Illinois Department of Human Services
Division of Mental Health

Illinois Mental Health Collaborative for Access and Choice

Memorandum

Attached is the 837P Companion Guide. Please note the following:

1. The Companion Guide is displayed in the HIPAA standard format. As such, it looks distinctively different from the ROCS format.

2. The beginning of the Companion Guide contains technical information used to prepare the file. This information may be unfamiliar to individuals who are not software program developers.

A moderated conference call is being scheduled to discuss the Companion Guide during the week of May 19th.

ILLINOIS DEPARTMENT OF HUMAN SERVICES

DIVISION OF MENTAL HEALTH

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

Illinois Health Care Claim Companion Guide 837 Professional

HIPAA 4010 Version

Version 1
May 16, 2008

TABLE OF CONTENTS

Version 1.0 Original **Published May 16, 2008**

INTRODUCTION

The Illinois Health Care Claims Transaction Companion guide provides the data requirements to be implemented for all electronic claims submissions to the Illinois Mental Health Collaborative for DHS/DMH covered services. This companion guide is to accompany the standard Implementation Guide and is intended to provide additional information that is specific to the data required for claims processing. The standard Implementation Guide provides the complete set of instructions for the EDI HIPAA 4010 version of the 837P.

Note: If researching in the standard Implementation Guide, the terms: “Subscriber”, “Patient”, and “Member” will appear in the Implementation Guide but have been substituted with the term “Consumer” in the Companion Guide.

PURPOSE

The purpose of this document is to provide the information necessary to submit claims/encounters electronically to the Illinois Mental Health Collaborative. The information herein describes specific requirements for processing data within the payer’s system.

Delimiters Supported in Header Segment

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

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

The Illinois Mental Health Collaborative will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Maximum Limitations

The Illinois Mental Health Collaborative transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, consumer, claim level, and claim service line level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the Implementation Guide. Some of these limitations are explicit, such as:

- The Claim Information loop (2300) is limited to 100 claims per consumer
- The Service Line loop (2400) is limited to 50 service lines per claim

However, some limitations are not explicitly defined. We recommend that trading partners limit the size of the transaction (ST/SE envelope) to a maximum of 5000 claims per transaction set.

The maximum file size is 8MB. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). The Illinois Mental Health Collaborative requires that the Interchange Control structure is limited to one type of Functional Group, such as 837 Health Care Claim. Professional functional groups are to be submitted in separate Interchange Control structures (ISA/IEA envelopes).

The Illinois Mental Health Collaborative will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Telecommunication Specifications

Trading partners wishing to submit electronic Health Care Claims to the Illinois Mental Health Collaborative must obtain a Submitter ID/Password. If you do not have a Submitter ID you may obtain one by completing the Account Request form available on The Illinois Mental Health Collaborative website at http://www.illinoismentalhealthcollaborative.com/
The Illinois Mental Health Collaborative can accommodate multiple submission methods for the Health Care Claim transactions. Please refer to the ETS (Electronic Transport System) Electronic Data Exchange Overview document on the Illinois Mental Health Collaborative website at http://www.illinoismentalhealthcollaborative.com for further details.

If you have any questions please contact The Illinois Mental Health Collaborative EDI help desk.

E-mail: e-supportservices@valueoptions.com
Telephone: 888-247-9311 (8am – 6pm Eastern, Monday – Friday)
FAX: 866-698-6032

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types of HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational
5. External Code Set Testing – This is testing of external code sets and tables. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at http://www.wedi.org/snip/public/articles/index.shtml.

The Illinois Mental Health Collaborative Recommendations:

The Illinois Mental Health Collaborative has obtained certification from Claredi™, the certifying agency selected by Centers for Medicare and Medicaid Services (CMS). There is no need to recertify the software prior to testing with The Illinois Mental Health Collaborative; however, you will still need to submit a test file and contact The Illinois Mental Health Collaborative EDI Helpdesk before submitting production files.

Trading Partner Acceptance Testing Specifications

Other trading partners wishing to submit claims electronically to The Illinois Mental Health Collaborative must first submit an error free test file and receive verification from The Illinois Mental Health Collaborative that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file you must obtain an ID & Password from The Illinois Mental Health Collaborative EDI help desk. Please contact them via e-mail at e-supportservices@ValueOptions.com or by calling 888-247-9311.

