837I

837 Institutional 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 – 837I Institutional Health Care Claim: Basic Instructions

Section 2 – 837I Institutional Health Care Claim: Enveloping

Section 3 – 837I Institutional Health Care Claim: Charts for Situational Rules

NOTE: UniCare has designated Availity to operate and serve as UniCare's EDI Gateway (entry point) as a no-cost option to our Trading Partners.

Get Started With Availity

The Availity Quick Start Guide will assist you with any EDI connection questions.

If you're a provider and wish to use a Clearinghouse or Billing company, please work with them to ensure connectivity.

Need Assistance?

For questions about signing up, contact Availity Client Services
1-800-AVAILITY (1-800-282-4548) or visit www.availity.com

Section 1 - Basic Instructions

1 X12 and HIPAA Compliance Checking, and Business Edits

EDI interchanges submitted to UniCare for processing pass through compliance edits. 5010 acknowledgments and reports for accepted/rejected files will be returned to the trading partner for pickup using the reporting method established at Availity.

- TA1 Interchange Acknowledgment. UniCare returns TA1 X12 and proprietary reports to the submitter of inbound 837 files containing envelope errors in the ISA and GS segments.
- Level 1. Immediate Batch Report (IBR). UniCare returns a 999 Interchange Acknowledgment to the submitter for every inbound 837 transaction received. If the X12 syntax or any other aspect of the 837 is not X12 compliant, the Immediate Batch Report/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, UniCare applies business edits to ensure that the necessary information is populated and complete for efficient processing. When encountering HIPAA compliance (including balancing), code set or business errors, UniCare returns details that identify these errors to the Trading Partner in the: 1) Electronic Batch Report (EBR) and 2) Delayed Payer Report (DPR) listing which claim(s) have failed. These reports are formatted based on the settings the trading partner chooses at Availity. Review the Availity EDI Guide for more information on report formatting options.

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) Clinical Modification
- International Classification of Diseases Clinical Mod (ICD-10-PCS) Procedure Coding System
- National Uniform Billing Committee (NUBC) Codes
- Diagnosis Related Group Number (DRG)
- Provider Taxonomy Codes
- National Drug Codes

3 Diagnosis Codes

According to the 837I TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, UniCare will return an Immediate Batch Report/999 to the submitter indicating that the transaction has been rejected.

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, an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

5 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.

6 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.
  - Data Element Separator, Asterisk (*)
  - Repetition Separator (ISA11), Caret (^)
  - Sub-Element Separator, Colon (:)
  - Segment Terminator, Tilde (~)
- 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, UniCare 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'.

7 Decimal "R" Data Element Types

"R" data element types contain a decimal point; involving monetary amounts, units, visits, weights, and frequency. UniCare 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, UniCare adjudicates the claim based on the whole number. Numbers after the decimal will not be considered.

8 Numeric Values, Monetary Amounts and Units

- UniCare pays all claims in US dollars and therefore, accepts monetary amounts in US dollars only. If codes related to foreign currencies are used, then an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.
- UniCare recognizes units in whole numbers only.
- UniCare recognizes units in values of less than 9999 and greater than or equal to zero.
- If a negative service line charge or negative units are used, then an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.
  SV203 Monetary Amount - Line Item Charge Amount
  SV205 Quantity - Service Unit Count

9 Address Information

- P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, an Electronic Batch Report and/or Delayed Payer 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, an Electronic Batch Report and/or Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

10 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between UniCare 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-I, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

UniCare 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, UniCare will fail the particular claim.

11 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, then an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

- Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV203 (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 SV203 (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).

12 Other COB Allowed Amount - Calculation

If Loop 2320 CAS populated: Claims Total Charge (Loop 2400 SV201-203 = 001 (Rev)) minus any instance when adjustment amount (Loop 2320 CAS03,06,09,12,15) is unrelated to deductible, coinsurance and/or copayment.

- Loop 2320 CAS01 = CO, OA, PR, PI
- Loop 2320 CAS02 ≠ 1, 2, 3 where '1'=Deductible, '2'=Co-insurance and '3'=Co-payment.

If Loop 2430 CAS populated: Claims Total Charge (Loop 2400 SV201-203 = 001 (Rev)) minus any instance when adjustment amount (Loop 2430 CAS03,06,09,12,15) is unrelated to deductible, coinsurance and/or copayment.

- Loop 2430 CAS01 = CO, OA, PR, PI
- Loop 2430 CAS02 ≠ 1, 2, 3 where '1'=Deductible, '2'=Co-insurance and '3'=Co-payment.

