

# *Administrative Simplification*

A program of the Washington Healthcare Forum  
Operated by OneHealthPort

## Best Practice Recommendation for

### *Exchanging Explanation of Payment Information between Providers and Health Plans (using 5010v transactions)*

**For use with ANSI ASC X12N 5010v  
Health Care Claim (835)  
Health Care Claim Payment/Advice (835)  
Technical Report Type 3**

<b>Version</b>	
<b>Issue Date</b>	<b>Explanation</b>
02-22-10	Initial release
09-28-10	Notes to highlight that 837 will not contain payer's allowed amount
12-14-2011	Clarification for handling dual coverage by the same health plan (pg 8-9)

**Table of Contents**

Background ..... 2

Recommended Best Practices for Providers ..... 3

When should claims be submitted to secondary, tertiary and subsequent payers..... 3

When must EOP information be included on the electronic-837 claims to secondary payers..... 3

If a patient has multiple coverage from the same health plan, one claim or two?..... 4

Do I still need to submit a claim if I don't expect any reimbursement from other payers?.....4

What happens if a patient has coverage with multiple health plans, yet I receive denials?..... 4

What EOP information should be included on the electronic-837 claims to subsequent payers? ..... 4

Recommended Best Practices for Health Plans ..... 7

Explanatory Materials - How are Medicare Claims Different? ..... 11

837 & 835 Coding Scenarios..... 13

Professional Claims ..... 14

Institutional Claims ..... 21

Best Practice Recommendation  
**Exchanging EOP Information between Providers and Health Plans**

**Topic:** Coordination of Benefits

NOTE: Issues related to liability and casualty coverage, e.g. accident, are outside the scope of this BPR

**Goal:** Speed up the turnaround of claims by secondary, tertiary, and subsequent payers while minimizing the provider work effort to do so.

**Summary:** *To speed up the processing of secondary, tertiary, etc. claims, providers should **include the EOP information on the electronic-837 claim**, instead of sending the paper Explanation of Payment.*

Including Explanation of Payment (EOP) information on the electronic-837 claim to secondary, tertiary, and subsequent payers will speed up the processing of that claim. Payers will not need to wait for the paper EOP and will not need to track down the previous payers to find out how much they paid.

**Applicability:** All providers and health plans are encouraged to follow these Recommended Best Practices. However, providers should be aware that the below listed health plans may still require a paper EOP or may not contact the prior payer if no EOP information is received. These payers may also not provide a remittance advice as described. Providers should check with the payer who administers these plans.

- Self-funded plans
- FEP
- Blue Card
- HRSA (Washington State Medicaid)
- And there may be others

**Background:**

Some patients receive insurance coverage from more than one health plan. In these situations, care providers submit multiple claims for the same service. The first claim is submitted to the health plan responsible for the primary coverage. That health plan will adjudicate the claim and respond to the provider with either an electronic-835 Remittance Advice (RA) and/or a paper EOP voucher. The provider then submits a claim to the health plan responsible for secondary coverage, along with information about how the prior payer adjudicated the claim. Secondary payers need this information in order to adjudicate the claim. Tertiary payers have the same requirements as secondary payers.

In the interest of timely and accurate payment, providers should include EOP information on the electronic-837 claims to secondary, tertiary and subsequent payers. Submitting a paper EOP voucher along with an electronic-837 claim adds administrative burden for the provider and adds a time delay before the health plan can process the claim. Not submitting any EOP information also adds a time delay as the health plan must track down the prior payer. Furthermore, if information from the prior payer cannot be obtained in a timely manner, the payer will inform the provider that additional information is required before the claim can be accurately paid.

### **Recommended Best Practices for Providers:**

Best Practices start with a provider obtaining comprehensive coverage information from the patient. Since a patient's coverage information is likely to change over time, providers should ask each patient the following questions when they register for EVERY visit:

- What is the insurance coverage for this patient?
- Are there any other insurance coverage for this patient, e.g multiple employers, multiple responsible parties, etc.?

The following describes the practices that providers should follow when submitting electronic-837 claims to secondary and tertiary payers. (The same procedures should be followed for claims sent to a fourth or subsequent payer.)

#### **When should claims be submitted to secondary, tertiary and subsequent payers?**

Electronic-837 claims should be submitted **sequentially** to the responsible health plans, one payer at a time, until all health plans that provide coverage to the patient have received a claim. The claim should be submitted to the secondary, the tertiary and subsequent payers in turn only after the prior payer has completed their processing of that claim. It is important that all contractual obligations and adjudication/processing errors with the prior payer be resolved, within the timelines established in statute or rule, before sending the claim to the subsequent payer.

