: N/A

REMARKS: N/A
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FB0-02.0

DATA ELEMENT: Sequence Number

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>02.0</td>
<td>X(02)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>04</td>
<td>05</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.
**RECORD NAME:** SERVICE LINE DETAIL  
**RECORD/FIELD:** FB0-03.0

**DATA ELEMENT:** Patient Control Number  
(PAT CONTROL NO)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.0</td>
<td>X(17)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>06</td>
<td>22</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** A unique number assigned by the provider to identify the patient.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

**FORM LOCATION:** HCFA-1500 Block 26

**REMARKS:** N/A

**MEDICAID NOTES:** This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FB0-04.0

DATA ELEMENT: Line Item Control Number

(LINE ITEM CONTROL NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
04.0 X(17) LEFT SPACES 23 39 C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Prescription Number (PRESCRIPTION NO)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.0</td>
<td>X(15)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>128</td>
<td>142</td>
<td>C</td>
</tr>
</tbody>
</table>

DEFINITION: The unique identification number assigned by the pharmacy or supplier.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payer.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: Only the first 10 positions of this field are used by the Medicaid payment system.

For Medical Supplies, enter the prescription number or invoice number of the dispensed item.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: EPSDT Indicator

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
22.0 X(01) LEFT SPACE 155 155 C

DEFINITION: An indicator of whether or not "Early and Periodic Screen for Diagnosis and Treatment of children" services are involved with this detail line.

CODE VALUES: Y – Yes for, EPSDT involvement

N – no for, EPSDT not involved

R- referral for, EPSDT and other services

VALIDATION: Must be entered if required by Payer.
If entered, must be valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24h

REMARKS: N/A

MEDICAID NOTES: This field is required by the Medicaid payment system.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FB0-23.0

DATA ELEMENT: Family Planning Indicator (FAMILY PLANNING IND)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
23.0 X(01) LEFT SPACE 156 156 C

DEFINITION: An indicator of whether or not Family Planning Services are involved with this detail line.

CODE VALUES: Y - Yes, family planning involved
N - No, family planning not involved

VALIDATION: Must be entered if required by Payer.
If entered, must be valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24h

REMARKS: N/A

MEDICAID NOTES: This field is required by the Medicaid payment system.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FD0

"DENTAL SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

LEVEL: CLAIM - DENTAL SEGMENT

PURPOSE: To provide information related to dental services rendered to the patient by the provider.

REQUIREMENTS: If required by the payer, this record must be submitted for dental claims.

ORDER:

<table>
<thead>
<tr>
<th>Preceding Record Type</th>
<th>Following Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA0, FB0, FB1</td>
<td>FD0, HA0 or XA0</td>
</tr>
<tr>
<td>FB2 or FD0</td>
<td></td>
</tr>
</tbody>
</table>

NOTES: There may be up to 99 record type FD0's entered for a claim.

MEDICAID NOTES: There must be at least one but not more than twenty-one line items per document.
# ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** SERVICE LINE DETAIL  
**DENタル SEGMENT**  
**ORD TYPE:** FD0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;FD0&quot;</td>
<td>3</td>
<td>X</td>
<td>01</td>
<td>03</td>
</tr>
<tr>
<td>02.0</td>
<td>SEQUENCE NO</td>
<td>2</td>
<td>X</td>
<td>04</td>
<td>05</td>
</tr>
<tr>
<td>03.0</td>
<td>PAT CONTROL NO</td>
<td>17</td>
<td>X</td>
<td>06</td>
<td>22</td>
</tr>
<tr>
<td>04.0</td>
<td>LINE ITEM CONTROL NO</td>
<td>17</td>
<td>X</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td>05.0</td>
<td>TOOTH CODE NUMBER 1</td>
<td>2</td>
<td>X</td>
<td>40</td>
<td>41</td>
</tr>
<tr>
<td>06.0</td>
<td>TOOTH SURFACE(S) 1</td>
<td>5</td>
<td>X</td>
<td>42</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>274</td>
<td>X</td>
<td>47</td>
<td>320</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

DATA ELEMENT: Record Identifier

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>X(03)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>01</td>
<td>03</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION: This is the record identifier for the Service Line Detail Record - FD0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "FD0".

