Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	**ISA**	**Interchange Control Header**			**green for Tahoma**	**blue - ACS**	**turquoise for gaps**		
Header	ISA01	Authorization Information Qualifier	ID2		"00"-No Authorization Information Present		Literal	Required	
Header	ISA02	Authorization Data Identification	AN10		"00"-No Meaningful Information		Literal	Required	
Header	ISA03	Security Information Qualifier	ID2		"00"-No Security Information Present		Literal	Required	
Header	ISA04	Security Information	AN10		"00"-No Meaningful Information		Literal	Required	
Header	ISA05	Interchange ID Qualifier	ID2		<Configured Sender's ID type>		Configure	Required	See Guide for valid values
Header	ISA06	Interchange Sender ID	AN15		<Configured Sender's ID>		Configure	Required	
Header	ISA07	Interchange ID Qualifier	ID2		<Configured Receiver's ID type>		Configure	Required	See Guide for valid values
Header	ISA08	Interchange Receiver ID	AN15		<Configured Receiver's ID>		Configure	Required	
Header	ISA09	Interchange Date	DT6		<Derive current date>		Derive	Required	YYMMDD
Header	ISA10	Interchange Time	TM4		<Derive current time>		Derive	Required	HHMM
Header	ISA11	Interchange Control Standards Identifier	ID1		"U"-U.S. EDI		Literal	Required	
Header	ISA12	Interchange Control Version Number	ID5		"00401"		Literal	Required	
Header	ISA13	Interchange Control Number	N9		<Derive unique ID for all ISAs from this sender: timestamp precise to hundredths of a second>		Derive	Required	
Header	ISA14	Acknowledgment Requrested	ID1		Default to "0"-No Ack Requested		Default	Required	"0"-No Ack Requested, "1"-Interchange Ack Requested
Header	ISA15	Usage Indicator	ID1		<Configured usage>		Configure	Required	"P"-Production, "T"-Test
Header	ISA16	Component Element Separator	1		":"=Component Delimiter		Literal	Required	
Header	**GS**	**Functional Group Header**							**One functional group for each set of same transactions**

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	GS01	Functional Identifier Code	ID2		"HP"-Health Care Claim Payment/Advice (835)		Literal	Required	Depends on transaction
Header	GS02	Application Sender's Code	AN15		<Configure Sender's sub-division>		Configure	Required	<ID for sub-div of ISA06>
Header	GS03	Application Receiver's Code	AN15		<Configure Receiver's sub-division>		Configure	Required	<ID for sub-div of ISA08>
Header	GS04	Date	DT8		<Derive current date>		Derive	Required	CCYYMMDD
Header	GS05	Time	TM8		<Derive current time>		Derive	Required	HHMM(SSDD)
Header	GS06	Group Control Number	N9		<Default to unique ID for each GS from this sender: timestamp precise to hundredths of a second>		Default	Required	Batch Number
Header	GS07	Responsible Agency Code	ID2		"X"-ASC X12		Literal	Required	
Header	GS08	Version/Release/Industry Identifier Code	AN12		"004010X091" or "004010X091A1"		Literal	Required	Depends on transaction
Header	**ST**	**Transaction Set Header**							
Header	ST01	Transaction Set Identifier Code	ID3		“835”-Health Care Claim Payment/Advice		Literal	Required	
Header	ST02	Transaction Set Control Number	AN9		<Derive: Sequence # from 1 by 1 for each tx>		Derive	Required	
Header	**BPR**	**Financial Information**							
Header	BPR01	Transaction Handling Code	ID2		"I"-payment sent separately		Literal	Required	See Guide for valid values, e.g., "I"-payment sent separately
Header	BPR02	Total Actual Provider Payment Amount	R18	Claim	REIMBURSEMENT-AMOUNT	S9(7)V99		**Required**	BALANCING: (sum of all CLP04- claim payments) minus (sum of PLB prov adj) must equal BPR02
Header	BPR03	Credit or Debit Flag Code	ID1		"C"-Credit		Literal	**Required**	"C"-Credit, "D"-Debit
Header	BPR04	Payment Method Code	ID3	Prov-File	EFT-TYPE	X(1)	Should always be "NON"	**Required**	See Guide for valid values
Header	BPR05	Payment Format Code	ID10				BPR04=NON, so not used	**Required if ACH, else not used**	See Guide for valid values

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	ID2				BPR04=NON, so not used	**Required if EFT, else not used**	"01"-ABA routing #, "04"-Canadian Bank #
Header	BPR07	Sender DFI Identifier	AN12				BPR04=NON, so not used	**Required if EFT, else not used**	<Payer's Bank ID>
Header	BPR08	Account Number Qualifier	ID3				BPR04=NON, so not used	**Required if EFT, else not used**	
Header	BPR09	Sender Bank Account Number	AN35				BPR04=NON, so not used	**Required if EFT, else not used**	<Payer's Bank Acct#>
Header	BPR10	Payer Identifier	AN10				BPR04=NON, so not used	**Required if EFT, else not used**	1<+payer tax ID>
Header	BPR11	Originating Company Supplemental Code	AN9				BPR04=NON, so not used	Not required	
Header	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	ID2				BPR04=NON, so not used	**Required if EFT, else not used**	"01"-ABA routing #, "04"-Canadian Bank #
Header	BPR13	Receiver or Provider Bank ID Number	AN12				BPR04=NON, so not used	**Required if EFT, else not used**	<Payee's Bank ID>
