Early Intervention
Central Billing Office

Companion Document and Transaction Specifications for HIPAA 837 Claim Transactions

Version 1.0 - January 2012
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## 1. Introduction

### 1.1 Document Purpose

**Companion Documents**

HIPAA Transaction Companion Documents are available to electronic trading partners to clarify information on HIPAA-compliant electronic interfaces with the Early Intervention Central Billing Office (EI-CBO).

The ASC X12 837 Claim Transaction for professional claims is covered in this document.

**HIPAA Overview**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept transmissions in the standard format and must not delay a transaction or adversely affect an entity that wants to conduct standard transactions electronically. For HIPAA, Early Intervention providers are covered entities. The EI-CBO is a Business Associate of a covered entity (DHS).

**Document Objective**

This Companion Guide instructs claim submitters on how to prepare and maintain a HIPAA compliant claim submission interface, including detailed information on populating claim data elements for submission to the
EI-CBO. The Companion Guide supplements the HIPAA Implementation Guide with information specific to the EI-CBO and its trading partners.

**Intended Users**

Companion Documents are intended for the technical staffs of providers and billing agents that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from the EI-CBO’s perspective.

Only providers that submit claims to the EI-CBO *electronically* are subject to HIPAA Transaction and Code Set requirements.

**Relationship To HIPAA Implementation Guides**

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document details the steps needed to FTP files to the EI-CBO for 837 Claim Transactions. It also provides specific information on the fields and values required for transactions sent to the EI-CBO.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

**Disclaimer**

This Companion Document is a technical document describing the specific technical and procedural requirements for interfaces between the EI-CBO and its trading partners. It does not supersede either the health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts
between this document and health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

If you believe there is an error in the document, please notify the EI-CBO Call Center at 1-800-634-8540.
### 1.2 Contents of this Companion Document

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>Section 1 provides general information on Companion Documents and HIPAA and outlines the information included in the remainder of the document.</td>
</tr>
<tr>
<td><strong>Transaction Overview</strong></td>
<td>Section 2 provides an overview of the transaction or transactions included in this Companion Document including information on:</td>
</tr>
<tr>
<td></td>
<td>- The purpose of the transaction.</td>
</tr>
<tr>
<td></td>
<td>- The standard Implementation Guide for the transaction.</td>
</tr>
<tr>
<td></td>
<td>- Replaced and impacted EI-CBO files and processes.</td>
</tr>
<tr>
<td></td>
<td>- Transmission schedules.</td>
</tr>
<tr>
<td><strong>Technical Infrastructure</strong></td>
<td>Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with the EI-CBO via electronic transactions.</td>
</tr>
<tr>
<td><strong>Transaction Standards</strong></td>
<td>Section 4 provides information relating to the transactions included in this Companion Document including:</td>
</tr>
<tr>
<td></td>
<td>- General HIPAA transaction standards.</td>
</tr>
<tr>
<td></td>
<td>- Data interchange conventions applicable to the transactions.</td>
</tr>
<tr>
<td></td>
<td>- Procedures for acknowledgment transactions.</td>
</tr>
<tr>
<td><strong>Transaction Specifications</strong></td>
<td>Section 5 provides specific information relating to the transaction(s) in this Companion Document including:</td>
</tr>
<tr>
<td></td>
<td>- A statement of the purpose of transaction specifications between the EI-CBO and their trading partners.</td>
</tr>
<tr>
<td></td>
<td>- EI-CBO specific data requirements for the transaction(s) at the data element level.</td>
</tr>
</tbody>
</table>

The Data Requirements portion of each Transaction Specification defines in detail how HIPAA Transactions are formatted and populated for exchanges with the EI-CBO. This section covers transaction data elements about which the EI-CBO provides information not to be found in the standard Implementation Guide.
2. **837 Claim Transactions**

2.1 **Transaction Overview**

**Claim Submission**

HIPAA compliant 837 Claim Transactions are designed for use by health care providers to electronically submit fee-for-service claims to health care payers. Providers and other entities that submit claims to the EI-CBO electronically are required to use the formats and code sets of the 837. The 837 Transaction has hundreds of data elements that describe medical services.

