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					Required	See Guide for valid values
Header	ISA06	Interchange Sender ID	AN15					Required	
Header	ISA07	Interchange ID Qualifier	ID2					Required	See Guide for valid values
Header	ISA08	Interchange Receiver ID	AN15					Required	
Header	ISA09	Interchange Date	DT6					Required	YYMMDD
Header	ISA10	Interchange Time	TM4					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				Use this to validate unique transmission	Required	
Header	ISA14	Acknowledgment Requrested	ID1				use this to determine type of ack to send	Required	"0"-No Ack Requested, "1"-Interchange Ack Requested
Header	ISA15	Usage Indicator	ID1					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
Header	GS01	Functional Identifier Code	ID2		"HC"-Health Care Claim (837)		Literal	Required	Depends on transaction

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	GS02	Application Sender's Code	AN15					Required	<ID for sub-div of ISA06>
Header	GS03	Application Receiver's Code	AN15					Required	<ID for sub-div of ISA08>
Header	GS04	Date	DT8					Required	CCYYMMDD
Header	GS05	Time	TM8					Required	HHMM(SSDD)
Header	GS06	Group Control Number	N9					Required	Batch Number
Header	GS07	Responsible Agency Code	ID2		"X"-ASC X12		Literal	Required	
Header	GS08	Version/Release/Industry Identifier Code	AN12		"004010X097" or "004010X097A1"		Literal	Required	Depends on transaction
Header	**ST**	**Transaction Set Header**							
Header	ST01	Transaction Set Identifier Code	ID3		"837"-Health Care Claim		Literal	Required	
Header	ST02	Transaction Set Control Number	AN9		"1"-first transaction in batch		Literal	Required	seq # from 1 by 1 for each tx
Header	**BHT**	**Beginning of Hierarchical Transaction**							
Header	BHT01	Hierarchical Structure Code	ID4		"0019"-Info Source, subscriber, Dependent		Literal	Required	
Header	BHT02	Transaction Set Purpose Code	ID2				If "18" - reissue, handle as reversal and correction	Required	"00"-original, "18"-resubmit
Header	BHT03	Originator Application Transaction Identifier	AN30					Required	unique ID for all 837s from originating system
Header	BHT04	Transaction Set Creation Date	DT8					Required	claim date
Header	BHT05	Transaction Set Creation Time	TM8					Required	HHMMSSDD
Header	BHT06	Claim or Encounter Identifier	ID2				whether FFS or encounter	Required	"RP"-Reporting (encounter), "CH"-Chargeable (FFS)
Header	**REF**	**Transmission Type Identification**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
Header	REF01	Reference Identification Qualifier	ID3		"87"-Functional Category		Literal	Required	
Header	REF02	Transmission Type Code	AN30					Required	"004010X097" = prod.; "004010X097D" = test; "004010X097A1" = prod.; "004010X097DA1" = test
1000A	**NM1**	**Submitter Name**							
1000A	NM101	Entity Identifier Code	ID3		"41"-Submitter		Literal	Required	
1000A	NM102	Entity Type Qualifier	ID1					Required	"1"-Person, "2"-Non-Person
1000A	NM103	Submitter Last or Organization Name	AN35					**Required**	
1000A	NM104	Submitter First Name	AN25					**Required if person**	
1000A	NM105	Submitter Middle Name	AN25					Not required	
1000A	NM108	Identification Code Qualifier	ID2		"46"-ETIN (local code)		Literal	Required	
1000A	NM109	Submitter Identifier	AN80	Prov-File	PROV-NUMBER	9(10)	Verify that submitter is approved for billing provider	**Required**	local ID for submitter
1000A	**PER**	**Submitter Contact Information**							
1000A	PER01	Contact Function Code	ID2		"IC"-Information Contact		Literal	Required	
1000A	PER02	Submitter Contact Name	AN60					**Required**	EDI contact person
1000A	PER03	Communication Number Qualifier	ID2					Required	See Guide for valid values
1000A	PER04	Communication Number	AN80					**Required**	
1000A	PER05	Communication Number Qualifier	ID2					Not required	See Guide for valid values
1000A	PER06	Communication Number	AN80					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
1000A	PER07	Communication Number Qualifier	ID2					Not required	See Guide for valid values
1000A	PER08	Communication Number	AN80					Not required	
1000B	**NM1**	**Receiver Name**							
1000B	NM101	Entity Identifier Code	ID3		"40"-Receiver		Literal	Required	
1000B	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Required	
1000B	NM103	Receiver Name	AN35					**Required**	
1000B	NM108	Identification Code Qualifier	ID2		"46"-ETIN (local ID)		Literal	Required	
1000B	NM109	Receiver Primary Identifier	AN80		<Configure payer data>		Validate WA DSHS ID; if not, error response	**Required**	
2000A	**HL**	**Billing/Pay-to Provider Hierarchical Level**							
2000A	HL01	Hierarchical ID Number	AN12		"1"-this is first HL		Derive	Required	increment from 1 by 1 for each HL segment in tx
2000A	HL03	Hierarchical Level Code	ID2		"20"-Information Source		Literal	Required	
2000A	HL04	Hierarchical Child Code	ID1		"1"-child HL follows		Literal	Required	
2000A	**PRV**	**Billing/Pay-to Provider Specialty Information**							
2000A	PRV01	Provider Code	ID3					Not required	"BI"-Billing, "PT"-Pay-To
2000A	PRV02	Reference Identification Qualifier	ID3		"ZZ"-provider taxonomy code		Literal	Not required	
2000A	PRV03	Provider Taxonomy Code	AN30					Not required	for valid values see www.wpc-edi.com
2000A	**CUR**	**Foreign Currency Information**							
2000A	CUR01	Entity Identifier Code	ID3		"85"-Billing Provider		Literal	Not required	
2000A	CUR02	Currency Code	ID3					Not required	External Code Set
2010AA	**NM1**	**Billing Provider Name**							
2010AA	NM101	Entity Identifier Code	ID3		"85"-Billing Provider		"85"	Required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010AA	NM102	Entity Type Qualifier	ID1					Required	"1"-Person, "2"-Non-Person
2010AA	NM103	Billing Provider Last or Organizational Name	AN35				Do not store incoming name	**Required**	May be a provider or a 3rd party biller
2010AA	NM104	Billing Provider First Name	AN25				Do not store incoming name	**Required if a person**	
2010AA	NM105	Billing Provider Middle Name	AN25				Do not store incoming name	Not required	
2010AA	NM107	Billing Provider Name Suffix	AN10				Do not store incoming name	Not required	
2010AA	NM108	Identification Code Qualifier	ID2					Required	"24"-Empl.ID, "34"-SSN, or "XX"-NPI (future)
2010AA	NM109	Billing Provider Identifier	AN80					**Required**	
2010AA	**N3**	**Billing Provider Address**							
2010AA	N301	Billing Provider Address Line	AN55					**Required**	
2010AA	N302	Billing Provider Address Line	AN55					Not required	
2010AA	**N4**	**Billing Provider City/State/ZIP Code**							
2010AA	N401	Billing Provider City Name	AN30					**Required**	
2010AA	N402	Billing Provider State or Province Code	ID2					**Required**	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID15					**Required**	
2010AA	N404	Country Code	ID3					Required if outside U.S.	
