

**Ohio Companion Guide  
837 Encounter Professional Claims**

**Version 1.9  
January 6, 2011**

**Document Information**

<b>Document Title:</b>	<b>837P Encounter</b>
<b>Document ID:</b>	<b>837P ENCT</b>
<b>Version:</b>	<b>1.9</b>
<b>Owner:</b>	<b>Ohio MITS Team</b>
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**Amendment History**

<b>Document Version Number</b>	<b>Submission Date</b>	<b>Modified By</b>	<b>Modifications</b>
1.0	10/1/08	Tina Adkins	Initial Version
1.1	10/28/08 – 10/30/08	Tina Adkins	Changes made based on workgroup sessions.
1.2	11/20/08	Tina Adkins	Changes made based on Deliverable Review Questions
1.3	11/26/08	Tina Adkins, Joyce Bowen, Ken Dason	Changes made based on Deliverable Review Questions
1.4	4/14/09	Tina Adkins	Changes made based on MCP feed back and Deliverable review.
1.5	4/21/09	Tina Adkins	Changes made based on Deliverable Review.
1.6	4/27/09	Tina Adkins	Changes made based on Deliverable Review.
1.7	9/20/10	Ken Dason	Changes made to 2000B-SBR based on QC defect 5228.
1.8	9/28/10	Ken Dason	Changes made to 2320-SBR and 2400-SVC based on QC defect 5470.
1.9	10/18/10	Ken Dason	Changes made to 2320-SBR based on QC defect 6028.

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## Disclosure Statement

The information contained in this guide is meant to provide assistance to providers regarding the electronic submission of health information to the Ohio Department of Job and Family Services (ODJFS). The sole purpose of this document is to provide guidance to entities who wish to become a Trading Partner. Every effort has been made to assure the information in this guide conforms to current requirements of the law. Each Medicaid provider and Trading Partner has the ultimate responsibility to follow federal and state laws, including the [Ohio Administrative Code](#). All users of this guide are advised to review these legal requirements with their legal counsel.

## Preface

The Ohio Electronic Data Interchange (EDI) Companion Guides are developed and maintained by ODJFS. They are designed to be used in conjunction with the Accredited Standards Committee (ASC) X12 Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Guides dated May 2000, the Addenda adopted October 2002, and other ASC X12 acknowledgement transactions. The EDI Companion Guides are compliant with both the ASC X12 syntax and the HIPAA guides.

Each EDI Companion Guide is intended to convey information that is contained within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. The EDI Companion Guides are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the ASC X12 Implementation Guides.

The ASC X12 HIPAA 837 Professional Implementation Guide presents the basic requirements for planning and implementing an EDI-based system for the exchange of ASC X12 HIPAA compliant transactions with the Ohio Medicaid Information Technology System (MITS). In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA 837 Professional Implementation Guide and then incorporate the ODJFS specific requirements.

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## INTRODUCTION

When submitting encounters to ODJFS in an EDI format, the following services must be submitted on the 837P:

Physician services provided by individual physician practices, physician group practices, hospice organizations, and ambulatory surgery centers;

Hospice services;

Ambulatory surgery center facility services;

Clinic services provided by clinics (e.g., federally qualified health centers, rural health clinics and outpatient health facilities)

Home health services;

Private duty nursing services;

Podiatry services;

Advanced practice nurse services;

Psychology services;

Physical therapy services;

Laboratory services;

Diagnostic facility services;

Ambulance services;

Ambulette services;

Chiropractor services;

Durable medical equipment services;

Medical supply services;

Vision, optometric, optician and eyewear services.

The 837 Professional ODJFS Encounter Data Companion Guide should be used in conjunction with the ASC X12 837 Professional Guide.

## GENERAL INFORMATION

This EDI Companion Guide supplements the 837 Professional Claim Implementation Guide, Version 004010X098A1.

The objectives of this document are:

- To identify the specific information needed by the ODJFS in those instances where the ASC X12 HIPAA Implementation Guide indicates that the choice is dependent on the Payer.
- To point out preferred selections for data elements where multiple alternatives exist.

In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA Implementation Guide and then incorporate the ODJFS specific requirements.