#### **When must EOP information be included on the electronic-837 claims to secondary and tertiary payers?**

In coordination of benefits situations, EOP information must be included on **ALL** electronic-837 claims sent to secondary, tertiary and subsequent payers.

#### **If a patient has multiple coverage from the same health plan, do I send one claim or two claims?**

Only send one claim. The health plan will automatically process the claim as primary payer AND as secondary payer, and will send the provider two 835RA records (as

described in item 5. under the section titled ‘Recommended Best Practices for Health Plans’)

By only sending one claim, the extra work of processing and reconciling duplicate claims will be eliminated. Remember, whenever you are in doubt about the status of a claim, always make a claim status inquiry rather than rebilling.

*Do I still need to submit a claim if I don't expect any reimbursement from secondary, tertiary or subsequent payers?*

Yes! Claims should be submitted to EVERY SINGLE payer that provides coverage to the patient, even if the provider does not expect reimbursement from that payer. Submitting a claim to every payer will ensure that the patient receives their full benefits, as COB savings accrue to the member.

This claim will be reflected on an 835 RA from the secondary/tertiary payer as a zero payment (as described in item 4. example #2 under the section titled ‘Recommended Best Practices for Health Plans’)

*What happens if a patient has coverage with multiple health plans, yet I receive denials from both of them because there is confusion over which plan is primary and which plan is secondary?*

Notify both health plans that the patient has coverage with them. Make sure that the health plans have complete and correct information about the patient's other coverage. Health plans have responsibility for solving this in a timely manner (as described in item 6. under the section titled ‘Recommended Best Practices for Health Plans’)

*What EOP information should be included on the electronic-837 claims to secondary, tertiary and subsequent payers? Where should it be placed?*

After processing the claim, each health plan will supply EOP information on their remittance advice. On the remittance advice, EOP information may be sent at a claim level or at a claim and line level.

EOP information will include:

- the amount they paid
- their allowed amount
- explanatory information about why they paid what they did. This typically includes reason codes and dollar amounts.

The following table identifies where the EOP information should be placed within the electronic-837 claim. *(Please refer to the HIPAA Implementation Guide for instructions on how to program the transaction correctly to convey this information.)*

**837**

<b>EOP-Related Information</b>	<b>837 fields</b>
Other Insured Name	Loop 2330A: <ul style="list-style-type: none"> <li>• NM101= 'IL'</li> <li>• NM102= '1' or '2'</li> <li>• NM103-105 is Other Insurance Name Information</li> </ul>
Other Insured Number	Loop 2330A: <ul style="list-style-type: none"> <li>• NM108 = 'MI'</li> <li>• NM109 is Identifying Number</li> </ul>
Other Payer Name	Loop 2330B: <ul style="list-style-type: none"> <li>• NM101= 'PR'</li> <li>• NM102 = '2'</li> <li>• NM103 is Payer Name Information</li> </ul>
Other Payer Number	Loop 2330B: <ul style="list-style-type: none"> <li>• NM108 = 'PI'</li> <li>• NM109 is payer identification information (the entered value is unimportant as it won't be used by the health plan)</li> </ul>
Claim Level Information <sup>*1</sup>	
Explanatory Information at Claim Level	Loop 2320—CAS segment (repeating as necessary) <ul style="list-style-type: none"> <li>• CAS01 = Claim Adjustment Group Code</li> <li>• CAS02 = Claim Adjustment Reason Code</li> <li>• CAS03 = Monetary Amount</li> </ul>
Amount Paid <sup>*2</sup> by Payer at Claim Level	Loop 2320 --COB Payer Prior Payment: <ul style="list-style-type: none"> <li>• AMT01 = 'D'</li> <li>• AMT02 is Amount Paid</li> </ul>
Line Level Information <sup>*1</sup>	
Amount Paid <sup>*2</sup> by Payer at Line Level	Loop 2430 <ul style="list-style-type: none"> <li>• SVD02 is Amount Paid</li> </ul>
Explanatory Information at Line Level	Loop 2430—CAS segment (repeating as necessary) <ul style="list-style-type: none"> <li>• CAS01 = Claim Adjustment Group Code</li> <li>• CAS02 = Claim Adjustment Reason Code</li> <li>• CAS03 = Monetary Amount</li> </ul>

<sup>\*1</sup> – Typically, the payer will provide EOP information at EITHER the claim level or the line level. Place this information in the 837 as appropriate to how it was received from the payer in the remittance advice.

<sup>\*2</sup> – While the previous payer's allowed amount will be reported on their 835, the 837 only provides a place for the previous payer's paid amount. There is no place to

put the previous payer's allowed amount on the 837 submitted to a subsequent payer.