Header	BPR14	Account Number Qualifier	ID3				BPR04=NON, so not used	**Required if EFT, else not used**	"DA"-Demand Deposit, "SG"-Savings
Header	BPR15	Receiver or Provider Account Number	AN35				BPR04=NON, so not used	**Required if EFT, else not used**	<Payee;s Bank Acct#>
Header	BPR16	Check Issue or EFT Effective Date	DT8	Claim	DATE-PAID	9(5)		**Required**	
Header	**TRN**	**Reassociation Trace Number**							
Header	TRN01	Trace Type Code	ID2		"1"-Current Transaction Trace Number (835)		Literal	Required	
Header	TRN02	Check or EFT Trace Number	AN30				ACS will get the check number or ACH number.	**Required**	If BPR04="NON" generate unique ID across all remittance advices; if BPR04="CHK" use check number; if BPR04="EFT" use ACH number
Header	TRN03	Payer Identifier	AN10		"11916001088"			**Required**	1<+payer tax ID>

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	TRN04	Originating Company Supplemental Code	AN30					Not required	Same as BPR11, if both are used
Header	**CUR**	**Foreign Currency Information**							
Header	CUR01	Entity Identifier Code	ID3		"PR"-Payer		Literal	Not required	
Header	CUR02	Currency Code	ID3					Not required	
Header	CUR03	Exchange Rate	R10					Not required	
Header	**REF**	**Receiver Identification**							
Header	REF01	Reference Identification Qualifier	ID3		"EV"-Receiver ID		Literal	Not required: only if receiver <> payee	EV
Header	REF02	Receiver Identifier	AN30	Prov-File	INTERMED-PROV-NUM	9(10)	If empty use PAY-TO-PROV-NUM	Not required: only if receiver <> payee	(from 837 Submitter ID)
Header	**REF**	**Version Identification**							
Header	REF01	Reference Identification Qualifier	ID3		"F2"-Version Code - Local		Literal	Not required	
Header	REF02	Version Identification Code	AN30		version number of MMIS			Not required	Payer's adjudication system version #
Header	**DTM**	**Production Date**							
Header	DTM01	Date Time Qualifier	ID3		"405"-Production		Literal	Required when adjud. cut-off date <> 835 date	
Header	DTM02	Production Date	DT8	Claim	DATE-OF-ADJUDICATION	9(5)	Date	Required when adjud. cut-off date <> 835 date	date adjudicated
1000A	**N1**	**Payer Identification**							
1000A	N101	Entity Identifier Code	ID3		"PR"-Payer		Literal	Required	
1000A	N102	Payer Name	AN60		"Washington State DSHS Medical Assistance Administration"		Literal	**Either N102 or N104 is Required**	
1000A	N103	Identification Code Qualifier	ID2					Required if N104 is used	
1000A	N104	Payer Identifier	AN80					**Either N102 or N104 is Required**	
1000A	**N3**	**Payer Address**							
1000A	N301	Payer Address Line	AN55		"ASST. SECRETARY"		Configure	**Required**	
1000A	N302	Payer Address Line	AN55		"P.O. BOX 4550"		Configure	Not required	
1000A	**N4**	**Payer City, State, ZIP Code**							
1000A	N401	Payer City Name	AN30		"OLYMPIA"		Configure	**Required**	
1000A	N402	Payer State Code	ID2		"WA"		Configure	**Required**	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
1000A	N403	Payer Postal Zone or ZIP Code	ID15		"98504-5500"		Configure	**Required**	
1000A	**REF**	**Additional Payer Identification**							
1000A	REF01	Reference Identification Qualifier	ID3		<Configured payer data>		Configure	Not required	"2U"-Payer ID, "EO"-Submitter ID, "HI"-HIN, "NF"-NAIC
1000A	REF02	Additional Payer Identifier	AN30		<Configured payer data>		Configure	Not required	
1000A	**PER**	**Payer Contact Information**							
1000A	PER01	Contact Function Code	ID2		"CX"-Payers Claim Office		Literal	Not required	
1000A	PER02	Payer Contact Name	AN60		"MAA Provider Relations"		Literal	Not required	
1000A	PER03	Communication Number Qualifier	ID2		"TE"-Telephone		Literal	Not required	See Guide for valid values
1000A	PER04	Payer Contact Communication Number	AN80		"(800) 652-6188"		Literal	Not required	
1000A	PER05	Communication Number Qualifier	ID2					Not required	See Guide for valid values
1000A	PER06	Payer Contact Communication Number	AN80					Not required	
1000A	PER07	Communication Number Qualifier	ID2					Not required	See Guide for valid values
1000A	PER08	Payer Contact Communication Number	AN80					Not required	
1000B	**N1**	**Payee Identification**							
1000B	N101	Entity Identifier Code	ID3		"PE"-Payee		Literal	Required	
1000B	N102	Payee Name	AN60	Prov-File	PROV-NAME	X(31)		**Required when N104 does not contain the NPI**	
1000B	N103	Identification Code Qualifier	ID2		"FI"-TaxID			Required	"FI"-TaxID, "XX"-NPI
1000B	N104	Payee Identification Code	AN80	Prov-File	PROV-EMPLR-IDENT-NUM	X(10)		**Required**	
1000B	**N3**	**Payee Address**							
1000B	N301	Payee Address Line	AN55	Prov-File	PROV-ADDR-LINE-1	X(26)		Not required	
1000B	N302	Payee Address Line	AN55	Prov-File	PROV-ADDR-LINE-2	X(26)		Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
1000B	**N4**	**Payee City, State, ZIP Code**							
1000B	N401	Payee City Name	AN30	Prov-File	PROV-CITY	X(18)		Not required	
1000B	N402	Payee State Code	ID2	Prov-File	PROV-STATE	X(02)		Not required	
1000B	N403	Payee Postal Zone or ZIP Code	ID15	Prov-File	PROV-ZIP-CODE	9(9)		Not required	