To properly process 837 transactions, the Ohio MITS requires only ONE transaction type in each transmission file beginning with the Interchange Control Header (ISA) and ending with the Interchange Control Trailer (IEA) envelope segments. A separate file for each transaction type should be submitted (e.g. one file containing only the 837P professional data, one file containing only 837I institutional data and one file containing only 837D dental data.)

All sets of billing codes, including ICD-9 procedure codes, ICD-9 diagnosis codes, HCPCs, and CPT codes must be HIPAA-compliant and follow standard billing rules, including the number of required digits as specified by the ICD.

In the examples given in this Companion Guide, a period (“.”) denotes a blank space.

The page reference to the ASC X12 837 Professional Implementation Guide (HIPAA IG) is provided at the beginning of each Element section.

Every effort has been made to prevent errors in this document. However, if discrepancies exist between the EDI Companion Guide and the ASC X12 837 Professional Implementation Guide, the Implementation Guide is the final authority.

## Provider Information Flow

Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, insurer, primary administrator, contract holder, or claimant.

Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

Loop 2420A is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing loop level (2010AA) and this particular service line has a different Rendering Provider that what is given in the 2010AA loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.

## Data Formatting

All objects including \*.837, \*.997 files can either be wrapped or unwrapped, which means the files must contain carriage return/line feed control characters at the end of every line or the data in the files must be streamed to be processed. The method chosen must be consistent throughout the entire file.

## American National Standards Institute (ANSI) X12 Formatting

The EDI objects must strictly adhere to the structure, syntax, and semantic requirements as specified in the ASC X12 National Standard, HIPAA legislation, and as provided in the ODJFS Companion Guides.

## American Standard Code for Information Exchange Formatting

ODJFS does not accept Extended Binary Coded Decimal Interchange Code (EBCDIC) files. All data transfers are expected to be in the American Standard Code for Information Exchange (ASCII) format.

For additional information, see the EDI Trading Partner Information Guide found on the ODJFS Trading Partner web site <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>

## References

In addition to the resources available on the ODJFS Trading Partner website at <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>, there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. The links to these websites are listed below and are separated by category for easy reference.

### EDI Basics

For information about EDI software and services, see 1EDI Source, Inc.

### Government / Associations

- Center for Medicare and Medicaid Services (CMS): <http://www.cms.hhs.gov>
- Answers to Frequently Asked Questions: [https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_sid=GiSFk8jj](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=GiSFk8jj)
- Health and Human Services (HHS) Office for Civil Rights (Privacy) <http://www.hhs.gov/ocr/hipaa/>
- WEDI SNIP: Workgroup for EDI, Strategic National Implementation Process: <http://www.wedi.org/snip/>
- CMS website for NPI: <http://www.cms.hhs.gov/NationalProvIdentStand/>

**ASC X12 Standards**

- Washington Publishing Company - <http://www.wpc-edi.com/>
- Data Interchange Standards Association - <http://disa.org/>
- American National Standards Institute - <http://ansi.org/>
- Accredited Standards Committee – <http://www.x12.org>

**Ohio Department of Job and Family Services**

- ODJFS web site - <http://jfs.ohio.gov>
- Ohio Health Plans (OHP) website - <http://jfs.ohio.gov/ohp/>
- ODJFS Communication/Security Partner – <http://www.eds.com>

**EDI Support**

- Email: [MMIS-EDI-Support@jfs.ohio.gov](mailto:MMIS-EDI-Support@jfs.ohio.gov) and Phone: (614) 387-1212

**ELEMENTS**

**ISA - Interchange Control Header – Page B3 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: ISA\*00\*.....\*00\*.....\*ZZ\*7.DIGIT.ID.....\*ZZ\*MMISODJFS.....\*010801\*1452\*U\*00401\*000000001\*0\*P\*::~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
ISA01	Authorization Information Qualifier	R	2/2	ID	00	
ISA03	Security Information Qualifier	R	2/2	ID	00	
ISA05	Sender Interchange ID Qualifier	R	2/2	ID	ZZ	Mutually defined. This is the only code that ODJFS recognizes for this element.
ISA06	Interchange Sender ID	R	15/15	AN		This field should contain the 7-digit Trading Partner ID assigned to the Sender of this file. Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.
ISA07	Interchange Receiver ID Qualifier	R	2/2	ID	ZZ	Mutually defined. This is the only code that ODJFS recognizes for this element.
ISA08	Interchange Receiver ID	R	15/15	AN	MMISODJFS	This field should contain the value MMISODJFS assigned to the Receiver of this file (Ohio Department of Job and Family Services). Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.
ISA14	Acknowledgment Requested	R	1/1	ID	0 1	No Acknowledgment Requested Interchange Acknowledgment Requested
ISA15	Usage Indicator	R	1/1	ID	P T	Production Test