#### 837 Notes:

- a) Providers are encouraged to supply information in the electronic-837 claim at the level of detail that was provided in the remittance advice supplied by the health plan. Claim level information on the remittance advice should be contained as claim level information in the 837. Line level information on the remittance advice should be contained as line level information in the 837. However, ...
  - i. In some cases, different health plans have different requirements for how to bill specific services. Due to these contract differences, providers may need to submit EOP information to a secondary payer in a format that is different than how it was received on the primary payer's 835.
  - ii. In other cases, provider information systems may only have the ability to store remittance advice information in one way, regardless of what was received on the 835. In these situations, provider should submit an 837 with the information that is contained in their information system.

The secondary health plan will contact the primary payer if they need additional or clarifying information

- b) If the payer pays more than the billed amount (i.e. the amount of the charges submitted), the payer will explain this situation on their remittance advice as part of their EOP information (in the CAS segment on the electronic-835). Include this exact information in the CAS segment of the electronic-837 claim to the subsequent payer.

#### **Recommended Best Practices for Health Plans:**

The following describe the practices that health plans should follow when adjudicating electronic-837 claims as a secondary, tertiary or subsequent payer.

Note: Descriptions of HIPAA Group, Reason and Remark Codes are not included in this BPR because they change on a periodic basis. Refer to [www.wpc-edi.com](http://www.wpc-edi.com) for the most up-to-date description of these codes.

1. Health Plans will accept and process electronic-837 claims as primary, secondary, tertiary or subsequent payer.
  - a) If a health plan receives a primary claim and they are not the primary payer, the health plan will respond with the following codes on the 835RA:
    - Group Code: CO or PI (as appropriate)

- Reason Code: 22

The provider should submit the claim to the correct primary payer.

- b) If a health plan receives a secondary/tertiary claim and they believe they are the primary payer, the health plan will pay as primary, process the claim and include the following remark code on the 835 RA.
  - Remark Code Remark Code: MA17
2. Health Plans will report claim adjudication information on the electronic-835 remittance advice, and/or paper remittance advice, at the claim and line level(s) appropriate to the type of claim submitted.
3. If the provider received payment from another payer and does not supply all of the required EOP information on the electronic-837 claim, or if additional EOP information is needed, the Health Plans will attempt to obtain the information from the other payer before responding to the provider with the following codes on the 835RA.
  - Group Code: CO or PI (as appropriate)
  - Reason Code: 125
  - Remark Code: N4
4. On their 835RA to the provider, the secondary health plan should report:
  - a. their own financial impact, i.e. allowed amount and payment, AND
  - b. the financial impact of the primary payer<sup>\*1</sup> using
    - Group Code: OA
    - Reason Code: 23

<sup>\*1</sup> - the secondary payer should report the actual impact of the prior payer rather than computing and reporting the impact based upon their own benefits structure. The amount in the OA 23 should '=' the amount paid by the primary payer '+' all adjustments made by the primary payer.

Example #1: .Secondary payer receives a claim in which their allowable is greater than the primary payer's. (Provider *expects* reimbursement from the secondary payer)

A provider submits a claim to the primary payer for \$1000. The primary payer allows \$900 and pays \$800. The patient is responsible for \$100. The primary payer's 835RA would look like this:

```
SVC*HC:99999*1000*800**1~; Paid $800 on a $1000 claim
DTM*472*20070729~
CAS*CO*45*100~; $100 contractual write-off
CAS*PR*2*100~; $100 patient responsibility
```

The provider submits the claim to the secondary payer with the primary payer's EOP information. The secondary payer allows \$900 and would pay up to \$900. The secondary payer's 835RA would look like this:

SVC\*HC:99999\*1000\*100\*\*1~; Paid \$100 on a \$1000 claim  
DTM\*472\*20070729~  
CAS\*OA\*23\*900; \$900 was the impact of the primary payer

Example #2: Secondary payer receives a claim in which their allowable is equal to the primary payer's. (Provider *does not* expect reimbursement from the secondary payer.)

A provider submits a claim to the primary payer for \$1000. The primary payer allows \$800 and pays \$800, e.g. preventive care benefit. The primary payer's 835RA would look like this:

SVC\*HC:99999\*1000\*800\*\*1~; Paid \$800 on a \$1000 claim  
DTM\*472\*20070729~  
CAS\*CO\*45\*200~; \$200 contractual write-off

The provider submits the claim to the secondary payer with the primary payer's EOP information. The secondary payer also allows \$800. Since the primary payer has paid the entire allowed amount, the secondary payer pays nothing (\$0.00). The secondary payer's 835RA would look like this:

SVC\*HC:99999\*1000\*0\*\*1~; Paid \$0 on a \$1000 claim  
DTM\*472\*20070729~  
CAS\*OA\*23\*1000; \$1000 was the impact of the primary payer

5. In those cases when a member has multiple coverage from the same health plan, the provider should only submit one claim to the responsible health plan. The health plan will first adjudicate the claim using the primary coverage and then automatically adjudicate the claim using the secondary coverage.