The Illinois Mental Health Collaborative Electronic Transport System (ETS) will validate the test file. The entire file will either pass (accept) or fail (reject) validation. ETS does not allow partial file submissions. Submitters will be notified via e-mail as to the results of the ETS validation. If your file failed validation, the message will provide explanations for the failure.
Any error message you do not understand can be explained thoroughly by The Illinois Mental Health Collaborative EDI specialist.

Helpful Hint: Create small batches of test claims to ensure that you will not have to re-create too many claims in the event of an error in the file.

After receiving notification that your test file has passed validation, contact the EDI Help Desk to switch your account into live mode. Provide your submitter ID and The Illinois Mental Health Collaborative file tracking number (if available). Once HIPAA compliance is validated, the EDI Help Desk specialist will work with the claim's department to ensure that the file uploads properly for claims adjudication.

National Provider Identifier Specifications

The Illinois Mental Health Collaborative requires covered entities to submit electronic claims with the NPI in the appropriate locations. The Illinois Mental Health Collaborative requests that taxonomy codes be included in the appropriate locations. The NPI is a standard provider identifier that replaces the provider numbers previously used in standard electronic transactions. The Illinois Mental Health Collaborative requires that all covered entities report their NPI to the Illinois Mental Health Collaborative prior to submitting electronic transactions containing a NPI. For additional information on how to report your NPI to The Illinois Mental Health Collaborative or to check out Frequently Asked Questions, please visit http://www.illinoismentalhealthcollaborative.com/providers.htm
or contact our National Provider Line at (800)397-1630, Monday through Friday, 8:00 AM to 6:00 PM (Eastern Time).

All electronic transactions for covered entities should contain the provider NPI, employee identification number and zip code + the 4 digit postal code in the appropriate loops. The NPI should be sent in the NM109, where NM108 equals XX. The Illinois Mental Health Collaborative also requests that the taxonomy code be included on electronic submissions. The taxonomy code should be sent in the PRV03, employee identification number should be sent in the REF02, and the zip code + the 4 digit postal code should be sent in the N403 and N404. If you do not submit taxonomy codes, you must submit appropriate service modifiers that represent the practitioner of service's licensure level.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the FEIN number in the appropriate provider loops within the appropriate REF segment.
Additional information on NPI including how to apply for a NPI can be found on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.hhs.gov/NationalProvIdentStand/

Provider Billing Requirements

The Health Care Claim transaction allows for a large amount of provider data at both the claim level and the service line level. The Illinois Mental Health Collaborative claim adjudication system only utilizes the provider data present at the claim level. Much of the provider data is situational and must be provided if the condition is met

The Billing/Pay-To loop (2000A) is a required loop. At a minimum, the transaction must have a billing provider. The pay-to, or service facility loops are dependent upon what is entered in the billing loop.

- **Billing Provider Name loop (2010AA)** - is a required loop used to identify the original entity that submitted the electronic claim/encounter. The billing provider entity may be a health care provider, a billing service or some other representative of the provider.

- **Pay-To Provider Name loop (2010AB)** - is a situational loop, required if the pay-to provider is a different entity from the billing provider.

Depending on the scenario one or more of the previously mentioned loops might be present in the Health Care Claim transaction. Refer to the scenarios below to determine the loops to be included in your transaction.

Billing Agent Scenario:

If the provider agency contracts with a billing agent to perform billing and reconciliation functions, the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the billing agent information
- Pay-To Provider Name (2010AB) – this loop will contain the provider, provider group, or agency information (the entity receiving payment for the claim)

Provider Service Address Scenario: (Professional Claims)

In this scenario the provider is performing the services at a different address than the billing address. In this case the following information should be provided:

- Billing Provider Name loop (2010AA) – this loop will contain the provider group information.
- Service Facility Location loop (2310D) – this loop will be included if services are rendered at a location different from the billing provider address.

Shading Key within this document:
Shading through this document pertains only to The Illinois Mental Health Collaborative proprietary software, ECLW- EDI Claims Link for Windows.