If no CAS segments present in either Loop 2320 or 2430, Total Charge will be the allowed amount.

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, 2310A, 2310E and 2320 for Medicaid reclamation.

14 Preparing Paper Attachments to Support a Claim

In order for an electronically submitted claim to be matched up with the paper documentation, an Attachment Face Sheet must be accessed from www.UniCare.com/edi, EDI Companion Guide, Section C: Appendices, and completed.

Fields on the Attachment Face Sheet include:

- Date Claim Transmitted
- Line of Business: Professional or Institutional
- Member's Contract Number (including prefix)
- Name of Patient
- Date(s) of Service
- Name of Provider
- State in which Services were Rendered
- Identification Code (Attachment Control #)

15 Sending Paper Attachments to Support a Claim

(1) Unsolicited

When a paper attachment follows submission of a claim, the Loop 2300 PWK segment is required.

PWK02 = BM (by mail) or FX (by fax)
PWK05 = AC (Identification Code Qualifier); required if PWK02 = BM, FX
PWK06 = Identification Code (Attachment Control #)

- Field reserved for self-assigned attachment control #. Digits will be pulled beginning from the left to match the Attachment Face Sheet with the appropriate electronically submitted claim.

In order to expedite processing of a claim:

- Complete the Attachment Face Sheet (from www.UniCare.com/edi, EDI Companion Guide, Section C: Appendices).
- Mail or fax the Face Sheet with attachment(s) the day before or on the day the claim is submitted (see bottom of Face Sheet for mailing addresses and fax numbers).
- 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 ID's card)

(2) Solicited

This process begins when UniCare requests specific documentation/attachment(s) from the provider to support a claim that has been received for processing.

Include the attachments along with the letter UniCare sent to you for documentation to appropriate mailing address listed on the Attachment Face Sheet (from www.UniCare.com/edi, EDI Companion Guide, Section C: Appendices).

16 Sending Electronic Attachments to Support a Claim

The 275 Companion Document (from www.UniCare.com/edi, EDI Companion Guide) assists with specific attachment requirements and enables providers to electronically submit attachments based on their business needs.

When attachments are sent electronically (PWK02 = EL) but transmitted in an X12 275 rather than by paper, PWK06 is used to identify the attached electronic documentation. The number in PWK06 of the 837 claim is carried in the TRN segment of the 275 attachment transaction.

(1) Unsolicited

When the provider knows that the payer requires additional information to process the claim

- Provider sends additional information when submitting the claim
- Provider sends the 837 claim with the Loop 2300 PWK segment:
  - PWK02 = EL (electronically only)
  - PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL
  - PWK06 = Identification Code (Attachment Control #) assigned by the provider or their clearinghouse vendor
- Provider then sends the 275 attachment transaction (TRN02 = Attachment Control #)

Provider PWK06 Attachment Control # is the key to unsolicited transaction matching

- When the attachment is unsolicited the Attachment Control # = X12 837 PWK06 = X12 275 TRN02

(2) Solicited

When the payer requests additional information from the provider to process a claim

- Provider sends a claim.
- When UniCare determines not enough information exists to process the claim, UniCare sends letter request for the additional information.
- Provider uses the X12 275 to respond to the letter request

UniCare Attachment Control # (Claim Number) is the key to solicited transaction matching.

- When the attachment is solicited, the Attachment Control # (Claim Number) is in both the UniCare request and the Provider Attachment response (X12 275 TRN02)
- The Attachment Control # (Claim Number) is assigned by UniCare

17 Social Security Number

Unless requested, do not send Social Security Number in the following of the 837 TR3:

- Loop 2010AA REF Billing Provider Tax Identification
- Loop 2010BA NM1 Subscriber Name
- Loop 2010BA REF Subscriber Name
- Loop 2330A NM1 Other Subscriber Name
- Loop 2330A REF Other Subscriber Secondary Identification

Section 2 - Enveloping

EDI envelopes control and track communications between you and UniCare. 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)

UniCare has designated Availity to operate and serve as UniCare's EDI Gateway (entry point) as a no-cost option to our Trading Partners. Availity has specific requirements that must be adhered to and should be reviewed in order to ensure transactions are accepted, processed and ultimately delivered to UniCare.

For more information on submitting claims and the required ISA and GS envelope values, review the following topics in the Availity EDI Guide.

