



Companion Document

837I

837 Institutional Health Care Claim

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

Section 1 – 837I Institutional Health Care Claim: Basic Instructions Section 2 – 837I Institutional Health Care Claim: Enveloping Section 3 – 837I Institutional Health Care Claim: Charts for Situational Rules

Get Started with Availity*

The [Availity Quick Start Guide](#) will assist you with any EDI connection questions.

If you use a Clearinghouse or Billing company, please work with them to ensure connectivity.

Need Assistance?

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

Release AV-3
(June 2022)

005010X223A2

* Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc.

Section 1 - Basic Instructions

1.1 X12 and HIPAA Compliance Checking, and Business Edits

Availity's batch EDI processing generates response files (acknowledgements and reports) for each submitted batch file. Availity provides standard response files recommended in the official HIPAA implementation guides (called TR3s) and proprietary reports for end-to-end tracking and accountability of each submitted transaction.

Please visit the [Availity Batch Electronic Data Interchange Standard Companion Guide](#) for report options.

1.2 HIPAA Compliant Codes

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

1. Physician's Current Procedure Terminology (CPT)
2. Health Care Financing Administration Common Procedural Coding System (HCPCS)
3. International Classification of Diseases Clinical Mod (ICD-10-CM) Clinical Modification
4. International Classification of Diseases Clinical Mod (ICD-10-PCS) Procedure Coding System
5. National Uniform Billing Committee (NUBC) Codes
6. Diagnosis Related Group Number (DRG)
7. Provider Taxonomy Codes
8. National Drug Code

1.3 Diagnosis Codes

According to the 837I TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, UniCare Health Plan of West Virginia, Inc. (UniCare) will return a 999 to the submitter indicating that the transaction has been rejected.

1.4 Procedure codes and Modifiers

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

1.5

Uppercase Letters, Special Characters, and Delimiters

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

1. All alpha characters must be submitted in UPPERCASE letters only.
2. Suggested delimiters for the transaction are assigned as part of the trading partner set up. E-Solutions Representative will discuss options with trading partners, if applicable.

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

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

Examples: Recommended: Zip Code 123456789 Medical Record # 1234567

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

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

1.6 Decimal "R" Data Element Type

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

1.7 Numeric Values, Monetary Amounts and Units

UniCare pays all claims in US dollars and therefore, accepts monetary amounts in US dollars only. If codes related to foreign currencies are used, then a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

UniCare recognizes units in whole numbers only.

If a negative service line charge or negative units are used, then a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

SV203 Monetary Amount - Line Item Charge Amount
SV205 Quantity - Service Unit Count

1.8 Address Information

P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

The Pay-to Address loop does support P.O. Box / Lock Box addresses. Therefore, if payment is expected to be remitted to a P.O. Box / Lock Box, submit the P.O. Box / Lock Box address.

Full 9-digit zip codes are required in the Billing Provider and Service Facility Location loops. If 5-digit zip codes are used in these loops, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.

1.9 Taxonomy Codes (PRV)

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

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

1.10 Coordination of Benefits

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

The provider sends the 837 to the primary payer.

The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider. The 835 includes the claim adjustment reason code and/or remark code for the claim.

Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops 2320, 2330A-I, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

UniCare recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier. When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

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

1.11 Claim and COB Balancing

For COB claims, balancing is performed at both claim and service line on the payment charges for each payer. If not balanced, then an Electronic Batch Report and/or a Delayed Payer Report will be returned to the submitter identifying which claim(s) have failed.

Loop 2300 CLM02 (Total Claim Charge) must equal the sum of Loop 2400 SV203 (Line Item Charge). Loop 2320 AMT02 (COB Payer Paid Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) less the sum of Loop 2300 CAS (Claim Level Adjustments).

Loop 2400 SV203 (Line Item Charge Amount) must equal the sum of Loop 2430 SVD02 (Line Adjudication Information) plus the sum of Loop 2430 CAS (Claim Level Adjustments).

