Companion Document

837P

837 Professional Health Care Claim

This companion document is for informational purposes only to describe certain aspects and expectations regarding the transaction and is not a complete guide. The details contained in this document are supplemental and should be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) as published by the Washington Publishing Company.

Section 1 – 837P Professional Health Care Claim: Basic Instructions

Section 2 – 837P Professional Health Care Claim: Enveloping

Section 3 – 837P Professional Health Care Claim: Charts for Situational Rules

Any questions?

Contact E-Solutions
www.empireblue.com/edi, LiveChat

Section 1 - Basic Instructions

1.1 X12 and HIPAA Compliance Checking, and Business Edits

EDI interchanges submitted to Empire for processing pass through compliance edits. 5010 acknowledgments and reports for accepted/rejected files will be placed in the submitter's trading partner mailbox for pickup. *E-Solutions Representative will review these reports thoroughly with submitters.

- TA1 Interchange Acknowledgment. Empire returns TA1 X12 and proprietary reports to the submitter of inbound 837 files containing envelope errors in the ISA and GS segments.
- Level 1. Empire returns a 999 Interchange Acknowledgment to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If the X12 syntax or any other aspect of the 837 is not X12 compliant, the 999 will also report the Level 1 errors in AK segments and indicate that the entire transaction set has been rejected.
- Level 2. In addition to HIPAA TR3 edits, Empire applies business edits, such as member validation to each 837 transaction. These business edits ensure that the necessary information is populated and complete for efficient processing. When encountering HIPAA compliance (including balancing), code set or business errors, Empire returns: 1) 277 Claims Acknowledgement (CA) and 2) 864 Level 2 Status Report to the submitter identifying which claim(s) have failed.

1.2 HIPAA Compliant Codes

Use HIPAA-compliant codes from current versions of the following:

- Physician's Current Procedure Terminology (CPT)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- International Classification of Diseases Clinical Mod (ICD-10-CM) Diseases
- Provider Taxonomy Codes
- National Drug Code

1.3 Diagnosis Codes

According to the 837P TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, Empire will return a 999 to the submitter indicating that the transaction has been rejected.

1.4 Procedure Codes and Modifiers

All valid CPT and HCPCS codes and modifiers are accepted for claim adjudication. Refer to your billing guidelines or provider contract for submission of these codes. If submitted codes are invalid, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.5 Uppercase Letters, Special Characters, and Delimiters

As specified in the TR3, the basic character set includes uppercase letters, digits, space, and other special characters.

- All alpha characters must be submitted in UPPERCASE letters only.

- Suggested delimiters for the transaction are assigned as part of the trading partner set up. E-Solutions Representative will discuss options with trading partners, if applicable.

Inbound Delimiters		
	Suggested Value	
Data Element Separator	*	Asterisk
Sub-Element Separator	:	Colon
Segment Terminator	~	Tilde
Repetition Separator	^	Caret

- To avoid syntax errors, hyphens, parentheses and spaces are not recommended to be used in values for identifiers.

  Examples: Recommended: Zip Code 123456789 Medical Record # 1234567

- Since originally submitted values may be returned on outbound transactions, Empire encourages trading partners to not use the following special characters as part of the value: asterisk (*), less than/greater than signs (<, >), colon (:), and slash (/). This minimizes the risk for a special character to be recognized as a delimiter.

  Example: Provider assigns a Patient Control Number '12*3456789'. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value '12*3456789' may process incorrectly as two separate values '12' and '3456789'.

1.6 Decimal "R" Data Element Types

"R" data element types contain a decimal point; involving monetary amounts, units, visits, weights, and frequency. Empire recommends using decimal points for monetary amounts, and whole numbers for other types of "R" data elements. Except for monetary amounts, if "R" data element type includes a decimal and numbers after the decimal, Empire adjudicates the claim based on the whole number. Numbers after the decimal will not be considered.

