835 Health Care Payment/ Remittance Advice

Companion Guide

Version 1.6

April 23, 2007

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VERSION CHANGE LOG

Version 1.0 Original — **Published May 12, 2003**

Version 1.1 — **Published June 18, 2003**

Changes were made to the Telecommunication Specifications.

Change was made to the GS02 Application Sender's Code, in the Functional Group Header segment.

Version 1.2 — **Published October 8, 2003**

Added the Payee Additional Identification Segment (Loop 1000B, REF).

Added the Entity Identifier Code to the Patient Name Segment (Loop 2100, NM1).

Added the Corrected Patient/Insured Name Segment (Loop 2100, NM1).

Version 1.3 — **Published February 24, 2004**

Added an additional Payee Additional Identification Segment (Loop 1000B, REF)

Added the Other Claim Related Identification Segment (Loop 2100, REF)

Removed the Correct Patient/Insured Name Segment (Loop 2100, NM1)

Changes were made to the Patient Name Segment (Loop 2100, NM1)

Version 1.4 — **Published April 22, 2004**

Changes were made to the Segment Terminator.

Level: Header
Segment: TRN (Reassociation Trace Number)
Field: 02 (Reference Identification)
Field length changed from 11 bytes to 10 bytes.

Hyphens were removed from CLP07 (Payer Claim Control Number)

Version 1.5 — **Published August 14, 2006**

Text Reformatted

New logo added

Version 1.6 — **Published April 23, 2007**

Instructions added for the National Provider Identifier (NPI) requirements.

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The Version 4010 ANSI X12N 835 Health Care Claim Payment/Advice transaction implementation guide provides the standardized data requirements to be implemented for all health care claim payment and associated remittance information issued electronically for providers by health plans and their intermediaries.

HIPAA does not require that a provider receive health care remittance information electronically. Providers may continue to request payment remittance information on paper from health plans. However, if a provider elects to conduct business electronically, HIPAA does mandate the use of the standard transactions and code sets; including the Version 4010 ANSI X12N 835 Health Care Claim Payment/Advice.

PURPOSE

This document provides information necessary for providers or their intermediaries to receive claim payment advice information electronically from ValueOptions. This companion guide is to be used in conjunction with the ANSI X12N implementation guides and, as such, supplements but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/ . Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

This document identifies how ValueOptions populates X12 835 4010 transactions using available data within the 004010X091 implementation guide. We are including usage of situational segments and elements or specifying qualifiers ValueOptions will be supporting. ValueOptions may at a future date support additional implementation guide values. This document must be used in conjunction with the implementation guide. Receivers of the X12 835 should have the capability to accept any valid value within the implementation
guide.

SPECIAL CONSIDERATIONS

Outbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 835 Health Care Claim Payment/Advice transaction that ValueOptions will issue:

- 835 Health Care Claim Payment/Advice - ASC X12N 835 (004010X098A1) ☒

Response Transactions Supported

In response to 835 transactions sent by ValueOptions, the following response transactions are expected from receivers of these 835 transactions:

- TA1 Interchange Acknowlegement ☐
- 997 Functional Acknowledement ☐

That is: ValueOptions expects neither a TA1 nor a 997 acknowledgment of 835 transactions sent by ValueOptions to receivers.

Delimiters Used

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

ValueOptions will utilize the following delimiters in the 835 transactions it issues to providers or their intermediaries (refer to the right hand column):

Description	Default Delimiter	Delimiter Used by ValueOptions in 835 Transactions
Data element separator	* Asterisk	* Asterisk
Sub-element separator	: Colon	: Colon
Segment Terminator	~ Tilde	~ “CR/LF” Tilde **“Carriage Return/ Line Feed”**

That is: ValueOptions will use the Default Delimiters in 835 transactions that it produces and issues to receivers.