1.12 Other COB Allowed Amount - Calculation

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

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

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

Loop 2430 CAS01 = CO, OA, PR, PI

Loop 2430 CAS02 ≠ 1, 2, 3 where '1'=Deductible, '2'=Co-insurance and '3'=Co-payment.

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

1.13 Medicaid Reclamation / Subrogation Claims

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

To reclaim monies, states submit claims to the primary insurance after reconciliation of eligibility files between BCBS and Medicaid. Exempt from NPI, trading partners on behalf of states must submit specific data elements in Loops 2010AA, 2010AC, 2010BB, 2310A, 2310E and 2320 for Medicaid reclamation.

1.14 Preparing Attachments to Support a Claim

(1) Unsolicited

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

PWK01 = Report type code (See TR3)

PWK02 = EL (Electronic)

PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL

PWK06 = Identification Code (Attachment Control #)

- The attachment control number is a unique identifier assigned by the provider organization or vendor and has a one-time use.

NOTE: Attachments must be received within seven calendar days from the claim submission date when there is a PWK indicator unless an alternate date is provided based on regulatory or contractual requirements.

(2) Solicited

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

275 Electronic Attachments to Support a Claim

The 275 Companion Document assists with specific attachment requirements and enables providers to electronically submit attachments based on their business needs.

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

Unsolicited: Claims submitted with PWK submission

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

PWK01 = Report type code (see TR3)

PWK02 = EL (electronic)

PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL

PWK06 = Identification Code (Attachment Control #)

- The attachment control number is a unique identifier assigned by the provider organization or vendor and has a one-time use.

NOTE: Attachments must be received within seven calendar days from the claim submission date when there is a PWK indicator unless an alternate date is provided based on regulatory or contractual requirements

Solicited: Claims submitted without PWK submission

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

1. Provider sends a claim without the PWK segment.
2. Payer determines not enough information exists to process the claim.
3. Payer sends letter request for the additional information, or provider wants to submit additional documentation on a processed claim.
4. Provider uses the 275 to submit documentation.
5. Provider sends the 275; the TRN02 is the attachment control # which will be the payer assigned claim number.

1.15 Social Security Number

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

1. Loop 2010AA REF Billing Provider Tax Identification
2. Loop 2010BA NM1 Subscriber Name
3. Loop 2010BA REF Subscriber Name
4. Loop 2330A NM1 Other Subscriber Name
5. Loop 2330A REF Other Subscriber Secondary Identification

Section 2 – Enveloping

EDI envelopes control and track communications between you and the payer. Once envelope may contain many transaction sets groups into the following.

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

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

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

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

Section 3 - Charts for Situational Rules

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

837 Institutional Health Care Claim

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to UniCare
P.67	ST Transaction Set Header	ST03 Implementation Convention Ref	005010X223A2	005010X223A2 - Health Care Claim, Institutional
P.68	BHT Beginning of Hierarchical Trx	BHT06 Transaction Type Code	RP CH 31	RP - Reporting; required to indicate the batch contains all encounters. CH – Chargeable 31 – Medicaid Reclamation

Loop ID 1000A—Submitter Name

NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway

P.71	NM1 Submitter Name	NM109 Identification Code	(Submitter Identifier) UPPERCASE	<ul style="list-style-type: none"> EDI assigned Sender ID. Equals the value entered in ISA06 and GS02.
------	------------------------------	-------------------------------------	---	--

P.73 **PER** Submitter EDI Contact Information - Refer to TR3

Loop ID 1000B—Receiver Name

NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway

P.76	NM1 Receiver Name	NM103 Last Name or Organization Name	UniCare	Receiver name
		NM109 Identification Code	80314	80314 - represents UniCare

Loop ID 2000A—Billing Provider Hierarchical Level

P.78 **HL** Billing Provider Hierarchical Level - Refer to TR3

P.80	PRV Billing Provider Specialty Info	PRV03 Reference Identification	(Provider Taxonomy Code)	Enter the taxonomy code to uniquely identify the provider.
P.81	CUR Foreign Currency Information	CUR02 Currency Code	USD	USD - US dollars <ul style="list-style-type: none"> Monetary amounts recognized in US dollars only.