Electronic claim submission by providers or their billing agents and claim adjudication by the EI-CBO are not changed by HIPAA mandates. What has changed significantly are the formats of the submitted claims and the code sets used to describe claim data.

**Claim Adjudication**

Within the EI-CBO system, claim adjudication and reporting will continue with modifications (state-only HCPCS Procedure Codes, for example, will no longer be recognized). Basic claim data elements, including identifiers, dates, and diagnosis codes remain unchanged.

Following claim adjudication, an additional HIPAA transaction set notifies submitting providers of the adjudication results. This is the 835 Claim Remittance Advice Transaction.

**Processes Replaced or Impacted**

**Replaced Processes**

None

**Impacted Processes**

- Claims from contracted fee-for-service providers now have HIPAA compliant transaction formats and code sets.
- Submitters of electronic claims can receive remittance advices from the EI-CBO with the HIPAA compliant 835 Transaction.
2.2 837 Claim Transactions

**Purpose**
The purpose of the two types of 837 Claims Transactions is to enable medical providers of all types to submit claims for payment for services. To some extent, the 837 Transactions reflect HCFA-1500 and UB-92 claim formats, with the addition of many supplementary and specialized data structures. Approved fee-for-service providers or their billing agents can transmit 837 Claim Transactions in batch mode through a clearinghouse, where they will be relayed on to the EI-CBO or to the EI-CBO File Transfer Protocol (FTP) Server directly.

**Standard Implementation Guides**
The Standard Implementation Guides for Claim Transactions are:

- 837 Health Care Claim: Professional (005010X222A1)
- 837 Health Care Claim: Institutional (005010X223A2)

**Submission Schedule**
Claim submitters can transmit 837 Transactions which contain batches of claims to the EI-CBO at any time during the day or night.

Upon receipt of an electronic submission, a 997 Functional Acknowledgment will be returned to the sender.

The EI-CBO processes claims every evening, and sends 835 Remittance Advice Transactions to claim submitters that request them on a weekly basis. They are issued at the same time as claim payments.
## 3. Technical Infrastructure and Procedures

### 3.1 Technical Environment

<table>
<thead>
<tr>
<th>Clearinghouse Submission</th>
<th>If you are not already submitting through a clearinghouse and would like to do so, Access the Availity Clearinghouse website at <a href="http://www.Availity.com">http://www.Availity.com</a>. Or call 1-800-AVAILITY (282-4548) If you are already submitting electronic claims through another clearinghouse, verify with Availity that these claims can be passed through the existing clearinghouse on to Availity for “pick up” by the EI-CBO.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EI-CBO Data Center Communications Requirements</strong></td>
<td>For those providers who have the technical expertise to send files directly to the EI-CBO, connection to the EI-CBO will be made by going through the Internet to the EI-CBO File Transfer Protocol (FTP) Server. EI-CBO will assign each provider a user name and password. All files must be encrypted using PGP.</td>
</tr>
</tbody>
</table>
Interest in Electronic Submission

Providers interested in electronic claims submission to the EI-CBO through a clearinghouse should contact Availity or their existing clearinghouse.

Providers interested in direct electronic claims submission to the EI-CBO should contact the EI-CBO at 1-800-634-8540.

Technical Assistance and Help

For technical assistance with electronic claims submitted via a clearinghouse, please contact the technical representative or project manager assigned to you by your clearinghouse.

For technical assistance with electronic claims submitted directly to the EI-CBO, please contact the EI-CBO at 1-800-634-8540.

File Naming Conventions

837 Transaction

The 837 Transaction has two separate formats for professional and institutional claims.

`xxxx.ccyymmdd.hhmmss.837`

`xxxx` is “prof” for professional and “inst” for institutional files.

`ccyymmdd` is the date processed, using the 4-digit calendar year, 2-digit month and 2-digit day (20040301).

`hhmmss` is the time processed in hours, minutes and seconds.

`837` is the Transaction type.

997 Functional Acknowledgement Transactions

A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors.
ccyymmdd.000000000.997

ccyymmdd is the date processed, using the 4-digit calendar year, 2-digit month and 2-digit day (20040301).

000000000 is the unique 9 character Interchange Control Number created for every file EI-CBO sends to the trading partner regardless of the transaction type.

