

837I

837 Institutional Health Care Claim

This companion document is for informational purposes only to describe certain aspects and expectations regarding the transaction and is not a complete guide. The details contained in this document are supplemental and should be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) as published by the Washington Publishing Company.

Section 1 – 837I Institutional Health Care Claim: Basic Instructions

Section 2 – 837I Institutional Health Care Claim: Enveloping

Section 3 – 837I Institutional Health Care Claim: Charts for Situational Rules

NOTE: Anthem has designated Availity to operate and serve as Anthem's EDI Gateway (entry point) as a no-cost option to our Trading Partners.

Get Started With Availity

The [Availity Quick Start Guide](#) will assist you with any EDI connection questions.

If you're a provider and wish to use a Clearinghouse or Billing company, please work with them to ensure connectivity.

Need Assistance?

For questions about signing up, contact Availity Client Services 1-800-AVAILITY (1-800-282-4548) or visit www.availity.com

Section 1 - Basic Instructions

1 X12 and HIPAA Compliance Checking, and Business Edits

EDI submissions to Availity for processing pass through compliance edits. 5010 acknowledgments and reports for accepted/rejected files will be returned to the trading partner for pickup using the reporting method established at Availity.

- TA1 Interchange Acknowledgment. Payer returns TA1 X12 and proprietary reports to the submitter of inbound 837 files containing envelope errors in the ISA and GS segments.
- Immediate Batch Report (IBR). Payer returns a 999 Interchange Acknowledgment to the submitter for every inbound 837 transaction received. If the X12 syntax or any other aspect of the 837 is not X12 compliant, the Immediate Batch Report/999 will also report the Level 1 errors in AK segments and indicate that the entire transaction set has been rejected.
- In addition to HIPAA TR3 edits, Payer applies business edits to ensure that the necessary information is populated and complete for efficient processing. When encountering HIPAA compliance (including balancing), code set or business errors, Payer returns details that identify these errors to the Trading Partner in the: 1) Electronic Batch Report (EBR) and 2) Delayed Payer Report (DPR) listing which claim(s) have failed. These reports are formatted based on the settings the trading partner chooses at Availity. Review the [Availity EDI Guide](#) for more information on report formatting options.

2 HIPAA Compliant Codes

Use HIPAA-compliant codes from current versions of the following:

- Physician's Current Procedure Terminology (CPT)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- International Classification of Diseases Clinical Mod (ICD-10-CM) Clinical Modification
- International Classification of Diseases Clinical Mod (ICD-10-PCS) Procedure Coding System
- National Uniform Billing Committee (NUBC) Codes
- Diagnosis Related Group Number (DRG)
- Provider Taxonomy Codes
- National Drug Codes

3 Diagnosis Codes

According to the 837I TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, Anthem will return an Immediate Batch Report/999 to the submitter indicating that the transaction has been rejected.

4 Procedure Codes and Modifiers

All valid CPT and HCPCS codes and modifiers are accepted for claim adjudication. Refer to your billing guidelines or provider contract for submission of these codes. If submitted codes are invalid, an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

5 Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are 10-alphanumeric positions in length. Health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

It is strongly recommended that the taxonomy be populated in PRV segments for all applicable claims that you are filing. Refer to the CMS website for a listing of codes, www.wpc-edi.com/taxonomy.

6 Uppercase Letters, Special Characters, and Delimiters

As specified in the TR3, the basic character set includes uppercase letters, digits, space, and other special characters.

- All alpha characters must be submitted in UPPERCASE letters only.
- Suggested delimiters for the transaction are assigned as part of the trading partner set up.
 - Data Element Separator, Asterisk (*)
 - Repetition Separator (ISA11), Caret (^)
 - Sub-Element Separator, Colon (:)
 - Segment Terminator, Tilde (~)
- To avoid syntax errors, hyphens, parentheses and spaces are not recommended to be used in values for identifiers.