Loop ID 2010AA—Billing Provider Name

P.87	N3 Billing Provider Address	N301 Billing Provider Address Line	(Billing Provider Street Address)	Enter the physical address to uniquely identify the provider. Submitting PO Box/Lock Box address will result in claim failure, and return on Availity response report
------	---------------------------------------	--	--	---

P.88 **N4** Billing Prov City, State, ZIP Code - Refer to TR3

P.90 Billing Provider Tax Identification - Refer to TR3

Information

Loop ID 2010BA—Subscriber Name

P.112 NM1 Subscriber Name	NM109 Identification Code	(Subscriber Primary Identifier)	Subscriber ID - 8-20 bytes. ***ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS. Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.
P.115 N3	<i>Subscriber Address - Refer to TR3</i>		
P.116 N4	<i>Subscriber City, State, ZIP Code - Refer to TR3</i>		
P.118 DMG	<i>Subscriber Demographic Information Refer to TR3</i>		
P.120 REF	<i>Subscriber Secondary Identification Refer to TR3</i>		
P.121 REF	<i>Property and Casualty Claim Number Refer to TR3</i>		

837 Institutional Health Care Claim

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to UniCare
-----	---------	-------------------------	-------	---

Loop ID 2010BB—Payer Name

P.122 NM1 Payer Name	NM103 Payer Name	UniCare	UniCare - identifies payer
	NM108 ID Code Qualifier	PI	PI - Payer Identification
	NM109 Identification Code	(Payer Primary Identifier)	80314 - represents UniCare
P.124 N3	<i>Payer Address - Refer to TR3</i>		
P.125 N4	<i>Payer City, State, ZIP Code - Refer to TR3</i>		
P.127 REF	<i>Payer Secondary Identification - Refer to TR3</i>		
P.129 REF	<i>Billing Provider Secondary Identification - Refer to TR3</i>		

Loop ID 2000C—Patient Hierarchical Level

P.131 HL	<i>Patient Hierarchical Level - Refer to TR3</i>
P.133 PAT	<i>Patient Information - Refer to TR3</i>

Loop ID 2010CA—Patient Name

P.135	<i>Patient Name - Refer to TR3</i>
-------	------------------------------------

- P.137 **NM1** *Patient Address - Refer to TR3*
- P.138 **N3** *Patient City, State, ZIP Code - Refer to TR3*
- N4**
- P.140 **DMG** *Patient Demographic Information - Refer to TR3*
- P.142 **REF** *Property and Casualty Claim Number - Refer to TR3*

Loop ID 2300—Claim Information

- P.143 **CLM** **CLM01** **(Patient Control Number)** ▪ Maximum of 20 alphanumeric characters. ▪ Value is returned on Claim Information Claim Submitter's Identifier outbound 835 and other transactions.
- CLM02** **(Total Claim Charge Amt)** Value must equal the sum of submitted Monetary Amount service line charges in Loop 2400 SV203.
- CLM05-3** **(Third Position of Uniform Billing Claim Type)** If '7' (replacement) or '8' (void/cancel) then Claim Frequency Loop 2300 REF02 Payer Claim Control # (F8) is required and must contain UniCare **Form Bill** originally assigned claim number.
- P.149 **DTP** *Discharge Hour- Refer to TR3*
- P.150 **DTP** **DTP03** **(Statement From / To Date)** Valid medical codes will be based on the Statement Dates Date Time Period "Statement From Date"
- P.151 **DTP** *Admission Date/Hour - Refer to TR3*
- P.152 **DTP** *Date-Repricer Received Date - Refer to TR3*
- P.153 **CL1** *Institutional Claim Code - Refer to TR3*