997 is the acknowledgement type.
4. Transaction Standards

4.1 General Information

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Implementation Guide Addenda. The Addenda Documents for the two types of 837 Transactions were published in final form in June 2010. In this Companion Document, the EI-CBO uses Version 5010 837 Transactions as modified by final Addenda.

An overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions.
- The format and content of the Header, Detail, and Trailer Segments specific to the transaction.
- Code sets and values authorized for use in the transaction.

Companion Documents can be seen as a bridge between Implementation Guides and claim requirements specific to the EI-CBO. For claims, this Companion Document, in combination with the Implementation Guides, tells how to prepare data in HIPAA standard formats for submission to the EI-CBO.
4.2 Data Interchange Conventions

Overview of Data Interchange

When receiving 837 Claim Transactions from providers, the EI-CBO follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides and later in this section.

Transaction Specifications assume that security considerations involving user identifiers, passwords, and encryption procedures are handled by the EI-CBO FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.
### Envelope Specifications Table

Definitions of table columns follow:

**Loop ID**
The Implementation Guide’s identifier for a data loop within a transaction.

**Element ID**
The Implementation Guide’s identifier for a data element within a segment.

**Description**
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

**ID**
- ID = Identifier
- AN = Alphanumeric
- DT = Date
- TM = Time
- N0 = Number

**Element Min/Max**
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated.

**Usage Requirement**
- R = Required
- S = Situational

**Valid Values**
The valid values from the Implementation Guide that are used by EI-CBO.

**1500 Box or UB92 Box**
Box on HCFA 1500 or UB 92 where data was printed.
Comment
Definitions of valid values used by the EI-CBO and additional information about the EI-CBO data element requirements.
4.3 Testing Procedures

Each EI-CBO trading partner is responsible for ensuring that its transactions are compliant with HIPAA mandates based on the types of testing described below.

The EI-CBO encourages providers and other entities to use a third party tool to certify that the entity can produce and accept HIPAA compliant transactions. Success is determined by the ability to pass the six types of compliance tests listed below. The initial four of the six types of testing are also used as categories for edits performed by the EI-CBO translator. The testing types have been developed by the Workgroup for Electronic Data Interchange (WEDI), a private sector organization concerned with implementation of electronic transactions.

They are:

1. Integrity Testing, which validates the basic syntactical integrity of the provider’s EDI file.
2. Implementation Guide Requirements Testing, which involves requirements imposed by the transaction’s HIPAA Implementation Guide, including validation of data element values specified in the Guide.
3. Balancing Testing, which requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction’s Implementation Guide.
4. Inter-Segment Situation Testing, which validates inter-segment situations specified in the Implementation Guide.
5. External Code Set Testing, which validates code set values for HIPAA mandated codes defined and maintained outside of Implementation Guides.
6. Product Type or Line of Service Testing, validates specific requirements defined in the Implementation Guide for specialized services such as services performed by an associate provider.
5. Transaction Specifications

5.1 837 Transaction Specifications

**Purpose**

Transaction specifications are designed, in combination with HIPAA Implementation Guides, to identify data to be transmitted between the EI-CBO trading partners along with data type and format. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section. Only transaction data with submission requirements specific to the EI-CBO claims is included.

The data element level Transaction Specifications in this section show in an Adjudication Usage column whether each element listed is required, required if applicable, or optional. Because the Transaction Specifications are limited to data elements not fully covered in Implementation Guides, they are not a complete list of the data elements required by the EI-CBO for claim adjudication. Some required claim data elements, primarily identification and control fields, are adequately covered in one of the 837 Implementation Guides and do not appear in this document.

EI-CBO claims fit the business model offered by the 837 Claim Transaction quite well. Providers submit fee-for-service claims to EI-CBO, which responds by editing and adjudicating the claims, authorizing payment to the provider the amounts determined, and reporting adjudication results on remittance advices. Under HIPPA, both the claim submission and the remittance advice components of the process are heavily impacted by new electronic transactions. However, the internal rules and algorithms that the EI-CBO uses to adjudicate claims are not directly affected.
Relationship to HIPAA Implementation Guide

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications portion of this Companion Document is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.
Professional 837 Claim Transactions from the EI-CBO fee-for-service providers contain data to enable the EI-CBO to adjudicate professional claims, plus a number of additional fields, including fields with coordination of benefits data, that are desirable for reporting and are of interest to the EI-CBO. The purpose of these Transaction Specifications are to identify critical data elements and data element values that the EI-CBO needs in Claim Transactions and to let providers know how to populate and transmit electronic claim data for the EI-CBO.

