Blue Shield of California

HIPAA Transaction
Standard Companion Guide
Section 1

Refers to the Implementation Guides Based on X12 version 005010

Companion Guide Version Number: 2.0

April, 2020

Preface

This *Companion Guide* to the *ASC X12N Implementation Guides* adopted under HIPAA clarifies and specifies the data content being requested when data is electronically transmitted to Blue Shield of California. Transmissions based on this *Companion Guide*, used in tandem with the X12N Implementation Guides and finalized Addenda dated February 20, 2003, are compliant with both X12 syntax and those guides.

This *Companion Guide* is intended to convey information that is within the framework of the *ASC X12N Implementation Guides* adopted for use under HIPAA. The *Companion Guide* is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the *Implementation Guides or finalized Addenda.*

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Trading Partner Information

1. Introduction

1.1 Purpose

This document is intended to provide information from the author of this guide to Trading Partners to give them the information they need to exchange EDI data with the author. This includes information about registration, testing, support, and specific information about control record setup. The majority of our providers using a business associate for their data exchange needs, such as a Practice Management software vendor or a clearinghouse

1.2 Scope

This Companion Guide is to provide information to Trading Partners on the procedures necessary to transmit or receive Electronic Data Interchange (EDI) transactions to/from Blue Shield of California.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Blue Shield of California will be supporting the following EDI transactions:

Transaction Code	Transaction Description
270	Eligibility Benefit Inquiry
271	Eligibility Benefit Response
276	Claim Status Request
277	Claim Status Response
278	Services Review – Request for Review and Response (Referral/Authorization Request)
820	Premium Payment
834	Benefit Enrollment and Maintenance
835	Claim Payment/Advice (Electronic Remittance Advice ERA, Electronic Funds Transfer EFT)
837	· Institutional · Professional · Dental
999	Implementation Acknowledgment for Health Care Claim

1.3 Overview

The HIPAA EDI Transaction Standard Companion Guide is intended to provide general information pertaining to all EDI transactions.

Transaction Code	Transaction Description	Identifier Code
277CA	Health Care Claim Acknowledgment	005010x214
835	Health Care Claim Payment/Advice	005010x221A1
837D	Health Care Claim: Dental	005010x224A2
837I	Health Care Claim: Institutional	005010x223A2
837P	Health Care Claim: Professional	005010x222A1
999	Implementation Acknowledgment for Health Care Claim	005010x231A1

1.4 References

The Companion Guide is NOT intended to replace the X12N Implementation Guides. It is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

A TR3 is a set of standards developed by the ASC X12N subcommittee that specify format and data requirements to be used for the electronic transactions for that specific TR3. These TR3 documents are available for purchase in PDF and/or hard copy formats at the ASC X12 website: http://store.x12.org/.

The X12N Implementation Guides may be obtained from the Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD 20852-2116; telephone 301-949-9740; and fax 301-949-9742. They are also available through the Washington Publishing Company on the Internet at http://www.wpc-edi.com.

1.5 Additional Information

Electronic claim submissions, eligibility, claim status, etc. to Blue Shield of California is available for all Blue Cross Blue Shield members. These members include out of state and federal employees.

There are several advantages to doing electronic transactions. Among these are:

- Reduced Administrative Cost: Transactions are sent from computer to computer thereby reducing the need for manual keying, correction and processing of this data.
- Increased Data Accuracy: Data is being submitted directly from one system to the other eliminating the possibility of keying errors or illegibly typed/written documents.
- Increased Data Timeliness: Electronic transmittal and processing of these transactions result in greatly reduced lag time.
- Increased Cash Flow: Providers can realize quicker claim/encounter processing through less paperwork and enhanced data accuracy. Clean electronic claims are processed, on average, in 3.7 days.

2. Getting Started

2.1 Working Together

You may contact the Blue Shield of California EDI Help Desk at EDI_BSC@blueshieldca.com or (800) 480-1221.

2.2 Trading Partner Registration

A Trading Partner who would like to submit electronic transactions must complete and forward a Trading Partner Agreement (TPA) and EDI Enrollment Form to Blue Shield of California EDI Platform Services.

The TPA must be completed and signed by an authorized representative of the organization. Complete and accurate reporting of information on both documents will insure that your request is processed in a timely manner.

You can obtain the TPA and the EDI Enrollment Form by accessing our website at https://www.blueshieldca.com or by calling the EDI Platform Services Help Desk at (800) 480-1221.