FORM LOCATION: N/A

REMARKS: N/A
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FD0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- ----- 02.0 X(02) LEFT SPACES 04 05 R

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the "Sequence Number" (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.
RECORD NAME:     SERVICE LINE DETAIL  
RECORD/FIELD:    FD0-03.0 

DATA ELEMENT:    Patient Control Number                  (PAT CONTROL NO)  

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.0</td>
<td>X(17)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>06</td>
<td>22</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION:  A unique number assigned by the provider to identify the patient.  

CODE VALUES:  N/A  

VALIDATION:  Must be entered.  

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.  

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.  

FORM LOCATION: HCFA-1500 Block 26  

REMARKS:  N/A  

MEDICAID NOTES:  This field is used to link all records for a single claim. The entire claim will be denied without this information.  

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FD0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
--- | -------------- | ------- | -------- | ----- | ----- | ----
04.0 | X(17)          | LEFT    | SPACES   | 23   | 39   | C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
RECORD/FIELD: FD0-05.0

DATA ELEMENT: Tooth Code Number 1

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.0</td>
<td>X(02)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>40</td>
<td>41</td>
<td>C</td>
</tr>
</tbody>
</table>

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent
10 Through 32 - Permanent
A Through T - Primary
SN - Supernumerary

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

FD0.7
DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

06/01 Date eyeglass order received.

CODE VALUES:
- M - Mesial
- O - Occlusal
- D - Distal
- L - Lingual
- F - Facial
- I - Incisal
- B - Buccal

VALIDATION: If entered must be a valid code or combination of up to five codes from the above table.
AMBULANCE CERTIFICATION RECORD

RECORD TYPE: GA0
RECORD NAME: AMBULANCE CERT RECORD
LEVEL: SERVICE LINE
PURPOSE: To provide additional information related to the ambulance service rendered to the patient.

REQUIREMENTS: If required by the payer, this record must be submitted.

ORDER: Preceding Following
Record Type Record Type
FA0, FB0, FB1 FA0, HA0, or XA0

NOTES: When used, this record must follow the FA0, FB0 or FB1 record related to this service.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;GA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>02.0</td>
<td>SEQUENCE NUMBER</td>
<td>2</td>
<td>X</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>31</td>
<td>X</td>
<td>23</td>
<td>53</td>
</tr>
<tr>
<td>17.0</td>
<td>MILES</td>
<td>4</td>
<td>X</td>
<td>54</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>250</td>
<td>X</td>
<td>58</td>
<td>307</td>
</tr>
<tr>
<td>23.1</td>
<td>TIME PATIENT WAS PICKED UP</td>
<td>4</td>
<td>X</td>
<td>308</td>
<td>311</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>9</td>
<td>X</td>
<td>312</td>
<td>320</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

RECORD/FIELD: GA0-01.0

DATA ELEMENT: Record Identification (RECORD ID "GA0")

FIELD     COBOL PICTURE     JUSTIFY     INITIAL     FROM    THRU    REQ
--------     --------------------     -----------     -----------    --------   -----  
01.0        X(03)            LEFT       SPACES      01        03       R

DEFINITION: This is the record identifier for the Ambulance Cert Record - GA0.

CODE VALUES: N/A

VALIDATION: Must be entered.
             Must be "GA0".