2010AA	**REF**	**Billing Provider Secondary Identification Number**							
2010AA	REF01	Reference Identification Qualifier	ID3		"1D" - Medicaid number			Not required	See Guide for list of valid values
2010AA	REF02	Billing Provider Additional Identifier	AN30	Medical-Claim	PAY-TO-PROV-NUM	9(10)		Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010AA	**REF**	**Claim Submitter Credit/Debit Card Information**							
2010AA	REF01	Reference Identification Qualifier	ID3					Not required: only between provider and submitter	See Guide for list of valid values
2010AA	REF02	Billing Provider Credit Card Identifier	AN30					Not required: only between provider and submitter	For billing services
2010AB	**NM1**	**Pay-to Provider's Name**					Pay-to is used if present, instead of Billing Prov		
2010AB	NM101	Entity Identifier Code	ID3		"87"-Pay-To		Literal	Not required	
2010AB	NM102	Entity Type Qualifier	ID1					Not required	"1"-Person, "2"-Non-Person
2010AB	NM103	Pay-to Provider Last or Organizational Name	AN35				Don't store incoming name	Not required	
2010AB	NM104	Pay-to Provider First Name	AN25				Don't store incoming name	Not required	
2010AB	NM105	Pay-to Provider Middle Name	AN25				Don't store incoming name	Not required	
2010AB	NM107	Pay-to Provider Name Suffix	AN10				Don't store incoming name	Not required	
2010AB	NM108	Identification Code Qualifier	ID2					Not required	"24"-Empl.ID, "34"-SSN, or "XX"-NPI (future)
2010AB	NM109	Pay-to Provider Identifier	AN80					Not required	
2010AB	**N3**	**Pay-to Provider's Address**							
2010AB	N301	Pay-to Provider Address Line	AN55					Not required	
2010AB	N302	Pay-to Provider Address Line	AN55					Not required	
2010AB	**N4**	**Pay-to Provider City/State/Zip**							
2010AB	N401	Pay-to Provider City Name	AN30					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010AB	N402	Pay-to Provider State Code	ID2					Not required	
2010AB	N403	Pay-to Provider Postal Zone or ZIP Code	ID15					Not required	
2010AB	N404	Country Code	ID3					Not required	
2010AB	**REF**	**Pay-to Provider Secondary Identification Number**							
2010AB	REF01	Reference Identification Qualifier	ID3		"1D" - Medicaid number			Not required	See Guide for list of valid values
2010AB	REF02	Pay-to Provider Identifier	AN30	Medical-Claim	PAY-TO-PROV-NUM	9(10)		Not required	
2000B	**HL**	**Subscriber Hierarchical Level**							
2000B	HL01	Hierarchical ID Number	AN12		"2"-this is second HL		Literal	Required	increment by 1 for each HL segment in tx
2000B	HL02	Hierarchical Parent ID Number	AN12		"1"-parent is second HL		Literal	Required	parent HL01 value
2000B	HL03	Hierarchical Level Code	ID2		"22"-Subscriber		Literal	Required	
2000B	HL04	Hierarchical Child Code	ID1					Required	"0"-patient is subscriber, "1"-patient is not subscriber
2000B	**SBR**	**Subscriber Information**							
2000B	SBR01	Payer Responsibility Sequence Number Code	ID1		"T"-Tertiary			**Required**	"P"-Primary, "S"-Secondary, "T"-Tertiary
2000B	SBR02	Individual Relationship Code	ID2		If patient = subscr, then "18"-Self, else nothing		If not "18", handle as baby on Mom's PIC	**Required if subscriber = patient**	"18"-Self, or nothing
2000B	SBR03	Insured Group or Policy Number	AN30					Required if subscr. ID includes Group or Plan Number	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2000B	SBR04	Insured Group Name	AN60					Required if subscr. ID includes Plan Name	
2000B	SBR06	Coordination of Benefits Code	ID1					**Required**	"1"-COB, "2"-no COB
2000B	SBR09	Claim Filing Indicator Code	ID2		"MC"-Medicaid			Required if no PlanID	See Guide for list of valid values
2010BA	**NM1**	**Subscriber Name**							
2010BA	NM101	Entity Identifier Code	ID3		"IL"-Subscriber or Insured		Literal	Required	
2010BA	NM102	Entity Type Qualifier	ID1					Required	"1"-Person, "2"-Non-Person (WC)
2010BA	NM103	Subscriber Last Name	AN35				Don't store incoming name	**Required**	
2010BA	NM104	Subscriber First Name	AN25				Don't store incoming name	**Required if a person**	
2010BA	NM105	Subscriber Middle Name	AN25				Don't store incoming name	Not required	
2010BA	NM107	Subscriber Name Suffix	AN10				Don't store incoming name	Not required	
2010BA	NM108	Identification Code Qualifier	ID2		"MI"-member ID		Literal	**Required if a person**	
2010BA	NM109	Subscriber Primary Identifier	AN80	Medical-Claim	RECIP-IDENT-NUMBER	X(14)	DSHS PIC	**Required if a person**	
2010BA	**N3**	**Subscriber Address**							
2010BA	N301	Subscriber Address Line	AN55					**Required if patient = subscriber**	
2010BA	N302	Subscriber Address Line	AN55					Not required	
2010BA	**N4**	**Subscriber City/State/ZIP Code**							
2010BA	N401	Subscriber City Name	AN30					**Required if patient = subscriber**	
2010BA	N402	Subscriber State Code	ID2				External Code Set	**Required if patient = subscriber**	
2010BA	N403	Subscriber Postal Zone or ZIP Code	ID15				External Code Set	**Required if patient = subscriber**	
2010BA	N404	Country Code	ID3				External Code Set	Required if outside U.S.	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010BA	**DMG**	**Subscriber Demographic Information**							
2010BA	DMG01	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	**Required if patient = subscriber**	
2010BA	DMG02	Subscriber Birth Date						**Required if patient = subscriber**	
2010BA	DMG03	Subscriber Gender Code						**Required if patient = subscriber**	"M", "F", "U"
2010BA	**REF**	**Subscriber Secondary Identification**							
2010BA	REF01	Reference Identification Qualifier	ID3					Not required	"1W"-Member ID, "23"-Client#, "IG"-Policy#, "SY"-SSN
2010BA	REF02	Subscriber Supplemental Identifier	AN30					Not required	
2010BA	**REF**	**Property and Casualty Claim Number**							
2010BA	REF01	Reference Identification Qualifier	ID3		"Y4"-Agency Claim Number		Literal	Not required	
2010BA	REF02	Property Casualty Claim Number	AN30					Not required	
2010BB	**NM1**	**Payer Name**							
2010BB	NM101	Entity Identifier Code	ID3		"PR"-Payer		Literal	Required	
2010BB	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Required	
2010BB	NM103	Payer Name	AN35					**Required**	
2010BB	NM108	Identification Code Qualifier	ID2					Required	"PI"=Payor ID, "XV"=Nat'l PlanID (future)
2010BB	NM109	Payer Identifier	AN80					**Required**	
2010BB	**N3**	**Payer Address**							
2010BB	N301	Payer Address Line	AN55					Not required	
2010BB	N302	Payer Address Line	AN55					Not required	
2010BB	**N4**	**Payer City/State/ZIP Code**							
2010BB	N401	Payer City Name	AN30					Not required	
2010BB	N402	Payer State Code	ID2					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010BB	N403	Payer Postal Zone or ZIP Code	ID15					Not required	
2010BB	N404	Payer Postal Zone or ZIP Code	ID3					Not required	
2010BB	**REF**	**Payer Secondary Identification Number**							
2010BB	REF01	Reference Identification Qualifier	ID3					Not required	"2U"-Payer ID, "FY"-Claim Ofc #, "NF"-NAIC, "TJ"-TaxID
2010BB	REF02	Payer Additional Identifier	AN30					Not required	
2010BC	**NM1**	**Credit/Debit Card Holder Name**							
2010BC	NM101	Entity Identifier Code	ID3		"AO"-Account Of		Literal	Not required: only from provider to billing service	
2010BC	NM102	Entity Type Qualifier	ID1					Not required: only from provider to billing service	See Guide for list of valid values
2010BC	NM103	Credit or Debit Card Holder Last or Organizational Name	AN35					Not required: only from provider to billing service	