1.7 Numeric Values, Monetary Amounts and Units

- Empire pays all claims in US dollars and therefore, accepts monetary amounts in US dollars only. If codes related to foreign currencies are used, then a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.
- Empire recognizes units in whole numbers only.
- If a negative service line charge (SV102) or negative units (SV104) are used, then a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.8 Address Information

- P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.
- The Pay-to Address loop does support P.O. Box / Lock Box addresses. Therefore, if payment is expected to be remitted to a P.O. Box / Lock Box, submit the P.O. Box / Lock Box address.
- Full 9-digit zip codes are required in the Billing Provider and Service Facility Location loops. If 5-digit zip codes are used in these loops, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.9 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between Empire and Medicare or other carriers. Following the Provider-to-Payer-to-Provider model;

- The provider sends the 837 to the primary payer.
- The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider. The 835 includes the claim adjustment reason code and/or remark code for the claim.
- Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops 2320, 2330A-G, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Empire recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

If data elements from previous payer(s) are omitted, Empire will fail the particular claim.

Since 5010 has made changes to COB reporting, Empire strongly encourages in-depth review of TR3 front matter. Empire adjudicates and pays professional services at the line level. Therefore, when Empire has any payment position other then primary, line level payments (SVD02), and line level adjustments (CAS), must be conveyed, when known by the submitter.

1.10 Claim and COB Balancing

For COB claims, balancing is performed at both claim and service line on the payment charges for each payer. If not balanced, a 277CA and an 864 Level 2 Status Report will be returned to the submitter indicating the particular claim has failed.

- Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV102 (Line Item Charge).
- Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments).
- Loop 2400 SV102 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments).

1.11 Sending Unsolicited Attachments to Support a Claim

Loop 2300 PWK segment is required when paper documentation (attachments) supports a claim.

In order to expedite processing of a claim:

- Mail the attachment the same day the claim is submitted
- Do not send a copy of the claim with the attachment
- Do not send unnecessary attachments (i.e., do not send a copy of the member's ID card)
- Include the attachment control # in the upper right hand corner of the supporting documentation

Mailing Address for FEP -

Federal Employee Program
PO Box 3876
Church Street Station
New York, NY 10008

1.12 Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are 10-alphanumeric positions in length. Health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

It is strongly recommended that the taxonomy be populated in PRV segments for all applicable claims that you are filing. Refer to the CMS website for a listing of codes, www.wpc-edi.com/taxonomy.

1.13 Medicaid Reclamation / Subrogation Claims

Situations exist when a Patient who has BCBS as primary and Medicaid as secondary (last payer), indicates to the provider that he has Medicaid insurance only. The service is rendered and the provider bills Medicaid as primary. Medicaid pays the claim as the sole payer ("pays out of turn") and later determines that the patient actually had primary insurance.

In order to reclaim monies, states submit claims to the primary insurance after reconciliation of eligibility files between BCBS and Medicaid. Exempt from NPI, trading partners on behalf of states must submit specific data elements in Loops 2010AA, 2010AC, 2010BB, 2310B, 2310C and 2430 for Medicaid reclamation.

Section 2 - Enveloping

EDI envelopes control and track communications between you and Empire. One envelope may contain many transaction sets grouped into the following:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

837 Professional Health Care Claim–Envelope Specific to Empire NY (TR3, Appendix C)

ISA—Interchange Control Header	
ISA01	00
ISA02	*refer to TR3*
ISA03	00
ISA04	*refer to TR3*
ISA05	ZZ
ISA06	*SENDER ID*
	EDI assigned Left-justified followed by spaces
ISA07	ZZ
ISA08	EMPIRENY
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	*^ (5E)*
ISA12	00501
ISA13	*refer to TR3*
ISA14	1
ISA15	*refer to TR3*
ISA16	*: (3A)*

GS—Functional Group Header	
GS01	HC
GS02	*SENDER ID* EDI assigned Left-justified followed by no zeroes or spaces
GS03	EMPIRENY
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	X
GS08	005010X222A1

GE—Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA—Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*refer to TR3*

NOTE. Critical Batching and Editing Information
****Transactions must be batched in separate functional group by GS03.***
****Unique group control number (GS06) MUST NOT be duplicated within 365 days by Trading Partner ID (GS02); files containing duplicate or previously received group control numbers will be rejected.***

