CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2103	**Date: November 19, 2010**
	Change Request 7065

NOTE TO CONTRACTORS: Transmittal 2065, dated October 15, 2010, is being rescinded and replaced with Transmittal 2103 dated November 19, 2010, which removes the "Sensitive and Controversial" status and corrects compatibility errors in the Internet Only Manual revision. All other information remains the same.

SUBJECT: Fractional Mileage Units Submitted on Ambulance Claims

I. SUMMARY OF CHANGES: Pursuant to the CY 2011 MPFS final rule, this CR implements the requirement to report and pay based on fractional mileage units for ambulance services. Providers and suppliers are required to bill ambulance mileage that is rounded up to the nearest tenth of a mile for trips totaling less than 100 miles.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30.1.2/Coding Instruction for Paper and Electronic Claim Forms
R	15/30.2.1/ A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation
R	26/10.4/Items 14-33 - Provider of Service or Supplier Information

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

NOTE TO CONTRACTORS: Transmittal 2065, dated October 15, 2010, is being rescinded and replaced with Transmittal 2103, dated November 19, 2010, which removes the "Sensitive and Controversial" status and corrects compatibility errors in the Internet Only Manual revision. All other information remains the same.

Pub. 100-04	Transmittal: 2103	Date: November 19, 2010	Change Request: 7065

SUBJECT: Fractional Mileage Amounts Submitted on Ambulance Claims

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background:

Pub.100-04, Medicare Claims Processing Manual, chapter 15, §§30.1.2 and 30.2.1, require that ambulance providers and suppliers submitting claims to the Carrier/A/B MACs or FI/A/B/MACs, respectively, utilize the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to CMS' instructions, providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837 electronic claim. For ambulance suppliers submitting claims to the Carrier/A/B MAC, Pub. 100-04, Medicare Claims Processing Manual, chapter 26, §10.4, additionally states that at least 1 unit must be billed in Item 24G on the Form CMS-1500 paper claim or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than 1 mile during a covered trip, the supplier would enter 1 unit on the claim form with the appropriate HCPCS code for mileage.

Previously, CMS' claims processing systems were not capable of accepting and processing claims containing fractional unit amounts, which resulted in payment being made for mileage in excess of what was actually traveled. This system limitation has been eliminated, and the system can now accommodate fractional mileage amounts.

Therefore, in the CY 2011 Physician Fee Schedule Final Rule, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. The final rule requires that, effective January 1, 2011, all Medicare ambulance providers and suppliers bill mileage that is accurate to a tenth of a mile. This transmittal will instruct contactors to accept and process claims for ambulance services submitted with fractional mileage amounts and will update the Pub. 100-04, Medicare Claims Processing Manual, to reflect the same. This transmittal upgrades the Medicare claims processing system to accept and process mileage HCPCS codes to a tenth of a mile.

NOTE: For FI/A/B MAC claims processing, currently the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in §30.2.1. That is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

B. Policy:

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Contractors shall truncate mileage units with fractional amounts reported to greater than one decimal place; e.g., 99.99 will become 99.9 after truncating the hundredths place.

For trips totaling 100 miles and greater, suppliers shall continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Contractors shall truncate mileage units totaling 100 and greater that are reported with fractional mileage (e.g., 100.99 will become 100 after truncating the decimal places).

For mileage totaling less than 1 mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Carrier/A/B MACS shall automatically default "0.1" unit when the total mileage units are missing in Item 24G of the Form CMS-1500 paper claim. FI/A/B MACs shall continue to return claims when the total mileage units are missing.

NOTE: This policy applies only to ambulances services billed on a Form CMS-1500 paper claim, ANSI X12N 837P and 837I electronic claims. This is not applicable for UB-04 paper claims. Mileage is reported in Item 24G of the Form CMS-1500 claim or the corresponding loop and segment of the ANSI X12N 837P electronic claim and the appropriate loop and segment of the ANSI X12N 837I electronic claim.

NOTE: The 4010A1 and 5010 flat files for the 837I have been updated to facilitate implementation of the requirements in this CR and are attached. Future changes to the 4010A1 and 5010 flat files will be made through the normal process. The 4010A1 and 5010 flat files for the 837P do not require revision in order to implement this CR as they are already formatted to accept fractional amounts in the units field.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7065.1	Contractors shall accept and process claims for ambulance services submitted with fractional mileage units reported in Item 24G of the Form CMS-1500 paper claim and the corresponding loop and segment of the ANSI X12N 837P electronic claim.	X			X						
7065.1.1	Contractors shall accept and process fractional mileage units up to one decimal place (i.e., the tenths place) on all ambulance claims.	X			X						
7065.1.2	Contractors shall truncate fractional mileage units submitted with more than one decimal place on all ambulance claims, if necessary.	X			X						
7065.2	Contractors shall accept and process claims for ambulance services submitted with less than 1 whole mileage unit reported in Item 24G on the paper claim and the electronic claim formats.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7065.2.1	On claims for ambulance mileages totaling less than 1 mile that are submitted without a leading "0", contractors shall infer the leading "0". For example, if the ambulance supplier submits ".9" miles, contractors shall automatically convert the units to "0.9" and process the claim accordingly.	X			X						
7065.3	Contractors shall continue to accept and process claims for ambulance services submitted with whole number miles for trips totaling 100 covered miles and greater as reported in Item 24G of the Form CMS-1500 paper claim and the corresponding loop and segment of the ANSI X12N 837P electronic claim.	X			X						
7065.3.1	Contractors shall truncate fractional mileage totaling 100 miles or greater submitted on ambulance claims, if necessary.	X			X			X			
7065.4	Contractors shall automatically default to "0.1" unit when the total mileage units are missing in Item 24G.	X			X			X			
7065.5	Contractors shall accept and process claims with ambulance services, identified by revenue code 0540, with fractional mileage units rounded reported in ANSI X12N 837I element SV205.	X		X			X				
7065.5.1	Contractors shall accept and process claims with fractional mileage units up to one decimal place (i.e., the tenths place) on ambulance claims submitted on the ANSI X12N 837I, element SV205.	X		X			X				
7065.5.2	Contractors shall truncate fractional mileage units rounded to greater than one decimal place on ambulance revenue code 0540 lines. For example, if 1.23 miles are submitted, contractors shall automatically convert the units to 1.2 and process the claim accordingly.	X		X			X				
7065.6	Contractors shall accept and process claims with ambulance services, identified by revenue code 0540, submitted with less than 1 whole mileage unit reported in ANSI X12N 837I element SV205.	X		X			X				
7065.7	On claims for ambulance mileages totaling less than 1 mile that are submitted without a leading "0", contractors shall infer the leading "0". For example, if the ambulance supplier submits ".9" miles, contractors shall automatically convert the units to "0.9" and process the claim accordingly.	X		X			X				
7065.8	Contractors shall continue to accept and process claims with ambulance services, identified by revenue code 0540, submitted with whole number miles for trips totaling 100 covered miles and greater as reported in ANSI X12N 837I element SV205.	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7065.8.1	Contractors shall truncate fractional mileage totaling 100 miles or greater submitted on ambulance revenue code 0540 lines. For example, if 100.5 mileage units are submitted, contractors shall automatically convert the units to 100 and process the claim accordingly.	X		X			X				
7065.9	Contractors shall allow the reporting of fractional mileage with revenue code 0540 on the FISS claim charges screen, and the Direct Data Entry screens.	X		X			X				
7065.10	Contractors shall calculate the total reimbursement for revenue code 0540 using existing mechanisms; that is, multiplying the total reported miles, either whole numbers or fractions, by the fee amount for the service.	X		X			X				
7065.11	FISS shall pass the whole unit (no fractional miles) to CWF. For example, if the ambulance supplier submits "20.9" miles, FISS shall process/pay based on "20.9 miles but shall only pass CWF "20" in the units field.						X				
7065.12	Contractors shall use the attached 837I 4010A1 and 5010 flat files (Attachments 1 and 2, respectively) to facilitate implementation of the requirements in this CR.	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7065.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe (410) 786-5655 or by email at Felicia.Rowe@cms.hhs.gov, Joseph Bryson (410) 786-2986 or by email at Joseph.Bryson@cms.hhs.gov , Jason Kerr (410) 786-2123 or by email at Jason.Kerr@cms.hhs.gov .

Post-Implementation Contact(s): Your local contractor or CMS Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*: N/A

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachments 2

Medicare Claims Processing Manual
Chapter 15 - Ambulance

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms
(Rev. 2103 Issued; 11-19-10; Effective Date: 01-01-11; Implementation Date: 01-03-11)
PMs AB-00-88, AB-00-118, AB-00-131

*Except as otherwise noted, b*eginning with dates of service *on or after* January 1, 2001, the following coding instructions must be used.

In item 23 of the CMS-1500 Form, billers shall code the 5-digit ZIP Code of the point of pickup.

Electronic billers using ANSI X12N 837 should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup).

Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable. Carriers use message N53 on the remittance advice in conjunction with reason code 16.

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, if mileage is billed it must be reported as fractional units in Item 24G of the Form CMS-1500 paper claim or the corresponding loop and segment of the ANSI X12N 837P electronic claim for trips totaling up to 100 covered miles. When reporting fractional mileage, suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number

with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, suppliers must report mileage rounded up to the next whole number mile without the use of a decimal (e.g., 998.5 miles should be reported as 999).

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

Fractional mileage reporting applies only to ambulance services billed on a Form CMS-1500 paper claim, ANSI X12N 837P, or 837I electronic claims. It does not apply to providers billing on the Form CMS-1450.

For mileage HCPCS billed on a Form CMS-1500 or ANSI X12N 837P only, contractors shall automatically default to "0.1" units when the total mileage units are missing in Item 24G.

30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

(Rev. 2103 Issued; 11-19-10; Effective Date: 01-01-11; Implementation Date: 01-03-11)

PMs AB-00-88, AB-00-118, A3-3660.1, PM A-01-48, SNF 539, HHA 477, HO 433, Cindy Murphy and Barbara Griffen e-mail, PMs AB-00-118, AB-00-131

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 6 – SNF Inpatient Part A Billing, Section 20.3.1 – Ambulance Services for additional information on SNF consolidated billing and ambulance transportation.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

In general, the A/MAC processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill A/MACs using only Method 2.

The provider must furnish the following data in accordance with A/MAC instructions. The A/MAC will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;

- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. Revenue Code Reporting

Providers report ambulance services under revenue code 540 in FL 42 "Revenue Code."

B. HCPCS Codes Reporting

Providers report the HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

Providers must report one of the following HCPCS codes in FL 44 "HCPCS/Rates" for each base rate ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

These are the same codes required effective for services January 1, 2001.

In addition, providers must report **one** of HCPCS mileage codes:

A0425;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, providers must report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each

loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

*For UB-04 hard copy claims submission, p*roviders code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

*For electronic claims submissions prior to January 1, 2011, p*roviders code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

Beginning with dates of service on or after January 1, 2011, for electronic claim submissions only, mileage must be reported as fractional units in the ANSI X12N 837I element SV205 for trips totaling up to 100 covered miles. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, providers must report mileage rounded up to the nearest whole number mile (e.g., 999) and not use a decimal when reporting whole number miles over 100 miles.

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

NOTE: Fractional mileage reporting applies only to ambulance services billed electronically via the ANSI X12N 837I format. It currently does not apply to billing via the UB-04 hardcopy format.

C. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided and either a QM (Ambulance service provided under arrangement by a provider of services) or QN (Ambulance service furnished directly by a provider of services) modifier in FL 44 "HCPCS/Rates".

D. Service Units Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in FL 46 "Service Units" for each ambulance trip provided. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0425, A0435, or A0436, providers must also report the number of loaded miles.

E. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in FL 47, "Total Charges," the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0425, A0435, or A0436, providers are to report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units. For the related charges, providers report $1.00 in non-covered charges. A/MACs should assign ANSI Group Code OA to the $1.00 non-covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

F. Edits (A/MAC Claims with Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, A/MACs perform the following edits to assure proper reporting:

- Edit to assure each pair of revenue codes 540 have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes - A0425, A0435, or A0436.

- Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540;

- Edit to assure that the unit's field is completed for every line item containing revenue code 540;

- Edit to assure that service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"; and

- Edit to assure on every claim that revenue code 540, a value code of A0 (zero), and a corresponding ZIP Code are reported. If the ZIP Code is not a valid ZIP Code in accordance with the USPS assigned ZIP Codes, intermediaries verify the ZIP Code to determine if the ZIP Code is a coding error on the claim or a new ZIP Code from the USPS not on the CMS supplied ZIP Code File.

G. CWF (A/MACs)

A/MACs report the procedure codes in the financial data section (field 65a-65j). They include revenue code, HCPCS code, units, and covered charges in the record. Where

more than one HCPCS code procedure is applicable to a single revenue code, the provider reports each HCPCS code and related charge on a separate line, and the A/MAC reports this to CWF. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h, "Covered Charges."

Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

10.4 - Items 14-33 - Provider of Service or Supplier Information
(Rev. 2103 Issued; 11-19-10; Effective Date: 01-01-11; Implementation Date: 01-03-11)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;

- Consultative services;

- Durable medical equipment;

- When the ordering physician is also the performing physician (as often is the case
with in-office clinical laboratory tests);

- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Leave blank.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the NPI of an ordering/referring/attending/certifying physician or non-physician practitioner is not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17b, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, Chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to the anti-markup payment limitation.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see Chapter 20, section 130.6 of this manual.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a "0" before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2

for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain *an appropriate numerical value*. The *B/MAC* should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable*, except on claims for ambulance mileage*. *For ambulance mileage claims, contractors shall automatically default "0.1" unit when total mileage units are missing in this field.*

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name,

address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. (See Pub. 100-04, Chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP *c*ode. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in Chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP *c*ode.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Effective May 23, 2008, Item 33b is not to be reported.

This summary is a result of items identifed in review and testing. Only the most current updates are identifed here and are shaded on the appropriate spread sheet.

1) Record 510, field 4, Contract Allowance or Charge Pct. Was changed from S9(3)V99 to 9(3)V99. The "S" was a typo.

2) Record 590, the note in the header changed. Replaced "This record occurs once per 575 record." with "This record may occur up to seven times per 575 record."

3) Record 630, the note in the header changed. Added "This record can repeat up to 25 times.".

4) Record 300, field 7 record position changed from 112 to 99.

5) Record 630 - updated field 5.

837 and COB 4010.A1
Flat File Spread Sheet

837 and COB Summary of Changes from the 4010 to the 4010A1 Flat File. The following changes fall into various categories, such as Addenda, Redesign and Miscellaneous based on identified issues. Only those that are a result of the Addenda will be identified as such.

		Addenda Change
1.	Record 001 was changed to Record 100	
2.	Record 100, field 10, Interchange Date was defined as alphanumeric.	
3.	Record 100, field 20, Functional Group Creation Date was defined as alphanumeric.	
4.	Record 100, field 24, Functional Group Version Code was changed to 004010X096A1.	Yes
5.	Record 100, field 30, Transaction Set Creation Date was defined as alphanumeric.	
6.	Record 100, field 34, Transaction Version Code was changed to 004010X096A1.	Yes
7.	Record 100, field 35, Date of Receipt was defined as alphanumeric.	
8.	Record 200, field 19, field size increased.	
9.	Record 200, field 21, field size increased.	
10.	Record 200, field 23, field size increased.	
11.	Record 200, field 25, field size increased.	
12.	Record 200, field 27, field size increased.	
13.	Record 200, field 29, field size increased.	
14.	Record 200, field 31, field size increased.	
15.	Record 200, field 33, field size increased.	
16.	Record 300, field 22, Subscriber Birth Date was defined as alphanumeric.	
17.	Record 300, PAT segment for measurement, weight, and pregnancy was removed.	Yes
18.	Record 300, REF segment for Property and Casualty was removed.	Yes
19.	Record 400, PAT Data Elements 7-9 for measurement, weight, and pregnancy was removed.	Yes
20.	Record 400, field 21, Patient Birth Date was defined as alphanumeric.	
21.	Record 400, REF segment for Property and Casualty was removed.	Yes
22.	Record 500 was split into multiple records, 500, 505, 510, 515, 520, and 525.	
23.	Record 500, CLM Data Elements 11 - 12 were removed.	Yes
24.	Record 500, field 21, Discharge Hour was defined as alphanumeric.	
25.	Record 500, field 24, Statement From Date was defined as alphanumeric.	
26.	Record 500, field 25, Statement Through Date was defined as alphanumeric.	
27.	Record 500, field 28, Admission Date was defined as alphanumeric.	
28.	Record 510, field 22, HH Document Control Id was added.	Yes
29.	Record 510, field 23, HH Document Control Id was added.	Yes

30. Record 530 was split into multiple records, 530, 531, 532, 533, 534, 535, 536, 537, 538, and 539.

31. Record 533, field 5, Principal Procedure date was defined as alphanumeric.

32. Record 534, field 5, Other Procedure Date was defined as alphanumeric.
33. Record 534, field 9, Other Procedure Date was defined as alphanumeric.
34. Record 534, field 13, Other Procedure Date was defined as alphanumeric.
35. Record 534, field 17, Other Procedure Date was defined as alphanumeric.
36. Record 534, field 21, Other Procedure Date was defined as alphanumeric.
37. Record 534, field 25, Other Procedure Date was defined as alphanumeric.
38. Record 534, field 29, Other Procedure Date was defined as alphanumeric.
39. Record 534, field 33, Other Procedure Date was defined as alphanumeric.
40. Record 534, field 37, Other Procedure Date was defined as alphanumeric.
41. Record 534, field 41, Other Procedure Date was defined as alphanumeric.
42. Record 534, field 45, Other Procedure Date was defined as alphanumeric.
43. Record 534, field 49, Other Procedure Date was defined as alphanumeric.

