837 Health Care Claim: Professional

HIPAA/V4010X098A1/837: Vision

Version: 1.0 Final

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Publication:	**06/19/2006**
Trading Partner:	**(Provider or Clearinghouse)**
Created:	**11/14/2005**
Modified:	**06/01/2006**
Current:	**06/01/2006**
Notes:	**For Dial-up, Tape and Internet Submissions**

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837 Health Care Claim: Professional-Vision

Functional Group=HC

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required
015	REF	Transmission Type Identification	O	1			Required
LOOP ID - 1000A					1	N1/020L	
020	NM1	Submitter Name	O	1		N1/020	Required
045	PER	Submitter EDI Contact Information	O	2			Required
LOOP ID - 1000B					1	N1/020L	
020	NM1	Receiver Name	O	1		N1/020	Required

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					>1		
001	HL	Billing/Pay-to Provider Hierarchical Level	M	1			Required
003	PRV	Billing/Pay-to Provider Specialty Information	O	1			Situational
LOOP ID - 2010AA					1	N2/015L	
015	NM1	Billing Provider Name	O	1		N2/015	Required
025	N3	Billing Provider Address	O	1			Required
030	N4	Billing Provider City/State/ZIP Code	O	1			Required
035	REF	Billing Provider Secondary Identification	O	8			Situational
040	PER	Billing Provider Contact Information	O	2			Situational
LOOP ID - 2000B					>1		
001	HL	Subscriber Hierarchical Level	M	>1			Required
005	SBR	Subscriber Information	O	1			Required
007	PAT	Patient Information	O	1			Situational
LOOP ID - 2010BA					1	N2/015L	
015	NM1	Subscriber Name	O	1		N2/015	Required
025	N3	Subscriber Address	O	1			Situational
030	N4	Subscriber City/State/ZIP Code	O	1			Situational
032	DMG	Subscriber Demographic Information	O	1			Situational
LOOP ID - 2010BB					1	N2/015L	
015	NM1	Payer Name	O	1		N2/015	Required
LOOP ID - 2300					100		
130	CLM	Claim Information	O	1			Required
135	DTP	Date - Hearing and Vision	O	150			Situational

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
		Prescription Date					
155	PWK	Claim Supplemental Information	O	10			Situational
175	AMT	Patient Amount Paid	O	40			Situational
175	AMT	Total Purchased Service Amount	O	40			Situational
180	REF	Prior Authorization or Referral Number	O	30			Situational
180	REF	Medical Record Number	O	30			Situational
185	K3	File Information	O	10			Situational
190	NTE	Claim Note	O	20			Situational
220	CRC	Patient Condition Information: Vision	O	100			Situational
220	CRC	EPSDT Referral	O	1			Situational
231	HI	Health Care Diagnosis Code	O	25			Situational
LOOP ID - 2310A					**1**	**N2/250L**	
250	NM1	Referring Provider Name	O	1		N2/250	Situational
255	PRV	Referring Provider Specialty Information	O	1			Situational
271	REF	Referring Provider Secondary Identification	O	20			Situational
LOOP ID - 2310B					**1**	**N2/250L**	
250	NM1	Rendering Provider Name	O	1		N2/250	Situational
255	PRV	Rendering Provider Specialty Information	O	1			Required
271	REF	Rendering Provider Secondary Identification	O	20			Situational
LOOP ID - 2320					**1**	**N2/290L**	
290	SBR	Other Subscriber Information	O	1		N2/290	Situational
295	CAS	Claim Level Adjustments	O	99			Situational
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	15			Situational
300	AMT	Coordination of Benefits (COB) Approved Amount	O	15			Situational
300	AMT	Coordination of Benefits (COB) Allowed Amount	O	1			Situational
300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	O	1			Situational
300	AMT	Coordination of Benefits (COB) Patient Paid Amount	O	1			Situational
305	DMG	Subscriber Demographic Information	O	1			Situational
310	OI	Other Insurance Coverage Information	O	1			Required
LOOP ID - 2330A					**1**	**N2/325L**	
325	NM1	Other Subscriber Name	O	1		N2/325	Required
332	N3	Other Subscriber Address	O	2			Situational
340	N4	Other Subscriber City/State/ZIP Code	O	1			Situational
LOOP ID - 2330B					**1**	**N2/325L**	
325	NM1	Other Payer Name	O	1		N2/325	Required
350	DTP	Claim Adjudication Date	O	2			Situational
355	REF	Other Payer Secondary Identifier	O	2			Situational
LOOP ID - 2400					**50**	**N2/365L**	
365	LX	Service Line	O	1		N2/365	Required

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
370	SV1	Professional Service	O	1			Required
455	DTP	Date - Service Date	O	15			Required
455	DTP	Date - Shipped	O	15			Situational
470	REF	Prior Authorization or Referral Number	O	30			Situational
470	REF	Line Item Control Number	O	30			Situational
480	K3	File Information	O	10			Situational
485	NTE	Line Note	O	10			Situational
LOOP ID - 2420A					**1**	**N2/500L**	
500	NM1	Rendering Provider Name	O	1		N2/500	Situational
505	PRV	Rendering Provider Specialty Information	O	1			Situational
525	REF	Rendering Provider Secondary Identification	O	20			Situational
LOOP ID - 2430					**1**	**N2/540L**	
540	SVD	Line Adjudication Information	O	1		N2/540	Situational
545	CAS	Claims Adjustment	O	99			Situational
550	DTP	Line Adjudication Date	O	9			Required
555	SE	Transaction Set Trailer	M	1			Required

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

Medi-Cal Note:

This transaction, set for Vision, is no longer valid for dates of service on or after July 1, 2006; use the 837 Health Care Claim: Professional HIPAA/V4010X098A1/837: Medical Companion Guide.

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 16

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
ISA01	I01	**Authorization Information Qualifier**	M	ID	2/2	Required	1
		Code Name 00 No Authorization Information Present (No Meaningful Information in I02)					
ISA02	I02	**Authorization Information**	M	AN	10/10	Required	1
		Medi-Cal Note: ***Space fill***					
ISA03	I03	**Security Information Qualifier**	M	ID	2/2	Required	1
		Code Name 00 No Security Information Present (No Meaningful Information in I04)					
ISA04	I04	**Security Information**	M	AN	10/10	Required	1
		Medi-Cal Note: ***Space fill***					
ISA05	I05	**Interchange ID Qualifier**	M	ID	2/2	Required	1
		Code Name ZZ Mutually Defined					
ISA06	I06	**Interchange Sender ID**	M	AN	15/15	Required	1
		Medi-Cal Note: ***Submitter Identifier. Medi-Cal uses the first 3 characters. Space fill the remaining characters.***					
ISA07	I05	**Interchange ID Qualifier**	M	ID	2/2	Required	1
		Code Name ZZ Mutually Defined					
ISA08	I07	**Interchange Receiver ID**	M	AN	15/15	Required	1
		Medi-Cal Note: ***"610442" Medi-Cal Identifier.***					
ISA09	I08	**Interchange Date**	M	DT	6/6	Required	1
		Medi-Cal Note: ***The date format is YYMMDD.***					
ISA10	I09	**Interchange Time**	M	TM	4/4	Required	1
		Medi-Cal Note: ***The time format is HHMM.***					
ISA11	I10	**Interchange Control Standards Identifier**	M	ID	1/1	Required	1
		Code Name U U.S. EDI Community of ASC X12, TDCC, and UCS					
ISA12	I11	**Interchange Control Version Number**	M	ID	5/5	Required	1
		Code Name 00401 Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997					
ISA13	I12	**Interchange Control Number**	M	N0	9/9	Required	1
ISA14	I13	**Acknowledgment Requested**	M	ID	1/1	Required	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		Code Name 0 No Acknowledgment Requested					
ISA15	I14	**Usage Indicator**	M	ID	1/1	Required	1
		Code Name P Production Data T Test Data					
ISA16	I15	**Component Element Separator**	M		1/1	Required	1
		Medi-Cal Note: ***X'1F' ANSI recommended Sub element Separator***					

Example:

ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*930602*1253*U*00401*000000905*1*T*:~

Medi-Cal Note:

The ISA is a fixed length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 8

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
GS01	479	**Functional Identifier Code** **Code Name** HC Health Care Claim (837)	M	ID	2/2	Required	1
GS02	142	**Application Sender's Code** **Medi-Cal Note:** ***Submitter Identifier Medi-Cal will only use the first 3 characters.***	M	AN	2/15	Required	1
GS03	124	**Application Receiver's Code** **Medi-Cal Note:** ***"610442" Medi-Cal Identifier.***	M	AN	2/15	Required	1
GS04	373	**Date** **Medi-Cal Note:** ***Use this date for the functional group creation date.***	M	DT	8/8	Required	1
GS05	337	**Time** **Medi-Cal Note:** ***Use this time for the creation time. The recommended format is HHMM.***	M	TM	4/8	Required	1
GS06	28	**Group Control Number** **Medi-Cal Note:** ***Must be identical to the same data element in the associated functional group trailer GE02.***	M	N0	1/9	Required	1
GS07	455	**Responsible Agency Code** **Code Name** X Accredited Standards Committee X12	M	ID	1/2	Required	1
GS08	480	**Version / Release / Industry Identifier Code** **Code** **Name** 004010X098A1 Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.	M	AN	1/12	Required	1

Example:

GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X098~

ST Transaction Set Header

Pos: 005	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
ST01	143	**Transaction Set Identifier Code**	M	ID	3/3	Required	1
		Code **Name** 837 Health Care Claim					
ST02	329	**Transaction Set Control Number**	M	AN	4/9	Required	1
		Alias: ***Transaction Set Control Number***					
		Medi-Cal Note: ***The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.***					

Example:

ST*837*987654~

BHT Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 6

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
BHT01	1005	**Hierarchical Structure Code** **Code Name** 0019 Information Source, Subscriber, Dependent	M	ID	4/4	Required	1
BHT02	353	**Transaction Set Purpose Code** **Alias:** ***Transaction Set Purpose Code*** **Code Name** 00 Original	M	ID	2/2	Required	1
BHT03	127	**Reference Identification** **Industry:** ***Originator Application Transaction Identifier***	O	AN	1/30	Required	1
BHT04	373	**Date** **Industry:** ***Transaction Set Creation Date*** **Medi-Cal Note:** ***Date Billed 45-1 claim form field number 84.***	O	DT	8/8	Required	1
BHT05	337	**Time** **Industry:** ***Transaction Set Creation Time***	O	TM	4/8	Required	1
BHT06	640	**Transaction Type Code** **Industry:** ***Claim or Encounter Identifier*** **Alias:** ***Claim or Encounter Indicator*** **Code Name** CH Chargeable	O	ID	2/2	Required	1

Example:

BHT*0019*00*0123*19970618*0932*CH~
BHT*0019*00*44445*19970213*0345*RP~

REF Transmission Type Identification

Pos: 015	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Required

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier** **Code Name** 87 Functional Category	M	ID	2/3	Required	1
REF02	127	**Reference Identification** **Industry:** ***Transmission Type Code*** **Medi-Cal Note:** ***When piloting the transaction set, this value is 004010X098DA1. When sending the transaction set in a production mode, this value is 004010X098A1.***	C	AN	1/30	Required	1

Example:

REF*87*004010X098A1~

Loop 1000A

Pos: 020	Repeat: 1
Optional	
Loop: 1000A	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
020	NM1	Submitter Name	O	1		Required
045	PER	Submitter EDI Contact Information	O	2		Required

Example:

NM1*41*2*CRAMMER, DOLE, PALMER, AND JOHANSON**46*W7933THU~***

NM1 Submitter Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** 41 Submitter	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Submitter Last or Organization Name*** **Alias:** ***Submitter Name*** **Medi-Cal Note:** ***Medi-Cal will only use the first 33 characters.***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Submitter First Name*** **Alias:** ***Submitter Name***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Submitter Middle Name*** **Alias:** ***Submitter Name***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix**	O	AN	1/10	Not used	1
NM108	66	**Identification Code Qualifier** **Code Name** 46 Electronic Transmitter Identification Number (ETIN)	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Submitter Identifier*** **Alias:** ***Submitter Primary Identification Number*** **Medi-Cal Note:** ***Medi-Cal Submitter ID Medi-Cal will only use the first 3 characters.***	C	AN	2/80	Required	1

Example:

NM1*41*2*CRAMMER, DOLE, PALMER, AND JOHANSON**46*W7933THU~***

PER Submitter EDI Contact Information

Pos: 045 **Max: 2**
Heading - Optional
Loop: 1000A **Elements: 4**

User Option (Usage): Required

To identify a person or office to whom administrative communications should be directed

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PER01	366	**Contact Function Code**	M	ID	2/2	Required	1
		Code Name IC Information Contact					
PER02	93	**Name**	O	AN	1/60	Required	1
		Industry: ***Submitter Contact Name***					
PER03	365	**Communication Number Qualifier**	C	ID	2/2	Required	1
		Code Name ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone					
PER04	364	**Communication Number**	C	AN	1/80	Required	1

Example:

PER*IC*JANE DOE*TE*9005555555~

Loop 1000B

Pos: 020	Repeat: 1
Optional	
Loop: 1000B	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
020	NM1	Receiver Name	O	1		Required

Example:

NM1*40*2*UNION MUTUAL OF OREGON**46*11122333~***

NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** 40 Receiver	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Receiver Name*** **Medi-Cal Note:** ***"Medi-Cal"***	O	AN	1/35	Required	1
NM104	1036	**Name First**	O	AN	1/25	Not used	1
NM105	1037	**Name Middle**	O	AN	1/25	Not used	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix**	O	AN	1/10	Not used	1
NM108	66	**Identification Code Qualifier** **Code Name** 46 Electronic Transmitter Identification Number (ETIN)	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Receiver Primary Identifier*** **Alias:** ***Receiver Primary Identification Number*** **Medi-Cal Note:** ***"610442" Medi-Cal Receiver Primary Identifier***	C	AN	2/80	Required	1

Example:

NM1*40*2*UNION MUTUAL OF OREGON**46*11122333~***

Loop 2000A

Pos: 001	Repeat: >1
Mandatory	
Loop: 2000A	Elements: N/A

User Option (Usage): Required

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

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
001	HL	Billing/Pay-to Provider Hierarchical Level	M	1		Required
003	PRV	Billing/Pay-to Provider Specialty Information	O	1		Situational
015		Loop 2010AA	O		1	Required

Example:

HL*1**20*1~

HL Billing/Pay-to Provider Hierarchical Level

Pos: 001 **Max: 1**
Detail - Mandatory
Loop: 2000A **Elements: 4**

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1
		Medi-Cal Note: ***HL01 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.***					
HL02	734	**Hierarchical Parent ID Number**	O	AN	1/12	Not used	1
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1
		Code Name 20 Information Source					
HL04	736	**Hierarchical Child Code**	O	ID	1/1	Required	1
		Code Name 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.					

Example:

HL*1**20*1~

PRV Billing/Pay-to Provider Specialty Information

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 3

User Option (Usage): Situational

To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PRV01	1221	**Provider Code** **Code Name** BI Billing	M	ID	1/3	Required	1
PRV02	128	**Reference Identification Qualifier** **Code Name** ZZ Mutually Defined	M	ID	2/3	Required	1
PRV03	127	**Reference Identification** **Industry:** ***Provider Taxonomy Code*** **Alias:** ***Provider Specialty Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 10 characters.*** **ExternalCodeList** **Name:** HCPT **Description:** Health Care Provider Taxonomy	M	AN	1/30	Required	1

Example:

PRV*BI*ZZ*203BA050N~

Loop 2010AA

Pos: 015	Repeat: 1
Optional	
Loop: 2010AA	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
015	NM1	Billing Provider Name	O	1		Required
025	N3	Billing Provider Address	O	1		Required
030	N4	Billing Provider City/State/ZIP Code	O	1		Required
035	REF	Billing Provider Secondary Identification	O	8		Situational
040	PER	Billing Provider Contact Information	O	2		Situational

Example:

NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNANSE**24*111223333~***

NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** 85 Billing Provider	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Billing Provider Last or Organizational Name*** **Alias:** ***Billing Provider Name*** **Medi-Cal Note:** ***Medi-Cal will only use the first 33 characters.*** ***45-1 claim form field number 2A.***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Billing Provider First Name*** **Alias:** ***Billing Provider Name*** **Medi-Cal Note:** ***45-1 claim form field number 2A.***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Billing Provider Middle Name*** **Alias:** ***Billing Provider Name*** **Medi-Cal Note:** ***45-1 claim form field number 2A.***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Billing Provider Name Suffix*** **Alias:** ***Billing Provider Name*** **Medi-Cal Note:** ***45-1 claim form field number 2A.***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Billing Provider Identifier*** **Alias:** ***Billing Provider Primary***	C	AN	2/80	Required	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		Identification Number					
		ExternalCodeList					
		Name: 537					
		Description: Health Care Financing Administration National Provider Identifier					

Example:

NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNANSE**24*111223333~***

N3 Billing Provider Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Required

To specify the location of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N301	166	**Address Information** **Industry:** ***Billing Provider Address Line*** **Alias:** ***Billing Provider Address 1*** **Medi-Cal Note:** ***Medi-Cal will only use the first 26 characters.*** ***45-1 claim form field number 2A.***	M	AN	1/55	Required	1
N302	166	**Address Information** **Industry:** ***Billing Provider Address Line*** **Alias:** ***Billing Provider Address 2*** **Medi-Cal Note:** ***Medi-Cal will only use the first 26 characters.*** ***45-1 claim form field number 2A.***	O	AN	1/55	Situational	1

Example:

N3*225 MAIN STREET*BARKLEY BUILDING~

N4 Billing Provider City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 3

User Option (Usage): Required

To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N401	19	**City Name** **Industry:** ***Billing Provider City Name*** **Alias:** ***Billing Provider's City*** **Medi-Cal Note:** ***Medi-Cal will only use the first 18 characters.*** ***45-1 claim form field number 2A.***	O	AN	2/30	Required	1
N402	156	**State or Province Code** **Industry:** ***Billing Provider State or Province Code*** **Alias:** ***Billing Provider's State*** **Medi-Cal Note:** ***45-1 claim form field number 2A.*** **ExternalCodeList** **Name:** 22 **Description:** States and Outlying Areas of the U.S.	O	ID	2/2	Required	1
N403	116	**Postal Code** **Industry:** ***Billing Provider Postal Zone or ZIP Code*** **Alias:** ***Billing Provider's Zip Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 5 characters.*** ***45-1 claim form field number 2A.*** **ExternalCodeList** **Name:** 51 **Description:** ZIP Code	O	ID	3/15	Required	1

Example:

N4*CENTERVILLE*PA*17111~

REF Billing Provider Secondary Identification

Pos: 035	Max: 8
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name 1D Medicaid Provider Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Billing Provider Additional Identifier***					
		Alias: ***Billing Provider Secondary Identification Number***					
		Medi-Cal Note: ***Medi-Cal Provider Number (Billing)*** ***Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 2.***					

Example:

REF*1G*98765~

Medi-Cal Note:

Medi-Cal uses this segment to identify the Medi-Cal billing provider number.