Fields Auto filled
Input data one time at set up of software
Select data from drop down box
Data Optional
Input data as required

INTERCHANGE CONTROL HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: '00' No Authorization Information Present '03' Additional Data Identification1000095	Use '03' Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for authorization.	Use The Illinois Mental Health Collaborative submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	Use '01' Password to indicate that a password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use The Illinois Mental Health Collaborative submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use 'ZZ' Mutually Defined.
	ISA08	Interchange Receiver ID	R		Use 'FHC &Affiliates'.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA09	Interchange Date	R	Date format YYMMDD.	The date (ISA09) is expected to be no more than seven days before the file is received. Any date that does not meet this criterion may cause the file to be rejected.
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specifications.
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' U.S. EDI Community of ASC X12	Use the value specified in the implementation guide.
	ISA12	Interchange Control Version Number	R	Valid value: '00401' Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997	Use the current standard approved for the ISA/IEA envelope. Other standards will not be accepted.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier zero fill this element.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	Use '0' No Acknowledgement Requested. The Illinois Mental Health Collaborative will not be generating the TA1 Interchange Acknowledgement or the 997 Functional Acknowledgements.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	The Usage Indicator should be set appropriately. The value in this element will be verified against the accounts "test" status in ETS and rejected if they do not match.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	The Illinois Mental Health Collaborative will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups		Count the number of functional groups in the interchange	Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e. functional identifier code 'HC' Health Care Claim (837). Segregate professional functional groups into separate ISA/IEA envelopes.
	IEA02	Interchange Control Number		The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

FUNCTIONAL GROUP HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
GS		**Functional Group Header**	**R**		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HC' Health Care Claim (837)	HC
	GS02	Application Sender's Code	R		The sender defines this value. The Illinois Mental Health Collaborative will not be validating this value.
	GS03	Application Receiver's Code	R		This field will identify how the file is received by The Illinois Mental Health Collaborative. Use 'EDI' for electronic transfer 'MAGMEDIA' for magnetic media such as tape or diskette.
	GS04	Date	R	Date format CCYYMMDD	Refer to the implementation guide for specifics.
	GS05	Time	R	Time format HHMM	Refer to the implementation guide for specifics.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	This value is defined by the sender's system. If The Illinois Mental Health Collaborative eventually implements the 997, this number will be used to identify the functional group being acknowledged.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' Accredited Standards Committee X12	Use the value specified in the implementation guide.
	GS08	Version/Release Industry ID Code	R	Valid value: Professional Addenda Approved for Publication by ASC X12. '004010X098A1'	Use the current standard approved for publication by ASC X12. Other standards will not be accepted.

Seg	Data Element	Name	Usage	Comments	Expected Value
				Institutional Addenda Approved for Publication by ASCX12. '004010X096A1'	

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group. Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
ST		**Transaction Set Header**	**R**		
	ST01	Transaction Set Identifier Code	R	Code uniquely identifying a Transaction Set	837
	ST02	Transaction Set Control Number	R	The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.	Number

Seg	Data Element	Name	Usage	Comments
TRAILER				
SE		**Transaction Set Trailer**	R	
	SE01	Number of included segments	R	Number of segments in the transaction set (*including ST through SE*)
	SE02	Transaction Set Control Number	R	The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
				HEADER			
BHT		**Beginning of Hierarchical Transaction**	**R**				
	BHT01	Hierarchical Structure Code	R		0019		
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18' Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original		
	BHT03	Reference Identification	R	This number operates as a batch control number. within the business owners operational system	Number		
	BHT04	Date	R	(Identifies the date that the submitter created the file)	CCYYMMDD		
	BHT05	Time	R	identify the time of day that the submitter created the file- Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59),			
	BHT06	Transaction Type Code	R	This element is required,	Use 'CH'		
REF		**Transmission Type Identification**	**R**				
	REF01	Reference Identification Qualifier	R		87= functional category		
	REF02	Transmission Type Code	R	The element contains the version number.	Use '004010X098A1' for Production transaction sets. Use ''004010X098DA1' for Test transaction sets.		
				LOOP 1000A – SUBMITTER NAME			
NM1		**Submitter Name**	**R**				