44. Record 535, field 5, Occurrence Span From Date was defined as alphanumeric.
45. Record 535, field 6, Occurrence Span To Date was defined as alphanumeric.
46. Record 535, field 10, Occurrence Span From Date was defined as alphanumeric.
47. Record 535, field 11, Occurrence Span To Date was defined as alphanumeric.
48. Record 535, field 15, Occurrence Span From Date was defined as alphanumeric.
49. Record 535, field 16, Occurrence Span To Date was defined as alphanumeric.
50. Record 535, field 20, Occurrence Span From Date was defined as alphanumeric.
51. Record 535, field 21, Occurrence Span To Date was defined as alphanumeric.
52. Record 535, field 25, Occurrence Span From Date was defined as alphanumeric.
53. Record 535, field 26, Occurrence Span To Date was defined as alphanumeric.
54. Record 535, field 30, Occurrence Span From Date was defined as alphanumeric.
55. Record 535, field 31, Occurrence Span To Date was defined as alphanumeric.
56. Record 535, field 35, Occurrence Span From Date was defined as alphanumeric.
57. Record 535, field 36, Occurrence Span To Date was defined as alphanumeric.
58. Record 535, field 40, Occurrence Span From Date was defined as alphanumeric.
59. Record 535, field 41, Occurrence Span To Date was defined as alphanumeric.
60. Record 535, field 45, Occurrence Span From Date was defined as alphanumeric.
61. Record 535, field 46, Occurrence Span To Date was defined as alphanumeric.
62. Record 535, field 50, Occurrence Span From Date was defined as alphanumeric.

63. Record 535, field 51, Occurrence Span To Date was defined as alphanumeric.
64. Record 535, field 55, Occurrence Span From Date was defined as alphanumeric.
65. Record 535, field 56, Occurrence Span To Date was defined as alphanumeric.
66. Record 535, field 60, Occurrence Span From Date was defined as alphanumeric.
67. Record 535, field 61, Occurrence Span To Date was defined as alphanumeric.

68. Record 536, field 5, Occurrence Date was defined as alphanumeric.
69. Record 536, field 9, Occurrence Date was defined as alphanumeric.
70. Record 536, field 13, Occurrence Date was defined as alphanumeric.
71. Record 536, field 17, Occurrence Date was defined as alphanumeric.
72. Record 536, field 21, Occurrence Date was defined as alphanumeric.
73. Record 536, field 25, Occurrence Date was defined as alphanumeric.
74. Record 536, field 29, Occurrence Date was defined as alphanumeric.
75. Record 536, field 33, Occurrence Date was defined as alphanumeric.
76. Record 536, field 37, Occurrence Date was defined as alphanumeric.
77. Record 536, field 41, Occurrence Date was defined as alphanumeric.
78. Record 536, field 45, Occurrence Date was defined as alphanumeric.
79. Record 536, field 49, Occurrence Date was defined as alphanumeric.

80. Record 555 was split into multiple records, 540 and 550.

81. Record 540, field 23, HCPC field was increased to be consistent with the service line HCPC.
82. Record 540, field 25, Service Unit Count field was increased to be consistent with the service line units.

83. Record 570 was reduced for physician information with repeats for each type of physician.
83.A Record 570, fields 10 - 15 added note in comment column.
83.B Record 570, fields 16 - 18 added note in comment column.

84. Record 575 was split into multiple records, 575, 580, 585, 590.
85. Record 575, field 4, Insurance Group Number field size was increased.
86. Record 575, field 5, Insurance Group Name field size was increased.

86.A Record 585, field 2, changed the qualifier to "C4".

87. Record 590, field 35, Claim Paid Date was defined as alphanumeric.
87.A Record 590, all fields except 33 - 35, the loop field was updated to reflect all applicable loops.

87.B	Record 590, fields 22 and 23 were added. The Other Payer Prior Authorization or Referreal Number REF segment was missing.	
88.	Record 600 was split into multiple records, 600, 605, 610, and 640.	
89.	Record 600, field 18, Prescription Number was removed	Yes
90.	Record 600, PRV segments were removed.	Yes
91.	Record 610, field 4, Service Line Date was defined as alphanumeric.	
92.	Record 610, field 7, Assessment Date was defined as alphanumeric.	
92.A	Record 610, field 3, changed the qualifier to "D8".	
93.	Record 620, Repricing was added.	Yes
94.	Record 630 was split out to multiple records 650, 660 and 670.	
95.	Record 630 was changed to NDC Information.	Yes
95.1	Record 630 - updated field 5.	
95.A	Record 640, field 2, added qualifier "72" and "73".	
96.	Record 670, field 4, Service Adjudication Date was defined as alphanumeric.	
97.	Record 999 fields were reduced.	
98.	An overall document change was the removal of the 837 IG PIC and the UB92 PIC. These columns were initially added to the 4010 document as guidance in the development of the flat file, thus no longer needed.	
99.	Record 600, changed SV205 picture to 9(6)V9	
100.	Record 650, changed SVD05 picture to 9(6)V9	

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 100

	Note: Record 100 is the first record or follows record 999 and precedes record 200. Total number of bytes this record **1,101**.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 100	X3	1	3					
2	AUTHORIZATION INFORMATION QUALIFIER	X2	4	5	HEADER	ISA	01	R	Pg. B.3
3	AUTHORIZATION INFORMATION	X10	6	15	HEADER	ISA	02	R	Pg. B.3
4	SECURITY INFORMATION QUALIFIER	X2	16	17	HEADER	ISA	03	R	Pg. B.4
5	SECURITY INFORMATION	X10	18	27	HEADER	ISA	04	R	Pg. B.4
6	INTERCHANGE SENDER ID QUALIFIER	X2	28	29	HEADER	ISA	05	R	Pg. B.4
7	INTERCHANGE SENDER ID	X15	30	44	HEADER	ISA	06	R	Pg. B.4
8	INTERCHANGE RECEIVER ID QUALIFIER	X2	45	46	HEADER	ISA	07	R	Pg. B.4
9	INTERCHANGE RECEIVER ID	X15	47	61	HEADER	ISA	08	R	Pg. B.5
10	INTERCHANGE DATE (YYMMDD)	X6	62	67	HEADER	ISA	09	R	Pg. B.5
11	INTERCHANGE TIME	X4	68	71	HEADER	ISA	10	R	Pg. B.5
12	INTERCHANGE CONTROL STANDARDS ID	X1		72	HEADER	ISA	11	R	Pg. B.5
13	INTERCHANGE CONTROL VERSION CODE (00401)	X5	73	77	HEADER	ISA	12	R	Pg. B.5
14	INTERCHANGE CONTROL NUMBER	9(9)	78	86	HEADER	ISA	13	R	Pg. B5
15	ACKNOWLEDGMENT REQUEST (0/1)	X1		87	HEADER	ISA	14	R	Pg. B6
16	TEST/PRODUCTION (T/P)	X1		88	HEADER	ISA	15	R	Pg. B6
17	FUNCTIONAL IDENTIFIER CODE	X2	89	90	HEADER	GS	01	R	Pg. B8
18	APPLICATION SENDERS CODE	X15	91	105	HEADER	GS	02	R	Pg. B8
19	APPLICATION RECEIVERS CODE	X15	106	120	HEADER	GS	03	R	Pg. B8
20	FUNCTIONAL GROUP CREATION DATE	X8	121	128	HEADER	GS	04	R	Pg. B8
21	FUNCTIONAL GROUP CREATION TIME	X8	129	136	HEADER	GS	05	R	Pg. B.8
22	FUNCTIONAL GROUP CONTROL NUMBER	9(9)	137	145	HEADER	GS	06	R	Pg. B.9
23	RESPONSIBLE AGENCY CODE (X)	X2	146	147	HEADER	GS	07	R	Pg. B9
24	FUNCTIONAL GROUP VERSION CODE (004010X096A1)	X12	148	159	HEADER	GS	08	R	Pg. B.9, Addenda Page 49
25	TRANSACTION SET IDENTIFIER CODE	X3	160	162	HEADER	ST	01	R	Pg. 56
26	TRANSACTION SET CONTROL NUMBER	X9	163	171	HEADER	ST	02	R	Pg. 56
27	HIERARCHICAL STRUCTURE CODE	X4	172	175	HEADER	BHT	01	R	Pg. 57
28	TRANSACTION PURPOSE CODE (00/18)	X2	176	177	HEADER	BHT	02	R	Pg. 58
29	ORIGINATOR APPLICATION TRANS ID (file sequence and serial number)	X30	178	207	HEADER	BHT	03	R	Pg. 58
30	TRANSACTION SET CREATION DATE	X8	208	215	HEADER	BHT	04	R	Pg. 58
31	TRANSACTION SET CREATION TIME (TIME BILL SUBMITTED)	X8	216	223	HEADER	BHT	05	R	Pg. 58
32	TRANSACTION TYPE CODE (CH/RP)	X2	224	225	HEADER	BHT	06	R	Pg. 59
33	TRANSACTION VERSION CODE-Q	X2	226	227	HEADER	REF	01	R	Pg. 60
34	TRANSACTION VERSION CODE (004010X096A1)	X30	228	257	HEADER	REF	02	R	Pg. 60, Addenda Page 11
35	DATE OF RECEIPT	X8	258	265		NA	Translator Generated		
36	ENTITY IDENTIFIER CODE	X2	266	267	1000A	NM1	01	R	Pg. 62
37	ENTITY TYPE QUALIFIER	X1		268	1000A	NM1	02	R	Pg. 62
38	SUBMITTER LAST NAME	X35	269	303	1000A	NM1	03	R	Pg. 62
39	SUBMITTER FIRST NAME	X25	304	328	1000A	NM1	04	S	Pg. 62
40	SUBMITTER MIDDLE NAME	X25	329	353	1000A	NM1	05	S	Pg. 62

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 100

	Note: Record 100 is the first record or follows record 999 and precedes record 200. Total number of bytes this record **1,101**.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
41	SUBMITTER ETIN QUALIFIER (46)	X(2)	354	355	1000A	NM1	08	R	Pg. 62
42	SUBMITTER ETIN	X(10)	356	365	1000A	NM1	09	R	Pg. 63
***Bgn** Segment PER **occurs 2 times**:*									
43	SUBMITTER FUNCTION CODE	X2	366		1000A	PER	01	R	Pg. 65
44	SUBMITTER CONTACT NAME	X60			1000A	PER	02	R	Pg. 65
45	SUBMITTER COMMUNICATION NUMBER QUALIFIER - 1 (TE, FX, EM, ED)	X2			1000A	PER	03	R	Pg. 65
46	SUBMITTER COMMUNICATION NUMBER - 1	X80			1000A	PER	04	R	Pg. 65
47	SUBMITTER COMMUNICATION NUMBER QUALIFIER - 2 (TE, FX, EX, EM, ED)	X2			1000A	PER	05	S	Pg. 65
48	SUBMITTER COMMUNICATION NUMBER - 2	X80			1000A	PER	06	S	Pg. 66
49	SUBMITTER COMMUNICATION NUMBER QUALIFIER - 3 (TE, FX, EX, EM, ED)	X2			1000A	PER	07	S	Pg. 66
50	SUBMITTER COMMUNICATION NUMBER - 3	X80		981	1000A	PER	08	S	Pg. 66
End** Segment PER**.									
51	RECEIVER ENTITY ID	X2	982	983	1000B	NM1	01	R	Pg. 68
52	RECEIVER ENTITY TYPE	X1		984	1000B	NM1	02	R	Pg. 68
53	RECEIVER NAME	X35	985	1019	1000B	NM1	03	R	Pg. 68
54	RECEIVER ETIN QUALIFIER (46)	X2	1020	1021	1000B	NM1	08	R	Pg. 68
55	RECEIVER ETIN	X80	1022	1101	1000B	NM1	09	R	Pg. 68

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 200

	Note: Record 200 - Loop 2000A has a loop repeat of > 1, so record 200 follows record 100 and can follow the last record of the previous claim, 600-670 (from the previous provider). Total number bytes this record 1,488.								
FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
1	RECORD TYPE 200	X3	1	3					
2	PROVIDER-TYPE CODE (BI = *Billing;* PT = *Pay-to*)	X2	4	5	2000A	PRV	01	R	Pg. 71
3	PROVIDER-SPECIALTY CODE QUAL	X2	6	7	2000A	PRV	02	R	Pg. 72
4	PROVIDER-SPECIALTY CODE	X30	8	37	2000A	PRV	03	R	Pg. 72
5	ENTITY ID CODE (85 = *Billing Provider*)	X2	38	39	2000A	CUR	01	R	Pg. 74
6	BILLING PROVIDER CURRENCY CODE	X3	40	42	2000A	CUR	02	R	Pg. 74
7	ENTITY ID CODE (85 = *Billing Provider*)	X2	43	44	2010AA	NM1	01	R	Pg. 77
8	ENTITY-TYPE QUALIFIER	X1		45	2010AA	MN1	02	R	Pg. 77
9	BILLING PROVIDER NAME	X35	46	80	2010AA	NM1	03	R	Pg. 77
10	BILLING PROVIDER NUMBER QUAL (24, 34, XX	X2	81	82	2010AA	MN1	08	R	Pg. 77
11	BILLING PROVIDER NUMBER	X13	83	95	2010AA	NM1	09	R	Pg. 78
12	BILLING PROVIDER ADDRESS - LN 1	X55	96	150	2010AA	N3	01	R	Pg. 79
13	BILLING PROVIDER ADDRESS - LN 2	X55	151	205	2010AA	N3	02	S	Pg. 79
14	BILLING PROVIDER CITY	X30	206	235	2010AA	N4	01	R	Pg. 80
15	BILLING PROVIDER STATE	X2	236	237	2010AA	N4	02	R	Pg. 81
16	BILLING PROVIDER ZIP CODE	X9	238	246	2010AA	N4	03	R	Pg. 81
17	COUNTRY CODE	X3	247	249	2010AA	N4	04	S	Pg. 81
18	BILLING PROVIDER SECONDARY ID QUAL -1	X2	250	251	2010AA	REF	01	R	Pg. 83
19	BILLING PROVIDER SECONDARY ID NUM - 1	X(30)	252	281	2010AA	REF	02	R	Pg. 84
20	BILLING PROVIDER SECONDARY ID QUAL - 2	X2	282	283	2010AA	REF	01	R	Pg. 83
21	BILLING PROVIDER SECONDARY ID NUM - 2	X(30)	284	313	2010AA	REF	02	R	Pg. 84
22	BILLING PROVIDER SECONDARY ID QUAL - 3	X2	314	315	2010AA	REF	01	R	Pg. 83
23	BILLING PROVIDER SECONDARY ID NUM - 3	X(30)	316	345	2010AA	REF	02	R	Pg. 84
24	BILLING PROVIDER SECONDARY ID QUAL - 4	X2	346	347	2010AA	REF	01	R	Pg. 83
25	BILLING PROVIDER SECONDARY ID NUM - 4	X(30)	348	377	2010AA	REF	02	R	Pg. 84
26	BILLING PROVIDER SECONDARY ID QUAL - 5	X2	378	379	2010AA	REF	01	R	Pg. 83
27	BILLING PROVIDER SECONDARY ID NUM - 5	X(30)	380	409	2010AA	REF	02	R	Pg. 84
28	BILLING PROVIDER SECONDARY ID QUAL - 6	X2	410	411	2010AA	REF	01	R	Pg. 83

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 200

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
1	RECORD TYPE 200	X3	1	3					
29	BILLING PROVIDER SECONDARY ID NUM - 6	X(30)	412	441	2010AA	REF	02	R	Pg. 84
30	BILLING PROVIDER SECONDARY ID QUAL - 7	X2	442	443	2010AA	REF	01	R	Pg. 83
31	BILLING PROVIDER SECONDARY ID NUM - 7	X(30)	444	473	2010AA	REF	02	R	Pg. 84
32	BILLING PROVIDER SECONDARY ID QUAL - 8	X2	474	475	2010AA	REF	01	R	Pg. 83
33	BILLING PROVIDER SECONDARY ID NUM - 8	X(30)	476	505	2010AA	REF	02	R	Pg. 84
34	BILLING PROVIDER CONTACT QUAL (1)	X2	506	507	2010AA	PER	01	R	Pg. 88
35	BILLING PROVIDER CONTACT NAME (1)	X60	508	567	2010AA	PER	02	R	Pg. 88
36	BILL PROV COMM. QUAL (1,1) PRIMARY	X2	568	569	2010AA	PER	03	R	Pg. 88
37	BILL PROV COMM. NUM (1,1) PRIMARY	X80	570	649	2010AA	PER	04	R	Pg. 88
38	BILL PROV COMM. QUAL (1,2) SECONDARY	X2	650	651	2010AA	PER	05	S	Pg. 89
39	BILL PROV COMM. NUM (1,2) SECONDARY	X80	652	731	2010AA	PER	06	S	Pg. 89
40	BILL PROV COMM. QUAL (1,3) TERTIARY	X2	732	733	2010AA	PER	07	S	Pg. 89
41	BILL PROV COMM. NUM (1,3) TERTIARY	X80	734	813	2010AA	PER	08	S	Pg. 89
42	BILLING PROVIDER CONTACT QUAL (2)	X2	814	815	2010AA	PER	01	R	Pg. 88
43	BILLING PROVIDER CONTACT NAME (2)	X60	816	875	2010AA	PER	02	R	Pg. 88
44	BILL PROV COMM. QUAL (2,1) PRIMARY	X2	876	877	2010AA	PER	03	R	Pg. 88
45	BILL PROV COMM. NUM (2,1) PRIMARY	X80	878	957	2010AA	PER	04	R	Pg. 88
46	BILL PROV COMM. QUAL (2,2) SECONDARY	X2	958	959	2010AA	PER	05	S	Pg. 89
47	BILL PROV COMM. NUM (2,2) SECONDARY	X80	960	1039	2010AA	PER	06	S	Pg. 89
48	BILL PROV COMM. QUAL (2,3) TERTIARY	X2	1040	1041	2010AA	PER	07	S	Pg. 89
49	BILL PROV COMM. NUM (2,3) TERTIARY	X80	1042	1121	2010AA	PER	08	S	Pg. 89
50	ENTITY ID CODE (87 = *Pay-to Provider*)	X2	1122	1123	2010AB	NM1	01	R	Pg. 92
51	ENTITY-TYPE QUALIFIER	X1		1124	2010AB	NM1	02	R	Pg. 92
52	PAY-TO PROVIDER NAME	X35	1125	1159	2010AB	NM1	03	R	Pg. 92
53	PAY-TO PROVIDER NUMBER QUALIFIER	X2	1160	1161	2010AB	NM1	08	R	Pg. 92
54	PAY-TO PROVIDER NUMBER	X13	1162	1174	2010AB	NM1	09	R	Pg. 93
55	PAY-TO PROVIDER ADDRESS - LN 1	X55	1175	1229	2010AB	N3	01	R	Pg. 94
56	PAY-TO PROVIDER ADDRESS - LN 2	X55	1230	1284	2010AB	N3	02	S	Pg. 94
57	PAY-TO PROVIDER CITY	X30	1285	1314	2010AB	N4	01	R	Pg. 95
58	PAY-TO PROVIDER STATE	X2	1315	1316	2010AB	N4	02	R	Pg. 95

