837P

837 Professional 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 – 837P Professional Health Care Claim: Basic Instructions

Section 2 – 837P Professional Health Care Claim: Enveloping

Section 3 – 837P Professional 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
- Provider Taxonomy Codes
- National Drug Codes

3 Diagnosis Codes

According to the 837P TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, 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 (SV102) or negative units (SV104) are used, then an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

  SV102 Monetary Amount - Line Item Charge Amount
  SV104 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-G, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Anthem 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 SV102 (Line Item Charge).
- Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments).
- Loop 2400 SV102 (Line-Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments).

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 Preparing 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.

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

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)

Anthem 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 837P TR3.

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
P.70	**ST** Transaction Set Header	**ST03** Implementation Convention Ref	***005010X222A1***	005010X222A1 - Health Care Claim, Professional
P.71	**BHT** Beginning of Hierarchical Trx	**BHT06** Transaction Type Code	***CH***	All submissions recognized as chargeable.
			31	required for Medicaid Reclamation
Loop ID 1000A—Submitter Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.74	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI assigned Sender ID. ▪ Equals the value entered in ISA06 and GS02.
P.76	**PER**	*Submitter EDI Contact Information - Refer to TR3*		
Loop ID 1000B—Receiver Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.79	**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.81	**HL**	*Billing Provider Hierarchical Level - Refer to TR3*		
P.83	**PRV** Billing Provider Specialty Info	**PRV03** Reference Identification	***(Provider Taxonomy Code)***	Enter the taxonomy code to uniquely identify the provider.
P.84	**CUR** Foreign Currency Info	**CUR02** Currency Code	***USD***	USD - US dollars ▪ Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.87	**NM1**	*Billing Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.91	**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 and/or DPR

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 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2010AA—Billing Provider Name (cont'd)				
P.92	**N4**	*Billing Provider City, State, ZIP Code - Refer to TR3*		(Medicaid Reclamation)
P.94	**REF** Billing Provider Tax Identification #	**Unless requested, do not send SSN (SY – Social Security Number)**		
		REF02 Reference Identification	***(Billing Provider Tax Identification #)***	(Medicaid Reclamation)
P.96	**REF**	*Billing Provider UPIN/License Information - Refer to TR3*		
P.98	**PER**	*Billing Provider Contact Information - Refer to TR3*		
Loop ID 2010AB—Pay-To Address Name				
P.101	**NM1**	*Pay-to Address Name*		
P.103	**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.104	**N4**	*Pay-To Address City, State, ZIP Code - Refer to TR3*		
Loop ID 2010AC—Pay-To Plan Name				
P.106	**NM1** Pay-to Plan Name	**NM103** Name Last or Organization Name	***(Pay-to Plan Organizational Name)***	(Medicaid Reclamation)
P.108	**N3**	*Pay-to Plan Address - Refer to TR3*		
P.109	**N4**	*Pay-to Plan City, State, ZIP Code - Refer to TR3*		
P.111	**REF**	*Pay-to Plan Secondary Identification - Refer to TR3*		
P.113	**REF** Pay-to Plan Tax Identification #	**REF02** Reference Identification	***(Pay-to Plan Tax Identification #)***	(Medicaid Reclamation)
Loop ID 2000B—Subscriber Hierarchical Level				
P.114	**HL**	*Subscriber Hierarchical Level - Refer to TR3*		
P.116	**SBR**	*Subscriber Information - Refer to TR3*		
P.119	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010BA—Subscriber Name				
P.121	**NM1** Subscriber Name	**NM109** Identification Code	***(Subscriber Primary Identifier)***	*****ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.** ***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.124	**N3**	*Subscriber Address - Refer to TR3*		
P.125	**N4**	*Subscriber City, State, ZIP Code - Refer to TR3*		
P.127	**DMG**	*Subscriber Demographic Information - Refer to TR3*		

P.129	**REF**	*Subscriber Secondary Identification - Refer to TR3*
	REF01	Unless requested to not send SSN (SY – Social Security Number)
P.130	**REF**	*Property and Casualty Claim Number - Refer to TR3*
P.131	**REF**	*Property and Casualty Subscriber Contact Information - Refer to TR3*