The health plan will send the provider an 835RA for each adjudication – the primary coverage adjudication and the secondary coverage adjudication. The 835 RA for the primary coverage adjudication will contain the primary payment information along with the appropriate Crossover Carrier Name Segment in Loop 2100 with NM1-01 = "TT".

In addition to including the Crossover Carrier Name Segment, the claim status code (CLP02) should reflect the appropriate code as follows:

- 19 – processed as primary, forwarded to additional payer(s)
- 20 – processed as secondary, forwarded to additional payer(s)
- 21 – processed as tertiary, forwarded to additional payer(s)

Finally, the remark code MA18 is added to the MIA/MOA segment to indicate that the claim was crossed to a subsequent payer.

Example

CLP\*XXXX\*19\*69.75\*18.7\*\*12\*22334~  
 NMI\*TT\*2\*PREMERA\*\*\*\*\*PI\*WABC1~  
 MOA\*\*\* MA18~

6. In those cases when a health plan learns of a possible COB order of liability conflict (i.e. multiple health plans believe they are primary or believe they are secondary), the health plan will
  - a) Obtain the patient’s other coverage information from the provider
  - b) Contact the other health plan and resolve the order of liability conflict within 5 business days of being notified of the conflict by the provider and obtaining comprehensive coverage information. (More than 5 business days may be required to resolve the conflict in situations where the patient has the required information, e.g. court orders, and this information is not in the possession of the health plan or provider.)
  - c) Document the resolution on the account so that future claims with the same criteria will process first time through. (Both health plans should do this.)
  - d) Notify the provider about the correct order of liability and instruct the provider to resubmit claims in accordance with this order of liability.
  
7. The following table identifies where the EOP information should be placed within the electronic-835 remittance advice. *(Please refer to the HIPAA Implementation Guide for instructions on how to program the transaction correctly to convey this information.)* This information should also be reported on the health plan specific paper remittance advice.

EOP-Related Information	835 fields
Claim Level Information <sup>*1</sup>	
Paid Amount	Loop 2100 <ul style="list-style-type: none"> <li>• CLP04 is Claim Payment Amount</li> </ul>
Allowed Amount <sup>*2</sup>	Loop 2100 <ul style="list-style-type: none"> <li>• AMT01 = ‘AU’</li> <li>• AMT02 is Coverage Amount</li> </ul>
Crossover Flag	Loop 2100-NM1 Segment for Crossover Carrier Name <ul style="list-style-type: none"> <li>• NM101 = TT (Transfer To)</li> <li>• NM102 = 2 (Non-Person Entity)</li> <li>• NM103 - <del>Name Last</del> or Organization Name</li> <li>• NM108 - see 835 IG for list of variables (Identification Code Qualifier)</li> <li>• NM109 - Identification Code)</li> </ul>
Explanatory Information at Claim Level	Loop 2100—CAS segment (repeating as necessary) <ul style="list-style-type: none"> <li>• CAS01 = Claim Adjustment Group Code</li> <li>• CAS02 = Claim Adjustment Reason Code</li> </ul>

<b>EOP-Related Information</b>	<b>835 fields</b>
	<ul style="list-style-type: none"> <li>• CAS03 = Monetary Amount</li> </ul> Remark Code <ul style="list-style-type: none"> <li>• Remark Code for inpatient related services will be stored at: MIA 05, 20, 21, 22, 23</li> <li>• Remark Code for outpatient related services will be stored at: MOA 03, 4, 5, 6, 7</li> </ul>
<b>Line Level Information</b> <sup>*1</sup>	
Paid Amount	Loop 2110 <ul style="list-style-type: none"> <li>• SVC03 is Line Payment Amount</li> </ul>
Allowed Amount <sup>*2</sup>	Loop 2110 <ul style="list-style-type: none"> <li>• AMT01 = 'B6'</li> <li>• AMT02 is Allowed Amount</li> </ul>
Explanatory Information at Line Level	Loop 2110 —CAS segment (repeating as necessary) <ul style="list-style-type: none"> <li>• CAS01 = Claim Adjustment Group Code</li> <li>• CAS02 = Claim Adjustment Reason Code</li> <li>• CAS03 = Monetary Amount</li> </ul> Loop 2110 (for Remark Code) <ul style="list-style-type: none"> <li>• LQ01 = HE</li> <li>• LQ02 = Remark Code</li> </ul>

<sup>\*1</sup> – Typically, EOP information will be placed at EITHER the claim level or the line level depending upon the type of service.

<sup>\*2</sup> – While the 835 provides space to report the allowed amount, the 837 does not. Thus the secondary payer will not receive the primary payer's allowed amount on the 837.