Maximum Limitations

The 835 transaction is designed to transmit remittance information on one payment for one or multiple claims from one Payer to one Payee, and/or non-claim related payment information from one Payer to one Payee. The hierarchy of the looping structure is Payer, Payee, one or more Claim payments with adjustments (“Claim Header Level”) with one or more associated Service Lines with adjustments. Finally, independent of Claim / Service payment information, there are multiple Provider level adjustments.

Each transaction set (each “835”) contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. Some of these limitations are explicit, such as:

- The Claim Adjustment Segment (CAS) is limited to a maximum of 99 occurrences within a Claim Payment Information loop (2100). That is: there can be no more than 99 claim adjustments, at the claim header level, per claim.
- The Claim Adjustment Segment (CAS) is limited to a maximum of 99 occurrences within a Service Payment Information loop (2110). That is: there can be no more than 99 claim adjustments, at the detail service line level, per service line.
- The Health Care Remark Codes are limited to 99 repetitions within the Service Payment Information loop (2110). That is: there can be no more than 99 Remark Codes per detail service line.
- An important change made in the 835 addenda (published February 20th, 2003 by Health & Human Services) relates to the length of monetary amounts in the 835. All monetary amounts in the 835 are now limited to 10 characters (not including decimal point and leading sign if used).

However, some limitations are not explicitly defined. The number of Claim Payment Information (CLP) segments within an 835 transaction set is specified in the implementation guide as >1. In fact, in the particular case of CLP segments within the 835 transaction set, the Implementation Guide recommends no more than 10,000 such segments.

ValueOptions has no file size limitations, but will rarely, if ever, issue an 835 transaction set with greater than 10,000 CLP segments.

For 835 transactions, the Interchange Control structure (ISA/IEA envelope) will be issued by ValueOptions as one file. ValueOptions will not mix 835 transactions with other ANSI transactions within one ISA/IEA envelope. In other words, for 835 transactions issued by ValueOptions, the Interchange Control structure will be limited to one type of Functional Group: the 835 Health Care Payment / Remittance Advice only.

Telecommunication Specifications

Providers or provider intermediaries wishing to receive 835 transactions from ValueOptions will normally also wish to submit health care claims electronically. To submit electronic claims or receive 835 transactions, providers must complete the appropriate ValueOptions Account Request form available on the ValueOptions website at http://www.valueoptions.com/providers.htm
Unless the Payee instructs otherwise, ValueOptions will send the 835 to the Submitter of the 837 claims reported on in that 835. Specifically, ValueOptions will use the Submitter ID from the ISA02 Authorization Information element of the 837. This Submitter ID from the 837’s will be populated in the Receiver ID in the 835’s ISA08 element. If you as the Payee wish to have the 835 sent to an alternate destination, please contact ValueOptions e-Support Services.

If you have any questions please contact the ValueOptions EDI help desk.
E-mail: e-supportservices@valueoptions.com
Telephone: 888-247-9311
FAX: 866-698-6032

National Provider Identifier

Beginning May 23, 2007, ValueOptions in accordance with the HIPAA mandate will utilize with the NPI and taxonomy codes to identify covered entities on electronic transactions in the appropriate locations. The NPI is a standard provider identifier that will replace the provider numbers used in standard electronic transactions today and was adopted as a provision of HIPAA. The NPI Final Rule was published on January 23, 2004 and applies to all health care providers.

ValueOptions requires that all covered entities report their NPI to ValueOptions prior to submitting electronic transactions containing a NPI. For additional information on how to report your NPI to ValueOptions and Frequently Asked Questions, please visit http://www.valueoptions.com/providers/npi/npi.htm or contact our National Provider Line at (800) 397-1630 Monday through Friday 8:00 AM to 5:00 PM (EST).

All electronic transactions for covered entities should contain the provider NPI, taxonomy code, employee identification number and zip code + the 4 digit postal code in the appropriate loops beginning May 23, 2007. The NPI should be sent in the NM109, where NM108 equals XX. The taxonomy code should be sent in the PRV03, employee identification number will be sent in the REF02 and the zip code + the 4 digit postal code should be sent in the N403 and N404.