1000B	N404	Country Code	ID3					Not required	
1000B	**REF**	**Payee Additional Identification**							
1000B	REF01	Reference Identification Qualifier	ID3		"0B"-state license; if N104 is NPI, send tax ID here			Not required	See Guide for list of valid values
1000B	REF02	Additional Payee Identifier	AN30	Prov-File	PROV-EMPLR-IDENT-NU	X(10)	with REF01="TJ"	Not required	
				Prov-File	PROV-LICENSE-NUM	X(8)	with REF01="0B"		
2000	**LX**	**Header Number**							
2000	LX01	Assigned Number	N06	Claim	REMITTANCE-ADVICE-NO	S9(6)		**Required if any claim data is sent**	See Guide for Medicare Pt A, B sorting
2000	**TS3**	**Provider Summary Information**							
2000	TS301	Provider Identifier	AN30	Claim	PROV-NUMBER	9(10)		Required if sorting by provider, bill type, or fiscal year	
2000	TS302	Facility Type Code	AN2	Claim	PLACE-OF-SERVICE	X(1)		Required if sorting by provider, bill type, or fiscal year	
2000	TS303	Fiscal Period Date	DT8	Prov-File	PROV-YEAR-END-DATE	9(4)		Required if sorting by provider, bill type, or fiscal year	
2000	TS304	Total Claim Count	R15		<Derive count of all CLP segments in tx>		Derive	Required if sorting by provider, bill type, or fiscal year	
2000	TS305	Total Claim Charge Amount	R18	Claim	Sum of all TOTAL-CLAIM-CHARGE	S9(7)V99		Required if sorting by provider, bill type, or fiscal year	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2000	TS306	Total Covered Charge Amount	R18		Compute (sum of all TOTAL-CLAIM-CHARGE) minus (sum of all NON-COVERED-CHARGE)			Not required: Only for Medicare Part A	
2000	TS307	Total Noncovered Charge Amount	R18	Claim	TOT-NON-COV-CLM-CHRG	S9(7)V99		Not required: Only for Medicare Part A	
2000	TS308	Total Denied Charge Amount	R18	Institutional-Claim	LI-SUBMITTED-CHARGE	S9(7)V99		Not required: Only for Medicare Part A	
				Medical-Claim	PROCEDURE-CHARGE	S9(7)V99			
2000	TS309	Total Provider Payment Amount	R18		Compute sum of all REIMBURSEMENT-AMOUNT (CLP04)			Not required: Only for Medicare Part A	
2000	TS310	Total Interest Amount	R18					Not required: Only for Medicare Part A	
2000	TS311	Total Contractual Adjustment Amount	R18					Not required: Only for Medicare Part A	
2000	TS312	Total Gramm-Rudman Reduction Amount	R18					Not required: Only for Medicare Part A	
2000	TS313	Total MSP Payer Amount	R18					Not required: Only for Medicare Part A	
2000	TS314	Total Blood Deductible Amount	R18					Not required: Only for Medicare Part A	
2000	TS315	Total Non-Lab Charge Amount	R18					Not required: Only for Medicare Part A	
2000	TS316	Total Coinsurance Amount	R18					Not required: Only for Medicare Part A	
2000	TS317	Total HCPCS Reported Charge Amount	R18					Not required: Only for Medicare Part A	
2000	TS318	Total HCPCS Payable Amount	R18					Not required: Only for Medicare Part A	
2000	TS319	Total Deductible Amount	R18					Not required: Only for Medicare Part A	
2000	TS320	Total Professional Component Amount	R18					Not required: Only for Medicare Part A	
2000	TS321	Total MSP Patient Liability Met Amount	R18					Not required: Only for Medicare Part A	
2000	TS322	Total Patient Reimbursement Amount	R18					Not required: Only for Medicare Part A	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2000	TS323	Total PIP Claim Count	R15					Not required: Only for Medicare Part A	
2000	TS324	Total PIP Adjustment Amount	R18					Not required: Only for Medicare Part A	
2000	**TS2**	**Provider Supplemental Summary Information**							
2000	TS201	Total DRG Amount	R18					Not required: Only for Medicare Part A	
2000	TS202	Total Federal Specific Amount	R18					Not required: Only for Medicare Part A	
2000	TS203	Total Hospital Specific Amount	R18					Not required: Only for Medicare Part A	
2000	TS204	Total Disproportionate Share Amount	R18					Not required: Only for Medicare Part A	
2000	TS205	Total Capital Amount	R18					Not required: Only for Medicare Part A	
2000	TS206	Total Indirect Medical Education Amount	R18					Not required: Only for Medicare Part A	
2000	TS207	Total Outlier Day Count	R15					Not required: Only for Medicare Part A	
2000	TS208	Total Day Outlier Amount	R18					Not required: Only for Medicare Part A	
2000	TS209	Total Cost Outlier Amount	R18					Not required: Only for Medicare Part A	
2000	TS210	Average DRG Length of Stay	R15					Not required: Only for Medicare Part A	
2000	TS211	Total Discharge Count	R15					Not required: Only for Medicare Part A	
2000	TS212	Total Cost Report Day Count	R15					Not required: Only for Medicare Part A	
2000	TS213	Total Covered Day Count	R15					Not required: Only for Medicare Part A	
2000	TS214	Total Noncovered Day Count	R15					Not required: Only for Medicare Part A	
2000	TS215	Total MSP Pass-Through Amount	R18					Not required: Only for Medicare Part A	
2000	TS216	Average DRG weight	R15					Not required: Only for Medicare Part A	
2000	TS217	Total PPS Capital FSP DRG Amount	R18					Not required: Only for Medicare Part A	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2000	TS218	Total PPS Capital HSP DRG Amount	R18					Not required: Only for Medicare Part A	
2000	TS219	Total PPS DSH DRG Amount	R18					Not required: Only for Medicare Part A	
2100	**CLP**	**Claim Payment Information**							
2100	CLP01	Patient Control Number	AN38	Claim	PATIENT-ACCT-NUMBER	X(20)		**Required**	Provider's unique ID for claim (or account)
2100	CLP02	Claim Status Code	ID2	Claim	CLAIM-STATUS	X(1)	Map codes per ACS 835 p. 152	**Required**	See Guide for list of valid values
2100	CLP03	Total Claim Charge Amount	R18	Claim	TOTAL-CLAIM-CHARGE	S9(7)V99		**Required**	
2100	CLP04	Claim Payment Amount	R18	Claim	REIMBURSEMENT-AMOUNT	S9(7)V99		**Required**	
2100	CLP05	Patient Responsibility Amount	R18	Claim	CLM-RECIP-PMT-AMT	S9(7)V99		Not required	This payer's statement of patient responsibility
2100	CLP06	Claim Filing Indicator Code	ID2		"MC"-Medicaid			**Required**	See Guide for list of valid values
2100	CLP07	Payer Claim Control Number	AN30	Claim	TRANS-CONTROL-NUM	X(18)		Not required	Payer's ICN/DCN
2100	CLP08	Facility Type Code	AN2	Medical-Claim	PLACE-OF-SERVICE	X(1)		Not required	
				Institutional-Claim	FACILITY-CODE	X(2)			
2100	CLP09	Claim Frequency Code	ID1	Claim	CLAIM-FREQ-CODE	X(1)		Not required	
2100	CLP11	Diagnosis Related Group (DRG) Code	ID4	Institutional-Claim	DRG-CODE	9(03)		Not required: institutional only	
2100	CLP12	Diagnosis Related Group (DRG) Weight	R15	Proc-Diag-Drug	DRG-RELATIVE-VALUE	S9(3)V9(4)		Not required: institutional only	
2100	CLP13	Discharge Fraction	R10					Not required	
2100	**CAS**	**Claim Adjustment**							
2100	CAS01	Claim Adjustment Group Code	ID2				**Define logic to derive this, see ACS design doc #5010**	**Required if paid <> billed amount**	See Guide for list of valid values

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	CAS02	Adjustment Reason Code	ID5		**Needs careful testing**		**Define logic to derive this, see ACS design doc #5010**	**Required if paid <> billed amount**	See www.wpc-edi.com
2100	CAS03	Adjustment Amount	R18	Claim	AMT-PAID-BY-MCARE	S9(7)V99		**Required if paid <> billed amount**	
				Claim	CLM-RECIP-PMT-AMT	S9(7)V99	**Define logic to derive this, see ACS design doc #5010**		
				Claim	THIRD-PARTY-PMT-AMT	S9(7)V99			
				Claim	SUBMITTED-CHARGE	S9(7)V100			
2100	CAS04	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>		Derive	Not required	
2100	CAS05	Adjustment Reason Code	ID5					Not required	See www.wpc-edi.com
2100	CAS06	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			Not required	
2100	CAS07	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2100	CAS08	Adjustment Reason Code	ID5					Not required	See www.wpc-edi.com
2100	CAS09	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			Not required	
2100	CAS10	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2100	CAS11	Adjustment Reason Code	ID5					Not required	See www.wpc-edi.com
2100	CAS12	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			Not required	
2100	CAS13	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2100	CAS14	Adjustment Reason Code	ID5					Not required	See www.wpc-edi.com
2100	CAS15	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			Not required	
2100	CAS16	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	

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Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	CAS17	Adjustment Reason Code	ID5					Not required	See www.wpc-edi.com
2100	CAS18	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			Not required	
2100	CAS19	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2100	**NM1**	**Patient Name**							
2100	NM101	Entity Identifier Code	ID3		"QC"-Patient		Literal	Required	
2100	NM102	Entity Type Qualifier	ID1		"1"-Person		Literal	Required	
2100	NM103	Patient Last Name	AN35	Recip-Elig-File	RECIP-LAST-NAME	X(13)	**ACS will only send back the MMIS name, not save from 837**	**Required**	
2100	NM104	Patient First Name	AN25	Recip-Elig-File	RECIP-FIRST-NAME	X(9)	**ACS will only send back the MMIS name, not save from 837**	**Required**	
2100	NM105	Patient Middle Name	AN25	Recip-Elig-File	RECIP-MIDDLE-INIT	X(1)	**ACS will only send back the MMIS name, not save from 837**	Not required	
2100	NM107	Patient Name Suffix	AN10					Not required	
2100	NM108	Identification Code Qualifier	ID2		"MR"-Medicaid ID			Not required	"34"-SSN, "HN"-HIC, "MI"-Member ID, "MR"-Medicaid ID
2100	NM109	Patient Identifier	AN80	Claim	RECIP-IDENT-NUMBER	X(14)	**Store from 837**	**Required if sent in 837**	
2100	**NM1**	**Insured Name**							
2100	NM101	Entity Identifier Code	ID3		"IL"-Insured or Subscriber		Literal	Not required	
2100	NM102	Entity Type Qualifier	ID1		<Store from 837>		Store	Not required	"1"-Person, "2"-Non-Person
2100	NM103	Subscriber Last Name	AN35		<Store from 837>		Store	Not required	
2100	NM104	Subscriber First Name	AN25		<Store from 837>		Store	Not required	