The specifications in this section apply only to 837 Professional Claim Transactions that providers send to EI-CBO. Only data elements that are used by EI-CBO in ways that require explanations that go beyond information in standard HIPAA Implementation Guides are included.

### General Transaction Specifications

Processing Stipulations:
- Patient loops, 2000C and 2010CA, are ignored because the EI-CBO subscriber is always the same as the patient.
- Negative quantities or amounts are rejected.
- The only valid values for CLM05-3 (Claim Frequency Type Code) are “1” original and “7” replacement. Claims with a value of “7” will be processed as original claims and may result in duplicate claim rejection if original claim resulted in a payment. These claim adjustments must be submitted through the paper process.
- Transportation claims must be submitted through the paper process.
- Associate Providers must be indicated in Loop 2300 NTE02 in the format ASSOCIATE LASTNAME, FIRSTNAME format.
- Valid EI HCPCS Procedure Codes, modifiers, and place of service codes are a subset of the standard set. See Section 6 for valid code sets.
## 5.3 837P Worksheet

<table>
<thead>
<tr>
<th>Element ID</th>
<th>Description</th>
<th>ID</th>
<th>Min Max</th>
<th>Usage</th>
<th>Valid Values</th>
<th>1500 BOX</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
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<td>30 = Tax ID, ZZ = Mutually Defined</td>
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<td>2-2</td>
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<td>36434 - CBO Assigned Payer ID</td>
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<td>R</td>
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<td>R</td>
<td>HC</td>
<td></td>
<td></td>
</tr>
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<td>GS02</td>
<td>Application Sender Code</td>
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<td>2-15</td>
<td>R</td>
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<td>Provider nine character federal tax ID number</td>
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<td>GS03</td>
<td>Application Receiver Code</td>
<td>AN</td>
<td>2-15</td>
<td>R</td>
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<td></td>
<td>36434 - CBO Assigned Payer ID</td>
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<tr>
<td>GS04</td>
<td>Date</td>
<td>DT</td>
<td>8-8</td>
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<td>Element ID</td>
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<td>Min Max</td>
<td>Usage</td>
<td>Valid Values</td>
<td>1500 BOX</td>
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<td>R</td>
<td>005010X222A</td>
<td>1</td>
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</tr>
</tbody>
</table>

**ST**  TRANSACTION SET HEADER

| ST01       | Transaction Set Identifier Code                  | ID | 3-3     | R     | 837          |          |                           |
| ST02       | Transaction Set Control Number                   | AN | 4-9     | R     |               |          |                           |
| ST03       | Implementation Convention Reference              | AN | 1-35    | R     | 005010X222A  | 1        |                           |

**BHT**  BEGINNING OF HIERARCHICAL TRANSACTION

| BHT01      | Hierarchical Structure Code                      | ID | 4-4     | R     | 0019         |          |                           |
| BHT02      | Transaction Set Purpose Code                     | ID | 2-2     | R     | 00           |          | 00 - Original             |
| BHT03      | Originator Application Transaction ID            | AN | 1-30    | R     |              |          |                           |
| BHT04      | Transaction Set Creation Date                    | DT | 8-8     | R     | CCYYMMDD     |          |                           |
| BHT05      | Transaction Set Creation Time                    | TM | 4-8     | R     | HHMM         |          |                           |
| BHT06      | Claim or Encounter ID                            | ID | 2-2     | R     | CH           |          | CH - Chargeable           |

**NM1**  SUBMITTER NAME

<p>| NM101      | Entity Identifier Code                           | ID | 2-3     | R     | 41           |          |                           |
| NM102      | Entity Type Qualifier                            | ID | 1-1     | R     | 1, 2         |          |                           |
| NM103      | Submitter Last or Organization Name             | AN | 1-35    | R     | 33           |          | Provider Billing Name-If submitter is the billing provider. |
| NM104      | Submitter First Name                             | AN | 1-25    | S     | 33           |          | Provider Billing Name-If submitter is the billing provider. |</p>
<table>
<thead>
<tr>
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<th>Description</th>
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**REF MEDICAL RECORD NUMBER**

**NTE CLAIM NOTE**

This segment is required if an associate provider rendered services.