837 Professional Health Care Claim–Envelope Specific to Empire NY Medicaid Reclamation (TR3, Appendix C)

ISA—Interchange Control Header	
ISA01	00
ISA02	*refer to TR3*
ISA03	00
ISA04	*refer to TR3*
ISA05	ZZ
ISA06	*SENDER ID*
	EDI assigned Left-justified followed by spaces
ISA07	ZZ
ISA08	MEDICAIDREC
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	*^ (5E)*
ISA12	00501
ISA13	*refer to TR3*
ISA14	1
ISA15	*refer to TR3*
ISA16	*: (3A)*

GS—Functional Group Header	
GS01	HC
GS02	*SENDER ID* EDI assigned Left-justified followed by no zeroes or spaces
GS03	MEDICAIDRECNY
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	X
GS08	005010X222A1

GE—Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA—Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*refer to TR3*

NOTE. Critical Batching and Editing Information
****Transactions must be batched in separate functional group by GS03.***
****Unique group control number (GS06) MUST NOT be duplicated within 365 days by Trading Partner ID (GS02); files containing duplicate or previously received group control numbers will be rejected.***

Section 3 - Charts for Situational Rules

Listed below are loops, segments, and data elements required for proper adjudication by Empire per the situational rules in the 837P TR3.

837 Professional Health Care Claim

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Empire NY
P.70	**ST** Transaction Set Header	**ST03** Implementation Convention Ref	***005010X222A1***	005010X222A1 - Health Care Claim, Professional
P.71	**BHT** Beginning of Hierarchical Trx	**BHT06** Transaction Type Code	***CH***	CH - Chargeable
			31	required for Medicaid Reclamation
Loop ID 1000A—Submitter Name				
P.74	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI assigned Sender ID. ▪ Equals the value entered in ISA06 and GS02.
P.76	**PER**	*Submitter EDI Contact Information - Refer to TR3*		
Loop ID 1000B—Receiver Name				
P.79	**NM1** Receiver Name	**NM109** Identification Code	***00803***	Code represents Empire Blue Shield.
Loop ID 2000A—Billing Provider Hierarchical Level				
P.81	**HL**	*Billing Provider Hierarchical Level - Refer to TR3*		
P.83	**PRV**	*Billing Provider Specialty Information - Refer to TR3*		
P.84	**CUR** Foreign Currency Information	**CUR02** Currency Code	***USD***	USD - US dollars ▪ Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.87	**NM1**	*Billing Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.91	**N3** Billing Provider Address	**N301** Address Information	***(Billing Provider Address Line)***	(Medicaid Reclamation) Enter the physical address to uniquely identify the provider.Submitting PO Box/Lock Box address will result in claim failure, and return of 277CA and Level 2 Status report.
P.92	**N4**	*Billing Prov City, State, ZIP Code - Refer to TR3*		(Medicaid Reclamation)
P.94	**REF** Billing Provider Tax Identification #	**REF02** Reference Identification	***(Billing Provider Tax Identification #)***	(Medicaid Reclamation)
P.96	**REF**	*Billing Provider UPIN/License Information - Refer to TR3*		
P.98	**PER**	*Billing Provider Contact Information - Refer to TR3*		
Loop ID 2010AB—Pay-To Address Name				
P.101	**NM1**	*Pay-to Address Name- Refer to TR3*		
P.103	**N3** Pay-to Address	**N301** Address Information	***(Pay-to Provider Address Line)***	Enter the address to uniquely identify the provider. If payment expected to be remitted to PO Box/Lock Box, submit in Pay-to loop.
P.104	**N4**	*Pay-To Address City, State, ZIP Code - Refer to TR3*		
Loop ID 2010AC—Pay-To Plan Name				
P.106	**NM1** Pay-to Plan Name	**NM103** Name Last or Organization Name	***(Pay-to Plan Organizational Name)***	(Medicaid Reclamation)
P.108	**N3**	*Pay-to Plan Address - Refer to TR3*		
P.109	**N4**	*Pay-to Plan City, State, ZIP Code - Refer to TR3*		
P.111	**REF**	*Pay-to Plan Secondary Identification - Refer to TR3*		
P.113	**REF** Pay-to Plan Tax Identification #	**REF02** Reference Identification	***(Pay-to Plan Tax Identification #)***	(Medicaid Reclamation)