2100	NM105	Subscriber Middle Name	AN25		<Store from 837>		Store	Not required	
2100	NM107	Subscriber Name Suffix	AN10		<Store from 837>		Store	Not required	
2100	NM108	Identification Code Qualifier	ID2		<Store from 837>		Store	Not required	"34"-SSN, "HI"-HIC, "MI"-Member ID
2100	NM109	Subscriber Identifier	AN80		<Store from 837>		Store	Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	**NM1**	**Corrected Patient/Insured Name**							
2100	NM101	Entity Identifier Code	ID3		"74"-Corrected Insured		Literal	Required if name in 837 <> name in 835	
2100	NM102	Entity Type Qualifier	ID1		"1"-Person		Coded Values	Required if name in 837 <> name in 835	"1"-Person, "2"-Non-Person
2100	NM103	Corrected Patient or Insured Last Name	AN35	Recip-Elig-File	RECIP-LAST-NAME	X(13)	**ACS will only send back the MMIS name, not save from 837**	**Required if name in 837 <> name in 835**	
2100	NM104	Corrected Patient or Insured First Name	AN25	Recip-Elig-File	RECIP-FIRST-NAME	X(9)	**ACS will only send back the MMIS name, not save from 837**	**Required if name in 837 <> name in 835**	
2100	NM105	Corrected Patient or Insured Middle Name	AN25	Recip-Elig-File	RECIP-MIDDLE-INIT	X(1)	**ACS will only send back the MMIS name, not save from 837**	**Required if name in 837 <> name in 835**	
2100	NM107	Corrected Patient or Insured Name Suffix	AN10				Text	Required if name in 837 <> name in 835	
2100	NM108	Identification Code Qualifier	ID2		"C"-Insured's changed unique ID		Coded Values	Required if name in 837 <> name in 835	
2100	NM109	Corrected Insured Identification Indicator	AN80	Claim	RECIP-IDENT-NUMBER	X(14)	Text	Required if name in 837 <> name in 835	
2100	**NM1**	**Service Provider Name**							
2100	NM101	Entity Identifier Code	ID3		"82"-Rendering Provider		Literal	Required if rendering <> payee	
2100	NM102	Entity Type Qualifier	ID1		"1"-Person		Store	Required if rendering <> payee	"1"-Person, "2"-Non-Person
2100	NM103	Rendering Provider Last or Organization Name	AN35	Prov-File	PROV-NAME	X(31)	**ACS will only send back the MMIS name, not save from 837**	Not required	
2100	NM104	Rendering Provider First Name	AN25	Prov-File	PROV-NAME	X(31)	**ACS will only send back the MMIS name, not save from 837**	Not required	
2100	NM105	Rendering Provider Middle Name	AN25	Prov-File	PROV-NAME	X(31)	**ACS will only send back the MMIS name, not save from 837**	Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	NM107	Rendering Provider Name Suffix	AN10					Not required	
2100	NM108	Identification Code Qualifier	ID2		"MC"-Medicaid ID			Required if rendering <> payee	"BD"-BC, "BS"-BS, "FI"-TaxID, "MC"-Medicaid, "PC"-commercial, "SL"-state license, "UP"-UPIN, "XX"-NPI
2100	NM109	Rendering Provider Identifier	AN80	Institutional-Claim	ATTENDING-PHYSICIAN	9(10)		**Required if rendering <> payee**	See also additional IDs in REF below
				Pharmacy-Claim	PRESC-PHYS-PROV-NUM	9(10)			
				Medical-Claim	PERFORMING-PROV-NUM	9(10)	**For prof., use 'performing'**		
2100	**NM1**	**Crossover Carrier Name**							**COB next payer**
2100	NM101	Entity Identifier Code	ID3		"TT"-transfer to		Literal	Not required	
2100	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Not required	
2100	NM103	Coordination of Benefits Carrier Name	AN35					Not required	TPL name for COB
2100	NM108	Identification Code Qualifier	ID2					Not required	"AD"-BCBS, "FI"-TaxID, "NI"-NAIC, "PI"-Payer ID, "PP"-Pharmacy, "XV"-PlanID
2100	NM109	Coordination of Benefits Carrier Identifier	AN80					Not required	
2100	**NM1**	**Corrected Priority Payer Name**							**COB payer before this payer**
2100	NM101	Entity Identifier Code	ID3		"PR"-Payer		Literal	Not required	
2100	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Not required	
2100	NM103	Corrected Priority Payer Name	AN35	Recip-Elig-File	CARRIER-NAME	X(20)		Not required	
2100	NM108	Identification Code Qualifier	ID2		"PI"-Payer ID			Not required	"AD"-BCBS, "FI"-TaxID, "NI"-NAIC, "PI"-Payer ID, "PP"-Pharmacy, "XV"-PlanID

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	NM109	Corrected Priority Payer Identification Number	AN80	Recip-Elig-File	CARRIER-ID	X(4)		Not required	
2100	**MIA**	**Inpatient Adjudication Information**						**Used for inpatient institutional claims only**	**Primarily used for Medicare**
2100	MIA01	Covered Days or Visits Count	R15		"0"		Literal	Not required	
2100	MIA02	PPS Operating Outlier Amount	R15					Not required	
2100	MIA03	Lifetime Psychiatric Days Count	R15					Not required	
2100	MIA04	Claim DRG Amount	R18	Institutional-Claim	DRG-ALLOWED-CHARGE	S9(7)V99		Not required	
2100	MIA05	Remark Code	AN30	Claim	EOB-CODE_claim_level	9(3)	**See design doc #5010**	Not required	
2100	MIA06	Claim Disproportionate Share Amount	R18	Prov-File	DISP-SHARE-AMOUNT	S9(5)V99	**Gordon says remove**	Not required	
2100	MIA07	Claim MSP Pass-through Amount	R18					Not required	
2100	MIA08	Claim PPS Capital Amount	R18					Not required	
2100	MIA09	PPS-Capital FSP DRG Amount	R18					Not required	