ADD = Additional Information

The first 10 characters will be "Associate " followed by the Associate's Lastname, Firstname.

Example: Associate: Jones, Mary
(Please note there is a space between the Associate: and the Lastname)

**HI HEALTH CARE DIAGNOSIS CODE**

BK = Principal diagnosis. Only the principal diagnosis is recognized by CBO.

**NM1 RENDERING PROVIDER NAME**

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**PRV RENDERING PROVIDER SPECIALTY INFORMATION**

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**SBR OTHER SUBSCRIBER INFORMATION**

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**OI OTHER INSURANCE COVERAGE**

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**SV107**

Diagnosis Code Pointer

- **SV107-1**: Diagnosis Code Pointer
  - ID: N0
  - Min: 1-2
  - Max: 2
  - Usage: R
  - Valid Values: 24E

**SV107-2**: Diagnosis Code Pointer

- ID: N0
- Min: 1-2
- Max: 2
- Usage: S
- Valid Values: 24E

**SV107-3**: Diagnosis Code Pointer

- ID: N0
- Min: 1-2
- Max: 2
- Usage: S
- Valid Values: 24E

**SV107-4**: Diagnosis Code Pointer

- ID: N0
- Min: 1-2
- Max: 2
- Usage: S
- Valid Values: 24E

**DTP**

**DATE - SERVICE DATE**

- DTP01: Date Time Qualifier
  - ID: 3-3
  - Usage: R
  - Valid Values: 472

- DTP02: Date Time Period Format Qualifier
  - ID: 2-3
  - Usage: R
  - Valid Values: D8, RD8

- DTP03: Service Date
  - ID: 1-35
  - Usage: R
  - Valid Values: CCYYMMDD

  Must always be a single date of service.

**SE**

**TRANSACTION SET TRAILER**

- SE01: Transaction Segment Count
  - ID: N0
  - Min: 1-10
  - Usage: R

- SE02: Transaction Set Control Number
  - ID: AN
  - Min: 4-9
  - Usage: R

**GE**

**FUNCTION GROUP TRAILER**

- GE01: Number of Transaction Sets Included
  - ID: N0
  - Min: 1-6
  - Usage: R

- GE02: Group Control Number
  - ID: N0
  - Min: 1-9
  - Usage: R
## 5.4 837I Worksheet

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**NM1**  
**SUBMITTER NAME**

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**PER**  
**SUBMITTER EDI CONTACT INFORMATION**

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**NM1 RECEIVER NAME**

| NM101      | Entity Identifier Code             | ID  | 2-3 |     | R     | 40          |          |                                               |
| NM102      | Entity Type Qualifier              | ID  | 1-1 |     | R     | 2           |          |                                               |
| NM103      | Receiver Name                      | AN  | 1-35| R   | Central Billing Office |          |                                               |
| NM108      | Identification Code Qualifier      | ID  | 1-2 |     | R     | 46          |          |                                               |
| NM109      | Receiver Primary Identifier        | AN  | 2-80| R   | 36434 | NONE        |          |                                               |

**HL BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL**

| HL01       | Hierarchical ID Number             | AN  | 1-12|     | R     |             |          |                                               |
| HL03       | Hierarchical Level Code            | ID  | 1-2 |     | R     | 20          |          |                                               |
| HL04       | Hierarchical Child Code            | ID  | 1-1 |     | R     | 1           |          |                                               |

**NM1 Billing Provider Name**

<p>| NM101      | Entity Identifier Code             | ID  | 2-3 |     | R     | 85          |          |                                               |
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**Comments:**
- BK = Principal diagnosis. Only the principal diagnosis is recognized by CBO.
- 61 = Only supported value
- Use Amount field to send Place of Service code
- Use 2310A or 2310C to send Rendering Provider
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## 6.0 Code Sets

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