- Uploading and downloading EDI files
- Control Segments/Envelopes
- FTP Client Confirmation
- Acknowledgements and Reports

Section 3 - Charts for Situational Rules

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

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
P.67	**ST** Transaction Set Header	**ST03** Implementation Convention Ref	***005010X223A2***	005010X223A2 - Health Care Claim, Institutional
P.68	**BHT** Beginning of Hierarchical Trx	**BHT06** Transaction Type Code	***CH***	CH - Chargeable
			31	required for Medicaid Reclamation
Loop ID 1000A—Submitter Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.71	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI assigned Sender ID. ▪ Equals the value entered in ISA06, GS02.
P.73	**PER**	*Submitter EDI Contact Information - Refer to TR3*		
Loop ID 1000B—Receiver Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.76	**NM1** Receiver Name	**NM103** Last Name or Organization Name	***UNICARE***	Receiver name
		NM109 Identification Code	***80314***	Represents UniCare
Loop ID 2000A—Billing Provider Hierarchical Level				
P.78	**HL**	*Billing Provider Hierarchical Level - Refer to TR3*		
P.80	**PRV** Billing Provider Specialty Info	**PRV03** Reference Identification	***(Provider Taxonomy Code)***	For BlueCard and state to state programs, submit the taxonomy code to uniquely identify the provider.
P.81	**CUR** Foreign Currency Info	**CUR02** Currency Code	***USD***	USD - US dollars ▪ Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.84	**NM1**	*Billing Provider Name - Refer to TR3*		(Medicaid Reclamation)
P.87	**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 EBR or DPR.

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 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
Loop ID 2010AA—Billing Provider Name (cont'd)				
P.88	**N4**	*Billing Provider City, State, ZIP Code - Refer to TR3*		(Medicaid Reclamation)
P.90	**REF** Billing Provider Tax Identification #	**Unless requested, do not send SSN (SY – Social Security Number)**		
		REF02 Reference Identification	***(Billing Provider Tax Identification #)***	(Medicaid Reclamation)
P.91	**PER**	*Billing Provider Contact Information - Refer to TR3*		
Loop ID 2010AB—Pay-To Address Name				
P.94	**NM1**	*Pay-to Address Name - Refer to TR3*		
P.96	**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.97	**N4**	*Pay-To Address City, State, ZIP Code - Refer to TR3*		
Loop ID 2010AC—Pay-To Plan Name				
P.99	**NM1** Pay-to Plan Name	**NM103** Name Last or Organization Name	***(Pay-to Plan Organizational Name)***	(Medicaid Reclamation)
P.101	**N3**	*Pay-to Plan Address - Refer to TR3*		
P.102	**N4**	*Pay-to Plan City, State, ZIP Code - Refer to TR3*		
P.104	**REF**	*Pay-to Plan Secondary Identification - Refer to TR3*		
P.106	**REF** Pay-to Plan Tax Identification #	**REF02** Reference Identification	***(Pay-to Plan Tax Identification #)***	(Medicaid Reclamation)
Loop ID 2000B—Subscriber Hierarchical Level				
P.107	**HL**	*Subscriber Hierarchical Level - Refer to TR3*		
P.109	**SBR**	*Subscriber Information - Refer to TR3*		
Loop ID 2010BA—Subscriber Name				
P.112	**NM1** Subscriber Name	**NM109** Identification Code	***ALL ALPHA CHARACTERS MUST BE IN UPPERCASE.** ***Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.*** ***Unless requested, do not send SSN**	
P.115	**N3**	*Subscriber Address - Refer to TR3*		
P.116	**N4**	*Subscriber City, State, ZIP Code - Refer to TR3*		
P.118	**DMG**	*Subscriber Demographic Information - Refer to TR3*		
P.120	**REF**	*Subscriber Secondary Identification - Refer to TR3*		
	REF01	Unless requested to not send SSN (SY – Social Security Number)		
P.121	**REF**	*Property and Casualty Claim Number - 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 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
Loop ID 2010BB—Payer Name				
NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway				
P.122	**NM1** Payer Name	**NM103** Last Name or Organization Name	***UNICARE***	Receiver name
		NM108 ID Code Qualifier	***PI***	PI - Payer Identification
		NM109 Identification Code	***80314***	Represents UniCare
P.124	**N3**	*Payer Address - Refer to TR3*		
P.125	**N4**	*Payer City, State, ZIP Code - Refer to TR3*		
P.127	**REF**	*Payer Secondary Identification - Refer to TR3*		
P.129	**REF** Billing Provider Secondary Identification	**REF01** Ref ID Qualifier	***G2***	G2 - Provider Commercial Number
		REF02 Reference Identification	***(Billing Provider Secondary Identification)***	(Medicaid Reclamation)
Loop ID 2000C—Patient Hierarchical Level				
P.131	**HL**	*Patient Hierarchical Level - Refer to TR3*		
P.133	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010CA—Patient Name				
P.135	**NM1**	*Patient Name - Refer to TR3*		
P.137	**N3**	*Patient Address - Refer to TR3*		
P.138	**N4**	*Patient City, State, ZIP Code - Refer to TR3*		
P.140	**DMG**	*Patient Demographic Information - Refer to TR3*		
P.142	**REF**	*Property and Casualty Claim Number - Refer to TR3*		
Loop ID 2300—Claim Information				
P.143	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Control Number)***	▪ Maximum of 20 alphanumeric characters. ▪ Value is returned on outbound 835 and other transactions.
		CLM02 Monetary Amount	***(Total Claim Charge Amount)***	Value must equal the sum of submitted service line charges in Loop 2400 SV203.
		CLM05-3 Claim Frequency Type Code	***(Third Position of Uniform Billing Claim Form Bill Type)***	If '7' (replacement) or '8' (void/cancel) then Loop 2300 REF02 Payer Claim Control # (F8) is required and must contain UniCare's originally assigned claim number.
P.149	**DTP**	*Discharge Hour - Refer to TR3*		
P.150	**DTP** Statement Dates	**DTP03** Date Time Period	***(Statement From or To Date)***	Valid medical codes will be based on the "Statement From Date"

