COMMUNITY FIRST
HEALTH PLANS

837P Professional Health Care Claim

This material is for informational purposes only. It describes certain aspects and expectations regarding the 837P Professional Health Care Claim transactions. Community First Health Plans does not intend for this to be a complete guide. The details contained in this document are supplemental and should be used in conjunction with the *ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3)* as published by the Washington Publishing Company.

X12 and HIPAA-Compliance Checking and Business Edits
Electronic data interchanges (EDIs) submitted to Community First Health Plans for processing, pass through compliance edits. 5010 acknowledgments and reports for accepted/rejected files will be placed in the submitter's trading partner mailbox for pickup.

- Community First returns a *999 Interchange Acknowledgment* to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12-compliant. If the X12 syntax or any other aspect of the 837 is not X12-compliant, the 999 will also report Level One errors in the AK segments and indicate that the entire transaction set was rejected.
- Level Two: Community First applies appropriate business edits to ensure that the necessary information is populated for efficient processing. When encountering HIPAA-compliance code set or business errors (including balancing), Community First returns the following:
  – *277 Claims Acknowledgment (CA)*

HIPAA-Compliant Codes:
Use HIPAA-compliant codes from current versions of the following source documents:
- Physician's Current Procedural Terminology (CPT codes) CPCS
- ICD-10-CM Diseases
- Provider Taxonomy Codes
- National Drug Code (NDC specific billing requirements)
  https://www.cfhp.com/provider-notice-ndc-billing-guidelines

Diagnosis Codes:
According to the *837P TR3*, a transaction is not X12-compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, Community First will return a *277CA* to the submitter indicating that the transaction was rejected. Additionally, duplicate diagnosis codes are not acceptable and will be rejected.

Procedure Codes and Modifiers:
All **valid** CPTs, HCPCS codes, and modifiers are accepted for claim adjudication. When submitting a claim using a modifier, it must be in the primary position or your entire claim will be rejected. If submitted codes are invalid, a *277CA Status Report* will be returned to the submitter identifying the failed claim(s).

Uppercase Letters, Special Characters, and Delimiters:
As specified in the TR3, the basic character set includes uppercase letters, digits, spaces, and other special characters:

- All alpha characters must be submitted in **uppercase** letters only.
- Suggested delimiters for the transaction are assigned as part of the trading partner set up.

An EDI representative will discuss options with trading partners if applicable:

- Data element separator — asterisk (*)
- Repetition separator (ISA11) — caret (^)
- Sub-element separator — colon (:)
- Segment terminator — tilde (~)

- To avoid syntax errors; hyphens, parentheses and spaces are not recommended for use in values for identifiers:
  - Example: recommended ZIP code 123456789 or medical record # 1234567
- Because originally submitted values may be returned on outbound transactions, Community First encourages trading partners **not** to use the following special characters as part of the value:
  - Asterisk (*)
  - Less than/greater than signs (<, >)
  - Colon (:)
  - Slash (/)

  This minimizes the risk for a special character to be recognized as a delimiter.
  - Example**:** Provider assigns a patient control number as 12*3456789. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value 12*3456789 may incorrectly be identified as two separate data element values (12 and 3456789).

Decimal R Data Element Type:
R data element types contain a decimal point — involving monetary amounts, units, visits, weights, and frequency.

Numeric Values, Monetary Amounts and Units:

- Community First pays all claims in U.S. dollars and therefore accepts monetary amounts in U.S. dollars **only**. If codes related to foreign currencies are used, then a *277CA* will be returned to the submitter identifying the rejected claim(s).
- Community First recognizes billed units in whole numbers only.
- Community First recognizes units in values of less than 9999 and greater than or equal to 0.
- If a negative service line charge (SV102) or negative units are used, then a *277CA* will be returned to the submitter identifying the failed claim(s).