835 Notes:

- a) See Note 'b' in '837 Notes' above for handling the situation when the payer pays more than the billed amount.

# Explanatory Materials

### How are Medicare claims different?

Medicare claims are handled differently by other commercial health plans. The following is a list of important considerations that affect the billing process. *It is important to note that Medicare Part A and Part B balance are handled differently by health plan.* For more specific information about how Medicare Part A and Part B balances are handled, contact the health plan directly.

1. Medicare is notified of secondary supplemental coverage for a patient, typically by the health plan that is providing that coverage to the patient.
2. Providers will submit Medicare claims to Medicare.
3. For Medicare Part A balances (institutional claims) and Medicare Part B balances (professional claims), Medicare will pay the care provider the amount that it determines to be due from Medicare. For patients who have a secondary supplemental policy with a participating health plan, Medicare will notify that health plan of balances owing. This notification is typically called a crossover. (Providers will also get a crossover notification.) In the case of crossovers, the health plan will pay in accordance with the benefits in the patient's supplemental policy. It is not necessary for the care provider to submit a secondary claim or an EOP from Medicare. *(Care providers should check with the health plan to determine if they receive Part A crossovers for their facilities.)*<sup>\*1</sup>

For all crossover situations, the care provider should look at the Medicare Remittance Notice to determine if they need to send in a claim to the secondary Health Plan. If Medicare sends a crossover, a message indicating such will be displayed on the Medicare Remittance Notice. This is usually reliable, although not fail safe.

If Medicare does not send Part A or Part B crossovers for unpaid balances to the participating health plan, the provider should send a secondary claim to the secondary payer and include the EOP information from Medicare. The secondary payer will accept this claim. If the health plan also received a cross-over from Medicare, they will deny the secondary claim from the provider as a duplicate and will notify the provider.

<sup>\*1</sup> - *Effective with the conversion to NPIs on May 23, 2008, HRSA may not be able to process crossovers from Medicare. They will notify providers if this changes.*

# 837 & 835 Coding Scenarios

<<These scenarios need to be tested once a 5010v of a validator is available>>

**Professional Claims:**

The following are 2 examples of how the sequence of 837Ps and 835s should be coded.

**Example 1****837P Sent to Primary Payer**

SBR\*P\*18\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19760704\*M~  
 NM1\*PR\*2\*PRIMARY INSURANCE\*\*\*\*\*PI\*PRIME ID~  
 N3\*5330 GRANITE AVE~  
 N4\*BEDROCK\*WA\*98223~  
 CLM\*X006807031\*220\*\*\*11::1\*Y\*A\*Y\*Y\*B~  
 REF\*EA\*X9722505~  
 HI\*BK:73300~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*\*MD\*XX\*1234567890~  
 PRV\*PE\*ZZ\*207RR0500X~  
 NM1\*77\*2\*BEDROCK FAMILY PRACTICE\*\*\*\*\*XX\*1831186766~  
 N3\*1800 PAVED DRIVE~  
 N4\*BEDROCK\*WA\*98223~  
 SBR\*S\*01\*\*\*C1\*\*\*\*BL~  
 DMG\*D8\*19760101\*F~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*Y\*\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*SECONDARY INSURANCE\*\*\*\*\*PI\*SECOND ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 LX\*1~  
 SV1\*HC:77080\*220\*UN\*1\*11\*\*1~  
 DTP\*472\*D8\*20071115~  
 REF\*6R\*94606173~

**835 from Primary Payer**

CLP\*X006807031\*1\*220\*180.09\*20.01\*13\*1762660609\*11~  
 NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*\*MD\*XX\*1234567890~  
 DTM\*050\*20071128~  
 SVC\*HC:77080\*220\*180.09\*\*1~  
 DTM\*472\*20071115~  
 CAS\*CO\*45\*19.9~  
 CAS\*PR\*2\*20.01~  
 REF\*6R\*94606173~

AMT\*B6\*200.1~

**837P Sent to Secondary Payer**

SBR\*S\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*SECONDARY INSURANCE\*\*\*\*\*PI\*SECOND ID~  
 N3\*2100 TRAIL RD~  
 N4\*BEDROCK\*WA\*98223~  
 HL\*102\*101\*23\*0~  
 PAT\*01~  
 NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19760704\*M~  
 CLM\*X006881749\*220\*\*\*11::1\*Y\*A\*Y\*Y\*B~  
 REF\*D9\*007350204~  
 REF\*EA\*X9722505~  
 HI\*BK:73300~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
 PRV\*PE\*ZZ\*207RR0500X~  
 SBR\*P\*18\*\*\*C1\*\*\*\*CI~  
 AMT\*D\*180.09~  
 AMT\*B6\*200.10~  
 DMG\*D8\*19760704\*M~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*PRIMARY INSURANCE\*\*\*\*\*PI\*PRIME ID~  
 DTP\*573\*D8\*20071213~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 LX\*1~  
 SV1\*HC:77080\*220\*UN\*1\*11\*\*1~  
 DTP\*472\*D8\*20071115~  
 REF\*6R\*94606173~  
 AMT\*AAE\*200.10~  
 SVD\*PRIME ID\*180.09\*HC:77080\*\*1\*1~  
 CAS\*CO\*45\*19.90~  
 CAS\*PR\*2\*20.01~  
 DTP\*573\*D8\*20071213~