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	NM101	Entity Identifier Code	R		41		
	NM102	Entity Type Qualifier	R		1 (Person) or 2 (Non-Person Entity)		
	NM103	Name Last or Organization Name	R		Last Name or Organization Name		
	NM108	Identification Code Qualifier	R	Identification Code Qualifier	46		
	NM109	**Submitter Primary Identifier**	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use The Illinois Mental Health Collaborative assigned submitter ID Maximum 10 characters.		
PER		**Submitter EDI Contact Information**	R				
	PER01	Contact function code	R		IC		
	PER02	Name	R		Submitter Contact Name		
	PER03	Communication number qualifier	R		ED (EDI Access Number, EM (E-mail), FX (Fax), TE (Telephone		
	PER04	Communication Number	R		Communication Number		
Loop 1000B- Receiver Name							
NM1		**Receiver Name**	**R**				
	NM101	Entity Identifier Code	R		40		
	NM102	Entity Type Qualifier	R		2 (Non-Person Entity)		
	NM103	Receiver Name	R		Use The Illinois Mental Health Collaborative		
	NM108	Identification Code Qualifier	R		46		
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier	Use 'FHC &Affiliates'		
LOOP 2000A – Billing/Pay-to Provider Specialty Information							
HL		**Billing/Pay-To Provider Hierarchical Level**	**R**				
	HL01	Hierarchical ID Number	R	HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.			
	HL03	Hierarchical Level Code	R		20 – Information Source		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	HL04	Hierarchical Child Code	R	Additional Subordinate HL Data Segment in This hierarchical Structure.			
PRV		**Provider Information**	O	This segment is currently optional			
	PRV01	Provider code	O		BI= Billing		
	PRV02	Reference Identification Qualifier	O	Submit the taxonomy of the rendering provider	ZZ=qualifier		
	PRV03	Reference Identification	O	Taxonomy for rendering provider licensure level	10 digit Rendering Provider taxonomy		
LOOP 2000B-CONSUMER INFORMATION							
HL		**Consumer Hierarchical Level**	**R**				
	HL01	Hierarchical ID Number	R	Each consumer in the file will have an incremental number	HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction		
	HL02	Hierarchical Parent ID Number					
	HL03	Hierarchical Level Code	R		22- Consumer		
	HL04	Hierarchical Child Code	R	If consumer only use 0 as code	0 – No Subordinate HL		
SBR		**Consumer Information**	**R**				
	SBR01	Payer Responsibility Sequence number code	R	If there is other insurance coverage, identify if the Illinois Mental Health Collaborative is the primary, secondary, or tertiary payer.	P (Primary) S (Secondary) T (Tertiary)- ‘payer of last resort’		
	SBR02	Individual Relationship Code	R		18 (Self)		
	SBR03	Reference Identification (Group or Policy Number)	R		DHS/DMH Program Code	Program Code	3 Bytes