Examples: Recommended: Zip Code 123456789 Medical Record # 1234567

- Since originally submitted values may be returned on outbound transactions, Anthem encourages trading partners to not use the following special characters as part of the value: asterisk (*), less than/greater than signs (<, >), colon (:), and slash (/). This minimizes the risk for a special character to be recognized as a delimiter.

Example: Provider assigns a Patient Control Number '12*3456789'. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value '12*3456789' may process incorrectly as two separate values '12' and '3456789'.

7 Decimal "R" Data Element Types

"R" data element types contain a decimal point; involving monetary amounts, units, visits, weights, and frequency. Anthem recommends using decimal points for monetary amounts, and whole numbers for other types of "R" data elements. Except for monetary amounts, if "R" data element type includes a decimal and numbers after the decimal, Anthem adjudicates the claim based on the whole number. Numbers after the decimal will not be considered.

8 Numeric Values, Monetary Amounts and Units

- Anthem pays all claims in US dollars and therefore, accepts monetary amounts in US dollars only. If codes related to foreign currencies are used, then an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.
- Anthem recognizes units in whole numbers only.
- Anthem recognizes units in values of less than 9999 and greater than or equal to zero.
- If a negative service line charge or negative units are used, then an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.
 - SV203 Monetary Amount - Line Item Charge Amount
 - SV205 Quantity - Service Unit Count

9 Address Information

- P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.
- The Pay-to Address loop does support P.O. Box / Lock Box addresses. Therefore, if payment is expected to be remitted to a P.O. Box / Lock Box, submit the P.O. Box / Lock Box address.
- Full 9-digit zip codes are required in the Billing Provider and Service Facility Location loops. If 5-digit zip codes are used in these loops, an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

10 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between Anthem and Medicare or other carriers. Following the Provider-to-Payer-to-Provider model;

- The provider sends the 837 to the primary payer.
- The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider. The 835 includes the claim adjustment reason code and/or remark code for the claim.
- Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops 2320, 2330A-I, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Payer recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier. When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

If data elements from previous payer(s) are omitted, Anthem will fail the particular claim.

11 Claim and COB Balancing

For COB claims, balancing is performed at both claim and service line on the payment charges for each payer. If not balanced, then an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

- Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV203 (Line Item Charge).
- Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments).
- Loop 2400 SV203 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments).

12 Other COB Allowed Amount - Calculation

If Loop 2320 CAS populated: Claims Total Charge (Loop 2400 SV201-203 = 001 (Rev)) minus any instance when adjustment amount (Loop 2320 CAS03,06,09,12,15) is unrelated to deductible, coinsurance and/or copayment.

- Loop 2320 CAS01 = CO, OA, PR, PI
- Loop 2320 CAS02 ≠ 1, 2, 3 where '1'=Deductible, '2'=Co-insurance and '3'=Co-payment.

If Loop 2430 CAS populated: Claims Total Charge (Loop 2400 SV201-203 = 001 (Rev)) minus any instance when adjustment amount (Loop 2430 CAS03,06,09,12,15) is unrelated to deductible, coinsurance and/or copayment.

- Loop 2430 CAS01 = CO, OA, PR, PI
- Loop 2430 CAS02 ≠ 1, 2, 3 where '1'=Deductible, '2'=Co-insurance and '3'=Co-payment.

If no CAS segments present in either Loop 2320 or 2430, Total Charge will be the allowed amount.

13 Medicaid Reclamation / Subrogation Claims

Situations exist when a Patient who has BCBS as primary and Medicaid as secondary (last payer), indicates to the provider that he has Medicaid insurance only. The service is rendered and the provider bills Medicaid as primary. Medicaid pays the claim as the sole payer ("pays out of turn") and later determines that the patient actually had primary insurance.

In order to reclaim monies, states submit claims to the primary insurance after reconciliation of eligibility files between BCBS and Medicaid. Exempt from NPI, trading partners on behalf of states must submit specific data elements in Loops 2010AA, 2010AC, 2010BB, 2310A, 2310E and 2320 for Medicaid reclamation.