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 200

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
1	RECORD TYPE 200	X3	1	3					
59	PAY-TO PROVIDER ZIP CODE	X9	1317	1325	2010AB	N4	03	R	Pg. 95
60	PAY-TO PROVIDER COUNTY CODE	X3	1326	1328	2010AB	N4	04	S	Pg. 96
61	PAY-TO PROV SECONDARY ID QUAL - 1	X2	1329	1330	2010AB	REF	01	R	Pg. 97
62	PAY-TO PROV SECONDARY ID NUM - 1	X30	1331	1360	2010AB	REF	02	R	Pg. 98
63	PAY-TO PROV SECONDARY ID QUAL - 2	X2	1361	1362	2010AB	REF	01	R	Pg. 97
64	PAY-TO PROV SECONDARY ID NUM - 2	X30	1363	1392	2010AB	REF	02	R	Pg. 98
65	PAY-TO PROV SECONDARY ID QUAL - 3	X2	1393	1394	2010AB	REF	01	R	Pg. 97
66	PAY-TO PROV SECONDARY ID NUM - 3	X30	1395	1424	2010AB	REF	02	R	Pg. 98
67	PAY-TO PROV SECONDARY ID QUAL - 4	X2	1425	1426	2010AB	REF	01	R	Pg. 97
68	PAY-TO PROV SECONDARY ID NUM - 4	X30	1427	1456	2010AB	REF	02	R	Pg. 98
69	PAY-TO PROV SECONDARY ID QUAL - 5	X2	1457	1458	2010AB	REF	01	R	Pg. 97
70	PAY-TO PROV SECONDARY ID NUM - 5	X30	1459	1488	2010AB	REF	02	R	Pg. 98

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAT SHEET RECORD 300

Note: Record 300 will always be used for beneficiary information on inbound claim. If a claim is secondary to Medicare it will have a payer responsibility sequence of "S" and then record 575 will be used for the primary subscriber, if different than the beneficiary along with the primary payer. If record 300, payer responsibility sequence other than a "P" must have records 575 to identify the primary payer. Record to identify the primary payer. Record 300 follows record 200 and could follow the last record of the previous claim, 600-670. Total number bytes this record 1,123

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
1	RECORD TYPE 300	X3	1	3					
2	PAYER RESPONSIBILITY SEQUENCE (P, S, T)	X1		4	2000B	SBR	01	R	Pg. 102
3	PATIENT RELATIONSHIP TO INSURED (18)	X2	5	6	2000B	SBR	02	S	Pg. 103
4	INSURANCE GROUP NUMBER	X30	7	36	2000B	SBR	03	S	Pg. 103
5	INSURANCE GROUP NAME	X60	37	96	2000B	SBR	04	S	Pg. 103
6	SOURCE PAY CODE	X2	97	98	2000B	SBR	09	S	Pg. 104
7	ENTITY IDENTIFIER CODE	X2	99	100	2010BA	NM1	01	R	Pg. 109 If 2000B - SBR02 = 18
8	ENTITY TYPE QUALIFIER	X1		101	2010BA	NM1	02	R	Pg. 109 If 2000B - SBR02 = 18
9	SUBSCRIBER LAST NAME	X35	102	136	2010BA	NM1	03	R	Pg. 109 If 2000B - SBR02 = 18
10	SUBSCRIBER FIRST NAME	X25	137	161	2010BA	NM1	04	R	Pg. 109 If 2000B - SBR02 = 18
11	SUBSCRIBER MIDDLE INITIAL	X25	162	186	2010BA	NM1	05	S	Pg. 109 If 2000B - SBR02 = 18
12	SUBSCRIBER NAME SUFFIX	X10	187	196	2010BA	NM1	07	S	Pg. 110
13	SUBSCRIBER PRIMARY ID QUAL	X2	197	198	2010BA	NM1	08	S	Pg. 110
14	SUBSCRIBER PRIMARY ID	X80	199	278	2010BA	NM1	09	S	Pg. 110, FFR30-7
15	SUBSCRIBER ADDRESS LN 1	X55	279	333	2010BA	N3	01	R	Pg. 112 If 2000B - SBR02 = 18
16	SUBSCRIBER ADDRESS LN 2	X55	334	388	2010BA	N3	02	S	Pg. 112 If 2000B - SBR02 = 18
17	SUBSCRIBER CITY	X30	389	418	2010BA	N4	01	R	Pg. 113 If 2000B - SBR02 = 18
18	SUBSCRIBER STATE	X2	419	420	2010BA	N4	02	R	Pg. 114 If 2000B - SBR02 = 18
19	SUBSCRIBER ZIP CODE	X9	421	429	2010BA	N4	03	R	Pg. 114 If 2000B - SBR02 = 18
20	SUBSCRIBER COUNTRY CODE	X3	430	432	2010BA	N4	04	S	Pg. 114
21	SUBSCRIBER BIRTH DATE QUAL	X2	433	434	2010BA	DMG	01	R	Pg. 116 - If sub is patient
22	SUBSCRIBER BIRTH DATE	X8	435	442	2010BA	DMG	02	R	Pg. 116 - If sub is patient
23	SUBSCRIBER SEX	X1		443	2010BA	DMG	03	R	Pg. 116 - If sub is patient
24	SUBSCRIBER SECONDARY ID QUAL - 1	X2	444	445	2010BA	REF	01	R	Pg. 117
25	SUBSCRIBER SECONDARY ID - 1	X30	446	475	2010BA	REF	02	R	Pg. 118
26	SUBSCRIBER SECONDARY ID QUAL - 2	X2	476	477	2010BA	REF	01	R	Pg. 117
27	SUBSCRIBER SECONDARY ID - 2	X30	478	507	2010BA	REF	02	R	Pg. 118
28	SUBSCRIBER SECONDARY ID QUAL - 3	X2	508	509	2010BA	REF	01	R	Pg. 117

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAT SHEET RECORD 300

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
29	SUBSCRIBER SECONDARY ID - 3	X30	510	539	2010BA	REF	02	R	Pg. 118
30	SUBSCRIBER SECONDARY ID QUAL - 4	X2	540	541	2010BA	REF	01	R	Pg. 117
31	SUBSCRIBER SECONDARY ID - 4	X30	542	571	2010BA	REF	02	R	Pg. 118
32	ENTITY IDENTIFIER CODE	X2	572	573	2010BC	NM1	01	R	Pg. 127
33	ENTITY TYPE QUALIFIER	X1		574	2010BC	NM1	02	R	Pg. 127
34	PAYER NAME (PR)	X35	575	609	2010BC	NM1	03	R	Pg. 127
35	PAYER IDENTIFICATION NUMBER (PI, XV)	X2	610	611	2010BC	NM1	08	R	Pg. 127
36	PAYER ID NUMBER (PI, XV)	X10	612	621	2010BC	NM1	09	R	Pg. 128
37	PAYER ADDRESS LINE 1	X55	522	676	2010BC	N3	01	R	Pg. 129
38	PAYER ADDRESS LINE 2	X55	677	731	2010BC	N3	02	S	Pg. 129
39	PAYER CITY	X30	732	761	2010BC	N4	01	R	Pg. 130
40	PAYER STATE	X2	762	763	2010BC	N4	02	R	Pg. 131
41	PAYER ZIP CODE	X9	764	772	2010BC	N4	03	R	Pg. 131
42	PAYER COUNTRY CODE	X3	773	775	2010BC	N4	04	S	Pg. 131
43	PAYER ADDITIONAL ID QUAL - 1	X2	776	777	2010BC	REF	01	R	Pg. 132
44	PAYER ADDITIONAL ID - 1	X30	778	807	2010BC	REF	02	R	Pg. 133
45	PAYER ADDITIONAL ID QUAL - 2	X2	808	809	2010BC	REF	01	R	Pg. 132
46	PAYER ADDITIONAL ID - 2	X30	810	839	2010BC	REF	02	R	Pg. 133
47	PAYER ADDITIONAL ID QUAL - 3	X2	840	841	2010BC	REF	01	R	Pg. 132
48	PAYER ADDITIONAL ID - 3	X30	842	871	2010BC	REF	02	R	Pg. 133
49	ENTITY IDENTIFIER CODE	X2	872	873	2010BD	NM1	01	R	Pg. 135
50	ENTITY TYPE QUALIFIER	X1		874	2010BD	NM1	02	R	Pg. 135
51	RESPONSIBLE PARTY LAST NAME (QD)	X35	875	909	2010BD	NM1	03	R	Pg. 135
52	RESPONSIBLE PARTY FIRST NAME	X25	910	934	2010BD	NM1	04	S	Pg. 135
53	RESPONSIBLE PARTY MIDDLE NAME	X25	935	959	2010BD	NM1	05	S	Pg. 135
54	RESPONSIBLE PARTY NAME SUFFIX	X10	960	969	2010BD	NM1	07	S	Pg. 135
55	RESPONSIBLE PARTY ADDRESS 1	X55	970	1024	2010BD	N3	01	R	Pg. 136
56	RESPONSIBLE PARTY ADDRESS 2	X55	1025	1079	2010BD	N3	02	S	Pg. 136
57	RESPONSIBLE PARTY CITY	X30	1080	1109	2010BD	N4	01	R	Pg. 137
58	RESPONSIBLE PARTY STATE	X2	1110	1111	2010BD	N4	02	R	Pg. 137
59	RESPONSIBLE PARTY ZIP CODE	X9	1112	1120	2010BD	N4	03	R	Pg. 137

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAT SHEET RECORD 300

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
60	RESPONSIBLE PARTY COUNTRY CODE	X3	1121	1123	2010BD	N4	04	S	Pg. 138

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 400

	Note: Record 400 follows record 300. Could follow the last record of the previous claim, 600-670, if there is more than 1 patient for the subscriber (N/A for Medicare claims, but could for other payers). Total number bytes this record **433**.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 400	X3	1	3					
2	PATIENT RELATIONSHIP TO INSURED	X2	4	5	2000C	PAT	01	R	Pg. 142
	PATIENT NAME								
3	PATIENT NAME QUALIFIER (QC)	X2	6	7	2010CA	NM1	01	R	Pg. 145
4	PATIENT NAME ENTITY TYPE	X1		8	2010CA	NM1	02	R	Pg. 146
5	PATIENT LAST NAME	X35	9	43	2010CA	NM1	03	R	Pg. 146
6	PATIENT FIRST NAME	X25	44	68	2010CA	NM1	04	R	Pg. 146
7	PATIENT MIDDLE INITIAL	X25	69	93	2010CA	NM1	05	S	Pg. 146
8	PATIENT NAME SUFFIX	X10	94	103	2010CA	NM1	07	S	Pg. 146
9	PATIENT PRIMARY ID QUAL (MI, ZZ)	X2	104	105	2010CA	NM1	08	S	Pg. 147
10	PATIENT PRIMARY ID	X13	106	118	2010CA	NM1	09	S	Pg. 147
	PATIENT ADDRESS								
11	PATIENT ADDRESS LN1	X55	119	173	2010CA	N3	01	R	Pg. 148
12	PATIENT ADDRESS LN 2	X55	174	228	2010CA	N3	02	S	Pg. 148
13	PATIENT CITY	X30	229	258	2010CA	N4	01	R	Pg. 149
14	PATIENT STATE	X2	259	260	2010CA	N4	02	R	Pg. 150
15	PATIENT ZIP CODE	X9	261	269	2010CA	N4	03	R	Pg. 150
16	PATIENT COUNTRY CODE	X3	270	272	2010CA	N4	04	S	Pg. 150
17	PATIENT BIRTH DATE FORMAT QUAL	X2	273	274	2010CA	DMG	01	R	Pg. 151 If sub is not patient
18	PATIENT BIRTH DATE	X8	275	282	2010CA	DMG	02	R	Pg. 152 If sub is not patient
19	PATIENT SEX	X1		283	2010CA	DMG	03	R	Pg. 152 If sub is not patient
20	PATIENT SECONDARY ID QUALIFIER - 1	X2	284	285	2010CA	REF	01	R	Pg. 153
21	PATIENT SECONDARY ID - 1	X30	286	315	2010CA	REF	02	R	Pg. 154
22	PATIENT SECONDARY ID QUALIFIER - 2	X2	314	317	2010CA	REF	01	R	Pg. 153
23	PATIENT SECONDARY ID - 2	X30	318	347	2010CA	REF	02	R	Pg. 154
24	PATIENT SECONDARY ID QUALIFIER - 3	X2	348	349	2010CA	REF	01	R	Pg. 153
25	PATIENT SECONDARY ID - 3	X30	350	379	2010CA	REF	02	R	Pg. 154
26	PATIENT SECONDARY ID QUALIFIER - 4	X2	380	381	2010CA	REF	01	R	Pg. 153
27	PATIENT SECONDARY ID - 4	X30	382	411	2010CA	REF	02	R	Pg. 154
28	PATIENT SECONDARY ID QUALIFIER - 5	X2	412	413	2010CA	REF	01	R	Pg. 153

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 400

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
29	PATIENT SECONDARY ID - 5	X30	414	443	2010CA	REF	02	R	Pg. 154

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 500

	Note: Record 500 can follow record 300 or 400. Could follow the last record of the previous claim, 600- 670. Total number bytes this record 96.								
FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
1	RECORD TYPE 500	X3	1	3					
2	PATIENT CONTROL NUMBER	X20	4	23	2300	CLM	01	R	Pg. 158
3	TOTAL CLAIM CHARGES	S9(8)V99	24	33	2300	CLM	02	R	Pg. 159
4	FACILITY TYPE CODE	X2	34	35	2300	CLM	05-1	R	Pg. 159
5	FACILITY CODE QUALIFIER	X1		36	2300	CLM	05-2	R	Pg. 159
6	CLAIM FREQUENCY TYPE CODE	X1		37	2300	CLM	05-3	R	Pg. 159
7	PROVIDER SIGNATURE ON FILE	X1		38	2300	CLM	06	R	Pg. 160
8	MEDICARE ASSIGNMENT	X1		39	2300	CLM	07	S	Pg. 160
9	ASSIGNMENT BENEFIT CERTIFICATION INDICATOR	X1		40	2300	CLM	08	R	Pg. 160
10	RELEASE INFO CERTIFICATION INDICATOR	X1		41	2300	CLM	09	R	Pg. 161
11	EOB INDICATOR	X1		42	2300	CLM	18	R	Pg. 163
12	DELAY REASON CODE	X2	43	44	2300	CLM	20	S	Pg. 164
13	DISCHARGE HOUR QUAL (096)	X3	45	47	2300	DTP	01	R	Pg. 165
14	DATE-TIME FORMAT QUAL	X2	48	49	2300	DTP	02	R	Pg. 165
15	DISCHARGE HOUR (TM = HHMM)	X4	50	53	2300	DTP	03	R	Pg. 166
16	STATEMENT DATE QUAL (434)	X3	54	56	2300	DTP	01	R	Pg. 167
17	DATE-TIME FORMAT QUAL	X3	57	59	2300	DTP	02	R	Pg. 167
18	STATEMENT FROM DATE	X8	60	67	2300	DTP	03	R	Pg. 168
19	STATEMENT THROUGH DATE	X8	68	75	2300	DTP	03	R	Pg. 168
20	ADMISSION DATE QUALIFIER (435)	X3	76	78	2300	DTP	01	R	Pg. 169
21	ADMISSION DATE FORMAT	X2	79	80	2300	DTP	02	R	Pg. 169
22	ADMISSION DATE (DT) (D8) (ccyymmdd)	X(8)	81	88	2300	DTP	03	R	Pg. 169
23	ADMISSION HOUR (DT = HHMM)	X(4)	89	92	2300	DTP	03	R	Pg. 170
24	TYPE OF ADMISSION	X1		93	2300	CL1	01	S	Pg. 171
25	SOURCE OF ADMISSION	X1		94	2300	CL1	02	S	Pg. 172
26	PATIENT STATUS	X(2)	95	96	2300	CL1	03	S	Pg. 172