**835 from Secondary Payer**

CLP\*X006881749\*2\*220\*20.01\*\*12\*932000\*11\*\*\*\*0~  
 NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~

NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*\*MD\*XX\*1234567890~  
 DTM\*232\*20071115~  
 DTM\*233\*20071115~  
 SVC\*HC:77080\*220\*20.01\*\*1~  
 DTM\*472\*20071115~  
 CAS\*OA\*23\*199.99~  
 REF\*6R\*94606173~

**EXAMPLE 2****837P from Primary Payer**

SBR\*P\*18\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19760704\*M~  
 NM1\*PR\*2\*PRIMARY INSURANCE\*\*\*\*\*PI\*PRIME ID~  
 N3\*5330 GRANITE AVE~  
 N4\*BEDROCK\*WA\*98223~  
 CLM\*X006929478\*110\*\*\*11::1\*Y\*A\*Y\*Y\*B~  
 REF\*EA\*X9916008~  
 HI\*BK:52460~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*\*MD\*XX\*1234567890~  
 PRV\*PE\*ZZ\*207RR0500X~  
 NM1\*77\*2\*BEDROCK FAMILY PRACTICE\*\*\*\*\*XX\*1831186766~  
 N3\*1800 PAVED DRIVE~  
 N4\*BEDROCK\*WA\*98223~  
 SBR\*S\*01\*\*\*C1\*\*\*BL~  
 DMG\*D8\*19760101\*F~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*Y\*\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*SECONDARY INSURANCE\*\*\*\*\*PI\*SECOND ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 SBR\*T\*01\*\*\*C1\*\*\*BL~  
 DMG\*D8\*19760101\*F~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*Y\*\*\*\*MI\*987654322~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*TERTIARY INSURANCE\*\*\*\*\*PI\*TERTIARY ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 LX\*1~  
 SV1\*HC:99213\*110\*UN\*1\*11\*\*1~

DTP\*472\*D8\*20071218~  
REF\*6R\*95744300~

**835 from Primary Payer**

CLP\*X006929478\*19\*110\*46.99\*11.75\*MB\*1108002361750~  
NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
DTM\*050\*20080102~  
SVC\*HC:99213\*110\*46.99\*\*1~  
DTM\*472\*20071218~  
CAS\*CO\*45\*51.26~  
CAS\*PR\*2\*11.75~  
REF\*6R\*95744300~  
AMT\*B6\*58.74~

**837P Sent to Secondary Payer**

SBR\*S\*\*\*\*\*CI~  
NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
N3\*301 COBBLESTONE WAY~  
N4\*BEDROCK\*WA\*98223~  
NM1\*PR\*2\*SECONDARY INSURANCE\*\*\*\*\*PI\*SECOND ID~  
N3\*2100 TRAIL RD~  
N4\*BEDROCK\*WA\*98223~  
HL\*102\*101\*23\*0~  
PAT\*01~  
NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
N3\*301 COBBLESTONE WAY~  
N4\*BEDROCK\*WA\*98223~  
DMG\*D8\*19760704\*M~  
CLM\*X007053655\*110\*\*\*11::1\*Y\*A\*Y\*Y\*B~  
REF\*EA\*X9916008~  
HI\*BK:52460~  
NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
PRV\*PE\*ZZ\*207RR0500X~  
NM1\*77\*2\*BEDROCK FAMILY PRACTICE\*\*\*\*\*XX\*1831186766~  
N3\*1800 PAVED DRIVE~  
N4\*BEDROCK\*WA\*98223~  
SBR\*P\*18\*\*\*C1\*\*\*CI~  
AMT\*D\*46.99~  
AMT\*B6\*58.74~  
DMG\*D8\*19760704\*M~  
OI\*\*\*Y\*B\*\*Y~  
NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
N3\*301 COBBLESTONE WAY~  
N4\*BEDROCK\*WA\*98223~  
NM1\*PR\*2\*PRIMARY INSURANCE\*\*\*\*\*PI\*PRIME ID~