14 Sending Attachments to Support a Claim

(1) Unsolicited

When an attachment follows submission of a claim, the Loop 2300 PWK segment is required.

PWK01 = Report type code (See TR3)

PWK02 = EL (Electronic)

PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL

PWK06 = Identification Code (Attachment Control #)

- The attachment control number is a unique identifier assigned by the provider organization or vendor and has a one-time use.

NOTE: Attachments must be received within seven calendar days from the claim submission date when there is a PWK indicator unless an alternate date is provided based on regulatory or contractual requirements.

(2) Solicited

This process begins when payer requests specific documentation/attachment(s) from the provider to support a claim that has been received for processing *without a PWK segment*.

15 275 Electronic Attachments to Support a Claim

The 275 Companion Document (from www.anthem.com/edi, EDI Companion Guide) assists with specific attachment requirements and enables providers to electronically submit attachments based on their business needs.

When attachments are sent electronically (PWK02 = EL) but transmitted in an X12 275 rather than by paper, PWK06 is used to identify the attached electronic documentation. The number in PWK06 of the 837 claim is carried in the TRN segment of the 275 transaction.

Unsolicited: Claims submitted with PWK submission

When an attachment follows submission of a claim, the Loop 2300 PWK segment is required.

PWK01 = Report type code (see TR3)

PWK02 = EL (electronic)

PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL

PWK06 = Identification Code (Attachment Control #)

- The attachment control number is a unique identifier assigned by the provider organization or vendor and has a one-time use.

NOTE: Attachments must be received within seven calendar days from the claim submission date when there is a PWK indicator unless an alternate date is provided based on regulatory or contractual requirements.

Solicited: Claims submitted without PWK submission

When the payer requests additional information from the provider to process a claim

1. Provider sends a claim without the PWK segment.
2. Payer determines not enough information exists to process the claim.
3. Payer sends letter request for the additional information, or provider wants to submit additional documentation on a processed claim.
4. Provider uses the 275 to submit documentation.
5. Provider sends the 275; the TRN02 is the attachment control # which will be the payer assigned claim number.

16 Social Security Number

Unless requested, do not send Social Security Number in the following of the 837 TR3:

- Loop 2010AA REF Billing Provider Tax Identification
- Loop 2010BA NM1 Subscriber Name
- Loop 2010BA REF Subscriber Name
- Loop 2330A NM1 Other Subscriber Name
- Loop 2330A REF Other Subscriber Secondary Identification

16 Social Security Number

Unless requested, do not send Social Security Number in the following of the 837 TR3:

- Loop 2010AA REF Billing Provider Tax Identification
- Loop 2010BA NM1 Subscriber Name
- Loop 2010BA REF Subscriber Name
- Loop 2330A NM1 Other Subscriber Name
- Loop 2330A REF Other Subscriber Secondary Identification

Section 2 - Enveloping

EDI envelopes control and track communications between you and Anthem. One envelope may contain many transaction sets grouped into the following:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

Payer has designated Availity to operate and serve as Anthem's EDI Gateway (entry point) as a no-cost option to our Trading Partners. Availity has specific requirements that must be adhered to and should be reviewed in order to ensure transactions are accepted, processed and ultimately delivered to Anthem.

For more information on submitting claims and the required ISA and GS envelope values, review the following topics in the [Availity EDI Guide](#).

- Uploading and downloading EDI files
- Control Segments/Envelopes
- FTP Client Confirmation
- Acknowledgements and Reports

Section 3 - Charts for Situational Rules

Listed below are loops, segments, and data elements required for proper adjudication by Anthem per the situational rules in the 837I TR3.

