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ANSI ASC X12N 837I
Health Care Claim Institutional

TCHP Companion Guide

Updated: September 14, 2018

Contents

Purpose

This is the technical report document for the ANSI ASC X12N 837 Health Care Claims (837) transaction for institutional claims. This document provides a definitive statement of what trading partners must be able to support in this version of the 837. This document is intended to be compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

The 837 Institutional transaction is the electronic correspondent to the paper UB-92 claim forms; therefore, any claim types submitted on the UB-92 forms correlate to the 837 Institutional transaction, if data is submitted electronically.

All required segments within the 837 Institutional transactions must always be sent by the submitter and received by the payer. Optional information is sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements are returned in other transactions such as the Remittance Advice (835 Transaction Set).

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Security and Privacy Statement

Overview of HIPAA Legislation

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

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

Compliance according to HIPAA

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

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

Compliance according to ASC X12

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

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

Contact Information / Trading Partner Testing

Texas Children's Health Plan is in compliance with HIPAA EDI requirements for all electronic transactions. For additional assistance, please call Texas Children's Health Plan Provider Care and Coordination at 832-828-1008 or toll-free 1-800-731-8527.

Claim submissions are required within 95 days from date of service.

You can file your electronic claims several ways:

Payer Name	Electronic Clearinghouse	Payer ID	Supported Transactions
Texas Children's Health Plan – CHIP	Emdeon (Change Healthcare) Availity	76048	Institutional Claims (Hospital)
Texas Children's Health Plan – STAR /STARKIDS	Emdeon (Change Healthcare) Availity	75228	Institutional Claims (Hospital)
~~STAR /Star Kids~~	~~Availity~~ ~~Emdeon (Change Healthcare)~~	~~TXCSM~~	No Longer Used

References

- Texas Children's Health Plan "Provider Manual"

  http://www.texaschildrenshealthplan.org/for-providers/provider-resources

- The following websites provide information for where to obtain documentation for WPS adopted EDI transactions and code sets.

  ASC X12 TR3 Implementation Guides: http://store.x12.org

  Washington Publishing Company Health Care Code Sets: http://www.wpc-edi.com/

Business Rules / Special Consideration

- Please contact your clearinghouse for hours of submissions and requirements.

837I Companion Guide

Loop ID	Reference	Name	Codes	Notes/Comments
ISA - INTERCHANGE CONTROL HEADER				
	ISA08	Interchange Receiver ID	See Description	TCHP requests the Receiver ID assigned.
	ISA12	Interchange Control Version Number	00501	TCHP will support the standards approved for Publication by ACS X12 Procedures Review Board through October 2003.
	ISA15	Usage Indicator	P	Production Claims
GS - FUNCTIONAL GROUP HEADER				
	GS03	Application Receiver Code		Must match the value in the ISA06
	GS08	Version/Release/Industry Identifier Code	005010X223A2	TCHP will support the standards approved for Publication by ACS X12 Procedures Review Board through October 2003. *As of January 1, 2012 – 4010 Electronic Submissions (legacy) are not permitted. 5010 formats are mandated for use.
BHT - BEGINNING OF HIERARCHICAL TRANSACTION				
	BHT02	Transaction Set Purpose Code	00	TCHP will only accept original transactions.
	BHT06	Transaction Type Code.	CH	TCHP will process all 837 transactions as Charges.
1000A - Submitter Name				
1000A	PER01-PER08			If submitting via an EDI Vendor check specific requirements for that vendor.
Billing Provider Hierarchical Level - Required				
2000A - Billing Provider Specialty Information				