Address Information:

- Post office mailboxes/lockboxes are **not** allowed in the Billing Provider loop. If submitted in the Billing Provider loop, a *277CA* will be returned to the submitter identifying the rejected claim(s).
- The Pay-To Address loop does support post office box/lockbox addresses. Therefore, if payment is expected to be remitted to a post office box/lockbox, submit the post office box/lockbox address.
- Full nine-digit ZIP codes are **required** in the Billing Provider and Service Facility Location loops. If five-digit ZIP codes are used in these loops, a *277CA* will be returned to the submitter identifying the rejected claim(s).

Taxonomy Codes (PRV):
The Health Care Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization assigning a code to each grouping.
The taxonomy consists of two parts: individuals (e.g., physicians) and nonindividuals (e.g.,

ambulatory health care facilities). All codes are 10 alphanumeric positions in length. Health care providers select the taxonomy code(s) that most closely represent(s) their education, license or certification. If a health care provider has more than one taxonomy code associated with him or her, a health plan **may** prefer the health care provider to use one over another when submitting claims for certain services.

Community First **requires** the taxonomy be populated in PRV segments for **all** applicable claims that are filed. Claims submitted **without** a billing or rendering taxonomy will be **rejected**. Refer to the CMS website for a listing of codes: www.wpc-edi.com/reference.

NPI Requirements:
The NPI final rule, *Federal Register 45, Code of Federal Regulations (CFR) Part 162*, established the NPI as the standard unique identifier for health care providers and requires covered health care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the NPPES. Providers can access the following website for more information on how to obtain an NPI: https://nppes.cms.hhs.gov. An NPI must be obtained before a provider can enroll as a Texas Medicaid provider. An NPI will be assigned to a health care provider who needs to submit claims or conduct other transactions specified by HIPAA.

A "health care provider" is defined as an individual, group or organization that provides medical or other health services or supplies. This includes:

- Physicians and other practitioners
- Physician/practitioner groups
- Institutions such as hospitals
- Laboratories
- Nursing homes
- Dental providers
- Suppliers such as pharmacies and medical supply companies
- Any health care provider who transmits any health information in electronic form in connection with a standard transaction.

Exception: Health industry workers, such as admissions and billing personnel, housekeeping staff, and orderlies who support the provision of health care are not eligible to obtain NPIs.

Medicaid NPI Provider Eligibility:
To be eligible for Texas Medicaid reimbursement, a provider of health care services (including an out of-state provider) must:

- Meet all applicable Texas Medicaid eligibility criteria.
- Be approved by the Texas Health and Human Services Commission (HHSC) for enrollment.
- Obtain a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES).
- File with the Texas Medicaid & Healthcare Partnership (TMHP) the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.
- Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General (OIG) in connection with the processing of the application.
- Be approved by HHSC for enrollment and entered into a written provider agreement with HHSC. Providers can use the online provider enrollment on the portal (PEP) tool to enroll. electronically through the TMHP website at www.tmhp.com.

After receipt of all information necessary to process the application, the entire process can typically take up to 60 days. The time period may be extended in special circumstances including requests for exceptions to the enrollment process, risk category, and provider types that require additional state approval.

All providers must be enrolled in Texas Medicaid before enrollment can be approved for any other service or program, including, but not limited to, Medicaid managed care. Community First validates all NPI's and taxonomy claim submissions against the State Master File. Failure to enroll appropriately can result in claim rejections.

Certain provider types are required to enroll in Medicare as a prerequisite for enrolling in Texas Medicaid. During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never serve Medicare-eligible individuals (e.g., pediatrics, obstetrician/gynecologist [OB/ GYN]).

Providers must maintain a valid, current license or certification to be entitled to Texas Medicaid reimbursement. Providers cannot enroll in Texas Medicaid if their license or certification is due to expire within 30 days of application. A current license or certification must be submitted, if applicable.

Ordering or Referring–Only Providers

Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order or refer for supplies or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers. This requirement is in accordance with provisions of the *Affordable Care Act of 2010 (ACA), 42 CFR §455.410(b)*, which requires all fee-for-service (FFS) and managed care network ordering or referring physicians or other professionals who order or refer for supplies or services under the Medicaid State plan, or under a waiver of the plan, to enroll in Medicaid as participating providers.