DTP\*573\*D8\*20071213~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 SBR\*T\*01\*\*\*C1\*\*\*\*BL~  
 DMG\*D8\*19760101\*F~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*Y\*\*\*\*MI\*987654322~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*TERTIARY INSURANCE\*\*\*\*\*PI\*TERTIARY ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 LX\*1~  
 SV1\*HC:99213\*110\*UN\*1\*11\*\*1~  
 DTP\*472\*D8\*20071218~  
 REF\*6R\*X95744300~  
 AMT\*AAE\*58.74~  
 SVD\*PRIME ID\*46.99\*HC:99213\*\*1\*1~  
 CAS\*CO\*45\*51.26~  
 CAS\*PR\*2\*11.75~  
 DTP\*573\*D8\*20080121~

**835 from Secondary Payer**

CLP\*X006929478\*2\*110\*0\*11.75\*12\*1800965190\*11~  
 NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
 DTM\*050\*20080121~  
 DTM\*232\*20071218~  
 SVC\*HC:99213\*110\*0\*\*1~  
 DTM\*472\*20071218~  
 CAS\*OA\*23\*98.25~  
 CAS\*PR\*2\*11.75~  
 REF\*6R\*95744300~  
 AMT\*B6\*58.74~

**837P to Tertiary Payer**

SBR\*T\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654322~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*TERTIARY INSURANCE\*\*\*\*\*PI\*TERTIARY ID~  
 N3\*1800 ROCK LN~  
 N4\*BEDROCK\*WA\*98223~  
 HL\*102\*101\*23\*0~  
 PAT\*01~  
 NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~

N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19760704\*M~  
 CLM\*X007053655\*110\*\*\*11::1\*Y\*A\*Y\*Y\*B~  
 REF\*EA\*X9916008~  
 HI\*BK:52460~  
 NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
 PRV\*PE\*ZZ\*207RR0500X~  
 NM1\*77\*2\*BEDROCK FAMILY PRACTICE\*\*\*\*\*XX\*1831186766~  
 N3\*1800 PAVED DRIVE~  
 N4\*BEDROCK\*WA\*98223~  
 SBR\*P\*18\*\*\*C1\*\*\*CI~  
 AMT\*D\*46.99~  
 AMT\*B6\*58.74~  
 DMG\*D8\*19760704\*M~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*PRIMARY INSURANCE\*\*\*\*\*PI\*PRIME ID~  
 DTP\*573\*D8\*20071213~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 SBR\*S\*01\*\*\*C1\*\*\*CI~  
 AMT\*D\*0~  
 AMT\*B6\*58.74~  
 DMG\*D8\*19760101\*F~  
 OI\*\*\*Y\*B\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*Y\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*SECONDARY INSURANCE\*\*\*\*\*PI\*SECOND ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*123456789~  
 LX\*1~  
 SV1\*HC:99213\*110\*UN\*1\*11\*\*1~  
 DTP\*472\*D8\*20071218~  
 REF\*6R\*X95744300~  
 AMT\*AAE\*58.74~  
 SVD\*PRIME ID\*46.99\*HC:99213\*\*1\*1~  
 CAS\*CO\*45\*51.26~  
 CAS\*PR\*2\*11.75~  
 DTP\*573\*D8\*20080121~  
 SVD\*SECOND ID\*0\*HC:99213\*\*1\*1~  
 CAS\*OA\*23\*98.25~  
 CAS\*PR\*2\*11.75~  
 DTP\*573\*D8\*20080121~

**835 from Tertiary Payer**

CLP\*X006929478\*3\*110\*0\*11.75\*12\*57893\*11~  
NM1\*QC\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*123456789~  
NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654322~  
NM1\*82\*1\*RUBBLE\*BERNARD\*\*\*MD\*XX\*1234567890~  
DTM\*050\*20080131~  
DTM\*232\*20071218~  
SVC\*HC:99213\*110\*0\*\*1~  
DTM\*472\*20071218~  
CAS\*OA\*23\*98.25~  
CAS\*PR\*2\*11.75~  
REF\*6R\*95744300~  
AMT\*B6\*58.74~

**Institutional Claims:**

The following is an example of how the sequence of 837Is and 835s should be coded.