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 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
Loop ID 2300—Claim Information (cont'd)				
P.151	**DTP** *Admission Date/Hour - Refer to TR3*			
P.152	**DTP** *Date-Repricer Received Date - Refer to TR3*			
P.153	**CL1** *Institutional Claim Code - Refer to TR3*			
NOTE: Refer to Basic Instructions 14-16 on Preparing and Sending Attachments				
P.154	**PWK** Claim Supplemental Information	**PWK02** Report Transmission Code	***BM*** ***EL*** ***FX***	BM - By Mail EL - Electronically Only FX - By Fax
		PWK06 Identification Code	▪ Field reserved for unique Attachment Control Number ▪ Digits will be drawn beginning from the left to match the attachment with the appropriate electronically submitted claim.	
P.158	**CN1** *Contract Information - Refer to TR3*			
P.160	**AMT** *Patient Estimated Amount Due - Refer to TR3*			
P.161	**REF** *Service Authorization Exception Code - Refer to TR3*			
P.163	**REF** *Referral Number - Refer to TR3*			
P.164	**REF** *Prior Authorization - Refer to TR3*			
P.166	**REF** Payer Claim Control Number	**REF01** Ref ID Qualifier	***F8***	F8 - Original Reference Number
		REF02 Reference Identification	***(Claim Original Reference Number)***	Represents the original claim # indicated on the 835 when Loop 2300 CLM05-3 Claim Freq. Type Code equals '7' or '8'.
P.167	**REF** *Repriced Claim Number - Refer to TR3*			
P.168	**REF** *Adjusted Repriced Claim Number - Refer to TR3*			
P.169	**REF** *Investigational Device Exemption Number - Refer to TR3*			
P.170	**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 EBR and/or DPR, if submitted.
P.172	**REF** *Auto Accident State - Refer to TR3*			
P.173	**REF** *Medical Record Number - Refer to TR3*			
P.174	**REF** *Demonstration Project Identifier - Refer to TR3*			
P.175	**REF** *PRO Approval Number - Refer to TR3*			
P.176	**K3** *File Information - Refer to TR3*			
P.178	**NTE** *Claim Note - Refer to TR3*			
P.180	**NTE** Billing Note	**NTE02** Description	When billing unlisted HCPCS (NOC codes) in Loop 2400 SV202-2 (Procedure Code), include the drug and dosage.	
P.181	**CRC** *EPSDT Referral - Refer to TR3*			

