TEXAS
Health and Human Services

Texas Department of State Health Services

5010 Outpatient Professional THCIC 837 Technical Specifications

Version 1.1 **February 17, 2026**

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1. Introduction

Texas Health Care Information Collection's (THCIC) primary charge is to collect data and report on the quality performance and differences in charges of hospitals and health maintenance organizations operating in Texas. The goal is to provide information that will enable consumers to have an impact on the cost and quality of health care in Texas.

1.1 Governing Legislation

The Department of State Health Service's governing legislation, which includes collecting data regarding outpatient surgical and radiological procedures covered under specified revenue codes listed in Title 25 Texas Administrative Code 421.67(e) and the HCPCS codes from the service and procedure categories listed in Title 25 Texas Administrative Code 421.67(f) for hospitals, ambulatory surgical centers, and freestanding emergency medical care facilities, is contained within Chapter 108, Texas Health & Safety Code.

The Hospital Procedures and Technical Specifications guides are available for download from the THCIC website at DSHS THCIC Hospital Reporting Requirements

This guide is written to be complementary to the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers rules, Title 25 Texas Administrative Code 421.61 to 421.68, and the Collection and Release of Hospital Outpatient Emergency Room Data rules, Title 25 Texas Administrative Code 421.71 to 421.78:

TITLE - 25 Health Services
PART - 1 Department of State Health Services
CHAPTER - 421 Health Care Information
SUBCHAPTER – D - Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers
SUBCHAPTER – E - Collection and Release of Hospital Outpatient Emergency Room Data

Related links to the Texas Health & Safety Code and Texas Administrative Code can also be found on the THCIC Web Site.

2. General Information

THCIC's primary purpose is to provide data that will enable Texas consumers and health plan purchasers to make informed health care decisions.

2.1 Overview

Submitters are required to use the THCIC 837 claim format (modified ANSI ASC X12N 837 Professional claim format) to submit data on patients that receive one or more of procedures covered by the specified revenue codes in Title 25 Texas Administrative Code 421.67(32).

System13, Inc. maintains the THCIC Health Care Data Collection System (HCDCS), hereafter referenced as "the system", "the System13/THCIC system", or similar variations. The system is accessed by providers via a website that allows providers to submit data files and manually enter, modify, delete, and report on data formatted using the requirements described in this document.

Submissions are acknowledged upon receipt into the system. When a file is received by the HCDCS (receiver process), an email receipt notification will be sent to the submitter indicating if the file was accepted or rejected for further processing. For a file to be accepted for further processing, its THCIC ID, NPI or EIN, and the first 15 characters of the facility's submission address must match the provider information THCIC has on file for each facility reported in the file.

The system pre-process checks for formatting compliance. Files failing the format audits will not be accepted into the system. If a file is not accepted for processing, the email notification includes information regarding the failed formatting audits.

The system pre-process determines if a file is a Test (T) file or a Production (P) file. Claims submitted and accepted into the system in either a Production or Test file will be subjected to THCIC data requirement audits. For claims submitted in a Production file, the results of the auditing process will be made available to the provider (facility) and the facility will be given an opportunity to correct the claims. Claims can be corrected using the system's web portal claim correction function, using the batch deletion component of the online system, or submitting corrected claims via the file submission process using the claim bill frequency type for deletion or replacement as appropriate.

For claims submitted in a test file, the result of the auditing process will be made available to the submitter.

For more detail on the file submission process as well as the use of the System13/THCIC system please see: DSHS THCIC Outpatient Data Reporting Requirements.

2.2 Reference Information

The THCIC 837 claim format draws from the specifications for the ANSI 837 health care claim format from the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, 837, ASC X12N 837 (005010X222), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (ANSI 837 Professional Guide, 005010X222A1) which can be purchased and downloaded from the following website: X12 Product Licensing Program.

The Department of State Health Services requested permission to reproduce portions of the ANSI 837 Institutional and ANSI 837 Professional Guides and has been granted conditional approval to reproduce or cite ASC X12 materials as presented.
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Only the sections required by THCIC, or situational ANSI 837 Institutional and Professional Guide sections are reproduced in this manual.

2.3 THCIC Business Associate - System13, Inc.

System13, Inc. provides a testing process to ensure that a hospital or vendor submits a HIPAA compatible ANSI 837 Institutional and Professional Guide formatted file with the additional required fields listed in this manual then that data file should pass the audits at System13, Inc. System13, Inc. (System13) located in Charlottesville, Virginia, is con-

tracted to provide data collection, auditing, and warehousing of the data submitted by hospitals. System13, Inc. Contact Information:

E-mail: thcichelp@system13.com
Helpdesk: (888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax: (434) 979-1047
Data Portal Web Site: https://thcic.system13.com/

2.4 THCIC Web Site

The THCIC web site contains the latest information about THCIC, the hospital discharge data reporting process, and other THCIC activities and publications. The site contains information about legislative mandates, instructions concerning the data reporting process, and THCIC staff contact information.

2.4.1 Important Links

- Data Reporting Schedule
- Outpatient Data Reporting Requirements
- Latest Version of these Specifications
- 5010 Inpatient and Outpatient Appendices

3. Definitions and Acronyms

Term	Definition
Accurate and Consistent Data	Data that has been edited by DSHS and subjected to provider validation and certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(1)
ANSI	American National Standards Institute
ANSI 837 Institutional Guide	American National Standards Institute, Accrediting Standards Committee electronic claims format for billing health care services [specifications can be obtained via the Internet at Washington Publishing Company and Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(5)
Attending Physician	The individual licensed under the Medical Practice Act (Occupations Code, Chapter 151) or the licensed health professional primarily responsible for the care of the patient during the hospital episode as reported on the claim. For Skilled Nursing Facility (SNF) services, the attending physician is the individual who certifies the SNF plan of care. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(3)
Audit	For the purposes of this manual, a methodological examination and review of data. Audits are performed during data collection to identify errors or potential errors (warnings).
Certification Process	The process by which a provider confirms the accuracy and completeness of the encounter data set required to produce the public use data file as specified in §421.7 of this title (relating to Certification of Discharge Reports). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(4)
Charge	The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules write-offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(5)
CHS	Texas Department of State Health Services, Center for Health Statistics.
CPT	Current Procedural Terminology – HCPCS Level 1 procedure codes

Term	Definition
Comments	The notes or explanations submitted by the hospitals, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(6)
Discharge	The formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death or by disposition to a residence or another health care provider. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(9)
Discharge Claim	A computer record as specified in §421.9 of this title (relating to Discharge Reports--Records, Data Fields and Codes) relating to a specific patient. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(10)
Discharge Report	A computer file as defined in §421.9 of this title periodically submitted on or on behalf of a Hospital in compliance with the provisions of this chapter. "Discharge report" corresponds to the ANSI 837 Institutional Guide terms, "Communication Envelope" or "Interchange Envelope." Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(11)
DRG	Diagnosis Related Group. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(12)
EDI	Electronic Data Interchange. A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(13)
Edit	An electronic standardized process developed and implemented by the THCIC to identify potential errors and mistakes in data elements by reviewing data fields for the presence or absence of data, and the accuracy and appropriateness of data. (§108.002(8) Health and Safety Code) For the purposes of this manual: 1. To make changes to a data file. 2. The process of adding, deleting, or changing data. The THCIC edits the public use data file to protect the confidentiality of patients and physicians. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(14)

Term	Definition
Electronic Filling	The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine-track magnetic tape, computer diskette or other magnetic media acceptable to the executive director. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(15)
EMC	Electronic Media Claims (National Standard Format).
Encounter	An electronic record that contains information on all services rendered for a patient episode of care (admission through discharge) by a provider in a patient care setting (e.g., hospital, out-patient clinic, doctor's office).
Error	Data submitted in a discharge data file, which are not consistent with the format, data standards, or auditing criteria established by the director of CHS, or the failure to submit required data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(16)
Ethnicity	The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non- Hispanic. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(17)
Facility Type Indicators	An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that facility (e.g., Teaching, Acute Care, Rehabilitation, Psychiatric, Pediatric, Cancer, Skilled Nursing, or other Long Term Care Facility). A facility may have more than one indicator. Hospitals may request updates to this field. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(18)
Geographic Identifiers	A set of codes indicating the public health region and county in which the patient resides. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(19)
HCDCS	Health Care Data Collection System

Term	Definition
HCPCS	Healthcare Common Procedure Coding System
Healthcare Facility	A hospital, an ambulatory surgery center licensed under Chapter 243 of the Health and Safety Code, a chemical dependency treatment facility licensed under Chapter 464 of the Health and Safety Code, a renal dialysis center, a birthing center, a rural health clinic or a federally qualified health center as defined by 42 United States Code, §1396(1)(2)(B). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(21)
HIPPS	Health Insurance Prospective Payment System. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(22)
Hospital	A public, for-profit, or nonprofit institution licensed or owned by this state that is a general or special hospital, private mental hospital, chronic disease hospital, or other type of hospital. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(23)
ICD	International Classification of Disease. The International Classification of Diseases, Clinical Modification (ICD-CM) is a system used to code and classify mortality data from death certificates. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(24)
Inpatient	A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital, and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, sub-acute, skilled nursing, long- term, psychiatric, substance abuse, physical rehabilitation, and all other types of hospital units. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(25)
Institutional Review Board	The department's appointees or agent who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the public use data as described in §421.10 of this title (relating to Institutional Review Board). The Institutional Review Board acts as the Scientific Review Panel described in the Health and Safety Code, §108.0135. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(26)

Term	Definition
Insured	Services for which the provider expects payment from a third-party insuring Payer (e.g., Medicare, Medicaid, Blue Cross).
Non-insured	Services for which the Provider cannot bill a third-party insuring payer (e.g., self-pay, charity).
Operating or Other Physician	The "physician" licensed by the Texas Medical Board or "other health professional" licensed by the State of Texas who performed the principal procedure or performed the surgical procedure most closely related to the principal diagnosis. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(27)
Other Exempted Provider	A hospital exempt by rule Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(28) or by waiver (2014 Sunset Review Commission Waiver Recommendation) to be established in rule.
Other Health Professional	A person licensed to provide health care services other than a physician. An individual other than a physician who admits patients to hospitals, or who provides diagnostic or therapeutic procedures to inpatients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the hospital to admit or treat patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(29)
Patient Account Number	A number assigned to each patient by the hospital, which appears on each computer record in a patient discharge claim. This number is not consistent for a given patient from one hospital to the next, or from one admission to the next in the same hospital. The department deletes or encrypts this number to protect patient confidentiality prior to release of data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(30)
Payer	The organization that pays for medical services. Payers usually are contractually responsible for adjudication and payment of provider claims for health care services rendered.

Term	Definition
Physician	An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(31)
Present on Admission (POA)	Diagnosis present on admission. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(32)
Provider	A hospital, physician, or other health professional that provides health care services to patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(33)
Provider Quality Data	A report or reports authored by the department on provider quality or outcomes of care, as defined in Health and Safety Code, Chapter 108, created from data collected by the department or obtained from other sources. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(34)
Public Use Data File	A data file composed of discharge claims with risk and severity adjustment scores which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of hospital discharge data imposed by statute. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(35)
Race	A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Hospitals shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(36)
Required Minimum Data Set	The list of data elements which hospitals are required to submit in a discharge claim for each inpatient stay in the hospital. The required minimum data set is specified in §421.9(d) of this title. This list does not include the data elements that are required by the ANSI 837 Institutional Guide to submit an acceptable discharge report. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify which qualify as subsequent data elements). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(37)

Term	Definition
Research Data File	A customized data file, which includes the data elements in the public use file and may include data elements other than the required minimum data set submitted to the department, except those data elements that could reasonably identify a patient or physician. The data elements may be released to a requestor when the requirements specified in §421.8 of this title (relating to Hospital Discharge Data Release) are completed. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(38)
Risk Adjustment	A statistical method to account for a patient's severity of illness at the time of admission and the likelihood of development of a disease or outcome, prior to any medical intervention. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(39)
Service Unit Indicator	An indicator derived from submitted data (based on bill type or revenue codes), which represent the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit, or Skilled Nursing Unit) where the patient received treatment. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(40)
Severity Adjustment	A method to stratify patient groups by degrees of illness and mortality. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(41)
Submission	The transfer of a set of computer records as specified in §421.9 of this title that constitutes the discharge report for one or more hospitals. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(42)
Submitter	The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to THCIC. A submitter may be a hospital or an agent designated by a hospital or its owner. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(43)
Submitting Agent	An organization authorized by a health care provider to submit billing claims on behalf of the provider.

Term	Definition
System13, Inc.	System13, Inc. The contractor that collects, audits, and warehouses the inpatient and outpatient health care claim data on behalf of THCIC.
THCIC	Texas Health Care Information Collection sub-unit in the Department of State Health Services, Center for Health Statistics Unit.
THCIC Identification Number	A string of six characters assigned by THCIC to identify health care facilities for reporting and tracking purposes. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(44)
Uniform Facility Identifier	A unique number assigned by the department to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the department will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(45)
Uniform Patient Identifier	A unique identifier assigned by the THCIC to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and inpatient admissions. The relationship of the identifier to the patient-specific data elements used to assign it is confidential. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(46)
Uniform Physician Identifier	A unique identifier assigned by the THCIC to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(47)
User	For the purposes of this manual, Hospital or Submitter.

Term	Definition
Validation	The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(48)

4. Technical Requirements Summary

4.1 Patient Inclusion Requirements

Hospitals and ASCs must submit the required data elements for all patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes specified in Title 25 Texas Administrative Code, Chapter 421, Rule 421.67(f) from the hospitals or ambulatory surgical centers (see Title 25 Texas Administrative Code, Chapter 421, Rule 421.62). Additionally, all hospital or freestanding emergency medical care facility are required to report all patient emergency medical care visits (see Title 25 Texas Administrative Code, Chapter 421, Rule 421.72). These include patients for which the hospital may not generate an electronic claim, such as self-pay and charity.