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 505

	Note: Record 505 can only follow record 500, could precede 510 - 600 (600 is requried as the first record of service line, and the service line loop is required). Total number bytes this record 1663.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**REC POS. TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 505	X3	1	3					
Claim Supplemental Information - ***occurs 10 times:***									
2	ATTACHMENT REPORT TYPE CODE	X2	4		2300	PWK	01	R	Pg. 174
3	ATTACHMENT TRANSMISSION CODE	X2			2300	PWK	02	R	Pg. 174
4	ATTACHMENT CONTROL NUMBER QUAL	X2			2300	PWK	05	S	Pg. 175
5	ATTACHMENT CONTROL NUMBER (AC)	X80			2300	PWK	06	S	Pg. 175
6	ATTACHMENT DESCRIPTION	X80		1663	2300	PWK	07	S	Pg. 175

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 510

	Note: Record 510 can only follow 500 or 505, could precede 515 - 600. Total number bytes this record 539.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 510	X3	1	3					
2	CONTRACT TYPE	X2	4	5	2300	CN1	01	R	Pg. 176
3	CONTRACT AMOUNT	S9(8)V99	6	15	2300	CN1	02	S	Pg. 177
4	CONTRACT ALLOWANCE *or* CHARGE PCT.	9(3)V999	16	21	2300	CN1	03	S	Pg. 177
5	CONTRACT CODE	X30	22	51	2300	CN1	04	S	Pg. 177
6	CONTRACT TERMS DISCOUNT PCT.	9(3)V999	52	57	2300	CN1	05	S	Pg. 177
7	CONTRACT VERSION ID	X30	58	87	2300	CN1	06	S	Pg. 177
8	AMOUNT QUALIFIER CODE (C5)	X2	88	89	2300	AMT	01	R	Pg. 178
9	PAYER ESTIMATED AMOUNT DUE (C5)	S9(8)V99	90	99	2300	AMT	02	R	Pg. 179
10	AMOUNT QUALIFIER CODE (F3)	X2	100	101	2300	AMT	01	R	Pg. 180
11	PATIENT ESTIMATED AMOUNT DUE (F3)	S9(8)V99	102	111	2300	AMT	02	R	Pg. 181
12	AMOUNT QUALIFIER CODE (F5)	X2	112	113	2300	AMT	01	R	Pg. 182
13	PATIENT PAID AMOUNT (F5)	S9(8)V99	114	123	2300	AMT	02	R	Pg. 183
14	ADJ. REPRICED CLAIM REF. NUM QUAL (9C)	X2	124	125	2300	REF	01	R	Pg. 185
15	ADJUSTED REPRICED CLAIM REFERENCE NUM (9C)	X30	126	155	2300	REF	02	R	Pg. 185
16	REPRICED CLAIM REF. NUM QUAL (9A)	X2	156	157	2300	REF	01	R	Pg. 186
17	REPRICED CLAIM REFERENCE NUM (9A)	X30	158	187	2300	REF	02	R	Pg. 186
18	VAN/CH CLAIM REF. NUM ID QUAL (D9)	X2	188	189	2300	REF	01	R	Pg. 187
19	CLAIM ID NUM FOR VAN OR CLEARINGHOUSE TRACE NUM (D9)	X30	190	219	2300	REF	02	R	Pg. 188

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 510

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
20	HH (HCFA 485/486) DOCUMENT CONTROL ID QUAL (DD)	X2	220	221	2300	REF	01	R	Pg. 189
21	HH (HCFA 485/486) DOCUMENT CONTROL ID	X30	222	251	2300	REF	02	R	Pg. 189
22	HH (HCFA 485/486) DOCUMENT CONTROL ID QUAL (DD)	X2	252	253	2300	REF	01	R	Pg. 189, Addenda Page 17
23	HH (HCFA 485/486) DOCUMENT CONTROL ID	X30	254	283	2300	REF	02	R	Pg. 189, Addenda Page 17
24	CLAIM ORIG REFERENCE NUMBER QUAL (F8)	X2	284	285	2300	REF	01	R	Pg. 191
25	ORIGINAL REF NUM FORM LOCATOR 37 (ICN/DCN) (F8)	X30	286	315	2300	REF	02	R	Pg. 192
26	INVESTIGATIONAL DEVICE EXCEPTION ID QUAL (LX)	X2	316	317	2300	REF	01	R	Pg. 193
27	AUTHORIZATION NUMBER IDE NUM (LX)	X30	318	347	2300	REF	02	R	Pg. 193
28	SERVICE AUTH. EXCEPTION CODE QUAL (4N)	X2	348	349	2300	REF	01	R	Pg. 194
29	SERVICE AUTHORIZATION EXCEPTION CODE (4N)	X30	350	379	2300	REF	02	R	Pg. 195
30	PRO NUMBER QUALIFIER (G4)	X2	380	381	2300	REF	01	R	Pg. 197
31	PEER REVIEW ORG. (PRO) APPROVAL NUM (G4)	X30	382	411	2300	REF	02	R	Pg. 197
32	PRIOR AUTHORIZATION or REFERRAL NUM QUAL - 1	X2	412	413	2300	REF	01	R	Pg. 198
33	PRIOR AUTH. or REFERRAL NUMBER - 1	X30	414	443	2300	REF	02	R	Pg. 199
34	PRIOR AUTH. or REFERRAL NUMBER QUAL - 2	X2	444	445	2300	REF	01	R	Pg. 198
35	PRIOR AUTH. or REF. NUMBER - 2	X30	446	475	2300	REF	02	R	Pg. 199
36	MEDICAL RECORD NUMBER QUAL (EA)	X2	476	477	2300	REF	01	R	Pg. 200

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 510

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
37	MEDICAL RECORD NUMBER (EA)	X30	478	507	2300	REF	02	R	Pg. 201
38	DEMONSTRATION PROJECT ID QUAL (P4)	X2	508	509	2300	REF	01	R	Pg. 202
39	DEMONSTRATION PROJECT ID (P4)	X30	510	539	2300	REF	02	R	Pg. 202

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 515

	Note: Record 515 can only follow record 500 or 510 and can precede records 520 - 600. Total number bytes this record 803.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**REC POS. TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 515	X3	1	3					
File Information - ***occurs 10 times:***									
2	FILE FIX INFORMATION	X80	4	803	2300	K3	01	R	Pg. 204

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 520

	Note: Record 520 can only follow record 500 - 515 and can precede records 525 - 600. Total number bytes this record 916.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**REC POS. TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 520	X3	1	3					
Bgn *Claim note,* ***occurs 10 times:***									
2	DATA ID NUMBER (CLAIM NOTE INFORMATION)	X3	4		2300	NTE	01	R	Pg. 206-7
3	CORRESPONDING DATA	X80			2300	NTE	02	R	Pg. 206-7
End *Claim Note.*									
4	NOTE REFERENCE CODE	X3			2300	NTE	01	R	Pg. 208
5	REMARKS BILLING NOTE (ADD)	X80		916	2300	NTE	02	R	Pg. 209

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 525

	Note: Record 525 can only follow record 500 - 600 and can precede records 530 - 600. Total number bytes this record 239.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 525	X3	1	3					
2	PROGNOSIS INDICATOR	X1		4	2300	CR6	01	R	Pg. 211
3	SOC DATE (ccyymmdd)	X(8)	5	12	2300	CR6	02	R	Pg. 211
4	CERTIFICATION DATE FORMAT QUAL (RD8)	X3	13	15	2300	CR6	03	S	Pg. 211
5	CERTIFICATION FROM DATE (ccyymmdd)	X(8)	16	23	2300	CR6	04	S	Pg. 212
6	CERTIFICATION THRU DATE (ccyymmdd)	X(8)	24	31	2300	CR6	04	S	Pg. 212 (part of prev field)
7	DATE OF ONSET OF PRINCIPAL DIAGNOSIS (ccyymmdd)	X(8)	32	39	2300	CR6	05	R	Pg. 212
8	PATIENT RECEIVING CARE IN SNF	X1		40	2300	CR6	06	R	Pg. 212
9	MEDICARE-COVERED INDICATOR	X1		41	2300	CR6	07	R	Pg. 213
10	CERTIFICATION TYPE INDICATOR	X1		42	2300	CR6	08	R	Pg. 213
11	DATE SURGICAL PROCEDURE PERFORMED (ccyymmdd)	X(8)	43	50	2300	CR6	09	S	Pg. 213
12	SURGICAL PROCEDURE QUALIFIER	X2	51	52	2300	CR6	10	S	Pg. 214
13	SURGICAL PROCEDURE CODE (HC/ID)	X7	53	59	2300	CR6	11	S	Pg. 214
14	VERBAL SOC DATE (ccyymmdd)	X(8)	60	67	2300	CR6	12	S	Pg. 214
15	DATE PHYSICIAN LAST SAW PATIENT (ccyymmdd)	X(8)	68	75	2300	CR6	13	S	Pg. 215
16	DATE LAST CONTACTED PHYSICIAN (ccyymmdd)	X(8)	76	83	2300	CR6	14	S	Pg. 215
17	ADMISSION DATE FORMAT (RD8)	X3	84	86	2300	CR6	15	S	Pg. 215
18	ADMISSION DATE (ccyymmdd)	X(8)	87	94	2300	CR6	16	S	Pg. 215
19	DISCHARGE DATE (ccyymmdd)	X(8)	95	102	2300	CR6	16	S	Pg. 215 (part of prev field)
20	TYPE OF FACILITY	X1		103	2300	CR6	17	R	Pg. 216
21	DATE OF SECONDARY DIAGNOSIS - 1 (ccyymmdd)	X(8)	104	111	2300	CR6	18	S	Pg. 216
22	DATE OF SECONDARY DIAGNOSIS - 2 (ccyymmdd)	X(8)	112	119	2300	CR6	19	S	Pg. 217
23	DATE OF SECONDARY DIAGNOSIS - 3 (ccyymmdd)	X(8)	120	127	2300	CR6	20	S	Pg. 217

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 525

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
24	DATE OF SECONDARY DIAGNOSIS - 4 (ccyymmdd)	X(8)	128	135	2300	CR6	21	S	Pg. 217
Bgn *Home Health Functional Limitations -* ***occurs 3 times:***									
25	FUNCTIONAL LIMITATION CODE CATEGORY	X2	136		2300	CRC	01	R	Pg. 218
26	CERTIFICATION CONDITION INDICATOR	X1			2300	CRC	02	R	Pg. 219
27	FUNCTIONAL LIMITATION CODE	X2			2300	CRC	03	R	Pg. 219
28	FUNCTIONAL LIMITATION CODE	X2			2300	CRC	04	S	Pg. 220
29	FUNCTIONAL LIMITATION CODE	X2			2300	CRC	05	S	Pg. 220
30	FUNCTIONAL LIMITATION CODE	X2			2300	CRC	06	S	Pg. 220
31	FUNCTIONAL LIMITATION CODE	X2		174	2300	CRC	07	S	Pg. 220
End *Home Health Functional Limitations* ***.***									
Bgn *Home Health Activities Permitted -* ***occurs 3 times:***									
32	ACTIVITIES PERMITTED CATEGORY CODE	X2	175		2300	CRC	01	R	Pg. 221
33	CERTIFICATION CONDITION INDICATOR	X1			2300	CRC	02	R	Pg. 222
34	ACTIVITIES PERMITTED CODE	X2			2300	CRC	03	R	Pg. 222
35	ACTIVITIES PERMITTED CODE	X2			2300	CRC	04	S	Pg. 223
36	ACTIVITIES PERMITTED CODE	X2			2300	CRC	05	S	Pg. 223
37	ACTIVITIES PERMITTED CODE	X2			2300	CRC	06	S	Pg. 223
38	ACTIVITIES PERMITTED CODE	X2		213	2300	CRC	07	S	Pg. 223
End *Home Health Activities Permitted* ***.***									
Bgn *Home Health Mental Status -* ***occurs 2 times:***									
39	MENTAL STATUS CODE QUALIFIER (77)	X2	214		2300	CRC	01	R	Pg. 224
40	CERTIFICATION CONDITION INDICATOR	X1			2300	CRC	02	R	Pg. 225
41	MENTAL STATUS CODES	X2			2300	CRC	03	R	Pg. 225
42	MENTAL STATUS CODES	X2			2300	CRC	04	S	Pg. 226
43	MENTAL STATUS CODES	X2			2300	CRC	05	S	Pg. 226
44	MENTAL STATUS CODES	X2			2300	CRC	06	S	Pg. 226
45	MENTAL STATUS CODES	X2		239	2300	CRC	07	S	Pg. 226
End *Home Health Mental Status* ***.***									

Health Information (HI)
Principal Diagnosis

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 530

	Note: Record 530 can follow record 500 - 539. Except, being that 530 only occurs once, it can not follow a 530. Total number bytes this record 27.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 530	X3	1	3					
2	PRINCIPAL DIAGNOSIS QUALIFIER (BK)	X2	4	5	2300	HI	01-1	R	Pg. 228
The Principal / BK / first Diag Code goes to occur 1 in the Claim.									
3	PRINCIPAL DIAGNOSIS CODE	X6	6	11	2300	HI	01-2	R	Pg. 228
4	ADMITTING DIAGNOSIS QUALIFIER (BJ/ZZ)	X2	12	13	2300	HI	02-1	R	Pg. 228
5	ADMITTING DIAGNOSIS CODE	X6	14	19	2300	HI	02-2	R	Pg. 228
6	EXTERNAL CAUSE OF INJURY (E CODE) QUAL (BN)	X2	20	21	2300	HI	03-1	R	Pg. 229
7	EXTERNAL CAUSE OF INJURY (E CODE)	X6	22	27	2300	HI	03-2	R	Pg. 229

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 531

	Note: Record 531 can follow record 500 - 539. Total number bytes this record 8.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 531	X3	1	3					
2	DIAGNOSIS RELATED GROUP (DRG) QUAL (DR)	X2	4	5	2300	HI	01-1	R	Pg. 230
3	DIAGNOSIS RELATED GROUP (DRG)	X3	6	8	2300	HI	01-2	R	Pg. 230

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 532

	Note: Record 532 can follow record 500 - 539. Total number bytes this record 99. This record must be repeated if there are greater than 12 Other Diagnosis Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**REC POS. TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 532	X3	1	3					
The first nine Diagnoses (BF) go to the Claim (occurs 1-9), their Qualifiers go to Repository. All subsequent Diagnoses & Qualifiers go to the Repository file.									
2	OTHER DIAGNOSIS QUAL - 1 (BF)	X2	4	5	2300	HI	01-1	R	Pg. 232
3	OTHER DIAGNOSIS CODE - 1	X6	6	11	2300	HI	01-2	R	Pg. 233
4	OTHER DIAGNOSIS QUAL - 2 (BF)	X2	12	13	2300	HI	02-1	R	
5	OTHER DIAGNOSIS CODE - 2	X6	14	19	2300	HI	02-2	R	Pg. 233
6	OTHER DIAGNOSIS QUAL - 3 (BF)	X2	20	21	2300	HI	03-1	R	
7	OTHER DIAGNOSIS CODE - 3	X6	22	27	2300	HI	03-2	R	Pg. 234
8	OTHER DIAGNOSIS QUAL - 4 (BF)	X2	28	29	2300	HI	04-1	R	
9	OTHER DIAGNOSIS CODE - 4	X6	30	35	2300	HI	04-2	R	Pg. 235
10	OTHER DIAGNOSIS QUAL - 5 (BF)	X2	36	37	2300	HI	05-1	R	
11	OTHER DIAGNOSIS CODE - 5	X6	28	43	2300	HI	05-2	R	Pg. 235
12	OTHER DIAGNOSIS QUAL - 6 (BF)	X2	44	45	2300	HI	06-1	R	
13	OTHER DIAGNOSIS CODE - 6	X6	46	51	2300	HI	06-2	R	Pg. 236
14	OTHER DIAGNOSIS QUAL - 7 (BF)	X2	52	53	2300	HI	07-1	R	
15	OTHER DIAGNOSIS CODE - 7	X6	54	59	2300	HI	07-2	R	Pg. 236
16	OTHER DIAGNOSIS QUAL - 8 (BF)	X2	60	61	2300	HI	08-1	R	
17	OTHER DIAGNOSIS CODE - 8	X6	62	67	2300	HI	08-2	R	Pg. 236
18	OTHER DIAGNOSIS QUAL - 9 (BF)	X2	68	69	2300	HI	09-1	R	
19	OTHER DIAGNOSIS CODE - 9	X6	70	75	2300	HI	09-2	R	Pg. 236
20	OTHER DIAGNOSIS QUAL - 10 (BF)	X2	76	77	2300	HI	10-1	R	

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 532

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMMENTS
21	OTHER DIAGNOSIS QUAL & CODE - 10	X6	78	83	2300	HI	10-2	R	Pg. 239
22	OTHER DIAGNOSIS QUAL - 11 (BF)	X2	84	85	2300	HI	11-1	R	
23	OTHER DIAGNOSIS QUAL & CODE - 11	X6	86	91	2300	HI	11-2	R	Pg. 240
24	OTHER DIAGNOSIS QUAL - 12 (BF)	X2	92	93	2300	HI	12-1	R	
25	OTHER DIAGNOSIS QUAL & CODE - 12	X6	94	99	2300	HI	12-2	R	Pg. 240

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 533

	Note: Record 533 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 22.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 533	X3	1	3					
2	PRINCIPAL PROCEDURE CODE QUAL (BP, BR)	X2	4	5	2300	HI	01-1	R	Pg. 242
3	PRINCIPAL PROCEDURE CODE	X7	6	12	2300	HI	01-2	R	Pg. 243
4	PRINCIPAL PROCEDURE DATE QUAL (D8)	X2	13	14	2300	HI	01-3	S	Pg. 243
5	PRINCIPAL PROCEDURE DATE (ccyymmdd)	X8	15	22	2300	HI	01-4	S	Pg. 243