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV03	Provider Identification (Provider Taxonomy Code)		TX Medicaid requires the billing provider taxonomy code. (Must be the one on file with Texas Medicaid).
Billing Provider Detail - Required				
2010AA - Billing Provider Name				
2010AA	NM108	Identification Code Qualifier	XX	If the NPI is submitted the qualifier must be "XX".
2010AA	NM109	Identification Code	10N	Must contained the 10 numeric NPI assigned to the Billing Provider.
N3 - Billing Provider Address				
2010AA	N301	Billing Provider Address Line		Must contain the physical street address on file with TX Medicaid.
N4 - Billing Provider City, State, Zip Code				
2010AA	N401	City Name		Must contain the city name on file with TX Medicaid
2010AA	N402	State Code	2AN	Must contain 2 alphanumeric State Code on file with TX Medicaid.
2010AA	N403	Postal Code		Must contain the zip code on file with TX Medicaid
REF - Billing Provider Tax Identification				
2010AA	REF01	Identification Code Qualifier	EI, SY	At least one REF segment is required.
2010AA	REF02	Billing Provider Tax Identification Number	9N	Must contain 9 Numeric Tax ID or Social Security Number (A single string of numbers should be sent. No separators should be used)
Payer Name - Required				
N3 - Pay-To Provider Address				
2010AB	N301	Pay-To Address Line		Must contain the physical street address on file with TX Medicaid.
N4 - Pay-To Provider City, State, Zip Code				
2010AB	N401	City Name		Must contain the city name on file with TX Medicaid
2010AB	N402	State Code	2AN	Must contain 2 alphanumeric State Code on file with TX Medicaid.
2010AB	N403	Postal Code		Must contain the zip code on file with TX Medicaid.
Subscriber Detail (Required) **This segment is used to record information specific to the primary insured and the insurance carrier for the insured.** Note: As an assumption for Medicaid, the Subscriber is the same individual as the Patient then the Patient Loop (2000C) is not to be populated per HIPAA compliance				
SBR - Subscriber Information (Required)				

Loop ID	Reference	Name	Codes	Notes/Comments
2000B	SBR03	Reference Identification	(See List)	Benefit codes are required if the service performed is part of the program. (Subscriber Group or Policy Number) Note: Providers who are providing specific benefit services that require an additional attestation (THSteps, ECI, Family Planning, CCP program, etc.) must be attested to that program and use the 3-digit benefit code on their claim and on file with TX Medicaid. • CA1: County Indigent Health Care Program (CIHCP) • CCP: Comprehensive Care Program (CCP) • CSN: Children with Special Health Care Needs (CSHCN) Services Program Provider • DE1: Texas Health Steps (THSteps) Dental • DM2: Durable medical equipment (DME) Home Health Acute Care • DM3: DME Home Health CSHCN • EC1: Early Childhood Intervention (ECI) Provider • EP1: THSteps Medical Provider • FP3: Family Planning • HA1: Hearing Aid • IM1: Immunization • MA1: Maternity • MH2: Mental Health Case Management • TB1: Tuberculosis (TB) Clinic WC1: Women, Infants, and Children (WIC) Clinic
NM1 - Subscriber Name				
2010BA	NM108	Identification Code Qualifier	MI	For correct identification of the Subscriber "MI" should be used.
2010BA	NM109	Identification Code	9N or 11-12AN	Enter the member/patient policy number as indicated on the ID card. TCHP member/patient policy numbers are 9 digits in length. All TCHP members are subscribers. Subscriber: 111111111 (9N) Newborn (Single): 111111111NB (11AN) Newborn (Twins): 111111111NB1 , 111111111NB2 (12AN)
N3 - Subscriber Address (Required)				
2010BA	N301-N302	Subscriber Address		Required if the patient is the same person as the subscriber.
N4 - Subscriber City, State, Zip Code (Required)				
2010BA	N401-N403	Subscriber City, State, Zip Code		Required if the patient is the same person as the subscriber.
DMG - Subscriber Name (All segments required)				
2010BA	DMG01	Date Qualifier	D8	Date of birth expressed as CCYYMMDD
2010BA	DMG02	Date Time Period	CCYYMMDD	Subscriber Date of Birth
2010BA	DMG03	Gender Code	F, M, U	Subscriber Gender
REF - Subscriber Secondary Identification				
2010BA	REF01	Reference Identification Qualifier	SY	TCHP Request the Subscriber Supplemental Identifier (SSN) if available. This is not a required field.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	REF02	Reference Identification	9N	Subscriber Supplemental Identifier
Payer Name (Required)				
NM1 - Payer Name				
2010BB	NM108	Identification Code Qualifier	PI	Payer Identification
2010BB	NM109	Identification Code		Payer Identifier
N3 - Payer Address				
2010BB	N301-N302	Payer Address		TCHP Request the Payer Address.
N4 - Payer City, State, Zip Code				
2010BB	N401-N403	Payer City, State, Zip Code		TCHP Request the Payer Zip Code.
REF - Payer Secondary Identifier				
2010BB	REF01	Reference Identification Number	G2	REF01 must contain G2 (Provider Commercial Number) when the API (Atypical Provider Identifier) is sent in REF02.
2010BB	REF02	Reference Identification		If an API (Atypical Provider Identifier) is sent, REF02 must contain the API (Atypical Provider Identifier).
Claim Detail (Required)				
CLM - Claim Information				
2300	CLM01	Claims Submitter Identifier		Patient Control Number - Only the first 17 bytes will be used.
2300	CLM05-01	Facility Code Value		TX Medicaid requires the Facility Code. For appropriate values please refer to the Texas Medicaid Provider Procedures Manual located at the following link: Texas Medicaid Provider Procedures Manual
2300	CLM05-03	Claim Frequency Type Code	1,7,8	Claim Frequency Values are seen as noted below: 1 - Original claim 7 - Replacement or corrected claim. The information present on this bill represents a complete replacement of the previously issued bill. 8 - Voided/canceled claim
2300	CLM07	Medicare Assignment Code	A	TCHP request "A". Other values or missing values may result in denial of claim.
2300	CLM10	Patient Signature Source Code	P	The Patient Signature Source Code (CLM10) is required when Release of Information Code (CLM09) does not equal N.
DTP - Discharge Hour				
2300	DTP01	Date Qualifier	096	Discharge
2300	DTP02	Date Time Period Format Qualifier	TM	Time Expressed as HHMM
2300	DTP03	Date Time Period	HHMM	The Discharge Time is required by TCHP when Type of Bill is 11X, 12X, 17X, 31X
DTP - Statement Dates				
2300	DTP01	Date Qualifier	434	Statement

