ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

837 (ENCOUNTERS) STANDARD COMPANION GUIDE
TRANSACTION INFORMATION
PROFESSIONAL, INSTITUTIONAL, AND DENTAL

INSTRUCTIONS RELATED TO TRANSACTIONS BASED ON ASC X12 STANDARDS FOR ELECTRONIC DATA INTERCHANGE TECHNICAL REPORT TYPE 3 (TR3) VERSION 005010

COMPANION GUIDE
VERSION NUMBER: 2.0
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1 INTRODUCTION

1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked not used in the standards implementation specifications or are not in the standards implementation specification(s)
- Change the meaning or intent of the standards implementation specification(s)

1.3 Compliance according to ASC X12 Standard for Electronic Data Interchange Report Type 3 (TR3)

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the TR3
- Modifying any requirement contained in the TR3.

1.4 Intended Use

The Transaction Specific Information of this companion guide must be used in conjunction with an associated ASC X12 Standard for Electronic Data Interchange Report Type 3 (TR3). The Transaction Specific Information in this companion guide is not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 TR3 and is in conformance with ASC X12s Fair Use and Copyright statements.

2 ASC X12 STANDARDS FOR ELECTRONIC DATA INTERCHANGE REPORT TYPE 3

- 005010X222A1 Health Care Claim: Professional
- 005010X223A2 Health Care Claim: Institutional
- 005010X224A2 Health Care Claim: Dental

3 TRANSACTION SPECIFIC INFORMATION

3.1 837 Health Care Claim: Professional – Encounters

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
	ISA	**INTERCHANGE CONTROL HEADER**	
	ISA06	Interchange Sender ID	Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID	Expect AHCCCS866004791
	GS	**FUNCTIONAL GROUP HEADER**	
	GS02	Application Sender Code	Expect 6-digit HP ID + 3-digit TSN For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN
	GS03	Application Receiver Code	Expect AHCCCS866004791 or AHCCCSDENIED AHCCCS8660047919 = Use for new day encounters (approved, replaced, voids) AHCCCSDENIED = Use for Denied encounter files (.deny; input mode 6)
	GS08	Version Identifier Code	Expect 005010X222A1
	ST	**TRANSACTION SET HEADER**	
	ST03	Implementation Convention Reference	Expect 005010X222A1
	BHT	**BEGINNING OF HIERARCHICAL TRANSACTION**	
	BHT06	Claim or Encounter ID	Expect Reporting: RP
1000A	**NM1**	**SUBMITTER NAME**	
1000A	NM109	Submitter Identifier	Expect 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: 079999 + 3-digit TSN + 1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**	**2nd occurrence is for BBA attestation in PER04**
1000A	PER01	Contact Function Code	Expect Information Contact: IC
1000A	PER03	Communication Number Qualifier	Expect Email: EM
1000A	PER04	Communication Number	Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier	Expect Email: EM
1000A	PER06	Communication Number	Expect Contact Email
1000A	PER07	Communication Number Qualifier	Expect Telephone: TE

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
1000A	PER08	Communication Number	Expect Contact Phone
1000B	**NM1**	**RECEIVER NAME**	
1000B	NM103	Receiver Name	Expect AHCCCS
1000B	NM109	Receiver Primary Identifier	Expect 866004791
2010AA	**NM1**	**BILLING PROVIDER NAME**	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	Expect Billing Provider 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of 0000 or 9999 is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2010BA	**NM1**	**SUBSCRIBER NAME**	
2010BA	NM109	Subscriber Primary Identifier	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**PAYER NAME**	
2010BB	NM103	Payer Name	Expect AHCCCS
2010BB	NM108	Identification Code Qualifier	Expect PI
2010BB	NM109	Payer Identifier	Expect 866004791
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	Atypical Provider
2010BB	REF01	Reference Identification Qualifier	Expect G2
2010BB	REF02	Payer Additional Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2300	**CLM**	**CLAIM INFORMATION**	
2300	CLM01	Patient Account Number	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-3	Claim Frequency Code	Expect Claim Frequency Code For Replacements, use 7 (Replacement of prior claim) For Voids, use 8 (Void/Cancel prior claim)
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. Same for Header and Detail
2300	REF01	Reference Identification Qualifier	Expect F8

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2300	REF02	Claim Original Reference Number	Expect Original CRN If submitting a void transaction, the AHCCCS 12 digit CRN of the encounter to be adjusted must be included in this field. AHCCCS only accepts professional (837P) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digit of the CRN. When replacing or voiding at the header only the first 12 digit of the CRN should be submitted. For replacements the encounter must reflect the plans final disposition of all claim lines.
2300	**REF**	**MEDICAL RECORD NUMBER**	Required when the provider needs to identify for future inquiries, the actual medical record of the patient identified in either Loop ID-2010BA or Loop ID-2010CA for this episode of care.
2300	REF02	Medical Record Number	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA
2300	**CR1**	**AMBULANCE TRANSPORT INFORMATION**	Required on all claims involving ambulance transport services.
2300	CR104	Ambulance Transport Reason Code	Expect A, B, C, D, or E Or Default to value A when not known A=Patient was transported to nearest facility for care of symptoms, complaints, or both B=Patient was transported for the benefit of a preferred physician C=Patient was transported for the nearness of family members E=Patient Transferred to Rehabilitation Facility
2300	CR105	Unit or Basis for Measurement Code	Expect DH or Default to DH when CR104 is not known
2300	CR106	Transport Distance 9(4)	Expect Transport Distance or Default to 0 when not known
2300	CR109	Round Trip Purpose Description	AHCCCS Transportation services are separate legs and are not tracked for round trip. Will leave open for usage as determined by the HP. Required when the ambulance service is for a round trip.
2310B	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**	**Atypical Provider**
2310B	REF01	Reference Identification Qualifier	Expect G2
2310B	REF02	Rendering Provider Secondary Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2310C	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information** If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, crossroad of State Road 34 and 45 or Exit near Mile marker 265 on Interstate 80.)
2310C	N301	Laboratory or Facility Address Line	Expect Laboratory or Facility Address Line PO Box or Lock Box is not allowed
2310C	**N4**	**SERVICE FACILITY LOCATION CITY/STATE/ZIP**	
2310C	N403	Laboratory or Facility Postal Zone ZIP Code	Expect Laboratory or Facility 9-digit zip code Health plans are encouraged to submit the full 9-digit zip code
2310E	**N3**	**AMBULANCE PICK UP LOCATION ADDRESS**	If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, crossroad of State Road 34 and 45 or Exit near Mile marker 265 on Interstate 80.)
2310E	N301	Ambulance Pick Up Address Line	Expect physical pick up address. PO Box address should not be used.
2310F	**N3**	**AMBULANCE DROP-OFF LOCATION**	If the ambulance drop off location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, crossroad of State Road 34 and 45 or Exit near Mile marker 265 on Interstate 80.)
2310F	N301	Ambulance Drop-Off Address Line	Expect physical drop-off address. PO Box address should not be used.
2330A	**NM1**	**OTHER SUBSCRIBER NAME**	If the patient can be uniquely identified to the Other Payer indicated in this iteration of Loop ID-2320 by a unique Member Identification Number, then the patient is the subscriber or is considered to be the subscriber and is identified in this Other Subscribers Name Loop ID-2330A.
2330A	NM109	Other Insured Identifier	Expect Other Insured Identifier or AHCCCS ID

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2330B	**NM1**	**OTHER PAYER NAME**	
2330B	NM109	Other Payer Primary Identifier	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect MA or MB For TPL/Other Insurance, expect OI For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.
2330B	**REF**	**OTHER PAYER PRIOR AUTHORIZATION NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect G1
2330B	REF02	Other Payer Prior Authorization Number	Expect Payer Prior Authorization number
2330B	**REF**	**OTHER PAYER REFERRAL NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect 9F
2330B	REF02	Other Payer Referral Number	Expect Other Payer Referral Number
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect F8
2330B	REF02	Other Payer Claim Control Number	Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**SV1**	**PROFESSIONAL SERVICE**	
2400	SV107	COMPOSITE DIAGNOSIS CODE POINTER	Expect to have the alpha letters A-L from the CMS1500 form cross-walked to a numeric equivalent for use in the 837 Encounter. Per the TR3, the only acceptable values that can be used for a Diagnosis code pointer is 1-12.

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
			Allowed values are 1-12 If SV107-1 is present, use the number represented here to determine which diagnosis from the HI segment should be moved.
2400	**CN1**	**CONTRACT INFORMATION**	This segment must always be sent for each line to capture the Health Plan Allowed Amount
2400	CN101	Contract Type Code	For non-BHS plans, expect any value For BHS plans, expect 05 or 09 05 Capitated 09 Other (use for FFS) 01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS)
2400	CN102	Contract Amount	Expect Health plan Allowed Amount Allowed Amount: What would have paid under FFS before other payer
2410	**CTP**	**DRUG QUANTITY**	
2410	CTP04	National Drug Unit Count	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999). when CTP05-1 = UN - 9(3).9, F2 - 9(7).999 ML - 9(2).99 GR - 9(2).99 ME - 9(5).999
2420A	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**	Atypical Provider Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
2420A	REF01	Reference Identification Qualifier	Expect G2
2420A	REF02	Rendering Provider Secondary Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2420C	**REF**	**SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION**	Atypical Provider Required on or after the mandated NPI implementation date when the entity is not a Health Care provider (a.k.a. an atypical provider), and an identifier is necessary for the claims processor to identify the entity.
2420C	REF01	Reference Identification Qualifier	Expect G2
2420C	REF02	Service Facility Location Secondary Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2430	**SVD**	**LINE ADJUDICATION INFORMATION**	AHCCCS currently allows for one 2430 Loop per payer, per line. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
2430	SVD01	Other Payer Primary Identifier	This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).
2430	**CAS**	**LINE ADJUSTMENT**	ENC captures 6 trios Required when the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.
2430	CAS03	Adjustment Amount	Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported

3.2 837 Health Care Claim: Institutional – Encounters

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
	ISA	**INTERCHANGE CONTROL HEADER**	
	ISA06	Interchange Sender ID	Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID	Expect AHCCCS866004791
	GS	**FUNCTIONAL GROUP HEADER**	
	GS02	Application Sender Code	Expect 6-digit HP ID+3-digit TSN For RBHAs: RBHA 6-digit Provider ID+3-digit TSN
	GS03	Application Receiver Code	Expect AHCCCS866004791, AHCCCSDENIED, or AHCCCSPARTIAL AHCCCSDENIED=Use for Denied encounter files (.deny; input mode 6) AHCCCS8660047919=Use for new day encounters (approved, replaced, voids) AHCCCSPARTIAL=Use for non-covered lines due to invalid code sets
	GS08	Version Identifier Code	Expect 005010X223A2
	ST	**TRANSACTION SET HEADER**	
	ST03	Implementation Convention Reference	Expect 005010X223A2
	BHT	**BEGINNING OF HIERARCHICAL TRANSACTION**	
	BHT06	Claim or Encounter ID	Expect Reporting: RP
1000A	**NM1**	**SUBMITTER NAME**	
1000A	NM109	Submitter Identifier	Expect 6-digit HP ID+3-digit TSN+1-digit Input Mode For RBHAs: 079999+TSN+1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**	**2nd occurrence is for BBA attestation in PER04**
1000A	PER03	Communication Number Qualifier	Expect Email: EM
1000A	PER04	Communication Number	Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier	Expect Email: EM
1000A	PER06	Communication Number	Expect Contact Email
1000A	PER07	Communication Number Qualifier	Expect Telephone: TE
1000A	PER08	Communication Number	Expect Contact Phone
1000B	**NM1**	**RECEIVER NAME**	

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
1000B	NM103	Receiver Name	Expect AHCCCS
1000B	NM109	Receiver Primary Identifier	Expect 866004791
2010BA	**NM1**	**SUBSCRIBER NAME**	
2010BA	NM109	Subscriber Primary Identifier	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**PAYER NAME**	
2010BB	NM103	Payer Name	Expect AHCCCS
2010BB	NM108	Identification Code Qualifier	Expect PI
2010BB	NM109	Payer Identifier	Expect 866004791
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	
2010BB	REF01	Reference Identification Qualifier	Expect G2
2010BB	REF02	Payer Additional Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2300	**CLM**	**CLAIM INFORMATION**	
2300	CLM01	Patient Control Number	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-1	Facility Type Code	The first and second positions of the Uniform Bill Type Code for Institutional Services
2300	CLM05-2	Facility Code Qualifier	Expect A
2300	CLM05-3	Claim Frequency Code	This is the third position of the Uniform Billing Claim Form Bill Type For Replacements, use 7 (Replacement of prior claim) For Voids, use 8 (Void/Cancel prior claim)
2300	**CN1**	**CONTRACT INFORMATION**	This segment must always be sent to capture the Health Plan Allowed Amount
2300	CN101	Contract Type Code	For non-BHS plans, expect any value For BHS plans, expect 05 or 09 05 Capitated 09 Other (use for FFS)
2300	CN102	Contract Amount	Expect Health plan Allowed Amount
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	
2300	REF01	Reference Identification Qualifier	Expect F8
2300	REF02	Claim Original Reference Number	Expect Payer Claim Control Number If submitting a void transaction, the AHCCCS CRN of the encounter to be adjusted must be included in this field.
2300	**REF**	**MEDICAL RECORD NUMBER**	
2300	REF01	Reference Identification Qualifier	Expect EA

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2300	REF02	Medical Record Number	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA
2300	**REF**	**DEMONSTRATION PROJECT IDENTIFIERS**	**Submit when identifying encounters related to a Structured Payment Contract** Required when it is necessary to identify claims which are atypical in ways such as content, purpose, and/or payment, as could be the case for a demonstration or other special project, or a clinical trial
2300	REF01	Reference Identification Qualifier	Expect P4
2300	REF02	Medical Record Number	Submit MCO VBP Contract ID (field must be between 3 and 30 characters in length)
2300	**HI**	**DIAGNOSIS RELATED GROUP (DRG) INFORMATION**	Required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
2300	HI01	Health Care Code Information	
2300	HI01-1	Qualifier	Expect DR (Diagnosis Related Group)
2300	HI01-2	DRG Code	Expect MCOs Qualified Diagnosis Related Group code - not the providers DRG. Format **without** hyphen: **DRG(3)SOI(1) ex. 0201**
2300	**HI**	**VALUE INFORMATION**	Required when there is a Value Code that applies to this claim Birth weight should be submitted in this loop when required (14 days and under). 2300/HIXX-2 - Value Code = 54 2300/HIXX-5 - Value Code Amount - Birth weight in format per standard
2300	HI01	Health Care Code Information	
2300	HI01-1	Qualifier	Expect BE
2300	HI01-2	Value Code	Expect Value code 80 - Covered Days 82 - Coinsurance Days 83 - Lifetime Reserve Days
2300	HI01-5	Value Code Amount	Expect Value code amount
2310E	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	**Expect the physical address information** **PO Box or Lock Box not allowed for the Service Facility Address**
2310E	N301	Laboratory or Facility Address Line	Expect Laboratory or Facility Address Line PO Box or Lock Box is not allowed
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**	01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files.

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2320	CAS03	Adjustment Amount	Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported
2330B	**NM1**	**OTHER PAYER NAME**	
2330B	NM109	Other Payer Primary Identifier	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect MA or MB For TPL/Other Insurance, expect OI For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.
2330B	**REF**	**OTHER PAYER PRIOR AUTHORIZATION NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect G1
2330B	REF02	Other Payer Prior Authorization Number	Expect Prior Authorization Number
2330B	**REF**	**OTHER PAYER REFERRAL NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect 9F
2330B	REF02	Other Payer Referral Number	Expect Referral Number
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	Required when it is necessary to identify the Other Payers Claim Control Number in a payer-to-payer COB situation. Or required when the Other Payers Claim Control Number is available.
2330B	REF01	Reference Identification Qualifier	Expect F8

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2330B	REF02	Other Payer Claim Control Number	Expect Health Plan Claim ID When the Payer is the Health Plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**LX**	**SERVICE LINE**	
2400	**SV2**	**INSTITUTIONAL SERVICE LINE**	
2400	SV205	Service Units/Days	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999). The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.
2410	**LIN**	**DRUG IDENTIFICATION**	Drug Information, including Hemophilia drugs, to be supplied in this segment along with 2410/CTP or 2400/SV2
2410	LIN02	Product or Service ID Qualifier	Expect N4
2410	LIN03	National Drug Code	Expect NDC code
2410	**CTP**	**DRUG QUANTITY**	
2410	CTP04	National Drug Unit Count	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2410	CTP05	Composite Unit of Measure	
2410	CTP05-1	Unit or Basis For Measurement Code	Expect Measurement code F2 International Unit GR Gram ME Milligram ML Milliliter UN Unit
2430	**SVD**	**LINE ADJUDICATION INFORMATION**	Currently only allow for one 2430 Loop per payer, per line.

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2430	SVD01	Other Payer Primary Identifier	For Health Plan: 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect MA or MB For TPL/Other Insurance, expect OI For Health plans: For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).

3.3 837 Health Care Claim: Dental – Encounters

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
	ISA	**Interchange Control Header**	
	ISA06	Interchange Sender ID	Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID	Expect AHCCCS866004791
	GS	**Functional Group Header**	
	GS02	Application Sender Code	Expect 6-digit HP ID + 3-digit TSN For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN
	GS03	Application Receiver Code	Expect AHCCCS866004791 or AHCCCSDENIED AHCCCS8660047919=Use for new day encounters (approved, replaced, voids) AHCCCSDENIED=Use for Denied encounter files (.deny; input mode 6)
	GS08	Version Identifier Code	005010X224A2
	ST	**Transaction Set Header**	
	ST03	Implementation Convention Reference	005010X224A2
	BHT	**Beginning of Hierarchical Transaction**	
	BHT06	Claim or Encounter ID	Expect Reporting: RP
1000A	**NM1**	**Submitter Name**	
1000A	NM109	Submitter Identifier	Expect 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: 079999 + 3-digit TSN + 1-digit Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**Submitter EDI Contact Information**	**2nd occurrence is for BBA attestation in PER04**
1000A	PER01	Contact Function Code	Expect IC Information Contact
1000A	PER03	Communication Number Qualifier	Expect Email: EM
1000A	PER04	Communication Number	Expect BBA attestation: TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE.CERTIFIER@CERTIFIED.COM
1000A	PER05	Communication Number Qualifier	Expect Email: EM
1000A	PER06	Communication Number	Expect Contact Email

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
1000A	PER07	Communication Number Qualifier	Expect Telephone: TE
1000A	PER08	Communication Number	Expect Contact Phone
1000B	**NM1**	**Receiver Name**	
1000B	NM103	Receiver Name	Expect AHCCCS
1000B	NM109	Receiver Primary Identifier	Expect 866004791
2010AA	**N4**	**Billing Provider City/State/Zip Code**	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	Expect Billing Provider 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of 0000 or 9999 is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2010BA	**NM1**	**Subscriber Name**	
2010BA	NM109	Subscriber Primary Identifier	Expect AHCCCS ID (A*, x(9)) For RBHAs: Expect AHCCCS ID (A*, x(9)), State Only ID (S*, X(9)), or CIS ID x(10).
2010BB	**NM1**	**Payer Name**	
2010BB	NM103	Payer Name	Expect AHCCCS
2010BB	NM108	Identification Code Qualifier	Expect PI
2010BB	NM109	Payer Identifier	Expect 866004791
2010BB	**REF**	**Billing Provider Secondary Identification**	Atypical Provider
2010BB	REF01	Reference Identification Qualifier	Expect G2
2010BB	REF02	Payer Additional Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2300	**CLM**	**Claim Information**	
2300	CLM01	Patient Control Number	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-3	Claim Frequency Code	Expect Claim Frequency Code For Replacements, use 7 (Replacement of prior claim) For Voids, use 8 (Void/Cancel prior claim)
2300	**REF**	**Payer Claim Control Number**	Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. Same for Header and Detail
2300	REF01	Reference Identification Qualifier	Expect F8

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2300	REF02	Payer Claim Control Number	Expect Original CRN If submitting a void transaction, the AHCCCS CRN of the encounter to be adjusted must be included in this field. AHCCCS only accepts dental (837D) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digits of the CRN. When replacing or voiding at the header only the first 12 digits of the CRN should be submitted. For replacements the encounter must reflect the plans final disposition of all claim lines.
2310B	**REF**	**Rendering Provider Secondary Identification**	Atypical Provider
2310B	REF01	Reference Identification Qualifier	Expect G2
2310B	REF02	Rendering Provider Secondary Identifier	Expect 6-digit AHCCCS Provider Registration ID when provider is not eligible for NPI
2310C	**N3**	**Service Facility Location Address**	PO Box or Lock Box not allowed for the Service Facility Address Must supply the physical address information
2310C	N301	Laboratory or Facility Address Line	Expect Laboratory or Facility Address Line PO Box or Lock Box is not allowed
2310C	**N4**	**Service Facility Location City/State/ Zip Code**	
2310C	N403	Laboratory or Facility Postal Zone Zip Code	Expect Laboratory or Facility 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of 0000 or 9999 is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2330A	**NM1**	**Other Subscriber Name**	
2330A	NM109	Other Insured Identifier	Expect Other Insured Identifier or AHCCCS ID
2330B	**NM1**	**Other Payer Name**	

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2330B	NM109	Other Payer Primary Identifier	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect MA or MB For TPL/Other Insurance, expect OI For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.
2330B	**REF**	**Other Payer Prior Authorization Number**	
2330B	REF01	Reference Identification Qualifier	Expect G1
2330B	REF02	Other Payer Prior Authorization Number	Expect Payer Prior Authorization number
2330B	**REF**	**Other Payer Referral Number**	
2330B	REF01	Reference Identification Qualifier	Expect 9F
2330B	REF02	Other Payer Referral Number	Expect Other Payer Referral Number
2330B	**REF**	**Other Payer Claim Control Number**	
2330B	REF02	Other Payer Claim Control Number	Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**CN1**	**Contract Information**	This segment must always be sent for each line to capture the Health plan Allowed amount Required when the submitter is contractually obligated to supply this information on post-adjudicated claims.

LOOP ID	ELEMENT	DESCRIPTION	AHCCCS USAGE/EXPECTIVE VALUE
2400	CN101	Contract Type Code	For non-BHS plans, expect any value For BHS plans, expect 05 or 09 05 Capitated 09 Other (use for FFS) 01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS)
2400	CN102	Contract Amount	Expect Health Plan Allowed Amount Allowed Amount: What would have paid under FFS before other payer
2430	**SVD**	**Line Adjudication Information**	AHCCCS currently allows for one 2430 Loop per payer, per line.
2430	SVD01	Other Payer Primary Identifier	For Health Plan: 6-digit HP ID + 3-digit TSN + 1-digit Input Mode For RBHAs: RBHA 6-digit Provider ID + 3-digit TSN + 1-digit Input Mode For Medicare, expect MA or MB For TPL/Other Insurance, expect OI For Health plans: For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).
2430	**CAS**	**Line Adjustment**	
2430	CAS03	Adjustment Amount	Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported

4 CHANGE SUMMARY

Ver #	Location & Section	Revision	Revision Date
1.0		• Final Version • Removed EDI X12 Proprietary Data to conform to the ASC X12s Fair Use and Copyright standard	October 2016
2.0	3.1 837 Health Care Claim: Professional – Encounters 3.2 837 Health Care Claim: Institutional – Encounters 3.3 837 Health Care Claim: Dental – Encounters	• Updated the Template • Remove 837 Notes Column • Page 6: Added 2310F Ambulance Drop-Off Location	September 2022