2010BC	NM104	Credit/Debit Card Holder Name	AN25					Not required: only from provider to billing service	
2010BC	NM105	Credit or Debit Card Holder Middle Name	AN25					Not required: only from provider to billing service	
2010BC	NM107	Credit or Debit Card Holder Name Suffix	AN10					Not required: only from provider to billing service	
2010BC	NM108	Identification Code Qualifier	ID2		"MI"-Member ID		Literal	Not required: only from provider to billing service	
2010BC	NM109	Credit or Debit Card Number	AN80					Not required: only from provider to billing service	For patient payments
2010BC	**REF**	**Credit/Debit Card Information**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010BC	REF01	Reference Identification Qualifier	ID3		"BB"-Authorization Number		Literal	Not required: only from provider to billing service	
2010BC	REF02	Credit or Debit Card Authorization Number	AN30					Not required: only from provider to billing service	
2000C	**HL**	**Patient Hierarchical Level**							
2000C	HL01	Hierarchical ID Number	AN12		"3"-this is third HL		Derive	Required if subscr <> patient	increment by 1 for each HL segment in tx
2000C	HL02	Hierarchical Parent ID Number	AN12		"2"-parent is second HL		Derive	Required if subscr <> patient	parent HL01 value
2000C	HL03	Hierarchical Level Code	ID2		"23"-Dependent		Literal	Required if subscr <> patient	
2000C	HL04	Hierarchical Child Code	ID1		"0"-No child HL		Literal	Required if subscr <> patient	
2000C	**PAT**	**Patient Information**							
2000C	PAT01	Individual Relationship Code	ID2					**Required if subscriber <> patient**	See Guide for list of valid values
2000C	PAT04	Student Status Code	ID1					Not required	See Guide for list of valid values
2010CA	**NM1**	**Patient Name**							
2010CA	NM101	Entity Identifier Code	ID3		"QC"-Patient		Literal	**Required if subscriber <> patient**	
2010CA	NM102	Entity Type Qualifier	ID1		"1"-Person		Literal	**Required if subscriber <> patient**	
2010CA	NM103	Patient Last Name	AN35				Don't store incoming name	**Required if subscriber <> patient**	
2010CA	NM104	Patient First Name	AN25				Don't store incoming name	**Required if subscriber <> patient**	
2010CA	NM105	Patient Middle Name	AN25				Don't store incoming name	Not required	
2010CA	NM107	Patient Name Suffix	AN10				Don't store incoming name	Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010CA	NM108	Identification Code Qualifier	ID2		"MI"-Member ID		Literal	**Required if patient ID <> subsc. ID**	
2010CA	NM109	Patient Primary Identifier	AN80	Medical-Claim	RECIP-IDENT-NUMBER	X(14)	DSHS PIC	**Required if patient ID <> subsc. ID**	
2010CA	**N3**	**Patient Address**							
2010CA	N301	Patient Address Line	AN55					**Required if subscriber <> patient**	
2010CA	N302	Patient Address Line	AN55					Not required	
2010CA	**N4**	**Patient City/State/ZIP Code**							
2010CA	N401	Patient City Name	AN30					**Required if subscriber<> patient**	
2010CA	N402	Patient State Code	ID2				External Code Set	**Required if subscriber<> patient**	
2010CA	N403	Patient Postal Zone or ZIP Code	ID15				External Code Set	**Required if subscriber<> patient**	
2010CA	N404	Country Code	ID3				External Code Set	Required if outside U.S.	
2010CA	**DMG**	**Patient Demographic Information**							
2010CA	DMG01	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	**Required if subscriber <> patient**	
2010CA	DMG02	Patient Birth Date	AN35					**Required if subscriber <> patient**	
2010CA	DMG03	Patient Gender Code	ID1					**Required if subscriber <> patient**	"M", "F", "U"
2010CA	**REF**	**Patient Secondary Identification**							
2010CA	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2010CA	REF02	Patient Secondary Identifier	AN30					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2010CA	**REF**	**Property and Casualty Claim Number**							
2010CA	REF01	Reference Identification Qualifier	ID3		"Y4"-Agency Claim Number		Literal	Not required	
2010CA	REF02	Property Casualty Claim Number	AN30					Not required	
2300	**CLM**	**Claim Information**							
2300	CLM01	Patient Account Number	AN38	Medical-Claim	PATIENT-ACCT-NUMBER	X(38)	**Store for use in 835**	**Required**	Patient Account Number or claim unique ID
2300	CLM02	Total Claim Charge Amount	R18	Medical-Claim	TOTAL-CLAIM-CHARGE	S9(7)V99		**Required**	
2300	CLM05	Health Care Service Location Information							
2300	CLM05-1	Facility Type Code	AN2	Medical-Claim	PLACE-OF-SERVICE	X(2)	**Store for use in 835**	**Required**	"11"-Ofc, "12"-Home, "21"-Inpat Hosp, "22"-Outpat Hosp, "31"-SNF, "35"-Adult Living
2300	CLM05-3	Claim Submission Reason Code	ID1				Used in Processing logic, not stored	**Required**	"1"-orig, "6"-corrected, "7"-replace, "8"-void
2300	CLM06	Provider or Supplier Signature Indicator	ID1					**Required**	Y/N whether provider has signed off on this claim
2300	CLM07	Medicare Assignment Code	ID1					Required if Medicare	Whether provider accepts Medicare assignment
2300	CLM08	Benefits Assignment Certification Indicator	ID1					**Required**	Y/N whether insured assigns benefits to provider
2300	CLM09	Release of Information Code	ID1					**Required**	Y/N whether patient releases data to others
2300	CLM11	Related Causes Information							
2300	CLM11-1	Related Causes Code	ID3	Medical-Claim	RELATED-CAUSE IND (1)	X(2)		**Required if accident or work-related**	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
2300	CLM11-2	Related Causes Code	ID3	Medical-Claim	RELATED-CAUSE IND (2)	X(2)		Not required	Used if more than 1 code applies
2300	CLM11-3	Related Causes Code	ID3	Medical-Claim	RELATED-CAUSE IND (3)	X(2)		Not required	Used if more than 2 codes apply
2300	CLM11-4	Auto Accident State or Province Code	ID2					**Required if auto accident**	See Guide for list of valid values
2300	CLM11-5	Country Code	ID3					Required if auto accident outside U.S.	See Guide for list of valid values
2300	CLM12	Special Program Indicator	ID3	Medical-Claim	SPECIAL-PROG-CODE	X(2)		Required if conditions apply	"01"-EPSDT or CHAP, "02"-Handicapped Child, "03-Special Federal Funding, "5"-Disability
2300	CLM19	Claim Submission Reason Code	ID2				Literal	Required if predetermination	"PB"-Predetermination of Dental Benefits
2300	CLM20	Delay Reason Code	ID2					**Required if late**	See Guide for list of valid values, e.g., "11"-Other
2300	**DTP**	**Date - Admission**							
2300	DTP01	Date Time Qualifier	ID3		"435"-Admission		Literal	Required if inpatient	
2300	DTP02	Date Time Period Format Qualifier	ID3		"DT"-CCYYMMDDHHMM		Literal	Required if inpatient	
2300	DTP03	Related Hospitalization Admission Date	AN35					**Required if there's a related inpatient stay**	
2300	**DTP**	**Date - Discharge**							
2300	DTP01	Date Time Qualifier	ID3		"096"-Dischage		Literal	Not required	
2300	DTP02	Date Time Period Format Qualifier	ID3		"TM"-HHMM		Literal	Not required	
2300	DTP03	Discharge or End Of Care Date	AN35					Not required	
2300	**DTP**	**Date - Referral**							
2300	DTP01	Date Time Qualifier	ID3		"330"-Referral Date		Literal	Required if referral involved	
2300	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if referral involved	
2300	DTP03	Referral Date	AN35					Required if referral involved	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2300	**DTP**	**Date - Accident**							