**GS – Functional Group Header – Page B8 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: GS\*HC\*MEDICAID ID\*MMISODJFS\*20080708\*0802\*1\*X\*004010X098A1~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
GS02	Application Sender's Code	R	2/15	AN		This field should contain the 7-digit Trading Partner ID assigned to the Sender of this file.
GS03	Application Receiver's Code	R	2/15	AN	MMISODJFS	This field should contain the value MMISODJFS assigned to the Receiver of this file.

**ST – Transaction Set Header – Page 61 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: ST\*837\*987654~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
ST01	Transaction Set Identifier Code	R	3/3	ID	837	The only valid value within this transaction set for ST01 is 837
ST02	Transaction Set Control Number	R	4/9	AN		The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.

**BHT – Beginning of Hierarchical Transaction – Page 62 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: None

Example: BHT\*0019\*00\*0123\*19970618\*0932\*RP~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
BHT02	Transaction Set Purpose Code	R	2/2	ID	00	Original
BHT06	Transaction Type Code	R	2/2	ID	RP	Reporting

**NM1 – Submitter Name – Page 66 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 1000A

Example: NM1\*41\*2\*CRAMMER, DOLE, PALMER, AND JOHANSON|\*\*\*\*\*46\*1234567~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	41	Submitter – Entity transmitting transaction set.
NM109	Identification Code	R	2/80	AN		This is the seven-digit number ODJFS assigned to the Medicaid Trading Partner. Medicaid numbers assigned to identify healthcare providers (e.g. Physicians) are not valid. Medicaid Trading Partners with a test status may only submit test EDI transactions. Medicaid Trading Partners with an active status may submit business transactions to ODJFS. A Medicaid Trading Partner is given an active status when they have passed the testing phase and have met all of the criteria specified by ODJFS.

**NM1 – Receiver Name – Page 72 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 1000B

Example: NM1\*40\*2\*OH DEPT OF JOB AND FAMILY SERVICES\*\*\*\*\*46\* MMISODJFS ~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	40	Receiver – Entity to accept transmission.
NM102	Entity Type Code	R	1/1	ID	2	Non-Person Entity
NM109	Identification Code	R	2/80	AN	MMISODJFS	Receiver ID for ODJFS = MMISODJFS

**NM1 – Billing Provider Name – Page 81 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010AA

Example: NM1\*85\*2\*CRAMMER, DOLE, PALMER, AND JOHNSON\*\*\*\*\*24\*111223333~

**NOTES: The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.**

**For group professional practices which are submitted as the billing provider, the individual rendering provider should be submitted in the 2310B loop.**

**The NPI for the following providers must be included in this segment: clinics, Hospice, Home Health Agencies, Ambulatory Surgery Centers, Federally Qualified Health Centers (FQHC's), Rural Health Clinics (RHC's), Individual Practitioners in solo (non-group) practice, professional Group practices, ambulance, pharmacies, durable medical equipment, medical supply (DME) providers, laboratories, Diagnostic facilities and Vision and eyewear providers.**

**The National Provider Identifier (NPI) is mandated to be used on electronic claims on or after May 23, 2008. Employer's Identification Number (EIN) and Social Security Number (SSN) must be submitted for Atypical providers without NPIs. If there is not a legacy Medicaid provider number associated with the NPI/EIN/SSN information submitted on the encounter, the Managed Care Plan (MCP) will receive an informational error.**

**An encounter that contains an NPI that does not pass check digit validation WILL REJECT.**

**For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**Atypical providers without NPIs should send a 24 qualifier in the NM108 with the Employer's Identification Number in the NM109 or a 34 qualifier in the NM108 with the Social Security Number in the NM109.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	85	Billing Provider
NM102	Entity Type Qualifier	R	1/1	ID	1	Person
					2	Non-Person Entity