4.1.1 Revenue Codes

Facilities shall submit the required minimum data set to DSHS for each patient who has one or more of the following revenue codes for services rendered to the patient in the facility.

Code	Description
320	Radiology - Diagnostic General Classification
321	Radiology - Diagnostic Angiocardiology
322	Radiology - Diagnostic Arthrography
323	Radiology - Diagnostic Arteriography
329	Radiology - Diagnostic Other Radiology – Diagnostic
330	Radiology - Therapeutic General Classification
333	Radiology - Therapeutic Radiation Therapy
339	Radiology - Therapeutic Other Radiology – Therapeutic
340	Nuclear Medicine General Classification
341	Nuclear Medicine Diagnostic
342	Nuclear Medicine Therapeutic
343	Nuclear Medicine Diagnostic Pharmaceuticals
344	Nuclear Medicine Therapeutic Pharmaceuticals

Code	Description
349	Nuclear Medicine Other Nuclear Medicine
350	Computed Tomography (CT) Scan General Classification
351	Computed Tomography (CT) - Head Scan
352	Computed Tomography (CT) - Body Scan
359	Computed Tomography (CT) - Other
360	Operating Room Services General Classification
361	Operating Room Services Minor Surgery
369	Operating Room Services Other Operating Room Services
400	Other Imaging Services General Classification
401	Other Imaging Services Diagnostic Mammography
403	Other Imaging Services Screening Mammography
404	Other Imaging Services Positron Emission Tomography (PET)
409	Other Imaging Services Other Imaging Services
450	ER -- General Classification
451	ER -- Emergency Medical Screening – EMTALA
452	ER -- Beyond EMTALA
456	ER -- Urgent Care
459	ER -- Other
481	Cardiology Cardiac Catheterization Lab
483	Cardiology Echocardiology
489	Cardiology Other Cardiology Services
490	Ambulatory Surgical Care General Classification
499	Ambulatory Surgical Care Other Ambulatory Surgical
500	Outpatient Services General Classification
509	Outpatient Services Other Outpatient
610	Magnetic Resonance Technology General Classification
611	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Brain/Brainstem
612	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) -

Code	Description
	Spinal Cord/Spine
614	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Other
615	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Head and Neck
616	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Lower Extremities
618	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Other
619	Magnetic Resonance Technology Other Magnetic Resonance Technology
760	Specialty Room – Treatment/Observation Room General Classification
761	Specialty Room – Treatment Room
762	Specialty Room – Observation Room
769	Specialty Room – Other Specialty Room

4.1.2 Service and Procedure Categories

Facilities shall submit the required minimum data set to DSHS for each patient who has one or more of the following services or procedures rendered to the patient in the facility:

- Services and Procedures Categories and related HCPCS Codes 2024
- Services and Procedures Categories and related HCPCS Codes 2025

These are the lists of outpatient procedure codes that, if performed by a hospital or ASC, indicates the patient claim requires submission for 2024-2025 under 25 TAC §§ 421.61- 421.68.

4.2 Communications Requirements

4.2.1 Data Submissions

Texas Administrative Code (TAC) rules require that all hospitals, in operation for any or all of the reporting periods described in Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(a) and (b) relating to the Collection and release of Hospital Discharge

Data, shall submit data on all discharged inpatients to the Texas Heath Care Information Collection program and are advised to reference Chapter 108, Health & Safety Code and the Texas Health Care Information Collection rules Title 25 Texas Administrative Code, Chapter 421, Rule 421.1 – 421.9 relating to data reporting.

To facilitate the implementation and operation of the Department of State Health Services data reporting programs under Chapter 108, Texas Health & Safety Code, it is necessary for each reporting health facility to provide the name and contact information for its designated THCIC contact person or liaison.

System13 accepts data from providers or from their submitting agents using transmission methods and protocols specified in this manual as authorized by THCIC Title 25 Texas Administrative Code, Chapter 421, Rule 421.4.

Prior to submitting electronic claims to System13, Inc. the submitter (Facility or facility's designee, corporate office or contact vendor) must register with System13, Inc. and complete the enrollment process. For enrollment information, please visit: System13 Enrollments

For more information, see THCIC Submitter and Provider Enrollment Guide.

4.2.2 Data Corrections

Hospitals that receive error or warning codes and messages can submit corrections either by making the corrections using Claim Correction (See Claim Correction at DSHS THCIC Inpatient Data Reporting Requirements) or by resubmitting claims to System13, Inc. Claims can be corrected in one of the following ways:

1. **Replacement of Errant Claim Data**
   Submit "Replacement claims" (XX7) to System13, Inc. "Replacement claims" are required to have the following data elements match exactly to replace the claim data from System13, Inc.:
   a. Patient Control Number (PCN) (can be changed in the THCIC System WebCorrect/Claims Correction [online])
   b. Medical Record Number (MRN)
   c. Admission Date
   d. Admission Hour

e. Statement Period From Date
f. Statement Period Thru Date

2. **Void or Cancel Errant Claim Data and Resubmit**
   Submit "Void/Cancel claims" (XX8) to System13, Inc., then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4, XX5, or XX6) with the corrected data included. "Void/Cancel claims" are required to have the following data elements match exactly to delete the claim data from System13, Inc.:
   a. Patient Control Number (PCN) (can be changed in the THCIC System Web-Correct/Claims Correction [online])
   b. Medical Record Number (MRN)
   c. Admission Date
   d. Admission Hour
   e. Statement Period From Date
   f. Statement Period Thru Date

3. **Delete Errant Claim Data and Resubmit**
   a. The designated Facility "Data Administrator" may log into the secure website and delete errant or duplicate batches or claims using the "Batches" tab or "Data Mgmt" tab.
   b. Contact System13, Inc. and request that they delete the claims/batches with errors (a charge is associated with this process), and then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4, XX5 or XX6) with the corrected data.

4.2.3 System13, Inc. Help Desk

System13, Inc. Help Desk Contact Information:

E-mail: thcichelp@system13.com
Helpdesk: (888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax: (434) 979-1047
Data Portal Web Site: https://thcic.system13.com/

4.3 Billing Claims Validation and Acceptance

All submitted claims are audited and validated for adherence to the THCIC 837 Specifications prior to being accepted for processing by System13, Inc. Audits required for validation include, at a minimum, those audits specified in the 5010 Inpatient and Outpatient Appendices found at Outpatient Data Reporting Requirements. Audits will be applied at the data element level or record level and without regard to other billing claim records previously received for a provider or a patient.

4.4 System Resources and Availability

The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day.

Secured electronic mailboxes for notification are available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

4.5 Auditing of Data by System13, Inc.

Format, syntax, and validation audits are performed on all claims data submitted to THCIC for processing. These audits and validations are summarized below. A list of the audit codes and descriptions of the codes can be found in the Appendices document. In general, the audits support the following rules:

- Each billing claims submission must contain at least one valid file, including valid file header /trailer records.
- A file/Transaction Set must contain one valid claim for the file/Transaction Set to be accepted.
- Claim file numbers may not be reused within six months of acceptance of the first use of the batch number.
- Claim detail charges and claim counts must balance with batch and file totals.
- Claims submission may contain only valid record types/Data segments as defined in the ANSI 837 specifications.
- All fields defined as number must contain numerical data.
- All fields designated as required date fields must contain valid dates. Dates must be submitted in CCYYMMDD format including the patient's birth date. All other date fields may contain a valid date or may be blank or zero filled.

Table 1. Sample Pre-Processing Audits (Format Check)

Audit ID	Message	Description

RJ001	Missing/Invalid ISA Interchange Control Header Segment.	The first three characters in all 837 files are 'ISA'. This file does not start with 'ISA'. Our system has stopped processing this file.
RJ002	ISA06 (Interchange Sender ID) contains invalid Submitter _ID='SUB999'	Submitter Id's are six characters long, begin with 'SUB', and are followed by three numbers (e.g. SUB999). Do not put 'TH' in front of your Submitter Id. THSUB999 is a login, SUB999 is a Submitter Id.

Table 2. Sample Claim-Level Audits

Audit ID	Status	Message	Description	Severity
600	I	Missing Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format	Error
601	I	Principal Procedure not reported when Other Procedure(s) reported	The Principal Procedure is not reported, is blank or contains zeroes and Other Procedure(s) are reported.	Error

4.6 Required Data File Format

Claims data must be submitted in the THCIC 837 (modified ANSI X12N 837, version 5010 Professional Claim, X222A1) Specification format. See Section 5 - THCIC 837 File Specifications of this document.

4.7 State Required Data Elements

The following data elements must be submitted for each inpatient stay.

1. Patient Name

   a. Patient Last Name
   b. Patient First Name
   c. Patient Middle Initial
2. Patient Address
   a. Patient Address Line 1
   b. Patient Address Line 2 (if applicable)
   c. Patient City
   d. Patient State
   e. Patient Zip
   f. Patient Country
3. Patient Birth Date
4. Patient Sex (at birth)
5. Patient Race
6. Patient Ethnicity
7. Patient Social Security Number
8. Patient Account Number
9. Patient Medical Record Number
10. Claim Filing Indicator Code (Payer Source – primary and secondary (if applicable for secondary payer source)
11. Payer Name - Primary and secondary (if applicable, for both)
12. National Plan Identifier - for primary and secondary (if applicable) payers (National Health Plan Identification number, if applicable and when assigned by the Federal Government)
13. Type of Bill (Facility Type Code plus Claim Frequency Code)
14. Statement Dates (i.e. Statement Period From and Statement Period Thru dates)
15. Principal Diagnosis
16. Other Diagnosis Codes - up to 24 occurrences (if applicable)
17. Related Cause Codes - up to 3 occurrences (if applicable)
18. Revenue Service Line Details (up to 50 service lines)
   a. Revenue Code
   b. Procedure Code
   c. HCPCS/HIPSS Procedure Modifier 1 (if applicable)
   d. HCPCS/HIPSS Procedure Modifier 2 (if applicable)
   e. HCPCS/HIPSS Procedure Modifier 3 (if applicable)
   f. HCPCS/HIPSS Procedure Modifier 4 (if applicable)
   g. Procedure From Date

h. Procedure Thru Date
i. Charge Amount
j. Unit Code
k. Unit Quantity
l. Unit Rate
m. Non-covered Charge Amount

19. Rendering Provider or Rendering Other Health Professional Name - up to 2 occurrences (if applicable)
    a. Rendering Provider or Rendering Other Health Professional Last Name
    b. Rendering Provider or Rendering Other Health Professional First Name
    c. Rendering Provider or Rendering Other Health Professional Middle Initial
20. Rendering Provider or Rendering Other Health Professional Primary Identifier (National Provider Identifier, when HIPAA rule is implemented) - up to 2 occurrences (if applicable)
21. Rendering Provider or Rendering Other Health Professional Secondary Identifier (Texas state license number) - up to 2 occurrences (if applicable)
22. Total Claim Charges
23. Service Provider Name
24. Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier (when HIPAA rule is implemented)
25. Service Provider Address
    a. Service Provider Address Line 1
    b. Service Provider Address Line 2 (if applicable)
    c. Service Provider City
    d. Service Provider State
    e. Service Provider Zip
26. Service Provider Secondary Identifier - THCIC 6-digit Hospital ID assigned to each facility

4.8 Data Element Locations

Data elements and their respective locations in the approved formats.

Table 3. Data Element Locations

DATA ELEMENT	Loop ID	Ref. Des.

DATA ELEMENT	Loop ID	Ref. Des.
Patient Last Name	2010BA or 2010CA	NM103
Patient First Name	2010BA or 2010CA	NM104
Patient Middle Initial	2010BA or 2010CA	NM105
Patient Street Address	2010BA or 2010CA	N301
Patient City	2010BA or 2010CA	N401
Patient State	2010BA or 2010CA	N402
Patient Zip	2010BA or 2010CA	N403
Patient Country Code	2010BA or 2010CA	N404
Patient Birth Date	2010BA or 2010CA	DMG02
Patient Sex (at birth)	2010BA or 2010CA	DMG03
Patient Race	2300	K301
Patient Ethnicity	2300	K301
Subscriber/Patient Social Security Number	2010BA	REF02
Patient Social Security Number	2300	K301
Patient Control Number/Patient Account Number	2300	CLM01
Medical Record Number	2300	REF02
Source of Payment Code (Standard)/ Claim Filing Indicator Code	2000B or 2320	SBR09
Payer Name	2010BB (and 2330B, if secondary payer)	NM103
National Plan Identifier (when implemented by Federal Government)	2010BB (and 2330B, if secondary payer)	NM109

DATA ELEMENT	Loop ID	Ref. Des.
Type of Bill	2300	CLM05
Statement Covers Period From	2300	DTP03
Statement Covers Period Through	2300	DTP03
Principal Diagnosis Code	2300	HI01
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Diagnosis Present on Admission	2300	HInn-9 (nn = 01- 12)
Attending Physician Name	2310A	NM103, NM104, and NM105
Attending Physician Number	2310A	NM109 (NPI) or REF02 (State License)
Operating or Other Physician Name	2310B	NM103, NM104, and NM105
Operating or Other Physician Number	2310B	NM109 (NPI) or REF02 (State License)
Total Claim Charges	2300	CLM02
Accommodations Revenue Codes or Revenue Codes	2400	SV201
HCPCS/HIPPS Procedure Codes	2400	SV202-2
HCPCS/HIPPS Procedure Code Modifiers	2400	SV202-3 to SV202- 6
Accommodation Total Charges or Charge Amount	2400	SV203
Ancillary Charges Total or Charge Amount	2400	SV203
Unit Code	2400	SV204
Accommodations Days or Unit Quantity	2400	SV205
Units of Service or Unit Quantity	2400	SV205
Accommodations Rate or Unit Rate	2400	SV206
Provider Name	2010AA or 2310C	NM103
Provider Address	2010AA or	N301

DATA ELEMENT	Loop ID	Ref. Des.
	2310C	
Provider City	2010AA or 2310C	N401
Provider ZIP Code	2010AA or 2310C	N403
Provider National Provider Identification Number (NPI)	2010AA or 2310C	NM109
Provider Tax Identification (EIN)	2010AA or 2310C	REF02
Provider THCIC ID Identification (6 Digit) number assigned by THCIC	2010AA or 2010BB or 2310C	REF02

5. THCIC 837 File Specifications

5.1 Reference Information

The THCIC 837 Outpatient Professional Claim Specification draws from the specifications for the ANSI 837 health care claim format published in the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, 837, ASC X12N 837 (005010X222), May 2006 version, and the addenda published by the Washington Publishing Company in June 2010 (ANSI 837 Professional Guide, 005010X222A1) which can be purchased from the following website:

X12 Product Licensing Program

5.1.1 Nomenclature

Key terms and phrases to better understand this portion of the specifications document, after which you will have a basic understanding of X12 syntax, usage, and related information.