FORM LOCATION: N/A

REMARKS: N/A
RECORD NAME: AMBULANCE CERT RECORD

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
----- -------------------- ----------- ----------- ----------- -----
02.0 X(02) LEFT SPACES 04 05 R

DEFINITION: A numeric value from 01 through 99 used to sequence the "GA0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
-------- | -------------------- | ----------- | ----------- | ----------- | ---- | ----
03.0 | X(17) | LEFT | SPACES | 06 | 22 | R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES:
This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
RECORD NAME: AMBULANCE CERT RECORD

DATA ELEMENT: Miles

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------|---------------|---------|---------|------|------|-----
17.0  | X(04)         | LEFT    | SPACES  | 54   | 57   | C

DEFINITION: Number of miles traveled during this ambulance service.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

If entered, must be numeric values.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for Transportation claims.

It is the total number of loaded miles.

Entry must be numeric and right justified.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

DATA ELEMENT: Time patient was picked up

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.1</td>
<td>X(4)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>308</td>
<td>311</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION: This is the hour and minute that the patient was picked up by the ambulance. The hour is represented in the military (24 hour clock) fashion.

CODE VALUES: N/A

VALIDATION: Only required for Transportation type claims.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for Transportation claims.

The time is required for each line item and must be expressed in military time. As an example, military time is represented as follows:

8:30 a.m. = 0830

2:15 p.m. = 1415
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

EXTRA NARRATIVE RECORD

RECORD TYPE: HA0

NATIONAL VER. 001.03 - 07/01/1993
RECORD NAME: NARRATIVE RECORD  
LEVEL: SERVICE LINE  
PURPOSE: To provide additional information related to the service rendered to the patient by the provider.  
REQUIREMENTS: If required by the payer, this record must be submitted.  
ORDER: Preceding Following  
Record Type Record Type  
FA0, FB0, FB1, FB2, FD0, FA0 or XA0  
GA0, GC0, GD0, GD1, GE0,  
GP0, GU0, GX0, GX1 or GX2  
NOTES: When used, this record must follow the FA0, FB0,  
FB1, FB2, FD0, GA0, GC0, GD0, GE0, GP0, GU0, GX0,  
GX1 or GX2 record related to this service.
**MEDICAID NOTES:**

Field number 05.0 should only be used for co-payment remarks.

Field number 06.0 should only be used for:
1. Multiple Surgeries
2. By-Report Procedures
3. Multiple passengers for transportation claims
4. Service codes 10000 thru 69999

Only 5 HA0 records per claim is allowed

01/01/06
**RECORD NAME:** NARRATIVE RECORD

"CLAIM DATA"

**RECORD/FIELD:** HA0-01.0

**DATA ELEMENT:** Record Identification

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>X(03)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>01</td>
<td>03</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** This is the record identifier for the Narrative Record - HA0.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

Must be "HA0".

**FORM LOCATION:** N/A

**REMARKS:** N/A
**RECORD NAME:** NARRATIVE RECORD

**RECORD/FIELD:** HA0-02.0

**DATA ELEMENT:** Sequence Number

**FIELD** | **COBOL PICTURE** | **JUSTIFY** | **INITIAL** | **FROM** | **THRU** | **REQ**
---|---|---|---|---|---|---
02.0 | X(02) | LEFT | SPACES | 04 | 05 | R

**DEFINITION:** A numeric value from 01 through 99 used to sequence the "HA0" record to the corresponding "FA0" record.

**CODE VALUES:** 01 through 99

**VALIDATION:** Must be entered.

Must be a valid value from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

**FORM LOCATION:** N/A

**REMARKS:** See sequencing instructions on page FA0.04.
**DATA ELEMENT:** Patient Control Number (PAT CONTROL NO)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.0</td>
<td>X(17)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>06</td>
<td>22</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** A unique number assigned by the provider to identify the patient.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

**FORM LOCATION:** HCFA-1500 Block 26

**REMARKS:** N/A

**MEDICAID NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD
"CLAIM DATA"

RECORD/FIELD: HA0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
-------|---------------|---------|---------|------|------|-----
04.0   | X(17)         | LEFT    | SPACES  | 23   | 39   | C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

If entered, value must match the "Line Item Control Number" submitted in the preceding FA0-04.0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is currently not returned on the Ohio Pay/Reject file.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** NARRATIVE RECORD  
"CLAIM DATA"  
**RECORD NAME:** CLAIM CONTROL SCREEN  
**DATA ELEMENT:** COPAY REMARKS

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.0</td>
<td>X(10)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>40</td>
<td>49</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** This field is used to report a co-payment exclusion.