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	SBR09	Claim Filing Indicator Code	R		13		
LOOP 2000C- CONSUMER INFORMATION							
PAT		**Consumer Information**	**R**				
	PAT01	Individual Relationship Code	R	The HIPAA standard value descriptions will appear in the software's dropdown box, however for the Illinois Mental Health Collaborative, use the values as shown under "Expected Value" (20, 01, or G8) in this guide. These descriptions are different than as they appear in the dropdown.	20- Consumer 01 - Family G8 -Collateral	Service Recipient Code	1 Byte
LOOP 2010AA – BILLING PROVIDER NAME							
NM1		**Billing Provider Name**	**R**				
	NM101	Entity Identifier Code	**R**		85- Billing Provider		
	NM102	Entity Type Qualifier	**R**	Agency will use 2	2- Non-Person Entity		
	NM103	Billing/Organizational Name	**R**		Billing Provider Name (Last) or Organizational Name		
	NM104	Billing Provider First Name	**S**	Does not apply for agency billing	Billing Provider Name (first)		
	NM105	Billing Provider Middle Name	**S**	Does not apply for agency billing	Billing Provider Name (Middle)		
	NM106	Billing Provider Name Suffix	**S**	Does not apply for agency billing	Billing Provider Name(Suffix)		
	NM108	Billing Provider Identification Code Qualifier	**R**	Agency NPI (National Provider Identification) XX-NPI(National Provider Identification)	Covered entities must send 'XX' as the NPI Qualifier, non-covered entities send qualifier '24'		
	NM109	Billing Provider Identifier	**R**	Agency NPI number	Covered entities must send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number (FEIN).		
N3		**Billing Provider Address**	**R**				
	N301	Address Information	**R**		Billing Address Line 1		
	N302	Address Information	S		Billing Address Line 2		
N4		**Billing Provider City/State/Zip Code**	**R**				
	N401	City Name	R		City Name		
	N402	State	R		State		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	N403	Postal Code	R		Zip Code		
	REF01	Reference Identification Qualifier	R	Billing Providers: EI-Employer's Identification number SY-Social Security Number	Place EI in REF01 if the Provider ID is EIN or place SY in REF01 if Provider ID is SSN	Agency FEIN	9 bytes
	REF02	Reference Identification	R	FEIN	EIN or SSN of the billing provider based on qualifier used in REF01, above		
LOOP 2010AB – PAY-TO PROVIDER NAME							
NM1		**Pay to Provider Name**	**S**	**Required if Pay To is different than Billing Provider**			
	NM101	Entity Identifier Code	R		87= Pay- to Provider		
	NM102	Entity type Qualifier	R		1= Person 2= Non-Person Entity		
	NM103	Last Name or Organizational Name	R		Individual Last name or Organization Name		
	NM104	Name First	S		Pay to First Name		
	NM105	Name Middle	S		Pay to Middle Name		
	NM107	Name Suffix	S	**Example Jr., I, II, III**	Pay to Suffix		
	NM108	Pay-To-Provider Identification Code Qualifier	**R**		Covered entities must send 'XX' as the NPI Qualifier, non-covered entities use qualifier '24'		
	NM109	Pay-To Provider Identifier	**R**	Pay –to –Provider's NPI	Covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.		
N3		**Pay- to Address**	**R**				
	N301	Address Information	R		Pay-to Address line 1		
	N302	Address Information	R		Pay-to Address line 2		
N4		**Pay-to Provider City/State/Zip code**	**R**				
	N401	City Name	R		City Name		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	N402	State	R		State		
	N403	Zip Code	R		Zip Code		
	REF01	Reference Identification Qualifier	R		EI=Employers Identification Number SY=Social Security Number		
	REF02	Reference Identification	R	Pay-to-Provider's FEIN-Employer's Identification number SY-Social Security Number	FEIN or SSN		
LOOP 2010BA – CONSUMER NAME							
NM1		**Consumer Name**	**R**				
	NM101	Entity Identifier Code	R		IL=Consumer		
	NM102	Entity Type Qualifier	R		1= Person		
	NM103	Last Name	R	Name should be shown as it is on enrollment system	Consumer Last Name		
	NM104	First Name	S	Name should be shown as it is on enrollment system	Consumer First Name		
	NM105	Middle Name	S	Name should be shown as it is on enrollment system	Consumer Middle Name		
	NM107	Name Suffix	S	Name should be shown as it is on enrollment system Example Jr., I, II, III;	Consumer Suffix		
	NM108	Identification Code Qualifier	R	. .Valid values: 'MI'-Consumer Identification Number	Use 'MI' Consumer Identification Number (RIN)		
	NM109	Consumer Primary Identifier	S	Consumer Identifier must be present There are very specific circumstances/services where claims can be submitted under pseudo- RIN. See training materials for when a pseudo-RIN may be appropriate.	RIN assigned by HFS	Recipient ID (RIN)	9 Bytes
N3		**Address Information**	**R**				

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	N301	Address Information 1	R		Address Line 1		
	N302	Address Information 2	R		Address Line 2		
N4		**Consumer City/State/Zip Code**	**S**				
	N401	City Name	R		City Name		
	N402	State	R		State		
	N403	Postal Code	R		Zip Code		
DMG		**Demographic Information**	S				
	DMG01	Date Format Qualifier	R		D8= Date		
	DMG02	Consumer Date of Birth	R	Should be shown as it appears in enrollment system Expressed in format CCYYMMDD			
	DMG03	Gender Code	R	F- Female, M- Male, U- Unknown	F, M or U		
LOOP 2010BB – PAYER NAME							
NM1		**Payer Name**	**R**				
	NM101	Entity Identifier Code	R		PR		
	NM102	Entity Type Qualifier	R		2 (Non-person identity)		
	NM103	Payer Name	R	Destination payer name	Use the Illinois Mental Health Collaborative		
	NM108	Identification Code Qualifier	R	Valid values: 'PI' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier' until the National Plan ID is mandated.		
	NM109	Payer Identifier	R	Destination payer identifier	Use 'FHC &Affiliates'		
LOOP 2300 – CLAIM INFORMATION							
CLM		**Claim Information**	**R**				
	CLM01	Claim Submitter's Identifier	R	This field is for your individual client ID and your claim DCN you can concatenate both numbers in this field. Individual Client|Claim ID –xxxxxxx|xxxxxxxxx Maximum 38 characters. If you wish to use *either* a client ID *or* DCN (rather than both) use a zero '0" to indicate no information but be sure to include the pipe (|) between the identifiers.	Individual Client|Claim ID xxxxxx|xxxxxxx If no client ID 0|xxxxxxxx If no DCN used Xxxxx|0	Client ID Billing Document Control Number	9 Bytes 17 Bytes
	CLM02	Monetary Amt	R		Total Submitted Charges	Charge Amount	7 Bytes