Term	Definition
Control Segment	A control segment has the same structure as a data segment but is used for transferring control information rather than application information.
Control Segment, Interchange Control Segments	The Interchange Control Header (ISA) is used to denote the start and end of Functional Groups (GS). Each element on the line is in a fixed position. It defines what characters are used for segment, element, and other control characters. The ISA has an associate Interchange Control Trailer (IEA) to
Control Segment, Functional Group	The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identi-

Term	Definition
Segments	fies one or more related transaction sets. It also provides control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.
Control Segment, Transaction Set Segments	The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.
Control Segment, Hierarchical Level Segments	Hierarchical Level segments denote the start of a group of information. The information may be about a provider of date, about the insured person, or about a patient claim. It ends when another Hierarchical Loop occurs, or when a transaction trailer (SE) is received.
Control Segment, Relations among Control Segments	The control segments of this standard must have a nested relationship, as shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments. ISA Interchange Control Header GS Functional Group Header starts a group of related Transaction sets. ST Transaction Set Header starts a transaction set. HL Hierarchical Level starts a bounded loop of data seg-

Term	Definition
	ments. SE Transaction Set Trailer ends a transaction set. GE Functional Group Trailer ends a group of related transaction sets. IEA Interchange Control Trailer
Data Element	The data element is the smallest unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.
Data Element, Numeric	A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data. The data element dictionary defines the number of implied decimal positions. The representation for this data element type is Nn where N indicates that it is numeric, and n indicates the number of decimal positions to the right of the implied decimal point. If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Lead-

Term	Definition
	ing zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of numeric type data elements does not include the optional sign. FOR EXAMPLE: Value is "-123.4". Numeric type is "N2" where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "-12340". The length is 5 (note padded zero).
Data Element, Decimal Number	A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R." The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly
Data Element, Identifier	An identifier data element always contains a value from a predefined list of values. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID."
Data Element, String	A string data element is a sequence of any characters from the basic or extended character sets. The significant

Term	Definition
	characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN."
Data Element, Date	A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the century or first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT." Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.
Data Element, Time	A time data element is used to express the ISO standard time HHMMSSdd format in which HH is the hour for a 24-hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and dd is decimal seconds. The representation for this data element type is "TM."
Data Element, Length	Length: Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements
Data Element, Reference Number	Data elements are assigned a unique reference number to locate them in the data dictionary. For each data element, the dictionary specifies the name, description, type, min-

Term	Definition
	imum length, and maximum length. For ID data elements, the dictionary lists all code values and their descriptions or references where the valid code list can be obtained.
Data Element Type	Numeric - Nn Decimal - R Identifier - ID String - AN Date - DT Time - TM
Data Segment	The data segment is used primarily to convey user information while the control segment is used primarily to convey control information and for grouping data segments. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each proceeded by a data element separator, and a segment terminator.
Data Segment, Identifier	Each data segment has a unique two- or three-position identifier. This identifier serves as a label for the data segment.
Data Segment, Data Elements in a Segment	In defining a segment, each simple data element or composite data structure within the data segment is further characterized by a reference designator and a data element reference number or composite data structure refer-

Term	Definition
	ence identifier. Simple data elements and composite data elements may have additional attributes, including a condition designator and a semantic note designator.
Data Segment Data Element	Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two- digit number that defines the position of the simple data element or composite data structure in that segment. For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two- digit number, prefixed with a hyphen that defines the position of the component data element in the composite data structure. For example: The first simple element of the SVC segment would be identified as SVC01 because the position count does not include the segment identifier, which is a label. If the second position in the SVC segment were occupied by a composite data structure that contained three component data elements, the reference designator for the second component data element would be SVC02-02.
Data Segment, Condition Designator	Data element conditions are of three types: mandatory, optional, and relational; they define the circumstances under which a data element may be required to be present or not present in a particular segment.
Data Segment,	M- Mandatory; The designation of mandatory is absolute

Term	Definition
Mandatory Condition	in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
Data Segment, Optional Condition	O- Optional; The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
Data Segment, Relational Condition	X- Relational; Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition.

Condition Code	Definition
P- Paired or Multiple	If any element specified in the relational condition is present, then all the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.

Term	Definition
	E- Exclusion: Not more than one of the elements specified in the condition may be present.
	C- Conditional: If the first element specified in the condition is present, then all other elements must be present. However, any or all the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
	L- List Conditional: If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
Data Segment, Se-	Simple data elements or composite data structures may

Term	Definition
mantic Note Designator	have a designation that indicates the existence of a semantic note. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements. Semantic notes are considered part of the relevant transaction set standard. Semantic Note (Z) A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.
Data Segment, Absence of Data	Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order, to maintain the element's or structure's position as defined in the data segment.
Delimiter	A delimiter is a character used to separate two data elements (or sub elements) or to terminate a segment. The delimiters are an integral part of the data.

Term	Definition
	Delimiters are specified in the interchange header segment, ISA and are not to be used in a data element value elsewhere in the interchange. These delimiters can be visualized on the printed page. They also display each segment on a separate line, adding human readability to the transaction set. Due to potential conflicts with either the data elements or with the special needs of transmission and device control, the historically used delimiters have caused problems.
Dependent	In the hierarchical loop coding, the dependent code 23 indicates the use of the patient hierarchical loop (Loop ID-2000C).
Destination Payer	The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB)
Functional Group	A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group.
Patient	The term "patient" is intended to convey the case where the Patient loop (Loop ID- 2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber's insurance plan. However, it also happens that the patient is sometimes the same per-

Term	Definition
	son as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1, HL Segment, (ANSI 837 Institutional and Professional Guides) for further details. Every effort has been made to ensure that the meaning of the word "patient" is clear in its specific context.
Provider	In a generic sense, the provider is the entity that originally submitted the claim/encounter. A provider may also have provided or participated in some aspect of the health care service described in the transaction. Specific types of providers are identified in this implementation section (e.g., billing provider, other provider, operating physician, rendering provider).
Secondary Payer	The term "secondary payer" indicates any payer, who is not the primary payer. The secondary payer may be the secondary, tertiary, or even quaternary payer.
Subscriber	The subscriber is the person whose name is listed in the health insurance policy. Other synonymous terms include "member" and/or "insured." In some cases, the subscriber is the same person as the patient. See the definition of patient, In Section 1.4.3.2.2.1 Hierarchical Level, HL Segment, (ANSI 837 Institutional) and for (ANSI 837 Professional) see Section B.1.1.4.3 in Appendix B contains a general description of HL structures Guides) for further details.
Transaction Set	The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a trans-

Term	Definition
	action set trailer segment.
Transaction Set, Header, and Trailer	The transaction set header and trailer segments are constructed as follows: • Transaction Set Header (ST) • Data Segment Group • Transaction Set Trailer (SE) The transaction set identifier uniquely identifies the transaction set. This identifier is the first data element of the transaction set header segment. The value for the transaction set control number, in the header and trailer control segments must be identical for any given transaction. The value for the number of included segments is the total number of segments in the transaction set including the ST and SE segments.
Transaction Set, Data Segment Groups	The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.
Transaction Set, Repeated Occurrences of Single Data Segments	When a single data segment is allowed, to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".
Transaction Set, Loops of Data Segments	Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded
Transaction Set,	In order, to establish the iteration of a loop, the first data

Term	Definition
Unbounded Loops.	segment in the loop shall appear Unbounded once and only once in each iteration. Loops may have a specified maximum number of Loops repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1". There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop. The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If unbounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop shall not start with the same segment as its immediate outer loop. For any segment that occurs in a loop and in the parent structure of that loop, that segment must occur prior to that loop in the parent structure or subsequent, to an intervening mandatory segment in the parent structure (parent structure is composed of all segments at the same level of nesting as the beginning segment of the loop).
Transaction Set, Bounded Loops	The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start segment to appear before the

Term	Definition
	first occurrence and a loop end segment to appear after the last occurrence of the loop. If the loop does not occur, the segments shall be suppressed. The requirement designator on the segments must match the requirement designator of the beginning segment of the loop. A bounded loop may contain only one loop structure at the level bracketed by the segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop must end before or on the same segment as its immediate outer loop.
Transaction Set, Data Segment in a Transaction Set	When data segments are combined to form a transaction set, three characteristics are applied to each data segment: A requirement designator, a position in the transaction set, and a maximum occurrence.
Transaction Set, Data Segment Requirement Designators	A data segment, or loop, has one of the following requirement designators for health care Data Segment and insurance transaction sets, indicating its appearance in the data stream of a Requirement transmission. These requirement designators are represented by a single character code.

Designator	Requirement
(M) Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is

Term	Definition
	optional if the beginning segment of the loop is designated as optional.)
	(O) Optional — The presence of this data segment is the option of the sending party.
Transaction Set, Data Segment Position	The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.
Transaction Set, Data Segment Occurrence	A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number.
Transmission Intermediary	A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term "intermediary" is not used to convey a specific Medicare contractor type.

5.1.2 Basic Structure

The X12 standards define commonly used business transactions in a formal, structured manner called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of a unique segment ID; one or more logically related simple data elements or composite data structures, or both, each proceeded by a data element separator; and a segment terminator.

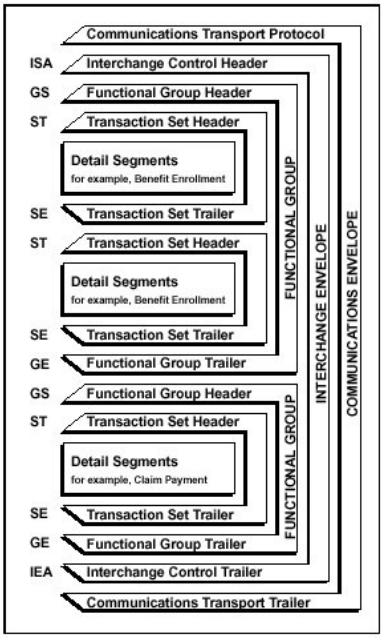

Figure 1. Basic 837 Structure

Composite data structures are composed of one or more logically related component data elements. Each composite data structure is followed by a component element separator except for the last one element. The data segment directory entry referenced by the data segment ID defines the sequence of simple data elements and composite data structures in the segment, and any interdependencies that may exist. The composite data structure directory entry referenced by the composite data structure number defines the sequence of component data elements in the composite data structure.

A data element in the transaction set header identifies the type of transaction set. A functional group contains one or more related transaction sets preceded by a functional group header control segment and terminated by a functional group trailer control segment.

5.1.3 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

5.1.4 Delimiters

A delimiter (from Section B.1.1.2.5 of ANSI 837 Institutional Guides) is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide (see Appendix C, ISA Segment Note 1) to be a 105-byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number 83; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses, and recommends, the delimiters shown in Table 4 - Delimiters, in all examples.

Table 4. Delimiters

Character	Name	Delimiter

*	Aster-isk	Data Element Separator
^	Caret	Repetition Separator
:	Colon	Component Element Separa-tor
~	Tilde	Segment Terminator

5.1.5 THCIC Implementation Usage

Only the sections and segments that are required or situational required by THCIC that are different from the ANSI 837 Institutional Guide sections are written in this manual. Following is a table of the data elements that have been modified from the ANSI 837 Institutional Guide to meet the THCIC requirements for data submission.

A rule of thumb: If a hospital or vendor submits a HIPAA compliant ANSI 837 Institutional Guide formatted file with the additional required fields listed below, that data file should pass the audits at System13, Inc.

Some data elements are listed as "Situational" or "Not Used" in the ANSI 837 Institutional Guide but are REQUIRED by THCIC, as detailed in the following table.

Table 5. Data Element Comparisons

Data Element	Loop ID	Ref. Des.	Difference
National Provider Identification (NPI) number (facility)	2010AA or 2310C[1]	NM109	The Name segments in Loop 2310C are dependent upon who renders the service.
Employer Identification Number	2010AA or 2310C[1]	REF02 (or NM109)	The REF segment in Loop 2010AA and 2310C are SITUATIONAL and would be required if the NPI is submitted in NM109 of the same Loop.
Facility ID Number (THCIC ID #)	2010AA or 2010BB[2] or 2310C	REF02	REF Segment is situational for all loops. Loop is dependent upon who renders the service to patient. Loop 2010BB usage is changed to "SITUATIONAL" from "REQUIRED" since this THCIC ID could be submitted in Loop 2010AA REF02

Data Element	Loop ID	Ref. Des.	Difference
Claim Filing Indicator Code	2000B or 2320	SBR09	SBR09
Subscriber/Patient Social Security Number	2010BA	REF02	REF segment
Patient Social Security Number	2300	K301	K3 segment (Required, if patient is not listed as the subscriber and SSN reported in 2010BA | REF02. SSN moves to 3rd -11th characters with change to new contract in response to HB 2641 84th Texas Legislature)
Patient Race	2300	K301	K3 segment second character
Principal Diagnosis	2300	HI01	HI segment
Patient Ethnicity	2300	K301	K3 segment first character
Medical Record Number	2300	REF02	REF segment
Subscriber Name	2010BA	NM103-Last NM104-First NM105-MI	Segment is situational for THCIC submissions, only required if Subscriber is Patient

1. Dependent on which facility is indicated as rendering the services to the patient.
2. Loop 2010BB (REF Segment) would not be used if THCIC ID reported in Loop 2010AA.

