

# MercyCare Health Plans

## 837 004010A Companion Document

### Health Care Claim – Professional and Institutional

**Disclosure**

The ANSI ASC X12 837 Health Care Claim, Professional and Institutional transaction will transfer professional and institutional claims from a provider or a designated agent of the provider to MercyCare Health Plans (MCHP). This transaction was designed to expedite data interchange health encounter/claims processing the payment environment.

**Business Use**

The following business events are supported by the 837 Health Care Claim, Professional and Institutional transaction.

- Execution of electronic information pertaining to a health encounter or health claim from provider-to-payer or from payer-payer.
- To accelerate the processing and payment of a claim or encounter.

***MercyCare Health Plans Specifications/Requirements***

This section covers the information that MCHP requests to process your files efficiently. Please see the matrix for any detailed information that may be needed by MCHP to process claims data. The segments listed are the MCHP required segments unless otherwise noted.

<b>Segment ID</b>	<b>Element ID</b>	<b>Element Name</b>	<b>Loop ID</b>	<b>Valid Value(s)</b>
ISA	01	Authorization Information Qualifier	N/A	Always “00” (zero-zero) No authorization
ISA	02	Authorization Information	N/A	Always blank (Fill with 10 spaces)
ISA	03	Security Information Qualifier	N/A	Always “00” – No authorization
ISA	04	Security Information	N/A	Always blank (Fill with 10 spaces)
ISA	05	Interchange ID Qualifier (Sender)	N/A	Always “ZZ” – expected value in this field
ISA	06	Interchange Sender ID	N/A	Name of sender submitting file. This field must be 15 bytes (alphanumeric) and left justified.

ISA	07	Interchange ID Qualifier (Receiver)	N/A	Always “ZZ” – expected value in this field
ISA	08	Interchange Receiver ID	N/A	Please use “391768192” in this field
ISA	09	Interchange Date	N/A	Interchange Creation Date
ISA	10	Interchange Time	N/A	Interchange Creation Time
ISA	16	Component Element Separator	N/A	Use a delimiter from the following list: >,*,~,^,   and :
GS	02	Application Sender’s Code	N/A	Same as ISA06
GS	03	Application Receiver’s Code	N/A	Same as ISA08
BHT	02	Transaction Set Purpose Code	N/A	Always “00” – Original
BHT	06	Transaction Type Code	N/A	Always “CH” – Chargeable
NM1	01	Billing Provider Name	2010AA	Always “85” –Billing Provider
NM1	02	Entity Type Qualifier	2010AA	See IG for valid values
NM1	03	Name Last or Organization Name	2010AA	Last Name or Organization Name
NM1	08	Identification Code Qualifier	2010AA	‘XX’ for NPI.
NM1	09	Identification Code	2010AA	NPI
N3	01	Billing Provider Address 1	2010AA	
N4	01	Billing Provider City	2010AA	
N4	02	Billing Provider State	2010AA	
N4	03	Billing Provider Postal Code	2010AA	5 digit Zip Code is Sufficient
REF	01	Reference Identification Qualifier	2010AA	EI or SY
REF	02	Reference Identification	2010AA	Employer ID or SSN
HL	01	Hierarchical ID Number	2000B	See IG
HL	02	Hierarchical Parent ID	2000B	See IG
HL	03	Hierarchical Level Code	2000B	See IG

HL	04	Hierarchical Child Code	2000B	See IG
SBR	01	Payer Responsibility Sequence #	2000B	See IG for Valid Values
SBR	02	Individual Relationship Code	2000B	Always "18" if using this segment
SBR	03	Reference ID	2000B	If used, this should contain the MCHP assigned group number.
SBR	09	Claim Filing Indicator Code	2000B	See IG for Valid Values
NM1	01	Subscriber Name	2010BA	Always "IL" for Insured or Subscriber
NM1	02	Entity Type Qualifier	2010BA	Always "1" for Person
NM1	03	Name Last	2010BA	Subscriber Last Name
NM1	04	Name First	2010BA	Subscriber First Name
NM1	08	Identification Code Qualifier	2010BA	Always "MI" for Member ID Number
NM1	09	Identification Code	2010BA	This must be the MCHP assigned Subscriber Number
N3	01	Subscriber Address	2010BA	
N4	01	Subscriber City	2010BA	
N4	02	Subscriber State	2010BA	
N4	03	Subscriber Postal Code	2010BA	5 digit Zip Code is Sufficient
DMG	01	Subscriber Date Qualifier	2010BA	Always "D8" for Format CCYYMMDD
DMG	02	Subscriber Date of Birth	2010BA	CCYYMMDD format
DMG	03	Subscriber Gender Code	2010BA	See IG for Values
NM1	01	Payer Name	2010BB	Always "PR" for Payer
NM1	02	Entity Type Qualifier	2010BB	Always "2" for non-person entity.