2300	DTP01	Date Time Qualifier	ID3		"439"-Accident		Literal	**Required if accident related**	
2300	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	**Required if accident related**	
2300	DTP03	Accident Date	AN35	Medical-Claim	DATE-OF-ACCIDENT	9(5) comp		**Required if accident related**	
2300	**DTP**	**Date - Appliance Placement**							
2300	DTP01	Date Time Qualifier	ID3		"452"-Appliance Placement		Literal	Required if orthodontics placed	452
2300	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if orthodontics placed	D8
2300	DTP03	Orthodontic Banding Date	AN35				**MAA needs this**	Required if orthodontics placed	
2300	**DTP**	**Date - Service**							
2300	DTP01	Date Time Qualifier	ID3		"472"-Service		Literal	**Required if services done**	
2300	DTP02	Date Time Period Format Qualifier	ID3					**Required if services done**	"D8"-CCYYMMDD, "RD8"-CCYYMMDD-CCYYMMDD
2300	DTP03	Service Date	AN35					**Required if services done**	
2300	**DN1**	**Orthodontic Total Months of Treatment**							
2300	DN101	Orthodontic Treatment Months Count	R15					**Required if orthodontics**	
2300	DN102	Orthodontic Treatment Months Remaining Count	R15					**Required if orthodontics**	
2300	DN103	Question Response	ID1					**Required if orthodontics**	
2300	**DN2**	**Tooth Status**							
2300	DN201	Tooth Number	AN30				External Code Set	Not required	
2300	DN202	Tooth Status Code	ID2					Not required	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
2300	**PWK**	**Claim Supplemental Information**							
2300	PWK01	Attachment Report Type Code	ID2	Medical-Claim	ATTACH-TYPE-CODE	X(2)		Required if there's an attachment	See Guide for list of valid values
2300	PWK02	Attachment Transmission Code	ID2	Medical-Claim	ATTACH-TRANS-CODE	X(2)		Required if there's an attachment	See Guide for list of valid values
2300	PWK05	Identification Code Qualifier	ID2		"AC"-Attachment Control Number		Literal	Required if there's an attachment	
2300	PWK06	Attachment Control Number	AN80	Medical-Claim	ATTACH-CONTROL-NUM	X(20)		Required if there's an attachment	
2300	**AMT**	**Patient Amount Paid**							
2300	AMT01	Amount Qualifier Code	ID3		"F5"-Patient Amount Paid		Literal	Required if the patient has paid part	
2300	AMT02	Patient Amount Paid	R18	Medical-Claim	CLM-RECIP-PMT-AMT	S9(7)V99		Required if the patient has paid part	applies to entire claim, e.g., co-pay
2300	**AMT**	**Credit/Debit Card - Maximum Amount**							
2300	AMT01	Amount Qualifier Code	ID3		"MA"-Maximum Amount		Literal	Not required: only from provider to billing service	
2300	AMT02	Credit or Debit Card Maximum Amount	R18					Not required: only from provider to billing service	
2300	**REF**	**Predetermination Identification**							
2300	REF01	Reference Identification Qualifier	ID3		"G3"-Predetermination ID Number		Literal	Not required	
2300	REF02	Predetermination of Benefits Identifier	AN30					Not required	
2300	**REF**	**Service Authorization Exception Code**							
2300	REF01	Reference Identification Qualifier	ID3		"4N"-Special Payment Reference Number		Literal	Not required	
2300	REF02	Service Authorization Exception Code	AN30					Not required	See Guide for valid values
2300	**REF**	**Original Reference Number (ICN/DCN)**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2300	REF01	Reference Identification Qualifier	ID3		"F8"-Original Reference Number		Literal	**Required if not original**	"F8"-Original Reference Number
2300	REF02	Claim Original Reference Number	AN30	Medical-Claim	TCN-TO-CREDIT	9(17)	**When CLM05-3=7-replacement, can be used to justify timelines**	**Required if not original**	
				Medical-Claim	RELATED-TCN	9(17)	**Return in 835**		
				Medical-Claim	ACCOUNTING CODE	X(1)	**Return in 835**		
2300	**REF**	**Prior Authorization or Referral Number**							
2300	REF01	Reference Identification Qualifier	ID3		"G1"-Prior Authorization		Literal	Required if prior authorization involved	"9F"-Referral Number, "G1"-PA#
2300	REF02	Referral Number	AN30	Medical-Claim	PRIOR-AUTH-NUM	9(9)		**Required if prior authorization involved**	Payer's prior auth. Number or referral num
2300	**REF**	**Prior Authorization or Referral Number**							
2300	REF01	Reference Identification Qualifier	ID3		"9F"-Referral Number		Literal	Required if referral involved	
2300	REF02	Referral Number	AN30					**Required if referral involved**	
2300	**REF**	**Claim Identification Number for Clearinghouses and Other Transmission Intermediaries**							
2300	REF01	Reference Identification Qualifier	ID3		"D9"-Claim Number		Literal	Not required	
2300	REF02	Value Added Network Trace Number	AN30	Medical-Claim	TRANS-TRACE-NUM	X(30)		Not required	
2300	**NTE**	**Claim Note**							
2300	NTE01	Note Reference Code	ID3		"ADD"-Additional Information		Literal	Required if periodontal charting	
2300	NTE02	Claim Note Text	AN80	Medical-Claim	COMMENT-LINE	X(72)	May find diag in claim note.	Required if periodontal charting	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2310A	**NM1**	**Referring Provider Name**							
2310A	NM101	Entity Identifier Code	ID3		"DN"-Referring Provider		Literal	Required if referral involved	"DN"-Referring 1st occur., "P3"-PCP 2nd occur.
2310A	NM102	Entity Type Qualifier	ID1					Required if referral involved	"1"-Person, "2"-Non-Person
2310A	NM103	Referring Provider Last Name	AN35				**Issue log: store name & ID?**	**Required if referral involved**	**support up to 2 referring prov 3210D loops**
2310A	NM104	Referring Provider First Name	AN25					Required if a person & referral involved	
2310A	NM105	Referring Provider Middle Name	AN25					Not required	
2310A	NM107	Referring Provider Name Suffix	AN10					Not required	
2310A	NM108	Identification Code Qualifier	ID2					**Required if referral involved: either this or REF Add'l ID**	"24"-Empl.ID, "34"-SSN, or "XX"-NPI (future)
2310A	NM109	Referring Provider Identifier	AN80					Not required	
2310A	**PRV**	**Referring Provider Specialty Information**							
2310A	PRV01	Provider Code	ID3		"RF"-Referring		Literal	Not required	
2310A	PRV02	Reference Identification Qualifier	ID3		"ZZ"-provider taxonomy		Literal	Not required	
2310A	PRV03	Provider Taxonomy Code	AN30					Not required	See www.wpc-edi.com for Provider Taxonomy Codes
2310A	**REF**	**Referring Provider Secondary Identification**							
2310A	REF01	Reference Identification Qualifier	ID3		"1D" = Medicaid number			Required if NM109 not used	See Guide for list of valid values
2310A	REF02	Referring Provider Secondary Identifier	AN30	Medical-Claim	REFERRING-PROV-NUM	9(10)		Required if NM109 not used	
2310B	**NM1**	**Rendering Provider Name**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2310B	NM101	Entity Identifier Code	ID3		"82"-Rendering Provider		Literal	Required if rendering <> billing/pay-to prov	
2310B	NM102	Entity Type Qualifier	ID1				**Issue log: store name & ID?**	Required if rendering <> billing/pay-to prov	"1"-Person, "2"-Non-Person
2310B	NM103	Rendering Provider Last or Organization Name	AN35					Required if rendering <> billing/pay-to prov	Applies to entire claim
2310B	NM104	Rendering Provider First Name	AN25					Required if a person rendering <> billng	
2310B	NM105	Rendering Provider Middle Name	AN25					Not required	
2310B	NM107	Rendering Provider Name Suffix	AN10					Not required	
2310B	NM108	Identification Code Qualifier	ID2		"XX"-NPI			Required if rendering <> billing/pay-to prov	"24"-Empl.ID, "34"-SSN, or "XX"-NPI (future)