For all non-healthcare providers where a NPI is not assigned, the transaction will contain the ValueOptions provider number in the appropriate provider loops within the appropriate REF segment.

Additional information on NPI including how to apply for an NPI can be found on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.hhs.gov/NationalProvIdentStand/

The ValueOptions 835 Remittance Advice

Definitions

For the sake of clarity in the ensuing discussion, the following definitions apply:

- **Sender:** refers to the entity sending the 835: ValueOptions. This is conveyed by ValueOptions in 835 transactions it issues, in the ISA segment ISA06. ValueOptions places 'FHC &Affiliates' in this field.
- **Receiver:** is the entity receiving the 835. The Receiver can be the Payee, or an intermediary designated by the Payee to receive the 835 on the Payee's behalf – such as a provider's billing agent, or a clearinghouse.
- **Payer:** refers to the entity responsible for the payment to the provider. In the following discussion, this is ValueOptions. This fact is conveyed by ValueOptions in Loop 1000A, segment N104 in the 835.
- **Payee:** is the entity to which the payment is intended. The appropriate Payee ID is conveyed by ValueOptions in the 835 thru Loop 1000B, segment N104.
- **Adjustment:** the 835 supports the conveyance of "adjustment information" at several levels: the claim, claim service line, and at the provider level. Adjustment as defined in this document (and in the 835 Implementation Guide) – means simply (in the case of claims), the difference between the monetary amount submitted ("billed charges") and the amount paid. In the case of provider level adjustments, "adjustment" generally means an additional payment, withholding, or deduction – unrelated to any claim.

Remittance Advice and Paper Check

For payees or their designated intermediaries who request their remittance advice information from ValueOptions via the 835 Health Care Claim Payment/Advice, ValueOptions issues the 835 and produces and mails a paper check to the payee (or their designated intermediary) corresponding to that 835.

Claim Identification Used in the 835

ValueOptions includes, for each claim reported on in 835's it issues, the Patient Control Number (also known as Claim Submitter's Identifier);included in the original 837 submission in Loop 2300, segment CLM01. ValueOptions populates the Patient Control Number in Loop 2100 (Claim Payment Information), Segment CLP01.

In addition to incorporating the Patient Control Number, ValueOptions will also transmit the Payer Claim Control Number; that is: the number assigned by ValueOptions to the submitted claim. ValueOptions populates this identifier in Loop 2100 (Claim Payment Information), segment CLP07 in the 835. Please include this information in any queries to ValueOptions concerning an 835 you have received from us.

INTERCHANGE CONTROL HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: '00' No Authorization Information Present '03' Additional Data Identification	ValueOptions will supply a 00.
	ISA02	Authorization Information	R	Information used for additional identification or authorization.	ValueOptions will zero fill.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	ValueOptions will supply a 00
	ISA04	Security Information	R	Additional security information identifying the sender.	ValueOptions will zero fill.
	ISA05	Interchange ID Qualifier	R	The element supports identification of the SENDER of the 835 Valid values: 01 – Duns (Dun & Bradstreet) 14 – Duns Plus Suffix 20 – Health Industry Number (HIN) 27 – Carrier ID Number 28 – Fiscal Intermediary ID Number 29 – Medicare Provider and Supplier ID Number 30 – Federal Tax ID Number 33 – National Assoc. of Insurance Commissioners Company Code. ZZ – Mutually Defined code	A value of ZZ will be used.
	ISA06	Interchange Sender ID	R	The element supports identification of the SENDER of the 835	A value of 'FHC &Affiliates' will be used.
	ISA07	Interchange ID Qualifier	R	The element supports identification of the RECEIVER of the 835 Valid values:	ValueOptions will populate this element with 'ZZ'