837

Institutional Health Care Claim

TR3 Segment	Reference	Value	Definitions and Notes	Designator(s)	Specific to UniCare
Loop ID 2300—Claim Information (cont'd)					
P.154	PWK	PWK02 - Report Transmission Code	EL = Electronic		
		PWK06 – Identification Code	Field reserved for Unique Attachment Control Number		
P.158	CN1	<i>Contract Information - Refer to TR3</i>			
P.160	AMT	<i>Patient Estimated Amount Due - Refer to TR3</i>			
P.161	REF	<i>Service Authorization Exception Code - Refer to TR3</i>			
P.163	REF	<i>Referral Number - Refer to TR3</i>			
P.164	REF	<i>Prior Authorization - Refer to TR3</i>			
P.166	REF	REF01	F8	F8 - Original Reference Number	
		Payer Claim Ref ID Qualifier			
		Control Number REF02	(Claim Original Reference Number)	Represents the claim # assigned by UniCare. Providers should submit the original claim # indicated on the 835 when Loop 2300 CLM053 Claim Freq. Type Code equals '7' or '8'.	
		Reference Identification			

- P.167 **REF** *Repriced Claim Number - Refer to TR3*
- P.168 **REF** *Adjusted Repriced Claim Number - Refer to TR3*
- P.169 **REF** *Investigational Device Exemption Number - Refer to TR3*
- P.170 **REF** *Claim ID for* **REF01** *Ref ID Qualifier* **U9** *U9 - Claim Number*
- Transmission **REF02 (Value Added)** *Will be returned on Level 2 Status Report, if Intermediaries Reference **Network Trace** submitted. Identification **Number***
- P.172 **REF** *Auto Accident State - Refer to TR3*
- P.173 **REF** *Medical Record Number - Refer to TR3*
- P.174 **REF** *Demonstration Project Identifier - Refer to TR3*
- P.175 **REF** *PRO Approval Number - Refer to TR3*
- P.176 **K3** *File Information - Refer to TR3*
- P.178 **K3** *File Information - Refer to TR3*
- P.180 **NTE** *Claim Note - Refer to TR3*
- P.181 **NTE** *Billing Note - Refer to TR3*
- CRC** *EPSDT Referral - Refer to TR3*

International Health Care Claim

TR3 Segment Reference Value Definitions and Notes Designator(s)
Specific to UniCare

- P.193 **HI** *External Cause of Injury - Refer to TR3*
- P.218 **HI** *DRG Information - Refer to TR3*
- P.220 **HI** *Other Diagnosis Information - Refer to TR3*
- P.239 **HI** *Principal Procedure Information - Refer to TR3*
- P.242 **HI** *Other Procedure Information - Refer to TR3*
- P.258 **HI** *Occurrence Span Information - Refer to TR3*
- P.271 **HI** *Occurrence Information - Refer to TR3*
- P.284 **HI** *Value Information - Refer to TR3*
- P.294 **HI** *Condition Information - Refer to TR3*
- P.304 **HI** *Treatment Code Information - Refer to TR3*
- P.313 **HCP** *Claim Pricing/Repricing Information - Refer to TR3*

Loop ID 2310A—Attending Physician Name
Required for services (non-emergency ambulance transportation) populated in 2400, SV202-2

- P.319 **NM1** *Attending Provider Name - Refer to TR3*

P.322	PRV Attending Physician Specialty	PRV03 Reference Identification	(Provider Taxonomy Code)	Enter the taxonomy code to uniquely identify the provider.
-------	---	---	---	---

Loop ID 2310A—Attending Physician Name (cont'd)

P.324	REF	<i>Attending Provider Secondary Identification - Refer to TR3</i>
-------	------------	---

Loop ID 2310B—Operating Physician Name

P.326	NM1	<i>Operating Physician Name - Refer to TR3</i>
-------	------------	--

P.329	REF	<i>Operating Physician Secondary Identification - Refer to TR3</i>
-------	------------	--

Loop ID 2310C—Other Operating Physician Name

P.331	NM1	<i>Other Operating Physician Name - Refer to TR3</i>
-------	------------	--