Loop ID	Reference	Name	Codes	Notes/Comments
2300	DTP02	Date Time Period Format Qualifier	RD8	RD8 expressed in format CCYYMMDD-CCYYMMDD and a single
2300	DTP03	Date Time Period	CCYYMMDD-CCYYMMDD	TCHP requires the statement date be submitted.
CL1 - Institutional Claim Code				
2300	CL101	Admission Type Code		TCHP Required when Type of Bill is 11X, 12X, 17X, 31X
2300	CL102	Admission Source Code		TCHP Required when Type of Bill is 11X, 12X, 17X, 31X
2300	CL103	Patient Status Code		TCHP Required when Type of Bill is 11X, 12X, 17X, 31X
PWK - Claim Supplemental Information				
2300	PWK05	Identification Code Qualifier	AC	Attachment control number.
2300	PWK06	Identification Code	17AN	Only the first 17 bytes will be used.
REF - Referral Number *Unique segment from Prior Authorization Number				
2300	REF01	Reference Identification Number	9F	Referral Number
2300	REF02	Reference Identification		The Referral Number is required if the service requires a referral. The referring/attending provider will be required when services require a referral. Example(s): Clinical or Radiological Laboratory Services
REF - Prior Authorization Number *Unique segment from Referral Number				
2300	REF01	Reference Identification Number	G1	Prior Authorization Number
2300	REF02	Reference Identification		TX Medicaid requires the 13 digit authorization number.
REF - Payer Claim Control Number				
2300	REF01	Reference Identification Number	F8	Original Reference Number
2300	REF02	Reference Identification		The Payer Claim Control Number is required when the CLM05-03 (claim frequency code) indicates this claim is a replacement or void to a previously adjudicated claim.
NTE - Claim Note				
2300	NTE01	Reference Identification Qualifier	ADD	TCHP Request that when sending NTE claim notes that "ADD" be used.
2300	NTE02	Reference Identification		Free Text added here with needed details.
CRC - EPSDT Referral				
2300	CRC01	Code Category	ZZ	TX Medicaid Requires the EPSDT
2300	CRC02	Yes/No Condition or Response Code	Y, N	If no, then NU in the CRC03 indicating no referral was given
2300	CRC03	Condition Indicator	AV, NU, S2, ST	Required when a first condition code is necessary. Use codes listed in the CRC03
2300	CRC04	Condition Indicator	AV, NU, S2, ST	Required when a second condition code is necessary. Use codes listed in the CRC03
2300	CRC05	Condition Indicator	AV, NU, S2, ST	Required when a third condition code is necessary. Use codes listed in the CRC03