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	CLM05	Health Care Service Location Information	R				
	CLM05-1	Facility Code Value	R	Use standard place of service codes	Place of Service	Location Description/Location Code	17 Bytes 1 Bytes
	CLM05-3	Claim Frequency Type Code	R		1=original 6=Corrected 7=Replacement 8=Void	Record Action	1 Bytes
	CLM06	Yes/No condition or Response Code	R	Provider signature on file-Medicare	Y=Yes N=No		
	CLM07	Provider accepts assignment Code	R	Provider accepts assignment for Medicare	A- Assigned B-Assignment accepted on Clinical Lab services only C- Not Assigned P- Patient refuses to Assign Benefits		
	CLM08	Yes/No condition or Response Code	R	Assignment of Benefits for this claim payment	Y=Yes N=No		
	CLM09	Release of Information	R	Consumer signature on file to release information	See Appendix 1A		
	CLM10	Consumer Signature Source Code	S		See Appendix 1D		
PWK		**Claim Supplemental Information**	**S**				
	PWK02	Attachment Transmission Code	R	Valid values: 'AA' Available on Request at Provider Site 'BM' By Mail 'EL' Electronic Only 'EM' E-mail 'FX' By FAX	Use 'AA' Available on Request at Provider Site		
AMT		**Consumer Paid Amount**	**S**	If consumer paid any portion to provider			
	AMT01	Amount Qualifier Code	R		F5= Consumer Paid Amount		
	AMT02	Monetary Amount			Consumer Paid Amount		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
REF		**Original Reference Number (ICN/DCN)**	**S**	For requested adjustment			
	REF01	Reference Identification Qualifier	R		F8- Original Reference Number		
	REF02	Reference Identification	R	Use Claim number from Original Claim	If this is a correction to a previously submitted claim use The Illinois Mental Health Collaborative claim number prefixed by an 'RC'.	Service Document Control Number	17 Bytes
HI		**Health Care Diagnosis Code**	**R**				
	HI101-1	Code List Qualifier Code	R		BK - Principal Diagnosis		
	HI101-2	Industry Code	R	Use ICD-9 standard Dx Code		Diagnosis Code	5 Bytes
	HI102-1	Code List Qualifier Code	S		BF - Diagnosis		
	HI102-2	Industry Code	S	Use ICD-9 standard Dx Code		Diagnosis Code	5 Bytes
	HI103-1	Code List Qualifier Code	S		BF - Diagnosis		
	HI103-2	Industry Code	S	Use ICD-9 standard Dx Code		Diagnosis Code	5 Bytes
	HI104-1	Code List Qualifier Code	S		BF - Diagnosis		
	HI104-2	Industry Code	S	Use ICD-9 standard Dx Code		Diagnosis Code	5 Bytes
NTE		**Claim Note**					
	NTE01	Note Reference Code	R		ADD- Additional Information		
	NTE02	Description	R	The qualifications level for staff person #1 identified by ID number, using the codes: '01 = Licensed practitioner of the healing arts (LPHA) '02 = QMHP '03 = MHP '04 = RSA **1 Instance of staff level is required**. Up to 6 instances are allowed i.e. 01|04|02|03|03|03	xx|xx|xx|xx|xx|xx		
LOOP 2310C- PURCHASED SERVICE PROVIDER							
NM1		**Purchased Service**	**S**	**This segment is required whenever a subcontractor**			