Trading Partners changing their information (i.e., adding a new provider, deleting a provider, address, EDI transactions, etc.) must inform EDI Platform Services in writing immediately. To change existing information, you would complete a new EDI Enrollment Form and either fax or mail the form to EDI Platform Services

2.3 Trading Partner Testing and Certification Process

As a new Trading Partner with Blue Shield of California, we require your EDI transactions to be tested. There are two phases of testing.

EDI Platform Services, along with the Trading Partner, will coordinate testing. EDI Platform Services will determine when the Trading Partner has completed testing and is ready for production.

3. Testing and Certification Requirements

3.1 Testing Requirements

The testing will involve connecting to Blue Shield of California and submitting validated transaction files. Transactions will be loaded into our test environment and validated through our internal processing systems. TA1, 999, and 277CA files will be returned indicating the results of the test. The Trading Partner is approved for production implementation once successful testing is completed.

3.2 Certification Requirements

Testing requires 2-3 rounds of accepted files before implementation to production.

4. Connectivity / Communications

4.1 Process flows

Trading Partners submitting transactions to Blue Shield of California will connect through a secure file transfer protocol (SFTP), aka "Sterling Platform".

4.2 Transmission Administrative Procedures

The SFTP server provides a path for electronic transmissions of confidential data to and from Blue Shield's Trading Partners. The server is protected behind a firewall. A unique login ID and password is created for each Trading Partner.

4.3 Communication Protocols

Connection to the server is only possible through the firewall using standard FTP connections or SSH SFTP connections over the internet. We use PGP encryption to ensure the data is kept confidential when using standard FTP connections. In most cases the Trading Partner will be responsible to pushing and pulling their files through the Blue Shield of California FTP server.

4.4 Security Protocols

A Trading Partner's password to access SFTP is assigned by Blue Shield of California system administrators. A password may be reset by Blue Shield upon request from the Trading Partner.

5. Contact information

5.1 EDI Customer Service & EDI Technical Assistance

The EDI Help Desk support representatives are available from 8 a.m. to 4 p.m., Monday through Friday. When calling the Help Desk, you will be prompted to stay on the line or press "1" to be connected to a representative. Any representative is prepared to discuss your concerns, issues and solutions.

Telephone Number: (800) 480-1221
Fax Number: (530) 351-6150
Email Address: EDI_BSC@blueshieldca.com

Address: EDI Platform Services
Blue Shield of California
4700 Bechelli Lane, 3rd Floor
Redding, CA 96002

5.2 EDI Technical Assistance

Please refer to Section 5.1 for EDI contact information.

Inquiries pertaining to Blue Shield of California's payments of claims should be directed to the appropriate Customer Service Department listed below:

Customer/Member Services: (General information number)	(800) 200-3242
Federal Employee Program	(800) 824-8839
ITS/BlueCard	(800) 622-0632

Provider Services

Blue Shield's Provider Services Department is available to answer your questions regarding address changes, new practice locations, obtaining a Blue Shield ID number, Blue Shield allowances and claim status. You can contact Provider Services at: **(800) 258-3091** and select option "3".

Representatives are available from 9:00 a.m. to noon and 1:00 p.m. to 4:00 p.m., Monday through Friday.

5.3 Applicable websites / e-mail

Information on Blue Shield of California can be accessed at https://www.blueshieldca.com.

The Implementation Guides for each transaction are available electronically at www.wpc-edi.com

6. Control Segments / Envelopes

6.1 ISA-IEA

Interchange Control (ISA/IEA) and Functional Group (GS/GE) envelopes must be used as described in the National Electronic Data Interchange Transaction Set Implementation Guides.

Blue Shield of California only supports one interchange (ISA/IEA envelope) per incoming transmission file. A file containing multiple interchanges will be rejected.

Trading Partners will work with a dedicated EDI Analyst to determine the submitter id (prior to testing) for all electronic transactions (often it is the tax-id, or some form of the trading partner name).

X12 Outer Envelope Information

	Inbound (270, 276, 278, 820, 834, 837)	**Outbound (271, 277, 278, 835, 837)**
Interchange Authorization Qualifier (ISA01)	00	00
Interchange Security Info. Qualifier (ISA03)	00	00
Interchange Sender ID Qualifier (ISA05)	ZZ	30
Interchange Sender ID (ISA06)		940360524 (followed by 6 spaces)
Interchange Receiver ID Qualifier (ISA07)	30	ZZ
Interchange Receiver ID (ISA08)	940360524 (followed by 6 spaces)	
Interchange Standard ID (ISA11)	^	^
Interchange Version Number (ISA12)	00501	00501

X12 Inner Envelope Information

	Inbound (270, 276, 278, 820, 834, 837)	Outbound (271, 277, 278, 835, 837)
Application Sender Code (GS02)		940360524
Application Receiver ID (GS03)	940360524	
Responsible Agency Code (GS07)	X	X

6.2 Delimiters

Delimiter Type	Character Used	(HEX Value)
Data Element Separator	* (Asterisk)	2A
Component Element Separator	> (Greater than)	3E
Segment Terminator	~ (Tilde)	7E

6.3 GS-GE

The Functional Group Header (GS) is intended to group similar transaction sets within the same interchange. If multiple functional groups are submitted in the same interchange they should all hold the same transaction type.