**Use the following table to indicate that a co-payment exclusion applies.**

**Note:** The caret denotes a space between the word COPAY and the 4-digit alpha exclusion code. The space must exist if billing for a co-payment exclusion.

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>Exclusion Code – Denotes a Co-payment Should Not Be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant or pregnancy ended recently (up to 90 days ago)</td>
<td>COPAY PREG</td>
</tr>
<tr>
<td>If Receiving Hospice Services</td>
<td>COPAY HSPC</td>
</tr>
<tr>
<td>Vision or Dental Services Rendered on an Emergency Basis</td>
<td>COPAY EMER</td>
</tr>
</tbody>
</table>

**VALIDATION:** This field is required.
DATA ELEMENT: Extra Narrative Data

DEFINITION: Free form narrative record to submit additional information that may assist in the adjudication of the Service Line Item in the preceding FA0 record.

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------- | ----------------- | -------- | -------- | ------ | ----- | -----
06.0   | X(271)            | LEFT    | SPACES  | 50    | 320   | C

DEFINITION: Free form narrative record to submit additional information that may assist in the adjudication of the Service Line Item in the preceding FA0 record.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

FORM LOCATION: N/A

REMARKS: This field may be used as follows:

1. To describe the service being submitted as an Unlisted/NOC HCPCS Procedure Code in the preceding FA0 record.

2. To report "Secondary" Diagnosis Codes that exceeded the number that could be submitted on the preceding FA0 record.

3. To report the substitute physician's UPIN (six bytes in length, alpha numeric) for "Reciprocal" or "Locum Tenens" billing arrangements.

Consult the Matrix/Users Guide supplied by the Payer/Receiver for additional details regarding submission instructions.

HA0.8
MEDICAID
NOTES:

These records are required when miscellaneous codes are used, such as Places of Service "0-9", "10", "13-19", "20", "27-99", "30", "35-39", "40", "43-49", "50", "57-59", "60", "63-64", "66-69", "70", "74-79", "80", "82-89", "90-99", Other Source of Insurance "6", or when special types of claims are submitted, such as:

1) HCPCS, CPT, drug and supply codes that need special handling, pricing or any miscellaneous codes needing an explanation.

2) Transportation claims requiring an explanation for the need for service (when the referring physician number is not available).

3) Claims with multiple surgeries.

4) Transportation claims for multiple passengers or air flight.

Item #3 in the above Remarks section is concerned with "Reciprocal" and "Locum Tenens" billing arrangements. These arrangements are not currently being Recognized by Ohio Medicaid.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

CLAIM TRAILER RECORD

RECORD TYPE: XA0
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD
RECORD TYPE: XA0

LEVEL: CLAIM

PURPOSE: The last record of every claim submitted electronically, it contains information pertinent to the balancing of each claim (i.e. claim record counts, claim charges) within a batch.

REQUIREMENTS: An ‘XA0’ Record is a REQUIRED record since it is the CLAIM TRAILER

ORDER:

<table>
<thead>
<tr>
<th>Preceding Record Type</th>
<th>Following Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA0, FB0, FB1, FB2, FD0, GA0 (CERT RECORDS), HA0 (NARRATIVE RECORD)</td>
<td>CA0, YA0</td>
</tr>
</tbody>
</table>

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type FA0 (SERVICE LINE DETAIL RECORD).