Loop ID	Reference	Name	Codes	Notes/Comments
HI - Health Care Diagnosis Code				
2300	HI01 thru HI12			Required Diagnosis codes must be coded to the highest level of specificity, i.e., coding to the fourth or fifth digit. There are multiple iterations of this segment all must have valid diagnosis codes. Duplicate diagnosis codes are not allowed. NOTE: There are multiple iterations for this segment if needed and all are required to have Diagnosis Code (HI01-HI12) **Mixed Diagnosis Codes with ICD9 and ICD10 are NOT permitted.** ICD9 - BK, BJ, PR, BN, BF, BR, BQ ICD10 - ABK, ABJ, APR, ABN, ABF, BBR, BBQ
2300	HI01-09, HI02-09, HI03-09, through HI12-09	Yes/No Condition or Response Code	N, U, W, Y	TX Medicaid will require the Present on Admission (POA) indicator for the following Diagnosis Categories: Principle Diagnosis (ABK, BK), External Cause of Injury (ABN, BN), and Other Diagnosis Information (ABF, BF) If the Diagnosis is exempt the POA is not required. A list of ICD-9 and ICD-10 exempt values are available under "Downloads" here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/coding.html
NM1 - Attending Provider Name ***Required when the Rendering Provider NM1 information is different than that carried in the Billing Provider Loop 2010AA and/or is different than the Rendering Provider Loop 2310B.**				
2310A	NM101	Entity Identifier Code	71	TX Medicaid requires the Attending Provider
2310A	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain "XX" (NPI).
2310A	NM109	Identification Code	10N	NM109 must contain the Attending Provider's assigned NPI (10 numeric).
PRV - Attending Provider Specialty Information				
2310A	PRV02	Reference Identification Qualifier	PXC	Qualifier value that is sent in PRV02.
2310A	PRV03	Reference Identification	10AN	PRV03 must contain the provider's assigned taxonomy code. This is a 10-byte taxonomy code. For a list of the taxonomy codes, visit web site www.wpc-edi.com (See Code List: "Health Care Provider Taxonomy Code Set ")
NM1 - Operating Physician Name				
2310B	NM101	Entity Identifier Code	72	TX Medicaid requires the Operating Physician if a surgical procedure is listed.
2310B	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain "XX" (NPI).
2310B	NM109	Identification Code	10N	NM109 must contain the Operating Physician's assigned NPI (10 numeric).
NM1 - Other Operating Physician Name				

Loop ID	Reference	Name	Codes	Notes/Comments
2310C	NM101	Entity Identifier Code	ZZ	TX Medicaid requires the Other Operating Physician if another Operating Physician is present.
2310C	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain "XX" (NPI).
2310C	NM109	Identification Code	10N	NM109 must contain the Other Operating Physician assigned NPI (10 numeric).
NM1 - Rendering Provider Name *Required when the Rendering Provider NM1 information is different than that carried in the Billing Provider Loop 2010AA and/or is different than the Attending Provider Loop 2310A.				
2310D	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain "XX" (NPI).
2310D	NM109	Identification Code	10N	NM109 must contain the provider's assigned NPI (10 numeric).
NM1 - Service Facility Information (Required)				
2310E	NM108	Identification Code Qualifier	XX	The value of NM108 must contain "XX" (NPI).
2310E	NM109	Identification Code	10N	NM109 must contain the Laboratory or Facility Primary Identifier's assigned NPI (10 numeric).
N3 - Service Facility Address				
2310E	N301-N302			TX Medicaid requires the Service Facility Address.
N4 - Service Facility City, State, Zip Code				
2310E	N401-N403			TX Medicaid requires the Service Facility Zip Code.
NM1 - Referring Provider Name				
2310F	NM108	Identification Code Qualifier	XX	If the NPI is submitted, the value of NM108 must contain "XX" (NPI). TCHP requires the referring/attending provider when there is a referral. Example(s): Clinical or Radiological Laboratory Services
2310F	NM109	Identification Code	10N	NM109 must contain the provider's assigned NPI (10 numeric) and be on file with TX Medicaid.
Other Subscriber Information				
CAS - Claim Level Adjustments				