PER Billing Provider Contact Information

Pos: 040	Max: 2
Detail - Optional	
Loop: 2010AA	Elements: 4

User Option (Usage): Situational

To identify a person or office to whom administrative communications should be directed

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PER01	366	**Contact Function Code** **Code Name** IC Information Contact	M	ID	2/2	Required	1
PER02	93	**Name** **Industry:** ***Billing Provider Contact Name***	O	AN	1/60	Required	1
PER03	365	**Communication Number Qualifier** **Code Name** TE Telephone	C	ID	2/2	Required	1
PER04	364	**Communication Number** **Medi-Cal Note:** ***Provider Phone Number. Medi-Cal will only use the first 10 characters.***	C	AN	1/80	Required	1

Example:

PER*IC*JIM*TE*8007775555~

Loop 2000B

Pos: 001	Repeat: >1
Mandatory	
Loop: 2000B	Elements: N/A

User Option (Usage): Required

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

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
001	HL	Subscriber Hierarchical Level	M	>1		Required
005	SBR	Subscriber Information	O	1		Required
007	PAT	Patient Information	O	1		Situational
015		Loop 2010BA	O		1	Required
015		Loop 2010BB	O		1	Required
130		Loop 2300	O		100	Required

Example:

HL*2*1*22*1~

HL Subscriber Hierarchical Level

Pos: 001	Max: >1
Detail - Mandatory	
Loop: 2000B	Elements: 4

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1
		Medi-Cal Note: ***Increment by "1" for each Hierarchical level in this transaction.***					
HL02	734	**Hierarchical Parent ID Number**	O	AN	1/12	Required	1
		Medi-Cal Note: ***HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.***					
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1
		Code Name 22 Subscriber					
HL04	736	**Hierarchical Child Code**	O	ID	1/1	Required	1
		Code Name 0 No Subordinate HL Segment in This Hierarchical Structure.					

Example:

HL*2*1*22*1~

SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 9

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SBR01	1138	**Payer Responsibility Sequence Number Code** **Alias:** ***Payer Responsibility Sequence Number Code*** **Code Name** P Primary S Secondary T Tertiary	M	ID	1/1	Required	1
SBR02	1069	**Individual Relationship Code** **Alias:** ***Relationship Code*** **Code Name** 18 Self	O	ID	2/2	Situational	1
SBR03	127	**Reference Identification** **Industry:** ***Insured Group or Policy Number*** **Alias:** ***Group or Policy Number***	O	AN	1/30	Situational	1
SBR04	93	**Name** **Industry:** ***Insured Group Name*** **Alias:** ***Group or Plan Name***	O	AN	1/60	Situational	1
SBR05	1336	**Insurance Type Code** **Alias:** ***Insurance type code*** **Code Name** 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month 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	O	ID	1/3	Situational	1
SBR06	1143	**Coordination of Benefits Code**	O	ID	1/1	Not used	1
SBR07	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Not used	1
SBR08	584	**Employment Status Code**	O	ID	2/2	Not used	1
SBR09	1032	**Claim Filing Indicator Code** **Alias:** ***Claim Filing Indicator Code*** **Code Name** MC Medicaid	O	ID	1/2	Situational	1

Example:

SBR*P**GRP01020102***MB~***

PAT Patient Information

Pos: 007	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 9

User Option (Usage): Situational

To supply patient information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PAT01	1069	**Individual Relationship Code**	O	ID	2/2	Not used	1
PAT02	1384	**Patient Location Code**	O	ID	1/1	Not used	1
PAT03	584	**Employment Status Code**	O	ID	2/2	Not used	1
PAT04	1220	**Student Status Code**	O	ID	1/1	Not used	1
PAT05	1250	**Date Time Period Format Qualifier**	C	ID	2/3	Situational	1
		Code Name D8 Date Expressed in Format CCYYMMDD					
PAT06	1251	**Date Time Period**	C	AN	1/35	Situational	1
		Industry: ***Insured Individual Death Date***					
		Alias: ***Date of Death***					
PAT07	355	**Unit or Basis for Measurement Code**	C	ID	2/2	Situational	1
		Code Name 01 Actual Pounds					
PAT08	81	**Weight**	C	R	1/10	Situational	1
		Industry: ***Patient Weight***					
PAT09	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Situational	1
		Industry: ***Pregnancy Indicator***					
		Code Name Y Yes					

Example:

PAT**D8*19970314*01*146~***

Loop 2010BA

Pos: 015	Repeat: 1
Optional	
Loop: 2010BA	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
015	NM1	Subscriber Name	O	1		Required
025	N3	Subscriber Address	O	1		Situational
030	N4	Subscriber City/State/ZIP Code	O	1		Situational
032	DMG	Subscriber Demographic Information	O	1		Situational

Example:

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

NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** IL Insured or Subscriber	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Subscriber Last Name*** **Medi-Cal Note:** ***Recipient Last Name. Medi-Cal will only use the first 14 characters. 45-1 claim form field number 2C.***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Subscriber First Name*** **Medi-Cal Note:** ***Recipient First Name. Medi-Cal will only use the first 8 characters. 45-1 claim form field number 2C.***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Subscriber Middle Name*** **Medi-Cal Note:** ***Recipient Middle Initial. Medi-Cal will only use the first one characters. 45-1 claim form field number 2C.***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Subscriber Name Suffix*** **Alias:** ***Subscriber Generation*** **Medi-Cal Note:** ***45-1 claim form field number 2C.***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** MI Member Identification Number	C	ID	1/2	Situational	1
NM109	67	**Identification Code** **Industry:** ***Subscriber Primary Identifier*** **Medi-Cal Note:** ***Medi-Cal Recipient ID. Medi-Cal will only use the first 15 characters. 45-1 claim form field number 4.***	C	AN	2/80	Situational	1

Example:

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

N3 Subscriber Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 2

User Option (Usage): Situational

To specify the location of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N301	166	**Address Information** **Industry:** ***Subscriber Address Line*** **Alias:** ***Subscriber Address 1*** **Medi-Cal Note:** ***Recipient Address Line 1. Medi-Cal will only use the first 29 characters. 45-1 claim form field number 2C.***	M	AN	1/55	Required	1
N302	166	**Address Information** **Industry:** ***Subscriber Address Line*** **Alias:** ***Subscriber Address 2*** **Medi-Cal Note:** ***Recipient Address Line 2. Medi-Cal will only use the first 29 characters. 45-1 claim form field number 2C.***	O	AN	1/55	Situational	1

Example:

N3*125 CITY AVENUE~

N4 Subscriber City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Situational

To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N401	19	**City Name** **Industry:** ***Subscriber City Name*** **Medi-Cal Note:** ***45-1 claim form field number 2C.***	O	AN	2/30	Required	1
N402	156	**State or Province Code** **Industry:** ***Subscriber State Code*** **Medi-Cal Note:** ***45-1 claim form field number 2C.*** **ExternalCodeList** **Name:** 22 **Description:** States and Outlying Areas of the U.S.	O	ID	2/2	Required	1
N403	116	**Postal Code** **Industry:** ***Subscriber Postal Zone or ZIP Code*** **Alias:** ***Subscriber Zip Code*** **Medi-Cal Note:** ***Recipient Zip Code. Medi-Cal will only use the first 5 characters. 45-1 claim form field number 3.*** **ExternalCodeList** **Name:** 51 **Description:** ZIP Code	O	ID	3/15	Required	1

Example:

N4*CENTERVILLE*PA*17111~

DMG Subscriber Demographic Information

Pos: 032	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Situational

To supply demographic information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DMG01	1250	**Date Time Period Format Qualifier** **Code Name** D8 Date Expressed in Format CCYYMMDD	C	ID	2/3	Required	1
DMG02	1251	**Date Time Period** **Industry:** ***Subscriber Birth Date*** **Alias:** ***Date of Birth - Patient*** **Medi-Cal Note:** ***Recipient Birth Date. Medi-Cal will only use the first 8 characters. 45-1 claim form field number 6.***	C	AN	1/35	Required	1
DMG03	1068	**Gender Code** **Industry:** ***Subscriber Gender Code*** **Alias:** ***Gender - Patient*** **Medi-Cal Note:** ***45-1 claim form field number 5.*** **Code Name** F Female M Male	O	ID	1/1	Required	1

Example:

DMG*D8*19330706*M~

Loop 2010BB

Pos: 015	Repeat: 1
Optional	
Loop: 2010BB	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
015	NM1	Payer Name	O	1		Required

Example:

NM1*PR*2*UNION MUTUAL OF OREGON**PI*11122333~***

NM1 Payer Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** Code Name PR Payer	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** Code Name 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Payer Name*** **Medi-Cal Note:** ***"Medi-Cal VIS". Please submit exactly as indicated. May be upper, lower or mixed case. "Medi-Cal VIS" is no longer required for dates of service on or after July 1, 2006.***	O	AN	1/35	Required	1
NM104	1036	**Name First**	O	AN	1/25	Not used	1
NM105	1037	**Name Middle**	O	AN	1/25	Not used	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix**	O	AN	1/10	Not used	1
NM108	66	**Identification Code Qualifier** Code Name PI Payor Identification	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Payer Identifier*** **Alias:** ***Payer Primary Identifier*** **Medi-Cal Note:** ***"610442" (Medi-Cal Payer/Receiver ID)*** **ExternalCodeList** **Name:** 540 **Description:** Health Care Financing Administration National Plan ID	C	AN	2/80	Required	1

Example:

NM1*PR*2*UNION MUTUAL OF OREGON**PI*11122333~***

Medi-Cal Note:

Medi-Cal uses field NM103 of this loop to appropriately differentiate between the two Professional claim types. The payer name is required for Medi-Cal processing.

As of July 1, 2006 it is no longer required to include Medi-Cal VIS in the Payer Last Name segment (NM1) (NM103 element).

Loop 2300

Pos: 130	Repeat: 100
Optional	
Loop: 2300	Elements: N/A

User Option (Usage): Required

To specify basic data about the claim

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
130	CLM	Claim Information	O	1		Required
135	DTP	Date - Hearing and Vision Prescription Date	O	150		Situational
155	PWK	Claim Supplemental Information	O	10		Situational
175	AMT	Patient Amount Paid	O	40		Situational
175	AMT	Total Purchased Service Amount	O	40		Situational
180	REF	Prior Authorization or Referral Number	O	30		Situational
180	REF	Medical Record Number	O	30		Situational
185	K3	File Information	O	10		Situational
190	NTE	Claim Note	O	20		Situational
220	CRC	Patient Condition Information: Vision	O	100		Situational
220	CRC	EPSDT Referral	O	1		Situational
231	HI	Health Care Diagnosis Code	O	25		Situational
250		Loop 2310A	O		1	Situational
250		Loop 2310B	O		1	Situational
290		Loop 2320	O		1	Situational
365		Loop 2400	O		50	Required

Example:

CLM*A37YH556*50011::1*Y*A*Y*Y*C~***

CLM Claim Information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 20

User Option (Usage): Required

To specify basic data about the claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CLM01	1028	**Claim Submitter's Identifier** **Industry:** ***Patient Account Number*** **Medi-Cal Note:** ***Medi-Cal will only use the first 20 characters.***	M	AN	1/38	Required	1
CLM02	782	**Monetary Amount** **Industry:** ***Total Claim Charge Amount*** **Alias:** ***Total Submitted Charges*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 70.***	O	R	1/18	Required	1
CLM03	1032	**Claim Filing Indicator Code**	O	ID	1/2	Not used	1
CLM04	1343	**Non-Institutional Claim Type Code**	O	ID	1/2	Not used	1
CLM05	C023	**Health Care Service Location Information** **Alias:** ***Place of Service Code (Composite)***	O	Comp		Required	1
	1331	**Facility Code Value** **Industry:** ***Facility Type Code*** **Medi-Cal Note:** ***Place of Service. For claims with dates of service prior to September 22, 2003, the Medi-Cal local place of service values must be used. These are located in the Medi-Cal Provider Manual. For dates of service on or after September 22, 2003, the national place of service values as referenced in external code list 237 must be used.*** ***45-1 claim form field number 7.*** **ExternalCodeList** **Name:** 237 **Description:** Place of Service from Health Care Financing Administration Claim Form	M	AN	1/2	Required	1
	1332	**Facility Code Qualifier**	O	ID	1/2	Not used	1
	1325	**Claim Frequency Type Code** **Industry:** ***Claim Frequency Code*** **Alias:** ***Claim Submission Reason Code*** **Medi-Cal Note:** ***"1" (Original) .*** **ExternalCodeList** **Name:** 235 **Description:** Claim Frequency Type Code	O	ID	1/1	Required	1
CLM06	1073	**Yes/No Condition or Response Code** **Industry:** ***Provider or Supplier Signature Indicator*** **Alias:** ***Provider Signature on File***	O	ID	1/1	Required	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		Code Name N No Y Yes					
CLM07	1359	**Provider Accept Assignment Code** **Industry:** ***Medicare Assignment Code*** **Code Name** A Assigned B Assignment Accepted on Clinical Lab Services Only C Not Assigned P Patient Refuses to Assign Benefits	O	ID	1/1	Required	1
CLM08	1073	**Yes/No Condition or Response Code** **Industry:** ***Benefits Assignment Certification Indicator*** **Alias:** ***Assignment of Benefits Indicator*** **Medi-Cal Note:** ***Benefits Assigned.*** **Code Name** N No Y Yes	O	ID	1/1	Required	1
CLM09	1363	**Release of Information Code** **Alias:** ***Release of Information Code*** **Code Name** A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M The Provider has Limited or Restricted Ability to Release Data Related to a Claim N No, Provider is Not Allowed to Release Data O On file at Payor or at Plan Sponsor Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim	O	ID	1/1	Required	1
CLM10	1351	**Patient Signature Source Code** **Alias:** ***Patient Signature Source Code*** **Code Name** B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C Signed HCFA-1500 Claim Form on file M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P Signature generated by provider because the patient was not physically present for services S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file	O	ID	1/1	Situational	1
CLM11	C024	**Related Causes Information** **Alias:** ***Accident/Employment/Related Causes (Composite)***	O	Comp		Situational	1
	1362	**Related-Causes Code** **Industry:** ***Related Causes Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 2 characters.*** **Code Name** AA Auto Accident AP Another Party Responsible	M	ID	2/3	Required	1

		Code **Name** EM Employment OA Other Accident					
	1362	**Related-Causes Code** **Industry:** ***Related Causes Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 2 characters.*** **Code** **Name** AA Auto Accident AP Another Party Responsible EM Employment OA Other Accident	O	ID	2/3	Situational	1
	1362	**Related-Causes Code** **Industry:** ***Related Causes Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 2 characters.*** **Code** **Name** AA Auto Accident AP Another Party Responsible EM Employment OA Other Accident	O	ID	2/3	Situational	1
	156	**State or Province Code** **Industry:** ***Auto Accident State or Province Code*** **ExternalCodeList** **Name:** 22 **Description:** States and Outlying Areas of the U.S.	O	ID	2/2	Situational	1
	26	**Country Code** **ExternalCodeList** **Name:** 5 **Description:** Countries, Currencies and Funds	O	ID	2/3	Situational	1
CLM12	1366	**Special Program Code** **Industry:** ***Special Program Indicator*** **Alias:** ***Special Program Code*** **Medi-Cal Note:** ***Medi-Cal uses this to identify a claim associated with EPSDT/CHDP services.*** ***Medi-Cal will only use the first 2 characters.*** **Code** **Name** 01 Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP) 02 Physically Handicapped Children's Program 03 Special Federal Funding 05 Disability 07 Induced Abortion - Danger to Life 08 Induced Abortion - Rape or Incest 09 Second Opinion or Surgery	O	ID	2/3	Situational	1
CLM13	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Not used	1
CLM14	1338	**Level of Service Code**	O	ID	1/3	Not used	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CLM15	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Not used	1
CLM16	1360	**Provider Agreement Code**	O	ID	1/1	Situational	1

Industry: ***Participation Agreement***

Code	Name
P	Participation Agreement

CLM17	1029	**Claim Status Code**	O	ID	1/2	Not used	1
CLM18	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Not used	1
CLM19	1383	**Claim Submission Reason Code**	O	ID	2/2	Not used	1
CLM20	1514	**Delay Reason Code**	O	ID	1/2	Situational	1

Alias: ***Delay Reason Code***

Medi-Cal Note: ***Medi-Cal Billing Limit Exception Code.***
For claims with dates of service prior to September 22, 2003, the Medi-Cal local Billing Limit Exception Code must be used. For dates of service on or after September 22, 2003, the national delay reason code value as listed below must be used.

Code	Name
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other
15	Natural Disaster

Example:

CLM*A37YH556*50011::1*Y*A*Y*Y*C~***

DTP Date - Hearing and Vision Prescription Date

Pos: 135	Max: 150
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required	1
		Industry: ***Date Time Qualifier***					
		Code Name 471 Prescription					
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Code Name D8 Date Expressed in Format CCYYMMDD					
DTP03	1251	**Date Time Period**	M	AN	1/35	Required	1
		Industry: ***Prescription Date***					
		Medi-Cal Note: ***Date appliance delivered can be conveyed at the service level using Shipped Date.*** ***Medi-Cal will only use the first 8 characters.*** ***45-1 claim form field number 23.***					

Example:

DTP*471*D8*19970115~

PWK Claim Supplemental Information

Pos: 155	Max: 10
Detail - Optional	
Loop: 2300	Elements: 4

User Option (Usage): Situational

To identify the type or transmission or both of paperwork or supporting information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PWK01	755	**Report Type Code** **Industry:** ***Attachment Report Type Code*** **Medi-Cal Note:** ***Currently, Medi-Cal will only accept 'OZ' for Vision Claims.***	M	ID	2/2	Required	1
PWK02	756	**Report Transmission Code** **Industry:** ***Attachment Transmission Code*** **Medi-Cal Note:** ***Currently, Medi-Cal will accept only 'BM', 'EL', and 'FX'.***	O	ID	1/2	Required	1
PWK05	66	**Identification Code Qualifier** **Medi-Cal Note:** ***'AC' is required for Vision Claims.***	C	ID	1/2	Situational	1

Code Name (PWK01 — 755)

Code	Name
77	Support Data for Verification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
CT	Certification
DA	Dental Models
DG	Diagnostic Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
MT	Models
NN	Nursing Notes
OB	Operative Note
OZ	Support Data for Claim **Medi-Cal Note:** ***'OZ' is required for Vision Claims.***
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report

Code Name (PWK02 — 756)

Code	Name
AA	Available on Request at Provider Site
BM	By Mail
EL	Electronically Only
EM	E-Mail
FX	By Fax

Code Name (PWK05 — 66)

Code	Name
AC	Attachment Control Number

PWK06	67	**Identification Code**	C	AN	2/80	Situational	1
		Industry: ***Attachment Control Number***					
		Medi-Cal Note: ***Please enter 11 digit Attachment Control Number (ACN) from the Medi-Cal Claim Attachment Control Form (ACF).***					

Example:

PWK*OZ*BMAC*12345678903~***

Medi-Cal Note:

Currently, Medi-Cal is accepting only ONE PWK segment for Attachments. You can submit only ONE set of attachment per claim {Medi-Cal will accept only ONE Attachment Control Number (ACN) from Medi-Cal Claim Attachment Control Form (ACF)}.

Currently, Medi-Cal is accepting attachments at the claim level and not at the service line level.

AMT Patient Amount Paid

Pos: 175	Max: 40
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required	1
		Code Name F5 Patient Amount Paid					
AMT02	782	**Monetary Amount**	M	R	1/18	Required	1
		Industry: ***Patient Amount Paid***					
		Medi-Cal Note: ***Medi-Cal Share of Cost Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 76.***					

Example:

AMT*F5*152.45~

AMT Total Purchased Service Amount

Pos: 175	Max: 40
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required	1
		Code Name NE Net Billed					
AMT02	782	**Monetary Amount**	M	R	1/18	Required	1
		Industry: ***Total Purchased Service Amount***					

Example:

AMT*NE*57.35~

REF Prior Authorization or Referral Number

Pos: 180	Max: 30
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name G1 Prior Authorization Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Prior Authorization or Referral Number***					
		Medi-Cal Note: ***Medi-Cal Treatment Authorization Request (TAR) Number. Medi-Cal will only use the first 11 characters. 45-1 claim form field number 24.***					

Example:

REF*G1*13579~

REF Medical Record Number

Pos: 180	Max: 30
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name EA Medical Record Identification Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Medical Record Number***					

Example:

REF*EA*44444TH56~

K3 File Information

Pos: 185	Max: 10
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

To transmit a fixed-format record or matrix contents

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
K301	449	**Fixed Format Information**	M	AN	1/80	Required	1
K302	1333	**Record Format Code**	O	ID	1/2	Not used	1
K303	C001	**Composite Unit of Measure**	O	Comp		Not used	1

Example:

K3*STATE DATA REQUIREMENT~

Medi-Cal Note:

Medi-Cal may use this segment at a future date for legislatively mandated data not otherwise accommodated by the Professional 837 version 4010A1 Implementation Guide.

NTE Claim Note

Pos: 190	Max: 20
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NTE01	363	**Note Reference Code**	O	ID	3/3	Required	1
		Code Name ADD Additional Information CER Certification Narrative DCP Goals, Rehabilitation Potential, or Discharge Plans DGN Diagnosis Description PMT Payment TPO Third Party Organization Notes					
NTE02	352	**Description** **Industry:** ***Claim Note Text***	M	AN	1/80	Required	1

Example:

NTE*ADD*SURGERY WAS UNUSUALLY LONG BECAUSE [FILL IN REASON*~

Medi-Cal Note:

Additional information previously sent in the CMC Remarks field may be submitted in this segment.

CRC Patient Condition Information: Vision

Pos: 220	Max: 100
Detail - Optional	
Loop: 2300	Elements: 7

User Option (Usage): Situational

To supply information on conditions

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CRC01	1136	**Code Category** **Code Name** E1 Spectacle Lenses E2 Contact Lenses E3 Spectacle Frames	M	ID	2/2	Required	1
CRC02	1073	**Yes/No Condition or Response Code** **Industry:** ***Certification Condition Indicator*** **Alias:** ***Certification Condition Code Applies Indicator*** **Code Name** Y Yes	M	ID	1/1	Required	1
CRC03	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Alias:** ***Condition Indicator*** **Code Name** L1 General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 Replacement Due to Loss or Theft L3 Replacement Due to Breakage or Damage L4 Replacement Due to Patient Preference L5 Replacement Due to Medical Reason	M	ID	2/2	Required	1
CRC04	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1
CRC05	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1
CRC06	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1
CRC07	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1

Example:

CRC*E1*Y*L1~

CRC EPSDT Referral

Pos: 220	Max: 1
Detail - Optional	
Loop: 2300	Elements: 5

User Option (Usage): Situational

To supply information on conditions

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CRC01	1136	**Code Category** **Code Name** ZZ Mutually Defined	M	ID	2/2	Required	1
CRC02	1073	**Yes/No Condition or Response Code** **Industry:** ***Certification Condition Indicator*** **Alias:** ***Certification Condition Code Applies Indicator*** **Code Name** Y Yes	M	ID	1/1	Required	1
CRC03	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Alias:** ***Condition Indicator*** **Code Name** AV Available - Not Used NU Not Used S2 Under Treatment ST New Services Requested	M	ID	2/2	Required	1
CRC04	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1
CRC05	1321	**Condition Indicator** **Industry:** ***Condition Code*** **Medi-Cal Note:** ***Use the codes listed in CRC03.***	O	ID	2/2	Situational	1

Example:

CRC*ZZ*Y*ST~

HI Health Care Diagnosis Code

Pos: 231	Max: 25
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HI01	C022	**Health Care Code Information**	M	Comp		Required	1
		Alias: ***Principal Diagnosis (Composite)***					
	1270	**Code List Qualifier Code**	M	ID	1/3	Required	1
		Industry: ***Diagnosis Type Code***					
		Code **Name** BK Principal Diagnosis					
	1271	**Industry Code**	M	AN	1/30	Required	1
		Industry: ***Diagnosis Code***					
		Medi-Cal Note: ***Primary Diagnosis Code. Medi-Cal will only use the first 5 characters. 45-1 claim form field number 21.***					
		ExternalCodeList **Name:** 131 **Description:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure					

Example:

HI*BK:8901*BF:87200*BF:5559~

Medi-Cal Note:

HI02-HI12 are not required for Medi-Cal Vision claims.

Loop 2310A

Pos: 250	Repeat: 1
Optional	
Loop: 2310A	Elements: N/A

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
250	NM1	Referring Provider Name	O	1		Situational
255	PRV	Referring Provider Specialty Information	O	1		Situational
271	REF	Referring Provider Secondary Identification	O	20		Situational

Example:

NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~

NM1 Referring Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 9

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** DN Referring Provider	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Referring Provider Last Name***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Referring Provider First Name***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Referring Provider Middle Name***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Referring Provider Name Suffix*** **Alias:** ***Referring Provider Generation***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	C	ID	1/2	Situational	1
NM109	67	**Identification Code** **Industry:** ***Referring Provider Identifier*** **Alias:** ***Referring Provider Primary Identifier*** **ExternalCodeList** **Name:** 537 **Description:** Health Care Financing Administration National Provider Identifier	C	AN	2/80	Situational	1

Example:

NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~

PRV Referring Provider Specialty Information

Pos: 255	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 3

User Option (Usage): Situational

To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PRV01	1221	**Provider Code** **Code** **Name** RF Referring	M	ID	1/3	Required	1
PRV02	128	**Reference Identification Qualifier** **Code** **Name** ZZ Mutually Defined	M	ID	2/3	Required	1
PRV03	127	**Reference Identification** **Industry:** ***Provider Taxonomy Code*** **Alias:** ***Provider Specialty Code*** **ExternalCodeList** **Name:** HCPT **Description:** Health Care Provider Taxonomy	M	AN	1/30	Required	1

Example:

PRV*RF*ZZ*363LP0200N~

REF Referring Provider Secondary Identification

Pos: 271	Max: 20
Detail - Optional	
Loop: 2310A	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name 0B State License Number 1D Medicaid Provider Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Referring Provider Secondary Identifier***					

Example:

REF*1D*A12345~

Loop 2310B

Pos: 250	Repeat: 1
Optional	
Loop: 2310B	Elements: N/A

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
250	NM1	Rendering Provider Name	O	1		Situational
255	PRV	Rendering Provider Specialty Information	O	1		Required
271	REF	Rendering Provider Secondary Identification	O	20		Situational

Example:

NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~

NM1 Rendering Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 9

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** 82 Rendering Provider	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Rendering Provider Last or Organization Name*** **Alias:** ***Rendering Provider Last Name***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Rendering Provider First Name***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Rendering Provider Middle Name***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Rendering Provider Name Suffix*** **Alias:** ***Rendering Provider Generation***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Rendering Provider Identifier*** **Alias:** ***Rendering Provider Primary Identifier*** **Medi-Cal Note:** ***Medi-Cal will only use the first 10 characters.*** **ExternalCodeList** **Name:** 537 **Description:** Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required	1

Example:

NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~

PRV Rendering Provider Specialty Information

Pos: 255	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 3

User Option (Usage): Required

To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PRV01	1221	**Provider Code** **Code Name** PE Performing	M	ID	1/3	Required	1
PRV02	128	**Reference Identification Qualifier** **Code Name** ZZ Mutually Defined	M	ID	2/3	Required	1
PRV03	127	**Reference Identification** **Industry:** ***Provider Taxonomy Code*** **Alias:** ***Provider Specialty Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 10 characters.*** **ExternalCodeList** **Name:** HCPT **Description:** Health Care Provider Taxonomy	M	AN	1/30	Required	1

Example:

PRV*PE*ZZ*203BA0200N~

REF Rendering Provider Secondary Identification

Pos: 271	Max: 20
Detail - Optional	
Loop: 2310B	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier** **Code Name** 0B State License Number 1D Medicaid Provider Number	M	ID	2/3	Required	1
REF02	127	**Reference Identification** **Industry:** ***Rendering Provider Secondary Identifier*** **Medi-Cal Note:** ***Medi-Cal Provider Number*** ***Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 20.***	C	AN	1/30	Required	1

Example:

REF*1D*A12345~

Medi-Cal Note:

Medi-Cal uses this segment to capture the Medi-Cal provider identifier or the state license number of the rendering provider.

Loop 2320

Pos: 290	Repeat: 1
Optional	
Loop: 2320	Elements: N/A

User Option (Usage): Situational

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

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
290	SBR	Other Subscriber Information	O	1		Situational
295	CAS	Claim Level Adjustments	O	99		Situational
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	15		Situational
300	AMT	Coordination of Benefits (COB) Approved Amount	O	15		Situational
300	AMT	Coordination of Benefits (COB) Allowed Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	O	1		Situational
300	AMT	Coordination of Benefits (COB) Patient Paid Amount	O	1		Situational
305	DMG	Subscriber Demographic Information	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
325		Loop 2330A	O		1	Required
325		Loop 2330B	O		1	Required

Example:

SBR*S*01*GR00786**MC*OF~***

SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 9

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SBR01	1138	**Payer Responsibility Sequence Number Code** **Alias:** ***Payer responsibility sequence number code*** **Code** **Name** P Primary S Secondary T Tertiary	M	ID	1/1	Required	1
SBR02	1069	**Individual Relationship Code** **Alias:** ***Individual relationship code*** **Code** **Name** 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship	O	ID	2/2	Required	1
SBR03	127	**Reference Identification** **Industry:** ***Insured Group or Policy Number*** **Alias:** ***Group or Policy Number***	O	AN	1/30	Situational	1
SBR04	93	**Name** **Industry:** ***Other Insured Group Name*** **Alias:** ***Group or Plan Name***	O	AN	1/60	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SBR05	1336	**Insurance Type Code**	O	ID	1/3	Required	1

Alias: ***Insurance type code***

Code	Name
AP	Auto Insurance Policy
C1	Commercial
CP	Medicare Conditionally Primary
GP	Group Policy
HM	Health Maintenance Organization (HMO)
IP	Individual Policy
LD	Long Term Policy
LT	Litigation
MB	Medicare Part B
MC	Medicaid
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PP	Personal Payment (Cash - No Insurance)
SP	Supplemental Policy

SBR06	1143	**Coordination of Benefits Code**	O	ID	1/1	Not used	1
SBR07	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Not used	1
SBR08	584	**Employment Status Code**	O	ID	2/2	Not used	1
SBR09	1032	**Claim Filing Indicator Code**	O	ID	1/2	Situational	1

Alias: ***Claim filing indicator code***

Code	Name
09	Self-pay
10	Central Certification
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
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Example:

SBR*S*01*GR00786**MC*OF~***

CAS Claim Level Adjustments

Pos: 295	Max: 99
Detail - Optional	
Loop: 2320	Elements: 19

User Option (Usage): Situational

To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CAS01	1033	**Claim Adjustment Group Code** **Alias:** ***Claim Adjustment Group Code*** **Code** **Name** CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M	ID	1/2	Required	1
CAS02	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	M	ID	1/5	Required	1
CAS03	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	M	R	1/18	Required	1
CAS04	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Claim Level***	O	R	1/15	Situational	1
CAS05	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS06	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CAS07	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Claim Level***	C	R	1/15	Situational	1
CAS08	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS09	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1
CAS10	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Claim Level***	C	R	1/15	Situational	1
CAS11	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS12	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1
CAS13	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Claim Level***	C	R	1/15	Situational	1
CAS14	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Claim Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS15	782	**Monetary Amount**	C	R	1/18	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		Industry: ***Adjustment Amount***					
		Alias: ***Adjusted Amount - Claim Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					
CAS16	380	**Quantity**	C	R	1/15	Situational	1
		Industry: ***Adjustment Quantity***					
		Alias: ***Adjusted Units - Claim Level***					
CAS17	1034	**Claim Adjustment Reason Code**	C	ID	1/5	Situational	1
		Industry: ***Adjustment Reason Code***					
		Alias: ***Adjustment Reason Code - Claim Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 3 characters.***					
		ExternalCodeList **Name:** 139 **Description:** Claim Adjustment Reason Code					
CAS18	782	**Monetary Amount**	C	R	1/18	Situational	1
		Industry: ***Adjustment Amount***					
		Alias: ***Adjusted Amount - Claim Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					
CAS19	380	**Quantity**	C	R	1/15	Situational	1
		Industry: ***Adjustment Quantity***					
		Alias: ***Adjusted Units - Claim Level***					

Example:

CAS*PR*1*7.93~
CAS*OA*93*15.06~

Medi-Cal Note:

Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

When the submitted charges are paid in full, the value for CAS03 should be zero.

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 300	Max: 15
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code** **Code Name** D Payor Amount Paid	M	ID	1/3	Required	1
AMT02	782	**Monetary Amount** **Industry:** ***Payer Paid Amount*** **Medi-Cal Note:** ***Other Health Coverage (OHC) includes insurance carriers as well as pre-paid health plans (PHPs) and health maintenance organizations (HMOs) that provide any of the recipient's health care needs. Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage or Medicare prior to billing Medi-Cal. (For details on Other Health Coverage, refer to the Other Health Coverage section or Medicare/Medi-Cal section in the Medi-Cal provider manual.) Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 75.***	M	R	1/18	Required	1

Example:

AMT*D*411~

AMT Coordination of Benefits (COB) Approved Amount

Pos: 300	Max: 15
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required	1
		Code Name AAE Approved Amount					
AMT02	782	**Monetary Amount**	M	R	1/18	Required	1
		Industry: ***Approved Amount***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					

Example:

AMT*AAE*500.35~

AMT Coordination of Benefits (COB) Allowed Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required	1
		Code **Name** B6 Allowed - Actual					
AMT02	782	**Monetary Amount**	M	R	1/18	Required	1
		Industry: ***Allowed Amount***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					

Example:

AMT*B6*519.21~

AMT Coordination of Benefits (COB) Patient Responsibility Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required	1
		Code Name F2 Patient Responsibility - Actual					
AMT02	782	**Monetary Amount**	M	R	1/18	Required	1
		Industry: ***Other Payer Patient Responsibility Amount***					

Example:

AMT*F2*15~

AMT Coordination of Benefits (COB) Patient Paid Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code** **Code Name** F5 Patient Amount Paid	M	ID	1/3	Required	1
AMT02	782	**Monetary Amount** **Industry:** ***Other Payer Patient Paid Amount*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	M	R	1/18	Required	1

Example:

AMT*F5*152.45~

DMG Subscriber Demographic Information

Pos: 305	Max: 1
Detail - Optional	
Loop: 2320	Elements: 3

User Option (Usage): Situational

To supply demographic information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DMG01	1250	**Date Time Period Format Qualifier**	C	ID	2/3	Required	1
		Code **Name** D8 Date Expressed in Format CCYYMMDD					
DMG02	1251	**Date Time Period**	C	AN	1/35	Required	1
		Industry: ***Other Insured Birth Date*** **Alias:** ***Date of Birth - Subscriber*** **Medi-Cal Note:** ***45-1 claim form field number 6.***					
DMG03	1068	**Gender Code**	O	ID	1/1	Required	1
		Industry: ***Other Insured Gender Code*** **Alias:** ***Gender - Subscriber*** **Medi-Cal Note:** ***45-1 claim form field number 5.***					
		Code **Name** F Female M Male U Unknown					

Example:

DMG*D8*19671105*F~

OI Other Insurance Coverage Information

Pos: 310	Max: 1
Detail - Optional	
Loop: 2320	Elements: 6

User Option (Usage): Required

To specify information associated with other health insurance coverage

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
OI01	1032	**Claim Filing Indicator Code**	O	ID	1/2	Not used	1
OI02	1383	**Claim Submission Reason Code**	O	ID	2/2	Not used	1
OI03	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Required	1
		Industry: ***Benefits Assignment Certification Indicator***					
		Alias: ***Assignment of Benefits Indicator***					
		Code Name N No Y Yes					
OI04	1351	**Patient Signature Source Code**	O	ID	1/1	Situational	1
		Alias: ***Patient Signature Source Code***					
		Code Name B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C Signed HCFA-1500 Claim Form on file M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P Signature generated by provider because the patient was not physically present for services S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file					
OI05	1360	**Provider Agreement Code**	O	ID	1/1	Not used	1
OI06	1363	**Release of Information Code**	O	ID	1/1	Required	1
		Alias: ***Release of Information Code***					
		Code Name A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M The Provider has Limited or Restricted Ability to Release Data Related to a Claim N No, Provider is Not Allowed to Release Data O On file at Payor or at Plan Sponsor Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim					

Example:

OIY*B**Y~***

Loop 2330A

Pos: 325	Repeat: 1
Optional	
Loop: 2330A	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
325	NM1	Other Subscriber Name	O	1		Required
332	N3	Other Subscriber Address	O	2		Situational
340	N4	Other Subscriber City/State/ZIP Code	O	1		Situational

Example:

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

NM1 Other Subscriber Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** IL Insured or Subscriber	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Other Insured Last Name*** **Alias:** ***Subscriber Last Name***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Other Insured First Name*** **Alias:** ***Subscriber First Name***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Other Insured Middle Name*** **Alias:** ***Subscriber Middle Name***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Other Insured Name Suffix*** **Alias:** ***Subscriber Generation***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** MI Member Identification Number ZZ Mutually Defined	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Other Insured Identifier*** **Alias:** ***Other Subscriber Primary Identifier*** **Medi-Cal Note:** ***Health Insurance Claim (HIC) Number. Medi-Cal will only use the first 12 characters.***	C	AN	2/80	Required	1

Example:

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

N3 Other Subscriber Address

Pos: 332	Max: 2
Detail - Optional	
Loop: 2330A	Elements: 2

User Option (Usage): Situational

To specify the location of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N301	166	**Address Information** **Industry:** ***Other Insured Address Line*** **Alias:** ***Subscriber Address 1***	M	AN	1/55	Required	1
N302	166	**Address Information** **Industry:** ***Other Insured Address Line*** **Alias:** ***Subscriber Address 2***	O	AN	1/55	Situational	1

Example:

N3*4320 WASHINGTON ST*SUITE 100~

N4 Other Subscriber City/State/ZIP Code

Pos: 340	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 3

User Option (Usage): Situational

To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
N401	19	**City Name** **Industry:** ***Other Insured City Name*** **Alias:** ***Subscriber City Name***	O	AN	2/30	Situational	1
N402	156	**State or Province Code** **Industry:** ***Other Insured State Code*** **Alias:** ***Subscriber State Code*** **ExternalCodeList** **Name:** 22 **Description:** States and Outlying Areas of the U.S.	O	ID	2/2	Required	1
N403	116	**Postal Code** **Industry:** ***Other Insured Postal Zone or ZIP Code*** **Alias:** ***Subscriber Zip Code*** **ExternalCodeList** **Name:** 51 **Description:** ZIP Code	O	ID	3/15	Situational	1

Example:

N4*PALISADES*OR*23119~

Loop 2330B

Pos: 325	Repeat: 1
Optional	
Loop: 2330B	Elements: N/A

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
325	NM1	Other Payer Name	O	1		Required
350	DTP	Claim Adjudication Date	O	2		Situational
355	REF	Other Payer Secondary Identifier	O	2		Situational

Example:

NM1*PR*2*UNION MUTUAL OF OREGON**PI*11122333~***

NM1 Other Payer Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 9

User Option (Usage): Required

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** PR Payer	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Other Payer Last or Organization Name*** **Alias:** ***Payer Name***	O	AN	1/35	Required	1
NM104	1036	**Name First**	O	AN	1/25	Not used	1
NM105	1037	**Name Middle**	O	AN	1/25	Not used	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix**	O	AN	1/10	Not used	1
NM108	66	**Identification Code Qualifier** **Code Name** PI Payor Identification XV Health Care Financing Administration National Payer Identification Number (PAYERID)	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Other Payer Primary Identifier*** **Alias:** ***Other Payer Primary Identification Number*** **Medi-Cal Note:** ***Medi-Cal will use only the first 5 characters.*** **ExternalCodeList** **Name:** 540 **Description:** Health Care Financing Administration National Plan ID	C	AN	2/80	Required	1

Example:

NM1*PR*2*UNION MUTUAL OF OREGON**PI*11122333~***

DTP Claim Adjudication Date

Pos: 350	Max: 2
Detail - Optional	
Loop: 2330B	Elements: 3

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier** **Industry:** ***Date Time Qualifier*** **Code Name** 573 Date Claim Paid	M	ID	3/3	Required	1
DTP02	1250	**Date Time Period Format Qualifier** **Code Name** D8 Date Expressed in Format CCYYMMDD	M	ID	2/3	Required	1
DTP03	1251	**Date Time Period** **Industry:** ***Adjudication or Payment Date*** **Medi-Cal Note:** ***Explanation of Medicare Benefits (EOMB) Date. Medi-Cal will only use the first 8 characters.***	M	AN	1/35	Required	1

Example:

DTP*573*D8*19980314~

REF Other Payer Secondary Identifier

Pos: 355	Max: 2
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name 2U Payer Identification Number F8 Original Reference Number FY Claim Office Number NF National Association of Insurance Commissioners (NAIC) Code TJ Federal Taxpayer's Identification Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Other Payer Secondary Identifier***					
		Medi-Cal Note: ***Medicare Internal Control Number (ICN).*** ***Medi-Cal will only use the first 15 characters.***					
		ExternalCodeList **Name:** 245 **Description:** National Association of Insurance Commissioners (NAIC) Code					

Example:

REF*FY*435261708~

Loop 2400

Pos: 365	Repeat: 50
Optional	
Loop: 2400	Elements: N/A

User Option (Usage): Required

To reference a line number in a transaction set

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
365	LX	Service Line	O	1		Required
370	SV1	Professional Service	O	1		Required
455	DTP	Date - Service Date	O	15		Required
455	DTP	Date - Shipped	O	15		Situational
470	REF	Prior Authorization or Referral Number	O	30		Situational
470	REF	Line Item Control Number	O	30		Situational
480	K3	File Information	O	10		Situational
485	NTE	Line Note	O	10		Situational
500		Loop 2420A	O		1	Situational
540		Loop 2430	O		1	Situational

Example:

LX*1~

LX Service Line

Pos: 365	Max: 1
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Required

To reference a line number in a transaction set

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
LX01	554	**Assigned Number** **Alias:** ***Line Counter***	M	N0	1/6	Required	1

Example:

LX*1~

Medi-Cal Note:

Although the professional 837 version 4010A1 Implementation Guide allows up 50 LX/Service Line Loops, Medi-Cal only accepts up to 6 lines per claim at this time.

SV1 Professional Service

Pos: 370	Max: 1
Detail - Optional	
Loop: 2400	Elements: 11

User Option (Usage): Required

To specify the claim service detail for a Health Care professional

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SV101	C003	**Composite Medical Procedure Identifier**	M	Comp		Required	1
		Alias: ***Procedure identifier (Composite)***					
	235	**Product/Service ID Qualifier**	M	ID	2/2	Required	1
		Industry: ***Product or Service ID Qualifier***					
		Code Name HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes					
	234	**Product/Service ID**	M	AN	1/48	Required	1
		Industry: ***Procedure Code***					
		Medi-Cal Note: ***See the Medi-Cal Provider Manual for additional information on the appropriate billing codes and descriptions.*** ***Medi-Cal will only use the first 5 characters.***					
		ExternalCodeList **Name:** 130 **Description:** Health Care Financing Administration Common Procedural Coding System **ExternalCodeList** **Name:** 513 **Description:** Home Infusion EDI Coalition (HIEC) Product/Service Code List					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Alias: ***Procedure Modifier 1***					
		Medi-Cal Note: ***See the Medi-Cal Provider Manual for additional information on the appropriate billing modifiers and descriptions. Medi-Cal uses this field for the Vision Qualifier Code.*** ***45-1 claim form field number 27, 33, 39, 45, 51, 57, and 63.***					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Alias: ***Procedure Modifier 2***					
		Medi-Cal Note: ***Medi-Cal does not use Procedure Modifiers 2-4 for vision claims.*** ***45-1 claim form field number 27, 33, 39, 45, 51, 57, and 63.***					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Alias: ***Procedure Modifier 3***					
		Medi-Cal Note: ***Medi-Cal does not use Procedure Modifiers 2-4 for vision claims.*** ***45-1 claim form field number 27, 33, 39,***					

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		45, 51, 57, and 63.					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Alias: ***Procedure Modifier 4***					
		Medi-Cal Note: ***Medi-Cal does not use Procedure Modifiers 2-4 for vision claims.*** ***45-1 claim form field number 27, 33, 39, 45, 51, 57, and 63.***					
SV102	782	**Monetary Amount**	O	R	1/18	Required	1
		Industry: ***Line Item Charge Amount***					
		Alias: ***Submitted charge amount***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 30, 36, 42, 48, 54, 60, and 66.***					
SV103	355	**Unit or Basis for Measurement Code**	C	ID	2/2	Required	1
		Code **Name** UN Unit					
SV104	380	**Quantity**	C	R	1/15	Required	1
		Industry: ***Service Unit Count***					
		Alias: ***Units or Minutes***					
		Medi-Cal Note: ***Medi-Cal will only use the first 3 characters.*** ***45-1 claim form field number 29, 35, 41, 47, 53, 59, and 65.***					
SV105	1331	**Facility Code Value**	O	AN	1/2	Situational	1
		Industry: ***Place of Service Code***					
		Alias: ***Place of Service Code***					
		Medi-Cal Note: ***For claims with dates of service prior to September 22, 2003, the Medi-Cal local Place of Service values must be used. For dates of service on or after September 22, 2003, the national facility type (place of service) values as referenced in external code list 237 must be used.*** ***45-1 claim form field number 7.***					
		ExternalCodeList **Name:** 237 **Description:** Place of Service from Health Care Financing Administration Claim Form					
SV106	1365	**Service Type Code**	O	ID	1/2	Not used	1
SV107	C004	**Composite Diagnosis Code Pointer**	O	Comp		Situational	1
		Alias: ***Diagnosis Code Pointer (Composite)***					
	1328	**Diagnosis Code Pointer**	M	N0	1/2	Required	1
		Medi-Cal Note: ***Medi-Cal uses values 1 and 2.***					
	1328	**Diagnosis Code Pointer**	O	N0	1/2	Situational	1
		Medi-Cal Note: ***Medi-Cal uses values 1 and 2.***					

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SV108	782	**Monetary Amount**	O	R	1/18	Not used	1
SV109	1073	**Yes/No Condition or Response Code** **Industry:** ***Emergency Indicator*** **Code Name** Y Yes	O	ID	1/1	Required	1
SV110	1340	**Multiple Procedure Code**	O	ID	1/2	Not used	1
SV111	1073	**Yes/No Condition or Response Code** **Industry:** ***EPSDT Indicator*** **Medi-Cal Note:** ***45-1 claim form field number 22.*** **Code Name** Y Yes	O	ID	1/1	Situational	1

Example:

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

DTP Date - Service Date

Pos: 455	Max: 15
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required	1
		Industry: ***Date Time Qualifier***					
		Code Name 472 Service					
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Code Name D8 Date Expressed in Format CCYYMMDD					
DTP03	1251	**Date Time Period**	M	AN	1/35	Required	1
		Industry: ***Service Date***					
		Medi-Cal Note: ***Medi-Cal will only use the first 8 characters.*** ***45-1 claim form field number 26, 32, 38, 44, 50, 56, and 62.***					

Example:

DTP*472*RD8*19970607-19970608~

DTP Date - Shipped

Pos: 455	Max: 15
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Situational

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required	1
		Industry: ***Date Time Qualifier***					
		Code Name 011 Shipped					
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Code Name D8 Date Expressed in Format CCYYMMDD					
DTP03	1251	**Date Time Period**	M	AN	1/35	Required	1
		Industry: ***Shipped Date***					
		Medi-Cal Note: ***Date Appliance Delivered. Medi-Cal will only use the first 8 characters. 45-1 claim form field number 23.***					

Example:

DTP*011*D8*19970526~

REF Prior Authorization or Referral Number

Pos: 470	Max: 30
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name G1 Prior Authorization Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Prior Authorization or Referral Number***					
		Medi-Cal Note: ***Medi-Cal Treatment Authorization Request Number Medi-Cal will only use the first 11 characters. 45-1 claim form field number 24.***					

Example:

REF*9F*12345678~

REF Line Item Control Number

Pos: 470	Max: 30
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name 6R Provider Control Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Line Item Control Number***					

Example:

REF*6R*54321~

K3 File Information

Pos: 480	Max: 10
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Situational

To transmit a fixed-format record or matrix contents

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
K301	449	**Fixed Format Information**	M	AN	1/80	Required	1

Example:

K3*STATE DATA REQUIREMENT~

Medi-Cal Note:

Medi-Cal may use this segment at a future date for legislatively mandated data not otherwise accommodated by the Professional 837 version 4010A1 Implementation Guide.

NTE Line Note

Pos: 485	Max: 10
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NTE01	363	**Note Reference Code**	O	ID	3/3	Required	1
		Code Name ADD Additional Information DCP Goals, Rehabilitation Potential, or Discharge Plans PMT Payment TPO Third Party Organization Notes					
NTE02	352	**Description** **Industry:** ***Line Note Text***	M	AN	1/80	Required	1

Example:

NTE*DCP*PATIENT GOAL TO BE OFF OXYGEN BY END OF MONTH~

Medi-Cal Note:

Providers may submit data in this segment that was previously sent in the Medi-Cal CMC Remarks records.