There may be multiple claims per batch.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** CLAIM TRAILER RECORD  
"RECORD SUMMARY"

**RECORD TYPE:** XA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>FIELD LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;XA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>2</td>
<td>X</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>03.0</td>
<td>PATIENT CONTROL NUMBER</td>
<td>17</td>
<td>X</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>12</td>
<td>X</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>10.0</td>
<td>CLAIM RECORD COUNT</td>
<td>3</td>
<td>N</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>40</td>
<td>X</td>
<td>38</td>
<td>77</td>
</tr>
<tr>
<td>12.0</td>
<td>TOTAL CLAIM CHARGES</td>
<td>7</td>
<td>N</td>
<td>78</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>42</td>
<td>X</td>
<td>85</td>
<td>126</td>
</tr>
<tr>
<td>19.9</td>
<td>PATIENT AMOUNT PAID</td>
<td>7</td>
<td>N</td>
<td>127</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>187</td>
<td>X</td>
<td>134</td>
<td>320</td>
</tr>
</tbody>
</table>

**NOTE:** Only positive numeric values are accepted as input, values are not allowable.

**2/95 Only 500 Batches Per Cartridge.**

XA0.2
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD
"RECORD SUMMARY"

RECORD/FIELD: XA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "XA0")

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- ----- 01.0 X(03) LEFT SPACES 01 03 R

DEFINITION: Field used to identify the "Claim Trailer Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "XA0".

FORM LOCATION: N/A

REMARKS: N/A
RECORD NAME:       CLAIM TRAILER RECORD
"RECORD SUMMARY"

DATA ELEMENT:      Patient Control Number           (PAT CONTROL NO)

FIELD     COBOL PICTURE     JUSTIFY     INITIAL     FROM    THRU    REQ
--------     --------------------     -----------     -----------    --------   -----  
03.0        X(17)          LEFT       SPACES            06          22       R

DEFINITION:      A unique number assigned by the provider to identify the patient.

CODE VALUES:    N/A

VALIDATION:      Must be entered.

Must be identical to the PATIENT CONTROL NUMBER found in Claim Header Record (CA0-03.0).

See GENERAL INSTRUCTIONS for “Patient Control Number” entry.

FORM LOCATION:  HCFA-1500 Block 26

REMARKS:        N/A

MEDICAID NOTES:

This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD
"RECORD SUMMARY"

DATA ELEMENT: Claim Record Count

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------ | -------------- | ------- | ------- | ---- | ---- | ----
10.0   | 9(03)          | RIGHT   | ZEROS   | 35   | 37   | R

DEFINITION: The total number of records submitted for this claim excluding this record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all records processed from the Claim Header Record (CA0) to the Claim Trailer Record (XA0).

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
RECORD NAME: CLAIM TRAILER RECORD
"RECORD SUMMARY"

DATA ELEMENT: Total Claim Charges

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.0</td>
<td>9(05)V99</td>
<td>RIGHT</td>
<td>ZEROS</td>
<td>78</td>
<td>84</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION: The sum of all line item charges included within this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all LINE CHARGES fields (FA0-13.0) included for this claim.

FORM LOCATION: HCFA-1500 Block 28

REMARKS: N/A

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.
**DATA ELEMENT:** Patient Amount Paid  

**RECORD/FIELD:** XA0-19.0  

**DEFINITION:** The amount the provider has received from the patient (or insured) toward payment of this claim.  

**CODE VALUES:** N/A  

**VALIDATION:** Must be entered.  

- Must be a positive, unsigned numeric value.  
- Must not exceed TOTAL CLAIM CHARGES (XA0-12.0).  

**FORM LOCATION:** HCFA-1500 Block 29  

**MEDICAID NOTES:**  

**04/19/04**  

1. **MEDICARE CROSSOVERS:**  
   Enter the amount collected from all insurance sources including the amount paid the Medicare Part C managed care plan (Medicare Advantage plan). Leave this item blank for Medicare Part A/B claims.  

2. **NON-MEDICARE CLAIMS:**  
   Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment.  