Loop ID	Reference	Name	Codes	Notes/Comments
2320	CAS	Other Subscriber Information		TX Medicaid requires all COB information be sent and must balance. COB Paid amounts of $0.00 in 2320 AMT02 indicates a paid claim and the date of the zero paid amounts should be submitted to TCHP. • 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). The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.
Service Line Number				
N3 - Other Subscriber Address				
2400	SV102	Monetary Amount		Negative values are invalid for the line item charge amount. Max length is 18 bytes. But only 7 bytes will be used at this time.
LIN - Drug Identification				
2410	LIN02	Product/Service ID Qualifier	N4	The value of LIN02 must be equal to N4 when the National Drug Code (NDC) is sent in LIN03.
2410	LIN03	Product/Service ID Qualifier	11AN	LIN02 must contain a valid 11 numeric NDC in the 5-4-2 format. No dashes should be sent or text that is not an NDC value.
CTP - Drug Quantity				

Loop ID	Reference	Name	Codes	Notes/Comments
2410	CTP04	Quantity		NDC drug unit quantity If milliliters are administered, then total number administered is the quantity reported "Each" or "ea" in the NDC description indicates a vial or tablet, which is a quantity of 1 Examples: –00002-1407-01, Quinidine gluconate, 10ml/vial If 10 ml were given, then NDC unit = 10 If 5 ml given, then NDC unit = 5 –00069-0058-02, Heparin sodium, 1000 USPS/ML (10 ml/vial) If 1 ml was given, then NDC unit = 1 –00409-1135-02, Morphine sulfate, 25 mg/ml If 25 mg were given, then NDC unit = 1
2410	CTP05-01	Unit or Basis for Measurement Code	F2, GR, ME, ML, UN	CTP05-01 must be equal to one of the valid Units Of Measurement (UOM) for each NDC.
Detail Provider (2420A - 2420F)				
2420A through 2420D				2420A through 2420D: TCHP expects all provider/facility detail(s) to be sent at the header (2310A-2310F). Provider Details sent at the 2420A-2420D will **NOT** be used for adjudication.
2430 - SVD, CAS, DTP, AMT - Service Line Adjudication, Adjustments, Adjudication Date and Amount				
2430	SVD, CAS, DTP, AMT			TX Medicaid requires all COB information be sent and must balance. COB Paid amounts of $0.00 in 2320 AMT02 indicates a paid claim and the date of the zero paid amounts should be submitted to TCHP. • 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). The sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02). Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.

Appendix A – 837I Example

This section is used to describe the *required* data sets for Medicaid claim processing. The 837I format is used for submission of Electronic Claims for health care professionals. As an assumption for these file formats, if the Subscriber is the same individual as the Patient then the Patient Loop (2000C) is not to be populated per HIPAA compliance.

In the following example, carriage return line feeds are inserted in place of ~ character for improved readability purposes.

STAR - 005010X223A2- Institutional Health Care Claim (837I)

ISA*00* *00* *ZZ*133052274 *ZZ*752280001 *160510*2258*|*00501*000004444*0*P*:
GS*HC*133052274*752280001*20160510*225850*4444*X*005010X223A2
ST*837*000000555*005010X223A2
BHT*0019*00*000083B94*20160510*225851*CH
NM1*41*2*EMDEON*****46*133052274
PER*IC*EMDEON CUSTOMER SOLUTIONS*TE*8008456592
NM1*40*2*TEXAS CHILDRENS STAR PLAN*****46*752280001
HL*1**20*1
PRV*BI*PXC*282N00000X
NM1*85*2*BILLING NAME ABC*****XX*1111111111
N3*11111 NO NAME ROAD
N4*HOUSTON*TX*770744336
REF*EI*111111111
PER*IC*BILLING SUPERVISOR*TE*1111111111
NM1*87*2
N3*PAY-TO-ADDY
N4*HOUSTON*TX*770744336
HL*2*1*22*0
SBR*P*18**TEXAS CHILDRENS STAR PLAN*****MC
NM1*IL*1*LASTNAME*FIRST****MI*111111111
N3*ADDRESSLINE ONE
N4*HOUSTON*TX*770744336
DMG*D8*11111111*F
REF*SY*111111111
NM1*PR*2*TEXAS CHILDRENS STAR PLAN*****PI*75228
N3*PO BOX 300286
N4*HOUSTON*TX*77230
CLM*8888888888*12385.56***11:A:1**A*Y*Y
DTP*434*RD8*20160428-20160503
DTP*435*DT*201604281648
DTP*096*TM*1603
CL1*3*1*01