NM1	03	Organization Name	2010BB	Always "MercyCare".
NM1	08	ID Code Qualifier	2010BB	Always "PI" for Payer ID
NM1	09	Identification Code	2010BB	Your defined code for MCHP.
HL	01	Patient Hierarchical Level	2000C	See IG
HL	02	Hierarchical Parent ID	2000C	See IG
HL	03	Hierarchical Level Code	2000C	See IG
HL	04	Hierarchical Child Code	2000C	See IG
PAT	01	Individual Relationship Code	2000C	See IG for valid values
NM1	01	Patient Name Entity ID	2010CA	Always "QC" for Patient
NM1	02	Patient Entity Type	2010CA	Always "1" for Person
NM1	03	Patient Last Name	2010CA	
NM1	04	Patient First Name	2010CA	
NM1	08	Patient ID Code Qualifier	2010CA	Always "MI" for Member ID Number
NM1	09	Patient ID Code	2010CA	This must be the MCHP assigned Member Number.
N3	01	Patient Address	2010CA	
N4	01	Patient City	2010CA	
N4	02	Patient State	2010CA	
N4	03	Patient Postal Code	2010CA	5 digit Zip Code is Sufficient
DMG	01	Patient Date Qualifier	2010CA	Always "D8" for format CCYYMMDD
DMG	02	Patient Birthdate	2010CA	CCYYMMDD format
DMG	03	Patient Sex Code	2010CA	See IG for valid Values

CLM	01	Claim Submitter's ID	2300	Defined by Submitter
CLM	02	Monetary Amount	2300	Total Charged Amount
CLM	05-1	Health Care Service Location	2300	See IG for Valid Values
CLM	05-3	Claim Frequency Type Code	2300	See IG for Valid Values
CLM	06	Provider or Supplier Signature	2300	See IG for Valid Values
CLM	07	Provider Accept Assignment	2300	See IG for Valid Values
CLM	08	Benefits Assignment Cert Indicator	2300	See IG for Valid Values
CLM	09	Release of Information	2300	See IG for Valid Values
CLM	10	Patient Signature Source	2300	See IG for Valid Values
REF	01	Claim ID for Clearinghouse	2300	Always "D9" if sent by clearinghouse.
REF	02	Reference ID	2300	Claim Number Assigned by Clearinghouse
HI	01-1	HealthCare Code Info	2300	Always "BK" for Principle Diagnosis ICD-9 Codes
HI	01-2	Primary Diagnosis Code	2300	Note: an "E" Code diagnosis is not allowed as primary.
HI	02-1	HealthCare Code Info	2300	Always "BF" for Diagnosis ICD-9 Codes
HI	02-2	Diagnosis Code	2300	ICD-9 Diagnosis Code
HI	03-08	Repeat HI02 as necessary	2300	Used for reporting additional Diagnosis Codes
NM1	01	Referring Provider Entity Identifier	2310A	Situational, if used, use "DN" for Referring Provider
NM1	02	Referring Entity Type Qualifier	2310A	See IG for Valid Values
NM1	03	Referring Name Last or Organization	2310A	Last Name or Organization Name of Referring
NM1	04	Referring Name First	2310A	
NM1	05	Referring Name Middle	2310A	

NM1	08	Referring ID Code Qualifier	2310A	See IG for Valid Values
NM1	09	Referring Identification Code	2310A	See IG for Valid Values
NM1	01	Rendering Provider Entity Code Qualifier	2310B	Always “82” for rendering provider.
NM1	02	Entity Type Qualifier	2310B	See IG for Valid Values.
NM1	03	Rendering Last Name or Organization	2310B	
NM1	04	Rendering First Name	2310B	
NM1	08	Rendering ID Code Qualifier	2310B	XX for NPI
NM1	09	Rendering ID Code	2310B	NPI
LX	01	Service Line Counter	2400	
SV1/SV2	01-1	Product/Service ID Qualifier	2400	Always “HC” – Health Care Common Coding System
SV1/SV2	01-2	Procedure Code	2400	
SV1/SV2	01-3 01-6	Procedure Modifier	2400	MCHP will accept 4 modifiers, however, only 2 may affect adjudication
SV1/SV2	02	Line Item Charge Amount	2400	Monetary amount submitted for the service line.
SV1	03	Units or Measurement	2400	See IG for Valid Values
SV1	04	Quantity	2400	
SV1	07-1 07-4	Diagnosis Pointer	2400	
SV1	09	Emergency Indicator	2400	Yes/No Response
DTP	01	Date/Time Qualifier	2400	Always “472” for Service
DTP	02	Date/Time Format Qualifier	2400	See IG for Valid Values
DTP	03	Date Time Period	2400	

QTY	01	Anesthesia Quantity Qualifier	2400	See IG for Valid Values
QTY	02	Anesthesia Quantity	2400	
SVD	02	Service Line Paid Amount	2430	Monetary amount paid for the service line

- 837 claim data must be submitted using the basic character set as defined in Appendix A of the 837 Implementation Guides. In addition to the basic character set, lower case characters and the “@” symbol from the extended character set may be submitted. Any other characters submitted from the extended character set may cause the transmission to be rejected at the carrier translator.
- Submitting delimiters not supported within the matrix may cause a transmission to be rejected. Members of the Base Control Set and the Extended Control Set will not be accepted as delimiters.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guides may cause files to be rejected.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejection of the claim or the applicable transmission.
- MCHP may reject a transmission that is submitted with a submitter identification number that is not authorized for electronic claim submission.
- Up to four modifiers may be submitted; however, the last two modifiers may not be considered. The MCHP processing system may only use the first two modifiers for adjudication and payment determination of claims.
- A 277U will be provided to Netwerkes.com.
- MCHP may reject any files that are found to be a duplication of a previous submission.
- For every claim that is submitted via electronic media, for all legal and other purpose will be considered signed by the provider or Provider’s authorized representative.

## ***Connecting with MCHP***

MCHP will receive electronic 837P and 837I claims through our clearinghouse, Netwerkes.com only. To set up an 837P or 837I transaction, please contact Netwerkes.com at their web site [www.netwerkes.com](http://www.netwerkes.com). Netwerkes.com has also set up a contracted agreement with WebMD. WebMD will forward claims to MCHP through Netwerkes.com if the MercyCare Health Plans WebMD Payer ID of 39114 is used. For additional information on this process, please contact the MCHP Provider Relations Department at 1-800-752-3431.