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 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2010BB—Payer Name				
NOTE: Refer to Avaiity guidelines for submission of claims through the Availity EDI Gateway				
P.133	**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.135	**N3**	*Payer Address - Refer to TR3*		
P.136	**N4**	*Payer City, State, ZIP Code - Refer to TR3*		
P.138	**REF**	*Payer Secondary Identification - Refer to TR3*		
P.140	**REF** Billing Provider Secondary Identification	**REF01** Ref ID Qualifier	***G2***	G2 - Provider Commercial Number
		REF02 Reference Identification	***(Billing Provider Secondary ID)***	(Medicaid Reclamation)
Loop ID 2000C—Patient Hierarchical Level				
P.142	**HL**	*Patient Hierarchical Level - Refer to TR3*		
P.144	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010CA—Patient Name				
P.147	**NM1**	*Patient Name - Refer to TR3*		
P.149	**N3**	*Patient Address - Refer to TR3*		
P.150	**N4**	*Patient City, State, ZIP Code - Refer to TR3*		
P.152	**DMG**	*Patient Demographic Information - Refer to TR3*		
P.154	**REF**	*Property and Casualty Claim Number - Refer to TR3*		
P.155	**REF**	*Property and Casualty Patient Contact Information - Refer to TR3*		
Loop ID 2300—Claim Information				

P.157	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Account Number)***	▪ 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 SV102.
		CLM05-3 Claim Frequency Type Code	***7, 8***	If '7' (replacement) or '8' (void/cancel) then the Payer Claim Control # (Loop 2300 REF02) is required and must contain the originally assigned claim #.
P.164	**DTP**	*Date - Onset of Current Illness or Symptom - Refer to TR3*		
P.165	**DTP**	*Date - Initial Treatment Date - Refer to TR3*		
P.166	**DTP**	*Date - Last Seen Date - Refer to TR3*		
P.167	**DTP**	*Date - Acute Manifestation - Refer to TR3*		
P.168	**DTP**	*Date - Accident - Refer to TR3*		
P.169	**DTP**	*Date - Last Menstrual Period - Refer to TR3*		
P.170	**DTP**	*Date - Last X-ray Date - Refer to TR3*		

****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 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2300—Claim Information (cont'd)				
P.171	**DTP**	*Date - Hearing and Vision Prescription Date - Refer to TR3*		
P.172	**DTP**	*Date - Disability Dates - Refer to TR3*		
P.174	**DTP**	*Date - Last Worked - Refer to TR3*		
P.175	**DTP**	*Date - Authorized Return to Work - Refer to TR3*		
P.176	**DTP**	*Date - Admission - Refer to TR3*		
P.177	**DTP**	*Date - Discharge - Refer to TR3*		
P.178	**DTP**	*Date - Assumed and Relinquished Care Dates - Refer to TR3*		
P.180	**DTP**	*Date - Property and Casualty Date of First Contact - Refer to TR3*		
P.181	**DTP**	*Date - Repricer Received Date - Refer to TR3*		
See Basic Instructions 1.14-1.16 on Preparing and Sending Attachments				
P.182	**PWK** Claim Supplemental Information	**PWK02** Report Transmission Code	***BM*** ***EL*** ***FX***	BM – By Mail EL – Electronic Only FX – By Fax
		PWK06 Identification Code	▪ Providers using mail/fax, submit the 151 Adjustment Request Form with the supporting documentation.	
P.186	**CN1**	*Contract Information - Refer to TR3*		
P.188	**AMT**	*Patient Amount Paid - Refer to TR3*		
P.189	**REF**	*Service Authorization Exception Code - Refer to TR3*		
P.191	**REF**	*Mandatory Medicare Crossover Indicator - Refer to TR3*		
P.192	**REF**	*Mammography Certification Number - Refer to TR3*		
P.193	**REF**	*Referral Number - Refer to TR3*		
P.194	**REF**	*Prior Authorization - Refer to TR3*		
P.196	**REF** Payer Claim	**REF01** Ref ID Qualifier	***F8***	F8 - Original Reference Number

	Control Number	**REF02** Reference Identification	***(Claim Original Reference Number)***	Represents the original claim # indicated on the 835 when Loop 2300, CLM05-3 equals values of '7' or '8'.
P.197	**REF**	*CLIA Number - Refer to TR3*		
P.199	**REF**	*Repriced Claim Number - Refer to TR3*		
P.200	**REF**	*Adjusted Repriced Claim Number - Refer to TR3*		
P.201	**REF**	*Investigational Device Exemption Number - Refer to TR3*		
P.202	**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.204	**REF**	*Medical Record Number - Refer to TR3*		
P.205	**REF**	*Demonstration Project Identifier - Refer to TR3*		
P.206	**REF**	*Care Plan Oversight - Refer to TR3*		
P.207	**K3**	*File Information - Refer to TR3*		
P.209	**NTE**	*Claim Note - Refer to TR3*		
P.211	**CR1**	*Ambulance Transport Information - Refer to TR3*		
P.214	**CR2**	*Spinal Manipulation Service Information - Refer to TR3*		

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2300—Claim Information (cont'd)				
P.216	**CRC**	*Ambulance Certification - Refer to TR3*		
P.219	**CRC**	*Patient Condition Information: Vision - Refer to TR3*		
P.221	**CRC**	*Homebound Indicator - Refer to TR3*		
P.223	**CRC**	*EPSDT Referral - Refer to TR3*		
ICD-10-CM Guide requires diagnosis codes to the highest level of specificity.				
P.226	**HI**	*Health Care Diagnosis Code - Refer to TR3*		
P.239	**HI**	*Anesthesia Related Procedure - Refer to TR3*		
P.242	**HI**	*Condition Information - Refer to TR3*		
P.252	**HCP**	*Claim Pricing/Repricing Information - Refer to TR3*		
Loop ID 2310A—Referring Provider Name				
P.257	**NM1**	*Referring Provider Name - Refer to TR3*		
P.260	**REF**	*Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2310B—Rendering Provider Name				
P.262	**NM1**	*Rendering Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.265	**PRV**	*Rendering Provider Specialty Information - Refer to TR3*		
P.267	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2310C—Service Facility Location Name				
P.269	**NM1**	*Service Facility Location Name - Refer to TR3*		(Medicaid Reclamation)
P.272	**N3**	*Service Facility Location Address - Refer to TR3*		(Medicaid Reclamation)
P.273	**N4**	*Service Facility Location City, State, ZIP - Refer to TR3*		(Medicaid Reclamation)
P.275	**REF**	*Service Facility Secondary Identification - Refer to TR3*		
P.277	**PER**	*Service Facility Contact Information - Refer to TR3*		
Loop ID 2310D—Supervising Provider Name				
P.280	**NM1**	*Supervising Provider Name - Refer to TR3*		
P.283	**REF**	*Supervising Provider Secondary Identification - Refer to TR3*		
Loop ID 2310E—Ambulance Pick-Up Location				
P.285	**NM1**	*Ambulance Pick-up Location - Refer to TR3*		
P.287	**N3**	*Ambulance Pick-up Location Address - Refer to TR3*		
P.288	**N4**	*Ambulance Pick-up Location City, State, ZIP Code - Refer to TR3*		
Loop ID 2310F—Ambulance Drop-Off Location				
P.290	**NM1**	*Ambulance Drop-off Location - Refer to TR3*		
P.292	**N3**	*Ambulance Drop-off Location Address - Refer to TR3*		
P.293	**N4**	*Ambulance Drop-off Location City, State, ZIP Code - Refer to TR3*		
For COB claims, enter data elements in Loops 2320, 2330A, 2330B, and/or 2430.				
Loop ID 2320—Other Subscriber Information				
P.295	**SBR**	*Other Subscriber Information - Refer to TR3*		
P.299	**CAS**	*Claim Level Adjustments - Refer to TR3*		

P.305	**AMT**	*COB Payer Paid Amount - Refer to TR3*
P.306	**AMT**	*COB Total Non-Covered Amount - Refer to TR3*
P.307	**AMT**	*Remaining Patient Liability - Refer to TR3*
P.308	**OI**	*Other Insurance Coverage Information - Refer to TR3*
P.310	**MOA**	*Outpatient Adjudication Information - Refer to TR3*

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837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2330A—Other Subscriber Name				
P.313	**NM1** **NM109**	*Other Subscriber Name - Refer to TR3* Unless requested, do not send SSN		
P.316	**N3**	*Other Subscriber Address - Refer to TR3*		
P.317	**N4**	*Other Subscriber City, State, ZIP Code - Refer to TR3*		
P.319	**REF** **REF01**	*Other Subscriber Secondary Identification - Refer to TR3* Unless requested to not send SSN (SY – Social Security Number)		
Loop ID 2330B—Other Payer Name				
P.320	**NM1**	*Other Payer Name - Refer to TR3*		
P.322	**N3**	*Other Payer Address - Refer to TR3*		
P.323	**N4**	*Other Payer City, State, ZIP Code - Refer to TR3*		
P.325	**DTP**	*Claim Check or Remittance Date - Refer to TR3*		
P.326	**REF**	*Other Payer Secondary Identifier - Refer to TR3*		
P.328	**REF**	*Other Payer Prior Authorization Number - Refer to TR3*		
P.329	**REF**	*Other Payer Referral Number - Refer to TR3*		
P.330	**REF**	*Other Payer Claim Adjustment Indicator - Refer to TR3*		
P.331	**REF**	*Other Payer Claim Control Number - Refer to TR3*		
Loop ID 2330C—Other Payer Referring Provider				
P.332	**NM1**	*Other Payer Referring Provider - Refer to TR3*		
P.334	**REF**	*Other Payer Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2330D—Other Payer Rendering Provider				
P.336	**NM1**	*Other Payer Rendering Provider - Refer to TR3*		
P.338	**REF**	*Other Payer Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2330E—Other Payer Service Facility Location				
P.340	**NM1**	*Other Payer Service Facility Location - Refer to TR3*		
P.342	**REF**	*Other Payer Service Facility Location Secondary Identification - Refer to TR3*		
Loop ID 2330F—Other Payer Supervising Provider				
P.343	**NM1**	*Other Payer Supervising Provider - Refer to TR3*		
P.345	**REF**	*Other Payer Supervising Provider Secondary Identification - Refer to TR3*		
Loop ID 2330G—Other Payer Billing Provider				
P.347	**NM1**	*Other Payer Billing Provider - Refer to TR3*		
P.349	**REF**	*Other Payer Billing Provider Secondary Identification - Refer to TR3*		
Loop ID 2400—Service Line				
P.350	**LX**	*Service Line Number - Refer to TR3*		
P.351	**SV1** Professional Service	**SV102** Monetary Amount	***(Line Item Charge Amount)***	Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.
P.359	**SV5**	*Durable Medical Equipment Service - Refer to TR3*		
P.362	**PWK**	*Line Supplemental Information - Refer to TR3*		
P.366	**PWK**	*Durable Medical Equipment Certificate of Medical Necessity Indicator - Refer to TR3*		
P.368	**CR1**	*Ambulance Transport Information - Refer to TR3*		

P.371	**CR3**	*Durable Medical Equipment Certification - Refer to TR3*
P.373	**CRC**	*Ambulance Certification - Refer to TR3*
P.376	**CRC**	*Hospice Employee Indicator - Refer to TR3*
P.378	**CRC**	*Condition Indicator/Durable Medical Equipment - Refer to TR3*

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2400—Service Line (cont'd)				
P.380	**DTP** Date - Service Date	**DTP03** Date Time Period	***(Service Date)***	Both "From Date" and "To Date" are required when place of service is 22 or 23.
P.382	**DTP**	*Date - Prescription Date - Refer to TR3*		
P.383	**DTP**	*Date - Certification Revision/Recertification Date - Refer to TR3*		
P.384	**DTP**	*Date - Begin Therapy Date - Refer to TR3*		
P.385	**DTP**	*Date - Last Certification Date - Refer to TR3*		
P.386	**DTP**	*Date - Last Seen Date - Refer to TR3*		
P.387	**DTP**	*Date - Test Date - Refer to TR3*		
P.388	**DTP**	*Date - Shipped Date - Refer to TR3*		
P.389	**DTP**	*Date - Last X-ray Date - Refer to TR3*		
P.390	**DTP**	*Date - Initial Treatment Date - Refer to TR3*		
P.391	**QTY**	*Ambulance Patient Count - Refer to TR3*		
P.392	**QTY**	*Obstetric Anesthesia Additional Units - Refer to TR3*		
P.393	**MEA**	*Test Result - Refer to TR3*		
P.395	**CN1**	*Contract Information - Refer to TR3*		
P.397	**REF**	*Repriced Line Item Reference Number - Refer to TR3*		
P.398	**REF**	*Adjusted Repriced Line Item Reference Number - Refer to TR3*		
P.399	**REF**	*Prior Authorization - Refer to TR3*		
P.401	**REF**	*Line Item Control Number - Refer to TR3*		
P.403	**REF**	*Mammography Certification Number - Refer to TR3*		
P.404	**REF**	*CLIA Number - Refer to TR3*		
P.405	**REF**	*Referring CLIA Facility Identification - Refer to TR3*		
P.406	**REF**	*Immunization Batch Number - Refer to TR3*		
P.407	**REF**	*Referral Number - Refer to TR3*		
P.409	**AMT**	*Service Tax Amount - Refer to TR3*		
P.410	**AMT**	*Postage Claimed Amount - Refer to TR3*		
P.411	**K3**	*File Information - Refer to TR3*		
P.413	**NTE**	*Line Note - Refer to TR3*		
P.413	**NTE** Line Note	**NTE01** Note Ref Code	***ADD***	ADD - Additional Information
		NTE02 Description	When billing unlisted HCPCS (NOC codes) in Loop 2400 SV202-2 (Procedure Code), include the drug and dosage	
P.414	**NTE**	*Third Party Organization Notes - Refer to TR3*		
P.415	**PS1**	*Purchased Service Information - Refer to TR3*		
P.416	**HCP**	*Line Pricing/Repricing Information - Refer to TR3*		
Loop ID 2410—Drug Identification				
P.423	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	NDC # for prescribed drugs and biologics when required by government regulation.
P.426	**CTP**	*Drug Quantity - Refer to TR3*		

P.428	**REF**	*Prescription of Compound Drug Association Number - Refer to TR3*

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Anthem**
Loop ID 2420A—Rendering Provider Name				
P.430	**NM1** *Rendering Provider Name - Refer to TR3*			
P.433	**PRV** Rendering Provider Specialty Info	**PRV03** Reference Identification	***(Provider Taxonomy Code)***	Enter the taxonomy code to uniquely identify the provider.
P.434	**REF** *Rendering Provider Secondary Identification - Refer to TR3*			
Loop ID 2420B—Purchased Service Provider Name				
P.436	**NM1** *Purchased Service Provider Name - Refer to TR3*			
P.439	**REF** *Purchased Service Provider Secondary Identification - Refer to TR3*			
Loop ID 2420C—Service Facility Location Name				
P.441	**NM1** *Service Facility Location Name - Refer to TR3*			
P.444	**N3** *Service Facility Location Address - Refer to TR3*			
P.445	**N4** *Service Facility Location City, State, ZIP Code - Refer to TR3*			
P.447	**REF** *Service Facility Location Secondary Identification - Refer to TR3*			
Loop ID 2420D—Supervising Provider Name				
P.449	**NM1** *Supervising Provider Name - Refer to TR3*			
P.452	**REF** *Supervising Provider Secondary Identification - Refer to TR3*			
Loop ID 2420E—Ordering Provider Name				
P.454	**NM1** *Ordering Provider Name - Refer to TR3*			
P.457	**N3** *Ordering Provider Address - Refer to TR3*			
P.458	**N4** *Ordering Provider City, State, ZIP Code - Refer to TR3*			
P.460	**REF** *Ordering Provider Secondary Identification - Refer to TR3*			
P.462	**PER** *Ordering Provider Contact Information - Refer to TR3*			
Loop ID 2420F—Referring Provider Name				
P.465	**NM1** *Referring Provider Name - Refer to TR3*			
P.468	**REF** *Referring Provider Secondary Identification - Refer to TR3*			
Loop ID 2420G—Ambulance Pick-Up Location				
P.470	**NM1** *Ambulance Pick-up Location - Refer to TR3*			
P.472	**N3** *Ambulance Pick-up Location Address - Refer to TR3*			
P.473	**N4** *Ambulance Pick-up Location City, State, ZIP Code - Refer to TR3*			
Loop ID 2420H—Ambulance Drop-Off Location				
P.475	**NM1** *Ambulance Drop-off Location - Refer to TR3*			
P.477	**N3** *Ambulance Drop-off Location Address - Refer to TR3*			
P.478	**N4** *Ambulance Drop-off Location City, State, ZIP Code - Refer to TR3*			
Loop ID 2430—Line Adjudication Information				
P.480	**SVD** Line Adjudication Info	**SVD02** Monetary Amount	***(Service Line Paid Amount)***	(Medicaid Reclamation)
P.484	**CAS** *Line Adjustment - Refer to TR3*			(Medicaid Reclamation)
P.490	**DTP** *Line Check or Remittance Date - Refer to TR3*			
P.491	**AMT** *Remaining Patient Liability - Refer to TR3*			

Loop ID 2440—Form Identification Code		
P.492	**LQ**	*Form Identification Code - Refer to TR3*
P.494	**FRM**	*Supporting Documentation - Refer to TR3*
P.496	**SE**	*Transaction Set Trailer - Refer to TR3*

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Release Notes		
Number	**Page(s)**	**Description**
11		*Added Cancel Date 7/18/16 on Edits E0523, E0756*
12		*Updated alphanumeric prefix and ICD10*
12.1		*Removed reference to 9999 units or less*
AV-1		*Updated references for Availity EDI Gateway* *Updated Acknowledgement and Reports to Electronic Batch Report and Delayed Payer Report* *Updated Basic Instructions*
AV-2		*Updated Basic Instructions – added Social Security Number*
AV-3		*Removed Availity Welcome Kit* *Updated Availity Quick Start Guide* *Updated Availity EDI Guide*