Providers who are out of network for Medicaid managed care organizations (MCOs) do not need to enroll as ordering or referring-only providers. The enrollment requirement includes providers who order or refer for supplies or services for dually eligible clients (i.e., clients who are enrolled in both Medicare and Medicaid), as the client's claims would be considered Medicaid claims.

These providers can enroll online using the PEP tool by clicking the check box for "Ordering/ Referring Provider", or they can use the streamlined paper "Texas Medicaid Provider Enrollment Application Ordering and Referring Providers Only", which is available for download on the TMHP website: www.tmhp.com.

Claim submissions are **required** with 95 days from the date of service and can be submitted in various ways. Below are clearinghouses Community First currently receives *837* data from.

Payer Name	Electronic Clearinghouse	Payer ID	Supported Transactions
COMMFIRST	Availity LLC	COMMF	837P/837I
CFHP	ClaimsMD	CFHP	837P/837I
Community First	Claim Logic	COMMF	837P/837I

837P (Professional) Electronic Data Interchange (EDI) Requirements

837P (Professional) is the standard format used by health care professionals and suppliers to transmit health care claims electronically. The following formats were established as guidelines for Community First Additional State Edits and can be found on the States Companion Guide.

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV01	Provider Code	BI	For correct identification *BI* should be used.
2000A	PRV02	Reference Identification Qualifier	PXC	For correct identification *PXC* should be used.
2000A	PRV03	Provider Identification (Provider Taxonomy Code)		Community First requires that the Billing Taxonomy code be sent. The Billing Taxonomy should be a valid one that is assigned to the Provider. Taxonomy sent will be validated.
2010AA – Billing Provider Name				
2010AA	NM101	Entity Identifier Code	85	For correct identification of the Billing Provider, *85* should be used.
2010AA	NM108	Identification Code Qualifier	XX	For correct identification, the qualifier must be *XX*.
2010AA	NM109	Identification Code		Community First requires that the Billing NPI be sent. The Billing NPI should be a valid one assigned to Provider. Must contain the 10 numeric value. Community First will validate the NPI.
N3 – Billing Provider Address				
2010AA	N301	Billing Provider Address Line		Community First requires that a physical street address be sent.
N4 – Billing Provider City, State, Zip Code				
2010AA	N401	City Name		Must contain the city name.
2010AA	N402	State Code		Must contain two alphanumeric state code.
2010AA	N403	Postal Code		Must contain the nine digit zip code. (No separators should be used)
REF - Billing Provider Tax Identification				
2010AA	REF01	Identification Code Qualifier	EI, SY	At least one REF segment is required.
2010AA	REF02	Billing Provider Tax Identification Number		Community First requires that a Tax ID or Social Security Number be sent. (No separators should be used)
Payer Name				
NM1 Pay-To Address Name				
2010AB	NM101	Entity Identifier Code	87	For correct identification of the Pay-To Provider, *87* should be used.
N3 - Pay-To Provider Address				
2010AB	N301	Pay-To Address Line		Must contain the address.