837 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
Loop ID 2300—Claim Information (cont'd)				
ICD-10-CM Guide requires diagnosis codes to the highest level of specificity.				
P.184	**HI** *Principal Diagnosis Information - Refer to TR3*			
P.187	**HI** *Admitting Diagnosis - Refer to TR3*			
P.189	**HI** *Patient's Reason for Visit - Refer to TR3*			
P.193	**HI** *External Cause of Injury - Refer to TR3*			
P.218	**HI** *DRG Information - Refer to TR3*			
P.220	**HI** *Other Diagnosis Information - Refer to TR3*			
P.239	**HI** *Principal Procedure Information - Refer to TR3*			
P.242	**HI** *Other Procedure Information - Refer to TR3*			
P.258	**HI** *Occurrence Span Information - Refer to TR3*			
P.271	**HI** *Occurrence Information - Refer to TR3*			
P.284	**HI** *Value Information - Refer to TR3*			
P.294	**HI** *Condition Information - Refer to TR3*			
P.304	**HI** *Treatment Code Information - Refer to TR3*			
P.313	**HCP** *Claim Pricing/Repricing Information - Refer to TR3*			
Loop ID 2310A—Attending Physician Name				
Required for services (non-emergency ambulance transportation) populated in Loop 2400, SV202-2				
P.319	**NM1** *Attending Provider Name - Refer to TR3*			(Medicaid Reclamation)
P.322	**PRV** Attending Physician Specialty Info	**PRV03** Reference Identification	***(Provider Taxonomy Code)***	For BlueCard and state to state programs, submit the taxonomy code to uniquely identify the provider.
P.324	**REF** *Attending Provider Sec Identification - Refer to TR3*			(Medicaid Reclamation)
Loop ID 2310B—Operating Physician Name				
P.326	**NM1** *Operating Physician Name - Refer to TR3*			
P.329	**REF** *Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2310C—Other Operating Physician Name				
P.331	**NM1** *Other Operating Physician Name - Refer to TR3*			
P.334	**REF** *Other Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2310D—Rendering Provider Name				
P.336	**NM1** *Rendering Provider Name - Refer to TR3*			
P.339	**REF** *Rendering Provider Secondary Identification - Refer to TR3*			
Loop ID 2310E—Service Facility Location Name				
P.341	**NM1** *Service Facility Location Name - Refer to TR3*			
P.344	**N3** *Service Facility Location Address - Refer to TR3*			(Medicaid Reclamation)
P.345	**N4** *Service Facility Location City, State, ZIP - Refer to TR3*			(Medicaid Reclamation)
P.347	**REF** *Service Facility Location Secondary Identification - Refer to TR3*			
Loop ID 2310F—Referring Provider Name				
P.349	**NM1** *Referring Provider Name - Refer to TR3*			
P.352	**REF** *Referring Provider Secondary Identification - 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 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
For COB claims, enter data elements in Loops 2320, 2330A, 2330B and/or 2430.				
Loop ID 2320—Other Subscriber Information				
P.354	**SBR**	*Other Subscriber Information - Refer to TR3*		
P.358	**CAS**	*Claim Level Adjustments - Refer to TR3*		(Medicaid Reclamation)
P.364	**AMT**	*COB Payer Paid Amount - Refer to TR3*		(Medicaid Reclamation)
P.365	**AMT**	*Remaining Patient Liability - Refer to TR3*		
P.366	**AMT**	*COB Total Non-Covered Amount - Refer to TR3*		
P.367	**OI**	*Other Insurance Coverage Information - Refer to TR3*		
P.369	**MIA**	*Inpatient Adjudication Information - Refer to TR3*		
P.374	**MOA**	*Outpatient Adjudication Information - Refer to TR3*		
Loop ID 2330A—Other Subscriber Name				
P.377	**NM1** **NM109**	*Other Subscriber Name - Refer to TR3* Unless requested, do not send SSN		
P.380	**N3**	*Other Subscriber Address - Refer to TR3*		
P.381	**N4**	*Other Subscriber City, State, ZIP Code - Refer to TR3*		
P.383	**REF** **REF01**	*Other Subscriber Secondary Identification - Refer to TR3* Unless requested to not send SSN (SY – Social Security Number)		
Loop ID 2330B—Other Payer Name				
P.384	**NM1**	*Other Payer Name - Refer to TR3*		
P.386	**N3**	*Other Payer Address - Refer to TR3*		
P.387	**N4**	*Other Payer City, State, ZIP Code - Refer to TR3*		
P.389	**DTP**	*Claim Check or Remittance Date - Refer to TR3*		
P.390	**REF**	*Other Payer Secondary Identifier - Refer to TR3*		
P.392	**REF**	*Other Payer Prior Authorization Number - Refer to TR3*		
P.393	**REF**	*Other Payer Referral Number - Refer to TR3*		
P.394	**REF**	*Other Payer Claim Adjustment Indicator - Refer to TR3*		