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
P.67	ST Transaction Set Header	ST03 Implementation Convention Ref	005010X223A2	005010X223A2 - Health Care Claim, Institutional
P.68	BHT Beginning of Hierarchical Trx	BHT06 Transaction Type Code	CH 31	CH - Chargeable required for Medicaid Reclamation
Loop ID 1000A—Submitter Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.71	NM1 Submitter Name	NM109 Identification Code	(Submitter Identifier) UPPERCASE	<ul style="list-style-type: none"> EDI assigned Sender ID. Equals the value entered in ISA06, GS02.
P.73	PER	<i>Submitter EDI Contact Information - Refer to TR3</i>		
Loop ID 1000B—Receiver Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.76	NM1 Receiver Name	NM103 Last Name or Organization Name	ANTHEM BLUE CROSS WESTERN GROWERS	ANTHEM BLUE CROSS – Identifies receiver WESTERN GROWERS – if file is known to contain Western Growers, exclusively
		NM109 Identification Code	47198 24375	47198 - Anthem Blue Cross 24375 – Western Growers
Loop ID 2000A—Billing Provider Hierarchical Level				
P.78	HL	<i>Billing Provider Hierarchical Level - Refer to TR3</i>		
P.80	PRV Billing Provider Specialty Info	PRV03 Reference Identification	(Provider Taxonomy Code)	For BlueCard and state to state programs, submit the taxonomy code to uniquely identify the provider.
P.81	CUR Foreign Currency Info	CUR02 Currency Code	USD	USD - US dollars <ul style="list-style-type: none"> Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.84	NM1	<i>Billing Provider Name - Refer to TR3</i> (Medicaid Reclamation)		
P.87	N3 Billing Provider Address	N301 Address Information	(Billing Provider Address Line)	(Medicaid Reclamation) Enter the physical address to uniquely identify the provider. Submitting PO

				Box/Lock Box address will result in claim failure, and return of EBR or DPR.
P.88	N4	Billing Provider City, State, ZIP Code - Refer to TR3		(Medicaid Reclamation)

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2010AA—Billing Provider Name (cont'd)				
P.90	REF Billing Provider Tax Identification #	REF02 Reference Identification	Unless requested, do not send SSN (SY – Social Security Number) (Billing Provider Tax Identification #)	(Medicaid Reclamation)
P.91	PER	<i>Billing Provider Contact Information - Refer to TR3</i>		
Loop ID 2010AB—Pay-To Address Name				
P.94	NM1	<i>Pay-to Address Name - Refer to TR3</i>		
P.96	N3 Pay-to Address	N301 Address Information	(Pay-to Provider Address Line)	Enter the address to uniquely identify the provider. If payment expected to be remitted to PO Box/Lock Box, submit in Pay-to loop.
P.97	N4	<i>Pay-To Address City, State, ZIP Code - Refer to TR3</i>		
Loop ID 2010AC—Pay-To Plan Name				
P.99	NM1 Pay-to Plan Name	NM103 Name Last or Organization Name	(Pay-to Plan Organizational Name)	(Medicaid Reclamation)
P.101	N3	<i>Pay-to Plan Address - Refer to TR3</i>		
P.102	N4	<i>Pay-to Plan City, State, ZIP Code - Refer to TR3</i>		
P.104	REF	<i>Pay-to Plan Secondary Identification - Refer to TR3</i>		
P.106	REF Pay-to Plan Tax Identification #	REF02 Reference Identification	(Pay-to Plan Tax Identification #)	(Medicaid Reclamation)
Loop ID 2000B—Subscriber Hierarchical Level				
P.107	HL	<i>Subscriber Hierarchical Level - Refer to TR3</i>		
P.109	SBR	<i>Subscriber Information - Refer to TR3</i>		
Loop ID 2010BA—Subscriber Name				
P.112	NM1 Subscriber Name	NM109 Identification Code	***ALL ALPHA CHARACTERS MUST BE IN UPPERCASE. Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX. ***Unless requested, do not send SSN	
P.115	N3	<i>Subscriber Address - Refer to TR3</i>		
P.116	N4	<i>Subscriber City, State, ZIP Code - Refer to TR3</i>		
P.118	DMG	<i>Subscriber Demographic Information - Refer to TR3</i>		
P.120	REF REF01	<i>Subscriber Secondary Identification - Refer to TR3</i> Unless requested to not send SSN (SY – Social Security Number)		
P.121	REF	<i>Property and Casualty Claim Number - Refer to TR3</i>		



Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2010BB—Payer Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.122	NM1 Payer Name	NM103 Last Name or Organization Name	ANTHEM BLUE CROSS WESTERN GROWERS	ANTHEM BLUE CROSS – Identifies receiver WESTERN GROWERS – if file is known to contain Western Growers, exclusively
		NM108 ID Code Qualifier	PI	PI - Payer Identification
		NM109 Identification Code	47198 24375	47198 - Anthem Blue Cross 24375 – Western Growers
P.124	N3	<i>Payer Address - Refer to TR3</i>		
P.125	N4	<i>Payer City, State, ZIP Code - Refer to TR3</i>		
P.127	RE F	<i>Payer Secondary Identification - Refer to TR3</i>		
P.129	REF Billing Provider Secondary Identification	REF01 Ref ID Qualifier	G2	G2 - Provider Commercial Number
		REF02 Reference Identification	(Billing Provider Secondary Identification)	(Medicaid Reclamation)
Loop ID 2000C—Patient Hierarchical Level				
P.131	HL	<i>Patient Hierarchical Level - Refer to TR3</i>		
P.133	PA T	<i>Patient Information - Refer to TR3</i>		
Loop ID 2010CA—Patient Name				
P.135	NM 1	<i>Patient Name - Refer to TR3</i>		
P.137	N3	<i>Patient Address - Refer to TR3</i>		
P.138	N4	<i>Patient City, State, ZIP Code - Refer to TR3</i>		
P.140	DM G	<i>Patient Demographic Information - Refer to TR3</i>		
P.142	RE F	<i>Property and Casualty Claim Number - Refer to TR3</i>		
Loop ID 2300—Claim Information				
P.143	CLM Claim Information	CLM01 Claim Submitter's Identifier	(Patient Control Number)	<ul style="list-style-type: none"> Maximum of 20 alphanumeric characters. Value is returned on outbound 835 and other transactions.
		CLM02 Monetary Amount	(Total Claim Charge Amount)	Value must equal the sum of submitted service line charges in Loop 2400 SV203.

		CLM05-3 Claim Frequency Type Code	(Third Position of Uniform Billing Claim Form Bill Type)	If '7' (replacement) or '8' (void/cancel) then Loop 2300 REF02 Payer Claim Control # (F8) is required and must contain Anthem's originally assigned claim number.
P.149	DT P	<i>Discharge Hour - Refer to TR3</i>		
P.150	DTP Statement Dates	DTP03 Date Time Period	(Statement From or To Date)	Valid medical codes will be based on the "Statement From Date"
P.151	DT P	<i>Admission Date/Hour - Refer to TR3</i>		
P.152	DT P	<i>Date-Repricer Received Date - Refer to TR3</i>		
P.153	CL 1	<i>Institutional Claim Code - Refer to TR3</i>		

****Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.***

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2300—Claim Information (cont'd)				
NOTE: Refer to Basic Instructions 14-16 on Preparing and Sending Attachments				
P.154	PWK Claim Supplemental Information	PWK02 Report Transmission Code	BM EL FX	BM - By Mail EL - Electronically Only FX - By Fax
		PWK06 Identification Code		<ul style="list-style-type: none"> Field reserved for unique Attachment Control Number Digits will be drawn beginning from the left to match the attachment with the appropriate electronically submitted claim.
P.158	CN1	Contract Information - Refer to TR3		
P.160	AMT	Patient Estimated Amount Due - Refer to TR3		
P.161	REF	Service Authorization Exception Code - Refer to TR3		
P.163	REF	Referral Number - Refer to TR3		
P.164	REF	Prior Authorization - Refer to TR3		
P.166	REF Payer Claim Control Number	REF01 Ref ID Qualifier	F8	F8 - Original Reference Number
		REF02 Reference Identification	(Claim Original Reference Number)	Represents the original claim # indicated on the 835 when Loop 2300 CLM05-3 Claim Freq. Type Code equals '7' or '8'.
P.167	REF	Repriced Claim Number - Refer to TR3		
P.168	REF	Adjusted Repriced Claim Number - Refer to TR3		
P.169	REF	Investigational Device Exemption Number - Refer to TR3		
P.170	REF Claim ID for Transmission Intermediaries	REF01 Ref ID Qualifier	D9	D9 - Claim Number
		REF02 Reference Identification	(Value Added Network Trace Number)	Will be returned on EBR and/or DPR, if submitted.
P.172	REF	Auto Accident State - Refer to TR3		
P.173	REF	Medical Record Number - Refer to TR3		
P.174	REF	Demonstration Project Identifier - Refer to TR3		
P.175	REF	PRO Approval Number - Refer to TR3		
P.176	K3	File Information - Refer to TR3		
P.178	NTE	Claim Note - Refer to TR3		
P.180	NTE Billing Note	NTE02 Description	When billing unlisted HCPCS (NOC codes) in Loop 2400 SV202-2 (Procedure Code), include the drug and dosage.	
P.181	CRC	EPSDT Referral - Refer to TR3		
ICD-10-CM Guide requires diagnosis codes to the highest level of specificity.				
P.184	HI	Principal Diagnosis Information - Refer to TR3		
P.187	HI	Admitting Diagnosis - Refer to TR3		
P.189	HI	Patient's Reason for Visit - Refer to TR3		
P.193	HI	External Cause of Injury - Refer to TR3		
P.218	HI	DRG Information - Refer to TR3		

P.220	HI	<i>Other Diagnosis Information - Refer to TR3</i>
P.239	HI	<i>Principal Procedure Information - Refer to TR3</i>
P.242	HI	<i>Other Procedure Information - Refer to TR3</i>
P.258	HI	<i>Occurrence Span Information - Refer to TR3</i>
P.271	HI	<i>Occurrence Information - Refer to TR3</i>

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2300—Claim Information (cont'd)				
P.284	HI		Value Information - Refer to TR3	
P.294	HI		Condition Information - Refer to TR3	
P.304	HI		Treatment Code Information - Refer to TR3	
P.313	HCP		Claim Pricing/Repricing Information - Refer to TR3	
Loop ID 2310A—Attending Physician Name				
Required for services (non-emergency ambulance transportation) populated in Loop 2400, SV202-2				
P.319	NM1		Attending Provider Name - Refer to TR3	(Medicaid Reclamation)
P.322	PRV	PRV03	(Provider Taxonomy Code)	For BlueCard and state to state programs, submit the taxonomy code to uniquely identify the provider.
	Attending Physician Specialty Info	Reference Identification		
P.324	REF		Attending Provider Sec Identification - Refer to TR3	(Medicaid Reclamation)
Loop ID 2310B—Operating Physician Name				
P.326	NM1		Operating Physician Name - Refer to TR3	
P.329	REF		Operating Physician Secondary Identification - Refer to TR3	
Loop ID 2310C—Other Operating Physician Name				
P.331	NM1		Other Operating Physician Name - Refer to TR3	
P.334	REF		Other Operating Physician Secondary Identification - Refer to TR3	
Loop ID 2310D—Rendering Provider Name				
P.336	NM1		Rendering Provider Name - Refer to TR3	
P.339	REF		Rendering Provider Secondary Identification - Refer to TR3	
Loop ID 2310E—Service Facility Location Name				
P.341	NM1		Service Facility Location Name - Refer to TR3	
P.344	N3		Service Facility Location Address - Refer to TR3	(Medicaid Reclamation)
P.345	N4		Service Facility Location City, State, ZIP - Refer to TR3	(Medicaid Reclamation)
P.347	REF		Service Facility Location Secondary Identification - Refer to TR3	
Loop ID 2310F—Referring Provider Name				
P.349	NM1		Referring Provider Name - Refer to TR3	
P.352	REF		Referring Provider Secondary Identification - Refer to TR3	
For COB claims, enter data elements in Loops 2320, 2330A, 2330B and/or 2430.				
Loop ID 2320—Other Subscriber Information				
P.354	SBR		Other Subscriber Information - Refer to TR3	
P.358	CAS		Claim Level Adjustments - Refer to TR3	(Medicaid Reclamation)
P.364	AMT		COB Payer Paid Amount - Refer to TR3	(Medicaid Reclamation)
P.365	AMT		Remaining Patient Liability - Refer to TR3	
P.366	AMT		COB Total Non-Covered Amount - Refer to TR3	
P.367	OI		Other Insurance Coverage Information - Refer to TR3	
P.369	MIA		Inpatient Adjudication Information - Refer to TR3	
P.374	MOA		Outpatient Adjudication Information - Refer to TR3	