Loop ID	Reference	Name	Codes	Notes/Comments
N4 - Pay-To Provider City, State, Zip Code				
2010AB	N401	City Name		Must contain the city name.
2010AB	N402	State Code		Must contain two alphanumeric state code.
2010AB	N403	Postal Code		Must contain the nine digit zip code. (No separators should be used)
Subscriber Detail (Required) **This segment is used to record information specific to the primary insured and the insurance carrier for the insured.** **Note:** As an assumption for Medicaid, if the Subscriber is the same individual as the Patient, the Patient Loop (2000C) is not to be populated per HIPAA compliance				
SBR - Subscriber Information (Required)				
2000B	SBR03	Reference Identification See List		Benefit codes are required if the service performed is part of the program (Subscriber Group or Policy Number). **Note:** Providers who are providing specific benefit services that require an additional attestation (THSteps, ECI, Family Planning, CCP program, etc.) must be attested to that program and use the three digit benefit code on their claim and on file with TX Medicaid. Providers who submit erroneous information will have their claims rejected. • CCP: Comprehensive Care Program (CCP) • CSN: Children with Special Health Care Needs (CSHCN) Services Program Provider • EC1: Early Childhood Intervention (ECI) Provider • EP1: THSteps Medical Provider • FP3: Family Planning • HA1: Hearing Aid • IM1: Immunization • MA1: Maternity • TB1: Tuberculosis (TB) Clinic
NM1 - Subscriber Name				
2010BA	NM108	Identification Code Qualifier	MI	For correct identification of the Subscriber, *MI* should be used.
2010BA	NM109	Identification Code		Community First requires that the Texas Medicaid ID be sent for government members. The member/patient policy number as indicated on the ID card. Community First member/patient policy numbers are nine digits in length. All Community First members are subscribers. Subscriber: 111111111 (9N)
N3 - Subscriber Address (Required)				
2010BA	N301	Subscriber Address		Community First requires the subscriber's address.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	N302	Subscriber Address 2		Subscriber address 2
N4 - Subscriber City, State, Zip Code (Required)				
2010BA	N401	Subscriber City		Must contain the city name.
2010BA	N402	Subscriber State Code		Must contain two alphanumeric state code.
2010BA	N403	Subscriber Postal Code		Must contain at least the five digit zip code. (No separators should be used.)
DMG - Subscriber Demographic (Required)				
2010BA	DMG01	Date Qualifier	D8	Date of birth expressed as CCYYMMDD
2010BA	DMG02	Date Time Period		Subscriber date of birth as CCYYMMDD
2010BA	DMG03	Gender Code		Subscriber Gender (F, M, U)
REF - Subscriber Secondary Identification				
2010BA	REF01	Reference Identification Qualifier	SY	Community First requests the Subscriber Supplemental Identifier (SSN) if available. This is not a required field.
2010BA	REF02	Reference Identification		Subscriber Supplemental Identifier (nine digits, no separators should be used).
Payer Name				
NM1 - Payer Name				
2010BB	NM108	Identification Code Qualifier	PI	Payer Identification
2010BB	NM109	Identification Code		Payer Identifier
N3 - Payer Address				
2010BB	N301	Payer Address		Must contain the address.
2010BB	N302	Payer Address 2		Must contain the address 2.
N4 - Payer City, State, Zip Code				
2010BB	N401	Payer City		Must contain the city name.
2010BB	N402	Payer State Code		Must contain two alphanumeric state code.
2010BB	N403	Payer Zip Code		Must contain the five digit zip code. (No separators should be used.)
REF - Payer Secondary Identifier				
2010BB	REF01	Reference Identification Number	G2	REF01 must contain G2 (Provider Commercial Number) when the API (Atypical Provider Identifier) is sent in REF02.
2010BB	REF02	Reference Identification		If an API (Atypical Provider Identifier) is sent, REF02 must contain the API (Atypical Provider Identifier).
Claim Information Claim Detail (Required)				
2300	CLM01	Claims Submitter's Identifier		Community First requires Patient Control Number. Only the first 17 bytes will be used.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM05-01	Facility Code Value		Community First requires the Place of Service Code. For appropriate values, please refer to the Texas Medicaid Provider Procedures Manual which can be found at TMHP.com or the National Uniform Billing Committee (NUBC) website: www.nubc.org
2300	CLM05-03	Claim Frequency Type Code		Claim Frequency Values are seen as noted below: 1 – Original claim 2 & 3 – Interim claim 4 – Final interim claim 5 – Late claim 7 – Replacement or corrected claim. The information present on this bill represents a complete replacement of the previously issued bill. 8 – Voided/canceled claim
2300	CLM07	Medicare Assignment Code	A	Community First requests *A*. Other values or missing values may result in denial of claim.
2300	CLM10	Patient Signature Source Code	P	The Patient Signature Source Code (CLM10) is required when Release of Information Code (CLM09) does not equal N.
DTP - Admission Date				
2300	DTP01	Date Qualifier	435	Admission Date
2300	DTP02	Date Time Period Format Qualifier		Date expressed as CCYYMMDD
2300	DTP03	Date Time Period		The Related Hospital Admission Date is required for the following: - All inpatient services - When the place of service in 2300 CLM05-1 = 21, 31, 51, 52, or 61 - All ambulance claims when the patient is known to be admitted to the hospital Admission date must not be after the condition date.
DTP - Discharge Date				
2300	DTP01	Date Qualifier	435	Discharge Date
2300	DTP02	Date Time Period Format Qualifier		Date expressed as CCYYMMDD
2300	DTP03	Date Time Period		The Related Hospital Discharge Date is a required segment when CLM05 -1 = 21,31,51,52, or 61 and DTP has admission date.
PWK - Claim Supplemental Information				
2300	PWK05	Identification Code Qualifier	AC	Attachment control number.
2300	PWK06	Identification Code		Only the first 17 bytes will be used.
AMT - Patient Amount Paid				