P.395	**REF**	*Other Payer Claim Control Number - Refer to TR3*		
Loop ID 2330C—Other Payer Attending Provider				
P.396	**NM1**	*Other Payer Attending Provider - Refer to TR3*		
P.398	**REF**	*Other Payer Attending Provider Secondary Identification - Refer to TR3*		
Loop ID 2330D—Other Payer Operating Physician				
P.400	**NM1**	*Other Payer Operating Physician - Refer to TR3*		
P.402	**REF**	*Other Payer Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2330E—Other Payer Other Operating Physician				
P.404	**NM1**	*Other Payer Other Operating Physician - Refer to TR3*		
P.406	**REF**	*Other Payer Other Operating Physician Secondary Identification - Refer to TR3*		
Loop ID 2330F—Other Payer Service Facility Location				
P.408	**NM1**	*Other Payer Service Facility Location - Refer to TR3*		
P.410	**REF**	*Other Payer Service Facility Location Secondary Identification - Refer to TR3*		
Loop ID 2330G—Other Payer Rendering Provider Name				
P.412	**NM1**	*Other Payer Rendering Provider Name - Refer to TR3*		
P.414	**REF**	*Other Payer Rendering Provider Secondary Identification - Refer to TR3*		
Loop ID 2330H—Other Payer Referring Provider				
P.416	**NM1**	*Other Payer Referring Provider - Refer to TR3*		
P.418	**REF**	*Other Payer Referring Provider Secondary Identification - 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 Institutional Health Care Claim				
TR3	**Segment**	**Reference Designator(s)**	**Value**	**Definitions and Notes Specific to UniCare**
Loop ID 2330I—Other Payer Billing Provider				
P.420	**NM1** *Other Payer Billing Provider - Refer to TR3*			
P.422	**REF** *Other Payer Billing Provider Secondary Identification - Refer to TR3*			
Loop ID 2400—Service Line Number				
P.423	**LX** *Service Line Number - Refer to TR3*			
P.424	**SV2** Institutional Service Line	**SV203** Monetary Amount	***(Line Item Charge Amount)***	Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.
P.429	**PWK** *Line Supplemental Information - Refer to TR3*			
P.433	**DTP** *Date - Service Date - Refer to TR3*			
P.435	**REF** *Line Item Control Number - Refer to TR3*			
P.437	**REF** *Repriced Line Item Reference Number - Refer to TR3*			
P.438	**REF** *Adjusted Repriced Line Item Reference Number - Refer to TR3*			
P.439	**AMT** *Service Tax Amount - Refer to TR3*			
P.440	**AMT** *Facility Tax Amount - Refer to TR3*			
P.441	**NTE** *Third Party Organization Notes - Refer to TR3*			
P.442	**HCP** *Line Pricing/Repricing Information - Refer to TR3*			
Loop ID 2410—Drug Identification				
P.449	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	NDC # for prescribed drugs and biologics when required by government regulation.
P.452	**CTP** *Drug Quantity - Refer to TR3*			
P.454	**REF** *Prescription of Compound Drug Association Number - Refer to TR3*			
Loop ID 2420A—Operating Physician Name				
P.456	**NM1** *Operating Physician Name - Refer to TR3*			
P.459	**REF** *Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2420B—Other Operating Physician Name				
P.461	**NM1** *Other Operating Physician Name - Refer to TR3*			
P.464	**REF** *Other Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2420C—Rendering Provider Name				
P.466	**NM1** *Rendering Provider Name - Refer to TR3*			
P.469	**REF** *Rendering Provider Secondary Identification - Refer to TR3*			
Loop ID 2420D—Referring Provider Name				
P.471	**NM1** *Referring Provider Name - Refer to TR3*			
P.474	**REF** *Referring Provider Secondary Identification - Refer to TR3*			
Loop ID 2430—Line Adjudication Information				
P.476	**SVD** *Line Adjudication Information - Refer to TR3*			
P.480	**CAS** *Line Adjustment - Refer to TR3*			
P.486	**DTP** *Line Check or Remittance Date - Refer to TR3*			
P.487	**AMT** *Remaining Patient Liability - Refer to TR3*			
P.488	**SE** *Transaction Set Trailer - Refer to TR3*			

Release Notes

Number	Page(s)	Description
5.1		*Removed reference to 9999 units or less*
AV-1		*Updated references for Availity EDI Gateway* *Updated Acknowledgement and Reports to Electronic Batch Report and Delayed Payer Report* *Updated Basic Instructions*
AV-2		*Updated Basic Instructions - Added Social Security Number*
AV-3		*Removed Availity Welcome Kit* *Updated Availity Quick Start Guide* *Updated Availity EDI Guide*