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
		Provider Name		**is used**			
	NM101	Entity Provider Code	R		QB= Purchase Service Provider		
	NM102	Entity Type Qualifier	R		1- Non-person Entity		
	NM103	Organization Name	R		Name		
	NM104	First name of provider	R		Name		
	NM108	Identification Code Qualifier	R	When a subcontractor has rendered the service, use qualifier 24	Qualifier 24-		
	NM109	Identification Code	R		The, the subcontractor's FEIN	Contractor FEIN	9 Bytes
LOOP 2310D- SERVICE FACILITY LOCATION							
NM1		**Individual or Organizational Name**	**S**	If a subcontractor is used, this loop should be blank.			
	NM101	Entity Identifier Code	R		77= Service Location	Site Number- will be derived by Service Location	17 Bytes
	NM102	Entity Type Qualifier	R		2= non-person entity		
	NM103	Last Name or Organization Name	R		Last Name or Organization Name		
	NM108	Identification Code Qualifier	R		Covered entities must send 'XX' as the NPI Qualifier, non-covered entities use qualifier '24'		
	NM109	Identification Code	R		Covered entities send the National Provider ID (NPI), a 10 digit number; non covered entities send Tax ID Number.		
N3		**Address Information**	**R**				
	N301	Address Line 1	R		Address Line 1		
	N302	Address Line 2	R		Address Line 2		
N4		**Consumer City/State/Zip Code**					
	N401	City Name	R		City Name		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	N402	State	R		State		
	N403	Postal Code	R		Zip Code		
LOOP 2320-OTHER CONSUMER INFORMATION							
SBR		**Consumer Information**	**S**				
	SBR05	Insurance Type Code	R	Primary Carrier Information Insurance Code	Insurance Code See Appendix 1C		
AMT		**Coordination of Benefits (COB) Payer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R	If there is a primary carrier payment, enter qualifier D	D- Payer Amount Paid		
	AMT02	Monetary Amount	R	Primary Carrier Paid Amount	Monetary value	Total Third Part Liability Amount	7 Bytes
AMT		**Consumer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R	If consumer paid a copay, deductible or coinsurance use qualifier F5	F5-Consumer Paid Amount	Total Third Part Liability	
	AMT02	Monetary Amount	R	Consumer Paid Amount- Copay	Monetary value	Total Third Part Liability	
AMT		**Coordination of Benefits allowed amount**	S				
	AMT01	Amount Qualifier Code	R		B6-Allowed Amount	Total Third Part Liability	
	AMT02	Monetary Amount	R	Primary Carrier Allowed Amount	monetary value	Total Third Part Liability	
SBR		**Consumer Information**	**S**				
	SBR05	Insurance Type Code	R	If there is a Second Carrier , Insurance Code See attachment 1C	Insurance Code	Total Third Part Liability	
AMT		**Coordination of Benefits (COB) Payer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R		D- Payer Amount Paid	Total Third Part Liability	
	AMT02	Monetary Amount	R	Second Carrier Paid Amount	monetary value	Total Third Part Liability	
AMT		**Consumer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R		F5-Consumer Paid Amount		
	AMT02	Monetary Amount	R	Consumer Paid Amount- Copay	monetary value		
AMT		**Coordination of Benefits allowed amount**	S				

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	AMT01	Amount Qualifier Code	R		B6-Allowed Amount	Total Third Part Liability Amount	7 Bytes
	AMT02	Monetary Amount	R	Second Carrier Allowed Amount	Dollar amount		
SBR		**Consumer Information**	**S**				
	SBR05	Insurance Type Code	R	Third Carrier Information -Insurance Code See attachment 1C	Insurance Code		
AMT		**Coordination of Benefits (COB) Payer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R		D- Payer Amount Paid		
	AMT02	Monetary Amount	R	Third Carrier Paid Amount	Monetary value		
AMT		**Consumer Paid Amount**	**S**				
	AMT01	Amount Qualifier Code	R		F5-Consumer Paid Amount		
	AMT02	Monetary Amount	R	Third carrier - Consumer Paid Amount- Copay			
AMT		**Coordination of Benefits allowed amount**	S				
	AMT01	Amount Qualifier Code	R		B6-Allowed Amount	Total Third Part Liability Amount	7 Bytes
	AMT02	Monetary Amount	R	Third Carrier Allowed Amount	Monetary value		
LOOP 2330B CLAIM ADJUDICATION DATE						Total Third Part Liability	
DPT		**Claim Adjudication Date**	S	This is the date the primary carrier paid the claim			
	DPT01	Date/Time Qualifier	R	(If there is more than one other carrier, enter one segment for each carrier)	573-Date Claim Paid		
	DPT02	Date Time Period Format Qualifier	R	Qualifier to indicate format	D8-Date expressed in Format CCYYMMDD		
	DPT03	Date Time Period	R		CCYYMMDD		
LOOP 2400 – SERVICE LINE							
LX		**Assigned Number**	**R**		The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter		
	LX01				The service line incremented by 1 for each		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
					service line		
SV1		**Professional Service**	**R**				
	SV101	Composite Medical Procedure Identifier	R				
	SV101-1	Product/Service ID Qualifier	R	Standard procedure codes qualifier	Use 'HC'		
	SV101-2	Product/Service ID	R	For Section E services (see reimbursement guide) – use code S9986. If S9986 is used you must add the appropriate W-code in the note segment NTE – Line Notes.	Standard procedure code	HCPCS Code Activity Codes	
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	S	There are a maximum of 4 modifiers- Last modifier in the sequence must be the modifier for licensure level of provider rendering service. ** Please submit separate claims if more than one licensure is billed.	Standard Modifier	Modifiers	2 Bytes
	SV102	Monetary Amount	R		Service Charge Amount	Net Charge Amount Agency Net Charge Amt	7 Bytes 7 Bytes
	SV103	Unit or Basis for Measurement Code	R		UN-Unit qualifier		
	SV104	Quantity	S	Submit all units for any one service code performed on the same day on the same claim.	Use whole number unit values.		
	SV107-1	Diagnosis Code Pointer	S	Use this pointer for the first diagnosis (Primary diagnosis for this service line)			
DTP		**Date – Service Date**	**R**				
	DTP01	DATE/Time Qualifier	R	Dates of service	472		
	DTP02	Date Time Period Format Qualifier	R	Qualifier for format	Use D8 for one date of service. Use 'RD8' to specify a range of dates. The from and through service dates should be sent for each service line.		