Loop ID	Reference	Name	Codes	Notes/Comments
2300	AMT01	Amount Qualifier Code	F5	Patient Amount Paid
2300	AMT02	Monetary Amount		The patient paid amount cannot be negative. Max length is 18 bytes. Nine bytes will be used by Community First at this time.
REF - Referral Number *Unique segment from Prior Authorization Number				
2300	REF01	Reference Identification Number	9F	Referral Number
2300	REF02	Reference Identification		The referring/ordering provider will be required when services require a referral. Example: Clinical or Radiological Laboratory Services.
REF - Prior Authorization Number *Unique segment from Referral Number				
2300	REF01	Reference Identification Number	G1	Prior Authorization Number
2300	REF02	Reference Identification		Community First requests the Prior Authorization number if the service requires a prior authorization.
REF - Payer Claim Control Number				
2300	REF01	Reference Identification Number	F8	Original Reference Number
2300	REF02	Reference Identification		The Payer Claim Control Number is required when the CLM05- 03 (claim frequency code) indicates this claim is a replacement or void to a previously adjudicated claim.
REF - Clinical Laboratory Improvement Amendment (CLIA) Number				
2300	REF01	Reference Identification Qualifier	X4	Clinical Laboratory Improvement Amendment (CLIA) Number
2300	REF02	Reference Identification		Community First requests the CLIA number if required. CLIA numbers are 10 digits with the letter *D* in third position.
NTE - Claim Note				
2300	NTE01	Reference Identification Qualifier	ADD	Community First request that when sending NTE claim notes that "ADD" be used.
2300	NTE02	Reference Identification		Free Text added here with needed details.
CRC - EPSDT Referral				
2300	CRC01	Code Category	ZZ	Community First requires the EPSDT when early and periodic screening, diagnosis, and treatment are billed.
2300	CRC02	Yes/No Condition	Y, N	If no, then NU in the CRC03 indicating no referral was given.
2300	CRC03	Condition Indicator	AV, NU, S2, ST	Required when a first condition code is necessary. Use codes listed in the CRC03.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CRC04	Condition Indicator	AV, NU, S2, ST	Required when a second condition code is necessary. Use codes listed in the CRC03
2300	CRC05	Condition Indicator	AV, NU, S2, ST	Required when a third condition code is necessary. Use codes listed in the CRC03
HI - Health Care Diagnosis Code				
2300	HI01 thru HI12			Required Diagnosis codes must be coded to the highest level of specificity, (i.e., coding to the fourth or fifth digit.) There are multiple iterations of this segment, all must have valid diagnosis codes. **Mixed Diagnosis Codes with ICD9 and ICD10 are NOT permitted.** ICD9 - BK, BF ICD10 - ABK, ABF
NM1 - Referring Provider Name				
2310A	NM101	Entity Identifier Code	DN, P3	DN (Referring Provider) or P3 (Primary Care Provider) Community First requires the referring provider when there is a referral. (i.e., Clinical or Radiological Laboratory Services)
2310A	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain *XX* (NPI).
2310A	NM109	Identification Code		NM109 must contain the Referring Provider's assigned NPI. The Referring NPI should be a valid one assigned to the Provider and must contain the 10 numeric value.
REF - Rendering Provider Name *Required when the Rendering Provider NM1 information is different than that carried in the Billing Provider Loop 2010AA.				
2310B	NM101	Entity Identifier Code	82	For correct identification of the Rendering provider, *82* should be used.
2310B	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain *XX* (NPI).
2310B	NM109	Identification Code		NM109 must contain the provider's assigned NPI. The Rendering NPI should be a valid one assigned to Provider. Must contain the 10 numeric value.
REF - Rendering Provider Specialty Information				
2310B	PRV01	Provider Code	PE	For correct identification, *PE* should be used.
2310B	PRV02	Reference Identification Qualifier	PXC	Qualifier value that is sent in PRV02.
2310B	PRV03	Reference Identification		PRV03 must contain the provider's assigned taxonomy code. This is a 10 character value taxonomy code. For a list of the taxonomy codes, visit the website: www.wpc-edi.com. (See Code List: "Health Care Provider Taxonomy Code Set")