The Application Receiver's Code (GS03) should contain the applicable receiver id: 940360524 for professional, and institutional claims and encounters, and dental claims.

If a Trading Partner submits more than one functional group to the same directory on the same day, it is advisable that there be unique functional control numbers in the GS06 in those submissions.

6.4 ST-SE

If a Trading Partner submits more than one transaction set to the same directory on the same day for the same type of transaction, it is required that there be unique transaction set control number in ST02 of those transactions. This is to allow for ease in matching the specific 277CA back to its 837 counterpart since a separate 277CA will be created for each 837.

Blue Shield allows a maximum of 5000 claims/encounters per ST/SE.

7. Acknowledgements and Reports

If an error is identified at the Interchange Control (ISA/IEA) and Functional Group (GS/GE) envelopes, a TA1 Report is returned electronically to the submitter. If an error is identified at the transaction level, a 999 Acknowledgement is returned electronically to the submitter. If this occurs, please correct the error and retransmit your transaction with a unique Interchange Control Number.

The 277CA file identifies how the claims/encounters were accepted and rejected, including the description for the errors. Only the rejected claims/encounters will need to be corrected and resubmitted electronically.

7.1 ASC X12 Acknowledgments

Trading Partners may expect to receive the following ASC X12 acknowledgments during the process of translating, validation and editing 837 claim files.

TA1: This segment acknowledges the interchange structure only. The 837 file does not progress to the next step if a rejection occurs at this level. When the ISA in the 837 is in error a TA1 will be created with only an envelope (interchange) to hold the structure errors (ISA, TA1, IEA segments only
999: The 999 contains TR3 compliance information. The 999 will be generated for:

- Rejected (IK5*R and/or AK9*R)
- Accepted (IK5*A and/or AK9*A)
- Accepted with errors noted (IK5*E or AK9*E)
    - Accepted with errors noted status is generated when there are non-fatal implementation errors. These will be listed as rejections in the 277CA.
    - Permitting these to pass the 999 edit checking will allow partial acceptance in the 277CA vs. rejecting the entire batch.

277CA: The Health Care Claim Acknowledgment 277 transaction will be created when an 837 file has received an Accepted or Accepted but with errors noted status in its 999. The 277CA will contain specific edit information in STC segments. STC segments will be generated to indicate acceptance or rejection at the Information Receiver, Billing Provider, Claim or Line Level. There may be one or a combination of STCs to help clarify the status of applicable information.

8. Additional Trading Partner Information

Below describes some of Blue Shield of California's business rules regarding transactions:

- The member identification number needs to be transmitted exactly as it appears on the identification card, including the prefix. Submitting the correct member ID number will ensure the transaction is processed correctly.
- Be careful not to confuse O (the letter) with 0 (the number) and vice a versa. Another common error is keying the Provider Identification Number incorrectly, e.g., incorrect **222**A1234**2** instead of correct **ZZZ**A1234**Z**.
- Out-of-state Blue Cross Blue Shield member's transactions should be submitted to Blue Shield of California for services rendered in California.
- Federal employee's transactions should be submitted to Blue Shield of California, except for UB-04 facility claims, those should be submitted to Anthem Blue Cross.
- Transactions from a provider in a contiguous county to the State of California, that has a direct contract with Blue Shield of California with a valid Blue Shield provider PIN, can submit California members to Blue Shield of California.
- If a claim is retransmitted with a frequency code of 5, 6, 7 or 8, it will be considered an adjustment to the prior claim, and an original claim number is required.
- Claims/Encounters can be submitted up to 50 lines for professional, and 999 lines for institutional claims/encounter. Unique claim numbers will be assigned.
- When submitting files do not use punctuation (i.e., John A. Doe). It will not be transferred into our system and could potentially cause errors.