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 534

	Note: Record 534 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 231. This record must be repeated if there are greater than 12 Other Procedure Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 534	X3	1	3					
*The first 6 Procedures with '**BQ**' qualifier go to the Claim; All subsequent (BQ) go to the Repository file:*									
*All Procedures with '**BO**' qualifier go to the Repository file:*									
2	OTHER PROCEDURE QUAL - 1 (BO ***or*** BQ)	X2	4	5	2300	HI	01-1	R	Pg. 244
3	OTHER PROCEDURE CODE - 1	X7	6	12	2300	HI	01-2	R	Pg. 245
4	OTHER PROC DATE QUAL - 1 (D8)	X2	13	14	2300	HI	01-3	S	Pg. 245
5	OTHER PROCEDURE DATE - 1 (ccyymmdd)	X8	15	22	2300	HI	01-4	S	Pg. 245
6	OTHER PROCEDURE QUAL - 2 (BO ***or*** BQ)	X2	23	24	2300	HI	02-1	R	Pg. 245
7	OTHER PROCEDURE CODE - 2	X7	25	31	2300	HI	02-2	R	Pg. 246
8	OTHER PROC DATE QUAL - 2 (D8)	X2	32	33	2300	HI	02-3	S	Pg. 246
9	OTHER PROCEDURE DATE - 2 (ccyymmdd)	X8	34	41	2300	HI	02-4	S	Pg. 246
10	OTHER PROCEDURE QUALI - 3 (BO ***or*** BQ)	X2	42	43	2300	HI	03-1	R	Pg. 246
11	OTHER PROCEDURE CODE - 3	X7	44	50	2300	HI	03-2	R	Pg. 246
12	OTHER PROC DATE QUAL - 3 (D8)	X2	51	52	2300	HI	03-3	S	Pg. 247
13	OTHER PROCEDURE DATE - 3 (ccyymmdd)	X8	53	60	2300	HI	03-4	S	Pg. 247
14	OTHER PROCEDURE QUALI - 4 (BO ***or*** BQ)	X2	61	62	2300	HI	04-1	R	Pg. 247
15	OTHER PROCEDURE CODE - 4	X7	63	69	2300	HI	04-2	R	Pg. 247
16	OTHER PROC DATE QUAL - 4 (D8)	X2	70	71	2300	HI	04-3	S	Pg. 248
17	OTHER PROCEDURE DATE - 4 (ccyymmdd)	X8	72	79	2300	HI	04-4	S	Pg. 248
18	OTHER PROCEDURE QUAL - 5 (BO ***or*** BQ)	X2	80	81	2300	HI	05-1	R	Pg. 248

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 534

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
1	RECORD TYPE 534	X3	1	3					
19	OTHER PROCEDURE CODE - 5	X7	82	88	2300	HI	05-2	R	Pg. 248
20	OTHER PROC DATE QUAL - 5 (D8)	X2	89	90	2300	HI	05-3	S	Pg. 249
21	OTHER PROCEDURE DATE - 5 (ccyymmdd)	X8	91	98	2300	HI	05-4	S	Pg. 249
22	OTHER PROCEDURE QUAL - 6 (BO ***or*** BQ)	X2	99	100	2300	HI	06-1	R	Pg. 249
23	OTHER PROCEDURE CODE - 6	X7	101	107	2300	HI	06-2	R	Pg. 249
24	OTHER PROC DATE QUAL - 6 (D8)	X2	108	109	2300	HI	06-3	S	Pg. 249
25	OTHER PROCEDURE DATE - 6 (ccyymmdd)	X8	110	117	2300	HI	06-4	S	Pg. 250
26	OTHER PROCEDURE QUAL - 7 (BO ***or*** BQ)	X2	118	119	2300	HI	07-1	R	Pg. 250
27	OTHER PROCEDURE CODE - 7	X7	120	126	2300	HI	07-2	R	Pg. 250
28	OTHER PROC DATE QUAL - 7 (D8)	X2	127	128	2300	HI	07-3	S	Pg. 250
29	OTHER PROCEDURE DATE - 7 (ccyymmdd)	X8	129	136	2300	HI	07-4	S	Pg. 251
30	OTHER PROCEDURE QUAL - 8 (BO ***or*** BQ)	X2	137	138	2300	HI	08-1	R	Pg. 251
31	OTHER PROCEDURE CODE - 8	X7	139	145	2300	HI	08-2	R	Pg. 251
32	OTHER PROC DATE QUAL - 8 (D8)	X2	146	147	2300	HI	08-3	S	Pg. 251
33	OTHER PROCEDURE DATE - 8 (ccyymmdd)	X8	148	155	2300	HI	08-4	S	Pg. 252
34	OTHER PROCEDURE QUAL - 9 (BO ***or*** BQ)	X2	156	157	2300	HI	09-1	R	Pg. 252
35	OTHER PROCEDURE CODE - 9	X7	158	164	2300	HI	09-2	R	Pg. 252
36	OTHER PROC DATE QUAL -9 (D8)	X2	165	166	2300	HI	09-3	S	Pg. 252
37	OTHER PROCEDURE DATE - 9 (ccyymmdd)	X8	167	174	2300	HI	09-4	S	Pg. 252

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 534

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
1	RECORD TYPE 534	X3	1	3					
38	OTHER PROCEDURE QUAL - 10 (BO ***or*** BQ)	X2	175	176	2300	HI	10-1	R	Pg. 253
39	OTHER PROCEDURE CODE - 10	X7	177	183	2300	HI	10-2	R	Pg. 253
40	OTHER PROC DATE QUAL - 10 (D8)	X2	184	185	2300	HI	10-3	S	Pg. 253
41	OTHER PROCEDURE DATE - 10 (ccyymmdd)	X8	186	193	2300	HI	10-4	S	Pg. 253
42	OTHER PROCEDURE QUAL - 11 (BO ***or*** BQ)	X2	194	195	2300	HI	11-1	R	Pg. 254
43	OTHER PROCEDURE CODE - 11	X7	196	202	2300	HI	11-2	R	Pg. 254
44	OTHER PROC DATE QUAL - 11 (D8)	X2	203	204	2300	HI	11-3	S	Pg. 254
45	OTHER PROCEDURE DATE - 11 (ccyymmdd)	X8	205	212	2300	HI	11-4	S	Pg. 254
46	OTHER PROCEDURE QUAL - 12 (BO ***or*** BQ)	X2	213	214	2300	HI	12-1	R	Pg. 255
47	OTHER PROCEDURE CODE - 12	X7	215	221	2300	HI	12-2	R	Pg. 255
48	OTHER PROC DATE QUAL - 12 (D8)	X2	222	223	2300	HI	12-3	S	Pg. 255
49	OTHER PROCEDURE DATE - 12 (ccyymmdd)	X8	224	231	2300	HI	12-4	S	Pg. 255

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 535

	Note: Record 535 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 279. This record must be repeated if there are greater than 12 Occurrence Span Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 535	X3	1	3					
2	OCCURRENCE SPAN CODE QUAL - 1	X2	4	5	2300	HI	01-1	R	Pg. 257
3	OCCURRENCE SPAN CODE - 1	X2	6	7	2300	HI	01-2	R	Pg. 257
4	OCCUR SPAN DATE QUAL - 1 (RD8)	X3	8	10	2300	HI	01-3	R	Pg. 257
5	OCCURRENCE SPAN FROM DATE - 1 (ccyymmdd)	X8	11	18	2300	HI	01-4	R	Pg. 257
6	OCCURRENCE SPAN THRU DATE - 1 (ccyymmdd)	X8	19	26	2300	HI	01-4	R	Pg. 257
7	OCCURRENCE SPAN QUAL - 2 (BI)	X2	27	28	2300	HI	02-1	R	Pg. 257
8	OCCURRENCE SPAN CODE - 2	X2	29	30	2300	HI	02-2	R	Pg. 257
9	OCCUR SPAN DATE QUAL - 2 (RD8)	X3	31	33	2300	HI	02-3	R	Pg. 258
10	OCCURRENCE SPAN FROM DATE- 2 (ccyymmdd)	X8	34	41	2300	HI	02-4	R	Pg. 258
11	OCCURRENCE SPAN THRU DATE- 2 (ccyymmdd)	X8	42	49	2300	HI	02-4	R	Pg. 258
12	OCCURRENCE SPAN QUAL - 3 (BI)	X2	50	51	2300	HI	03-1	R	Pg. 258
13	OCCURRENCE SPAN CODE - 3	X2	52	53	2300	HI	03-2	R	Pg. 258
14	OCCUR SPAN DATE QUAL - 3 (RD8)	X3	54	56	2300	HI	03-3	R	Pg. 258
15	OCCURRENCE SPAN FROM DATE- 3 (ccyymmdd)	X8	57	64	2300	HI	03-4	R	Pg. 259
16	OCCURRENCE SPAN THRU DATE - 3 (ccyymmdd)	X8	65	72	2300	HI	03-4	R	Pg. 259
17	OCCURRENCE SPAN QUAL - 4 (BI)	X2	73	74	2300	HI	04-1	R	Pg. 259
18	OCCURRENCE SPAN CODE - 4	X2	75	76	2300	HI	04-2	R	Pg. 259
19	OCCUR SPAN DATE QUAL - 4 (RD8)	X3	77	79	2300	HI	04-3	R	Pg. 259

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 535

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
20	OCCURRENCE SPAN FROM DATE- 4 (ccyymmdd)	X8	80	87	2300	HI	04-4	R	Pg. 259
21	OCCURRENCE SPAN THRU DATE- 4 (ccyymmdd)	X8	86	95	2300	HI	04-4	R	Pg. 259
22	OCCURRENCE SPAN QUAL - 5 (BI)	X2	96	97	2300	HI	05-1	R	Pg. 260
23	OCCURRENCE SPAN CODE - 5	X2	98	99	2300	HI	05-2	R	Pg. 260
24	OCCUR SPAN DATE QUAL - 5 (RD8)	X3	100	102	2300	HI	05-3	R	Pg. 260
25	OCCURRENCE SPAN FROM DATE-5 (ccyymmdd)	X8	103	110	2300	HI	05-4	R	Pg. 260
26	OCCURRENCE SPAN THRU DATE - 5 (ccyymmdd)	X8	111	118	2300	HI	05-4	R	Pg. 260
27	OCCURRENCE SPAN QUAL - 6 (BI)	X2	119	120	2300	HI	06-1	R	Pg. 261
28	OCCURRENCE SPAN CODE - 6	X2	121	122	2300	HI	06-2	R	Pg. 261
29	OCCUR SPAN DATE QUAL - 6 (RD8)	X3	123	125	2300	HI	06-3	R	Pg. 261
30	OCCURRENCE SPAN FROM DATE- 6 (ccyymmdd)	X8	126	133	2300	HI	06-4	R	Pg. 261
31	OCCURRENCE SPAN THRU DATE - 6 (ccyymmdd)	X8	134	141	2300	HI	06-4	R	Pg. 261
32	OCCURRENCE SPAN QUAL - 7 (BI)	X2	142	143	2300	HI	07-1	R	Pg. 261
33	OCCURRENCE SPAN CODE - 7	X2	144	145	2300	HI	07-2	R	Pg. 262
34	OCCUR SPAN DATE QUAL - 7 (RD8)	X3	146	148	2300	HI	07-3	R	Pg. 261
35	OCCURRENCE SPAN FROM DATE-7 (ccyymmdd)	X8	149	156	2300	HI	07-4	R	Pg. 262
36	OCCURRENCE SPAN THRU DATE - 7 (ccyymmdd)	X8	157	164	2300	HI	07-4	R	Pg. 262
37	OCCURRENCE SPAN QUAL - 8 (BI)	X2	165	166	2300	HI	08-1	R	Pg. 262
38	OCCURRENCE SPAN CODE - 8	X2	167	168	2300	HI	08-2	R	Pg. 262

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 535

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
39	OCCUR SPAN DATE QUAL - 8 (RD8)	X3	169	171	2300	HI	08-3	R	Pg. 263
40	OCCURRENCE SPAN FROM DATE- 8 (ccyymmdd)	X8	172	179	2300	HI	08-4	R	Pg. 263
41	OCCURRENCE SPAN THRU DATE- 8 (ccyymmdd)	X8	180	187	2300	HI	08-4	R	Pg. 263
42	OCCURRENCE SPAN QUAL - 9 (BI)	X2	188	189	2300	HI	09-1	R	Pg. 263
43	OCCURRENCE SPAN CODE - 9	X2	190	191	2300	HI	09-2	R	Pg. 263
44	OCCUR SPAN DATE QUAL - 9 (RD8)	X3	192	194	2300	HI	09-3	R	Pg. 263
45	OCCURRENCE SPAN FROM DATE - 9 (ccyymmdd)	X8	195	202	2300	HI	09-4	R	Pg. 263
46	OCCURRENCE SPAN THRU DATE - 9 (ccyymmdd)	X8	203	210	2300	HI	09-4	R	Pg. 263
47	OCCURRENCE SPAN QUAL - 10 (BI)	X2	211	212	2300	HI	10-1	R	Pg. 264
48	OCCURRENCE SPAN CODE - 10	X2	213	214	2300	HI	10-2	R	Pg. 264
49	OCCUR SPAN DATE QUAL - 10 (RD8)	X3	215	217	2300	HI	10-3	R	Pg. 264
50	OCCURRENCE SPAN FROM DATE - 10 (ccyymmdd)	X8	218	225	2300	HI	10-4	R	Pg. 264
51	OCCURRENCE SPAN THRU DATE- 10 (ccyymmdd)	X8	226	233	2300	HI	10-4	R	Pg. 264
52	OCCURRENCE SPAN QUAL - 11 (BI)	X2	234	235	2300	HI	11-1	R	Pg. 265
53	OCCURRENCE SPAN CODE - 11	X2	236	237	2300	HI	11-2	R	Pg. 265
54	OCCUR SPAN DATE QUAL - 11 (RD8)	X3	238	240	2300	HI	11-3	R	Pg. 265
55	OCCURRENCE SPAN FROM DATE - 11 (ccyymmdd)	X8	241	248	2300	HI	11-4	R	Pg. 265
56	OCCURRENCE SPAN THRU DATE - 11 (ccyymmdd)	X8	249	256	2300	HI	11-4	R	Pg. 265

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 535

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
57	OCCURRENCE SPAN QUAL - 12 (BI)	X2	257	258	2300	HI	12-1	R	Pg. 265
58	OCCURRENCE SPAN CODE - 12	X2	259	260	2300	HI	12-2	R	Pg. 266
59	OCCUR SPAN DATE QUAL - 12 (RD8)	X3	261	263	2300	HI	12-3	R	Pg. 266
60	OCCURRENCE SPAN FROM DATE- 12 (ccyymmdd)	X8	264	271	2300	HI	12-4	R	Pg. 266
61	OCCURRENCE SPAN THRU DATE- 12 (ccyymmdd)	X8	272	279	2300	HI	12-4	R	Pg. 266

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 536

	Note: Record 536 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 171. This record must be repeated if there are greater than 12 Occurrence Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 536	X3	1	3					
	Occurrence 2 (Values 13 thru 24) occupy po								
2	OCCURRENCE CODE QUAL - 1 (BH)	X2	4	5	2300	HI	01-1	R	Pg. 267
3	OCCURRENCE CODE - 1	X2	6	7	2300	HI	01-2	R	Pg. 268
4	OCCUR DATE/TIME QUAL - 1 (D8)	X2	8	9	2300	HI	01-3	R	Pg. 268
5	OCCURRENCE DATE - 1 (ccyymmdd)	X8	10	17	2300	HI	01-4	R	Pg. 268
6	OCCURRENCE CODE QUAL - 2 (BH)	X2	18	19	2300	HI	02-1	R	Pg. 268 - 269
7	OCCURRENCE CODE - 2	X2	20	21	2300	HI	02-2	R	
8	OCCUR DATE/TIME QUAL - 2 (D8)	X2	22	23	2300	HI	02-3	R	
9	OCCURRENCE DATE - 2 (ccyymmdd)	X8	24	31	2300	HI	02-4	R	
10	OCCURRENCE CODE QUAL - 3 (BH)	X2	32	33	2300	HI	03-1	R	Pg. 269 - 270
11	OCCURRENCE CODE - 3	X2	34	35	2300	HI	03-2	R	
12	OCCUR DATE/TIME QUAL - 3 (D8)	X2	36	37	2300	HI	03-3	R	
13	OCCURRENCE DATE - 3 (ccyymmdd)	X8	38	45	2300	HI	03-4	R	
14	OCCURRENCE CODE QUAL - 4 (BH)	X2	46	47	2300	HI	04-1	R	Pg. 270 - 271
15	OCCURRENCE CODE - 4	X2	48	49	2300	HI	04-2	R	
16	OCCUR DATE/TIME QUAL - 4 (D8)	X2	50	51	2300	HI	04-3	R	
17	OCCURRENCE DATE - 4 (ccyymmdd)	X8	52	59	2300	HI	04-4	R	
18	OCCURRENCE CODE QUAL - 5 (BH)	X2	60	61	2300	HI	05-1	R	Pg. 271 - 272
19	OCCURRENCE CODE - 5	X2	62	63	2300	HI	05-2	R	