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2000B—Subscriber Hierarchical Level				
P.114	**HL**	*Subscriber Hierarchical Level - Refer to TR3*		
P.116	**SBR**	*Subscriber Information - Refer to TR3*		
P.119	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010BA—Subscriber Name				
P.121	**NM1** Subscriber Name	**NM109** Identification Code	***Enter the ID Number exactly as it appears on the front of the ID card, WITHOUT suffix or dependent number.***	
			Must be left justified.	
			Do not submit leading spaces.	
			Do not submit all alpha characters.	
			Do not submit embedded spaces or special characters.	
			Subscriber ID body must begin immediately following the alphanumeric prefix. No space after prefix.	
			Do not submit ID body containing all 1's, 2's, 3's, 4's, 5's, 6's, 7's, 8's, 9's, 0's, 123456789, 1234567890 or literals equal to UNKNOWN, UNK, INDIVIDUAL, SELF, or NONE.	
			Do not submit lowercase alpha characters.	
P.124	**N3**	*Subscriber Address - Refer to TR3*		
P.125	**N4**	*Subscriber City, State, ZIP Code - Refer to TR3*		
P.127	**DMG**	*Subscriber Demographic Information - Refer to TR3*		
P.129	**REF**	*Subscriber Secondary Identification - Refer to TR3*		
P.130	**REF**	*Property and Casualty Claim Number - Refer to TR3*		
P.131	**REF**	*Property and Casualty Subscriber Contact Information - Refer to TR3*		
Loop ID 2010BB—Payer Name				
P.133	**NM1** Payer Name	**NM108** ID Code Qualifier	***PI***	PI - Payer Identification
		NM109 Identification Code	***00803***	Code represents Empire Blue Shield.
P.135	**N3**	*Payer Address - Refer to TR3*		
P.136	**N4**	*Payer City, State, ZIP Code - Refer to TR3*		
P.138	**REF**	*Payer Secondary Identification - Refer to TR3*		
P.140	**REF** Billing Provider Secondary Identification	**REF01** Ref ID Qualifier	***G2***	G2 - Provider Commercial Number
		REF02 Reference Identification	***(Billing Provider Secondary ID)***	(Medicaid Reclamation)
Loop ID 2000C—Patient Hierarchical Level				
P.142	**HL**	*Patient Hierarchical Level - Refer to TR3*		
P.144	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010CA—Patient Name				
P.147	**NM1** Patient Name	**NM109** Identification Code	Must be 1) left justified, 2) not contain leading spaces, 3) not contain all alpha characters, 4) not contain embedded spaces or special characters, 5) not contain low values. • No space after prefix; Patient ID body must begin immediately following the alphanumeric prefix. • The ID body must not contain all 1's, 2's, 3's, 4's, 5's, 6's, 7's, 8's, 9's, 0's, 123456789, 1234567890 or literals equal to UNKNOWN, UNK, INDIVIDUAL, SELF, NONE.	
P.149	**N3**	*Patient Address - Refer to TR3*		
P.150	**N4**	*Patient City, State, ZIP Code - Refer to TR3*		
P.152	**DMG**	*Patient Demographic Information - Refer to TR3*		