2100	MIA10	PPS-Capital HSP DRG Amount	R18					Not required	
2100	MIA11	PPS-Capital DSH DRG Amount	R18					Not required	
2100	MIA12	Old Capital Amount	R18					Not required	
2100	MIA13	PPS-Capital IME amount	R18					Not required	
2100	MIA14	PPS-Operating Hospital Specific DRG Amount	R18					Not required	
2100	MIA15	Cost Report Day Count	R15					Not required	
2100	MIA16	PPS-Operating Federal Specific DRG Amount	R18					Not required	
2100	MIA17	Claim PPS Capital Outlier Amount	R18					Not required	
2100	MIA18	Claim Indirect Teaching Amount	R18					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	MIA19	Nonpayable Professional Component Amount	R18		If no DRG (CLP11), sum of all service amounts (SVC02) where REVENUE-CODE=960-989 (prof. serv.) AND any HCPCS codes with modifier 26.			Not required	
2100	MIA20	Remark Code	AN30	Claim	EOB-CODE_claim_level	9(3)	**See design doc #5010**	Not required	
2100	MIA21	Remark Code	AN30					Not required	
2100	MIA22	Remark Code	AN30					Not required	
2100	MIA23	Remark Code	AN30					Not required	
2100	MIA24	PPS-Capital Exception Amount	R18					Not required	
2100	**MOA**	**Outpatient Adjudication Information**						**Used for all claims except inpatient institutional**	**Primarily used for Medicare**
2100	MOA01	Reimbursement Rate	R10					Not required	
2100	MOA02	Claim HCPCS Payable Amount	R18	Claim	ALLOWED-CHARGE	S9(7)V99	sum of all services' SVC03 where HCPCS code is used (SVC01-1 = "HC")	Not required	sum of all services' SVC03 where HCPCS code is used (SVC01-1 = "HC")
2100	MOA03	Remark Code	AN30	Claim	EOB-CODE_claim_level	9(3)	**See design doc #5010**	Not required	
2100	MOA04	Remark Code	AN30					Not required	
2100	MOA05	Remark Code	AN30					Not required	
2100	MOA06	Remark Code	AN30					Not required	
2100	MOA07	Remark Code	AN30					Not required	
2100	MOA08	Claim ESRD Payment Amount	R18					Not required	
2100	MOA09	Nonpayable Professional Component Amount	R18		If no DRG (CLP11), sum of all service amounts (SVC02) where REVENUE-CODE=960-989 (prof. serv.) AND any HCPCS codes with modifier 26.			Not required	If no DRG (CLP11), sum of all service amounts (SVC02) where REVENUE-CODE=960-989 (prof. serv.) AND any HCPCS codes with modifier 26.
2100	**REF**	**Other Claim Related Identification**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2100	REF02	Other Claim Related Identifier	AN30	Claim	PRIOR-AUTH-NUM	9(9)	with REF01="G1"	Not required	
				~~Claim~~	~~RECIP-CLIENT-ID~~	~~X(09)~~	~~with REF01="1W"~~		
				~~Claim~~	~~RECIP-SS-NUMBER~~	~~X(9)~~	~~don't send SSN~~		
				Claim	TCN-TO-CREDIT with "F8"	9(17)	useful to send		
2100	**REF**	**Rendering Provider Identification**							
2100	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values: "G2"-Commercial Number
2100	REF02	Rendering Provider Secondary Identifier	AN30					Not required	Additional IDs to NM109 above
2100	**DTM**	**Claim Date**							
2100	DTM01	Date Time Qualifier	ID3					Required: "232" if not all service lines have dates	"036"-coverage expired, "050"-payer received, "232"-claim start, "233"-claim end
2100	DTM02	Claim Date	DT8	~~Claim~~	~~DATE-ENTERED-LOC~~	~~9(5)~~	~~DTM01="050"~~	**Required: "232" if not all service lines have dates**	
				Claim	FIRST-DATE-OF-SVC_claim_level	9(5)	DTM01="232"		
				Claim	LAST-DATE-OF-SVC_claim_level	9(5)	DTM01="233"		
				~~Recip-Elig-File~~	~~RECIP-ELIG-END-DATE~~	~~9(5)~~	~~DTM01="036"~~		
2100	**PER**	**Claim Contact Information**							
2100	PER01	Contact Function Code	ID2					Not required	Claim specific contact
2100	PER02	Claim Contact Name	AN60					Not required	
2100	PER03	Communication Number Qualifier	ID2					Not required	See Guide for valid values
2100	PER04	Claim Contact Communications Number	AN80					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2100	PER05	Communication Number Qualifier	ID2					Not required	See Guide for valid values
2100	PER06	Claim Contact Communications Number	AN80					Not required	
2100	PER07	Communication Number Qualifier	ID2					Not required	See Guide for valid values
2100	PER08	Communication Number Extension	AN80					Not required	
2100	**AMT**	**Claim Supplemental Information**							
2100	AMT01	Amount Qualifier Code	ID3					Not required	See Guide for list of valid values
2100	AMT02	Claim Supplemental Information Amount	R18	Claim	ALLOWED-CHARGE	S9(7)V99	with AMT01="AU"	Not required	
				Claim	CLM-RECIP-PMT-AMT	S9(7)V99	with AMT01="F5"		
				Claim	TAX-AMOUNT	S9(7)V99	with AMT01="D8"		
2100	**QTY**	**Claim Supplemental Information Quantity**							
2100	QTY01	Quantity Qualifier	ID2					Not required	See Guide for list of valid values
2100	QTY02	Claim Supplemental Information Quantity	R15					Not required	
2110	**SVC**	**Service Payment Information**							
2110	SVC01	Composite Medical Procedure Identifier							
2110	SVC01-1	Product or Service ID Qualifier	ID2	Claim	CLM-INPUT-FORM-IND	X(1)	If "K" -> "AD", else "HC"	Required if service level adjustments	See Guide for list of valid values