NM108	Identification Code Qualifier	R	1/2	ID	24 34 XX	Employer's Identification Number Social Security Number Health Care Financing Administration National Provider Identifier
NM109	Identification Code	R	2/80	AN		<p>For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop.</p> <p>Atypical providers without NPIs should send a 24 qualifier in the NM108 with the Employer's Identification Number in the NM109 or a 34 qualifier in the NM108 with the Social Security Number in the NM109.</p> <p>An encounter that contains an NPI that does not pass check digit validation WILL REJECT</p>

**REF – Billing Provider Secondary Identification – Page 87 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 20

Loop ID: 2010AA

Example: REF\*SY\*123456789~

**NOTE: The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**Atypical providers without NPI should send their EIN or SSN in the NM1 segment.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	EI SY	Employer’s Identification Number Social Security Number
REF02	Reference Identification	R	1/30	AN		For Typical providers or Atypical providers with NPIs, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code. Atypical providers without NPIs should send their EIN or SSN in the NM1 segment.

**HL - Subscriber Hierarchical Level – Page 103 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2000B

Example: HL\*2\*1\*22\*0~

**NOTE: For Ohio Medicaid, the “insured”, “subscriber” and the ”patient” are always the same person.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
HL03	Hierarchical Level Code	R	1/2	ID	22	Subscriber - Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits
HL04	Hierarchical Child Code	R	1/1	ID	0	No Subordinate HL in This Hierarchical Structure

**SBR – Subscriber Information – Page 105 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2000B

Example: SBR\*S\*18\*GRP01020102\*\*\*\*\*MC~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	S	Secondary
					T	Tertiary
SBR02	Individual Relationship Code	R	2/2	ID	18	Self Required for Medicaid, the subscriber is always the same person as the patient.
SBR09	Claim Filing Indicator Code	S	1/2	ID	MC	Since Medicaid is the destination payer "MC" must be submitted.

**NM1 – Subscriber Name – Page 112 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010BA

Example: NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*123456789123~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	IL	Insured or Subscriber
NM108	Identification Code Qualifier	R	1/2	ID	MI	Member Identification Number
NM109	Identification Code	R	2/80	AN		12-digit Medicaid recipient billing number.

**NM1 – Payer Name – Page 124 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010BB

Example: NM1\*PR\*2\*OH DEPT OF JOB AND FAMILY SERV\*\*\*\*\*PI\*MMISODJFS~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	PR	Payer
NM109	Payer Identifier	R	2/80	AN	MMISODJFS	

**CLM – Claim Information – Page 160 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2300

Example: CLM\*A37YH556\*500\*\*\*11::1\*Y\*A\*Y\*Y\*C~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CLM01	Claim Submitter's Identifier	R	1/38	AN		This field should contain the MCP generated Transaction Control Number (TCN)
CLM02	Total Claim Charge Amount	R	1/18	R		Total claim charges must be equal to the sum of all line item charges. For Third Party Liability (TPL) claims total charges must balance.
CLM05-3	Claim Frequency Type Code	R	1/1	ID	1 7 8	Original - Admit thru Discharge Claim Replacement – Replacement of prior claim Void – Void/cancel of prior claim.

**DTP – Date, Last Menstrual Period – Page 182 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*484\*D8\*19970607~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	484	Last Menstrual Period
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges

**CN1 – Contract Information – Page 202 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2300

Example: CN1\*02\*550~

**NOTE: MCP payment arrangement at the claim level.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CN101	Contract Type code	R	2/2	ID	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
CN102	Monetary Amount	O	1/18	R		
CN103	Percent	O	1/6	R		Allowance or charge percent
CN104	Reference Identification	O	1/30	AN		
CN105	Terms Discount Percent	O	1/6	R		
CN106	Version Identifier	O	1/30	AN		

**AMT – Patient Amount Paid – Page 205 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 40

Loop ID: 2300

Example: AMT\*F5\*20~

**NOTE: Patient Co-Pay Amount.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	F5	Patient Co-Pay Amount

**REF – Original Reference Number (ICN/DCN) – Page 216 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 30

Loop ID: 2300

Example: REF\*F8\*1234567891234~

**NOTE: Use this REF segment when submitting a reversal/correction to the original claim. The value is the unique 13-digit InterChange control number (ICN) assigned to the original claim. The format of this 13-digit ICN should not include any spaces or hyphens.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	F8	Original Reference Number
REF02	Reference Identification	R	1/30	AN		The value is the unique 13-digit ICN assigned to the original claim. The format of this 13-digit ICN should not include any spaces or hyphens.