5.2 Transaction Set Listing

This section lists the levels, loops, and segments contained in the THCIC 837 Institutional Specifications, and describes the expected Transaction Set for each Inpatient claim submission.

Table 6. Header

POS	ID	NAME	USG	RPT	LOOP RPT
0050	ST	Transaction Set Header	R	1	
0100	BHT	Beginning of Hierarchical Transaction	R	1	
LOOP ID - 1000A SUBMITTER NAME					**1**
0200	NM1	Submitter Name	R	1	
LOOP ID - 1000B RECEIVER NAME					**1**

0200	NM1	Receiver Name	R	1	

Table 7. Billing Provider Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000A BILLING PROVIDER HIERARCHICAL LEVEL					**>1**
0010	HL	Billing Provider Hierarchical Level	R	1	
LOOP ID - 2010AA BILLING PROVIDER NAME					**1**
0150	NM1	Billing Provider Name	R	1	
0250	N3	Billing Provider Address	R	1	
0300	N4	Billing Provider City, State, ZIP Code	R	1	
0350	REF	Billing Provider Tax Identification	R	1	
0350	REF	Billing Provider THCIC Identification	S	1	

Table 8. Subscriber Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL					**>1**
0010	HL	Subscriber Hierarchical Level	R	1	
0050	SBR	Subscriber Information	R	1	
LOOP ID - 2010BA SUBSCRIBER NAME					**1**
0150	NM1	Subscriber Name	S	1	
0250	N3	Subscriber Address	R	1	
0300	N4	Subscriber City, State, ZIP Code	R	1	
0320	DMG	Subscriber Demographic Information	R	1	
0350	REF	Subscriber Secondary Identification	R	1	
LOOP ID - 2010BB PAYER NAME					**1**
0150	NM1	Payer Name	R	1	
0350	REF	Billing Provider Secondary Identification	S	1	

Table 9. Patient Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL					**>1**
0010	HL	Patient Hierarchical Level	S	1	
0070	PAT	Patient Information	R	1	
LOOP ID - 2010CA PATIENT NAME					**1**
0150	NM1	Patient Name	S	1	
0250	N3	Patient Address	R	1	
0300	N4	Patient City, State, ZIP Code	R	1	
0320	DMG	Patient Demographic Information	R	1	

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2300 CLAIM INFORMATION					**100**
1300	CLM	Claim Information	R	1	
1800	REF	Medical Record Number	S	1	
1850	K3	File Information	S	10	
2310	HI	Health Care Diagnosis Code	R	1	
2310	HI	Anesthesia Related Procedure	S	1	
LOOP ID - 2310B RENDERING PROVIDER NAME					**1**
2500	NM1	Attending Provider Name	R	1	
2710	REF	Attending Provider Secondary Identification	R	1	
LOOP ID - 2310C SERVICE FACILITY LOCATION NAM					**1**
2500	NM1	Service Facility Location Name	S	1	
2650	N3	Service Facility Location Address	R	1	
2700	N4	Service Facility Location City, State, ZIP Code	R	1	
2710	REF	Service Facility Location Secondary Identification	S	1	
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION					**1**
2900	SBR	Other Subscriber Information	S	1	
LOOP ID - 2330B OTHER PAYER NAME					**1**
3250	NM1	Other Payer Name	S	1	
LOOP ID - 2400 SERVICE LINE NUMBER					**50**
3650	LX	Service Line Number	R	1	
3750	SV1	Professional Service	R	1	
4550	DTP	Date - Service Date	R	1	
LOOP ID - 2420A RENDERING PROVIDER NAME					**1**
2500	NM1	Attending Provider Name	R	1	
2710	REF	Attending Provider Secondary Identification	R	1	
5550	SE	Transaction Set Trailer	R	1	

5.3 837 Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Additional segment details can be found in Section 2.4 837 Segment Detail of the ASC X12N/005010X222 Health Care Claim: Professional (837) Specifications.

ST - TRANSACTION SET HEADER

To indicate the start of a transaction set and to assign a control number.

Repeat: 1

Usage: REQUIRED

Example: **ST*837*987654*005010X222A1~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **Code: 837 — Definition: Health Care Claim**	**M 1 ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA) but can repeat in other interchanges.**	**M 1 AN 4/9**
REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention **SEMANTIC:** The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08. **INDUSTRY NAME: Implementation Guide Version Name** **This element must be populated with the following value:** **Code: 005010X222A1 — Definition: Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003** **This field contains the same value as GS08. Some**	**O 1 AN 1/35**

translator products strip off the ISA and GS segments prior to application (ST-SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is used at translation time.

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time.

Repeat: 1

Usage: REQUIRED

Notes: 1. THCIC treats each submission as Original, irrespective of the value in BHT02.

2. The value for BHT03 MUST NOT be duplicated or reused within a 12-month timeframe.

At the time of this writing, Subrogation Demand is not a HIPAA mandated use of the 837 transaction.

Example: **BHT*0019*00*0123*20040618*0932*CH~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set **Code: 0019 — Definition: Information Source, Subscriber, Dependent**	**M 1 ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set BHT02 is intended to convey the electronic transmission status of the 837-batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. **Code: 00 — Definition: Original** **Code: 18 — Definition: Reissue**	**M 1 ID 2/2**

REQUIRED	**BHT03**	**127**	**Reference Identification**	**O**	**1**	**AN**	**1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

INDUSTRY NAME: Originator Application Transaction Identifier

The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number.

REQUIRED	**BHT04**	**373**	**Date**	**O**	**1**	**DT**	**8/8**

Date expressed as CCYYMMDD

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

INDUSTRY NAME: Transaction Set Creation Date

This is the date that the original submitter created the claim file from their business application system.

REQUIRED	**BHT05**	**337**	**Time**	**O**	**1**	**TM**	**4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

INDUSTRY NAME: Transaction Set Creation Time

This is the time that the original submitter created the claim file from their business application system.

REQUIRED	**BHT06**	**640**	**Transaction Type Code**	**O**	**1**	**ID**	**2/2**

Code specifying the type of transaction

IMPLEMENTATION NAME: Claim Identifier

CODE	DEFINITION
31	**Subrogation Demand**
CH	**Chargeable**
RP	**Reporting**

NM1 - SUBMITTER NAME

To supply the full name of an individual or organizational entity.

Loop: 1000A — SUBMITTER NAME Loop Repeat: 1
Repeat: 1
Usage: REQUIRED
Notes: 1. The submitter is the entity responsible for the creation and formatting of this transaction.
2. The value of NM109 MUST match ISA06 and GS02.
Example: **NM1*41*2*ABC SUBMITTER*****46*999999999~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code** **Definition** **41** **Submitter**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code** **Definition** **1** **Person** **2** **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Submitter Last or Organization Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Submitter First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **Required when NM102 = 1 (person) and the**	**O 1 AN 1/25**

			person has a first name. If not required by this implementation guide, do not send. **INDUSTRY NAME: Submitter Middle Name or Initial**				
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE** **DEFINITION** **46** **Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement**	**X**	**1**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **INDUSTRY NAME: Submitter Identifier** **CODE** **DEFINITION** **SUBnnn** **System13, Inc. Submitter ID Number**	**X**	**1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

NM1 - RECEIVER NAME

To supply the full name of an individual or organizational entity.

Loop: 1000B — RECEIVER NAME Loop Repeat: 1
Repeat: 1
Usage: REQUIRED
Example: **NM1*40*2*XYZRECEIVER*****46*111222333~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M**	**1**	**ID**	**2/3**

			CODE DEFINITION **40 Receiver**				
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **CODE DEFINITION** **2 Non-Person Entity**	**M**	**1**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Receiver Name** **CODE DEFINITION** **THCIC Identifies THCIC as the Receiver**	**X**	**1**	**AN**	**1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**1**	**AN**	**1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **46 Electronic Transmitter Identification Number (ETIN)**	**X**	**1**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **INDUSTRY NAME: Receiver Primary Identifier** **CODE DEFINITION** **YTH837 THCIC Receiver Code**	**X**	**1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

HL - BILLING PROVIDER HIERARCHICAL LEVEL

To identify dependencies among and the content of hierarchically related groups of data segments.

Loop: 2000A — BILLING PROVIDER HIERARCHICAL LEVEL Loop Repeat: >1
Repeat: 1

Usage: REQUIRED

Notes: 1. Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.

2. The Billing Provider Hierarchical Level may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID- 2010AA.

3. If the Service Facility Provider is the same entity as the Billing Provider then do not use Loop 2310C.

4. THCIC uses the provider HLs as base for batching claim submissions. Each set of claims for a provider HL results in one set of reports. Multiple provider HLs will result in multiple sets of reports. Thus, the number of provider HLs should be minimized where possible, to reduce the numbers of reports that must be reviewed.

Example: **HL*1**20*1~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **The first HL01 within each ST-SE envelope must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M 1 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **Code** **Definition** **20** **Information Source**	**M 1 ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described **Code** **Definition** **1** **Additional Subordinate HL Data Segment in This Hierarchical Structure.**	**O 1 ID 1/1**

NM1 - BILLING PROVIDER NAME

To supply the full name of an individual or organizational entity.

Loop: 2010AA — BILLING PROVIDER NAME Loop Repeat: 1
Repeat: 1
Usage: REQUIRED
Notes: 1. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities
2. Use Loop ID 2310C if the Billing Provider did not render
Example: **NM1*85*2*ABC HOSPITAL*****XX*1234567890~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code 85 = Billing Provider**	**M**	**1**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code 2 = Non-Person Entity**	**M**	**1**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Billing Provider Organizational Name** **This is the name of the facility as reported to Bureau of Facility Licensing, Texas Department of Health.**	**X**	**1**	**AN**	**1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**1**	**AN**	**1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**

NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier**	**X**	**1**	**ID**	**1/2**
			Code designating the system/method of code structure used for Identification Code (67)				
			CODE **DEFINITION** **XX** **Centers for Medicare and Medicaid Services National Provider Identifier**				
SITUATIONAL	**NM109**	**67**	**Identification Code**	**X**	**1**	**AN**	**2/80**
			Code identifying a party or other code				
			INDUSTRY NAME: Billing Provider Identifier				
			CODE **DEFINITION** **XXXXXXXXXX** **National Provider Identifier (NPI) Number** **nnnnnnnnnn** **Employer Identification Number (EIN)**				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

N3 - BILLING PROVIDER ADDRESS

To specify the location of the named party.

Loop: 2010AA — BILLING PROVIDER NAME

Repeat: 1

Usage: REQUIRED

Notes: 1. The first 15 characters of N301 are used to validate the billing provider.

2. Post Office Box addresses are not allowed.

Example: **N3*123 MAIN STREET~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**N301**	**166**	**Address Information**	**M**	**1**	**AN**	**1/55**
			Address information				
			INDUSTRY NAME: Billing Provider Address Line				
SITUATIONAL	**N302**	**166**	**Address Information**	**O**	**1**	**AN**	**1/55**

Address information

Required when there is a second address line. If not required by this implementation guide, do not send.

INDUSTRY NAME: Billing Provider Address Line

N4 - BILLING PROVIDER CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010AA — BILLING PROVIDER NAME
Repeat: 1
Usage: REQUIRED
Notes: 1. THCIC does not require a nine-digit zip code for Billing Provider.
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **INDUSTRY NAME: Billing Provider City Name**	**O**	**1**	**AN**	**2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **INDUSTRY NAME: Billing Provider State or Province Code**	**X**	**1**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **INDUSTRY NAME: Billing Provider Postal Zone or ZIP Code** **When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.**	**O**	**1**	**ID**	**3/15**
NOT USED	**N404**	**26**	**Country Code**	**X**	**1**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**1**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**1**	**ID**	**1/3**

REF - BILLING PROVIDER TAX IDENTIFICATION

To specify identifying information.

Loop: 2010AA — BILLING PROVIDER NAME
Repeat: 1
Usage: REQUIRED
Notes: 1. This is the tax identification number (TIN) of the entity to be paid for the submitted services.

2. This is used as part of facility identification, if NPI is not provided in NM109 of this segment (2010AA – Billing Provider Name).

Example: **REF*EI*123456789~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code** **Definition** **EI** **Employer's Identification Number** **The Employer's Identification Number must be a string of exactly nine numbers with no separators.**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY NAME: Billing Provider Tax Identification Number **Code** **Definition** **nnnnnnnnn** **Employer Identification Number (EIN)**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

REF - BILLING PROVIDER THCIC IDENTIFICATION

To specify THCIC identifying information.

Loop: 2010AA — BILLING PROVIDER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. THCIC allows a second REF segment in Loop 2010AA. THCIC requires the 6-digit number (THCIC ID) assigned to the Provider identified in Loop 2010AA. The THCIC ID, along with either the NPI (NM109), EIN (REF02), and the Address (N301) is used to verify a Provider's identity.

2. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310C.

3. The Billing Provider Secondary Identification moved to Loop 2010BB (Payer Name) in the Subscriber Hierarchical Level. THCIC allows for either location to be used.

Example: **REF*1J*000116~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code: 1J — Definition: Facility ID Number**	**M**	**1**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Code: nnnnnn — Definition: ID Number assigned by THCIC**	**X**	**1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

HL - SUBSCRIBER HIERARCHICAL LEVEL

To identify dependencies among and the content of hierarchically related groups of data segments.

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL Loop Repeat: >1

Repeat: 1

Usage: REQUIRED

Notes: 1. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA).

2. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.

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

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **The first HL01 within each ST-SE envelope must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **Code 22 — Definition: Subscriber**	**M 1 ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described **The claim (Loop ID-2300) can be used when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1).** **In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims.**	**O 1 ID 1/1**

The second case (HL04 = 1) happens when claims for one or more dependents of the subscriber are being sent under the same billing provider HL (for example, a spouse and son are both treated by the same provider).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SBR - SUBSCRIBER INFORMATION

To record information specific to the primary insured and the insurance carrier for that insured.