2310B	NM109	Rendering Provider Identifier	AN80					Required if rendering <> billing/pay-to prov	
2310B	**PRV**	**Rendering Provider Specialty Information**							
2310B	PRV01	Provider Code	ID3		"PE"-Performing		Literal	Not required	
2310B	PRV02	Reference Identification Qualifier	ID3		"ZZ"-provider taxonomy		Literal	Not required	
2310B	PRV03	Provider Taxonomy Code	AN30					Not required	See www.wpc-edi.com for Provider Taxonomy Codes
2310B	**REF**	**Rendering Provider Secondary Identification**							
2310B	REF01	Reference Identification Qualifier	ID3		"1D" = Medicaid number			Not required	See Guide for list of valid values
2310B	REF02	Rendering Provider Secondary Identifier	AN30	Medical-Claim	PERFORMING-PROV-NUM	9(10)	**Store for use in 835**	Not required	
2310C	**NM1**	**Service Facility Location**							
2310C	NM101	Entity Identifier Code	ID3		"FA"-Facility		Literal	Required if location is hospital, SNF, adult care	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2310C	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Required if location is hospital, SNF, adult care	
2310C	NM103	Laboratory or Facility Name	AN35					Required if location is hospital, SNF, adult care	
2310C	NM108	Identification Code Qualifier	ID2					Required if location is hospital, SNF, adult care	"34"-EIN, "34"-SSN, "XX"-NPI (future)
2310C	NM109	Laboratory or Facility Primary Identifier	AN80					Required if location is hospital, SNF, adult care	
2310C	**REF**	**Service Facility Location Secondary Identification**							
2310C	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2310C	REF02	Laboratory or Facility Secondary Identifier	AN30					Not required	
2310D	**NM1**	**Assistant Surgeon Name**							
2310D	NM101	Entity Identifier Code	ID3		"DD"-Assistant Surgeon		Literal	Not required; not used if rendering prov present	
2310D	NM102	Entity Type Qualifier	ID1					Not required	"1"-Person, "2"-Non-Person
2310D	NM103	Assistant Surgeon Last Name	AN35					Not required	
2310D	NM104	Assistant Surgeon First Name	AN25					Not required	
2310D	NM105	Assistant Surgeon Middle Name	AN25					Not required	
2310D	NM107	Assistant Surgeon Name Suffix	AN10					Not required	
2310D	NM108	Identification Code Qualifier	ID2					Not required	"24"-EIN, "34"-SSN, "XX"-NPI (future)
2310D	NM109	Assistant Surgeon Identifier	AN80					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2310D	**PRV**	**Assistant Surgeon Specialty Information**							
2310D	PRV01	Provider Code	ID3		"AS"-Assistant Surgeon		Literal	Not required	
2310D	PRV02	Reference Identification Qualifier	ID3		"ZZ"-Provider Taxonomy Code		Literal	Not required	
2310D	PRV03	Provider Taxonomy Code	AN30				External Code Set	Not required	See www.wpc-edi.com for Provider Taxonomy Codes
2310D	**REF**	**Assistant Surgeon Secondary Identification**							
2310D	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2310D	REF02	Rendering Provider Secondary Identifier	AN30					Not required	
2320	**SBR**	**Other Subscriber Information**							support up to 10 other subscriber 2320 loops
2320	SBR01	Payer Responsibility Sequence Number Code	ID1	W1471091 (TPL)	PAYER-SEQUENCE	X(1)	10 occurences	Required if other payer is known	"P"-Primary, "S"-Secondary, "T"-Tertiary
2320	SBR02	Individual Relationship Code	ID2	W1471091 (TPL)	RELATIONTION-CODE	X(2)	10 occurences	Required if other payer is known	See Guide for list of valid values
2320	SBR03	Insured Group or Policy Number	AN30	W1471091 (TPL)	GROUP-POLICY	X(30)	10 occurences	Required if other payer is known & if subscr ID includes Grp or Plan #	
2320	SBR04	Policy Name	AN60	W1471091 (TPL)	POLICY-NAME	X(60)	10 occurences	Required if other payer is known & if subscr ID includes plan name	Plan Name
2320	SBR09	Claim Filing Indicator Code	ID2	W1471091 (TPL)	CLAIM-FILING-INDICATOR	X(2)	10 occurences	Required if no PlanID	See Guide for list of valid values
2320	**CAS**	**Claim Adjustment**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2320	CAS01	Claim Adjustment Group Code	ID2		<Derive from CAS02>		Derive	Required if 835 from prior payer with service adjusts	CO-Contractual, "CR"-Correction, "OA"-Other, "PI"-Payor Reduction, "PR"-Patient Responsibility
2320	CAS02	Adjustment Reason Code	ID5	W1471091 (TPL)	ADJUST-REASON	X(5)	3 occurences	Required if other payer did claim level adjustments	See www.wpc-edi.com
2320	CAS03	Adjustment Amount	R18	W1471091 (TPL)	ADJUST-AMOUNT	S9(9)V99	3 occurences	Required if other payer did claim level adjustments	
2320	CAS04	Adjustment Quantity	R15	W1471091 (TPL)	ADJUST-QUANTITY	S9(6)	3 occurences	Not required	
2320	CAS05	Adjustment Reason Code	ID5	W1471091 (TPL)	ADJUST-REASON	X(5)	3 occurences	Not required	
2320	CAS06	Adjustment Amount	R18	W1471091 (TPL)	ADJUST-AMOUNT	S9(9)V99	3 occurences	Not required	
2320	CAS07	Adjustment Quantity	R15	W1471091 (TPL)	ADJUST-QUANTITY	S9(6)	3 occurences	Not required	
2320	CAS08	Adjustment Reason Code	ID5	W1471091 (TPL)	ADJUST-REASON	X(5)	3 occurences	Not required	
2320	CAS09	Adjustment Amount	R18	W1471091 (TPL)	ADJUST-AMOUNT	S9(9)V99	3 occurences	Not required	
2320	CAS10	Adjustment Quantity	R15	W1471091 (TPL)	ADJUST-QUANTITY	S9(6)	3 occurences	Not required	
2320	CAS11	Adjustment Reason Code	ID5		<From prior payer's 835>			Not required	
2320	CAS12	Adjustment Amount	R18		<From prior payer's 835>			Not required	
2320	CAS13	Adjustment Quantity	R15		<From prior payer's 835>			Not required	
2320	CAS14	Adjustment Reason Code	ID5		<From prior payer's 835>			Not required	
2320	CAS15	Adjustment Amount	R18		<From prior payer's 835>			Not required	
2320	CAS16	Adjustment Quantity	R15		<From prior payer's 835>			Not required	
2320	CAS17	Adjustment Reason Code	ID5		<From prior payer's 835>			Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2320	CAS18	Adjustment Amount	R18		<From prior payer's 835>			Not required	
2320	CAS19	Adjustment Quantity	R15		<From prior payer's 835>			Not required	
2320	**AMT**	**Coordination of Benefits (COB) Payer Paid Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"D"-Payor Amount Paid		Literal	Required if adjudicated by other payer	
2320	AMT02	Payer Paid Amount	R18	Medical-Claim	THIRD-PARTY-PMT-AMT	S9(7)V99		Required if adjudicated by other payer	Can be zero
2320	**AMT**	**Coordination of Benefits (COB) Approved Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"AAE"-Amount Approved		Literal	Not required: only if payer-to-payer COB	
2320	AMT02	Approved Amount	R18	Medical-Claim	APPROVED-AMT	S9(7)V99	**This is line level in MMIS; sum lines for here**	Not required: only if payer-to-payer COB	total claim amount approved by sending payer
2320	**AMT**	**Coordination of Benefits (COB) Allowed Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"B6"-Allowed - Actual		Literal	Not required: only if payer-to-payer COB	
2320	AMT02	Allowed Amount	R18	COB	ALLOWED-AMT	S9(7)V99	**This is line level in MMIS; sum lines for here**	Not required: only if payer-to-payer COB	total claim amount allowed by sending payer
2320	**AMT**	**Coordination of Benefits (COB) Patient Responsibility Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"F2"-Patient Responsibility - Actual			**Required if sent in 837 from other payer**	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2320	AMT02	Patient Responsibility Amount	R18	COB	PATIENT-RESP-AMT	S9(7)V99		**Required if sent in 837 from other payer**	