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
				01 – Duns (Dun & Bradstreet) 14 – Duns Plus Suffix 20 – Health Industry Number (HIN) 27 – Carrier ID Number 28 – Fiscal Intermediary ID Number 29 – Medicare Provider and Supplier ID Number 30 – Federal Tax ID Number 33 – National Assoc. of Insurance Commissioners Company Code. ZZ – Mutually Defined code	
	ISA08	Interchange Receiver ID	R	The element supports identification of the RECEIVER of the 835	ValueOptions will populate this element with the ValueOptions Submitter ID.
	ISA09	Interchange Date	R	Date format YYMMDD.	
	ISA10	Interchange Time	R	Time format HHMM.	
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' U.S. EDI Community of ASC X12	ValueOptions will use the current standard adopted for ISA records as of October 01, 2003. Older standards will not be used.
	ISA12	Interchange Control Version Number	R	Valid value: '00401' Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997.	ValueOptions will use the current standard approved for the ISA/IEA envelope. Other standards will not be used.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	ValueOptions uses this value (created by ValueOptions) to identify the transaction on its system.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	ValueOptions will populate this element with a '0'.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	ValueOptions will populate this element with a 'P'; unless prior arrangements are made thru ValueOptions e-Support Services for testing purposes.
	ISA16	Component Element	R	The delimiter must be a unique character not found	ValueOptions will use the default

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
		Separator		in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	delimiters specified in the 835 Implementation Guide. See Delimiters Used on page 5.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
TRAILER					
ISA		**Interchange Control Trailer**	**R**		
	IEA01	Number of included functional groups	R	Count of the number of functional groups in the interchange. Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure.	For 835 transmissions, ValueOptions will limit the ISA/IEA envelope to one type of functional group: HP (Health Care Claim Payment/Advice (835)). In other words, this number (IEA01) will always be '1' for 835 transmissions.
	IEA02	Interchange Control Number	R	The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	ValueOptions sets this value to the value in ISA13.

FUNCTIONAL GROUP HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
	HEADER				
GS		**Functional Group Header**	R		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets.	ValueOptions will populate this element with: ‘HP’ (Health Care Claim Payment/Advice (835).
	GS02	Application Sender’s Code	R		ValueOptions will populate this element with ‘FHC &Affiliates’.
	GS03	Application Receiver’s Code	R		ValueOptions will zero-fill this element.
	GS04	Date	R	Date format YCCYMMDD.	Refer to the implementation guide specifications.
	GS05	Time	R	Time format HHMM.	Refer to implementation guide specifications.
	GS06	Group Control Number	R	The group control number in GS06 must be identical to the associated group trailer GE02.	Defined by ValueOptions. If ValueOptions implements the 997 at a later date, this number will be used to identify the functional group being acknowledged.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: ‘X’ Accredited Standards Committee X12	ValueOptions will populate this element with ‘X’.
	GS08	Version/Release Industry ID Code	R	Valid value: Professional Addenda Approved for Publication by ASC X12. ‘004010X091A1’	ValueOptions will use the current standard approved for publication by ASC X12. 835 transactions based on other standards will not be issued by ValueOptions. Normally, ValueOptions will populate this element with ‘004010X091A1’, unless prior arrangements are made thru ValueOptions e-Support Services for testing purposes.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 Implementation
		TRAILER			
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	ValueOptions will populate this element with the total number of 835 transaction sets included in the functional group. (Remember: there will only be one functional group in ValueOptions' 835 transmissions).
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated interchange header value sent in GS06.	ValueOptions will populate this element with the value it populates in GS06.

835 Health Care Claim Payment/Advice TRANSACTION SPECIFICATION

Table 1

Table 1 contains general payment information, such as the total amount paid in the 835, the payer, the payee, a trace number (usually the check number), and the payment method. We enumerate below those segments and elements that ValueOptions will populate with 'constant' values – that is: values that will not vary with individual 835 transmissions, or for those elements where further clarification is illustrative. Refer to the 835 Implementation Guide for the manner in which ValueOptions will support all other loops, segments, and elements.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
				HEADER	
BPR		**Beginning Segment for Payment Order/Remittance Advice**	**R**		
	BPR01	Transaction Handling Code	R	Valid values: 'C' Payment Accompanies Remittance Advice 'D' Make Payment Only 'H' Notification Only (used for predetermination of benefits) 'I' Remittance Information Only 'P' Pre-notification of Future Transfers 'U' Split Payment and Remittance 'X' Handling Party's Option to Split Payment and Remittance	ValueOptions will populate this element with 'I'.
	BPR03	Credit/Debit Flag Code	R	Valid values: 'C' Credit 'D' Debit.	ValueOptions will populate this element with 'C'.
	BPR04	Payment Method Code	R	Valid values: 'ACH' Automated Clearing House	ValueOptions will populate this element with 'CHK'.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
				'BOP' Financial Institution Option 'CHK' Check 'FWT' Federal Reserve Funds/Wire Transfer – Non-repetitive 'NON' Non-Payment Data - This code used when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.	
	BPR16	Check Issue or EFT Effective Date	R		ValueOptions will populate this element with the check issuance date.
TRN		**Reassociation Trace Number**	**R**		
	TRN02	Check or EFT Trace Number	R	This field is required in the implementation guide and a number will always be present. Previously, this field was 11 bytes in length. The TRN02 field will now show as 10 bytes in length.	ValueOptions will populate this element with the check number that was issued for the remittance. If there is no payment for the remittance, this element will be populated with 'NO CHECK GENERATED' concatenated with the check run date.
	TRN03	Payer Identifier	R	TRN03 must contain the Payer's Federal Tax ID Number, preceded by a "1." (The "1" denotes that the subsequent characters are a Federal Tax ID Number. See implementation guide for details).	This is ValueOptions' Federal Tax ID preceded by a '1'.
REF		**Receiver Identification**	**S**		**ValueOptions will use this segment when the receiver of the 835 is other than the payee (e.g. a clearinghouse or provider's billing service).**
	REF01	Receiver Identifier Qualifier	R	One allowable value: 'EV' (Receiver Identification Number).	ValueOptions will populate this element with 'EV' if the Receiver of the 835 is other than the Payee.
	REF02	Receiver Identifier	R		ValueOptions will populate this element with the ValueOptions Submitter ID.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
LOOP 1000A – PAYER IDENTIFICATION (Required)					
N1		**Payer Name**	**R**		
	N102	Payer Name	S	Required if the National Plan ID is not transmitted in N104.	ValueOptions will populate this element with 'ValueOptions, Inc.'.
LOOP 1000B – PAYEE IDENTIFICATION (Required)					
N1		**Payee Identification**	**R**		
	N103	Identification Code Qualifier	S	Valid Values: 'FI' Federal Taxpayer's Identification Number. For individual providers as payees, use thisnumber to represent the Social Security Number. 'XX' Health Care Financing Administration National Provider Identifier. Required when mandated.	As of 5/23/07, ValueOptions will populate 'XX' – NPI qualifier and 'FI' for non-covered entities.
	N104	Payee Identifier	S		As of 5/23/07, covered entities will receive the National Provider ID(NPI), a 10 digit #, non-covered entities will receive their Tax ID number.
REF		**Reference Identification**	**R**		
	REF01	Reference Identification Qualifier	R	Valid Values: 'TJ' Federal Taxpayer's Identification Number	After 5/23/07, ValueOptions will populate this element with 'TJ'.
	REF02	Reference Identification	R		ValueOptions will populate this element with the Tax ID number.
REF		**Reference Identification**	**R**		**After 5/23/07 in accordance with the NPI mandate, this segment will not be sent.**
	REF01	Reference Identification Qualifier	R	Valid Values: '1G' Provider UPIN Number	ValueOptions will populate this element with 'PQ'.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
				‘D3’ National Association of Boards of Pharmacy Number ‘PQ’ Payee Identification ‘TJ’ Federal Taxpayer’s Identification Number. This information should be in the N1 segment. ‘N5’ Provider Plan Network Identification Number	
	REF02	Reference Identification	R		ValueOptions will populate this element with the Pay-To Vendor Number.
REF(2)		**Reference Identification**	**R**		**After 5/23/07 in accordance with the NPI mandate, this segment will not be sent.**
	REF01	Reference Identification Qualifier	R	Valid Values: ‘1G’ Provider UPIN Number ‘D3’ National Association of Boards of Pharmacy Number ‘PQ’ Payee Identification ‘TJ’ Federal Taxpayer’s Identification Number. This information should be in the N1 segment ‘N5’ Provider Plan Network Identification Number	ValueOptions will populate this element with ‘N5’.
	REF02	Reference Identification	R		ValueOptions will populate this element with the Pay-To Provider Number.

Table 2

Table 2 contains the “explanation of payment” information related to adjudicated claims and services, including information on related adjustments to the billed amounts for these services.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
		LOOP 2100 – Claim Payment Information (Required)			
CLP		**Claim Level Data**	**R**		
	CLP01	Claim Submitter's Identifier (Industry term: Patient Control Number)	R		ValueOptions will populate this element with the number for the patient control number assigned by the provider.
	CLP07	Payer Claim Control Number	S	Removed hyphens from the ValueOptions Claim Control Number.	CLP07 is ValueOptions’ assigned claim number, and applies to the entire claim being reported on in the 835.
NM1		**Patient Name**	**R**		
	NM101	Entity Identifier Code	R	Valid Values: ‘QC’ Patient	ValueOptions will populate this element with ‘QC’.
	NM108	Identification Code Qualifier	S	Required if the patient identifier is known or was reported on the health care claim. Valid Values: ‘34’ Social Security Number ‘HN’ Health Insurance Claim (HIC) Number Advised ‘II’ United States National individual Identifier This code is not part of the ASC X12 004010 release. Use this code if mandated in a final Federal Rule. ‘MI’ Member Identification Number ‘MR’ Medicaid Recipient Identification Number	ValueOptions will populate this element with ‘MI’.
	NM109	Identification Code	S	Required if the patient identifier is known or was reported on the health care claim.	ValueOptions will populate this element with the ValueOptions EDI input member number.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
LOOP 2100 – Claim Payment Information (Required)					
NM1		**Service Provider Name**	**S**		
	NM108	Identification Code Qualifier	R	Valid Values: 'FI' Federal Taxpayer's Identification Number For individual providers as payees, use this number to represent the Social Security Number. 'XX' Health Care Financing Administration National Provider Identifier. Required when mandated.	As of 5/23/07, ValueOptions will populate 'XX' – NPI qualifier and 'FI' for non-covered entities.
	NM109	Rendering Provider Identifier	R		As of 5/23/07, covered entities will receive the National Provider ID(NPI), a 10 digit #, non-covered entities will receive their Tax ID number.
REF		**Other Claim Related Identification**	**S**		
	REF01	Entity Identifier Code	R	Valid Values: '1L' Group or Policy Number '1W' Member Identification Number '9A' Repriced Claim Reference Number '9C' Adjusted Repriced Claim Reference Number 'A6' Employee Identification Number 'BB" Authorization Number 'CE' Class of Contract Code 'EA' Medical Record Identification Number 'F8' Original Reference Number 'G1' Prior Authorization Number	ValueOptions will populate this element with 'A6'.

Seg	Data Element	Name	Usage	Comments	ValueOptions 835 implementation
LOOP 2100 – Claim Payment Information (Required)					
				‘G3’ Predetermination of Benefits Identification Number ‘IG’ Insurance Policy Number ‘SY’ Social Security Number	
	REF02	Reference Identification	S		ValueOptions will populate this element with the ValueOptions member number.