**NM1 – Referring Provider Name – Page 271 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310A

Example: NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*XX\*4443332222~

**NOTE: The 2310A Referring Provider loop should be submitted on all encounters except in situations in which there is not a specific referring provider with an NPI.**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Atypical providers without NPIs should not be sent in this segment.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	DN	Referring Provider
NM108	Identification Code Qualifier	R	1/2	ID	XX	Health Care Financing Administration National Provider Identifier
NM109	Identification Code	R	2/80	AN		For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109.  An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

**NM1 - Rendering Provider Name – Page 278 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310B

Example: NM1\*82\*1\*BEATTY\*GARY\*C\*\*SR\*XX\*4443332222~

**NOTE: The 2310B Rendering Provider loop should be submitted on all encounters except in situations in which there is not a specific rendering provider with an NPI.**

The National Provider Identifier (NPI) is mandated to be used on electronic claims on or after May 23, 2008. Employer’s Identification Number (EIN) and Social Security (SSN) must be submitted for Atypical providers without NPIs. If there is not a legacy Medicaid provider number associated with the NPI/EIN/SSN information submitted on the encounter, the Managed Care Plan (MCP) will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers without NPIs should send the 24 qualifier in the NM108 with the Employer’s Identification number in the NM109 or a 34 qualifier in the NM108 with the Social Security Number in the NM109.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	82	Rendering Provider
NM108	Identification Code Qualifier	R	1/2	ID	XX	Health Care Financing Administration National Provider Identifier
					24	Employer’s Identification Number
					34	Social Security Number
NM109	Identification Code	R	2/80	AN		For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers should send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

						<p>Atypical providers without NPIs should send the 24 qualifier in the NM108 with the Employer's Identification number in the NM109 or a 34 qualifier in the NM108 with the Social Security Number in the NM109.</p> <p>An encounter that contains an NPI that does not pass check digit validation WILL REJECT.</p>
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**PRV – Rendering Provider Specialty Information – Page 281 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310A

Example: PRV\*PE\*ZZ\*203BA0200N~

**NOTE: ODJFS does not require provider taxonomy codes.**

**SBR – Other Subscriber Information – Page 303 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2320

Example: SBR\*P\*18\*1234567\*\*HM\*\*\*\*HM~

**NOTE: This is required for the first occurrence and subsequent occurrences when there is other payer information.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	P  S T	<b>The first occurrence must contain information for the MCP as the primary/secondary payer.</b> If the primary payer is a third party, the second occurrence of this segment should contain a P and information related to the relevant third party payer.  Secondary Tertiary
SBR02	Individual Relationship Code	R	2/2	ID	18	18 – This is the only option for Professional Encounter claims for the first occurrence. Subsequent occurrences should be billed as appropriate. <b>Refer to the Implementation Guide for the other codes/values to use.</b>
SBR03	Reference Identification	O	1/30	AN		For the first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP. Subsequent occurrences may contain COB payer information (e.g. National Association of Insurance Commissioners [NAIC]).
SBR05	Insurance Type Code	O	1/3	ID	HM	Health Maintenance Organization (HMO) – This is only for the first occurrence. On subsequent occurrences fill out as appropriate.
SBR09	Claim Filing Indicator Code	O	1/2	ID	HM	Health Maintenance Organization (HMO) – This is only for the first occurrence. On subsequent occurrences fill out as appropriate.

**AMT – Coordination of Benefits (COB) Payer Paid Amount – Page 317 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 15

Loop ID: 2320

Example: AMT\*D\*152~

**NOTE: This is required for the first occurrence of the 2320 loop and should contain the MCP paid amount at the claim level.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	D	Payer paid amount.
AMT02	Monetary Amount	R	1/18	R		For the first occurrence, this element will always contain the amount that the MCP paid on the claim. Zero "0" is an acceptable value for this element. For capitated claims the value must be zero "0". Where applicable, in subsequent occurrences, this element will contain the amount paid by the other payer.