2320	**AMT**	**Coordination of Benefits (COB) Covered Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"AU"-Coverage Amount		Literal	Not required: only if payer-to-payer COB	
2320	AMT02	Covered Amount	R18	COB	COVERED-AMT	S9(7)V99		Not required: only if payer-to-payer COB	amount covered by sending payer
2320	**AMT**	**Coordination of Benefits (COB) Discount Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"D8"-Discount Amount		Literal	Required if included in 837 from other payer	
2320	AMT02	Other Payer Discount Amount	R18	COB	DISCOUNT-AMT	S9(7)V99		**Required if included in 837 from other payer**	
2320	**AMT**	**Coordination of Benefits (COB) Patient Paid Amount**							
2320	AMT01	Amount Qualifier Code	ID3		"F5"-Patient Amount Paid		Literal	Required if included in 837 from other payer	
2320	AMT02	Other Payer Patient Paid Amount	R18	COB	PATIENT-PAID	S9(7)V99		**Required if included in 837 from other payer**	Amount paid to patient by payer
2320	**DMG**	**Other Insured Demographic Information**							
2320	DMG01	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if other subscriber is a person	
2320	DMG02	Other Insured Birth Date	AN35					Required if other subscriber is a person	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2320	DMG03	Other Insured Gender Code	ID1					Required if other subscriber is a person	M, F, U
2320	**OI**	**Other Insurance Coverage Information**							
2320	OI03	Benefits Assignment Certification Indicator	ID1		<From prior 837 CLM08 or OI03>			**Required if loop 2320 is used**	Y/N whether patient assigns benefits to provider
2320	OI06	Release of Information Code	ID1		<From prior 837 CLM09 or OI06>			**Required if loop 2320 is used**	Y/N whether patient releases data to others
2330A	**NM1**	**Other Subscriber Name**							
2330A	NM101	Entity Identifier Code	ID3		"IL"-Insured or Subscriber			**Required if loop 2320 is used**	
2330A	NM102	Entity Type Qualifier	ID1		"1"-Person			**Required if loop 2320 is used**	"1"-Person, "2"-Non-Person
2330A	NM103	Other Insured Last Name	AN35	COB	INSURED-LAST-NAME	X(35)		**Required if loop 2320 is used**	
2330A	NM104	Other Insured First Name	AN25	COB	INSURED-FIRST-NAME	X(25)		**Required if loop 2320 is used**	
2330A	NM105	Other Insured Middle Name	AN25	COB	INSURED-MIDDLE-NAME	X(25)		Not required	
2330A	NM107	Other Insured Name Suffix	AN10	COB	INSURED-SUFFIX	X(20)		Not required	
2330A	NM108	Identification Code Qualifier	ID2		"MI"=Member ID			**Required if loop 2320 is used**	"24"-EIN, "MI"-Member ID
2330A	NM109	Other Insured Identifier	AN80	COB	INSURED-IDENTIFIER	X(80)		**Required if loop 2320 is used**	
2330A	**N3**	**Other Subscriber Address**							
2330A	N301	Other Insured Address Line	AN55					Not required	
2330A	N302	Other Insured Address Line	AN55					Not required	
2330A	**N4**	**Other Subscriber City/State/Zip Code**							
2330A	N401	Other Insured City Name	AN30					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2330A	N402	Other Insured State Code	ID2					Not required	
2330A	N403	Other Insured Postal Zone or ZIP Code	ID15					Not required	
2330A	N404	Country Code	ID3					Required if outside U.S.	
2330A	**REF**	**Other Subscriber Secondary Identification**							
2330A	REF01	Reference Identification Qualifier	ID3	COB	REF-IDENT-QUAL	X(2)		Not required	See Guide for list of valid values
2330A	REF02	Other Insured Additional Identifier	AN30	COB	OTHER-INS-ADD-IDENT	X(30)		Not required	
2330B	**NM1**	**Other Payer Name**							
2330B	NM101	Entity Identifier Code	ID3		"PR"-Payer		Literal	**Required if loop 2320 is used**	
2330B	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	**Required if loop 2320 is used**	
2330B	NM103	Other Payer Last or Organization Name	AN35	COB	OTHER-PAYER-LAST-ORG-NAME	X(35)		**Required if loop 2320 is used**	
2330B	NM108	Identification Code Qualifier	ID2		"PI"-Payer ID			**Required if loop 2320 is used**	"PI"-Payer ID, "XV"-PlanID (future)
2330B	NM109	Other Payer Primary Identifier	AN80	COB	OTHER-PAYER-PRIMARY-ID	X(80)		**Required if loop 2320 is used**	
2330B	**PER**	**Other Payer Contact Information**							
2330B	PER01	Contact Function Code	ID2		"IC"-Information Contact		Literal	Not required: only if payer-to-payer COB	
2330B	PER02	Other Payer Contact Name	AN60	COB	OTHER-PAYER-CONTACT-NAME	X(60)		Not required: only if payer-to-payer COB	
2330B	PER03	Communication Number Qualifier	ID2					Not required: only if payer-to-payer COB	See Guide for valid values
2330B	PER04	Communication Number	AN80					Not required: only if payer-to-payer COB	
2330B	PER05	Communication Number Qualifier	ID2					Not required: only if payer-to-payer COB	See Guide for valid values
2330B	PER06	Communication Number	AN80					Not required: only if payer-to-payer COB	
2330B	PER07	Communication Number Qualifier	ID2					Not required: only if payer-to-payer COB	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
2330B	PER08	Communication Number	AN80					Not required: only if payer-to-payer COB	
2330B	**DTP**	**Claim Paid Date**							
2330B	DTP01	Date Time Qualifier	ID3		"573"-Date Claim Paid		Literal	Required if loop 2310 is used & 2430 is not used	
2330B	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if loop 2310 is used & 2430 is not used	
2330B	DTP03	Date Claim Paid	AN35	COB	DATE-CLAIM-PAID	S9(5)		Required if loop 2310 is used & 2430 is not used	
2330B	**REF**	**Other Payer Secondary Identifier**							
2330B	REF01	Reference Identification Qualifier	ID3		"2U"-Payer ID Num		Coded Values	Not required	See Guide for list of valid values
2330B	REF02	Other Payer Secondary Identifier	AN30	COB	OTHER-PAYER-SEC-ID	X(30)		Not required	
2330B	**REF**	**Other Payer Prior Auth or Referral Number**							
2330B	REF01	Reference Identification Qualifier	ID3				Coded Values	Not required	"9F"-Referral Number, "1G"-PA#
2330B	REF02	Other Payer Prior Authorization or Referral Number	AN30					Not required	Payer's prior auth. Number or referral num
2330B	**REF**	**Other Payer Claim Adjustment Indicator**							
2330B	REF01	Reference Identification Qualifier	ID3		"T4"-Signal Code		Literal	Required if current payer is re-adjudicating	
2330B	REF02	Other Payer Claim Adjustment Indicator	AN30					Required if current payer is re-adjudicating	"Y" if current payer priovious adjudicated & sent to destination payer & now changed
2330C	**NM1**	**Other Payer Patient Information**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2330C	NM101	Entity Identifier Code	ID3		"QC"-Patient		Literal	Not required	
2330C	NM102	Entity Type Qualifier	ID1		"1"-Person		Literal	Not required	
2330C	NM108	Identification Code Qualifier	ID2		"MI"-Member ID		Literal	Not required	
2330C	NM109	Other Payer Patient Primary Identifier	AN80					Not required	
2330C	**REF**	**Other Payer Patient Identification**							
2330C	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2330C	REF02	Other Payer Patient Primary Identifier	AN30					Not required	
2330D	**NM1**	**Other Payer Referring Provider**							
2330D	NM101	Entity Identifier Code	ID3					Not required	"DN"-Referring, "P3"-PCP
2330D	NM102	Entity Type Qualifier	ID1					Not required	See Guide for list of valid values
2330D	**REF**	**Other Payer Referring Provider Identification**							
2330D	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2330D	REF02	Other Payer Referring Provider Identifier	AN30					Not required	