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL
Repeat: 1
Usage: REQUIRED
Example: **SBR*P**GRP01020102******CI~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **CODE** **DEFINITION** **P** **Primary**	**M 1 ID 1/1**
SITUATIONAL	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities **SEMANTIC:** SBR02 specifies the relationship to the person insured. **Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.** **CODE** **DEFINITION** **18** **Self**	**O 1 ID 2/2**
NOT USED	**SBR03**	**127**	**Reference Identification**	**O 1 AN 1/50**

NOT USED	**SBR04**	**93**	**Name**	**O**	**1**	**AN**	**1/60**
NOT USED	**SBR05**	**1336**	**Insurance Type Code**	**O**	**1**	**ID**	**1/3**
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O**	**1**	**ID**	**2/2**
REQUIRED	**SBR09**	**1032**	**Claim Filing Indicator Code**	**O**	**1**	**ID**	**1/2**

Code identifying type of claim

CODE	DEFINITION
11	**Other Non-Federal Programs**
12	**Preferred Provider Organization (PPO)**
13	**Point of Service (POS)**
14	**Exclusive Provider Organization (EPO)**
15	**Indemnity Insurance**
16	**Health Maintenance Organization (HMO) Medicare Risk**
17	**Dental Maintenance Organization**
AM	**Automobile Medical**
BL	**Blue Cross/Blue Shield**
CH	**Champus**
CI	**Commercial Insurance Co.**
DS	**Disability**
FI	**Federal Employees Program**
HM	**Health Maintenance Organization**
LM	**Liability Medical**
MA	**Medicare Part A**
MB	**Medicare Part B**
MC	**Medicaid**
OF	**Other Federal Program** **Use code OF when submitting Medicare Part D claims.**
TV	**Title V**
VA	**Veterans Affairs Plan**
WC	**Workers' Compensation Health Claim**
ZZ	**Mutually Defined** **Use Code ZZ when Type of Insurance is not known.**

NM1 - SUBSCRIBER NAME

To supply the full name of an individual or organizational entity.

Loop: 2010BA — SUBSCRIBER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Loop ID 2010BA is Required when Subscriber is the Patient.

2. Loop ID 2010BA is Not Used when Subscriber is not the Patient.

3. Loop ID 2010CA is Required when Subscriber is not the Patient.

4. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (for example, the employer).

5. NM109, when it contains SSN, MUST match the value for REF – Subscriber Secondary Information.

For patients that are covered by 42 USC 290DD-2 or 42 CFR Part 2 and facilities that are participating with SAMSHA, use the following naming conventions: JOHN or JANE DOE. Sequential Numbering is allowed, for example: JOHN1, JANE2, etc.

Example: **NM1*IL*1*DOE*JOHN*T**JR*MI*123456~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code: IL — Definition: Insured or Subscriber**	**M**	**1**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code: 1 — Definition: Person** **Code: 2 — Definition: Non-Person Entity**	**M**	**1**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Subscriber Last Name**	**X**	**1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Required when NM102 = 1 (person) and the**	**O**	**1**	**AN**	**1/35**

			person has a first name. If not required by this implementation guide, do not send. **INDUSTRY NAME: Subscriber First Name**					
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Subscriber Middle Name or Initial**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **Required when NM102 = 1 (person). If not required by this implementation guide, do not send.**	**X**	**1**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **Required when NM102 = 1 (person). If not re-**	**X**	**1**	**AN**	**2/80**

CODE	DEFINITION
II	**Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value `MI' instead.**
MI	**Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.) MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number (SSN) is also available on an IHS/CHS claim, put the SSN in REF02.**

			quired by this implementation guide, do not send. **INDUSTRY NAME: Subscriber Primary Identifier**				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

N3 - SUBSCRIBER ADDRESS

To specify the location of the named party.

Loop: 2010BA — SUBSCRIBER NAME
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.
Example: **N3*123 MAIN STREET~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**N301**	**166**	**Address Information** Address information **INDUSTRY NAME: Subscriber Address Line**	**M**	**1**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information **Required when there is a second address line. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Subscriber Address Line**	**O**	**1**	**AN**	**1/55**

N4 - SUBSCRIBER CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010BA — SUBSCRIBER NAME
Repeat: 1

Usage: REQUIRED

Notes: 1. Refer to Appendix A1 – Valid Country Codes and State Codes for a list of valid State and Province Codes allowed in N402.

Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **INDUSTRY NAME: Subscriber City Name**	**O 1 AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **INDUSTRY NAME: Subscriber State Code** **Code Definition** **aa Valid State or Province Code** **FC Foreign Country** **XX Foreign Country**	**X 1 ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **INDUSTRY NAME: Subscriber Postal Zone or ZIP Code** **When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.** **Code Definition** **00000 Foreign Country; Recommended value for foreign addresses** **XXXXX Foreign Country**	**O 1 ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**X 1 ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X 1 ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1 AN 1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X 1 ID 1/3**

DMG - SUBSCRIBER DEMOGRAPHIC INFORMATION

To supply demographic information.

Loop: 2010BA — SUBSCRIBER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.

2. DMG03 is gender, or sex at birth.

Example: **DMG*D8*19690815*M~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **Code** **Definition** **D8** **Date Expressed in Format CCYYMMDD**	**X**	**1**	**ID**	**2/3**
REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times **SEMANTIC:** DMG02 is the date of birth. **INDUSTRY NAME: Subscriber Birth Date**	**X**	**1**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual **INDUSTRY NAME: Subscriber Gender Code** **Code** **Definition** **F** **Female** **M** **Male** **U** **Unknown**	**O**	**1**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status**	**O**	**1**	**ID**	**I/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X**	**10**		
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**1**	**R**	**1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X**	**1**	**ID**	**1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X**	**1**	**AN**	**1/30**

REF - SUBSCRIBER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2010BA — SUBSCRIBER NAME
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.

2. Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

3. The value in REF02 MUST match NM109 when the Subscriber is the patient and NM109 contains the SSN.

Example: **REF*SY*123456789~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code** **Definition** **SY** **Social Security Number** **The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **INDUSTRY NAME: Subscriber Supplemental Identifier** **Code** **Definition** **nnnnnnnnn** **Social Security Number** **999999999** **Unknown SSN** **This value is required for:**	**X 1 AN 1/50**

				1. Newborns without an SSN 2. Foreigners without an SSN 3. Patients refusing or cannot provide an SSN			
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

NM1 - PAYER NAME

To supply the full name of an individual or organizational entity.

Loop: 2010BB — PAYER NAME Loop Repeat: 1

Repeat: 1

Usage: REQUIRED

Notes: 1. No Patient Personally Identifiable Information (PII) data should be present.

2. This is the destination payer; primary or only payer.

3. For the purposes of this implementation the term payer is synonymous with several other terms, such as, repricer and third-party administrator.

Example: **NM1*PR*2*ABC INSURANCE CO*****PI*11122333~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code: PR — Definition: Payer**	**M**	**1**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code: 2 — Definition: Non-Person Entity**	**M**	**1**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Payer Name**	**X**	**1**	**AN**	**1/60**

				Code	**Definition**			
				SELF-PAY	**For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")**			
				CHARITY	**For Charity Claims (Claim Filing Indicator Code is "ZZ")**			
				UNKNOWN	**With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")**			
NOT USED	**NM104**	**1036**	**Name First**			**O**	**1**	**AN**	**1/35**
NOT USED	**NM105**	**1037**	**Name Middle**			**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**			**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**			**O**	**1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier**			**X**	**1**	**ID**	**1/2**
			Code designating the system/method of code structure used for Identification Code (67)						
				Code	**Definition**			
				PI	**Payor Identification unless Self-Pay, Charity, or Unknown Payer claim**			
				XV	**Centers for Medicare and Medicaid Services PlanID**			
				ZY	**Temporary Identification Number for use with Self-Pay, Charity, or Unknown Payer claim**			
REQUIRED	**NM109**	**67**	**Identification Code**			**X**	**1**	**AN**	**2/80**
			Code identifying a party or other code						
			INDUSTRY NAME: Payer Identifier						
				Code	**Definition**			
				XXXXXXXXXX	**National Plan Identifier (NPI) Number**			
					CMS currently has delayed the implementation date for all plans and providers until further notice.			
				SELF-PAY	**For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")**			
				CHARITY	**For Charity Claims (Claim Filing Indicator Code is "ZZ")**			
				UNKNOWN	**With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")**			
NOT USED	**NM110**	**706**	**Entity Relationship Code**			**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**			**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**			**O**	**1**	**AN**	**1/60**

REF - BILLING PROVIDER SECONDARY IDENTIFICATION

To specify THCIC identifying information.

Loop: 2010BB — PAYER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. If the THCIC ID is not submitted in Loop ID 2010AA REF segment REF01 (with qualifier "1J" in the REF02), then it is REQUIRED to be submitted here.

2. THCIC requires the 6-digit number (THCIC ID) assigned to the Provider identified in Loop 2010AA. The THCIC ID, along with either the NPI (NM109), EIN (REF02), and the Address (N301) is used to verify a Provider's identity.

3. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310C.

Example: **REF*1J*000116~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code: 1J — Definition: Facility ID Number**	**M**	**1**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Code: nnnnnn — Definition: ID Number assigned by THCIC**	**X**	**1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

HL - PATIENT HIERARCHICAL LEVEL

To identify dependencies among and the content of hierarchically related groups of data segments.

Loop: 2000C — PATIENT HIERARCHICAL LEVEL Loop Repeat: >1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the patient is a dependent of the subscriber identified in Loop ID-2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.

2. There are no HLs subordinate to the Patient HL.

3. If a patient is a dependent of a subscriber and can be uniquely identified to the payer by a unique Identification Number, then the patient is considered the subscriber and is to be identified in the Subscriber Level.

Example: **HL*3*2*23*0~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **The first HL01 within each ST-SE envelope must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **Code** **Definition** **23** **Dependent** **The code DEPENDENT conveys that the information in this HL applies to**	**M 1 ID 1/2**

			the patient when the subscriber and the patient are not the same person.					
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described	**O**	**1**	**ID**	**1/1**

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

PAT - PATIENT INFORMATION

To supply patient information.

Loop: 2000C — PATIENT HIERARCHICAL LEVEL
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when the patient is a dependent of the subscriber identified in Loop ID-2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.
Example: **PAT*01~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**PAT01**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**O**	**1**	**ID**	**2/2**
			Specifies the patient's relationship to the person insured.				

CODE	DEFINITION
01	**Spouse**
18	**Self**
19	**Child**
20	**Employee**
21	**Unknown**
39	**Organ Donor**
40	**Cadaver Donor**
53	**Life Partner**
G8	**Other Relationship**

NOT USED	**PAT02**	**1384**	**Patient Location Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**PAT03**	**584**	**Employment Status Code**	**O**	**1**	**ID**	**2/2**
NOT USED	**PAT04**	**1220**	**Student Status Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**PAT05**	**1250**	**Date Time Period Format Qualifier**	**X**	**1**	**ID**	**2/3**
NOT USED	**PAT06**	**1251**	**Date Time Period**	**X**	**1**	**AN**	**1/35**
NOT USED	**PAT07**	**355**	**Unit or Basis for Measurement Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**PAT08**	**81**	**Weight**	**X**	**1**	**R**	**1/10**
NOT USED	**PAT09**	**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**

NM1 - PATIENT NAME

To supply the full name of an individual or organizational entity.

Loop: 2010CA — PATIENT NAME Loop Repeat: 1
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Loop ID 2010CA is Required when Subscriber is not the Patient.
2. Patient SSN MUST be captured in the K3 segment.

For patients that are covered by 42 USC 290DD-2 or 42 CFR Part 2 and facilities that are participating with SAMSHA, use the following naming conventions: JOHN or JANE DOE. Sequential Numbering is allowed, for example: JOHN1, JANE2, etc.

Example: **NM1*QC*1*DOE*SALLY*J~**

Element Detail

Usage	Ref. Des.	Data Element	Name			Attributes	
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code** **Definition** **QC** **Patient**	**M**	**1**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M**	**1**	**ID**	**1/1**

			CODE DEFINITION				
			1 Person				
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Patient Last Name**	**X**	**1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Required when the person has a first name. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Patient First Name**	**O**	**1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Patient Middle Name or Initial**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**1**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X**	**1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

N3 - PATIENT ADDRESS

To specify the location of the named party.

Loop: 2010CA — PATIENT NAME
Repeat: 1
Usage: REQUIRED
Example: **N3*123 MAIN STREET~**

Element Detail

USAGE	REF.	DATA	NAME	ATTRIBUTES

	Des.	Element					
REQUIRED	**N301**	**166**	**Address Information** Address information **INDUSTRY NAME: Patient Address Line**	**M**	**1**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information **Required when there is a second address line. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Patient Address Line**	**O**	**1**	**AN**	**1/55**

N4 - PATIENT CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010CA — PATIENT NAME
Repeat: 1
Usage: REQUIRED
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **INDUSTRY NAME: Patient City Name**	**O**	**1**	**AN**	**2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **INDUSTRY NAME: Patient State Code**	**X**	**1**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **INDUSTRY NAME: Patient Postal Zone or ZIP Code**	**O**	**1**	**ID**	**3/15**

Code	Definition
aa	**Valid State or Province Code**
FC	**Foreign Country**
XX	**Foreign Country**

			When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided. **CODE** **DEFINITION** **00000** **Foreign Country; Recommended value for foreign addresses** **XXXXX** **Foreign Country**				
NOT USED	**N404**	**26**	**Country Code**	**X**	**1**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**1**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**1**	**ID**	**1/3**

DMG - PATIENT DEMOGRAPHIC INFORMATION

To supply demographic information.