2110	SVC01-2	Procedure Code	AN48	Claim	PROC-CODE	X(5)		**Required if service level adjustments**	External Code set
2110	SVC01-3	Procedure Modifier	AN2	Claim	PROC-CODE-MODIFIER (1)	X(2)		Not required	
2110	SVC01-4	Procedure Modifier	AN2	Claim	PROC-CODE-MODIFIER (2)	X(2)		Not required	
2110	SVC01-5	Procedure Modifier	AN2	Claim	PROC-CODE-MODIFIER (3)	X(2)		Not required	
2110	SVC01-6	Procedure Modifier	AN2	Claim	PROC-CODE-MODIFIER (4)	X(2)		Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2110	SVC01-7	Procedure Code Description	AN80	Procedure-Master	PROC-NAME	X(40)		Not required	
2110	SVC02	Line Item Charge Amount	R18	Institutional-Claim	LI-SUBMITTED-CHARGE	S9(7)V99		**Required if service level adjustments**	BALANCING: SVC02-submitted service charge minus (the sum of all CAS adjustments) must equal SVC03-service payment
				Medical-Claim	PROCEDURE-CHARGE	S9(7)V99			
2110	SVC03	Line Item Provider Payment Amount	R18	Claim	ALLOWED-CHARGE	S9(7)V99		**Required if service level adjustments**	
				Institutional-Claim	DRG-ALLOWED-CHARGE	S9(7)V100			
2110	SVC04	National Uniform Billing Committee Revenue Code	AN48	Institutional-Claim	REVENUE-CODE	X(4)		Not required	
2110	SVC05	Units of Service Paid Count	R15	Claim	UNITS-OF-SERVICE	S9(7)		Not required	
2110	SVC06	Composite Medical Procedure Identifier							
2110	SVC06-1	Product or Service ID Qualifier	ID2		<Submitted code, if <> adjudicated code>			Required when the adjudicated proc code in SVC01 <> the proc code from the orig. claim	See Guide for list of valid values
2110	SVC06-2	Procedure Code	AN48		<Submitted code, if <> adjudicated code>			Required when the adjudicated proc code in SVC01 <> the proc code from the orig. claim	See Guide for list of valid values
2110	SVC06-3	Procedure Modifier	AN2		<Submitted code, if <> adjudicated code>			Not required	
2110	SVC06-4	Procedure Modifier	AN2		<Submitted code, if <> adjudicated code>			Not required	
2110	SVC06-5	Procedure Modifier	AN2		<Submitted code, if <> adjudicated code>			Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2110	SVC06-6	Procedure Modifier	AN2		<Submitted code, if <> adjudicated code>			Not required	
2110	SVC06-7	Procedure Code Description	AN80		<Submitted code, if <> adjudicated code>			Required if sent in 837 & submitted code <> adjudicated code	
2110	SVC07	Original Units of Service Count	R15	Claim	SUBMITTED-UNITS-OF-SERVICE		need to store original units from 837 SV104	**Required if paid units <> billed units**	
2110	**DTM**	**Service Date**							
2110	DTM01	Date Time Qualifier	ID3		<Store from 837>			**Required if no claim statement period start date**	"150"-Service Period Start, "151"-Service Period End, "472"-Service Date (single date)
2110	DTM02	Service Date	DT8	Claim	FIRST-DATE-OF-SVC_service_level	9(5)	with DTM01="150"	**Required if no claim statement period start date**	(send multiple DTP segs)
				Claim	LAST-DATE-OF-SVC_service_level	9(5)	with DTM01="151"		
2110	**CAS**	**Service Adjustment**							
2110	CAS01	Claim Adjustment Group Code	ID2	Claim	ALLOWED-CHRG-SOURCE	X(1)	**See design doc #5010**	**Required if there are service level adjustments**	See Guide for list of valid values
2110	CAS02	Adjustment Reason Code	ID5	Claim	EOB-CODE_service_level	9(3)	**See design doc #5010**	**Required if there are service level adjustments**	See www.wpc-edi.com
				Claim	ADJUST-REASON-CODE	X(5)			
2110	CAS03	Adjustment Amount	R18	Claim	NON-COVERED-CHARGE	S9(7)V99	**See design doc #5010**	**Required if there are service level adjustments**	
2110	CAS04	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>		Derive	Not required	subtract paid units (SVC05) from submitted units (SVC07)
2110	CAS05	Adjustment Reason Code	ID5					**Required if additional adjustments apply**	See www.wpc-edi.com

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2110	CAS06	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			**Required if additional adjustments apply**	
2110	CAS07	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2110	CAS08	Adjustment Reason Code	ID5					**Required if additional adjustments apply**	See www.wpc-edi.com
2110	CAS09	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			**Required if additional adjustments apply**	
2110	CAS10	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2110	CAS11	Adjustment Reason Code	ID5					**Required if additional adjustments apply**	See www.wpc-edi.com
2110	CAS12	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			**Required if additional adjustments apply**	
2110	CAS13	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2110	CAS14	Adjustment Reason Code	ID5					**Required if additional adjustments apply**	See www.wpc-edi.com
2110	CAS15	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			**Required if additional adjustments apply**	
2110	CAS16	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2110	CAS17	Adjustment Reason Code	ID5					**Required if additional adjustments apply**	See www.wpc-edi.com