Loop ID 2330A—Other Subscriber Name		
P.377	NM1 NM109	<i>Other Subscriber Name - Refer to TR3</i> Unless requested, do not send SSN
P.380	N3	<i>Other Subscriber Address - Refer to TR3</i>
P.381	N4	<i>Other Subscriber City, State, ZIP Code - Refer to TR3</i>
P.383	REF REF01	<i>Other Subscriber Secondary Identification - Refer to TR3</i> Unless requested, do not send SSN (SY – Social Security Number)

****Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.***

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2330B—Other Payer Name				
P.384	NM1			<i>Other Payer Name - Refer to TR3</i>
P.386	N3			<i>Other Payer Address - Refer to TR3</i>
P.387	N4			<i>Other Payer City, State, ZIP Code - Refer to TR3</i>
P.389	DTP			<i>Claim Check or Remittance Date - Refer to TR3</i>
P.390	REF			<i>Other Payer Secondary Identifier - Refer to TR3</i>
P.392	REF			<i>Other Payer Prior Authorization Number - Refer to TR3</i>
P.393	REF			<i>Other Payer Referral Number - Refer to TR3</i>
P.394	REF			<i>Other Payer Claim Adjustment Indicator - Refer to TR3</i>
P.395	REF			<i>Other Payer Claim Control Number - Refer to TR3</i>
Loop ID 2330C—Other Payer Attending Provider				
P.396	NM1			<i>Other Payer Attending Provider - Refer to TR3</i>
P.398	REF			<i>Other Payer Attending Provider Secondary Identification - Refer to TR3</i>
Loop ID 2330D—Other Payer Operating Physician				
P.400	NM1			<i>Other Payer Operating Physician - Refer to TR3</i>
P.402	REF			<i>Other Payer Operating Physician Secondary Identification - Refer to TR3</i>
Loop ID 2330E—Other Payer Other Operating Physician				
P.404	NM1			<i>Other Payer Other Operating Physician - Refer to TR3</i>
P.406	REF			<i>Other Payer Other Operating Physician Secondary Identification - Refer to TR3</i>
Loop ID 2330F—Other Payer Service Facility Location				
P.408	NM1			<i>Other Payer Service Facility Location - Refer to TR3</i>
P.410	REF			<i>Other Payer Service Facility Location Secondary Identification - Refer to TR3</i>
Loop ID 2330G—Other Payer Rendering Provider Name				
P.412	NM1			<i>Other Payer Rendering Provider Name - Refer to TR3</i>
P.414	REF			<i>Other Payer Rendering Provider Secondary Identification - Refer to TR3</i>
Loop ID 2330H—Other Payer Referring Provider				
P.416	NM1			<i>Other Payer Referring Provider - Refer to TR3</i>
P.418	REF			<i>Other Payer Referring Provider Secondary Identification - Refer to TR3</i>
Loop ID 2330I—Other Payer Billing Provider				
P.420	NM 1			<i>Other Payer Billing Provider - Refer to TR3</i>
P.422	REF			<i>Other Payer Billing Provider Secondary Identification - Refer to TR3</i>