Loop: 2010CA — PATIENT NAME
Repeat: 1
Usage: REQUIRED
Notes: 1. DMG03 is gender, or sex at birth.
Example: **DMG*D8*19690815*M~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **Date Expressed in Format CCYYMMDD**	**X**	**1**	**ID**	**2/3**
REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times **SEMANTIC:** DMG02 is the date of birth. **INDUSTRY NAME: Patient Birth Date**	**X**	**1**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual **INDUSTRY NAME: Patient Gender Code** **CODE** **DEFINITION**	**O**	**1**	**ID**	**1/1**

			F Female M Male U Unknown				
NOT USED	**DMG04**	**1067**	**Marital Status**	**O**	**1**	**ID**	**I/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X**	**10**		
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**1**	**R**	**1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X**	**1**	**ID**	**1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X**	**1**	**AN**	**1/30**

CLM - CLAIM INFORMATION

To specify basic data about the claim.

Loop: 2300 — CLAIM INFORMATION Loop Repeat: 100

Repeat: 1

Usage: REQUIRED

Notes: 1. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.

2. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, Loop ID-2300, is placed following Loop ID-2010BB in the Subscriber Hierarchical Level (HL) when patient information is sent in Loop ID-2010BA of the Subscriber HL. Claim information is placed in the Patient HL when the patient information is sent in Loop ID-2010CA of the Patient HL. When the patient is the subscriber, Loop ID-2000C and Loop ID-2010CA are not sent.

Example: **CLM*A37YH556*500***11:B:1*Y*A*Y*I*P~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment **INDUSTRY NAME: Patient Control Number** **The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim.** **The maximum number of characters to be supported for this field is `20'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.**	**M 1 AN 1/38**
REQUIRED	**CLM02**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** CLM02 is the total amount of all submitted charges of service segments for this claim. **INDUSTRY NAME: Total Claim Charge Amount** **The Total Claim Charge Amount must be greater than or equal to zero.** **The total claim charge amount must balance to the sum of all service line charge amounts reported in the Professional Service (SV1) segments for this claim.**	**O 1 R 1/18**
NOT USED	**CLM03**	**1032**	**Claim Filing Indicator Code**	**O 1 ID 1/2**
NOT USED	**CLM04**	**134**	**Non-Institutional Claim**	**O 1 ID 1/2**

				Type Code			
REQUIRED	**CLM05**		**C023**	**HEALTH CARE SERVICE LOCATION INFORMATION** To provide information that identifies the place of service, or the type of bill related to the location at which a health care service was rendered	**O**	**1**	
REQUIRED	**CLM05**	**- 1**	**1331**	**Facility Code Value** Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. **INDUSTRY NAME: Place of Service Code** **CODE / DEFINITION** **22** Outpatient Hospital **23** Emergency Room – Hospital **24** Ambulatory Surgical Center **31** Skilled Nursing Facility **32** Nursing Facility **34** Hospice **50** Federally Qualified Health Center **52** Psychiatric Facility Partial Hospitalization **62** Comprehensive Outpatient Rehabilitation Facility **99** Other Unlisted Facility	**M**	**AN**	**1/2**
REQUIRED	**CLM05**	**- 2**	**1332**	**Facility Code Qualifier** Code identifying the type of facility referenced **CODE / DEFINITION** **B** Place of Service Codes for Professional or Dental Services	**O**	**ID**	**1/2**
REQUIRED	**CLM05**	**- 3**	**1325**	**Claim Frequency Type Code** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type **INDUSTRY NAME: Claim Frequency Code** **CODE / DEFINITION** **0** Non-Payment/Zero **1** Admit through Discharge Claim **6** Corrected (Adjustment to Prior	**O**	**ID**	**1/1**

				Claim) **7 Replacement of Prior Claim** **8 Void/Cancel of Prior Claim**				
NOT USED	**CLM06**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM07**		**1359**	**Provider Accept Assignment Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM08**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM09**		**1363**	**Release of Information Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM10**		**1351**	**Patient Signature Source Code**	**O**	**1**	**ID**	**1/1**
SITUATIONAL	**CLM11**		**C024**	**RELATED CAUSES INFORMATION** To identify one or more related causes and associated state or country information **Required when the services provided are employment related or the result of an accident. If not required by this implementation guide, do not send.**	**O**	**1**		
REQUIRED	**CLM11**	**- 1**	**1362**	**Related-Causes Code** Code identifying an accompanying cause of an illness, injury or an accident **INDUSTRY NAME: Related Causes Code** **CODE DEFINITION** **AA Auto Accident** **AB Abuse** **AP Another Party Responsible** **EM Employment** **OA Other Accident**	**M**		**ID**	**2/3**
SITUATIONAL	**CLM11**	**- 2**	**1362**	**Related-Causes Code** Code identifying an accompanying cause of an illness, injury or an accident **INDUSTRY NAME: Related Causes Code** **Required when more than one related cause code applies. If not required by this implementation guide, do not send.** **CODE DEFINITION** **AA Auto Accident** **AB Abuse** **AP Another Party Responsible** **EM Employment**	**O**		**ID**	**2/3**

				OA **Other Accident**				
SITUATIONAL	**CLM11**	**- 3**	**1362**	**Related-Causes Code** Code identifying an accompanying cause of an illness, injury or an accident **INDUSTRY NAME: Related Causes Code** **Required when more than one related cause code applies. If not required by this implementation guide, do not send.** **CODE** **DEFINITION** **AA** **Auto Accident** **AB** **Abuse** **AP** **Another Party Responsible** **EM** **Employment** **OA** **Other Accident**	**O**		**ID**	**2/3**
NOT USED	**CLM11**	**- 4**	**156**	**State or Province Code**	**O**		**ID**	**2/2**
NOT USED	**CLM11**	**- 5**	**26**	**Country Code**	**O**		**ID**	**2/2**
NOT USED	**CLM12**		**1366**	**Special Program Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**CLM13**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM14**		**1338**	**Level of Service Code**	**O**	**1**	**ID**	**1/3**
NOT USED	**CLM15**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM16**		**1360**	**Provider Agreement Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM17**		**1029**	**Claim Status Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**CLM18**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**CLM19**		**1383**	**Claim Submission Reason Code**	**O**	**1**	**ID**	**2/2**
NOT USED	**CLM20**		**1514**	**Delay Reason Code**	**O**	**1**	**ID**	**1/2**

REF - MEDICAL RECORD NUMBER

To specify identifying information.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the provider needs to identify for future inquiries, the actual medical record of the patient identified in either Loop ID-

2010BA or Loop ID-2010CA for this episode of care. If not required by this implementation guide, do not send.

Example: **REF*EA*44444TH56~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code** **Definition** **EA** **Medical Record Identification Number**	**M**	**1**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **INDUSTRY NAME: Medical Record Number**	**X**	**1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

K3 - FILE INFORMATION

To transmit a fixed-format record or matrix contents.

Loop: 2300 — CLAIM INFORMATION

Repeat: 10

Usage: REQUIRED

Notes: 1. Per Texas Government Code, Title 4, Section 531.0162, to meet national standard reporting requirements, the "Patient Ethnicity" and "Patient Race" is collected in the K3 segment. The adopted location for "Patient Ethnicity" is the 1st character of the K301 data element, and the "Patient Race" is the 2nd character. To obtain "Patient Race" and "Patient Ethnicity" data, the facility staff retrieves the patient's response from a written form or asks the patient, or the person speaking for the patient, to classify the patient. If the patient, or person speaking for the patient, declines to answer, the facility staff is to use its best judgment to make the correct classification based on available data.

2. When the patient is not the subscriber their Social Security Number

is required to be reported in the 3rd through 11th characters of the K301 data element. THCIC requires that the Patient's Social Security Number be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.

Example: **K3*25~**

K3*1199999999~

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**K301**	**449**	**Fixed Format Information**	**M 1 AN 1/80**

Data in fixed format agreed upon by sender and receiver

SEMANTIC: Position 1 denotes Ethnicity

Code	Definition
1	**Hispanic or Latino**
2	**Not Hispanic or Latino**

SEMANTIC: Position 2 denotes Race

Code	Definition
1	**American Indian/Eskimo/Aleut**
2	**Asian, Native Hawaiian or Pacific Islander**
3	**Black or African American**
4	**White**
5	**Other Race**

SEMANTIC: Positions 3 to 11 denotes Social Security Number

Required when the patient is not the subscriber. If not required by this implementation guide, do not send.

Code	Definition
nnnnnnnnn	**Social Security Number**
999999999	**Unknown SSN** **This value is required for:** **1. Newborns without an SSN** **2. Foreigners without an SSN** **3. Patients refusing or cannot provide an SSN**

NOT USED	**K302**	**1333**	**Record Format Code**	**O 1 ID 1/2**
NOT USED	**K303**	**C001**	**COMPOSITE UNIT OF MEA-**	**O 1**

HI - HEALTH CARE DIAGNOSIS CODE

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION
Repeat: 1
Usage: REQUIRED
Notes: 1. THCIC REQUIRES a "Principal Diagnosis Code/Health Care Diagnosis Code". "External Cause of Injury/Morbidity Codes (Ecodes)" and "Other Diagnosis Codes", if required to provide additional information, can be specified in this segment.

2. Do not transmit the decimal point for ICD codes. The decimal point is implied.

Example: **HI*ABK:T23151A*ABF:T23152A*ABN:X0820XA~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes		
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**	**1**	
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			INDUSTRY NAME: Diagnosis Type Code **Code** **Definition** **ABK** **International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis**			
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY NAME: Principal Diagnosis Code			
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X**	**A**	**1/3**

							N	5
NOT USED	**HI01**	**- 5**	**782**	**Monetary Amount**	**O**		**R**	**1/18**
NOT USED	**HI01**	**- 6**	**380**	**Quantity**	**O**		**R**	**1/15**
NOT USED	**HI01**	**- 7**	**799**	**Version Identifier**	**O**		**AN**	**1/30**
NOT USED	**HI01**	**- 8**	**1271**	**Industry Code**	**X**		**AN**	**1/30**
NOT USED	**HI01**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**		**ID**	**1/1**
SITUATIONAL	**HI02**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**		
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**				
REQUIRED	**HI02**	**- 1**	**1270**	**Code List Qualifier Code**	**M**		**ID**	**1/3**
				Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**				
REQUIRED	**HI02**	**- 2**	**1271**	**Industry Code**	**M**		**AN**	**1/30**
				Code indicating a code from a specific industry code list **INDUSTRY NAME: Other Diagnosis** **INDUSTRY NAME: External Cause of Injury**				

				Code			
NOT USED	**HI02**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**			
REQUIRED	**HI03**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI03**	**- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

				Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**			
NOT USED	**HI03**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**		**C022**	**HEALTH CARE CODE INFORMATION** **Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.** **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**	**M**	**1**	
REQUIRED	**HI04**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-**	**M**	**ID**	**1/3**

				10-CM) External Cause of Injury Code			
REQUIRED	**HI04**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY NAME: External Cause of Injury Code **INDUSTRY NAME: Other Diagnosis**			
NOT USED	**HI04**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**		**C022**	**HEALTH CARE CODE INFORMATION** **Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.** **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**	**M**	**1**	
REQUIRED	**HI05**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				INDUSTRY NAME: Diagnosis Type Code **CODE** **DEFINITION** **ABF** **International Classification of Dis-**			

				eases Clinical Modification (ICD-10-CM) Diagnosis			
				ABN **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**			
REQUIRED	**HI05**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI05**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**		**C022**	**HEALTH CARE CODE INFORMATION** **Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.** **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**	**M**	**1**	
REQUIRED	**HI06**	**- 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

				Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**			
REQUIRED	**HI06**	**- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
				Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**			
NOT USED	**HI06**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required**			

				by this implementation guide, do not send.			
REQUIRED	**HI07**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI07**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI07**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**		**C022**	**HEALTH CARE CODE INFORMATION** **Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.**	**M**	**1**	

				Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.			
REQUIRED	**HI08**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE DEFINITION** **ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI08**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI08**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				Required when an additional External Cause of Injury must be sent, and the			

				preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**			
REQUIRED	**HI09**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE DEFINITION** **ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI09**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI09**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI10**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**			
REQUIRED	**HI10**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI10**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI10**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

NOT USED	**HI10**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send. **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**			
REQUIRED	**HI11**	**- 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **INDUSTRY NAME: Diagnosis Type Code** **CODE** **DEFINITION** **ABF** **International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** **ABN** **International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**	**M**	**ID**	**1/3**
REQUIRED	**HI11**	**- 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **INDUSTRY NAME: External Cause of Injury Code** **INDUSTRY NAME: Other Diagnosis**	**M**	**AN**	**1/30**
NOT USED	**HI11**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	**HI11**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	

Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.

REQUIRED	**HI12**	**- 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

INDUSTRY NAME: Diagnosis Type Code

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis**
ABN	**International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code**

REQUIRED	**HI12**	**- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY NAME: External Cause of Injury Code

INDUSTRY NAME: Other Diagnosis

NOT USED	**HI12**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	**HI12**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI12**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

HI - ANESTHESIA RELATED PROCEDURE

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required on claims where anesthesiology services are being billed or reported when the provider knows the surgical code and knows the adjudication of the claim will depend on provision of the surgical code. If not required by this implementation guide, do not send.

Example: **HI*BP:33414~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes		
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**	**1**	
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **Code** **Definition** **BP** **Health Care Financing Administration Common Procedural Coding System Principal Procedure**	**M**	**ID**	**1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Anesthesia Related Surgical Procedure			
NOT USED	**HI01**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI01**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI01**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI02**		**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.			
REQUIRED	**HI02**	**- 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
				Code identifying a specific industry code list			
				CODE **DEFINITION**			
				BO **Health Care Financing Administration Common Procedural Coding System**			
REQUIRED	**HI02**	**- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
				Code indicating a code from a specific industry code list			
NOT USED	**HI02**	**- 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02**	**- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02**	**- 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02**	**- 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02**	**- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02**	**- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02**	**- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI03**		**C022**	**HEALTH CARE CODE IN-**	**M**	**1**	

			FORMATION		
NOT USED	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**M**	**1**

NM1 - RENDERING PROVIDER NAME

To supply the full name of an individual or organizational entity.