2110	CAS18	Adjustment Amount	R18		<Derive: billed amount minus paid amount>			**Required if additional adjustments apply**	
2110	CAS19	Adjustment Quantity	R15		<Derive: billed quantity minus paid quantity>			Not required	
2110	**REF**	**Service Identification**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2110	REF01	Reference Identification Qualifier	ID3		"6R"=Provider's line item number; "G1"=prior authorization number			Required if "6R"-Prov Control Num sent in 837 2400 REF	See Guide for list of valid values
2110	REF02	Provider Identifier	AN30	Claim	LINE-ITEM-CODE	X(2)	with REF01="6R"=Provider's line item number	**Required if "6R"-Prov Control Num sent in 837 2400 REF**	
				Claim	PRIOR-AUTH-NUM		**2 claim & 2 line level**		
2110	**REF**	**Rendering Provider Information**							
2110	REF01	Reference Identification Qualifier	ID3		"1C'-Medicare Provider Number			Not required	See Guide for list of valid values
2110	REF02	Rendering Provider Identifier	AN30	Claim	ATTENDING-PHYSICIAN	9(10)		Not required	
				Claim	PRESC-PHYS-PROV-NUM	9(10)			
				Claim	PERFORMING-PROV-NUM	9(10)			
2110	**AMT**	**Service Supplemental Amount**							
2110	AMT01	Amount Qualifier Code	ID3					Not required	See Guide for list of valid values
2110	AMT02	Service Supplemental Amount	R18					Not required	
2110	**QTY**	**Service Supplemental Quantity**							
2110	QTY01	Quantity Qualifier	ID2					Not required	See Guide for list of valid values
2110	QTY02	Service Supplemental Quantity Count	R15					Not required	
2110	**LQ**	**Health Care Remark Codes**							**Remarks not linked to adjustment amounts**
2110	LQ 01	Code List Qualifier Code	ID3		"HE", claim payment remark code			Not required	See Guide for list of valid values
2110	LQ 02	Remark Code	AN30	Claim	EOB-CODE_service_level	9(3)	**See design doc #5010**	Not required	See www.wpc-edi.com
				Claim	RA-REMARK-CODE	X(5)			

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Trailer	**PLB**	**Provider Adjustment**							
Trailer	PLB01	Provider Identifier	AN30	Claim	PROV-NUMBER	9(10)		**Required for adjustments that are not specific to a claim**	
Trailer	PLB02	Fiscal Period Date	DT8	Prov-File	PROV-YEAR-END-DATE	9(4)		**Required for adjustments that are not specific to a claim**	
Trailer	PLB03	Adjustment Identifier							
Trailer	PLB03-1	Adjustment Reason Code	ID2	Adjustment	EOB-CODE_provider_level	9(4)	**See design doc #5010**	**Required for adjustments that are not specific to a claim**	See www.wpc-edi.com
Trailer	PLB03-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB04	Provider Adjustment Amount	R18	Adjustment	REIMBURSEMENT-AMOUNT			**Required for adjustments that are not specific to a claim**	
Trailer	PLB05	Adjustment Identifier							
Trailer	PLB05-1	Adjustment Reason Code	ID2					Not required	See www.wpc-edi.com
Trailer	PLB05-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB06	Provider Adjustment Amount	R18					Not required	
Trailer	PLB07	Adjustment Identifier							
Trailer	PLB07-1	Adjustment Reason Code	ID2					Not required	See www.wpc-edi.com
Trailer	PLB07-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB08	Provider Adjustment Amount	R18					Not required	
Trailer	PLB09	Adjustment Identifier							
Trailer	PLB09-1	Adjustment Reason Code	ID2					Not required	See www.wpc-edi.com
Trailer	PLB09-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB10	Provider Adjustment Amount	R18					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Trailer	PLB11	Adjustment Identifier							
Trailer	PLB11-1	Adjustment Reason Code	ID2					Not required	See www.wpc-edi.com
Trailer	PLB11-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB12	Provider Adjustment Amount	R18					Not required	
Trailer	PLB13	Adjustment Identifier							
Trailer	PLB13-1	Adjustment Reason Code	ID2					Not required	See www.wpc-edi.com
Trailer	PLB13-2	Provider Adjustment Identifier	AN30					Not required	
Trailer	PLB14	Provider Adjustment Amount	R18					Not required	
Trailer	**SE**	**Transaction Set Trailer**							
Trailer	SE01	Transaction Segment Count	N010		<Derive number of segs in tx>		Derive	Required	count of segments in transaction
Trailer	SE02	Transaction Set Control Number	AN9		<Derive: same as ST02>		Derive	Required	same as ST02
Trailer	**GE**	**Functional Group Trailer**							
Trailer	GE01	Number of Transaction Sets Included	N6		"1"-one tx in group		Derive	Required	Count number of transactions in gorup
Trailer	GE02	Group Control Number	N9		<Derive: same as GS06>		Derive	Required	Unique ID for each GS/GE from this sender
Trailer	**IEA**	**Interchange Control Trailer**							
Trailer	IEA01	Number of Included Functional Groups	N5		"1"-one func group in interchange		Derive	Required	
Trailer	IEA02	Interchange Control Number	N9		<Derive: same as ISA13>		Derive	Required	Unique ID for each ISA/IEA from this sender

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