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 536

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
20	OCCUR DATE/TIME QUAL - 5 (D8)	X2	64	65	2300	HI	05-3	R	
21	OCCURRENCE DATE - 5 (ccyymmdd)	X8	66	73	2300	HI	05-4	R	
22	OCCURRENCE CODE QUAL - 6 (BH)	X2	74	75	2300	HI	06-1	R	Pg. 272 - 273
23	OCCURRENCE CODE - 6	X2	76	77	2300	HI	06-2	R	
24	OCCUR DATE/TIME QUAL - 6 (D8)	X2	78	79	2300	HI	06-3	R	
25	OCCURRENCE DATE - 6 (ccyymmdd)	X8	80	87	2300	HI	06-4	R	
26	OCCURRENCE CODE QUAL - 7 (BH)	X2	88	89	2300	HI	07-1	R	Pg. 273 - 274
27	OCCURRENCE CODE - 7	X2	90	91	2300	HI	07-2	R	
28	OCCUR DATE/TIME QUAL - 7 (D8)	X2	92	93	2300	HI	07-3	R	
29	OCCURRENCE DATE - 7 (ccyymmdd)	X8	94	101	2300	HI	07-4	R	
30	OCCURRENCE CODE QUAL - 8 (BH)	X2	102	103	2300	HI	08-1	R	Pg. 274 - 275
31	OCCURRENCE CODE - 8	X2	104	105	2300	HI	08-2	R	
32	OCCUR DATE/TIME QUAL - 8 (D8)	X2	106	107	2300	HI	08-3	R	
33	OCCURRENCE DATE - 8 (ccyymmdd)	X8	108	115	2300	HI	08-4	R	
34	OCCURRENCE CODE QUAL - 9 (BH)	X2	116	117	2300	HI	09-1	R	Pg. 275 - 276
35	OCCURRENCE CODE - 9	X2	118	119	2300	HI	09-2	R	
36	OCCUR DATE/TIME QUAL - 9 (D8)	X2	120	121	2300	HI	09-3	R	
37	OCCURRENCE DATE - 9 (ccyymmdd)	X8	122	129	2300	HI	09-4	R	
38	OCCURRENCE CODE QUAL - 10 (BH)	X2	130	131	2300	HI	10-1	R	Pg. 276 - 277
39	OCCURRENCE CODE - 10	X2	132	133	2300	HI	10-2	R	

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 536

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
40	OCCUR DATE/TIME QUAL - 10 (D8)	X2	134	135	2300	HI	10-3	R	
41	OCCURRENCE DATE - 10 (ccyymmdd)	X8	136	143	2300	HI	10-4	R	
42	OCCURRENCE CODE QUAL - 11 (BH)	X2	144	145	2300	HI	11-1	R	Pg. 277 - 278
43	OCCURRENCE CODE - 11	X2	146	147	2300	HI	11-2	R	
44	OCCUR DATE/TIME QUAL - 11 (D8)	X2	148	149	2300	HI	11-3	R	
45	OCCURRENCE DATE - 11 (ccyymmdd)	X8	150	157	2300	HI	11-4	R	
46	OCCURRENCE CODE QUAL - 12 (BH)	X2	158	159	2300	HI	12-1	R	Pg. 278 - 279
47	OCCURRENCE CODE - 12	X2	160	161	2300	HI	12-2	R	
48	OCCUR DATE/TIME QUAL - 12 (D8)	X2	162	163	2300	HI	12-3	R	
49	OCCURRENCE DATE - 12 (ccyymmdd)	X8	164	171	2300	HI	12-4	R	

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 537

	Note: Record 537 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 171. This record must be repeated if there are greater than 12 Value Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 537	X3	1	3					
Value Code Information, ***occurs 2 times:***									
2	VALUE CODE QUAL - 1	X2	4	5	2300	HI	01-1	R	Pg. 280
3	VALUE CODE - 1	X2	6	7	2300	HI	01-2	R	Pg. 281
4	VALUE AMOUNT - 1	S9(8)V99	8	17	2300	HI	01-5	R	Pg. 281
5	VALUE CODE QUAL - 2	X2	18	19	2300	HI	02-1	R	Pg. 281
6	VALUE CODE - 2	X2	20	21	2300	HI	02-2	R	Pg. 281
7	VALUE AMOUNT - 2	S9(8)V99	22	31	2300	HI	02-5	R	Pg. 282
8	VALUE CODE QUAL - 3	X2	32	33	2300	HI	03-1	R	Pg. 282
9	VALUE CODE - 3	X2	34	35	2300	HI	03-2	R	Pg. 282
10	VALUE AMOUNT - 3	S9(8)V99	36	45	2300	HI	03-5	R	Pg. 282
11	VALUE CODE QUAL - 4	X2	46	47	2300	HI	04-1	R	Pg. 283
12	VALUE CODE - 4	X2	48	49	2300	HI	04-2	R	Pg. 283
13	VALUE AMOUNT - 4	S9(8)V99	50	59	2300	HI	04-5	R	Pg. 283
14	VALUE CODE QUAL - 5	X2	60	61	2300	HI	05-1	R	Pg. 283
15	VALUE CODE - 5	X2	62	63	2300	HI	05-2	R	Pg. 283
16	VALUE AMOUNT - 5	S9(8)V99	64	73	2300	HI	05-5	R	Pg. 284
17	VALUE CODE QUAL - 6	X2	74	75	2300	HI	06-1	R	Pg. 284
18	VALUE CODE - 6	X2	76	77	2300	HI	06-2	R	Pg. 284
19	VALUE AMOUNT - 6	S9(8)V99	78	87	2300	HI	06-5	R	Pg. 284
20	VALUE CODE QUAL - 7	X2	88	89	2300	HI	07-1	R	Pg. 285
21	VALUE CODE - 7	X2	90	91	2300	HI	07-2	R	Pg. 285
22	VALUE AMOUNT - 7	S9(8)V99	92	101	2300	HI	07-5	R	Pg. 285
23	VALUE CODE QUAL - 8	X2	102	103	2300	HI	08-1	R	Pg. 285
24	VALUE CODE - 8	X2	104	105	2300	HI	08-2	R	Pg. 286
25	VALUE AMOUNT - 8	S9(8)V99	106	115	2300	HI	08-5	R	Pg. 286
26	VALUE CODE QUAL - 9	X2	116	117	2300	HI	09-1	R	Pg. 286
27	VALUE CODE - 9	X2	118	119	2300	HI	09-2	R	Pg. 286
28	VALUE AMOUNT - 9	S9(8)V99	120	129	2300	HI	09-5	R	Pg. 287
29	VALUE CODE QUAL - 10	X2	130	131	2300	HI	10-1	R	Pg. 287
30	VALUE CODE - 10	X2	132	133	2300	HI	10-2	R	Pg. 287
31	VALUE AMOUNT - 10	S9(8)V99	134	143	2300	HI	10-5	R	Pg. 287
32	VALUE CODE QUAL - 11	X2	144	145	2300	HI	11-1	R	Pg. 288

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 537

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
33	VALUE CODE - 11	X2	146	147	2300	HI	11-2	R	Pg. 288
34	VALUE AMOUNT - 11	S9(8)V99	148	157	2300	HI	11-5	R	Pg. 288
35	VALUE CODE QUAL - 12	X2	158	159	2300	HI	12-1	R	Pg. 288
36	VALUE CODE - 12	X2	160	161	2300	HI	12-2	R	Pg. 288
37	VALUE AMOUNT - 12	S9(8)V99	162	171	2300	HI	12-5	R	Pg. 289

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 538

	Note: Record 538 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 51. This record must be repeated if there are greater than 12 Condition Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 538	X3	1	3					
2	CONDITION CODE QUAL - 1 (BG)	X2	4	5	2300	HI	01-1	R	Pg. 290
3	CONDITION CODE - 1	X2	6	7	2300	HI	01-2	R	Pg. 291
4	CONDITION CODE QUAL - 2 (BG)	X2	8	9	2300	HI	02-1	R	Pg. 291
5	CONDITION CODE - 2	X2	10	11	2300	HI	02-2	R	Pg. 291
6	CONDITION CODE QUAL - 3 (BG)	X2	12	13	2300	HI	03-1	R	Pg. 292
7	CONDITION CODE - 3	X2	14	15	2300	HI	03-2	R	Pg. 292
8	CONDITION CODE QUAL - 4 (BG)	X2	16	17	2300	HI	04-1	R	Pg. 293
9	CONDITION CODE - 4	X2	18	19	2300	HI	04-2	R	Pg. 293
10	CONDITION CODE QUAL - 5 (BG)	X2	20	21	2300	HI	05-1	R	Pg. 293
11	CONDITION CODE - 5	X2	22	23	2300	HI	05-2	R	Pg. 293
12	CONDITION CODE QUAL - 6 (BG)	X2	24	25	2300	HI	06-1	R	Pg. 294
13	CONDITION CODE - 6	X2	26	27	2300	HI	06-2	R	Pg. 294
14	CONDITION CODE QUAL - 7 (BG)	X2	28	29	2300	HI	07-1	R	Pg. 295
15	CONDITION CODE - 7	X2	30	31	2300	HI	07-2	R	Pg. 295
16	CONDITION CODE QUAL - 8 (BG)	X2	32	33	2300	HI	08-1	R	Pg. 295
17	CONDITION CODE - 8	X2	34	35	2300	HI	08-2	R	Pg. 295
18	CONDITION CODE QUAL - 9 (BG)	X2	36	37	2300	HI	09-1	R	Pg. 296
19	CONDITION CODE - 9	X2	38	39	2300	HI	09-2	R	Pg. 296
20	CONDITION CODE QUAL - 10 (BG)	X2	40	41	2300	HI	10-1	R	Pg. 297
21	CONDITION CODE - 10	X2	42	43	2300	HI	10-2	R	Pg. 297
22	CONDITION CODE QUAL - 11 (BG)	X2	44	45	2300	HI	11-1	R	Pg. 297
23	CONDITION CODE - 11	X2	46	47	2300	HI	11-2	R	Pg. 297
24	CONDITION CODE QUAL - 12 (BG)	X2	48	49	2300	HI	12-1	R	Pg. 298
25	CONDITION CODE - 12	X2	50	51	2300	HI	12-2	R	Pg. 298

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 539

	Note: Record 539 can follow record 500 - 539 and can precede records 530 - 600. Total number bytes this record 63. This record must be repeated if there are greater than 12 Treatment Codes per Claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 539	X3	1	3					
2	TREAT. CODE QUAL - 1 (TC)	X2	4	5	2300	HI	01-1	R	Pg. 299
3	TREATMENT CODE - 1	X3	6	8	2300	HI	01-2	R	Pg. 300
4	TREAT. CODE QUAL - 2 (TC)	X2	9	10	2300	HI	02-1	R	Pg. 300
5	TREATMENT CODE - 2	X3	11	13	2300	HI	02-2	R	Pg. 300
6	TREAT. CODE QUAL - 3 (TC)	X2	14	15	2300	HI	03-1	R	Pg. 300
7	TREATMENT CODE - 3	X3	16	18	2300	HI	03-2	R	Pg. 300
8	TREAT. CODE QUAL - 4 (TC)	X2	19	20	2300	HI	04-1	R	Pg. 301
9	TREATMENT CODE - 4	X3	21	23	2300	HI	04-2	R	Pg. 301
10	TREAT. CODE QUAL - 5 (TC)	X2	24	25	2300	HI	05-1	R	Pg. 301
11	TREATMENT CODE - 5	X3	26	28	2300	HI	05-2	R	Pg. 302
12	TREAT. CODE QUAL - 6 (TC)	X2	29	30	2300	HI	06-1	R	Pg. 302
13	TREATMENT CODE - 6	X3	31	33	2300	HI	06-2	R	Pg. 302
14	TREAT. CODE QUAL - 7 (TC)	X2	34	35	2300	HI	07-1	R	Pg. 302
15	TREATMENT CODE - 7	X3	36	38	2300	HI	07-2	R	Pg. 302
16	TREAT. CODE QUAL - 8 (TC)	X2	39	40	2300	HI	08-1	R	Pg. 303
17	TREATMENT CODE - 8	X3	41	43	2300	HI	08-2	R	Pg. 303
18	TREAT. CODE QUAL - 9 (TC)	X2	44	45	2300	HI	09-1	R	Pg. 303
19	TREATMENT CODE - 9	X3	46	48	2300	HI	09-2	R	Pg. 304
20	TREAT. CODE QUAL - 10 (TC)	X2	49	50	2300	HI	10-1	R	Pg. 304
21	TREATMENT CODE - 10	X3	51	53	2300	HI	10-2	R	Pg. 304
22	TREAT. CODE QUAL - 11 (TC)	X2	54	55	2300	HI	11-1	R	Pg.304
23	TREATMENT CODE - 11	X3	56	58	2300	HI	11-2	R	Pg. 304
24	TREAT. CODE QUAL - 12 (TC)	X2	59	60	2300	HI	12-1	R	Pg. 305
25	TREATMENT CODE - 12	X3	61	63	2300	HI	12-2	R	Pg. 305

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 540

	Note: Record 540 can follow record 500 - 539 and can precede records 550 - 600. Total number bytes this record 183.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 540	X3	1	3					
2	QUANTITY QUALIFIER - 1 (CA)	X2	4	5	2300	QTY	01	R	Pg. 306
3	COVERED DAYS - 1	9(15)	6	20	2300	QTY	02	R	Pg. 307
4	BASIS FOR MEASUREMENT - 1	X2	21	22	2300	QTY	03-1	R	Pg. 307
5	QUANTITY QUALIFIER - 3 (CD)	X2	23	24	2300	QTY	01	R	Pg. 306
6	COINSURANCE DAYS - 3	9(15)	25	39	2300	QTY	02	R	Pg. 307
7	BASIS FOR MEASUREMENT - 3	X2	40	41	2300	QTY	03-1	R	Pg. 307
8	QUANTITY QUALIFIER - 4 (LA)	X2	42	43	2300	QTY	01	R	Pg. 306
9	LIFETIME RESERVED DAYS - 4	9(15)	44	58	2300	QTY	02	R	Pg. 307
10	BASIS FOR MEASUREMENT -4	X2	59	60	2300	QTY	03-1	R	Pg. 307
11	QUANTITY QUALIFIER - 2 (NA)	X2	61	62	2300	QTY	01	R	Pg. 306
12	NON-COVERED DAYS - 2	9(15)	63	77	2300	QTY	02	R	Pg. 307
13	BASIS FOR MEASUREMENT - 2	X2	78	79	2300	QTY	03-1	R	Pg. 307
14	PRICING METHODOLOGY	X2	80	81	2300	HCP	01	R	Pg. 309
15	REPRICED ALLOWED AMT	S9(8)V99	82	91	2300	HCP	02	R	Pg. 309
16	REPRICED SAVINGS AMT	S9(8)V99	92	101	2300	HCP	03	S	Pg. 310
17	REPRICING ORGANIZATION ID	X30	102	131	2300	HCP	04	S	Pg. 310
18	REPRICING PER DIEM *or* FLAT RATE	S9(7)V99	132	140	2300	HCP	05	S	Pg. 310
19	REPRICED APPROVED DRG CODE	X3	141	143	2300	HCP	06	S	Pg. 310
20	REPRICED APPROVED DRG AMT	S9(8)V99	144	153	2300	HCP	07	S	Pg. 310
21	REPRICED APPROVED REVENUE CODE	X4	154	157	2300	HCP	08	S	Pg. 311
22	APPROVED HCPCS CODE QUAL (HC)	X2	158	159	2300	HCP	09	S	Pg. 311
23	APPROVED HCPCS CODE	X11	160	170	2300	HCP	10	S	Pg. 311
24	REPRICED APPROVED SERVICE UNIT COUNT QUALIFIER (DA/UN)	X2	171	172	2300	HCP	11	S	Pg. 311
25	REPRICED APPROVED SERVICE UNIT COUNT	9(7)	173	179	2300	HCP	12	S	Pg. 312
26	REJECTION MESSAGE	X2	180	181	2300	HCP	13	S	Pg. 312
27	POLICY COMPLIANCE CODE	X1		182	2300	HCP	14	S	Pg. 312
28	EXCEPTION REASON CODE	X1		183	2300	HCP	15	S	Pg. 312

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 550

	Note: Record 550 can follow record 500 - 540 and precedes records 570 - 600. Total number bytes this record 2,415.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**REC POS. TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 550	X3	1	3					
Outer loop, *Home Health Care Plan Information,* ***occurs 6 times:***									
29	DISCIPLINE TYPE CODE	X2	4		2305	CR7	01	R	Pg. 314
30	TOTAL VISITS PRIOR TO RECERTIFICATION	9(2)			2305	CR7	02	R	Pg. 315
31	TOTAL VISITS PROJECTED THIS CERT.	9(2)			2305	CR7	03	R	Pg. 315
Inner loop, *Health Care Services Delivery,* ***occurs 12 times within each of the above 6*** ***(6 * 12 = 72):***									
32	FREQUENCY NUMBER QUALIFIER (VS)	X2			2305	HSD	01	S	Pg. 317
33	FREQUENCY NUMBER	9(15)			2305	HSD	02	S	Pg. 317
34	FREQUENCY PERIOD QUALIFIER (DA, MO, Q1, WK)	X2			2305	HSD	03	S	Pg. 317
35	FREQUENCY PERIOD	9(6)			2305	HSD	04	S	Pg. 318
36	DURATION NUMBER OF VISITS/UNITS QUALIFIER (7, 35)	X2			2305	HSD	05	S	Pg. 318
37	DURATION NUMBER OF VISITS/UNITS	9(3)			2305	HSD	06	S	Pg. 318
38	SHIP, DELIVERY OR CALENDAR PATTERN	X2			2305	HSD	07	S	Pg. 318
39	SHIP, DELIVERY PATTERN TIME CODE	X1		2415	2305	HSD	08	S	Pg. 320
Inner loop end.									
Outer loop end.									