837 Institutional Health Care Claim				
TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
Loop ID 2400—Service Line Number				
P.423	LX	<i>Service Line Number - Refer to TR3</i>		
P.424	SV2 Institutional Service Line	SV203 Monetary Amount	(Line Item Charge Amount)	Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.
P.429	PWK	<i>Line Supplemental Information - Refer to TR3</i>		
P.433	DTP	<i>Date - Service Date - Refer to TR3</i>		
P.435	REF	<i>Line Item Control Number - Refer to TR3</i>		
P.437	REF	<i>Repriced Line Item Reference Number - Refer to TR3</i>		
P.438	REF	<i>Adjusted Repriced Line Item Reference Number - Refer to TR3</i>		
P.439	AMT	<i>Service Tax Amount - Refer to TR3</i>		
P.440	AMT	<i>Facility Tax Amount - Refer to TR3</i>		
P.441	NTE	<i>Third Party Organization Notes - Refer to TR3</i>		
P.442	HCP	<i>Line Pricing/Repricing Information - Refer to TR3</i>		
Loop ID 2410—Drug Identification				
P.449	LIN Drug Identification	LIN03 Product/Service ID	(National Drug Code)	NDC # for prescribed drugs and biologics when required by government regulation.
P.452	CTP	<i>Drug Quantity - Refer to TR3</i>		
P.454	REF	<i>Prescription of Compound Drug Association Number - Refer to TR3</i>		
Loop ID 2420A—Operating Physician Name				
P.456	NM1	<i>Operating Physician Name - Refer to TR3</i>		
P.459	REF	<i>Operating Physician Secondary Identification - Refer to TR3</i>		
Loop ID 2420B—Other Operating Physician Name				
P.461	NM1	<i>Other Operating Physician Name - Refer to TR3</i>		
P.464	REF	<i>Other Operating Physician Secondary Identification - Refer to TR3</i>		
Loop ID 2420C—Rendering Provider Name				
P.466	NM1	<i>Rendering Provider Name - Refer to TR3</i>		
P.469	REF	<i>Rendering Provider Secondary Identification - Refer to TR3</i>		
Loop ID 2420D—Referring Provider Name				
P.471	NM1	<i>Referring Provider Name - Refer to TR3</i>		
P.474	REF	<i>Referring Provider Secondary Identification - Refer to TR3</i>		
Loop ID 2430—Line Adjudication Information				
P.476	SVD	<i>Line Adjudication Information - Refer to TR3</i>		
P.480	CAS	<i>Line Adjustment - Refer to TR3</i>		
P.486	DTP	<i>Line Check or Remittance Date - Refer to TR3</i>		
P.487	AMT	<i>Remaining Patient Liability - Refer to TR3</i>		
Loop ID 2488—Transaction Set Trailer				
P.488	SE	<i>Transaction Set Trailer - Refer to TR3</i>		

Release Notes		
Number	Page(s)	Description
9		<i>Updated charts and basic instructions referencing MEA to Vyne Medical</i>
10		<i>Updated alphanumeric prefix and ICD10</i>
10.1		<i>Removed reference to 9999 or less units</i>
AV-1		<i>Updated references for Availity EDI Gateway Updated Acknowledgement and Reports to Electronic Batch Report and Delayed Payer Report Updated Basic Instructions</i>
AV-2		<i>Updated Basic Instructions - Added Social Security Number</i>
AV-3		<i>Removed Availity Welcome Kit Updated Availity Quick Start Guide Updated Availity EDI Guide</i>