9. File naming requirements for inbound 837 files via SFTP

1. Files **MUST** begin with the sender ID (FX feed number/submitter number) in ALL CAPS. Example: **FCRAY**

2. **For PGP Only**, files must have two file extensions: **.837** and the appropriate encryption extension of **.asc**
    a. It is critical that you **always** use the same encryption extension.
    b. Example: **FCRAY.837.asc**

3. You may want to include other characters of your choosing, such as a file name and a file date. Separate the Sender ID and additional characters with an underscore (_). (.asc is for PGP only).
    a. Example: **FCRAY_YYYYMMDD.837**

4. You may also want to include a sequence number/letter in the event that you submit more than one file per day. (.asc is for PGP only).
    a. Example: **FCRAY_YYYYMMDDa.837.asc**

5. File names should be no longer than 32 characters. File names should remain consistent. If they vary, they may not be recognized by the scripts looking for them. (.asc is for PGP only).

    Example of complete file name: **FCRAY_YYYYMMDDa.837.asc**

10. File naming conventions for outbound 835

835_ZZZ99999Z_FACETS_21_1.835 = Blue Shield of California Standard Business

Note: The value ZZZ99999Z will be replaced with your unique 835 Receiver ID.

11. Trading Partner Agreement

Trading Partner Agreements (TPAs) are not required by HIPAA, at this time. TPAs define the duties and responsibilities of the partners that enable business documents to be electronically interchanged between them.

TPAs are requested by Blue Shield of California clearinghouses that assist in processing electronic transactions on behalf of their clients. TPAs define Trading Partner, Blue Shield of California and mutual obligations under the contract.

Trading Partners

An EDI Trading Partner is defined as any Blue Shield customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Blue Shield.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

12. Blue Shield of California Specific Requirements

The tables below include Blue Shield of California specific requirements for **837 Institutional & 837 Professional** claim and encounter transactions, in addition to **835 Claims Remittance Advice**

837 Institutional [005010x223A2]

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV	Billing Provider Specialty Information		To identify the billing provider specialty when the billing provider Name and address is similar to other providers.
2000A	PRV01	Provider Code	BI	BI = Billing
2000A	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Code
2000A	PRV03	Reference Identification		The Billing Provider's Taxonomy Code that also identifies the specialty
2010AA	N3	Billing Provider Address		
2010AA	N301	Address Information		When submitting with NPI provide the physical address where services were rendered
2010AA	N4	Billing Provider City/State/Zip		
2010AA	N401	Address Information		When submitting with NPI provide the physical address where services were rendered
2000B	SBR	Subscriber Information		
2000B	SBR03	Reference Identification		Claims for members in National Account groups require submission of the **group number** found on their ID Card
2010BA	NM1	Subscriber Name		
2010BA	NM101	Entity Identifier Code	IL	Insured or Subscriber
2010BA	NM109	Subscriber Primary ID		Subscriber ID from Blue Shield of California ID Card, MBI or HICN. Subscriber ID is recommended. **Any other type of ID# will not be recognized and will be rejected as unable to identity the member.** **HICN will not be recognized if a member has provided BSC their MBI ID.**

Loop ID	Reference	Name	Codes	Notes/Comments
2300	NTE	Claim Note		
2300	NTE01	Note Reference Code	MED	
2300	NTE02	Description	Up to 80 bytes	Name of drugs. Show in order of service lines. Example: (NTE*MED*J9265
2310A	PRV	Attending Physician Specialty Information		To identify the attending provider specialty.
2310A	PRV01	Provider Code	AT	AT = Attending
2310A	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Code
2310A	PRV03	Reference Identification		The Billing Provider's Taxonomy Code that also identifies the specialty
2310F	NM1	Referring Provider Name		
2310F	NM103	Name Last or Organization Name	SELFREFERRAL	NM1*DN*1*SELFREFERRAL*****XX*1002233777~
2310F	NM104	Name First	Leave Blank	NM1*DN*1*SELFREFERRAL*****XX*1002233777~
2310F	NM109	Identification Code	1002233777	Use generic NPI

837 Institutional [005010x223A2] continued

Loop ID	Reference	Name	Codes	Notes/Comments
2400	SV2	Institutional Service Line		
2400	SV202-3, 4, 5 & 6	Procedure Modifier		With the exception of members in National Account and Medicare Risk groups, BSC can take adjudicative action on only the first modifier received, SV202-3, for anesthesia services. Claims including anesthesia services for members in National Account groups require submission of both the HCPCS and CPT modifiers appropriate for the anesthesia service provided. i.e., both SV202-3 and SV202-4 should be populated.
2410	LIN	Drug Identification		
2410	LIN	Drug Identification		BSC can take adjudicative action on only the first of any 2410 loops received
2410	CTP	Drug Quantity		If the price of the NDC drug reported in LIN03 is different from the charges reported in SV203, create a CTP segment in loop 2410