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2010CA—Patient Name (cont'd)				
P.154	**REF** *Property and Casualty Claim Number - Refer to TR3*			
P.155	**REF** *Property and Casualty Patient Contact Information - Refer to TR3*			
Loop ID 2300—Claim Information				
P.157	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Account Number)***	▪ Maximum of 20 alphanumeric characters. ▪ Value is returned on outbound 835 and other transactions.
		CLM02 Monetary Amount	***(Total Claim Charge Amt)***	Value must equal the sum of submitted service line charges in Loop 2400 SV102.
		CLM05-3 Claim Frequency Type Code	***7, 8***	If '7' (replacement) or '8' (void/cancel) then the first 3 positions of following value must be submitted in Claim or Line Note (Loop 2300, 2400 NTE02).
			CHG Charges (Total or Line); ***DOS*** Date of Service; ***PVN*** Provider Number; ***DIA*** Diagnosis; ***PRC*** Procedure Code; ***POS*** Place of Service; ***UNT*** Units of Service; ***MDF*** Modifier; ***OCA*** Other Carrier Allowance; ***IDC*** ID Number Change; ***DEP*** Dependent Number Change; ***SOA*** Questioning Schedule of Allowance; ***MED*** Medical Necessity Appeal; ***AUT*** Authorization on File Appeal Denial; ***TFD*** Timely Filing Denial - Appeals; ***CDR*** Contractual Denial Review; ***OTH*** Other	
P.164	**DTP** *Date - Onset of Current Illness or Symptom - Refer to TR3*			
P.165	**DTP** *Date - Initial Treatment Date - Refer to TR3*			
P.166	**DTP** *Date - Last Seen Date - Refer to TR3*			
P.168	**DTP** *Date - Accident - Refer to TR3*			
P.169	**DTP** *Date - Last Menstrual Period - Refer to TR3*			
P.170	**DTP** *Date - Last X-ray Date - Refer to TR3*			
P.172	**DTP** *Date - Disability Dates - Refer to TR3*			
P.174	**DTP** *Date - Last Worked - Refer to TR3*			
P.175	**DTP** *Date - Authorized Return to Work - Refer to TR3*			
P.176	**DTP** *Date - Admission - Refer to TR3*			
P.177	**DTP** *Date - Discharge - Refer to TR3*			
P.181	**DTP** *Date - Repricer Received Date - Refer to TR3*			
P.182	**PWK** *Claim Supplemental Information - Refer to TR3*			
P.188	**AMT** *Patient Amount Paid - Refer to TR3*			
P.189	**REF** *Service Authorization Exception Code - Refer to TR3*			
P.193	**REF** *Referral Number - Refer to TR3*			
P.194	**REF** *Prior Authorization - Refer to TR3*			
P.196	**REF** Payer Claim Control Number	**REF01** Ref ID Qualifier	***F8***	F8 - Original Reference Number
		REF02 Reference Identification	***(Claim Original Reference Number)***	Represents the claim # assigned by Empire. Providers should submit the original claim # indicated on the 835 when Loop 2300, CLM05-3 equals values of '7' or '8'.
P.197	**REF** *CLIA Number - Refer to TR3*			
P.199	**REF** *Repriced Claim Number - Refer to TR3*			
P.200	**REF** *Adjusted Repriced Claim Number - Refer to TR3*			
P.202	**REF** Claim ID for Transmission Intermediaries	**REF01** Ref ID Qualifier	***D9***	D9 - Claim Number
		REF02 Reference Identification	***(Value Added Network Trace Number)***	Will be returned on Level 2 Status Report, if submitted.

837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2300—Claim Information (cont'd)				
P.204	**REF**	*Medical Record Number - Refer to TR3*		
P.205	**REF**	*Demonstration Project Identifier - Refer to TR3*		
P.206	**REF**	*Care Plan Oversight - Refer to TR3*		
P.207	**K3**	*File Information - Refer to TR3*		
P.209	**NTE**	*Claim Note - Refer to TR3*		
P.211	**CR1**	*Ambulance Transport Information - Refer to TR3*		
P.216	**CRC**	*Ambulance Certification - Refer to TR3*		
P.219	**CRC**	*Patient Condition Information: Vision - Refer to TR3*		
P.221	**CRC**	*Homebound Indicator - Refer to TR3*		
P.223	**CRC**	*EPSDT Referral - Refer to TR3*		
ICD-10-CM Guide requires diagnosis codes to the highest level of specificity.				
P.226	**HI**	*Health Care Diagnosis Code - Refer to TR3*		
P.239	**HI**	*Anesthesia Related Procedure - Refer to TR3*		
P.242	**HI**	*Condition Information - Refer to TR3*		
P.252	**HCP**	*Claim Pricing/Repricing Information - Refer to TR3*		
Loop ID 2310A—Referring Provider Name				
P.257	**NM1**	*Referring Provider Name - Refer to TR3*		
P.260	**REF**	*Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2310B—Rendering Provider Name				
P.262	**NM1**	*Rendering Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.265	**PRV**	*Rendering Provider Specialty Information - Refer to TR3*		
P.267	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2310C—Service Facility Location Name				
P.269	**NM1**	*Service Facility Location Name - Refer to TR3*		(Medicaid Reclamation)
P.272	**N3**	*Service Facility Location Address - Refer to TR3*		(Medicaid Reclamation)
P.273	**N4**	*Serv Fac Loc City, State, ZIP - Refer to TR3*		(Medicaid Reclamation)
P.275	**REF**	*Service Facility Secondary Identification - Refer to TR3*		
P.277	**PER**	*Service Facility Contact Information - Refer to TR3*		
Loop ID 2310D—Supervising Provider Name				
P.280	**NM1**	*Supervising Provider Name - Refer to TR3*		
P.283	**REF**	*Supervising Provider Secondary Identification - Refer to TR3*		
Loop ID 2310E—Ambulance Pick-Up Location				
P.285	**NM1**	*Ambulance Pick-up Location - Refer to TR3*		
P.287	**N3**	*Ambulance Pick-up Location Address - Refer to TR3*		
P.288	**N4**	*Ambulance Pick-up Location City, State, ZIP Code - Refer to TR3*		
Loop ID 2310F—Ambulance Drop-Off Location				
P.290	**NM1**	*Ambulance Drop-off Location - Refer to TR3*		
P.292	**N3**	*Ambulance Drop-off Location Address - Refer to TR3*		
P.293	**N4**	*Ambulance Drop-off Location City, State, ZIP Code - Refer to TR3*		
Loop ID 2320—Other Subscriber Information				
P.295	**SBR**	*Other Subscriber Information - Refer to TR3*		
P.299	**CAS**	*Claim Level Adjustments - Refer to TR3*		
P.305	**AMT**	*COB Payer Paid Amount - Refer to TR3*		
P.306	**AMT**	*COB Total Non-Covered Amount - Refer to TR3*		
P.307	**AMT**	*Remaining Patient Liability - Refer to TR3*		

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837 Professional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2320—Other Subscriber Information				
P.308	**OI**	*Other Insurance Coverage Information - Refer to TR3*		
P.310	**MOA**	*Outpatient Adjudication Information - Refer to TR3*		
Loop ID 2330A—Other Subscriber Name				
P.313	**NM1**	*Other Subscriber Name - Refer to TR3*		
P.316	**N3**	*Other Subscriber Address - Refer to TR3*		
P.317	**N4**	*Other Subscriber City, State, ZIP Code - Refer to TR3*		
P.319	**REF**	*Other Subscriber Secondary Identification - Refer to TR3*		
Loop ID 2330B—Other Payer Name				
P.320	**NM1**	*Other Payer Name - Refer to TR3*		
P.322	**N3**	*Other Payer Address - Refer to TR3*		
P.323	**N4**	*Other Payer City, State, ZIP Code - Refer to TR3*		
P.325	**DTP**	*Claim Check or Remittance Date - Refer to TR3*		
P.326	**REF**	*Other Payer Secondary Identifier - Refer to TR3*		
P.328	**REF**	*Other Payer Prior Authorization Number - Refer to TR3*		
P.329	**REF**	*Other Payer Referral Number - Refer to TR3*		
P.330	**REF**	*Other Payer Claim Adjustment Indicator - Refer to TR3*		
P.331	**REF**	*Other Payer Claim Control Number - Refer to TR3*		
Loop ID 2400—Service Line				
P.350	**LX**	*Service Line Number - Refer to TR3*		
P.351	**SV1** Professional Service	**SV102** Monetary Amount	***(Line Item Charge Amount)***	Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.
P.359	**SV5**	*Durable Medical Equipment Service - Refer to TR3*		
P.362	**PWK**	*Line Supplemental Information - Refer to TR3*		
P.366	**PWK**	*Durable Medical Equipment Certificate of Medical Necessity Indicator - Refer to TR3*		
P.368	**CR1**	*Ambulance Transport Information - Refer to TR3*		
P.371	**CR3**	*Durable Medical Equipment Certification - Refer to TR3*		
P.373	**CRC**	*Ambulance Certification - Refer to TR3*		
P.376	**CRC**	*Hospice Employee Indicator - Refer to TR3*		
P.378	**CRC**	*Condition Indicator/Durable Medical Equipment - Refer to TR3*		
P.380	**DTP**	*Date - Service Date - Refer to TR3*		
P.382	**DTP**	*Date - Prescription Date - Refer to TR3*		
P.390	**DTP**	*Date - Initial Treatment Date - Refer to TR3*		
P.391	**QTY**	*Ambulance Patient Count - Refer to TR3*		
P.392	**QTY**	*Obstetric Anesthesia Additional Units - Refer to TR3*		
P.393	**MEA**	*Test Result - Refer to TR3*		
P.397	**REF**	*Repriced Line Item Reference Number - Refer to TR3*		
P.398	**REF**	*Adjusted Repriced Line Item Reference Number - Refer to TR3*		
P.399	**REF**	*Prior Authorization - Refer to TR3*		
P.401	**REF**	*Line Item Control Number - Refer to TR3*		
P.404	**REF**	*CLIA Number - Refer to TR3*		
P.405	**REF**	*Referring CLIA Facility Identification - Refer to TR3*		
P.407	**REF**	*Referral Number - Refer to TR3*		
P.409	**AMT**	*Service Tax Amount - Refer to TR3*		
P.410	**AMT**	*Postage Claimed Amount - Refer to TR3*		
P.411	**K3**	*File Information - Refer to TR3*		
P.413	**NTE**	*Line Note - Refer to TR3*		
P.414	**NTE**	*Third Party Organization Notes - Refer to TR3*		
P.415	**PS1**	*Purchased Service Information - Refer to TR3*		

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TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to Empire NY**
Loop ID 2410—Drug Identification				
P.423	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	NDC # for prescribed drugs and biologics when required by government regulation.
P.426	**CTP**	*Drug Quantity - Refer to TR3*		
P.428	**REF**	*Prescription of Compound Drug Association Number - Refer to TR3*		
Loop ID 2420A—Rendering Provider Name				
P.430	**NM1**	*Rendering Provider Name - Refer to TR3*		
P.433	**PRV**	*Rendering Provider Specialty Information - Refer to TR3*		
P.434	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2420B—Purchased Service Provider Name				
P.436	**NM1**	*Purchased Service Provider Name - Refer to TR3*		
P.439	**REF**	*Purchased Service Provider Secondary Identification - Refer to TR3*		
Loop ID 2420C—Service Facility Location Name				
P.441	**NM1**	*Service Facility Location Name - Refer to TR3*		
P.444	**N3**	*Service Facility Location Address - Refer to TR3*		
P.445	**N4**	*Service Facility Location City, State, ZIP Code - Refer to TR3*		
P.447	**REF**	*Service Facility Location Secondary Identfication - Refer to TR3*		
Loop ID 2420D—Supervising Provider Name				
P.449	**NM1**	*Supervising Provider Name - Refer to TR3*		
P.452	**REF**	*Supervising Provider Secondary Identification - Refer to TR3*		
Loop ID 2420F—Referring Provider Name				
P.465	**NM1**	*Referring Provider Name - Refer to TR3*		
P.468	**REF**	*Referring Provider Secondary Identification - Refer to TR3*		
Loop ID 2420G—Ambulance Pick-Up Location				
P.470	**NM1**	*Ambulance Pick-up Location - Refer to TR3*		
P.472	**N3**	*Ambulance Pick-up Location Address - Refer to TR3*		
P.473	**N4**	*Ambulance Pick-up Location City, State, ZIP Code - Refer to TR3*		
Loop ID 2420H—Ambulance Drop-Off Location				
P.475	**NM1**	*Ambulance Drop-off Location - Refer to TR3*		
P.477	**N3**	*Ambulance Drop-off Location Address - Refer to TR3*		
P.478	**N4**	*Ambulance Drop-off Location City, State, ZIP Code - Refer to TR3*		
Loop ID 2430—Line Adjudication Information				
P.480	**SVD** Line Adjudication Information	**SVD02** Monetary Amount	***(Service Line Paid Amount)***	(Medicaid Reclamation)
P.484	**CAS**	*Line Adjustment - Refer to TR3*		(Medicaid Reclamation)
P.490	**DTP**	*Line Check or Remittance Date - Refer to TR3*		
P.491	**AMT**	*Remaining Patient Liability - Refer to TR3*		
Loop ID 2440—Form Identification Code				
P.492	**LQ**	*Form Identification Code - Refer to TR3*		
P.494	**FRM**	*Supporting Documentation - Refer to TR3*		
P.496	**SE**	*Transaction Set Trailer - Refer to TR3*		

Although loops, segments and/or data elements required for Medicaid Reclamation are clarified in the definition and notes as (Medicaid Reclamation), they are not exclusive to Medicaid Reclamation type of claims only.