P.334	REF	<i>Other Operating Physician Secondary Identification - Refer to TR3</i>
-------	------------	--

Loop ID 2310D—Rendering Provider Name

P.336	NM1	<i>Rendering Provider Name - Refer to TR3</i>
-------	------------	---

P.339	REF	<i>Rendering Provider Secondary Identification - Refer to TR3</i>
-------	------------	---

Loop ID 2310E—Service Facility Location Name

P.341	NM1	<i>Service Facility Location Name - Refer to TR3</i>
-------	------------	--

P.344	N3	<i>Service Facility Location Address - Refer to TR3</i>
-------	-----------	---

P.345	N4	<i>Serv Fac Loc City, State, ZIP - Refer to TR3</i>
-------	-----------	---

P.347	REF	<i>Service Facility Location Secondary Identification - Refer to TR3</i>
-------	------------	--

Loop ID 2310F—Referring Provider Name

P.349	NM1	<i>Referring Provider Name - Refer to TR3</i>
-------	------------	---

P.352	REF	<i>Referring Provider Secondary Identification - Refer to TR3</i>
-------	------------	---

Loop ID 2320—Other Subscriber Information

P.354	SBR	<i>Other Subscriber Information - Refer to TR3</i>
-------	------------	--

P.358	CAS	<i>Claim Level Adjustments - Refer to TR3</i>
-------	------------	---

P.364	AMT	<i>COB Payer Paid Amount - Refer to TR3</i>
-------	------------	---

P.365	AMT	<i>Remaining Patient Liability - Refer to TR3</i>
-------	------------	---

P.366	AMT	<i>COB Total Non-Covered Amount - Refer to TR3</i>
-------	------------	--

P.367	OI	<i>Other Insurance Coverage Information - Refer to TR3</i>
-------	-----------	--

P.369	MIA	<i>Inpatient Adjudication Information - Refer to TR3</i>
-------	------------	--

P.374	MOA	<i>Outpatient Adjudication Information - Refer to TR3</i>
-------	------------	---

Loop ID 2330A—Other Subscriber Name

P.377	NM1	<i>Other Subscriber Name - Refer to TR3</i>
-------	------------	---

P.380	N3	<i>Other Subscriber Address - Refer to TR3</i>
P.381	N4	<i>Other Subscriber City, State, ZIP Code - Refer to TR3</i>
P.383	REF	<i>Other Subscriber Secondary Identification - Refer to TR3</i>

Loop ID 2330B—Other Payer Name

P.384	NM1	<i>Other Payer Name - Refer to TR3</i>
P.386	N3	<i>Other Payer Address - Refer to TR3</i>
P.387	N4	<i>Other Payer City, State, ZIP Code - Refer to TR3</i>
P.389	DTP	<i>Claim Check or Remittance Date - Refer to TR3</i>
P.390	REF	<i>Other Payer Secondary Identifier - Refer to TR3</i>
P.392	REF	<i>Other Payer Prior Authorization Number - Refer to TR3</i>
P.393	REF	<i>Other Payer Referral Number - Refer to TR3</i>
P.394	REF	<i>Other Payer Claim Adjustment Indicator - Refer to TR3</i>
P.395	REF	<i>Other Payer Claim Control Number - Refer to TR3</i>

Loop ID 2330C—Other Payer Attending Provider

P.396	NM1	<i>Other Payer Attending Provider - Refer to TR3</i>
P.398	REF	<i>Other Payer Attending Provider Secondary Identification - Refer to TR3</i>

Loop ID 2330D—Other Payer Operating Physician

P.400	NM1	<i>Other Payer Operating Physician - Refer to TR3</i>
P.402	REF	<i>Other Payer Operating Physician Secondary Identification - Refer to TR3</i>

Loop ID 2330E—Other Payer Other Operating Physician

P.404	NM1	<i>Other Payer Other Operating Physician - Refer to TR3</i>
P.406	REF	<i>Other Payer Other Operating Physician Secondary Identification - Refer to TR3</i>