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 570

	Note: Record 570 can follow record 570 and can precede records 570 when there are multiple 570 records. Total number of bytes this record 377. This record may be repeated if the Claim requires greater than one physician but not greater than four, one each for Attending, Operating, Other and Service Facility.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMENTS**
1	RECORD TYPE 570	X3	1	3					
	ATTENDING/OPERATING/OTHER/SERVICE PHYSICIAN								
2	PHYSICIAN NAME QUAL (71/72/73/FA)	X2	4	5	2310A/ B/C/E	NM1	01	R	Pg. 322, Pg. 328, Pg. 335, Pg. 349
3	PHYSICIAN NAME TYPE QUALIFIER (1/2)	X1		6	2310A/ B/C/E	NM1	02	R	Pg. 322
4	PHYSICIAN LAST NAME	X35	7	41	2310A/ B/C/E	NM1	03	R	Pg. 322
5	PHYSICIAN FIRST NAME	X25	42	66	2310A/ B/C/E	NM1	04	S	Pg. 322
6	PHYSICIAN MIDDLE NAME	X25	67	91	2310A/ B/C/E	NM1	05	S	Pg. 322
7	PHYSICIAN NAME SUFFIX	X10	92	101	2310A/ B/C/E	NM1	07	S	Pg. 323
8	PHYSICIAN PRIMARY NUM QUAL (24, 34, XX)	X2	102	103	2310A/ B/C/E	NM1	08	R	Pg. 323
9	PHYSICIAN PRIMARY NUM	X16	104	119	2310A/ B/C/E	NM1	09	R	Pg. 323
10	FACILITY ADDRESS LINE 1	X55	120	174	2310E	N3	01		Pg. 354, This is only for the Service Facility NM1 segment.
11	FACILITY ADDRESS LINE 2	X55	175	229	2310E	N3	02		Pg. 354, This is only for the Service Facility NM1 segment.
12	FACILITY CITY	X30	230	259	2310E	N4	01		Pg. 355, This is only for the Service Facility NM1 segment.
13	FACILITY STATE	X2	260	261	2310E	N4	02		Pg. 355, This is only for the Service Facility NM1 segment.
14	FACILITY ZIP	X9	262	270	2310E	N4	03		Pg. 356, This is only for the Service Facility NM1 segment.
15	FACILITY COUNTRY	X3	271	273	2310E	N4	04		Pg. 356, This is only for the Service Facility NM1 segment.
16	PHYSICIAN SPECIALTY QUAL (AT/SU)	X2	274	275	2310A	PRV	01	R	Pg. 324, This is only for the Attending Physician.

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 570

FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	COMENTS
17	PHYSICIAN SPECIALTY TAXONOMY QUAL (ZZ)	X2	276	277	2310A	PRV	02	R	Pg. 325, This is only for the Attending Physician.
18	PHYSICIAN SPECIALTY CODE	X10	278	287	2310A	PRV	03	R	Pg. 325, This is only for the Attending Physician.
19	PHYSICIAN 2NDARY ID QUAL - 1	X2	288	289	2310A/ B/C/E	REF	01	R	Pg. 326
20	PHYSICIAN SECONDARY ID - 1	X16	290	305	2310A/ B/C/E	REF	02	R	Pg. 327
21	PHYSICIAN 2NDARY ID QUAL - 2	X2	306	307	2310A/ B/C/E	REF	01	R	Pg. 326
22	PHYSICIAN SECONDARY ID - 2	X16	308	323	2310A/ B/C/E	REF	01/02	R	Pg. 327
23	PHYSICIAN 2NDARY ID QUAL - 3	X2	324	325	2310A/ B/C/E	REF	01	R	Pg. 326
24	PHYSICIAN SECONDARY ID - 3	X16	326	341	2310A/ B/C/E	REF	01/02	R	Pg. 327
25	PHYSICIAN 2NDARY ID QUAL - 4	X2	342	343	2310A/ B/C/E	REF	01	R	Pg. 326
26	PHYSICIAN SECONDARY ID - 4	X16	344	359	2310A/ B/C/E	REF	01/02	R	Pg. 327
27	PHYSICIAN 2NDARY ID QUAL - 5	X2	360	361	2310A/ B/C/E	REF	01	R	Pg. 326
28	PHYSICIAN SECONDARY ID - 5	X16	362	377	2310A/ B/C/E	REF	01/02	R	Pg. 327

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 575

	Note: Record 575 is required if record 300 is not equal to "P." There would only be one 300 record. Record 575 can follow records 500 - 570 and can precede records 580 - 600. This record can repeat up to 10 times as required. Total number bytes this record 98.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 575	X3	1	3					
2	PAYER RESPONSIBILITY SEQUENCE CODE (P, S, T)	X1		4	2320	SBR	01	R	Pg. 360
3	PATIENT RELATIONSHIP TO INSURED	X2	5	6	2320	SBR	02	R	Pg. 361
4	INSURANCE GROUP NUMBER	X30	7	36	2320	SBR	03	S	Pg. 363
5	INSURANCE GROUP NAME	X60	37	96	2320	SBR	04	S	Pg. 363
6	SOURCE PAY CODE (Claim filing indicator code)	X2	97	98	2320	SBR	09	S	Pg. 363

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 580

	Note: Record 580 can only follow record 575 and can precede records 585 - 600. Total number bytes this record 137. This record may be repeated as required for claim level adjustments, up to 5 times, per 575 record.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 580	X3	1	3					
Bgn *Claim Level Adjustments -* ***occurs 5 times:***									
2	GROUP CODE	X2	4	5	2320	CAS	01	R	Pg. 367
3	REASON CODE - 1	X5	6	10	2320	CAS	02	R	Pg. 367
4	ADJUSTMENT AMOUNT - 1	S9(8)V99	11	20	2320	CAS	03	R	Pg. 367
5	ADJUSTMENT QUANTITY - 1	S9(7)	21	27	2320	CAS	04	S	Pg. 367
6	REASON CODE - 2	X5	28	32	2320	CAS	05	S	Pg. 368
7	ADJUSTMENT AMOUNT - 2	S9(8)V99	33	42	2320	CAS	06	S	Pg. 368
8	ADJUSTMENT QUANTITY - 2	S9(7)	43	49	2320	CAS	07	S	Pg. 368
9	REASON CODE - 3	X5	50	54	2320	CAS	08	S	Pg. 368
10	ADJUSTMENT AMOUNT - 3	S9(8)V99	55	64	2320	CAS	09	S	Pg. 368
11	ADJUSTMENT QUANTITY - 3	S9(7)	65	71	2320	CAS	10	S	Pg. 369
12	REASON CODE - 4	X5	72	76	2320	CAS	11	S	Pg. 369
13	ADJUSTMENT AMOUNT - 4	S9(8)V99	77	86	2320	CAS	12	S	Pg. 369
14	ADJUSTMENT QUANTITY - 4	S9(7)	87	93	2320	CAS	13	S	Pg. 369
15	REASON CODE - 5	X5	94	98	2320	CAS	14	S	Pg. 369
16	ADJUSTMENT AMOUNT - 5	S9(8)V99	99	108	2320	CAS	15	S	Pg. 370
17	ADJUSTMENT QUANTITY - 5	S9(7)	109	115	2320	CAS	16	S	Pg. 370
18	REASON CODE - 6	X5	116	120	2320	CAS	17	S	Pg. 370
19	ADJUSTMENT AMOUNT - 6	S9(8)V99	121	130	2320	CAS	18	S	Pg. 370
20	ADJUSTMENT QUANTITY - 6	S9(7)	131	137	2320	CAS	19	S	Pg. 370
End *Claim Level Adjustments.*									

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 585

	Note: Record 585 can only follow records 575 - 580 and can precede records 590 - 600. This record occurs once per 575 record. Total number bytes this record 369.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 585	X3	1	3					
2	COB PAYER PRIOR PAYMENT (C4)	X2	4	5	2320	AMT	01	S	Pg. 371
3	COB PAYER PRIOR PAYMENT	S9(8)V99	6	15	2320	AMT	02	S	Pg. 371
4	COB TOTAL ALLOWED AMOUNT QUALIFIER (B6)	X2	16	17	2320	AMT	01	R	Pg. 372
5	COB TOTAL CHARGES ALLOWED	S9(8)V99	18	27	2320	AMT	02	R	Pg. 372
6	COB TOTAL SUBMITTED CHARGES QUALIFIER (T3)	X2	28	29	2320	AMT	01	R	Pg. 373
7	COB TOTAL SUBMITTED CHARGES	S9(8)V99	30	39	2320	AMT	02	R	Pg. 373
8	DRG OUTLIER AMOUNT QUALIFIER (ZZ)	X2	40	41	2320	AMT	01	R	Pg. 374
9	DRG OUTLIER AMOUNT	S9(8)V99	42	51	2320	AMT	02	R	Pg. 375
10	COB TOTAL MEDICARE PAID AMOUNT QUALIFIER (N1)	X2	52	53	2320	AMT	01	R	Pg. 376
11	COB TOTAL MEDICARE PAID AMOUNT	S9(8)V99	54	63	2320	AMT	02	R	Pg. 377
12	MEDICARE PAID AMOUNT 100% QUALIFIER (KF)	X2	64	65	2320	AMT	01	R	Pg. 378
13	MEDICARE PAID AMOUNT 100%	S9(8)V99	66	75	2320	AMT	02	R	Pg. 378
14	MEDICARE PAID AMOUNT 80% QUALIFIER (PG)	X2	76	77	2320	AMT	01	R	Pg. 380
15	MEDICARE PAID AMOUNT 80%	S9(8)V99	78	87	2320	AMT	02	R	Pg. 380
16	COB MEDICARE A TRUST FUND PAID QUALIFIER (AA)	X2	88	89	2320	AMT	01	R	Pg. 382
17	COB MEDICARE A TRUST FUND PAID	S9(8)V99	90	99	2320	AMT	02	R	Pg. 383

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 585

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
18	COB MEDICARE B TRUST FUND PAID QUALIFIER (B1)	X2	100	101	2320	AMT	01	R	Pg. 384
19	COB MEDICARE B TRUST FUND PAID	S9(8)V99	102	111	2320	AMT	02	R	Pg. 385
20	COB TOTAL NON COVERED AMOUNT QUALIFIER (A8)	X2	112	113	2320	AMT	01	R	Pg. 386
21	COB TOTAL NON COVERED AMOUNT	S9(8)V99	114	123	2320	AMT	02	R	Pg. 386
22	COB TOTAL DENIED AMOUNT QUALIFIER (YT)	X2	124	125	2320	AMT	01	R	Pg. 387
23	COB TOTAL DENIED AMOUNT	S9(8)V99	126	135	2320	AMT	02	R	Pg. 387
24	OTHER SUBSCRIBER / INSURED BIRTH DATE QUAL (D8)	X2	136	137	2320	DMG	01	R	Pg. 388
25	OTHER SUBSCRIBER / INSURED BIRTH DATE (CCYYMMDD)	X8	138	145	2320	DMG	02	R	Pg. 389
26	OTHER SUBSCRIBER / INSURED SEX	X1		146	2320	DMG	03	R	Pg. 389
27	ASSIGNMENT BENEFIT CERTIFICATION INDICATOR	X1		147	2320	OI	03	R	Pg. 390
28	RELEASE OF INFORMATION CODE	X1		148	2320	OI	06	R	Pg. 391
29	COVERED DAYS/VISITS	9(4)	149	152	2320	MIA	01	R	Pg. 393
30	LIFETIME RESERVE DAYS	9(4)	163	156	2320	MIA	02	S	Pg. 393
31	LIFETIME PSYCHIATRIC DAYS	9(4)	157	160	2320	MIA	03	S	Pg. 393
32	DRG/APC AMOUNT APPLIED (PRICER)	S9(8)V99	161	170	2320	MIA	04	S	Pg. 393
33	DISPROPORTIONATE SHARE AMOUNT	S9(8)V99	171	180	2320	MIA	06	S	Pg. 393
34	MSP PASS THROUGH AMT	S9(8)V99	181	190	2320	MIA	07	S	Pg. 394
35	PPS CAPITAL AMT	S9(8)V99	191	200	2320	MIA	08	S	Pg. 394
36	PPS CAPITAL FSP DRG AMT	S9(8)V99	201	210	2320	MIA	09	S	Pg. 394

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 585

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
37	PPS CAPITAL HSP DRG AMT	S9(8)V99	211	220	2320	MIA	10	S	Pg. 394
38	PPS CAPITAL DSH DRG AMT	S9(8)V99	221	230	2320	MIA	11	S	Pg. 394
39	OLD CAPITAL AMT	S9(8)V99	231	240	2320	MIA	12	S	Pg. 394
40	PPS CAPITAL IME AMT	S9(8)V99	241	250	2320	MIA	13	S	Pg. 395
41	PPS OPERATING HOSPITAL SPECIFIC DRG AMT	S9(8)V99	251	260	2320	MIA	14	S	Pg. 395
42	COST REPORT DAYS	9(4)	261	264	2320	MIA	15	S	Pg. 395
43	PPS OPERATING FEDERAL SPECIFIC DRG AMT	S9(8)V99	265	274	2320	MIA	16	S	Pg. 395
44	PPS CAPITAL OUTLIER AMT	S9(8)V99	275	284	2320	MIA	17	S	Pg. 395
45	INDIRECT TEACHING AMT	S9(8)V99	285	294	2320	MIA	18	S	Pg. 395
46	PPS CAPITAL EXCEPTION AMT	S9(8)V99	295	304	2320	MIA	24	S	Pg. 396
47	REIMBURSEMENT RATE (%)	S9(8)V99	305	314	2320	MOA	01	S	Pg. 397
48	CLAIMS HCPCS PAYABLE AMT	S9(8)V99	315	324	2320	MOA	02	S	Pg. 398
49	ESRD PAYMENT AMT	S9(8)V99	325	334	2320	MOA	08	S	Pg. 399
50	MIA/MOA REMARK CODE - 1	X5	335	339	2320	MIA/MOA	05/03	S/S	Pg. 393 - 398
51	MIA/MOA REMARK CODE - 2	X5	340	344	2320	MIA/MOA	20/04	S/S	Pg. 396 - 398
52	MIA/MOA REMARK CODE - 3	X5	345	349	2320	MIA/MOA	21/05	S/S	Pg. 396 - 398
53	MIA/MOA REMARK CODE - 4	X5	350	354	2320	MIA/MOA	22/06	S/S	Pg. 396 - 399
54	MIA/MOA REMARK CODE - 5	X5	355	359	2320	MIA/MOA	23/07	S/S	Pg. 396 - 399
55	NON PAYABLE PROFESSIONAL COMPONENT AMT	S9(8)V99	360	369	2320	MIA/MOA	19/9	S/S	Pg. 395 - 399

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 590

	Note: Record 590 is required if record 300 is not equal to "P." There would only be one 300 record. Record 590 can only follow records 575 - 590 and can precede records 590 - 600. This record can follow or precede 590 when there are multiple 590 records. This record may occur up to seven times per 575 record. Total number bytes this record 428.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 590	X3	1	3					
2	OTHER SUBSCRIBER / INSURED ENTITY ID CODE (IL)	X2	4	5	2330A/B/ C/D/E/F/H	NM1	01	R	Pg. 401
3	OTHER SUBSCRIBER/INSURED QUALIFIER (1/2)	X1		6	2330A/B/ C/D/E/F/H	NM1	02	R	Pg. 401
4	OTHER SUBSCRIBER / INSURED LAST NAME	X35	7	41	2330A/B/ C/D/E/F/H	NM1	03	R	Pg. 401
5	OTHER SUBSCRIBER / INSURED FIRST NAME	X25	42	66	2330A/B/ C/D/E/F/H	NM1	04	S	Pg. 401
6	OTHER SUBSCRIBER / INSURED MIDDLE NAME	X25	67	91	2330A/B/ C/D/E/F/H	NM1	05	S	Pg. 402
7	OTHER SUBSCRIBER / INSURED NAME SUFFIX	X10	92	101	2330A/B/ C/D/E/F/H	NM1	07	S	Pg. 402
8	OTHER SUBSCRIBER/INSURED ID CODE QUAL (MI/ZZ)	X2	102	103	2330A/B/ C/D/E/F/H	NM1	08	R	Pg. 402
9	OTHER SUBSCRIBER / INSURED CERTIFICATE / SSN / HIC/ID NUMBER (MI/ZZ)	X30	104	133	2330A/B/ C/D/E/F/H	NM1	09	R	Pg. 403
10	OTHER SUBSCRIBER / INSURED ADDRESS LINE 1	X55	134	188	2330A/B/ C/D/E/F/H	N3	01	R	Pg. 404
11	OTHER SUBSCRIBER / INSURED ADDRESS LINE 2	X55	189	243	2330A/B/ C/D/E/F/H	N3	02	R	Pg. 405

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 590

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
12	OTHER SUBSCRIBER / INSURED CITY	X30	244	273	2330A/B/ C/D/E/F/H	N4	01	R	Pg. 406
13	OTHER SUBSCRIBER / INSURED STATE	X2	274	275	2330A/B/ C/D/E/F/H	N4	02	R	Pg. 407
14	OTHER SUBSCRIBER / INSURED ZIP CODE	X9	276	284	2330A/B/ C/D/E/F/H	N4	03	R	Pg. 407
15	OTHER SUBSCRIBER / INSURED COUNTRY CODE	X3	285	287	2330A/B/ C/D/E/F/H	N4	04	R	Pg. 407
33	CLAIM PAID DATE QUALIFIER (573)	X3	288	290	2330B	DTP	01	R	Pg. 415
34	CLAIM PAID DATE FORMAT QUALIFIER (D8)	X2	291	292	2330B	DTP	02	R	Pg. 415
35	CLAIM PAID DATE (CCYYMMDD)	X8	293	300	2330B	DTP	03	R	Pg. 415
16	OTHER SUBSCRIBER/INSURED 2NDARY ID QUAL - 1	X2	301	302	2330A/B/ C/D/E/F/H	REF	01	R	Pg. 408
17	OTHER SUBSCRIBER / INSURED SECONDARY ID 1	X30	303	332	2330A/B/ C/D/E/F/H	REF	02	R	Pg. 409
18	OTHER SUBSCRIBER/INSURED 2NDARY ID QUAL - 2	X2	333	334	2330A/B/ C/D/E/F/H	REF	01	R	Pg. 408
19	OTHER SUBSCRIBER / INSURED SECONDARY ID 2	X30	335	364	2330A/B/ C/D/E/F/H	REF	01/02	R	Pg. 409
20	OTHER SUBSCRIBER/INSURED 2NDARY ID QUAL - 3	X2	365	366	2330A/B/ C/D/E/F/H	REF	01	R	Pg. 408
21	OTHER SUBSCRIBER / INSURED SECONDARY ID 3	X30	367	396	2330A/B/ C/D/E/F/H	REF	01/02	R	Pg. 409

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 590

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	COMMENTS
			FROM	TO					
22	OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER QUALIFIER	X2	397	398	2330B	REF	01	R	Pg. 418
23	OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER	X30	399	428	2330B	REF	02	R	Pg. 419

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 600

	Note: Record 600 can only follow records 500 - 590 and can precede records 600 - 650, 999, 100 - 500. Total number bytes this record 73. This record may be repeated as needed up to 999 times.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 600	X3	1	3					
2	SERVICE LINE NUMBER	9(6)	4	9	2400	LX	01	R	Pg. 444
3	REVENUE CODE	X4	10	13	2400	SV2	01	R	Pg. 446
4	HCPCS PROCEDURE / NDC QUALIFIER	X2	14	15	2400	SV2	02-1	R	Pg. 446
5	HCPCS PROCEDURE / NDC NUMBER	X11	16	26	2400	SV2	02-2	R	Pg. 447
6	HCPCS MODIFIER 1	X2	27	28	2400	SV2	02-3	S	Pg. 447
7	HCPCS MODIFIER 2	X2	29	30	2400	SV2	02-4	S	Pg. 447
8	HCPCS MODIFIER 3	X2	31	32	2400	SV2	02-5	S	Pg. 448
9	HCPCS MODIFIER 4	X2	33	34	2400	SV2	02-6	S	Pg. 448
10	SERVICE LINE CHARGE AMOUNT	S9(8)V99	35	44	2400	SV2	03	R	Pg. 448
11	BASIS FOR MEASUREMENT CODE	X2	45	46	2400	SV2	04	R	Pg. 448
12	SERVICE LINE DAYS/UNITS	9(6)V9	47	53	2400	SV2	05	R	Pg. 449
13	SERVICE LINE RATE AMOUNT	S9(8)V99	54	63	2400	SV2	06	S	Pg. 449
14	SERVICE LINE NON-COVERED CHARGE AMOUNT	S9(8)V99	64	73	2400	SV2	07	S	Pg. 449

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 605

	Note: Record 605 can only follow record 600 and can precede records 600 - 650, 999 and 100 - 500. Total number bytes this record 433.								
FIELD NO.	FIELD NAME	PIC	REC POS. FROM	REC POS. TO	LOOP	SEG	ELEM	RQMT	IG PAGE NUMBER
1	RECORD TYPE 605	X3	1	3					
2	LINE ATTACHMENT REPORT TYPE CODE - 1	X2	4	5	2400	PWK	01	R	Pg. 453
3	LINE ATTACHMENT TRANSMISSION CODE - 1	X2	6	7	2400	PWK	02	R	Pg. 454
4	LINE ATTACHMENT ID CODE QUALIFIER (AC) - 1	X2	8	9	2400	PWK	05	S	Pg. 454
5	LINE ATTACHMENT CNTRL NUM (BM, EL, EM, FX) - 1	X80	10	89	2400	PWK	06	S	Pg. 454
6	LINE ATTACHMENT REPORT TYPE CODE - 2	X2	90	91	2400	PWK	01	R	Pg. 453
7	LINE ATTACHMENT TRANSMISSION CODE - 2	X2	92	93	2400	PWK	02	R	Pg. 454
8	LINE ATTACHMENT ID CODE QUALIFIER (AC) - 2	X2	94	95	2400	PWK	05	S	Pg. 454
9	LINE ATTACHMENT CNTRL NUM (BM, EL, EM, FX) - 2	X80	96	175	2400	PWK	06	S	Pg. 454
10	LINE ATTACHMENT REPORT TYPE CODE - 3	X2	176	177	2400	PWK	01	R	Pg. 453
11	LINE ATTACHMENT TRANSMISSION CODE - 3	X2	178	179	2400	PWK	02	R	Pg. 454
12	LINE ATTACHMENT ID CODE QUALIFIER (AC) - 3	X2	180	181	2400	PWK	05	S	Pg. 454
13	LINE ATTACHMENT CNTRL NUM (BM, EL, EM, FX) - 3	X80	182	261	2400	PWK	06	S	Pg. 454
14	LINE ATTACHMENT REPORT TYPE CODE - 4	X2	262	263	2400	PWK	01	R	Pg. 453
15	LINE ATTACHMENT TRANSMISSION CODE - 4	X2	264	265	2400	PWK	02	R	Pg. 454
16	LINE ATTACHMENT ID CODE QUALIFIER (AC) - 4	X2	266	267	2400	PWK	05	S	Pg. 454
17	LINE ATTACHMENT CNTRL NUM (BM, EL, EM, FX) - 4	X80	268	347	2400	PWK	06	S	Pg. 454

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 605

FIELD NO.	FIELD NAME	PIC	REC POS.		LOOP	SEG	ELEM	RQMT	IG PAGE NUMBER
			FROM	TO					
18	LINE ATTACHMENT REPORT TYPE CODE - 5	X2	348	349	2400	PWK	01	R	Pg. 453
19	LINE ATTACHMENT TRANSMISSION CODE - 5	X2	350	351	2400	PWK	02	R	Pg. 454
20	LINE ATTACHMENT ID CODE QUALIFIER (AC) - 5	X2	352	353	2400	PWK	05	S	Pg. 454
21	LINE ATTACHMENT CNTRL NUM (BM, EL, EM, FX) - 5	X80	354	433	2400	PWK	06	S	Pg. 454

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 610

	Note: Record 610 can only follow records 600 - 605 and can precede records 600, 620 - 650, 999 and 100 - 500. Total number bytes this record 62.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 610	X3	1	3					
2	SERVICE LINE DATE QUALIFIER (472)	X3	4	6	2400	DTP	01	R	Pg. 456
3	SERVICE LINE DATE FORMAT (D8)	X3	7	9	2400	DTP	02	R	Pg. 457
4	SERVICE LINE DATE (ccyymmdd / ccyymmdd)	X16	10	25	2400	DTP	03	R	Pg. 457
5	ASSESSMENT DATE QUALIFIER (866)	X3	26	28	2400	DTP	01	R	Pg. 458
6	ASSESSMENT DATE FORMAT QUALIFIER (D8)	X2	29	30	2400	DTP	02	R	Pg. 458
7	ASSESSMENT DATE (ccyymmdd)	X8	31	38	2400	DTP	03	R	Pg. 459
8	SERVICE TAX AMOUNT QUALIFIER (GT)	X2	39	40	2400	AMT	01	R	Pg. 460
9	SERVICE TAX AMOUNT	S9(8)V99	41	50	2400	AMT	02	R	Pg. 460
10	FACILITY TAX AMOUNT QUALIFIER (N8)	X2	51	52	2400	AMT	01	R	Pg. 461
11	FACILITY TAX AMOUNT	S9(8)V99	53	62	2400	AMT	02	R	Pg. 461

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 620

	Note: Record 620 can only follow records 600-610 and can precede records 600, 630 - 650, 999, and 100 - 500. Total number bytes this record 107.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 620	X3	1	3					
2	REPRICED METHODOLOGY	X2	4	5	2400	HCP	01	R	Addenda page 30
3	REPRICED ALLOWED AMT	S9(8)V99	6	15	2400	HCP	02	R	Addenda page 30
4	REPRICED SAVINGS AMT	S9(8)V99	16	25	2400	HCP	03	S	Addenda page 31
5	REPRICED ORGANIZATION ID	X30	26	55	2400	HCP	04	S	Addenda page 31
6	REPRICED RATE	S9(7)V99	56	64	2400	HCP	05	S	Addenda page 31
7	REPRICED DRG CODE	X3	65	67	2400	HCP	06	S	Addenda page 31
8	REPRICED DRG AMOUNT	S9(8)V99	68	77	2400	HCP	07	S	Addenda page 31
9	REPRICED REVENUE CODE	X4	78	81	2400	HCP	08	S	Addenda page 32
10	REPRICED HCPC QUALIFIER	X2	82	83	2400	HCP	09	S	Addenda page 32
11	REPRICED HCPC CODE	X11	84	94	2400	HCP	10	S	Addenda page 32
12	REPRICED UNITS QUALIFIER	X2	95	96	2400	HCP	11	S	Addenda page 32
13	REPRICED UNITS	9(7)	97	103	2400	HCP	12	S	Addenda page 32
14	REJECT REASON CODE	X2	104	105	2400	HCP	13	S	Addenda page 33
15	POLICY COMPLIANCE CODE	X1		106	2400	HCP	14	S	Addenda page 33
16	EXCEPTION CODE	X1		107	2400	HCP	15	S	Addenda page 33

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 630

	Note: Record 630 can only follow records 600 - 620 and can precede records 600, 640 - 650, 999, and 100 - 500. This record can repeat up to 25 times. Total number bytes this record 77.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS. FROM**	**TO**	**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
1	RECORD TYPE 630	X3	1	3					
2	NDC QUALIFIER	X2	4	5	2410	LIN	02	R	Addenda Page 37
3	NDC	X13	6	18	2410	LIN	03	R	Addenda Page 37
4	UNIT PRICE	S9(8)V99	19	28	2410	CTP	03	R	Addenda Page 39
5	UNITS	9(7)V999	29	38	2410	CTP	04	R	Addenda Page 39
6	FILLER	X5	39	43					
7	UNITS QUALIFIER	X2	44	45	2410	CTP	05-1	R	Addenda Page 39
8	PRESCRIPTION NUMBER QUALIFIER	X2	46	47	2410	REF	01	R	Addenda Page 40
9	PRESCRIPTION NUMBER	X30	48	77	2410	REF	02	R	Addenda Page 40

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 640

	Note: Record 640 can only follow records 600 - 640 and can precede records 600, 640 - 650, 999, and 100 - 500. Could follow or precede 640 when there are multiple 640 records. Total number bytes this record 137. This record may be repeated as necessary up to three times for Attending, Operating and Other, per revenue line.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 640	X3	1	3					
	LINE PHYSICIAN INFORMATION								
2	LINE PHYSICIAN ENTY CODE (71/72/73)	X2	4	5	2420A	NM1	01	R	Pg. 463
3	LINE PHYSICIAN ENTY TYPE (1, 2)	X1		6	2420A	NM1	02	R	Pg. 463
4	LINE PHYSICIAN LAST NAME	X35	7	41	2420A	NM1	03	R	Pg. 463
5	LINE PHYSICIAN FIRST NAME	X25	42	66	2420A	NM1	04	S	Pg. 463
6	LINE PHYSICIAN MIDDLE NAME	X25	67	91	2420A	NM1	05	S	Pg. 463
7	LINE PHYSICIAN NAME SUFFIX	X10	92	101	2420A	NM1	07	S	Pg. 463
8	LINE PHYSICIAN ID CODE QUAL (24, 34, XX)	X2	102	103	2420	NM1	08	R	Pg. 463
9	LINE PHYSICIAN PRIMARY ID	X16	104	119	2420A	NM1	09	R	Pg. 464
10	LINE PHYSICIAN SECONDARY ID	X2	120	121	2420A	REF	01	R	Pg. 467
11	LINE PHYSICIAN SECONDARY ID	X16	122	137	2420A	REF	02	R	Pg. 468

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 650

	Note: Record 650 can only follow records 600 - 650 and can precede records 600, 650 - 999, and 100 - 500. Total number bytes this record 141. This record may repeat up to 25 times per 999 service lines.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 650	X3	1	3					
2	PAYER IDENTIFICATION (must be same as 2010BC or 2330B)	X10	4	13	2430	SVD	01	R	Pg. 491
3	SERVICE LINE PAID AMOUNT	S9(8)V99	14	23	2430	SVD	02	R	Pg. 491
4	SERVICE QUALIFIER (HC and N4)	X2	24	25	2430	SVD	03-1	R	Pg. 491
5	PROCEDURE CODE	X11	26	36	2430	SVD	03-2	S	Pg. 492
6	SERVICE MODIFIER - 1	X2	37	38	2430	SVD	03-3	S	Pg. 492
7	SERVICE MODIFIER - 2	X2	39	40	2430	SVD	03-4	S	Pg. 492
8	SERVICE MODIFIER - 3	X2	41	42	2430	SVD	03-5	S	Pg. 492
9	SERVICE MODIFIER - 4	X2	43	44	2430	SVD	03-6	S	Pg. 492
10	PROCEDURE CODE DESCRIPTION	X80	45	124	2430	SVD	03-7	S	Pg. 492
11	SERVICE REVENUE LINE CODE	9(4)	125	128	2430	SVD	04	R	Pg. 492
12	LINE PAID UNITS OF SERVICE	9(6)V9	129	135	2430	SVD	05	R	Pg. 493
13	BUNDLED / UNBUNDLED LINE NUMBER	9(6)	136	141	2430	SVD	06	S	Pg. 493

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 660

	Note: Record 660 can only follow records 650 - 660 and can precede records 600, 650 - 999, and 100 - 500. Total number bytes this record 137. This record may be repeated as required up to 99 times per service line adjustment (650/25), per 999 service lines per claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 660	X3	1	3					
Bgn *Service Line Adjustments* - ***occurs 99 times.***									
2	GROUP CODE	X2	4	5	2430	CAS	01	R	Pg. 495
3	REASON CODE - 1	X5	6	10	2430	CAS	02	R	Pg. 496
4	ADJUSTMENT AMOUNT - 1	S9(8)V99	11	20	2430	CAS	03	R	Pg. 496
5	ADJUSTMENT QUANTITY - 1	S9(7)	21	27	2430	CAS	04	S	Pg. 496
6	REASON CODE - 2	X5	28	32	2430	CAS	05	S	Pg. 496
7	ADJUSTMENT AMOUNT - 2	S9(8)V99	33	42	2430	CAS	06	S	Pg. 497
8	ADJUSTMENT QUANTITY - 2	S9(7)	43	49	2430	CAS	07	S	Pg. 497
9	REASON CODE - 3	X5	50	54	2430	CAS	08	S	Pg. 497
10	ADJUSTMENT AMOUNT - 3	S9(8)V99	55	64	2430	CAS	09	S	Pg. 498
11	ADJUSTMENT QUANTITY - 3	S9(7)	65	71	2430	CAS	10	S	Pg. 498
12	REASON CODE - 4	X5	72	76	2430	CAS	11	S	Pg. 498
13	ADJUSTMENT AMOUNT - 4	S9(8)V99	77	86	2430	CAS	12	S	Pg. 499
14	ADJUSTMENT QUANTITY - 4	S9(7)	87	93	2430	CAS	13	S	Pg. 499
15	REASON CODE - 5	X5	84	98	2430	CAS	14	S	Pg. 499
16	ADJUSTMENT AMOUNT - 5	S9(8)V99	99	108	2430	CAS	15	S	Pg. 500
17	ADJUSTMENT QUANTITY - 5	S9(7)	109	115	2430	CAS	16	S	Pg. 500
18	REASON CODE - 6	X5	116	120	2430	CAS	17	S	Pg. 500
19	ADJUSTMENT AMOUNT - 6	S9(8)V99	121	130	2430	CAS	18	S	Pg. 501
20	ADJUSTMENT QUANTITY - 6	S9(7)	131	137	2430	CAS	19	S	Pg. 501
End *Service Line Adjustments*.									

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 670

	Note: Record 670 can only follow records 650 - 660 and can precede records 600, 650 999 and 100 - 500. Total number bytes this record 16. This record may be repeated once per service line adjustment (25) per 999 service lines per claim.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 670	X3	1	3					
2	SERVICE LINE ADJUDICATION DATE QUALIFIER (573)	X3	4	6	2430	DTP	01	R	Pg. 502
3	SERVICE LINE ADJUDICATION DATE FORMAT (D8)	X2	7	8	2430	DTP	02	R	Pg. 502
4	SERVICE ADJUDICATION PAYMENT DATE (ccyymmdd)	X8	9	16	2430	DTP	03	R	Pg. 502

HEALTH CARE CLAIM
837 4010A1 ADDENDA
FLAT FILE SPREAD SHEET RECORD 999

	Note: The 999 record closes out an ISA - IEA for inbound files. Record 999 can follow records 600 - 670 and can precede a 100 if multiple ISA - IEA files are processed in a single file. Total number bytes this record 17.								
FIELD NO.	**FIELD NAME**	**PIC**	**REC POS.**		**LOOP**	**SEG**	**ELEM**	**RQMT**	**COMMENTS**
			FROM	**TO**					
1	RECORD TYPE 999	X3	1	3					
2	Physical Record Count	9(7)	4	10	N/A	N/A	N/A	N/A	
3	Number of Claims	9(7)	11	17	N/A	N/A	N/A	N/A	