**NM1 – Other Payer Name – Page 343 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2330B

Example: NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*1234567~

**NOTE: This is required for the first occurrence on all Encounter claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	PR	Payer
NM108	Identification Code Qualifier	R	1/2	ID	PI	Payer Identification
NM109	Identification Code	R	2/80	AN		The NM109 must match the information in SVD01. For the first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP. Subsequent occurrences may contain COB payer information (e.g. National Association of Insurance Commissioners [NAIC]).

**DTP – Claim Adjudication Date – Page 349 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 2

Loop ID: 2330B

Example: DTP\*573\*D8\*19970607~

**NOTE: This is required for the first occurrence on all Encounter claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	573	Date claim was paid by the MCP.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

**SV1 – Professional Service – Page 383 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2400

Example: SV1\*HC:99211:25\*12.25\*UN\*1\*11\*\*1:2:3\*\*N \*Y\*Y ~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SV111	Yes/No Condition or Response Code	S	1/1	ID		Required if Medicaid services are the result of a screening referral. Must be completed for all referrals made under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
SV112	Yes/No Condition or Response Code	S	1/1	ID	Y N	Must be completed on all family planning related procedures.

**DTP – Date – Service Date – Page 416 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 15

Loop ID: 2400

Example: DTP\*472\*D8\*19970607~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	472	Service
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	For Ohio Medicaid only D8 is valid. Medicaid does not allow date ranges. Procedures must be itemized separately for each date of service. D8 Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

**CN1 – Contract Information – Page 444 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2400

Example: CN1\*04\*550~

**NOTE: MCP payment arrangement at the line level.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CN101	Contract Type code	R	2/2	ID	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
CN102	Monetary Amount	O	1/18	R		
CN103	Percent	O	1/6	R		Allowance or charge percent
CN104	Reference Identification	O	1/30	AN		
CN105	Terms Discount Percent	O	1/6	R		
CN106	Version Identifier	O	1/30	AN		

**NM1 - Rendering Provider Name – Page 488 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2420A

Example: NM1\*82\*1\*BEATTY\*GARY\*C\*\*SR\*XX\*4443332222~

**NOTE: The 2420A Rendering Provider loop should be submitted on all encounters except in situations in which there is not a specific rendering provider with an NPI.**

**The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109.**

**If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.**

**An encounter that contains an NPI that does not pass check digit validation WILL REJECT.**

**Atypical providers without NPIs should not be sent in this segment.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	82	Rendering Provider
NM108	Identification Code Qualifier	R	1/2	ID	XX	Health Care Financing Administration National Provider Identifier
NM109	Identification Code	R	2/80	AN		For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

**NM1 – Referring Provider Name – Page 524 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2420F

Example: NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*XX\*4443332222~

**NOTE: The 2420F Referring Provider loop should be submitted on all encounters except in situations in which there is not a specific referring provider with an NPI.**

**The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109.**

**If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.**

**An encounter that contains an NPI that does not pass check digit validation WILL REJECT.**

**Atypical providers without NPIs should not be sent in this segment.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	DN	Referring Provider
NM108	Identification Code Qualifier	R	1/2	ID	XX	Health Care Financing Administration National Provider Identifier
NM109	Identification Code	R	2/80	AN		For Typical providers or Atypical providers with NPI, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109.

**SVD – Line Adjudication Information – Page 536 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2430

Example: SVD\*1234567\*55\*HC:84550\*\*3~

**NOTE: This is required for the first occurrence of the 2320 loop and should contain the MCP paid amount of the line level.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SVD01	Identification Code	M	2/80	AN		This number should match NM109 in Loop ID-2330B identifying Other Payer For the first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP. Subsequent occurrences may contain COB payer information (e.g. NAIC).
SVD02	Monetary Amount	M	1/18	R		This is required for the first occurrence this should be the MCP line level amount paid. Zero '0' is an acceptable value for this element. For capitated line items, the value must be '0'. Subsequent occurrences may contain COB payment amounts.

**DTP – Line Adjudication Date – Page 548 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 9

Loop ID: 2430

Example: DTP\*573\*D8\*19970607~

**NOTE: This is required for the first occurrence on all Encounter claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	573	Date claim was paid by the Managed Care Plan.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		