**837I Sent to Primary Payer**

SBR\*P\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*WEU123456789~  
 NM1\*PR\*2\*PRIMARY PAYER\*\*\*\*\*PI\*PRIME ID~  
 N3\*5330\*GRANITE AVE~  
 N4\*BEDROCK\*WA\*98223~  
 HL\*3\*2\*23\*0~  
 PAT\*19~  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WEU123456789~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19911015\*F~  
 CLM\*XX123456\*2397.7\*\*\*13:A:2\*Y\*A\*Y\*Y\*\*\*\*\*Y~  
 DTP\*434\*RD8\*20080115-20080115~  
 DTP\*435\*DT\*200801151300~  
 HI\*BK:99859~  
 SBR\*S\*17\*\*\*\*\*CI~  
 DMG\*D8\*19761204\*F~  
 OI\*\*\*Y\*\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 NM1\*PR\*2\*SECONDARY PAYER\*\*\*\*\*PI\*SECOND ID~  
 NM1\*QC\*1\*\*\*\*\*MI\*987654321~  
 LX\*1~  
 SV2\*0480\*HC:93303\*1712.1\*UN\*1~  
 DTP\*472\*D8\*20080115~  
 LX\*2~  
 SV2\*0480\*HC:93320\*685.6\*UN\*1~  
 DTP\*472\*D8\*20080115~

**835 from Primary Payer**

CLP\*XX123456\*1\*2397.7\*1822.26\*455.56\*13\*999999999\*13\*2\*\*\*0~  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*WEU123456789~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*WEU123456789~  
 NM1\*TT\*2\*SECONDARY PAYER\*\*\*\*\*PI\*SECOND ID~  
 DTM\*232\*20080115~  
 DTM\*233\*20080115~  
 AMT\*AU\*2277.82~

SVC\*NU:0480\*1712.1\*1301.2\*\*1~  
 DTM\*472\*20080115~  
 CAS\*CO\*45\*85.6~  
 CAS\*PR\*2\*325.3~  
 REF\*6R\*1~  
 AMT\*B6\*1626.5~  
 SVC\*NU:0480\*685.6\*521.06\*\*1~  
 DTM\*472\*20080115~  
 CAS\*CO\*45\*34.28~  
 CAS\*PR\*2\*130.26~  
 REF\*6R\*2~  
 AMT\*B6\*651.32~

### 837I Sent to Secondary Payer

SBR\*S\*\*911180\*\*\*\*\*CI~  
 NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
 NM1\*PR\*2\*SECONDARY PAYER\*\*\*\*\*PI\*SECOND ID~  
 HL\*3\*2\*23\*0~  
 PAT\*19~  
 NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*987654321~  
 N3\*301 COBBLESTONE WAY~  
 N4\*BEDROCK\*WA\*98223~  
 DMG\*D8\*19911015\*F~  
 CLM\*XX123456\*2397.7\*\*\*13:A:2\*Y\*A\*Y\*Y\*\*\*\*\*Y~  
 DTP\*434\*RD8\*20080115-20080115~  
 DTP\*435\*DT\*200801151300~  
 HI\*BK:99859~  
 SBR\*P\*19\*\*\*\*\*CI~  
 AMT\*C4\*1822.26~  
 AMT\*B6\*2277.82~  
 DMG\*D8\*19760704\*F~  
 OI\*\*\*Y\*\*\*Y~  
 NM1\*IL\*1\*FLINTSTONE\*FREDERICK\*\*\*\*MI\*WEU123456789~  
 NM1\*PR\*2\*PRIMARY PAYER\*\*\*\*\*PI\*PRIME ID~  
 DTP\*573\*D8\*20080130~  
 LX\*1~  
 SV2\*0480\*HC:93303\*1712.1\*UN\*1~  
 DTP\*472\*D8\*20080115~  
 SVD\*PRIME ID\*1301.2\*\*0480\*1~  
 CAS\*CO\*45\*85.6~  
 CAS\*PR\*2\*325.3~  
 DTP\*573\*D8\*20070313~  
 LX\*2~  
 SV2\*0480\*HC:93320\*685.6\*UN\*1~

DTP\*472\*D8\*20080115~  
SVD\*PRIME ID\*521.06\*\*0480\*1~  
CAS\*CO\*45\*34.28~  
CAS\*PR\*2\*130.26~  
DTP\*573\*D8\*20070313~

**835 from Secondary Payer**

CLP\*XX123456\*2\*2397.7\*455.56\*\*12\*8888888888\*13\*2~  
NM1\*QC\*1\*FLINTSTONE\*PEBBLES\*\*\*\*MI\*987654321~  
NM1\*IL\*1\*FLINTSTONE\*WILMA\*\*\*\*MI\*987654321~  
DTM\*050\*20080206~  
DTM\*232\*20080115~  
DTM\*233\*20080115~  
AMT\*AU\*2277.82~  
SVC\*HC:93320\*685.6\*130.26\*0480\*1~  
DTM\*472\*20080115~  
CAS\*OA\*23\*555.34~  
REF\*6R\*2~  
AMT\*B6\*651.32~  
SVC\*HC:93303\*1712.1\*325.3\*0480\*1~  
DTM\*472\*20080115~  
CAS\*OA\*23\*1386.8~  
REF\*6R\*1~  
AMT\*B6\*1626.5~  
LQ\*HE\*N130~