Loop ID	Reference	Name	Codes	Notes/Comments
NM1 - Service Facility Information (Required)				
2310C	NM101	Entity Identifier Code	77	For correct identification of the Service Facility, *77* should be used.
2310C	NM108	Identification Code Qualifier	XX	The value of NM108 must contain *XX* (NPI).
2310C	NM109	Identification Code		NM109 must contain the Laboratory or Facility Primary Identifier's assigned NPI. The NPI should be a valid one assigned to Provider and must contain the 10 numeric value.
N3 - Service Facility Address				
2310C	N301- N302			Required for print to paper payers.
N4 - Service Facility City, State, Zip Code				
2310C	N401- N403			Required for print to paper payers.
NM1 - Supervising Provider Name				
2310D	NM101	Entity Identifier Code	DQ	For correct identification of the Supervising Provider *DQ* should be used.
2310D	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain *XX* (NPI).
2310D	NM109	Identification Code		NM109 must contain the Supervising Provider's assigned NPI. The Supervising NPI should be a valid one assigned to Provider and must contain the 10 numeric value.
Other Subscriber Information				

Loop ID	Reference	Name	Codes	Notes/Comments
CAS - Claim Level Adjustments				
2320	CAS	Claim Adjustment	CO, CR, OA, PI, PR	Commmunity First requires that all COB information be sent and must balance. COB paid amounts of $0.00 in 2320 AMT02 indicates a paid claim and the date of the zero paid amounts should be submitted to Community First. • Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV102 (Line Item Charge). • Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments). • Loop 2400 SV102 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments). The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.
N3 - Other Subscriber Address				
2330A	N301- N302	Address Information		Only the first 30 bytes will be used from the Other Insured Address Line 1 and Line 2.
Service Line Number				
SV1 - Professional Service				
2400	SV102	Monetary Amount		The line item charge amount cannot be negative. Max length is 18 bytes. At this time, 10 bytes will be used by Community First.
NTE - Line Note				
2400	NTE02	Line Note Text		Required when procedure code used is “Not Otherwise Classified" or as directed by payer.
LIN - Drug Identification				
2410	LIN02	Product/Service ID Qualifier	N4	The value of LIN02 must be equal to N4 when the National Drug Code (NDC) is sent in LIN03.
2410	LIN03	Product/Service ID Qualifier		LIN02 must contain a valid 11 numeric NDC in the 5-4-2 format. No dashes or text that is not an NDC value should be sent.

Loop ID	Reference	Name	Codes	Notes/Comments
CTP - Drug Quantity				
2410	CTP04	Quantity		NDC drug unit quantity If milliliters are administered, then total number administered is the quantity reported "Each" or "ea" in the NDC description indicates a vial or tablet, which is a quantity of ibe, **Examples:** – 00002-1407-01, Quinidine gluconate, 10ml/vial If 10 ml were given, then NDC unit = 10 If 5 ml given, then NDC unit = 5 – 00069-0058-02, Heparin sodium, 1000 USPS/ML (10 ml/vial) If 1 ml was given, then NDC unit = 1 – 00409-1135-02, Morphine sulfate, 25 mg/ml If 25 mg were given, then NDC unit = 1
2410	CTP05-01	Unit or Basis for Measurement Code	F2, GR, ML, UN	CTP05-01 must be equal to one of the valid Units Of Measurement (UOM) for each NDC.
Detail Provider (2420A - 2420F)				
2420A through 2420F				Provider Details sent at the 2420A-2420F will **not** be used for adjudication.
Ordering Provider 2420E				
2420E	NM101	Entity Identifier Code	DK	For correct identification of the Ordering Provider, *DK* should be used.
2420E	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain *XX* (NPI).
2420E	NM109	Identification Code		NM109 must contain the Ordering Provider's assigned NPI. The Ordering NPI should be a valid one assigned to Provider and must contain the 10 numeric value.