**05/01**  

3. For (Federally Qualified Health Centers FQHCs) and Rural health Clinics (RHCs) only:  
   If billing for the Medicaid managed care supplemental payment, enter the sum of the dollar amount the provider was paid by the Medicaid managed care plan for services provided to a Medicaid managed care consumer and any amount the FQHC or RHC was paid from any other third party insurance.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

BATCH TRAILER RECORD

RECORD TYPE: YA0

NATIONAL VER. 001.03 - 07/01/1993
RECORD NAME: BATCH TRAILER RECORD

LEVEL: BATCH

PURPOSE: The last record of any batch submitted electronically, it contains information pertinent to the balancing of each batch (i.e. batch record count, batch charges) within a file.

REQUIREMENTS: A 'YA0' Record is a REQUIRED record since it is the BATCH TRAILER.

ORDER:

<table>
<thead>
<tr>
<th>Preceding Record Type</th>
<th>Following Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>XA0</td>
<td>BA0, ZA0</td>
</tr>
</tbody>
</table>

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type XA0 (CLAIM TRAILER RECORD).

There may be multiple batches per file.
**ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT**

**RECORD NAME:** BATCH TRAILER RECORD

**RECORD TYPE:** YA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;YA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>18</td>
<td>X</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>04.0</td>
<td>BATCH NUMBER</td>
<td>4</td>
<td>N</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>21</td>
<td>X</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>08.0</td>
<td>BATCH SERVICE LINE COUNT</td>
<td>7</td>
<td>N</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>09.0</td>
<td>BATCH RECORD COUNT</td>
<td>7</td>
<td>N</td>
<td>54</td>
<td>60</td>
</tr>
<tr>
<td>10.0</td>
<td>BATCH CLAIM COUNT</td>
<td>7</td>
<td>N</td>
<td>61</td>
<td>67</td>
</tr>
<tr>
<td>11.0</td>
<td>BATCH TOTAL CHARGES</td>
<td>9</td>
<td>N</td>
<td>68</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>244</td>
<td>X</td>
<td>77</td>
<td>320</td>
</tr>
</tbody>
</table>

**NOTE:** Only positive numeric values are acceptable as input, values are not allowable.
RECORD NAME: BATCH TRAILER RECORD

DATA ELEMENT: Record Identifier

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
--- | -------------- | -------- | -------- |------ | ------ |-----
01.0  | X(03)         | LEFT     | SPACES   | 01   | 03    | R

DEFINITION: Field used to identify the "Provider Batch Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "YA0".

FORM LOCATION: N/A

REMARKS:

YA0.3
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD
RECORD/FIELD: YA0-04.0

DATA ELEMENT: Batch Number
(BATCH NO)

FIELD
04.0

COBOL PICTURE
9(04)

JUSTIFY
RIGHT

INITIAL
Zero

FROM
22

THRU
25

REQ
R

DEFINITION: A sequential number assigned by the submitter to each batch of claims.

CODE VALUES: Must be "0001" through "9999".

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be "0001".

Must be identical to the BATCH NUMBER entered in the corresponding Batch Header Record (BA0-04.0).

FORM LOCATION: N/A

REMARKS:

MEDICAID NOTES: For submission coming from providers and electronic intermediaries, the Medicaid payment system will accept up to 9,999 batches in a submission.

For submissions coming from Scanning and Data Entry, Medicaid payment system will accept up to 999 batches in a submission.

YA0.4
RECORD NAME: BATCH TRAILER RECORD

DATA ELEMENT: Batch Service Line Count

FIELD    COBOL PICTURE     JUSTIFY     INITIAL     FROM    THRU    REQ
--------     --------------------     -----------     -----------    --------   -----  
08.0        9(07)            RIGHT      ZEROS            47        53        R

DEFINITION: The number of line items included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Type FA0's within this batch.

FORM LOCATION: N/A

REMARKS:

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
RECORD NAME: BATCH TRAILER RECORD

DATA ELEMENT: Batch Record Count

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------|---------------|---------|---------|------|------|-----
09.0  | 9(07)         | RIGHT   | ZEROS   | 54   | 60   |  R

DEFINITION: The number of records included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Types BA0 through YA0.

FORM LOCATION: N/A

REMARKS:

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
**RECORD NAME:** BATCH TRAILER RECORD

**RECORD/FIELD:** YA0-10.0

**DATA ELEMENT:** Batch Claim Count

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.0</td>
<td>9(07)</td>
<td>RIGHT</td>
<td>ZEROS</td>
<td>61</td>
<td>67</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** The number of claims that are included within this batch.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

Must be numeric.

Must be the computed sum of all the Record Type CA0's included between this Batch Trailer Record (YA0) and the preceding Batch Header Record (BA0).

**FORM LOCATION:** N/A

**REMARKS:**

**MEDICAID NOTES:** This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.
RECORD NAME: BATCH TRAILER RECORD

DATA ELEMENT: Batch Total Charges

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------|---------------|---------|---------|------|------|-----
11.0  | 9(07)V99     | RIGHT   | ZEROS   | 68   | 76   | R   

DEFINITION: The sum of all "Total Claim Charges" fields included within this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the TOTAL CLAIM CHARGES fields (XA0-12.0) included within this batch.

FORM LOCATION: N/A

REMARKS:

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

FILE TRAILER RECORD

RECORD TYPE: ZA0
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME:        FILE TRAILER RECORD
RECORD TYPE:        ZA0

LEVEL:             FILE

PURPOSE:    The last record of any file submitted electronically, it contains information pertinent to the balancing of the file (i.e. file record counts, file charges).

REQUIREMENTS:  A "ZA0" Record is a REQUIRED record since it is the FILE TRAILER RECORD.

ORDER:

<table>
<thead>
<tr>
<th>Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>YA0</td>
</tr>
<tr>
<td>NONE</td>
</tr>
</tbody>
</table>

NOTES:    Fields that require balancing should be the sum of all the corresponding fields in Record Type YA0 (BATCH TRAILER RECORD).
## ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

**RECORD NAME:** FILE TRAILER RECORD  
**RECORD TYPE:** ZA0

<table>
<thead>
<tr>
<th>FIELD NO.</th>
<th>FIELD NAME</th>
<th>LENGTH</th>
<th>TYPE</th>
<th>FROM</th>
<th>THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.0</td>
<td>RECORD ID &quot;ZA0&quot;</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>02.0</td>
<td>SUBMITTER ID NUMBER</td>
<td>16</td>
<td>X</td>
<td>04</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>25</td>
<td>X</td>
<td>20</td>
<td>44</td>
</tr>
<tr>
<td>05.0</td>
<td>FILE SERVICE LINE COUNT</td>
<td>7</td>
<td>N</td>
<td>45</td>
<td>51</td>
</tr>
<tr>
<td>06.0</td>
<td>FILE RECORD COUNT</td>
<td>7</td>
<td>N</td>
<td>52</td>
<td>58</td>
</tr>
<tr>
<td>07.0</td>
<td>FILE CLAIM COUNT</td>
<td>7</td>
<td>N</td>
<td>59</td>
<td>65</td>
</tr>
<tr>
<td>08.0</td>
<td>BATCH COUNT</td>
<td>4</td>
<td>N</td>
<td>66</td>
<td>69</td>
</tr>
<tr>
<td>09.0</td>
<td>FILE TOTAL CHARGES</td>
<td>11</td>
<td>N</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>FILLER</td>
<td>240</td>
<td>X</td>
<td>81</td>
<td>320</td>
</tr>
</tbody>
</table>

**NOTE:** positive numeric values are accepted as input, values are not allowable.
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD
RECORD/FIELD: ZA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "ZA0")

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- -------- -----
01.0 X(03) LEFT SPACES 01 03 R

DEFINITION: Field used to identify the "File Trailer Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "ZA0".

