Wellpoint

Companion Document

837I

837 Institutional Health Care Claim

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

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

Get Started with Availity

The Availity Quick Start Guide will assist you with any EDI connection questions.

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

Need Assistance?

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

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Section 1 - Basic Instructions

1.1 X12 and HIPAA Compliance Checking, and Business Edits

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

Please visit the Availity Batch Electronic Data Interchange Standard Companion Guide for report options.

1.2 HIPAA Compliant Codes

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

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

1.3 Diagnosis Codes

According to the 837I TR3, a transaction is not X12 compliant if decimal points are used in diagnosis codes. Therefore, should a diagnosis code contain a decimal point, Wellpoint will return a 999 to the submitter indicating that the transaction has been rejected.

1.4 Procedure codes and Modifiers

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

1.5 Uppercase Letters, Special Characters, and Delimiters

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

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

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

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

   Examples: Recommended: Zip Code 123456789 Medical Record # 1234567

4. Since originally submitted values may be returned on outbound transactions, Wellpoint encourages trading partners to not use the following special characters as part of the value: asterisk (*), less than/greater than signs (<, >), colon (:), and slash (/). This minimizes the risk for a special character to be recognized as a delimiter.
   Example: Provider assigns a Patient Control Number '12*3456789'. Although an asterisk (*) is a valid special character, it adversely affects processing since it is also a common delimiter. The value '12*3456789' may incorrectly be identified as two separate data element values '12' and '3456789'.

1.6 Decimal "R" Data Element Type

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

1.7 Numeric Values, Monetary Amounts and Units

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

Wellpoint recognizes units in whole numbers only.

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

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

1.8 Address Information

P.O. mailboxes / Lock Boxes are not allowed in the Billing Provider loop. If submitted in the Billing Provider loop, a 277CA and an 864 Level 2 Status Report will be returned to the submitter identifying which claim(s) have failed.
The Pay-to Address loop does support P.O. Box / Lock Box addresses. Therefore, if payment is expectedto be remitted to a P.O. Box / Lock Box, submit the P.O. Box / Lock Box address.

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

1.9 Taxonomy Codes (PRV)

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

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

1.10 Coordination of Benefits

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

The provider sends the 837 to the primary payer.

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

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

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

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

1.11 Claim and COB Balancing

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

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

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

1.12 Other COB Allowed Amount - Calculation

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

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

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

Loop 2430 CAS01 = CO, OA, PR, PI
Loop 2430 CAS02 ≠ 1, 2, 3 where ‘1’=Deductible, ‘2’=Co-insurance and ‘3’=Co-payment.

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

1.13 Medicaid Reclamation / Subrogation Claims

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

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

1.14 Preparing Attachments to Support a Claim

(1) Unsolicited

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

PWK01 = Report type code (See TR3)
PWK02 = EL (Electronic)
PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL
PWK06 = Identification Code (Attachment Control #)

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

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

(2) Solicited

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

275 Electronic Attachments to Support a Claim

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

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

Unsolicited: Claims submitted with PWK submission

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

PWK01 = Report type code (see TR3)
PWK02 = EL (electronic)
PWK05 = AC (Identification Code Qualifier); required if PWK02 = EL
PWK06 = Identification Code (Attachment Control #)

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

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

Solicited: Claims submitted without PWK submission

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

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

1.15 Social Security Number

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

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

Section 2 – Enveloping

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

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

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

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

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

Section 3 - Charts for Situational Rules

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

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Wellpoint
837 Institutional Health Care Claim				
P.67	**ST** Transaction Set Header	**ST03** Implementation Convention Ref	***005010X223A2***	005010X223A2 - Health Care Claim, Institutional
P.68	**BHT** Beginning of Hierarchical Trx	**BHT06** Transaction Type Code	***RP*** ***CH*** ***31***	RP - Reporting; required to indicate the batch contains all encounters. CH – Chargeable 31 – Medicaid Reclamation
Loop ID 1000A—Submitter Name ***NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway***				
P.71	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI assigned Sender ID. ▪ Equals the value entered in ISA06 and GS02.
P.73	**PER**	*Submitter EDI Contact Information - Refer to TR3*		
Loop ID 1000B—Receiver Name ***NOTE: Refer to Availity guidelines for submission of claims through the Availity EDI Gateway***				
P.76	**NM1** Receiver Name	**NM103** Last Name or Organization Name	***Wellpoint***	Receiver name
		NM109 Identification Code	***80314***	80314 - represents Wellpoint
Loop ID 2000A—Billing Provider Hierarchical Level				
P.78	**HL**	*Billing Provider Hierarchical Level - Refer to TR3*		
P.80	**PRV** Billing Provider Specialty Info	**PRV03** Reference Identification	***(Provider Taxonomy Code)***	Enter the taxonomy code to uniquely identify the provider.
P.81	**CUR** Foreign Currency Information	**CUR02** Currency Code	***USD***	USD - US dollars ▪ Monetary amounts recognized in US dollars only.
Loop ID 2010AA—Billing Provider Name				
P.87	**N3** Billing Provider Address	**N301** Billing Provider Address Line	***(Billing Provider Street Address)***	Enter the physical address to uniquely identify the provider. Submitting PO Box/Lock Box address will result in claim failure, and return on Availity response report
P.88	**N4**	*Billing Prov City, State, ZIP Code - Refer to TR3*		
P.90		*Billing Provider Tax Identification - Refer to TR3*		

Page	Segment	Element	Name	Notes
P.91	**REF** **PER**	*Billing Provider Contact Information - Refer to TR3*		
Loop ID 2010AB—Pay-To Address Name				
P.94	**NM1**	*Pay-to Address Name - Refer to TR3*		
P.96	**N3** Pay-to Address	**N301** Address Information	***(Pay-to Provider Address Line)***	Enter the address to uniquely identify the provider. If payment expected to be remitted to PO Box/Lock Box, submit in Pay-to loop.
P.97	**N4**	*Pay-To Address City, State, ZIP Code - Refer to TR3*		
Loop ID 2010AC—Pay-To Plan Name				
P.99	**NM1**	*Pay-to Plan Name - Refer to TR3*		
P.101	**N3**	*Pay-to Plan Address - Refer to TR3*		
P.102	**N4**	*Pay-to Plan City, State, ZIP Code - Refer to TR3*		
P.104	**REF**	*Pay-to Plan Secondary Identification - Refer to TR3*		
P.106	**REF**	*Pay-to Plan Tax Identification Number - Refer to TR3*		
Loop ID 2000B—Subscriber Hierarchical Level				
P.107	**HL**	*Subscriber Hierarchical Level - Refer to TR3*		
Loop ID 2000B—Subscriber Hierarchical Level (cont'd)				
P.109	**SBR** Subscriber	*Subscriber Hierarchical Level - Refer to TR3*		

Information

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Wellpoint
Loop ID 2010BA—Subscriber Name				
P.112	**NM1** Subscriber Name	**NM109** Identification Code	***(Subscriber Primary Identifier)***	Subscriber ID - 8-20 bytes. *****ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.** ***Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.***
P.115	**N3**	*Subscriber Address - Refer to TR3*		
P.116	**N4**	*Subscriber City, State, ZIP Code - Refer to TR3*		
P.118	**DMG**	*Subscriber Demographic Information - Refer to TR3*		
P.120	**REF**	*Subscriber Secondary Identification - Refer to TR3*		
P.121	**REF**	*Property and Casualty Claim Number - Refer to TR3*		

837 Institutional Health Care Claim

TR3	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Wellpoint
Loop ID 2010BB—Payer Name				
P.122	**NM1** Payer Name	**NM103** Payer Name	***Wellpoint***	Wellpoint - identifies payer
		NM108 ID Code Qualifier	***PI***	PI - Payer Identification
		NM109 Identification Code	***(Payer Primary Identifier)***	80314 - represents Wellpoint
P.124	**N3**	*Payer Address - Refer to TR3*		
P.125	**N4**	*Payer City, State, ZIP Code - Refer to TR3*		
P.127	**REF**	*Payer Secondary Identification - Refer to TR3*		
P.129	**REF**	*Billing Provider Secondary Identification - Refer to TR3*		
Loop ID 2000C—Patient Hierarchical Level				
P.131	**HL**	*Patient Hierarchical Level - Refer to TR3*		
P.133	**PAT**	*Patient Information - Refer to TR3*		
Loop ID 2010CA—Patient Name				
P.135		*Patient Name - Refer to TR3*		

P.137	**NM1**	*Patient Address - Refer to TR3*		
P.138	**N3** **N4**	*Patient City, State, ZIP Code - Refer to TR3*		
P.140	**DMG**	*Patient Demographic Information - Refer to TR3*		
P.142	**REF**	*Property and Casualty Claim Number - Refer to TR3*		
Loop ID 2300—Claim Information				
P.143	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Control Number)***	▪ Maximum of 20 alphanumeric characters. ▪ Value is returned on outbound 835 and other transactions.
		CLM02 Monetary Amount	***(Total Claim Charge Amt)***	Value must equal the sum of submitted service line charges in Loop 2400 SV203.
		CLM05-3 Claim Frequency Type Code	***(Third Position of Uniform Billing Claim Form Bill Type)***	If '7' (replacement) or '8' (void/cancel) then Loop 2300 REF02 Payer Claim Control # (F8) is required and must contain Wellpoint originally assigned claim number.
P.149	**DTP**	*Discharge Hour- Refer to TR3*		
P.150	**DTP** Statement Dates	**DTP03** Date Time Period	***(Statement From / To Date)***	Valid medical codes will be based on the "Statement From Date"
P.151	**DTP**	*Admission Date/Hour - Refer to TR3*		
P.152	**DTP**	*Date-Repricer Received Date - Refer to TR3*		
P.153	**CL1**	*Institutional Claim Code - Refer to TR3*		

837

Institutional Health Care Claim

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

TR3	Segment	Reference	Value	Definitions and Notes
P.167	REF			*Repriced Claim Number - Refer to TR3*
P.168	REF			*Adjusted Repriced Claim Number - Refer to TR3*
P.169	REF			*Investigational Device Exemption Number - Refer to TR3*
P.170	REF Claim ID for Transmission Intermediaries	REF01 Ref ID Qualifier REF02 Reference	D9 ***(Value Added Network Trace Number)***	D9 - Claim Number Will be returned on Level 2 Status Report, if submitted. Identification
P.172	REF			*Auto Accident State - Refer to TR3*
P.173	REF			*Medical Record Number - Refer to TR3*
P.174	REF			*Demonstration Project Identifier - Refer to TR3*
P.175	REF			*PRO Approval Number - Refer to TR3*
P.176	K3			*File Information - Refer to TR3*
P.178	NTE			*Claim Note - Refer to TR3*
P.180	NTE			*Billing Note - Refer to TR3*
P.181	CRC			*EPSDT Referral - Refer to TR3*

Institutional Health Care Claim

TR3	Segment	Reference	Value	Definitions and Notes Specific to Wellpoint	Designator(s)
P.193	HI			*External Cause of Injury - Refer to TR3*	
P.218	HI			*DRG Information - Refer to TR3*	
P.220	HI			*Other Diagnosis Information - Refer to TR3*	
P.239	HI			*Principal Procedure Information - Refer to TR3*	
P.242	HI			*Other Procedure Information - Refer to TR3*	
P.258	HI			*Occurrence Span Information - Refer to TR3*	
P.271	HI			*Occurrence Information - Refer to TR3*	
P.284	HI			*Value Information - Refer to TR3*	
P.294	HI			*Condition Information - Refer to TR3*	
P.304	HI			*Treatment Code Information - Refer to TR3*	
P.313	HCP			*Claim Pricing/Repricing Information - Refer to TR3*	

Loop ID 2310A—Attending Physician Name

Required for services (non-emergency ambulance transportation) populated in 2400, SV202-2

TR3	Segment	Definitions and Notes
P.319	NM1	*Attending Provider Name - Refer to TR3*

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

Loop ID 2310A—Attending Physician Name (cont'd)		
P.324	**REF**	*Attending Provider Secondary Identification - Refer to TR3*
Loop ID 2310B—Operating Physician Name		
P.326	**NM1**	*Operating Physician Name - Refer to TR3*
P.329	**REF**	*Operating Physician Secondary Identification - Refer to TR3*
Loop ID 2310C—Other Operating Physician Name		
P.331	**NM1**	*Other Operating Physician Name - Refer to TR3*
P.334	**REF**	*Other Operating Physician Secondary Identification - Refer to TR3*
Loop ID 2310D—Rendering Provider Name		
P.336	**NM1**	*Rendering Provider Name - Refer to TR3*
P.339	**REF**	*Rendering Provider Secondary Identification - Refer to TR3*
Loop ID 2310E—Service Facility Location Name		
P.341	**NM1**	*Service Facility Location Name - Refer to TR3*
P.344	**N3**	*Service Facility Location Address - Refer to TR3*
P.345	**N4**	*Serv Fac Loc City, State, ZIP - Refer to TR3*
P.347	**REF**	*Service Facility Location Secondary Identification - Refer to TR3*
Loop ID 2310F—Referring Provider Name		
P.349	**NM1**	*Referring Provider Name - Refer to TR3*
P.352	**REF**	*Referring Provider Secondary Identification - Refer to TR3*
Loop ID 2320—Other Subscriber Information		
P.354	**SBR**	*Other Subscriber Information - Refer to TR3*
P.358	**CAS**	*Claim Level Adjustments - Refer to TR3*
P.364	**AMT**	*COB Payer Paid Amount - Refer to TR3*
P.365	**AMT**	*Remaining Patient Liability - Refer to TR3*
P.366	**AMT**	*COB Total Non-Covered Amount - Refer to TR3*
P.367	**OI**	*Other Insurance Coverage Information - Refer to TR3*
P.369	**MIA**	*Inpatient Adjudication Information - Refer to TR3*
P.374	**MOA**	*Outpatient Adjudication Information - Refer to TR3*
Loop ID 2330A—Other Subscriber Name		
P.377	**NM1**	*Other Subscriber Name - Refer to TR3*

P.380	**N3**	*Other Subscriber Address - Refer to TR3*
P.381	**N4**	*Other Subscriber City, State, ZIP Code - Refer to TR3*
P.383	**REF**	*Other Subscriber Secondary Identification - Refer to TR3*
Loop ID 2330B—Other Payer Name		
P.384	**NM1**	*Other Payer Name - Refer to TR3*
P.386	**N3**	*Other Payer Address - Refer to TR3*
P.387	**N4**	*Other Payer City, State, ZIP Code - Refer to TR3*
P.389	**DTP**	*Claim Check or Remittance Date - Refer to TR3*
P.390	**REF**	*Other Payer Secondary Identifier - Refer to TR3*
P.392	**REF**	*Other Payer Prior Authorization Number - Refer to TR3*
P.393	**REF**	*Other Payer Referral Number - Refer to TR3*
P.394	**REF**	*Other Payer Claim Adjustment Indicator - Refer to TR3*
P.395	**REF**	*Other Payer Claim Control Number - Refer to TR3*
Loop ID 2330C—Other Payer Attending Provider		
P.396	**NM1**	*Other Payer Attending Provider - Refer to TR3*
P.398	**REF**	*Other Payer Attending Provider Secondary Identification - Refer to TR3*
Loop ID 2330D—Other Payer Operating Physician		
P.400	**NM1**	*Other Payer Operating Physician - Refer to TR3*
P.402	**REF**	*Other Payer Operating Physician Secondary Identification - Refer to TR3*
Loop ID 2330E—Other Payer Other Operating Physician		
P.404	**NM1**	*Other Payer Other Operating Physician - Refer to TR3*
P.406	**REF**	*Other Payer Other Operating Physician Secondary Identification - Refer to TR3*

837 Institutional Health Care Claim

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

Loop ID 2330F—Other Payer Service Facility Location

P.408 **NM1** *Other Payer Service Facility Location - Refer to TR3*

P.410 **REF** *Other Payer Service Facility Location Secondary Identification - Refer to TR3*

Loop ID 2330G—Other Payer Rendering Provider Name

P.412 **NM1** *Other Payer Rendering Provider Name - Refer to TR3*

P.414 **REF** *Other Payer Rendering Provider Secondary Identification - Refer to TR3*

Loop ID 2330H—Other Payer Referring Provider

P.416 **NM1** *Other Payer Referring Provider - Refer to TR3*

P.418 **REF** *Other Payer Referring Provider Secondary Identification - Refer to TR3*

Loop ID 2330I—Other Payer Billing Provider

P.420 **NM1** *Other Payer Billing Provider - Refer to TR3*

P.422 **REF** *Other Payer Billing Provider Secondary Identification - Refer to TR3*

Loop ID 2400—Service Line Number

P.423 **LX** *Service Line Number - Refer to TR3*

Page	Segment	Element	Name	Note
P.424	**SV2** Institutional Service Line	**SV202-2** Product/Service ID	***(Procedure Code)***	Attending Provider (2310A) required for nonemergency ambulance transportation codes A0426, A0428 (without modifier QL).
P.429	**PWK** *Line Supplemental Information - Refer to TR3*			
P.433	**DTP** *Date - Service Date - Refer to TR3*			
P.435	**REF** *Line Item Control Number - Refer to TR3*			
P.437	**REF** *Repriced Line Item Reference Number - Refer to TR3*			
P.438	**REF** *Adjusted Repriced Line Item Reference Number - Refer to TR3*			
P.439	**AMT** *Service Tax Amount - Refer to TR3*			
P.440	**AMT** *Facility Tax Amount - Refer to TR3*			
P.441	**NTE** *Third Party Organization Notes - Refer to TR3*			
P.442	**HCP** *Line Pricing/Repricing Information - Refer to TR3*			
Loop ID 2410—Drug Identification				
P.449	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	NDC # for prescribed drugs and biologics when required by government regulation.
P.452	**CTP** *Drug Quantity - Refer to TR3*			
P.454	**REF** *Prescription of Compound Drug Association Number - Refer to TR3*			
Loop ID 2420A—Operating Physician Name				
P.456	**NM1** *Operating Physician Name - Refer to TR3*			
P.459	**REF** *Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2420B—Other Operating Physician Name				
P.461	**NM1** *Other Operating Physician Name - Refer to TR3*			
P.464	**REF** *Other Operating Physician Secondary Identification - Refer to TR3*			
Loop ID 2420C—Rendering Provider Name				
P.466	**NM1** *Rendering Provider Name - Refer to TR3*			
P.469	**REF** *Rendering Provider Secondary Identification - Refer to TR3*			
Loop ID 2420D—Referring Provider Name				
P.471	**NM1** *Referring Provider Name - Refer to TR3*			
P.474	**REF** *Referring Provider Secondary Identification - Refer to TR3*			
Loop ID 2430—Line Adjudication Information				
P.476	**SVD** *Line Adjudication Information - Refer to TR3*			
P.480	**CAS** *Line Adjustment - Refer to TR3*			
P.486	**DTP** *Line Check or Remittance Date - Refer to TR3*			
P.487	**AMT** *Remaining Patient Liability - Refer to TR3*			
P.488	**SE** *Transaction Set Trailer - Refer to TR3*			