Loop ID	Reference	Name	Codes	Notes/Comments
2430 - SVD, CAS, DTP, AMT - Service Line Adjudication, Adjustments, Adjudication Date and Amount				
2430	SVD, CAS, DTP, AMT			Community First requires that all COB information be sent and must balance. COB Paid amounts of $0.00 in 2320 AMT02 indicates a paid claim and the date of the zero paid amounts should be submitted. • Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV102 (Line Item Charge). • Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments). • Loop 2400 SV102 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments). The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.

837P Example #1

This section is used to describe the **required data sets** for claim processing. The 837P format is used for submission of Electronic Claims for health care professionals. As an assumption for these file formats, if the Subscriber is the same individual as the Patient then the Patient Loop (2000C) is not to be populated per HIPAA compliance.

In the following example, carriage return line feeds are inserted in place of ~ character for improved readability purposes.

BHT*0019*00*25270514680*20210219*1632*CH~
NM1*41*2*AVAILITY LLC*****46*030240928~
PER*IC*AVAILITY CLIENT SERVICES*TE*8002824548*FX*9044702187~
NM1*40*2*Community First Health Plan*****46*COMMFIRST~
HL*307**20*1~
PRV*BI*PXC*193200000X~
NM1*85*2*LEO MOUSE MD*****XX*1222222222~
N3*718 MOCKINGBIRD RD STE 104~
N4*SAN ANTONIO*TX*782044354~
REF*EI*100103333~
PER*IC*LEO MOUSE*TE*2102263232*FX*2102251511~
HL*308*307*22*0~
SBR*P*18*EP1******MC~
NM1*IL*1*MINNIE*MOUSE****MI*103555295~
N3*5135 DISNEY LANE~
N4*SAN ANTONIO*TX*78204~
DMG*D8*20090603*F~
NM1*PR*2*COMMUNITY FIRST MEDICAID*****PI*COMMF~
N3*12238 SILICON DRIVE*SUITE 100~
N4*SAN ANTONIO*TX*78249~
CLM*00014273XX68432*65.02***11:B:1*Y*A*Y*Y~
REF*X4*45D0499943~
REF*D9*25270514680~
CRC*ZZ*N*NU~
HI*ABK:H1033*ABF:Z6852~
NM1*DN*1*MOUSE*LEO****XX*1222222222~
NM1*82*1*MOUSE*LEO****XX*1222222222~
PRV*PE*PXC*208000000X~
LX*1~
SV1*HC:99213:::::ESTABLISHED OFFICE*65*UN*1***1:2~
DTP*472*D8*20210212~
REF*6R*334285~
LX*2~
SV1*HC:3074F:::::SYSTOLIC BP 130*.01*UN*1***1:2~
DTP*472*D8*20210212~
REF*6R*334286~
LX*3~
SV1*HC:3078F:::::DIASTOLIC BP 80*.01*UN*1***1:2~
DTP*472*D8*20210212~
REF*6R*334287~
SE*42*0010~
ST*837*0011*005010X222A1~

SAMPLE: Paper Claim with EP1 requirements

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program In Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Including Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
EP1

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ✔ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) ICD Ind.