REF*EA*015917296
REF*D9*0510161111111111111
REF*G1*A11111
HI*ABK:O2402:::::::Y
HI*ABJ:O24013
HI*ABF:O6014X0:::::::Y*ABF:E1065:::::::Y*ABF:E6601:::::::Y*ABF:O3421:::::::Y*ABF:Z3A35:::::::Y*ABF:Z370*ABF:O99214:::::::Y*ABF:Z6835*ABF:Z302
HI*BBR:10D00Z1:D8:20160429
HI*BBQ:0UL70ZZ:D8:20160429
HI*DR:5403
HI*BE:01:::650*BE:80:::5
HI*BH:10:D8:20150804*BH:11:D8:20160428
NM1*71*1*LAST-ATTENDING*FIRSTNAME*M***XX*1111111111
PRV*AT*PXC*207VM0101X
LX*1
SV2*0131**2920*DA*4**0
REF*6R*1
LX*2
SV2*0206**1236*DA*1**0
REF*6R*2
LX*3
SV2*0250**4210.35*UN*2765**0
REF*6R*3
LX*4
SV2*0258**7.21*UN*3**0
REF*6R*4
LX*5
SV2*0300**3667*UN*50**0
REF*6R*5
LX*6
SV2*0310**164*UN*2**0
REF*6R*6
LX*7
SV2*0729**181*UN*1**0
REF*6R*7
SE*65*000000555
GE*1*4444
IEA*1*000004444

CHIP - 005010X223A2- Institutional Health Care Claim (837I)

ISA*00* *00* *ZZ*133052274 *ZZ*760486264 *160510*2258*|*00501*000008888*0*P*:
GS*HC*133052274*760486264*20160510*225848*8888*X*005010X223A2
ST*837*000000037*005010X223A2
BHT*0019*00*00001013A*20160510*225848*CH
NM1*41*2*EMDEON*****46*133052274
PER*IC*EMDEON CUSTOMER SOLUTIONS*TE*8008456592
NM1*40*2*TEXAS CHILDRENS CHIP MG MCAID*****46*760486264
HL*1**20*1
PRV*BI*PXC*283Q00000X
NM1*85*2*BILLING NAME ABC*****XX*1111111111
N3*11111 NO NAME ROAD
N4*HOUSTON*TX*770744336
REF*EI*111111111
PER*IC*BILLING SUPERVISOR*TE*1111111111
NM1*87*2
N3*PAY-TO-ADDY
N4*HOUSTON*TX*770744336
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*LASTNAME*FIRST****MI*111111111
N3*ADDRESSLINE ONE
N4*HOUSTON*TX*770744336
DMG*D8*11111111*M
REF*SY*111111111
NM1*PR*2*TEXAS CHILDRENS CHIP MG MCAID*****PI*76048
N3*PO BOX 300286
N4*HOUSTON*TX*772300000
CLM*61100960014S1C4510*9450***11:A:1**A*Y*Y
DTP*434*RD8*20160426-20160505
DTP*435*DT*201604261028
DTP*096*TM*1725
CL1*2*1*01
REF*EA*000021434
REF*D9*051016204039287
REF*G1*A40812
HI*ABK:F200:::::::Y
HI*ABJ:F250
HI*ABF:R45850:::::::Y*ABF:G251:::::::Y*ABF:T50905A:::::::Y*ABF:Z9114:::::::Y*ABF:G4700:::::::Y
HI*DR:885
HI*BE:01:::2150*BE:80:::9
NM1*71*1*LAST-ATTENDING*FIRSTNAME*M***XX*1111111111
LX*1
SV2*0124**9450*DA*9
REF*6R*1
SE*43*000000037
GE*1*8888
IEA*1*000008888

Appendix B – Change Log

Version	Change Date	Description of Change
1.0	07/20/2016	Published
1.1	10/10/2017	Payer List Update
1.2	9/14/2018	Updated the following: • ISA11 from ^ to | (pipe) • Verbiage from "On File with TCHP" to "On File with TX Medicaid" • 2000A PRV – (required) • 2000B SBR03 – (required)