Loop: 2310B — RENDERING PROVIDER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the Rendering Provider information is different than that carried in Loop ID-2010AA - Billing Provider. If not required by this implementation guide, do not send.

2. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

3. 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.

Example: **NM1*82*1*DOE*JANE*C***XX*1234567804~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code** **Definition** **82** **Rendering Provider**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code** **Definition** **1** **Person** **2** **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Rendering Provider Last or Organization Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider Middle Name or Initial**	**O 1 AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1 AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O 1 AN 1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementa-**	**X 1 ID 1/2**

			tion date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send. **CODE** **DEFINITION** **XX** **Centers for Medicare and Medicaid Services National Provider Identifier**					
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider Identifier** **CODE** **DEFINITION** **XXXXXXXXXX** **National Provider Identifier (NPI) Number**	**X**	**1**	**AN**	**2/80**	
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**	
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**	
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**	

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2310B — RENDERING PROVIDER NAME
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
Example: **REF*0B*A12345~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID**	**2/3**

			Code qualifying the Reference Identification **CODE** **DEFINITION** **0B** **State License Number**				
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**1**	**AN**	**1/50**
			INDUSTRY NAME: Rendering Provider Secondary Identifier				
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

NM1 - SERVICE FACILITY LOCATION NAME

To supply the full name of an individual or organizational entity.

Loop: 2310C — SERVICE FACILITY LOCATION NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
If not required by this implementation guide, do not send.

2. When an organization health care provider's NPI is provided to identify the Service Location, the organization health care provider must be external to the entity identified as the Billing Provider (for example, reference lab). It is not permissible to report an organization health care provider NPI as the Service Location if the entity being identified is a component (for example, subpart) of the Billing Provider. In that case, the subpart must be the Billing Provider.

3. The purpose of this loop is to identify specifically where the service was rendered.

4. 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.

Example: **NM1*77*2*ABC CLINIC*****XX*1234567891~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES

REQUIRED	**NM101**	**98**	**Entity Identifier Code**	**M**	**1**	**ID**	**2/3**
			Code identifying an organizational entity, a physical location, property or an individual **CODE** **DEFINITION** **77** **Service Location**				
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID**	**1/1**
			Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **CODE** **DEFINITION** **2** **Non-Person Entity**				
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN**	**1/60**
			Individual last name or organizational name **INDUSTRY NAME: Laboratory or Facility Name**				
NOT USED	**NM104**	**1036**	**Name First**	**O**	**1**	**AN**	**1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**1**	**ID**	**1/2**
			Code designating the system/method of code structure used for Identification Code (67) **CODE** **DEFINITION** **XX** **Centers for Medicare and Medicaid Services National Provider Identifier** **24** **Employer's Identification Number**				
REQUIRED	**NM109**	**67**	**Identification Code**	**X**	**1**	**AN**	**2/80**
			Code identifying a party or other code **INDUSTRY NAME: Laboratory or Facility Primary Identifier** **CODE** **DEFINITION** **XXXXXXXXXX** **National Provider Identifier (NPI) Number** **nnnnnnnnn** **Employer Identification Number (EIN)**				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

N3 - SERVICE FACILITY LOCATION ADDRESS

To specify the location of the named party.

Loop: 2310C — SERVICE FACILITY LOCATION NAME
Repeat: 1
Usage: REQUIRED
Notes: 1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)
Example: **N3*123 MAIN STREET~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**N301**	**166**	**Address Information** Address information **INDUSTRY NAME: Laboratory or Facility Address Line**	**M**	**1**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information **Required when there is a second address line. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Laboratory or Facility Address Line**	**O**	**1**	**AN**	**1/55**

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2310C — SERVICE FACILITY LOCATION NAME
Repeat: 1
Usage: REQUIRED
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

Usage	Ref. Des.	Data	Name	Attributes

		ELEMENT					
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **INDUSTRY NAME: Laboratory or Facility City Name**	**O**	**1**	**AN**	**2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **INDUSTRY NAME: Laboratory or Facility State or Province Code** **CODE** **DEFINITION** **aa** **Valid State or Province Code** **FC** **Foreign Country** **XX** **Foreign Country**	**X**	**1**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **INDUSTRY NAME: Laboratory or Facility Postal Zone or ZIP Code** **When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.** **CODE** **DEFINITION** **00000** **Foreign Country; Recommended value for foreign addresses** **XXXXX** **Foreign Country**	**O**	**1**	**ID**	**3/15**
NOT USED	**N404**	**26**	**Country Code**	**X**	**1**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**1**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**1**	**ID**	**1/3**

REF - SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

To specify THCIC identifying information.

Loop: 2310C — SERVICE FACILITY LOCATION NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. THCIC requires the 6-digit number (THCIC ID) assigned to the Service Facility identified in Loop 2310C. The THCIC ID, along with either the NPI (NM109), EIN (NM109), and the Address (N301) is used to

verify a Provider's identity.

2. Required by THCIC when the Service Facility Provider is different than the Billing Provider.

Example: **REF*1J*000116~**

Element Detail

Usage	Ref. Des.	Data Element	Name		Attributes		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Code: 1J — Definition: Facility ID Number**	**M**	**1**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Code: nnnnnn — Definition: ID Number assigned by THCIC**	**X**	**1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

SBR - OTHER SUBSCRIBER INFORMATION

To record information specific to the primary insured and the insurance carrier for that insured.

Loop: 2320 — OTHER SUBSCRIBER INFORMATION Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when other payers are known to potentially be involved in paying on this claim. If not required by this implementation guide, do not send.

2. All information contained in Loop ID-2320 applies only to the payer identified in Loop ID-2330B of this iteration of Loop ID-2320. It is specific only to that payer.

3. THCIC only collects Secondary Payer data.

Example: **SBR*S*01*GR00786******13~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **Code** **Definition** **S** **Secondary**	**M 1 ID 1/1**
REQUIRED	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities **SEMANTIC:** SBR02 specifies the relationship to the person insured. **Code** **Definition** **01** **Spouse** **18** **Self** **19** **Child** **20** **Employee** **21** **Unknown** **39** **Organ Donor** **40** **Cadaver Donor** **53** **Life Partner** **G8** **Other Relationship**	**O 1 ID 2/2**
SITUATIONAL	**SBR03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SEMANTIC:** SBR03 is policy or group number. **Required when the subscriber's identification card for the non-destination payer identified in Loop ID-2330B of this iteration of Loop ID-2320 shows a group number. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Insured Group or Policy Number** **This is not the number uniquely identifying the subscriber. The unique subscriber number is submitted in Loop 2330A-NM109 for this iteration of Loop ID-2320.**	**O 1 AN 1/50**
SITUATIONAL	**SBR04**	**93**	**Name** Free-form name **SEMANTIC:** SBR04 is plan name.	**O 1 AN 1/60**

			Required when SBR03 is not used, and the group name is available. If not required by this implementation guide, do not send. **INDUSTRY NAME: Other Insured Group Name**					
SITUATIONAL	**SBR05**	**1336**	**Insurance Type Code** Code identifying the type of insurance policy within a specific insurance program	**O**	**1**	**ID**	**1/3**
			Required when the payer identified in Loop ID-2330B for this iteration of Loop ID-2320 is Medicare and Medicare is not the primary payer (Loop ID-2320 SBR01 is not P). If not required by this implementation guide, do not send.					
			CODE / **DEFINITION** **12** Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan **13** Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan **14** Medicare Secondary, No-fault Insurance including Auto is Primary **15** Medicare Secondary Worker's Compensation **16** Medicare Secondary Public Health Service (PHS)or Other Federal Agency **41** Medicare Secondary Black Lung **42** Medicare Secondary Veteran's Administration **43** Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) **47** Medicare Secondary, Other Liability Insurance is Primary					
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O**	**1**	**ID**	**2/2**
REQUIRED	**SBR09**	**1032**	**Claim Filing Indicator Code** Code identifying type of claim	**O**	**1**	**ID**	**1/2**
			CODE / **DEFINITION** **11** Other Non-Federal Programs **12** Preferred Provider Organization					

	(PPO)
13	**Point of Service (POS)**
14	**Exclusive Provider Organization (EPO)**
15	**Indemnity Insurance**
16	**Health Maintenance Organization (HMO) Medicare Risk**
17	**Dental Maintenance Organization**
AM	**Automobile Medical**
BL	**Blue Cross/Blue Shield**
CH	**Champus**
CI	**Commercial Insurance Co.**
DS	**Disability**
FI	**Federal Employees Program**
HM	**Health Maintenance Organization**
LM	**Liability Medical**
MA	**Medicare Part A**
MB	**Medicare Part B**
MC	**Medicaid**
OF	**Other Federal Program Use code OF when submitting Medicare Part D claims.**
TV	**Title V**
VA	**Veterans Affairs Plan**
WC	**Workers' Compensation Health Claim**
ZZ	**Mutually Defined Use Code ZZ when Type of Insurance is not known.**

NM1 - OTHER PAYER NAME

To supply the full name of an individual or organizational entity.

Loop: 2330B — OTHER PAYER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. No Patient Personally Identifiable Information (PII) data should be present.

2. This is the secondary payer.

3. For the purposes of this implementation the term payer is synonymous with several other terms, such as, repricer and third-party administrator.

Example: **NM1*PR*2*ABC INSURANCE CO*****PI*11122333~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code** **Definition** **PR** **Payer**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Code** **Definition** **2** **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY NAME: Other Payer Organization Name** **Code** **Definition** **SELF-PAY** **For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")** **CHARITY** **For Charity Claims (Claim Filing Indicator Code is "ZZ")** **UNKNOWN** **With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")**	**X 1 AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O 1 AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O 1 AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1 AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O 1 AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **Code** **Definition** **PI** **Payor Identification unless Self-Pay, Charity, or Unknown Payer claim** **XV** **Centers for Medicare and Medicaid Services PlanID** **ZY** **Temporary Identification Number for use with Self-Pay, Charity, or Unknown Payer claim**	**X 1 AN 2/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X 1 AN 2/80**

				INDUSTRY NAME: Other Payer Identifier **CODE** **DEFINITION** **XXXXXXXXXX** **National Plan Identifier (NPI) Number** **CMS currently has delayed the implementation date for all plans and providers until further notice.** **SELF-PAY** **For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")** **CHARITY** **For Charity Claims (Claim Filing Indicator Code is "ZZ")** **UNKNOWN** **With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")**				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

LX - SERVICE LINE NUMBER

To reference a line number in a transaction set.

Loop: 2400 — SERVICE LINE NUMBER Loop Repeat: 50
Repeat: 1
Usage: REQUIRED
Notes: 1. The LX functions as a line counter.
2. The Service Line LX segment must begin with one and is incremented by one for each additional service line of a claim.
Example: **LX*1~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set	**M**	**1**	**N0**	**1/6**

SV1 - PROFESSIONAL SERVICE LINE

To specify the service line-item detail for a health care institution.

Loop: 2400 — SERVICE LINE NUMBER
Repeat: 1
Usage: REQUIRED
Example: **SV1*HC:99211:25*12.25*UN*1*11**1:2:3**Y~**

Element Detail

Usage	Ref. Des.		Data Element	Name		Attributes	
REQUIRED	**SV101**		**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**X**	**1**	
				To identify a medical procedure by its standardized codes and applicable modifiers			
REQUIRED	**SV101**	**- 1**	**235**	**Product/Service ID Qualifier**	**M**	**ID**	**2/2**
				Code identifying the type/source of the descriptive number used in Product/Service ID (234)			
				INDUSTRY NAME: Product or Service ID Qualifier			
				Code **Definition** **HC** **Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**			
REQUIRED	**SV101**	**- 2**	**234**	**Product/Service ID**	**M**	**AN**	**1/48**
				Identifying number for a product or service			
				INDUSTRY NAME: Procedure Code			
SITUATIONAL	**SV101**	**- 3**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**
				This identifies special circumstances related to the performance of the service, as defined by trading partners			
				Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.			

SITUATIONAL	**SV101**	**- 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.**	**O**		**AN**	**2/2**
SITUATIONAL	**SV101**	**- 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.**	**O**		**AN**	**2/2**
SITUATIONAL	**SV101**	**- 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.**	**O**		**AN**	**2/2**
NOT USED	**SV101**	**- 7**	**352**	**Description**	**O**		**AN**	**1/80**
NOT USED	**SV101**	**- 8**	**234**	**Product/Service ID**	**M**		**AN**	**1/48**
REQUIRED	**SV102**		**782**	**Monetary Amount** Monetary Amount **SEMANTIC:** SV102 is the submitted service line-item amount. **INDUSTRY NAME: Line Item Charge Amount** **This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and any applicable tax and/or postage claimed amounts reported within this line's AMT segments.** **Zero "0" is an acceptable value for this element.**	**O**	**1**	**R**	**1/18**
REQUIRED	**SV103**		**355**	**Unit or Basis for Mea-**	**X**	**1**	**ID**	**2/2**

				surement Code Code specifying the units in which a value is being expressed, or way a measurement has been taken **CODE DEFINITION** **MJ Minutes** **UN Unit**				
REQUIRED	**SV104**		**380**	**Quantity** Numeric value of quantity **INDUSTRY NAME: Service Unit Count** **Note: When a decimal is needed to report units, include it in this element, for example, "15.6".**	**X**	**1**	**R**	**1/15**
SITUATIONAL	**SV105**		**1331**	**Facility Code Value** Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. **SEMANTIC:** SV105 is the place of service. **Required when value is different than value carried in CLM05-1 in Loop ID-2300. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Place of Service Code** **CODE DEFINITION** **22 Outpatient Hospital** **23 Emergency Room – Hospital** **24 Ambulatory Surgical Center** **31 Skilled Nursing Facility** **32 Nursing Facility** **34 Hospice** **50 Federally Qualified Health Center** **52 Psychiatric Facility Partial Hospitalization** **62 Comprehensive Outpatient Rehabilitation Facility** **99 Other Unlisted Facility**	**O**	**1**	**AN**	**1/2**
NOT USED	**SV106**		**1365**	**Service Type Code**	**O**	**1**	**ID**	**1/2**
REQUIRED	**SV107**		**C004**	**COMPOSITE DIAGNOSIS CODE POINTER** To identify one or more diagnosis code pointers	**O**	**1**		
REQUIRED	**SV107**	**- 1**	**1328**	**Diagnosis Code Pointer**	**M**		**N0**	**1/2**

				A pointer to the diagnosis code in the order of importance to this service				
				This first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12 and correspond to Composite Data Elements 01 through 12 in the Health Care Diagnosis Code HI segment in the Claim Loop ID-2300.				
SITUATIONAL	**SV107**	**- 2**	**1328**	**Diagnosis Code Pointer**	**O**		**N0**	**1/2**
				A pointer to the diagnosis code in the order of importance to this service				
				Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.				
SITUATIONAL	**SV107**	**- 3**	**1328**	**Diagnosis Code Pointer**	**O**		**N0**	**1/2**
				A pointer to the diagnosis code in the order of importance to this service				
				Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.				
SITUATIONAL	**SV107**	**- 4**	**1328**	**Diagnosis Code Pointer**	**O**		**N0**	**1/2**
				A pointer to the diagnosis code in the order of importance to this service				
				Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.				
NOT USED	**SV108**		**782**	**Monetary Amount**	**O**	**1**	**R**	**1/18**
NOT USED	**SV109**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV110**		**1340**	**Multiple Procedure Code**	**O**	**1**	**ID**	**1/2**
NOT USED	**SV111**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV112**		**1073**	**Yes/No Condition or Response Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV113**		**1364**	**Review Code**	**O**	**1**	**ID**	**1/2**

NOT USED	**SV114**	**1341**	**National or Local Assigned Review Value**	**O**	**1**	**ID**	**1/2**
NOT USED	**SV115**	**1327**	**Copay Status Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV116**	**1327**	**Health Care Professional Shortage Area Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV117**	**127**	**Reference Identification**	**O**	**1**	**AN**	**1/50**
NOT USED	**SV118**	**116**	**Postal Code**	**O**	**1**	**ID**	**3/15**
NOT USED	**SV119**	**782**	**Monetary Amount**	**O**	**1**	**R**	**1/18**
NOT USED	**SV120**	**1337**	**Level of Care Code**	**O**	**1**	**ID**	**1/1**
NOT USED	**SV121**	**1360**	**Provider Agreement Code**	**O**	**1**	**ID**	**1/1**

DTP - DATE - SERVICE DATE

To specify any or all a date, a time, or time period.

Loop: 2400 — SERVICE LINE NUMBER
Repeat: 1
Usage: REQUIRED
Example: **DTP*472*RD8*20050314-20050325~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier**	**M**	**1**	**ID**	**3/3**
			Code specifying type of date or time, or both date and time				
			INDUSTRY NAME: Date Time Qualifier				
			Code Definition **472 Service**				
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**	**M**	**1**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03.				
			RD8 is required only when the "To and From" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "To and From" dates are the same.				

			CODE	**DEFINITION**				
			D8	**Date Expressed in Format CCYYMMDD**				
			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**				
REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M**	**1**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times					
			INDUSTRY NAME: Service Date					

NM1 - RENDERING PROVIDER NAME

To supply the full name of an individual or organizational entity.

Loop: 2420A — RENDERING PROVIDER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider.

2. Required when Loop ID-2310B Rendering Provider is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop ID-2010AA Billing Provider. If not required by this implementation guide, do not send.

Example: **NM1*82*1*DOE*JANE*C***XX*1234567804~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBUTES			
REQUIRED	**NM101**	**98**	**Entity Identifier Code**		**M**	**1**	**ID**	**2/3**
			Code identifying an organizational entity, a physical location, property or an individual					
			CODE	**DEFINITION**				
			82	**Rendering Provider**				
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier**		**M**	**1**	**ID**	**1/1**
			Code qualifying the type of entity					
			SEMANTIC: NM102 qualifies NM103.					
			CODE	**DEFINITION**				
			1	**Person**				
			2	**Non-Person Entity**				
REQUIRED	**NM103**	**1035**	**Name Last or Organization**		**X**	**1**	**AN**	**1/60**

			Name Individual last name or organizational name **INDUSTRY NAME: Rendering Provider Last or Organization Name**					
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider First Name**	**O**	**1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider Middle Name or Initial**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.** **CODE** **DEFINITION** **XX** **Centers for Medicare and Medicaid Services National Provider Identifier**	**X**	**1**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.** **INDUSTRY NAME: Rendering Provider Identifier**	**X**	**1**	**AN**	**2/80**

			CODE **DEFINITION**				
			XXXXXXXXXX National Provider Identifier (NPI) Number				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2420A — RENDERING PROVIDER NAME
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.
Example: **REF*0B*A12345~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID**	**2/3**
			Code qualifying the Reference Identification				
			CODE **DEFINITION**				
			0B State License Number				
REQUIRED	**REF02**	**127**	**Reference Identification**	**X**	**1**	**AN**	**1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			INDUSTRY NAME: Rendering Provider Secondary Identifier				
NOT USED	**REF03**	**352**	**Description**	**X**	**1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**	**1**		

SE - TRANSACTION SET TRAILER

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Repeat: 1
Usage: REQUIRED
Example: **SE*1230*987654~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments IMPLEMENTATION NAME: Transaction Segment Count	**M**	**1**	**N0**	**1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA) but can repeat in other interchanges.**	**M**	**1**	**AN**	**4/9**

5.4 Control Segments

ISA - INTERCHANGE CONTROL HEADER

To start and identify an interchange of zero or more functional groups and interchange-related control segments.

Repeat: 1

Usage: REQUIRED

Notes: 1. All positions within each of the data elements must be filled.

2. For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.

3. The first element separator defines the element separator to be used through the entire interchange.

4. The ISA segment terminator defines the segment terminator used throughout the entire interchange.

5. Spaces in the example interchanges are represented by "." for clarity.

6. Submitters will receive an Acknowledgement and a Claim Acceptance Response Report, regardless of ISA14 value.

7. Submitters must submit test data to System13, Inc. and receive approval prior to submitting production data. Submitters must be on the approved Submitter List at System13, Inc. prior to submitting Production Data.

Example: **ISA*00*.....*01*SECRET....*ZZ*SUB999.....*ZZ*YTH837.....*030101*1253*^*00501*000000905*1*T*:~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code identifying the type of information in the Authorization Information	**M 1 ID 2/2**

CODE	DEFINITION
00	**No Authorization Information Present**
03	**Additional Data Identification**

REQUIRED	**ISA02**	**I02**	**Authorization Information**	**M**	**1**	**AN**	**10/10**
			Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)				
			This element is fixed in length with identical minimum and maximum lengths. Spaces are inserted to meet the minimum length in an AN data element. With the associated code 00 in ISA01 or ISA03, an all space value indicates no information.				
REQUIRED	**ISA03**	**I03**	**Security Information Qualifier**	**M**	**1**	**ID**	**2/2**
			Code identifying the type of information in the Security Information				
			CODE **DEFINITION** **00** **No Security Information Present** **01** **Password**				
REQUIRED	**ISA04**	**I04**	**Security Information**	**M**	**1**	**AN**	**10/10**
			This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)				
			This element is fixed in length with identical minimum and maximum lengths. Spaces are inserted to meet the minimum length in an AN data element. With the associated code 00 in ISA01 or ISA03, an all space value indicates no information.				
REQUIRED	**ISA05**	**I05**	**Interchange ID Qualifier**	**M**	**1**	**ID**	**2/2**
			Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified				
			This ID qualifies the Sender in ISA06.				
			CODE **DEFINITION** **ZZ** **Mutually Defined**				
REQUIRED	**ISA06**	**I06**	**Interchange Sender ID**	**M**	**1**	**AN**	**15/15**
			Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element				

CODE	DEFINITION
SUBnnn	**System13, Inc. Submitter ID Number**

The Submitter ID Number must be obtained from System13, Inc.

REQUIRED	**ISA07**	**I05**	**Interchange ID Qualifier**	**M**	**1**	**ID**	**2/2**

Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
ZZ	**Mutually Defined**

REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID**	**M**	**1**	**AN**	**15/15**

Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them

CODE	DEFINITION
YTH837	**Required by THCIC**

REQUIRED	**ISA09**	**I08**	**Interchange Date**	**M**	**1**	**DT**	**6/6**

Date of the interchange

The date format is YYMMDD.

REQUIRED	**ISA10**	**I09**	**Interchange Time**	**M**	**1**	**TM**	**4/4**

Time of the interchange

The time format is HHMM.

REQUIRED	**ISA11**	**I65**	**Repetition Separator**	**M**	**1**		**1/1**

Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator

CODE	DEFINITION
^	**THCIC-Recommended Repetition Separator**

REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**	**M**	**1**	**ID**	**5/5**

Code specifying the version number of the interchange control segments

CODE	DEFINITION

			00501 Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
REQUIRED	**ISA13**	**I12**	**Interchange Control Number M 1 N0 9/9** A control number assigned by the interchange sender **The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.** **Must be a positive unsigned number and must be identical to the value in IEA02.**
REQUIRED	**ISA14**	**I13**	**Acknowledgment Requested M 1 ID 1/1** Code indicating sender's request for an interchange acknowledgment **CODE DEFINITION** **0 No Interchange Acknowledgment Requested** **1 Interchange Acknowledgment Requested (TA1)**
REQUIRED	**ISA15**	**I14**	**Interchange Usage Indicator M 1 ID 1/1** Code indicating whether data enclosed by this interchange envelope is test, production or information **CODE DEFINITION** **P Production Data** **T Test Data**
REQUIRED	**ISA16**	**I15**	**Component Element Separator M 1 1/1** Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator **CODE DEFINITION** **: THCIC-Recommended Component Element Separator**

GS - FUNCTIONAL GROUP HEADER

To indicate the beginning of a functional group and to provide control information.

Repeat: 1
Usage: REQUIRED

Notes: 1. A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Example: **GS*XX*SUB999*YTH837*20150101*0700*1*X*005010X223A2~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets. **Code: HC — Definition: Health Care Claim (837)**	**M 1 ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners. **Code: SUBnnn — Definition: System13, Inc. Submitter ID Number** The Submitter ID Number must be obtained from System13, Inc. **Must be identical to the value in ISA06.**	**M 1 AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners. **Code: YTH837 — Definition: Required by THCIC**	**M 1 AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date. Use this date for the functional group creation date.	**M 1 DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time.	**M 1 TM 4/8**

Use this time for the creation time. The recommended format is HHMM.

REQUIRED GS06 28 Group Control Number M 1 N0 1/9

Assigned number originated and maintained by the sender.

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period to be determined by the sender.

REQUIRED GS07 455 Responsible Agency Code M 1 ID 1/2

Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED GS08 480 Version / Release / Industry Identifier Code M 1 AN 1/12

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE	DEFINITION
005010X223A2	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003**

GE - FUNCTIONAL GROUP TRAILER

To indicate the end of a functional group and to provide control information.

Repeat: 1

Usage: REQUIRED

Notes: 1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Example: **GE*1*1~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	**M**	**1**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06. **Must be a positive unsigned number and must be identical to the value in GS06.**	**M**	**1**	**N0**	**1/9**

IEA - INTERCHANGE CONTROL TRAILER

To define the end of an interchange of zero or more functional groups and interchange-related control segments.

Repeat: 1
Usage: REQUIRED
Example: **IEA*1*000000905~**

Element Detail

Usage	Ref. Des.	Data Element	Name	Attributes			
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange.	**M**	**1**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender.	**M**	**1**	**N0**	**9/9**

	Must be a positive unsigned number and must be identical to the value in ISA13.

5.5 Examples

1. Subscriber is the Patient

```
ISA*00*          *00*          *ZZ*SUB999         *ZZ*YTH837
*250401*1512*^*00501*000000001*0*P*:~
GS*HC*SUB999*YTH837*20250401*1512*000000002*X*005010X222A1~
ST*837*0003*005010X222A1~
BHT*0019*00*202504011512*20250401*1512*RP~
NM1*41*2*ABC SUBMITTER*****46*SUB999~
PER*IC*ABC SUBMITTER*TE*8883084953~
NM1*40*2*THCIC*****46*YTH837~
HL*1**20*1~
NM1*85*2*SYSTEM13 QA 1*****XX*0100000008~
N3*1648 STATE FARM~
N4*CHARLOTTESVILLE*TX*22911~
REF*EI*987654321~
REF*1J*000001~
HL*2*1*22*0~
SBR*P*18*******MB~
NM1*IL*1*DOE*JOHN****MI*1A2B3C4D~
N3*100 MAIN ST*~
N4*AUSTIN*TX*78756*US~
DMG*D8*19590918*M~
REF*SY*999999999~
NM1*PR*2*MEDICARE OF TEXAS*****PI*99999~
CLM*10000*2089.10***24:A:1**A*Y*Y~
CL1*3*1*01~
REF*EA*50000~
HI*ABK:H25812~
HI*APR:H25812~
HI*BBR:66984:D8:20250102~
HI*BBQ:J1097:D8:20250102*BBQ:J1096:D8:20250102~
K3*24~
NM1*82*1*STEPHENS*MICHAEL*P***XX*1234567890~
SBR*S********MC~
NM1*PR*2*MEDICAID*****PI*88888~
LX*1~
SV1*HC:66984:LT*1083.18*UN*1.00***1~
DTP*472*D8*20250102~
LX*2~
SV1*HC:J1097:JZ*500.00*UN*4.00***1~
DTP*472*D8*20250102~
LX*3~
SV1*HC:J1096:JZ*505.92*UN*4.00***1~
DTP*472*D8*20250102~
SE*40*0003~
GE*1*000000002~
IEA*1*000000001~
```

6. Revision Changes

Revision Changes
Version 1.1
1. Replaced “2310E” with “2310C”
Version 1.0
1. Extracted from Outpatient Technical Specifications v11.4 2. Add 837 Example