FORM LOCATION: N/A

REMARKS: N/A

ZA0.3
**RECORD NAME:** FILE TRAILER RECORD

**RECORD/FIELD:** ZA0-02.0

**DATA ELEMENT:** Submitter Identifier (SUB ID)

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>02.0</td>
<td>X(16)</td>
<td>LEFT</td>
<td>SPACES</td>
<td>04</td>
<td>19</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** Identifies the submitter as defined by receiver.

**CODE VALUES:** N/A

**VALIDATION:** Must be entered.

Must be identical to the SUBMITTER ID entered in the File Header Record (AA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

**FORM LOCATION:** N/A

**REMARKS:** May be a Federally assigned Employer Identification Number (EIN). EIN is also referred to as Tax Identification Number (TIN) depending on the receiver's requirements.

**MEDICAID NOTES:** This field is required.

Please refer to the Medicaid Notes on Record AA0, Field Number 2.0, Submitter Identifier.
RECORD NAME: FILE TRAILER RECORD
DATA ELEMENT: File Service Line Count

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU REQ
-------- -------------------- ----------- ----------- ----------- ------ -----
05.0 9(07) RIGHT ZEROS 45           51         R

DEFINITION: The number of service lines included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

- Must be the computed sum of all BATCH SERVICE LINE COUNT fields (YA0-08.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for the Medicaid payment system.

- For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

- For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
RECORD NAME:    FILE TRAILER RECORD          RECORD/FIELD: ZA0-06.0

DATA ELEMENT:  File Record Count

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>06.0</td>
<td>9(07)</td>
<td>RIGHT</td>
<td>ZEROS</td>
<td>52</td>
<td>58</td>
<td>R</td>
</tr>
</tbody>
</table>

DEFINITION:  The number of records included in this file.

CODE VALUES:  N/A

VALIDATION:  Must be numeric.

Must be the computed sum of all BATCH RECORD COUNT fields (YA0-09.0) within this file.

FORM LOCATION:  N/A

REMARKS:  This field does not include any count of the AA0 or the ZA0 records.

MEDICAID NOTES:  This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
RECORD NAME: FILE TRAILER RECORD

RECORD/FIELD: ZA0-07.0

DATA ELEMENT: File Claim Count

FIELD | COBOL PICTURE | JUSTIFY | INITIAL | FROM | THRU | REQ
------|---------------|---------|---------|------|------|-----
07.0  | 9(07)         | RIGHT   | ZEROS   | 59   | 65   | R

DEFINITION: The number of claims included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH CLAIM COUNT fields (YA0-10.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.
**DATA ELEMENT:** Batch Count

<table>
<thead>
<tr>
<th>FIELD</th>
<th>COBOL PICTURE</th>
<th>JUSTIFY</th>
<th>INITIAL</th>
<th>FROM</th>
<th>THRU</th>
<th>REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.0</td>
<td>9(04)</td>
<td>RIGHT</td>
<td>ZEROS</td>
<td>66</td>
<td>69</td>
<td>R</td>
</tr>
</tbody>
</table>

**DEFINITION:** The number of batches included within this file.

**CODE VALUES:** N/A

**VALIDATION:**
- Must be entered.
- Must be numeric.
- Must be the computed sum of all Record Type YA0's within this file.

**MEDICAID NOTES:**
- This field is required for the Medicaid payment system.
- For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.
- For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.
RECORD NAME: FILE TRAILER RECORD

RECORD/FIELD: ZA0-09.0

DATA ELEMENT: File Total Charges

FIELD COBOL PICTURE JUSTIFY INITIAL FROM THRU `REQ
-------- ------------------ ----------- ----------- ----------- -----
09.0    9(09)V99      RIGHT ZEROS  70      80      R

DEFINITION: The sum of all total charges from each batch contained within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all BATCH TOTAL CHARGES fields (YA0-11.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission. This amount must equal the total claim amount on the Letter of Certification/Batch Recap Form (ODJFS06312).

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ZA0.09