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
	DTP3	**Date Time Period**		Service date or range of service dates. If billing for a date range, be sure units agree with date span.	ccyymmdd If date range ccyymmdd - ccyymmdd	Date of Service	8 Bytes
REF		**Line Control Number**	**S**				
	REF01	Reference Identification Qualifier	**R**		6R= Provider Control Number		
	REF02	Reference Identification Number	**R**	Add this Segment as the Control number for each Line of the claim 30 bytes	Line Item Control Number		
NTE		**Line Note**	**S**				
	NTE01	Note Reference code	R		ADD- Additional Information		
	NTE02	Description	R	This field is used for various data needs. Please be sure to include the pipe (|) between the identifiers. Activity code – Illinois defined activity code When using service code S9986 enter the W – code. (Section E Services) Delivery Method- Face to Face, Telephone, or Video Time- service begin(military time)|Duration in minutes Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59),	 S|WXXXX M|F|T|V T|begin time|MMM	 Activity Code Service Start Time: Duration of Service	 5 Bytes 2 Bytes 4 Bytes 5 Bytes

Seg	Data Element	Name	Usage	Comments	Expected Value	ROCS File Name	ROCS File Bytes
				If the following values do not apply to the service, the fields must be 0 (zero) filled: for group based services: group id|# clients in group|#of staff	 CL|#####|##|##	 Group ID Number of Clients in Group Number of Staff in Group	 5 Bytes 3 Bytes 2 Bytes

Appendix 1A-Release of Information Code

A- Appropriate Release of Information on file at Health Care Service Provider or at Utilization Review Organization
I- Informed Consent to Release Medical Information for Conditions or Diagnosis's regulated by Federal Statutes
M- The Provider has Limited or Restricted Ability to Release Data Related to a Claim
N- No, Provider is not Allowed to Release Data
O- On file at Payor or Plan Sponsor
Y- Yes, Provider has a signed Statement Permitting Release of Medical Billing Data Related to a Claim

Appendix 1B- Patient Signature Source Code

B- Signed Signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file
C- Signed HCFA-1500 Claim Form on file
M- Signed signature authorization form for HCFA-1500 Claim Form block 13 on file

P- Signature generated by provider because the patient was not physically present for services
S- Signed signature authorization from for HCFA-1500 Claim Form block 12 on file

Appendix 1C- Insurance Type Code

AP- Auto Insurance Policy
C1- Commercial
CP- Medicare Conditional Primary
GP- Group Policy
HM- Health Maintenance Organization (HMO)
IP- Individual Policy
LD- Long Term Policy
LT- Litigation
MB-Medicare Part B
MC- Medicaid
MI-Medigap Part B
MP- Medicare Primary
OT- Other
PP- Personal Payment (Cash- No Insurance)
SP- Supplemental Policy