837 Institutional Health Care Claim

TR3	Segment	Reference	Value	Definitions and Notes	Designator(s)	Specific to UniCare
-----	---------	-----------	-------	-----------------------	---------------	---------------------

Loop ID 2330F—Other Payer Service Facility Location

P.408	NM1	<i>Other Payer Service Facility Location - Refer to TR3</i>
P.410	REF	<i>Other Payer Service Facility Location Secondary Identification - Refer to TR3</i>

Loop ID 2330G—Other Payer Rendering Provider Name

P.412	NM1	<i>Other Payer Rendering Provider Name - Refer to TR3</i>
P.414	REF	<i>Other Payer Rendering Provider Secondary Identification - Refer to TR3</i>

Loop ID 2330H—Other Payer Referring Provider

P.416	NM1	<i>Other Payer Referring Provider - Refer to TR3</i>
P.418	REF	<i>Other Payer Referring Provider Secondary Identification - Refer to TR3</i>

Loop ID 2330I—Other Payer Billing Provider

P.420	NM1	<i>Other Payer Billing Provider - Refer to TR3</i>
P.422	REF	<i>Other Payer Billing Provider Secondary Identification - Refer to TR3</i>

Loop ID 2400—Service Line Number

P.423	LX	<i>Service Line Number - Refer to TR3</i>
-------	-----------	---

P.424 **SV2** **SV202-2** **(Procedure** Attending Provider (2310A) required for
 Institutional Product/Service ID **Code)** nonemergency ambulance transportation
 Service codes A0426, A0428 (without modifier QL).
 Line

P.429 **PWK** *Line Supplemental Information - Refer to TR3*

P.433 **DTP** *Date - Service Date - Refer to TR3*

P.435 **REF** *Line Item Control Number - Refer to TR3*

P.437 **REF** *Repriced Line Item Reference Number - Refer to TR3*

P.438 **REF** *Adjusted Repriced Line Item Reference Number - Refer to TR3*

P.439 **AMT** *Service Tax Amount - Refer to TR3*

P.440 **AMT** *Facility Tax Amount - Refer to TR3*

P.441 **NTE** *Third Party Organization Notes - Refer to TR3*

P.442 **HCP** *Line Pricing/Repricing Information - Refer to TR3*

Loop ID 2410—Drug Identification

P.449 **LIN** **LIN03** **(National Drug** NDC # for prescribed drugs and biologics
 Drug Identification Product/Service ID **Code)** when required by government regulation.

P.452 **CTP** *Drug Quantity - Refer to TR3*

P.454 **REF** *Prescription of Compound Drug Association Number - Refer to TR3*

Loop ID 2420A—Operating Physician Name

P.456 **NM1** *Operating Physician Name - Refer to TR3*

P.459 **REF** *Operating Physician Secondary Identification - Refer to TR3*

Loop ID 2420B—Other Operating Physician Name

P.461 **NM1** *Other Operating Physician Name - Refer to TR3*

P.464 **REF** *Other Operating Physician Secondary Identification - Refer to TR3*

Loop ID 2420C—Rendering Provider Name

P.466 **NM1** *Rendering Provider Name - Refer to TR3*

P.469 **REF** *Rendering Provider Secondary Identification - Refer to TR3*

Loop ID 2420D—Referring Provider Name

P.471 **NM1** *Referring Provider Name - Refer to TR3*

P.474 **REF** *Referring Provider Secondary Identification - Refer to TR3*

Loop ID 2430—Line Adjudication Information

P.476 **SVD** *Line Adjudication Information - Refer to TR3*

P.480 **CAS** *Line Adjustment - Refer to TR3*

P.486 **DTP** *Line Check or Remittance Date - Refer to TR3*

P.487 **AMT** *Remaining Patient Liability - Refer to TR3*

P.488 **SE** *Transaction Set Trailer - Refer to TR3*