2330E	**NM1**	**Other Payer Rendering Provider**							
2330E	NM101	Entity Identifier Code	ID3		"82"-Rendering		Literal	Not required	
2330E	NM102	Entity Type Qualifier	ID1					Not required	"1"-Person, "2"-Non-Person
2330E	**REF**	**Other Payer Rendering Provider Identification**							
2330E	REF01	Reference Identification Qualifier	ID3					Not required	See Guide for list of valid values
2330E	REF02	Other Payer Rendering Provider Identifier	AN30					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2400	**LX**	**Line Counter**							**support up to 999 service lines: loop 2400**
2400	LX 01	Assigned Number	N06					Required	<Must derive sequential # from 1 by 1 for each service line>
2400	**SV3**	**Dental Service**							
2400	SV301	Composite Medical Procedure Identifier							
2400	SV301-1	Product or Service ID Qualifier	ID2		"AD"-ADA Codes		Literal	**Required**	"AD"-ADA Codes
2400	SV301-2	Procedure Code	AN48	Medical-Claim	PROC-CODE	X(5)	map local codes to HCPCS	**Required**	
2400	SV301-3	Procedure Modifier	AN2	Medical-Claim	PROC-CODE-MODIFIER (1)	X(1)		Not required	
2400	SV301-4	Procedure Modifier	AN2	Medical-Claim	PROC-CODE-MODIFIER (2)	X(1)		Not required	
2400	SV301-5	Procedure Modifier	AN2	Medical-Claim	PROC-CODE-MODIFIER (3)	X(1)		Not required	
2400	SV301-6	Procedure Modifier	AN2	Medical-Claim	PROC-CODE-MODIFIER (4)	X(1)		Not required	
2400	SV302	Line Item Charge Amount	R18	Medical-Claim	PROCEDURE-CHARGE	S9(7)V99		**Required**	
2400	SV303	Facility Type Code	AN2	Medical-Claim	PLACE-OF-SERVICE	X(2)	**Store for use in 835**	**Required if different place of service than CLM05**	See Guide for list of valid values
2400	SV304	Oral Cavity Designation							
2400	SV304-1	Oral Cavity Designation Code	ID3	Medical-Claim	TOOTH-QUADRANT	X(2)		Required	See Guide for list of valid values
2400	SV304-2	Oral Cavity Designation Code	ID3	Medical-Claim	TOOTH-QUADRANT	X(2)		Not required	See Guide for list of valid values
2400	SV304-3	Oral Cavity Designation Code	ID3	Medical-Claim	TOOTH-QUADRANT	X(2)		Not required	See Guide for list of valid values
2400	SV304-4	Oral Cavity Designation Code	ID3	Medical-Claim	TOOTH-QUADRANT	X(2)		Not required	See Guide for list of valid values
2400	SV304-5	Oral Cavity Designation Code	ID3	Medical-Claim	TOOTH-QUADRANT	X(2)		Not required	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
2400	SV305	Prosthesis, Crown, or Inlay Code	ID1					**Required**	See Guide for list of valid values
2400	SV306	Procedure Count	R15	Medical-Claim	UNITS-OF-SERVICE	S9(3)V99		**Required**	
2400	**TOO**	**Tooth Information**							**support up to 32 TOO segments**
2400	TOO01	Code List Qualifier Code	ID3		"JP"-National Standard Tooth Numbering System		Literal	**Required if proc relates to a certain tooth or teeth**	
2400	TOO02	Tooth Code	AN30	Medical-Claim	TOOTH-NUMBER	X(2)	External Code Set	**Required if proc relates to a certain tooth or teeth**	See Guide for list of valid values
2400	TOO03	Tooth Surface							
2400	TOO03-1	Tooth Surface Code	ID2	Medical-Claim	TOOTH-SURFACE	X(1)		**Required if proc relates to a certain tooth or teeth**	
2400	TOO03-2	Tooth Surface Code	ID2	Medical-Claim	TOOTH-SURFACE	X(1)		Required to report a 2nd tooth surface	
2400	TOO03-3	Tooth Surface Code	ID2	Medical-Claim	TOOTH-SURFACE	X(1)		Required to report a 3rd tooth surface	
2400	TOO03-4	Tooth Surface Code	ID2	Medical-Claim	TOOTH-SURFACE	X(1)		Required to report a 4th tooth surface	
2400	TOO03-5	Tooth Surface Code	ID2	Medical-Claim	TOOTH-SURFACE	X(1)		Required to report a 5th tooth surface	
2400	**DTP**	**Date - Service**							
2400	DTP01	Date Time Qualifier	ID3		"472"-Service		Literal	Required if service line date <> claim serv date	
2400	DTP02	Date Time Period Format Qualifier	ID3				If it's a date range, use format: CCMMYYDD-CCMMYYDD	Required if service line date <> claim serv date	
2400	DTP03	Service Date	AN35	Medical-Claim	FIRST-DATE-OF-SVC_service_level	9(5)	Store for use in 835	Required if service line date <> claim serv date	
				Medical-Claim	LAST-DATE-OF-SVC_service_level	9(5)	Store for use in 835		
2400	**DTP**	**Date - Prior Placement**							

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2400	DTP01	Date Time Qualifier	ID3		"441"-Prior Placement		Literal	Required if prosthetics were previously placed (SV305=R)	
2400	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if prosthetics were previously placed (SV305=R)	
2400	DTP03	Prior Placement Date	AN35					Required if prosthetics were previously placed (SV305=R)	
2400	**DTP**	**Date - Appliance Placement**							
2400	DTP01	Date Time Qualifier	ID3		"452"-Appliance Placement		Literal	Required if this date <> date at claim level	
2400	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if this date <> date at claim level	
2400	DTP03	Orthodontic Banding Date	AN35					Required if this date <> date at claim level	
2400	**DTP**	**Date - Replacement**							
2400	DTP01	Date Time Qualifier	ID3		"446"-Replacement		Literal	Not required	
2400	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Not required	
2400	DTP03	Replacement Date	AN35					Not required	Date orthodontics replaced
2400	**QTY**	**Anesthesia Quantity**							
2400	QTY01	Quantity Qualifier	ID2				Coded Values	Required if anesthesia coded conditions apply	See Guide for list of valid values
2400	QTY02	Anesthesia Unit Count	R15				Number	Required if anesthesia coded conditions apply	
2400	**REF**	**Service Predetermination Identification**							
2400	REF01	Reference Identification Qualifier	ID3		"G3"-Predetermination of Benefits ID Number		Literal	Not required	
2400	REF02	Predetermination of Benefits Identifier	AN30					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2400	**REF**	**Prior Auth or Referral Number**							
2400	REF01	Reference Identification Qualifier	ID3		"1G"-PA#		Coded Values	Required if service involved referral diff. than claim level	"9F"-Referral Number, "1G"-PA#
2400	REF02	Prior Authorization or Referral Number	AN30	Medical-Claim	LINE-PRIOR-AUTH-NUM	9(9)		Required if service involved referral diff. than claim level	Payer's prior auth. Number or referral num
2400	**REF**	**Line Item Control Number**							
2400	REF01	Reference Identification Qualifier	ID3		"6R"-Provider Control Number		Literal	Not required	
2400	REF02	Line Item Control Number	AN30	Medical-Claim	LINE-ITEM-CNTL-NUM	X(30)	**Store and send back in 835 2110 REF "6R"-provider control number**	Not required	
2400	**AMT**	**Approved Amount**							
2400	AMT01	Amount Qualifier Code	ID3		"AAE"-Approved Amount		Literal	Not required: only for payer-to-payer COB	
2400	AMT02	Approved Amount	R18					Not required: only for payer-to-payer COB	
2400	**AMT**	**Sales Tax Amount**							
2400	AMT01	Amount Qualifier Code	ID3		"T"-Tax		Literal	Not required	
2400	AMT02	Sales Tax Amount	R18					Not required	
2400	**NTE**	**Line Note**							
2400	NTE01	Note Reference Code	ID3		"ADD"-Additional Information		Literal	Required for non-std proc code	
2400	NTE02	Line Note Text	AN80					Required for non-std proc code	
2420A	**NM1**	**Rendering Provider Name**							
2420A	NM101	Entity Identifier Code	ID3		"82"-Rendering Provider		Literal	Required if rendering <> claim level	82
2420A	NM102	Entity Type Qualifier	ID1					Required if rendering <> claim level	"1"-Person, "2"-Non-Person
2420A	NM103	Rendering Provider Last or Organization Name	AN35					Required if rendering <> claim level	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2420A	NM104	Rendering Provider First Name	AN25					Required if rendering <> claim level, and a person	
2420A	NM105	Rendering Provider Middle Name	AN25					Not required	
2420A	NM107	Rendering Provider Name Suffix	AN10					Not required	
2420A	NM108	Identification Code Qualifier	ID2					Required if rendering <> claim level	"24"-EIN, "34"-SSN, "XX"-NPI (future)
2420A	NM109	Rendering Provider Identifier	AN80					Required if rendering <> claim level	
2420A	**PRV**	**Rendering Provider Specialty Information**							
2420A	PRV01	Provider Code	ID3		"PE"-Performing		Literal	Not required	
2420A	PRV02	Reference Identification Qualifier	ID3		"ZZ"-Provider Taxonomy Code		Literal	Not required	
2420A	PRV03	Provider Taxonomy Code	AN30					Not required	
2420A	**REF**	**Rendering Provider Secondary Identification**							
2420A	REF01	Reference Identification Qualifier	ID3		"1D" = Medicaid number			Not required	See Guide for list of valid values
2420A	REF02	Rendering Provider Secondary Identifier	AN30				**Need to add Rendering at line level**	Not required	
2420B	**NM1**	**Other Payer Prior Auth or Referral Number**							
2420B	NM101	Entity Identifier Code	ID3		"PR"-Payer		Literal	Not required	
2420B	NM102	Entity Type Qualifier	ID1		"2"-Non-Person		Literal	Not required	
2420B	NM103	Other Payer Last or Organization Name	AN35					Not required	
2420B	NM108	Identification Code Qualifier	ID2					Not required	"PI"-Payer ID, "XV"-PlanID (future)
2420B	NM109	Other Payer Prior Authorization or Referral Number	AN80					Not required	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2420B	**REF**	**Other Payer Prior Authorization or Referral Number**							
2420B	REF01	Reference Identification Qualifier	ID3					Not required	"9F"-Referral Number, "1G"-PA#
2420B	REF02	Other Payer Prior Authorization or Referral Number	AN30					Not required	Payer's prior auth. Number or referral num
2420C	**NM1**	**Assistant Surgeon Name**							
2420C	NM101	Entity Identifier Code	ID3		"DD"-Assistant Surgeon		Literal	Required if <> claim level	
2420C	NM102	Entity Type Qualifier	ID1					Required if <> claim level	"1"-Person, "2"-Non-Person
2420C	NM103	Assistant Surgeon Last Name	AN35					Required if <> claim level	
2420C	NM104	Assistant Surgeon First Name	AN25					Not required	
2420C	NM105	Assistant Surgeon Middle Name	AN25					Not required	
2420C	NM107	Assistant Surgeon Name Suffix	AN10					Not required	
2420C	NM108	Identification Code Qualifier	ID2					Required if <> claim level	"24"-EIN, "34"-SSN, "XX"-NPI (future)
2420C	NM109	Assistant Surgeon Identifier	AN80					Required if <> claim level	
2420C	**PRV**	**Assistant Surgeon Specialty Information**							
2420C	PRV01	Provider Code	ID3		"AS"-Assistant Surgeon		Literal	Not required	
2420C	PRV02	Reference Identification Qualifier	ID3		"ZZ"-Provider Taxonomy Code		Literal	Not required	
2420C	PRV03	Provider Taxonomy Code	AN30					Not required	
2420C	**REF**	**Assistant Surgeon Secondary Identification**							
2420C	REF01	Reference Identification Qualifier	ID3					Not required	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
2420C	REF02	Rendering Provider Secondary Identifier	AN30					Not required	
2430	**SVD**	**Line Adjudication Information**							
2430	SVD01	Other Payer Primary Identifier	AN80		<From prior payer's 835 1000A>			Required if 835 from prior payer with service adjusts	Same as 2330B NM109 & 835 1000A
2430	SVD02	Service Line Paid Amount	R18	Medical-Claim	TPL-LINE-AMOUNT	S9(9)V99		Required if 835 from prior payer with service adjusts	
2430	SVD03	Composite Medical Procedure Identifier							
2430	SVD03-1	Product or Service ID Qualifier	ID2		<From prior payer's 835 SVC01>			Required if 835 from prior payer with service adjusts	See Guide for list of valid values
2430	SVD03-2	Procedure Code	AN48		<From prior payer's 835 SVC01>			Required if 835 from prior payer with service adjusts	External Code Set
2430	SVD03-3	Procedure Modifier	AN2		<From prior payer's 835 SVC01>			Not required	External Code Set
2430	SVD03-4	Procedure Modifier	AN2		<From prior payer's 835 SVC01>			Not required	External Code Set
2430	SVD03-5	Procedure Modifier	AN2		<From prior payer's 835 SVC01>			Not required	External Code Set
2430	SVD03-6	Procedure Modifier	AN2		<From prior payer's 835 SVC01>			Not required	External Code Set
2430	SVD03-7	Procedure Code Description	AN80		<From prior payer's 835 SVC01>			Not required	External Code Set
2430	SVD05	Paid Service Unit Count	R15		<From prior payer's 835 SVC01>			Required if 835 from prior payer with service adjusts	
2430	SVD06	Bundled or Unbundled Line Number	N06		<From prior payer's 835 SVC01>			Not required	
2430	**CAS**	**Service Adjustment**							
2430	CAS01	Claim Adjustment Group Code	ID2		<Derive from CAS02>			Required if 835 from prior payer with service adjusts	CO-Contractual, "CR"-Correction, "OA"-Other, "PI"-Payor Reduction, "PR"-Patient Responsibility

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2430	CAS02	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Required if 835 from prior payer with service adjusts	See www.wpc-edi.com
2430	CAS03	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Required if 835 from prior payer with service adjusts	
2430	CAS04	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	CAS05	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Not required	
2430	CAS06	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Not required	
2430	CAS07	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	CAS08	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Not required	
2430	CAS09	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Not required	
2430	CAS10	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	CAS11	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Not required	
2430	CAS12	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Not required	
2430	CAS13	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	CAS14	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Not required	
2430	CAS15	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Not required	
2430	CAS16	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	CAS17	Adjustment Reason Code	ID5	TPL rec	ADJUST-PAY-REASON	X(5)		Not required	
2430	CAS18	Adjustment Amount	R18	TPL rec	ADJUST-DOLLARS	S9(9)V99		Not required	
2430	CAS19	Adjustment Quantity	R15	TPL rec	ADJUST-UNITS	S9(6)		Not required	
2430	**DTP**	**Line Adjudication Date**							
2430	DTP01	Date Time Qualifier	ID3		"573"-Date Claim Paid		Literal	Required if 835 from prior payer with service adjusts	
2430	DTP02	Date Time Period Format Qualifier	ID3		"D8"-CCYYMMDD		Literal	Required if 835 from prior payer with service adjusts	

Loop	Segment	HIPAA Name	Data Type	Legacy Record	Legacy Field / Literal	Data Type	Mapping Comment / Gap	HIPAA Requirement	HIPAA Content
2430	DTP03	Adjudication or Payment Date	AN35					Required if 835 from prior payer with service adjusts	
2430	**SE**	**Transaction Set Trailer**							
2430	SE01	Transaction Segment Count	N010				Derive	Required	number of segments in trans
2430	SE02	Transaction Set Control Number	AN9				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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