A. Z00121 B. Z6852 C. Z713 D. Z7182
E. B354 F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 29 20	12 29 20	11		99384	SA	A	150 00	1		NPI	1528064741
												20800000X
2	12 29 20	12 29 20	11		92552		A	40 00	1		NPI	1528064741
												20800000X
3	12 29 20	12 29 20	11		99173		A	01	1		NPI	1528064741
												20800000X
4	12 29 20	12 29 20	11		G0438		A	01	1		NPI	15280264741
												20800000X
5	12 29 20	12 29 20	11		G9716		B C D	01	1		NPI	1528064741
												20800000X
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
742947261 ✔

26. PATIENT'S ACCOUNT NO.
C11006YC

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ✔ YES NO

28. TOTAL CHARGE $ 190 03

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
Y

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICKEY MOUSE PEDIATRICS
17026 DISNEYLAND DR, STE. 105
SAN ANTONIO, TX 782474700

a. 1981742575 b.

33. BILLING PROVIDER INFO & PH #
MICKEY MOUSE PEDIATRICS
17026 DISNEYLAND DR, STE. 105
SAN ANTONIO, TX 782474700

a. 1981742575 b. 193400000X EI

PLEASE PRINT OR TYPE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example #2 (Claim containing NDC segments)

HL*1303**20*1~
PRV*BI*PXC*207V00000X~
NM1*85*2* TEXAS OBGYN *****XX*1710291111~
N3*7718 WOOD PINE DR*SUITE 1~
N4*AUSTIN*TX*787221601~
REF*EI*271782222~
PER*IC* TEXAS OBGYN *TE*8443189921~
NM1*87*2~
N3*PO BOX 23~
N4*FAST*ME*04915333~
HL*1304*1303*22*0~
SBR*P*18**COMMUNITY FIRST MEDICAID HMO*****CI~
NM1*IL*1*DUCK*DAISY*S***MI*501111111~
N3*8030 WONDERLAND DR~
N4*SUNNY CITY*TX*78204~
DMG*D8*19891206*F~
REF*SY*642093993~
NM1*PR*2*COMMUNITY FIRST MEDICAID HMO*****PI*COMMF~
N3*PO BOX 853927~
N4*RICHARDSON*TX*750853927~
CLM*215447V18264*335***11:B:1*Y*A*Y*Y~
REF*D9*11477600388~
HI*ABK:00990*ABF:Z3A30*ABF:Z23~
NM1*82*1*GOOFY*DON*JR***XX*1235422222~
PRV*PE*PXC*207V00000X~
NM1*77*2* TEXAS OBGYN ~
N3*18 SLOW LANE BLVD SUITE 230~
N4*SUNNY CITY*TX*782584890~
LX*1~
SV1*HC:99214:TH:25*200*UN*1***1:2~
DTP*472*D8*20190731~
REF*6R*1060255P18264B17303~
LX*2~
SV1*HC:90715*100*UN*1***3~
DTP*472*D8*20190731~
REF*6R*1060256P18264B17303~
NTE*ADD*TDAP VACCINE 7 YRS IM~
LIN**N4*49281040010~
CTP****1*UN~
LX*3~
SV1*HC:90471*35*UN*1***3~
DTP*472*D8*20190731~
REF*6R*1060257P18264B17303~

SAMPLE: Paper Claim with NDC requirements

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program In Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Including Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **SIGNATURE ON FILE** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **SIGNATURE ON FILE**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **DN DOE, JANE W**

17a. **ZZ** **FA1801111**

17b. NPI **1111111111**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) ICD Ind.

A. **G12.9** B. **G12.0** C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER **19800771**

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N4644060058 01 SPIRANZA 12MG/5ML SDV ML 5.00											
1 **02 18 21**	**02 18 21**	**22**		**J2326**		**AB**	**127500 00**	**120**		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN **113351111** ✔

26. PATIENT'S ACCOUNT NO. **64853556**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE **$ 127500 00**

29. AMOUNT PAID **$ 0 00**

30. BALANCE DUE **127500 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED **XX** DATE **02/21**

32. SERVICE FACILITY LOCATION INFORMATION

ACCREDO HEALTH GROUP-AT/DALLAS
IRVING, TX 75063-2299

a. **1111222233** b. **333600000X**

33. BILLING PROVIDER INFO & PH #

ACCREDO HEALTH GROUP
ST. LOUIS, MO 63195-4041

a. **111122224** b. **ZZ 333600000X**

PLEASE PRINT OR TYPE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION