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Schenectady, NY 12305

MVP Health Care

Testing and Implementation Guide

*ASC X12N Version 005010X222A1
Health Care Claim: Professional*

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VERSION CHANGE LOG

Version 1.0 Original	May 16,2005
Add new 277U Requirements	July 29, 2005
Updated Implementation Procedures, added sign off sheet.	August 10,2005
Add segments CAS, AMT, SVD for COB information	August 03,2006
Add rules for submission of secondary Medicare Claims	August 04,2006
Add rules for submission of secondary Commercial Claims	August 21,2006
Added in NPI rules.	October, 13 2006
Version 2.0 Updated NPI rules	May 22, 2008
Updated 277U Status Messages	May 1, 2010
Updated Anesthesia rules from units to minutes	May 1, 2010
Version 3.0 Updated for 5010	June 17, 2010
5010 Revisions	February 18, 2011
Revised	April 11, 2011

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 837 Health Care Claim: Professional transaction implementation guide provides the standardized data requirements to be implemented for this transaction.

PURPOSE

The purpose of this document is to provide the information necessary to submit Health Care Claim Status Inquiry transactions electronically to MVP Health Care. **This companion guide is to be used in conjunction with the ANSI X12N implementation guides.** The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The HIPAA implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/. Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>
United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admsimp/>
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>
Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>
National Council of Prescription Drug Programs (NCPDP) – <http://www.ncpdp.org/>
National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

SPECIAL CONSIDERATIONS

Request Transactions Supported

This section is intended to identify the type and version of the ASC X12N Health Care Claim: Professional transaction that MVP will accept.

- | |
|--|
| <ul style="list-style-type: none">• 837 Health Care Claim: Professional – ASC X12N 837 (005010X222A1) |
|--|

Response Transactions Supported

This section is intended to identify the response transactions supported by MVP.

- | |
|---|
| <ul style="list-style-type: none">• 277 Health Care Claim Acknowledgment – ASC X12N 277CA (005010X214) |
| <ul style="list-style-type: none">• 999 Functional Acknowledgement – ASC X12C 999 (005010X231A1) |

Communication Specifications

MVP currently supports the receipt of the 837, Health Care Claim: Professional, in batch mode only. The file can be uploaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 999, Unsolicited Claim Status, in batch mode to its trading partners. The file can be downloaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 277CA, Health Care Claim Acknowledgment, in batch mode to its trading partners. The file can be downloaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

Use of the 837 Health Care Claim: Professional

The 837 Professional Health Care Claim is designed to submit claim information electronically to the payer (MVP).

<ul style="list-style-type: none">• Key Fields:<ol style="list-style-type: none">1. NPI Identifier Qualifier NM108 - XX<ol style="list-style-type: none">a. Billing Provider Identifier (Loop 2010AA – NM109)b. Pay-To Provider Identifier (Loop 2010AB – NM109)c. Rendering Provider Identifier (Loop 2310A – NM109)2. Assignment Indicator (Loop 2000B – SBR01)3. Subscriber Last Name (Loop 2010BA – NM103)4. Subscriber First Name (Loop 2010BA – NM104)5. Subscriber Identifier (Loop 2010BA – NM109)6. Subscriber Date of Birth (Loop 2010BA – DMG02)7. Unique Patient Account Number (Loop 2300 – CLM01)8. Place of Service (Loop 2300 – CLM05-1)9. Diagnosis Code (Loop 2300 – HI01-2)10. Service Dates (Loop 2400 – DTP03)11. Procedure Code (Loop 2400 – SV101-2)12. Requested Amount (Loop 2400 – SV102)13. Service Unit Count/Quantity (Loop 2400 – SV104)
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Use of NPI

MVP requires all providers and facilities to use their National Provider Identifier (NPI) number on all electronic transactions covered by HIPAA.

This means that when billing, providers and facilities must use NPI numbers not only for the billing, pay to, and rendering fields, but also for all secondary provider fields such as referring and supervising provider when used. ***Tax ID number may only be used in connection with the billing provider loop.***

MVP requires providers with multiple specialties to submit their service location with ZIP + 4 and their taxonomy number.

Providers and facilities must ***not*** include their existing MVP provider ID or any secondary provider identifier in any of the provider loops except for TIN as required for billing/pay to loops.

If a provider or facility uses a MVP provider ID or any secondary provider identifier for electronic transactions, MVP will reject them for NPI non-compliance.

Anesthesia Billing

MVP will require all anesthesia services to be billed using minutes (MJ) rather than units (UN) as of July 1, 2010.

Patient Loop

For MVP, all Patients are considered Subscribers when creating your 837. Please do not use the Patient Loop (2000C/2010CA) and inserting a member number in this loop is non-compliant. This may also result in "Member not Found" claim level rejections.

Secondary Payer and COB rules for Medicare Claims

For correct processing of secondary payer Medicare claims the submission of information is as follows.

Loop and Segment	Value	Description
Loop 2000B/SBR01	S	Secondary Payer
Loop 2300/CLM07	A	Assigned
Loop 2300/AMT01	F5	Patient Paid Amount Qualifier
Loop 2300/AMT02	Dollar Amount	Patient Paid Amount
Loop 2320/SBR01	P	Primary Payer
Loop 2320/SBR09	MA, MB	Type of Carrier
Loop 2320/CAS01	PR, CO, OA	Claim Adjustment Group Code
Loop 2320/CAS02		Claim Adjustment Reason Code
Loop 2320/CAS03	Dollar Amount	Claim Adjustment Amount
Loop 2320/AMT01	D	Payer Paid Amount Qualifier
Loop 2320/AMT02	Dollar Amount	Payer Paid Amount
Loop 2320/AMT01	EAF	Remaining Patient Liability
Loop 2320/AMT02	Dollar Amount	Remaining Patient Liability
Loop 2430/CAS01	PR, CO, OA	Claim Adjustment Group Code
Loop 2430/CAS02		Claim Adjustment Reason Code
Loop 2430/CAS03	Dollar Amount	Claim Adjustment Amount
Loop 2430/AMT01	EAF	Remaining Patient Liability
Loop 2430/AMT02	Dollar Amount	Remaining Patient Liability

Secondary Payer and COB rules for Commercial Claims

For correct processing of secondary payer Commercial claims the submission of information is as follows.

Loop and Segment	Value	Description
Loop 2000B/SBR01	S	Secondary Payer
Loop 2300/CLM07	A	Assigned
Loop 2300/AMT01	F5	Patient Paid Amount Qualifier
Loop 2300/AMT02	Dollar Amount	Patient Paid Amount
Loop 2320/SBR01	P	Primary Payer
Loop 2320/SBR09		Type of Carrier
Loop 2320/CAS01	PR, CO, OA	Claim Adjustment Group Code
Loop 2320/CAS02		Claim Adjustment Reason Code
Loop 2320/CAS03	Dollar Amount	Claim Adjustment Amount
Loop 2320/AMT01	D	Payer Paid Amount Qualifier
Loop 2320/AMT02	Dollar Amount	Payer Paid Amount
Loop 2320/AMT01	EAF	Remaining Patient Liability
Loop 2320/AMT02	Dollar Amount	Remaining Patient Liability
Loop 2430/CAS01	PR, CO, OA	Claim Adjustment Group Code
Loop 2430/CAS02		Claim Adjustment Reason Code
Loop 2430/CAS03	Dollar Amount	Claim Adjustment Amount
Loop 2430/AMT01	EAF	Remaining Patient Liability
Loop 2430/AMT02	Dollar Amount	Remaining Patient Liability

277CA Status Code List

The 277CA, Health Care Claim Acknowledgment transaction is used to provide claim level acceptance and rejections for basic business edits.

<ul style="list-style-type: none"> The following error codes are possible in the 277CA 		
A1	19	Entity acknowledges receipt of claim/encounter.
A3	30	Subscriber/ Patient name mismatched.
A3	33	Subscriber/Patient id not found.
A3	85	MVP is not the policyholder's primary insurance carrier
A3	88	Patient not eligible/not approved for dates of service.
A3	116	Claim submitted to incorrect payer.
A3	158	Patient date of birth mismatch
A3	481	Claim/submission format is invalid: Multiple providers billed.
A3	510	Future date of service
A6	145	provider specialty/taxonomy code.
A6	189	Facility admission date
A6	251	Total anesthesia minutes
A7	228	Type of bill for UB claim
A7	231	Hospital admission type.
A7	234	Patient status.
A7	249	Place of service.
A7	255	Diagnosis code.
A7	402	Claim amount must be greater than zero
A7	453	Procedure Code Modifier(s) for Service(s) Rendered
A7	454	Procedure code for services rendered.
A7	455	Revenue code for services rendered.
A7	460	NUBC Condition Code(s)
A7	461	NUBC Occurrence Code(s) and Date(s)
A7	462	NUBC Occurrence Span Code(s) and Date(s)
A7	488	Diagnosis code(s) for the services rendered.
A7	562	National Provider Identifier (NPI)
A7	634	Remark Code
A8	128/562/145	Taxonomy not on file for tax id/NPI affiliation
<p>Note: A1 - The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.</p> <p>A3 - Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.</p> <p>A6 - Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.</p> <p>A7 - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.</p> <p>A8 - Acknowledgement / Rejected for relational field in error.</p> <p>Note: The codes and descriptions above are as the writing of this document. Although we will endeavor to keep this guide current, some changes may occur. If this does occur, please visit www.wpc-edi.com for a complete list and detailed explanation please visit.</p>		

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Repetition separator	^ Carrot
Segment Terminator	~ Tilde

MVP will support these default delimiters or any delimiter specified by the trading partner in the ISA / IEA envelope structure.

Implementation of Health Care Claim: Professional

There will be four phases of implementation.

1. Development Phase - An MVP appointed Representative would contact the client to review these procedures. MVP will set up a client specific profile to receive claim submissions, process claims, and send acknowledgments and business edit reports. In response, the client will create or modify their programs as necessary to provide MVP with the required data and to receive required data from MVP.
2. Test Phase – The client must notify MVP when they are ready to begin submitting test files. MVP and the client will set up a schedule to receive and send data across the desired media. Upon receiving the file, MVP will validate the file format and data for accuracy. MVP will run the file through the claim submission process, which will do a series of error checking. Upon completion of the claim submission process, a response will be created. MVP will identify any errors that will assist client with submitting clean claim submissions. The MVP IT Representative will test and identify all technical errors. During the testing phase, the EDI Coordinator will be responsible for the education of providers/hospitals with regard to EDI errors/failures. The Client will review and discuss any questions or problems with MVP. The goal will be to achieve a 100% HIPAA compliant claim submission, **and 80% or better for business edits** prior to going live.
3. Production - Once testing has reached an acceptance level and both parties have signed off, MVP will move the process into production and go live with the claim submissions. **For denied claims, call Provider Relations / Provider Claim Services.** All transaction error questions should be directed to the EDI Coordinators: 1-877-461-4911.
4. Post Production - MVP will closely monitor the client's claim submissions. MVP will insure that the client's claim submissions are being received, processed; an acknowledgement and business edit report is created and delivered to the client's mailbox properly

MVP Requirements for the ANSI X12 837 Transaction - Health Care Claim: Professional

Required	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	ISA	INTERCHANGE CONTROL HEADER		
R	01	AUTHORIZATION INFORMATION QUALIFIER	00	No authorization information present in 02
R	02	AUTHORIZATION INFORMATION		Blank
R	03	SECURITY INFORMATION QUALIFIER	00	No security information present in 04
R	04	SECURITY INFORMATION		Blank
R	05	INTERCHANGE ID QUALIFIER	30	Federal tax ID
R	06	INTERCHANGE SENDER ID		Sender tax ID
R	07	INTERCHANGE ID QUALIFIER	30	Federal tax ID
R	08	INTERCHANGE RECEIVER ID	141650868	MVP tax ID
R	09	INTERCHANGE DATE	YYMMDD	Date of interchange
R	10	INTERCHANGE TIME	HHMM	Time of interchange
R	11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	^	Repetition separator
R	12	INTERCHANGE CONTROL VERSION NUMBER	00501	Draft Standards approved by ASCx12
R	13	INTERCHANGE CONTROL NUMBER	Assigned by sender	Must match IEA02
R	14	ACKNOWLEDGMENT REQUESTED	0	0 = NO
R	15	TEST INDICATOR	P OR T	Production or Test
R	16	COMPONENT ELEMENT SEPARATOR	:	Delimiter
R	GS	FUNCTIONAL GROUP HEADER		
R	01	FUNCTIONAL IDENTIFIER CODE	HC	Health Care Claim 837
R	02	APPLICATION SENDER'S CODE		Sender's code / Tax Identification Number
R	03	APPLICATION RECEIVER'S CODE	141650868	Receiver's code
R	04	DATE	CCYYMMDD	Group creation date
R	05	TIME	HHMM	Creation time
R	06	GROUP CONTROL NUMBER		Assigned by sender

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R	07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12
R	08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	005010X222A1	Version/Release/Industry Identifier Code
R	ST	TRANSACTION SET HEADER		
R	01	TRANSACTION SET IDENTIFIER CODE	837	Health Care Claim
R	BHT	BEGINNING OF HIERARCHICAL TRANSACTION		
R	01	HIERARCHICAL STRUCTURE CODE	0019	Information Source, Subscriber, Dependent
R	02	TRANSACTION SET PURPOSE CODE	00	00-Original
R	03	DATE		Transaction set create date in CCYYMMDD format
R	04	TIME		Transaction set create time in HHMM format
R	05	TRANSACTION SET TYPE CODE	CH	Chargeable-fee for service
R	REF	TRANSMISSION TYPE IDENTIFICATION		
R	01	REFERENCE IDENTIFICATION QUALIFIER	87	Functional Category
R	02	REFERENCE IDENTIFICATION CODE	005010X222A1	Reference Identification
Loop 1000A				
R	NM1	SUBMITTER NAME-1000A		
R	01	ENTITY IDENTIFIER CODE	41	Submitter
R	02	ENTITY TYPE QUALIFIER	1, 2	1-Person, 2-Non-person entity
R	03	ORGANIZATION NAME/LAST NAME		Submitter Name
S	04	FIRST NAME		Subscriber First Name
S	05	MIDDLE NAME		Subscriber Middle Name
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE		Submitter tax ID
R	PER	SUBMITTER EDI CONTACT INFORMATION-1000A		
R	01	CONTACT FUNCTION CODE	IC	Information Contact

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R	02	NAME		Submitter Contact Name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Area code number + phone number
S	05	COMMUNICATION QUALIFIER	EM	Email
S	06	COMMUNICATION NUMBER		Email address
Loop 1000B				
R	NM1	RECEIVER NAME-1000B		
R	01	ENTITY IDENTIFIER CODE	40	Receiver
R	02	ENTITY TYPE QUALIFIER	2	2-Non-person Entity
R	03	ORGANIZATION NAME	MVP HEALTH PLAN	Receiver name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE	141650868	Receiver Identifier
Loop 2000A				
R	HL	HIERARCHICAL LEVEL		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender, must begin at "1"
NOT USED	02	HIERARCHICAL PARENT ID NUMBER		NOT USED
R	03	HIERARCHICAL LEVEL CODE	20	Information Source
R	04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segment
S	PRV	BILLING / PAY-TO PROVIDER SPECIALTY 2000A		**IDENTIFIES BILLING / PAY-TO SPECIALTY
R	01	PROVIDER CODE	BI	Provider Code
R	02	REFERENCE IDENTIFICATION QUALIFER	PXC	Mutually Defined
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code - Required if the provider has more then one specialty.

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Loop 2010AA				
R	NM1	BILLING PROVIDER NAME 2010AA		
R	01	ENTITY IDENTIFIER CODE	85	Billing provider
R	2	ENTITY TYPE QUALIFIER	1 or 2	1-Person, 2-Non-person entity
R	03	NAME LAST		Billing Provider Last or Organizational Name
S	04	NAME FIRST		Billing Provider First Name
S	05	NAME MIDDLE		Billing Provider Middle Name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Billing Provider Suffix, if known
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
R	N3	BILLING PROVIDER ADDRESS		
R	01	STREET		Billing Provider Street (Physical address)
S	02	STREET 2		Billing Provider Street 2
R	N4	BILLING PROVIDER CITY, STATE, ZIP CODE		
R	01	CITY		Billing Provider City
R	02	STATE		Billing Provider State
R	03	POSTAL CODE		Billing Provider Zip code
S	REF	BILLING PROVIDER SECONDARY IDENTIFICATION		
R	01	REFERENCE IDENTIFICATION QUALIFIER	EI, SY	Billing Provider Federal Tax ID, Billing Provider SSN
R	02	REFERENCE IDENTIFICATION		Billing provider ID
S	PER	BILLING PROVIDER CONTACT INFORMATION		
R	01	CONTACT FUNCTION CODE	IC	Information contact
R	02	NAME		Billing provider contact name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Physician phone number

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Loop 2010AB				
S	NM1	PAY TO ADDRESS NAME 2010AB		
R	01	ENTITY IDENTIFIER CODE	87	Pay to provider
R	2	ENTITY TYPE QUALIFIER	1 or 2	Person/non-person entity
NOT USED	03	NAME LAST		Pay to provider last name
NOT USED	04	NAME FIRST		Pay to provider first name
NOT USED	05	NAME MIDDLE		Pay to provider middle initial
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		Pay to provider suffix
NOT USED	08	IDENTIFICATION CODE QUALIFIER		National Provider ID
NOT USED	09	IDENTIFICATION CODE		NPI Number
S	N3	PAY-TO ADDRESS 2010AB		
R	01	Address Information		Pay to provider address
S	02	Address Information		Pay to provider address 2
S	N4	PAY TO ADDRESS 2010AB		
R	01	CITY NAME		Pay to provider city
R	02	STATE		Pay to provider state
R	03	ZIP CODE		Pay to provider zip code
Loop 2000B				
R	HL	SUBSCRIBER HIERARCHICAL LEVEL 2000B		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	04	HIERARCHICAL CHILD CODE	0 or 1	No subordinates or has subordinates
R	SBR	SUBSCRIBER INFORMATION 2000B		
R	01	PAYER RESPONSIBILITY SEQUENCE CODE NUMBER	A - H P, S, T, U	Primary Payer, Secondary Payer If claim is for primary payer then "P" else if claim is for secondary payer then "S".

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S	02	INDIVIDUAL RELATIONSHIP CODE	18	18-Self (required when subscriber is patient)
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME		Group name
S	05	INSURANCE TYPE CODE		Type of policy
NOT USED	06	COORDINATION OF BENEFITS CODE		NOT USED
NOT USED	07	YES/NO CONDITION OR REPOSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR	HM	Health Maintenance Organization
S	PAT	PATIENT INFORMATION 2000B		
NOT USED	01	INDIVIDUAL RELATIONSHIP CODE		NOT USED
NOT USED	02	PATIENT LOCATION CODE		NOT USED
NOT USED	03	EMPLOYMENT STATUS CODE		NOT USED
NOT USED	04	STUDENT STATUS CODE		NOT USED
S	05	DATE QUALIFIER	D8	CCYYMMDD
S	06	DATE TIME PERIOD		Date of death
S	07	UNIT CODE	01	Actual pounds
S	08	PATIENT WEIGHT		Patient weight
S	09	YES/NO CONDITION OR RESPONSE CODE	Y	Pregnancy indicator
Loop 2010BA				
R	NM1	SUBSCRIBER SECONDARY IDENTIFICATION 2010BA		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Subscriber last name
S	04	NAME FIRST		Subscriber first name
S	05	NAME MIDDLE		Subscriber middle name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Subscriber suffix
R	08	IDENTIFICATION CODE QUALIFIER	II, MI	Member Identification number
R	09	IDENTIFICATION CODE		MVP subscriber member number

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S	N3	SUBSCRIBER ADDRESS 2010BA		
R	01	ADDRESS INFORMATION		Subscriber address
S	02	ADDRESS INFORMATION		Subscriber address 2
S	N4	SUBSCRIBER ADDRESS 2010BA		
R	01	CITY NAME		Subscriber City
R	02	STATE		Subscriber State
R	03	POSTAL CODE		Subscriber Zip code
S	DMG	SUBSCRIBER DEMOGRAPHIC INFORMATION 2010BA		
R	01	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	02	DATE TIME PERIOD		Subscriber date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
Loop 2010BB				
R	NM1	PAYER NAME		
R	01	ENTITY IDENTIFIER CODE	PR	Payer
R	02	ENTITY TYPE DESCRIPTION	2	Non-Person Entity
R	03	NAME LAST OR ORGANIZATION	MVP Health Plan	Payer Name
NOTUSED	04	NAME FIRST		NOTUSED
NOTUSED	05	NAME MIDDLE		NOTUSED
NOTUSED	06	NAME PREFIX		NOTUSED
NOTUSED	07	NAME SUFFIX		NOTUSED
R	08	IDENTIFICATION CODE QUALIFER	XV, PI	Payer Identification PI Prior to mandated Plan ID
R	09	IDENTIFICATION CODE NUMBER	141650868	MVP Health Care's Tax Identification Number
S	N3	PAYER ADDRESS 2010BB		
R	01	ADDRESS INFORMATION		PAYER ADDRESS LINE
S	02	ADDRESS INFORMATION		PAYER ADDRESS LINE

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R	N4	PAYER CITY, STATE, ZIP CODE		
R	01	CITY NAME	FREEFORM	PAYER CITY NAME
S	02	STATE OR PROVINCE CODE		PAYER STATE OR PROVINCE CODE
S	03	POSTAL CODE		PAYER POSTAL ZONE OR ZIP CODE
S	04	COUNTRY CODE		

LOOP 2300				
R	CLM	CLAIM INFORMATION 2300		
R	01	CLAIM SUBMITTER'S IDENTIFIER		Patient account number
R	02	MONETARY AMOUNT		Total charges (must equal sum of the SV102's)
NOT USED	03	CLAIM FILING INDICATOR CODE		NOT USED
NOT USED	04	NON-INSTITUTIONAL CLAIM TYPE CODE		NOT USED
R	05	HEALTH CARE SERVICE LOCATION		Place of service
R	05-1	FACILITY CODE VALUE		Facility code
R	05-2	FACILITY CODE QUALIFIER	B	Place of service Codes for Professional or Dental Services
R	05-3	CLAIM FREQUENCY TYPE	1-5-7-8	Original-claim frequency
R	06	RESPONSE CODE	Y or N	Provider signature on file
R	07	PROVIDER ACCEPT ASSIGN	A, B, C	Provider accept Medicare assignment code
R	08	RESPONSE CODE	W	Assign of benefits indicator
R	09	RELEASE OF INFORMATION	I, Y,W	Release of information
S	10	PATIENT SIGNATURE SOURCE CODE	P	Patient signature on file
S	11	RELATED CAUSES INFORMATION		Related causes
R	11 - 1	RELATED CAUSES CODE	AA, EM, OA	Auto Accident, Employment, Other Accident
S	11 - 2	RELATED CAUSES CODE	AA, EM, OA	Used if more than 1 applies
NOT USED	11 - 3	RELATED CAUSES CODE	AA, EM, OA	NOT USED
S	11 - 4	STATE		State where accident occurred
S	11 - 5	COUNTRY		Country where accident occurred

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S	12	SPECIAL PROGRAM CODE		Special circumstances
NOT USED	13	YES/NO CONDITION OR RESPONSE CODE		NOTUSED
NOT USED	14	LEVEL OF SERVICE CODE		NOT USED
NOT USED	15	YES/NO CONDITION OR RESPONSE CODE		NOT USED
S	16	PROVIDER AGREEMENT CODE		P-Participation agreement
NOT USED	17	CLAIM STATUS CODE		NOTUSED
NOT USED	18	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	19	CLAIM SUBMISSION REASON CODE		NOT USED
S	20	DELAY REASON CODE		Delay reason code
S	DTP	DATE ONSET OF CURRENT ILLNESS OR SYMPTOM		
R	01	DATE/TIME QUALIFIER	431	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE/TIME PERIOD		
S	DTP	DATE - INITIAL TREATMENT DATE 2300		
R	01	DATE/TIME QUALIFIER	454	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE TIME PERIOD		INITIAL TREATMENT DATE
R	DTP	DATE - LAST SEEN DATE 2300		
R	01	DATE/TIME QUALIFIER	304	
R	02	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	03	DATE TIME PERIOD		
S	DTP	DATE OF ACCIDENT 2300		
R	01	DATE QUALIFIER	439	Accident date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE OF CURRENT		Accident Date
S	DTP	DATE LAST WORKED 2300		

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R	01	DATE QUALIFIER	297	Date last worked
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE OF CURRENT		Date Last Worked
S	DTP	DATE AUTHORIZED RETURN TO WORK 2300		
R	01	DATE QUALIFIER	296	Authorized return to work date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE TO RETURN TO WORK		Date Authorized return to work
S	DTP	DATE OF ADMISSION 2300		
R	01	DATE QUALIFIER	435	Admission date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE ADMISSION		Date of Admission
S	DTP	DATE OF DISCHARGE 2300		
R	01	DATE QUALIFIER	096	Discharge date
R	02	DATE FORMAT	D8	Date format: CCYYMMDD
R	03	DATE DISCHARGE		Date of Discharge
S	PWK	CLAIM SUPPLEMENTAL INFORMATION 2300		
	01	REPORT TYPE C ODE		
R	02	REPORT TRANSMISSION CODE	AA, BM, EL, EM, FT, FX	Code defining timing, transmission method or format
NOT USED	03	REPORT COPIES NEEDED		NOT USED
NOT USED	04	ENTITY IDENTIFIER CODE		NOT USED
S	05	IDENTIFICATION CODE QUALIFIER	AC	Required when PWK02=BM, EL, EM, FX, OR FT
S	06	IDENTIFICATION CODE		
S	AMT	PATIENT AMOUNT PAID 2300		
R	01	AMOUNT QUALIFIER	F5	Patient amount paid
R	02	MONETARY AMOUNT		Amount Paid

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S	REF	SERVICE AUTHORIZATION EXCEPTION CODE 2300		
R	01	REFERENCE IDENTIFICATION QUALIFIER	4N	Special Payment Reference Number
R	02	REFERENCE IDENTIFICATION	1, 2, 3, 4, 5, 6, 7,	Service Authorization Exception Code
S	REF	REFERRAL NUMBER 2300		**Required when Referring Provider is sent (REF*DN)
R	01	REFERENCE IDENTIFICATION QUALIFIER	9F	Referral number qualifier
R	02	REFERENCE IDENTIFICATION		Referral number
S	REF	PRIOR AUTHORIZATION 2300		Required when services on this claim were preauthorized
R	01	REFERENCE IDENTIFICATION QUALIFIER	G1	Prior Authorization qualifier
R	02	PRIOR AUTHORIZATION NUMBER		Prior Authorization number
S	REF	PAYER CLAIM CONTROL NUMBER 2300		(Required when CLM05-03 indicates replacement or void
R	01	REFERENCE IDENTIFICATION QUALIFIER	F8	to a previously adjudicated claim)
R	02	REFERENCE IDENTIFICATION		Original claim number
S	REF	CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA)		Facilities performing CLIA covered Laboratory services
R	01	REFERENCE IDENTIFICATION QUALIFIER	X4	
R	02	REFERENCE IDENTIFICATION		Clinical Laboratory Improvement Amendment Number
S	REF	MEDICAL RECORD NUMBER 2300		ACTUAL MEDICAL RECORD OF THE PATIENT
R	01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical record qualifier
R	02	MEDICAL RECORD NUMBER		Medical record number
S	NTE	CLAIM NOTE 2300		
R	01	REFERENCE CODE	ADD, CER, DCP, DGN, TPO	Note reference code
R	02	MESSAGE		Free form data-Additional information
S	CR1	AMBULANCE TRANSPORT INFORMATION 2300		

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S	101	UNIT OR BASIS FOR MEASUREMENT CODE	LB	USED WHEN JUSTIFYING MEDICAL NECESSITY
S	102	WEIGHT		MEASURES LEVEL OF AMBULANCE SERVICES
NOT USED	103	AMBULANCE TRANSPORT CODE		NOT USED
R	104	AMBULANCE TRANSPORT REASON CODE	A, B, C, D, E	Ambulance transport reason code
R	105	UNITS OR BASIS FOR MEASUREMENT CODE	DH	MILES
R	106	QUANTITY		NUMBER OF MILES - TRANSPORT DISTANCE
NOT USED	107	ADDRESS INFORMATION		NOT USED
NOT USED	108	ADDRESS INFORMATION		NOT USED
S	109	DESCRIPTION	FREEFORM	REQUIRED WHEN AMB SERVICE FOR ROUND TRIP
S	110	DESCRIPTION	FREEFORM	TO JUSTIFY USAGE OF STRETCHER
2300				
S	HI	HEALTH CARE DIAGNOSIS CODE 2300		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BK	Principal diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BF	Diagnosis ICD-9 codes
R	02-2	INDUSTRY CODE		Diagnosis code
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BF	Diagnosis ICD-9 codes
R	03-2	INDUSTRY CODE		Diagnosis code
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BF	Diagnosis ICD-9 codes
R	04-2	INDUSTRY CODE		DIAGNOSIS CODE
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BF	DIAGNOSIS ICD-9 CODES
R	05-2	INDUSTRY CODE		DIAGNOSIS CODE
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BF	DIAGNOSIS ICD-9 CODES
R	06-2	INDUSTRY CODE		DIAGNOSIS CODE

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S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BF	DIAGNOSIS ICD-9 CODES
R	07-2	INDUSTRY CODE		DIAGNOSIS CODE
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BF	DIAGNOSIS ICD-9 CODES
R	08-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H109	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER CODE	BF	DIAGNOSIS ICD-9 CODES
R	09-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H110	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER CODE	BF	DIAGNOSIS ICD-9 CODES
R	10-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H111	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER CODE	BF	DIAGNOSIS ICD-9 CODES
R	11-2	INDUSTRY CODE		DIAGNOSIS CODE
S	H112	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER CODE	BF	DIAGNOSIS ICD-9 CODES
R	12-2	INDUSTRY CODE		DIAGNOSIS CODE

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Loop 2310A				
S	NM1	REFERRING PROVIDER NAME 2310A		
R	01	ENTITY IDENTIFIER CODE	DN	Referring provider
R	02	ENTITY TYPE	1	MUST BE A PERSON
R	03	LAST NAME		Referring physician last name
S	04	FIRST NAME		Referring physician first name
S	05	NAME MIDDLE		Referring physician middle initial
S	07	NAME SUFFIX		Referring physician suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
Loop 2310B				
S	NM1	RENDERING PROVIDER NAME		
R	01	ENTITY IDENTIFIER CODE	82	Rendering provider
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Rendering provider last name
S	04	NAME FIRST		Rendering provider first name
S	05	NAME MIDDLE		Rendering provider middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
S	PRV	RENDERING PROVIDER SPECIALTY		
R	01	PROVIDER CODE	RE	Provider Code
R	02	REFERENCE IDENTIFICATION QUALIFER	PXC	Mutually Defined
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code - Required if the provider has more then one specialty.
2310C				
R	NM1	SERVICE FACILITY LOCATION 2310C		

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R	01	ENTITY IDENTIFIER CODE	77	77-Service location
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity
S	03	NAME LAST OR ORGANIZATION NAME		Laboratory/facility name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
Loop 2320				
S	SBR	OTHER SUBSCRIBER INFORMATION 2320		
R	01	PAYER RESPONSIBILITY SEQUENCE NUMBER	P, S	If claim is for secondary payer then this should equal "P" for Primary Payer else "S" for Secondary Payer
R	02	INDIVIDUAL RELATIONSHIP CODE		Individual Relationship Code
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME	FREEFORM	Group or plan name
R	05	INSURANCE TYPE CODE		Required when Medicare is other payer but not primary
NOT USED	06	COORDINATION OF BENEFITS		NOT USED
NOT USED	07	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR CODE	WC, MB, MA, HM	Workers' Compensation Health Claim, Medicare Part B, Medicare Part A, Health maintenance organization
S	CAS	LINE ADJUDICATION INFORMATION		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.

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R	02	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	04	QUANTITY		Adjusted Units - Claim Level
S	05	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	07	QUANTITY		Adjusted Units - Claim Level
S	08	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	10	QUANTITY		Adjusted Units - Claim Level
S	11	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	12	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	13	QUANTITY		Adjusted Units - Claim Level
S	14	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	16	QUANTITY		Adjusted Units - Claim Level
S	17	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	19	QUANTITY		Adjusted Units - Claim Level
S	AMT	COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT 2320		
R	01	AMOUNT QUALIFIER	D	Payer amount paid
R	02	MONETARY AMOUNT		Amount Paid
LOOP 2320				
S	AMT	COORDINATION OF BENEFITS (COB TOTAL NON-COVERED AMOUNT 2320		

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NOT USED	01	AMOUNT QUALIFIER CODE		
NOT USED	02	MONETARY AMOUNT		NON COVERED AMOUNT
R	OI	Other Insurance Coverage Information		
NOT USED	01	CLAIM FILING INDICATOR CODE		NOT USED
NOT USED	02	CLAIM SUBMISSION REASON CODE		NOT USED
R	03	YES/NO CONDITION REPOSE	Y, N, W	Assignment of Benefits Indicator
S	04	PATIENT SIGNATURE SOURCE CODE	B, C, M, P, S	Patient Signature Source Code
NOT USED	05	PROVIDER AGREEMENT CODE		NOT USED
R	06	RELEASE OF INFORMATION CODE	I, Y	Release of Information Code
S	MOA	OUTPATIENT ADJUDICATION INFORMATION 2320		*****
S	01	PERCENTAGE AS DECIMAL		REIMBURSEMENT RATE
S	02	MONETARY AMOUNT		REQUIRED WHEN RETURNED IN TNE REMITTANCE
S	03 - 07	REFERENCE IDENTIFICATION		ADVICE
S	08 - 09	MONETARY AMOUNT		*****
S	NM1	OTHER SUBSCRIBER NAME 2330A		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		SUBSCRIBER LAST NAME
S	04	NAME FIRST		SUBSCRIBER FIRST NAME
S	05	NAME MIDDLE		SUBSCRIBER MIDDLE NAME
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		SUBSCRIBER SUFFIX
R	08	IDENTIFICATION CODE QUALIFIER	MI	MEMBER IDENTIFICATION
R	09	IDENTIFICATION CODE		SUBSCRIBER IDENTIFCATION NUMBER
Loop 2330B				
S	NM1	OTHER PAYER NAME 2330B		
R	01	ENTITY IDENTIFIER CODE	PR	PAYER

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R	02	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	03	ORGANIZATION NAME		OTHER PAYER ORGANIZATION NAME
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	PAYER IDENTIFICATION
R	09	IDENTIFICATION CODE		PAYER IDENTIFICATION NUMBER
Loop 2330C				
S	NM1	OTHER PAYER PATIENT INFORMATION 2330C		
R	01	ENTITY IDENTIFIER CODE	QC	PATIENT
R	02	ENTITY TYPE QUALIFIER	1	PERSON
R	03	ORGANIZATION NAME/LAST NAME		OTHER PAYER NAME
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	MI	MEMBER IDENTIFICATION
R	09	IDENTIFICATION CODE		OTHER INSURANCE MEMBER NUMBER
Loop 2400				
R	LX	SERVICE LINE NUMBER 2400		
R	01	ASSIGNED NUMBER		Line counter
Loop 2400				
R	SV1	PROFESSIONAL SERVICE 2400		
R	01-1	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	ER, HC, IV, WK	HC-HCPCS codes,
R	01-2	PRODUCT/SERVICE ID		Procedure Code
S	01-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	01-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	01-5	PROCEDURE MODIFIER		Procedure Modifier 3

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S	01-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	01-7	DESCRIPTION	FREEFORM	DEFINITIVE DESCRIPTION OF PROCEDURE CODE
NOT USED	01-08	PRODUCT/ SERVICE ID		Line item charge amount
R	SV102	MONETARY AMOUNT		"0" ZERO IS AN ACCEPTABLE VALUE
R	SV103	MINUTES (ANESTHESIA)	MJ	MINUTES - Effective 7/1/2010
R	SV104	QUANTITY		MINUTES
S	05	FACILITY CODE VALUE		Place of service
NOT USED	06	SERVICE TYPE CODE		NOT USED
R	07	DIAGNOSIS CODE POINTER		
R	07-1	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-2	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-3	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
S	07-4	DIAGNOSIS CODE POINTER		Diagnosis Code Pointer
NOT USED	08	MONETARY AMOUNT		NOT USED
S	09	YES/NO INDICATOR	Y	Emergency indicator
NOT USED	10	MULTIPLE PROCEDURE CODE		NOT USED
S	11	YES/NO CONDITION OR RESPONSE CODE	Y	Y=EPSDT-MEDICAID SCREENING FOR CHILDREN
S	12	YES/NO CONDITION OR RESPONSE CODE	Y	
NOT USED	13	REVIEW CODE		NOT USED
NOT USED	14	NATIONAL OR LOCAL ASSIGNED REVIEW VALUE		NOT USED
S	15	COPAY STATUS CODE	0	COPAY EXEMPT
S	SV5	DURABLE MEDICAL EQUIPMENT 2400		
R	01	COMPOSITE MEDICAL PROCEDURE		TO IDENTIFY A MEDICAL PROCEDURE
R	01-1	PRODUCT/SERVICE ID QUALIFIER	HC	HCPCS CODES -
R	01-2	PRODUCT/SERVICE ID		PROCEDURE CODE-VALUE MUST EQUAL SV101-2
R	02	UNITS OR BASIS FOR MEASUREMENT CODE	DA	DAYS
R	03	QUANTITY		LENGTH OF MEDICAL NECESSITY
R	04	MONETARY AMOUNT		DME RENTAL PRICE
R	05	MONETARY AMOUNT		DME PURCHASE PRICE

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R	06	FREQUENCY CODE	1, 4, 6	FREQUENCY AT WHICH RENTAL IS BILLED(W-M-D)
S	PWK	PWK - LINE SUPPLEMENTAL INFORMATION		
R	01	REPORT CODE TYPE		TITLE OF SUPPORTING DOCUMENTATION REPORT
R	02	REPORT TRANSMISSION CODE	AA, BM, EL, EM, FT, FX	METHOD OR FORMAT OF TRANSMSSION
NOT USED	03 - 04			NOT USED
S	05	IDENTIFICATION CODE QUALIFIER	AC	
S	06	IDENTIFICATION CODE		ATTACHMENT CONTROL NUMBER
R	DTP	DATE- SERVICE DATE		
R	01	DATE/TIME QUALIFIER	472	SERVICE DATE QUALIFIER
R	02	DATE/TIME FORMAT	RD8	Date Time Period Format Qualifier
R	03	DATE/TIME PERIOD	CCYYMMDD-CCYYMMDD	SERVICE DATE
Loop 2420A				
S	NM1	RENDERING PROVIDER NAME		
R	01	ENTITY IDENTIFIER CODE	82	RENDERING
R	02	ENTITY TYPE QUALIFIER	1	PERSON
R	03	NAME LAST		RENDERING PROVIDER LAST NAME
S	04	NAME FIRST		RENDERING PROVIDER FIRST NAME
S	05	NAME MIDDLE		RENDERING PROVIDER MIDDLE INITIAL
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		RENDERING PROVIDER SUFFIX
R	08	IDENTIFICATION CODE QUALIFIER	XX	NATIONAL PROVIDER ID
R	09	IDENTIFICATION CODE		NPI NUMBER
Loop 2430				
S	SVD	LINE ADJUDICATION INFORMATION 2430		
R	01	IDENTIFICATION CODE		Other Payer Primary Identifier. This number should match NM109 in Loop ID-2330B identifying Other Payer.

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R	02	MONETARY AMOUNT		Service Line Paid Amount. Zero "0" is an acceptable value for this element.
R	03	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		
R	03-1	PRODUCT/SERVICE ID QUALIFIER	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
S	03-2	PRODUCT/SERVICE ID		Procedure Code
S	03-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	03-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	03-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	03-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	03-7	DESCRIPTION		Procedure Code Description
NOT USED	04	PRODUCT/SERVICE ID		NOT USED
R	05	QUANTITY		Paid Service Unit Count
S	06	ASSIGNED NUMBER		Bundled or Unbundled Line Number
S	CAS	LINE ADJUDICATION INFORMATION 2430		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount - Line Level
S	04	QUANTITY		Adjusted Units - Line Level
S	05	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount - Line Level
S	07	QUANTITY		Adjusted Units - Line Level
S	08	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount - Line Level
S	10	QUANTITY		Adjusted Units - Line Level
S	11	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code

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S	12	MONETARY AMOUNT		Adjusted Amount - Line Level
S	13	QUANTITY		Adjusted Units - Line Level
S	14	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount - Line Level
S	16	QUANTITY		Adjusted Units - Line Level
S	17	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount - Line Level
S	19	QUANTITY		Adjusted Units - Line Level
S	DTP	LINE Check or Remittance Date		
R	01	DATE/TIME QUALIFIER	573	Date Claim Paid
R	02	DATE/TIME FORMAT	D8	Date Time Period Format Qualifier
R	03	DATE/TIME PERIOD	CCYYMMDD	Adjudication or Payment Date
R	SE	TRANSACTION SET TRAILER		
R	01	NUMBER OF INCLUDED SEGMENTS		Segment count
R	02	TRANSACTION SET CONTROL NUMBER		Unique number assigned by originator/must match ST 02
R	GE	FUNCTIONAL GROUP TRAILER		
R	01	NUMBER OF TRANSACTION SETS INCLUDED		Total number of transaction sets
R	02	GROUP CONTROL NUMBER		Assigned by sender
R	IEA	INTERCHANGE CONTROL TRAILER		
R	01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Number of groups in the interchange
R	02	INTERCHANGE CONTROL NUMBER	Assigned by sender	Must match ISA13

MVP Requirements for the ANSI 277CA Transaction - Health Care Claim Acknowledgment

Required	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	ISA	INTERCHANGE CONTROL HEADER		
R	01	AUTHORIZATION INFORMATION QUALIFIER	00	NO AUTHORIZATION INFORMATION PRESENT
R	02	AUTHORIZATION INFORMATION		BLANK
R	03	SECURITY INFORMATION	00	NO SECURITY INFORMATION PRESENT
R	04	SECURITY INFORMATION		BLANK
R	05	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	06	INTERCHANGE SENDER ID	141650868	SENDER TAX ID
R	07	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	08	INTERCHANGE RECEIVER ID		RECEIVER TAX ID
R	09	INTERCHANGE DATE	YYMMDD	DATE OF INTERCHANGE
R	10	INTERCHANGE TIME	HHMM	TIME OF INTERCHANGE
R	11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	US EDI COMMUNITY OF ASC X12
R	12	INTERCHANGE CONTROL VERSION NUMBER	00501	VERSION NUMBER
R	13	INTERCHANGE CONTROL NUMBER		ASSIGNED BY SENDER, MUST MATCH IEA02
R	14	ACKNOWLEDGEMENT REQUESTED	0	NO ACKNOWLEDGEMENT REQUESTED
R	15	USAGE INDICATOR	P OR T	PRODUCTION OR TEST
R	16	COMPONENT ELEMENT SEPARATOR	:	COMPOSITE DELIMITER
R	GS	FUNCTIONAL GROUP HEADER		
R	01	FUNCTIONAL IDENTIFIER CODE	HN	HEALTH CARE CLAIM STATUS NOTIFICATION
R	02	APPLICATION SENDER'S CODE	141650868	MVP HEALTH PLAN
R	03	APPLICATION RECEIVER'S CODE		CODE FOR RECEIVER
R	04	DATE	CCYYMMDD	FUNCTIONAL GROUP CREATION DATE
R	05	TIME	HHMM	CREATION TIME
R	06	GROUP CONTROL NUMBER		MUST MATCH GE02- ASSIGNED BY SENDER

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R	07	RESPONSIBLE AGENCY CODE	X	ACCREDITED STANDARDS COMMITTEE X12
R	08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	005010X214	VERSION CODE
R	ST	TRANSACTION SET HEADER		
R	01	TRANSACTION SET IDENTIFIER CODE	277	HEALTH CARE CLAIM STATUS NOTIFICATION
R	02	TRANSACTION SET CONTROL NUMBER		MUST MATCH SE CONTROL NUMBER
R	03	IMPLEMENTATION CONVENTIONAL REFERENCE	005010X214	REFERENCE CODE
R	BHT	BEGINNING OF HIERARCHICAL TRANSACTION		
R	01	HIERARCHICAL STRUCTURE CODE	0010	INFORMATION SOURCE
R	02	TRANSACTION SET PURPOSE CODE	08	STATUS
R	03	REFERENCE IDENTIFICATION		NUMBER USED TO IDENTIFY TRANSACTION
R	04	DATE	CCYYMMDD	TRANSACTION SET CREATION DATE
R	05	TIME	HHMMSS	TIME
R	06	TRANSACTION TYPE CODE	TH	ACKNOWLEDGEMENT ADVICE
	2000A			
R	HL	HIERARCHICAL LEVEL 2000A - INFO SENDER LEVEL		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY THE SENDER
NOT USED	02	HIERARCHICAL PARENT ID NUMBER		NOTE USED
R	03	HIERARCHICAL LEVEL CODE	20	INFORMATION SOURCE
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUB HL DATA SEGMENT IN HIER STRUCTURE
	2100A			
R	NM1	PAYER NAME 2100A		
R	01	ENTITY IDENTIFIER CODE	PR	PAYER
R	02	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	03	ORGANIZATION NAME	MVP HEALTH CARE	PAYER NAME
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED

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NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	MVP ID
R	09	IDENTIFICATION CODE	141650868	MVP's TAX ID
	2200A			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200A		
R	01	TRACE TYPE CODE	1	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		MVP HEALTH CARE EXTERNAL CORE SYSTEM NUMBER.
R	DTP	CLAIM SERVICE DATE 2200A		
R	01	DATE/TIME QUALIFIER	050	CLAIM RECIEPT DATE
R	02	DATE PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM RECEIPT DATE
S	DTP	CLAIM SERVICE DATE 2200A		
R	01	DATE/TIME QUALIFIER	009	CLAIM PROCESS DATE
R	02	DATE PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM PROCESS DATE
	2000B			
R	HL	HIERARCHICAL LEVEL 2000B - INFO RECEIVER LEVEL		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		ID NUMBER OF NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	21	INFORMATION RECEIVER
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL
	2100B			
R	NM1	INFORMATION RECEIVER NAME 2100B		
R	01	ENTITY IDENTIFIER CODE	41	SUBMITTER
R	02	ENTITY TYPE QUALIFIER	1, 2	PERSON, NON-PERSON

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R	03	ORGANIZATION NAME		LAST NAME, ORGANIZATION NAME
S	04	NAME FIRST		FIRST NAME
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	FI	FEDERAL TAX ID
R	09	IDENTIFICATION CODE		VENDOR TAX ID
	2200B			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200B		
R	01	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		VALUE OF THE BHT03 DATA ELEMENT FROM THE SUBMITTED 837 CLAIM FILE
	2000C			
R	HL	HIERARCHICAL LEVEL 2000C - SERVICE PROVIDER LEVEL		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		NUMBER OF NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	19	PROVIDER OF SERVICE
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	2100C			
R	NM1	PROVIDER NAME 2100C		
R	01	ENTITY IDENTIFIER CODE	1P	RENDERING PROVIDER
R	02	ENTITY TYPE QUALIFIER	1,2	PERSON, ORGANIZATION
R	03	NAME LAST		LAST NAME, ORGANIZATION NAME
S	04	NAME FIRST		FIRST NAME
S	05	NAME MIDDLE		MIDDLE INITIAL
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	XX	Nation Provider ID
R	09	IDENTIFICATION CODE		NPI Number.

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	2000D			
M	HL	HIERARCHICAL LEVEL 2000D-PATIENT LEVEL		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		NUMBER OF THE NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	PT	PATIENT
R	04	HIERARCHICAL CHILD CODE	0	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	2100D			
R	NM1	PATIENT NAME 2100D		
R	01	ENTITY IDENTIFIER CODE	QC	PATIENT
R	02	ENTITY QUALIFIER	1	PERSON
R	03	NAME LAST		PATIENT LAST NAME
S	04	NAME FIRST		PATIENT FIRST NAME
S	05	NAME MIDDLE		PATIENT MIDDLE INITIAL
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
S	08	IDENTIFICATION CODE QUALIFIER	MI	PATIENT IDENTIFICATION
S	09	IDENTIFICATION CODE		MVP MEMBER ID NUMBER
	2200D			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200D		
R	01	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		PATIENT ACCOUNT NUMBER
R	STC	CLAIM LEVEL STATUS 2200D		
R	01	HEALTH CARE CLAIM STATUS		
				ANSI CATEGORY CODE FROM CODE SOURCE 507
R	01-1	INDUSTRY CODE		Note: For a reference to MVP used codes see codes identified during the introduction of this document.
R	01-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 Note: For a reference to MVP used codes see codes

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				identified during the introduction of this document.
S	01-3	ENTITY IDENTIFIER CODE		NOT USED
R	01-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
R	02	DATE		EFFECTIVE DATE
R	03	ACTION CODE	WQ	THE WQ INDICATES THAT IT IS NECESSARY TO REVIEW INFORMATION IN THE 2200D LOOP FOR INFORMATION ON THE STATUS OF INDIVIDUAL CLAIMS.
R	04	MONETARY AMOUNT		TOTAL CLAIM CHARGES
NOT USED	05	MONETARY AMOUNT		NOT USED
NOT USED	06	DATE		NOT USED
NOT USED	07	PAYMENT METHOD CODE		NOT USED
NOT USED	08	DATE		NOT USED
NOT USED	09	CHECK NUMBER		NOT USED
S	10	HEALTH CARE CLAIM STATUS		ANSI CATEGORY CODE FROM CODE SOURCE 507
R	10-1	INDUSTRY CODE		Note: For a reference to MVP used codes see codes identified during the introduction of this document.
R	10-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 Note: For a reference to MVP used codes see codes identified during the introduction of this document.
NOT USED	10-3	ENTITY IDENTIFIER CODE		NOT USED
R	10-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
S	11	HEALTH CARE CLAIM STATUS		ANSI CATEGORY CODE FROM CODE SOURCE 507
R	11-1	INDUSTRY CODE		Note: For a reference to MVP used codes see codes identified during the introduction of this document.
R	11-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 Note: For a reference to MVP used codes see codes identified during the introduction of this document.
NOT USED	11-3	ENTITY IDENTIFIER CODE		NOT USED
S	11-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
S	12	FREE FORM MESSAGE TEXT		DESCRIPTION

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S	REF	PAYER CLAIM IDENTIFICATION NUMBER 2200D		
R	01	REFERENCE IDENTIFICATION QUALIFIER	1K	PAYER'S CLAIM NUMBER
R	02	REFERENCE IDENTIFICATION		MVP HEALTH CARE'S EXTERNAL SYSTEM REFERENCE NUMBER. Note: This is not the same as the claim number used for payment.
S	REF	PAYER CLAIM IDENTIFICATION NUMBER 2200D		
R	01	REFERENCE IDENTIFICATION QUALIFIER	D9	SUBMITTER'S NUMBER
R	02	REFERENCE IDENTIFICATION		IDENTIFIER THAT WAS SUBMITTED BY THE TRADING PARTNER IN THE REF*D9 OF THE 837 CLAIM BEING ACKNOWLEDGED.
S	DTP	CLAIM SERVICE DATE 2200D		
R	01	DATE/TIME QUALIFIER	232	CLAIM STATEMENT PERIOD START
R	02	DATE PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD - CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM SERVICE PERIOD
R	SE	TRANSACTION SET TRAILER		
R	01	NUMBER OF INCLUDED SEGMENTS		TOTAL NUM OF SEGMENTS
R	02	TRANSACTION SET CONTROL NUMBER		MUST BE IDENTICAL TO ST02
R	GE	FUNCTIONAL GROUP TRAILER		
R	01	NUMBER OF TRANSACTION SETS INCLUDED		Number of GS segments
R	02	GROUP CONTROL NUMBER		ASSIGNED BY SENDER
R	IEA	INTERCHANGE CONTROL TRAILER		
R	01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Number of GS segments
R	02	INTERCHANGE CONTROL NUMBER		ASSIGNED BY SENDER/MUST MATCH ISA13