Loop 2420A

Pos: 500	Repeat: 1
Optional	
Loop: 2420A	Elements: N/A

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
500	NM1	Rendering Provider Name	O	1		Situational
505	PRV	Rendering Provider Specialty Information	O	1		Situational
525	REF	Rendering Provider Secondary Identification	O	20		Situational

Example:

NM1*82*1*SMITH*JUNE*LXX*87654321~***

NM1 Rendering Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 9

User Option (Usage): Situational

To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Code Name** 82 Rendering Provider	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Code Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Industry:** ***Rendering Provider Last or Organization Name*** **Alias:** ***Rendering Provider Last Name***	O	AN	1/35	Required	1
NM104	1036	**Name First** **Industry:** ***Rendering Provider First Name***	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Industry:** ***Rendering Provider Middle Name***	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix**	O	AN	1/10	Not used	1
NM107	1039	**Name Suffix** **Industry:** ***Rendering Provider Name Suffix*** **Alias:** ***Rendering Provider Generation***	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Code Name** 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required	1
NM109	67	**Identification Code** **Industry:** ***Rendering Provider Identifier*** **Alias:** ***Rendering Provider Primary Identifier*** **Medi-Cal Note:** ***Medi-Cal will only use the first 10 characters.*** **ExternalCodeList** **Name:** 537 **Description:** Health Care Financing Administration National Provider Identifier	C	AN	2/80	Required	1

Example:

NM1*82*1*SMITH*JUNE*LXX*87654321~***

PRV Rendering Provider Specialty Information

Pos: 505	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 3

User Option (Usage): Situational

To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
PRV01	1221	**Provider Code** **Code Name** PE Performing	M	ID	1/3	Required	1
PRV02	128	**Reference Identification Qualifier** **Code Name** ZZ Mutually Defined	M	ID	2/3	Required	1
PRV03	127	**Reference Identification** **Industry:** ***Provider Taxonomy Code*** **Alias:** ***Provider Specialty Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 10 characters.*** **ExternalCodeList** **Name:** HCPT **Description:** Health Care Provider Taxonomy	M	AN	1/30	Required	1

Example:

PRV*PE*ZZ*203BA050N~

Medi-Cal Note:

Required when adjudication is known to be impacted by provider taxonomy code.

REF Rendering Provider Secondary Identification

Pos: 525	Max: 20
Detail - Optional	
Loop: 2420A	Elements: 2

User Option (Usage): Situational

To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Code Name 0B State License Number 1D Medicaid Provider Number					
REF02	127	**Reference Identification**	C	AN	1/30	Required	1
		Industry: ***Rendering Provider Secondary Identifier***					
		Medi-Cal Note: ***Medi-Cal Provider Number or Refractionist License Number Medi-Cal will only use the first 9 characters.*** ***45-1 claim form field number 20.***					

Example:

REF*1D*A12345~

Medi-Cal Note:

Medi-Cal uses this segment to capture the Medi-Cal provider identifier of the rendering provider or the license number of the refractionist.

Loop 2430

Pos: 540	Repeat: 1
Optional	
Loop: 2430	Elements: N/A

User Option (Usage): Situational

To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
540	SVD	Line Adjudication Information	O	1		Situational
545	CAS	Claims Adjustment	O	99		Situational
550	DTP	Line Adjudication Date	O	9		Required

Example:

SVD*43*55*HC:84550**3~

SVD Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 6

User Option (Usage): Situational

To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SVD01	67	**Identification Code** **Industry:** ***Other Payer Primary Identifier*** **Alias:** ***Other Payer identification code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 5 characters.***	M	AN	2/80	Required	1
SVD02	782	**Monetary Amount** **Industry:** ***Service Line Paid Amount*** **Alias:** ***Paid Amount*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	M	R	1/18	Required	1
SVD03	C003	**Composite Medical Procedure Identifier** **Alias:** ***Procedure identifier (Composite)***	O	Comp		Required	1
	235	**Product/Service ID Qualifier** **Industry:** ***Product or Service ID Qualifier*** **Code Name** HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	M	ID	2/2	Required	1
	234	**Product/Service ID** **Industry:** ***Procedure Code*** **Medi-Cal Note:** ***Medi-Cal will only use the first 5 characters.*** **ExternalCodeList** **Name:** 130 **Description:** Health Care Financing Administration Common Procedural Coding System **ExternalCodeList** **Name:** 513 **Description:** Home Infusion EDI Coalition (HIEC) Product/Service Code List	M	AN	1/48	Required	1
	1339	**Procedure Modifier** **Alias:** ***Procedure Modifier 1***	O	AN	2/2	Situational	1
	1339	**Procedure Modifier** **Alias:** ***Procedure Modifier 2***	O	AN	2/2	Situational	1
	1339	**Procedure Modifier** **Alias:** ***Procedure Modifier 3***	O	AN	2/2	Situational	1
	1339	**Procedure Modifier** **Alias:** ***Procedure Modifier 4***	O	AN	2/2	Situational	1
	352	**Description** **Industry:** ***Procedure Code Description***	O	AN	1/80	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SVD04	234	**Product/Service ID**	O	AN	1/48	Not used	1
		Medi-Cal Note:					
SVD05	380	**Quantity**	O	R	1/15	Required	1
		Industry: ***Paid Service Unit Count***					
		Alias: ***Paid units of service***					
		Medi-Cal Note: ***Medi-Cal will only use the first 3 characters.***					
SVD06	554	**Assigned Number**	O	N0	1/6	Situational	1
		Industry: ***Bundled Line Number***					
		Alias: ***Bundled Line Number***					
		Medi-Cal Note: ***Medi-Cal will only use the first 2 characters.***					

Example:

SVD*43*55*HC:84550**3~

CAS Claims Adjustment

Pos: 545	Max: 99
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Situational

To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CAS01	1033	**Claim Adjustment Group Code** **Alias:** ***Adjustment Group Code*** **Code** **Name** CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M	ID	1/2	Required	1
CAS02	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	M	ID	1/5	Required	1
CAS03	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	M	R	1/18	Required	1
CAS04	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Line Level***	O	R	1/15	Situational	1
CAS05	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS06	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
CAS07	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Line Level***	C	R	1/15	Situational	1
CAS08	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS09	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1
CAS10	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Line Level***	C	R	1/15	Situational	1
CAS11	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS12	782	**Monetary Amount** **Industry:** ***Adjustment Amount*** **Alias:** ***Adjusted Amount - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 9 characters.***	C	R	1/18	Situational	1
CAS13	380	**Quantity** **Industry:** ***Adjustment Quantity*** **Alias:** ***Adjusted Units - Line Level***	C	R	1/15	Situational	1
CAS14	1034	**Claim Adjustment Reason Code** **Industry:** ***Adjustment Reason Code*** **Alias:** ***Adjustment Reason Code - Line Level*** **Medi-Cal Note:** ***Medi-Cal will only use the first 3 characters.*** **ExternalCodeList** **Name:** 139 **Description:** Claim Adjustment Reason Code	C	ID	1/5	Situational	1
CAS15	782	**Monetary Amount**	C	R	1/18	Situational	1

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		Industry: ***Adjustment Amount***					
		Alias: ***Adjusted Amount - Line Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					
CAS16	380	**Quantity**	C	R	1/15	Situational	1
		Industry: ***Adjustment Quantity***					
		Alias: ***Adjusted Units - Line Level***					
CAS17	1034	**Claim Adjustment Reason Code**	C	ID	1/5	Situational	1
		Industry: ***Adjustment Reason Code***					
		Alias: ***Adjustment Reason Code - Line Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 3 characters.***					
		ExternalCodeList **Name:** 139 **Description:** Claim Adjustment Reason Code					
CAS18	782	**Monetary Amount**	C	R	1/18	Situational	1
		Industry: ***Adjustment Amount***					
		Alias: ***Adjusted Amount - Line Level***					
		Medi-Cal Note: ***Medi-Cal will only use the first 9 characters.***					
CAS19	380	**Quantity**	C	R	1/15	Situational	1
		Industry: ***Adjustment Quantity***					
		Alias: ***Adjusted Units - Line Level***					

Example:

CAS*PR*1*7.93~
CAS*OA*93*15.06~

DTP Line Adjudication Date

Pos: 550	Max: 9
Detail - Optional	
Loop: 2430	Elements: 3

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier** **Industry:** ***Date Time Qualifier*** **Code Name** 573 Date Claim Paid	M	ID	3/3	Required	1
DTP02	1250	**Date Time Period Format Qualifier** **Code Name** D8 Date Expressed in Format CCYYMMDD	M	ID	2/3	Required	1
DTP03	1251	**Date Time Period** **Industry:** ***Adjudication or Payment Date*** **Medi-Cal Note:** ***Explanation of Medicare Benefits (EOMB) Date. Medi-Cal will only use the first 8 characters.***	M	AN	1/35	Required	1

Example:

DTP*573*D8*19970131~

SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SE01	96	**Number of Included Segments**	M	N0	1/10	Required	1
		Industry: ***Transaction Segment Count***					
		Alias: ***Segment Count***					
SE02	329	**Transaction Set Control Number**	M	AN	4/9	Required	1
		Alias: ***Transaction Set Control Number***					

Example:

SE*211*987654~

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
GE01	97	**Number of Transaction Sets Included**	M	N0	1/6	Required	1
GE02	28	**Group Control Number**	M	N0	1/9	Required	1
		Medi-Cal Note: ***Must match Group Control Number of GS Segment.***					

IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

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

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
IEA01	I16	**Number of Included Functional Groups**	M	N0	1/5	Required	1
IEA02	I12	**Interchange Control Number**	M	N0	9/9	Required	1
		Medi-Cal Note: ***Must match Interchange Control Number of ISA Segment.***					

Example:

IEA*1*000000905~