837 Professional [005010x222A1]

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV	Billing Provider Specialty Information		To identify the billing provider specialty when the billing provider Name and address is similar to other providers.
2000A	PRV01	Provider Code	BI	BI = Billing
2000A	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Code
2000A	PRV03	Reference Identification		The Billing Provider's Taxonomy Code that also identifies the specialty
2010AA	N3	Billing Provider Address		
2010AA	N3	Billing Provider Address		
2010AA	N301	Address Information		Provide the physical address where services were rendered with an NPI
2010AA	N4	Billing Provider City/State/Zip		
2010AA	N401	Address Information		Provide the physical address where services were rendered with an NPI
2000B	SBR	Subscriber Information		
2000B	SBR03	Reference Identification		Claims for members in National Account groups require submission of the **group number** found on their ID Card
2010BA	NM1	Subscriber Name		
2010BA	NM101	Entity Identifier Code	IL	Insured or Subscriber
2010BA	NM109	Subscriber Primary ID		Subscriber ID from Blue Shield of California ID Card, MBI or HICN. Subscriber ID is recommended. **Any other type of ID# will not be recognized and will be rejected as unable to identity the member.** **HICN will not be recognized if a member has provided BSC their MBI ID.**

Loop ID	Reference	Name	Codes	Notes/Comments
2310A	NM1	Referring Provider Name		
2310A	NM103	Name Last or Organization Name	SELFREFERRAL	NM1*DN*1*SELFREFERRAL*****XX*1002233777~
2310A	NM104	Name First	Leave Blank	NM1*DN*1*SELFREFERRAL*****XX*1002233777~
2310A	NM109	Identification Code	1002233777	Use generic NPI
2310B	PRV	Rendering Provider Specialty Information		To identify the rendering provider specialty.
2310B	PRV01	Provider Code	PE	PE = Performing

Loop ID	Reference	Name	Codes	Notes/Comments
2310B	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Code
2310B	PRV03	Reference Identification		The Billing Provider's Taxonomy Code that also identifies the specialty
2310B	PRV	Attending Physician Specialty Information		To identify the attending provider specialty.
2400	SV1	Professional Service		
2400	SV101-2	Product/Service ID		Use J codes for home infusion drugs
2400	SV101-3, 4, 5 & 6	Procedure Modifier		With the exception of members in National Account and Medicare Risk groups, BSC can take adjudicative action on only the first modifier received, SV202-3, for anesthesia services. Claims including anesthesia services for members in National Account groups require submission of both the HCPCS and CPT modifiers appropriate for the anesthesia service provided.
2410	LIN	Drug Identification		
2410	LIN	Drug Identification		BSC can take adjudicative action on only the first of any 2410 loops.
2420A	PRV	Rendering Provider Specialty Information		To identify the rendering provider specialty.
2420A	PRV01	Provider Code	PE	PE = Performing
2420A	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Code
2420A	PRV03	Reference Identification		The Billing Provider's Taxonomy Code that also identifies the specialty
2310B	PRV	Attending Physician Specialty Information		To identify the attending provider specialty.

837 Professional [005010x222A1] - Ambulance

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM	Claim Information		
2300	CLM05	Health Care Service Location Indicator (Place of Service)	41,42	41- Land 42 Air or Water Use for 'Type of Transport'
2300	REF	Referral Number		
2300	REF02	Reference Identification		Indicate if 911, plus any free form comments up to 26 characters
2300	NTE	Claim Note		
2300	NTE01	Note Reference Code	ADD	Used in conjunction with NTE02 to identify the purpose of the notes in NTE02
2300	NTE02	Description		Report location where patient was transported to. Include facility name, city and zip

837 Professional [005010x222A1] – Encounters

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT 06	Transaction Type Code	RP	Use RP when the entire ST-SE envelope contains only capitated encounters
2010AA	NM1	Billing Provider		Send original billing provider, do not send capitated entity data
2010AA	NM103	Billing Provider Last or Organizational Name		Name of the provider that was received on the claim that the capitated entity received for processing
2010AA	NM104	Billing Provider First Name		First Name of the provider that was received on the claim that the capitated entity received for processing
2010AA	NM109	Identification Code		NPI for the billing provider that was received on the claim that the capitated entity received for processing
2010AA	N3	Billing Provider Address		Physical Address for the Billing Provider that was received on the claim that the capitated entity received for processing PO Box information should be sent in the Pay To Address Loop 2010AB if Necessary
2010AA	N4	Billing Provider City, State, Zip		City, State, Zip for the Billing Provider that was received on the claim that the capitated entity received for processing
2010AB	NM1	Pay to Address Name		
2010AB	N3	Pay to Address		PO Box Address for the Billing Provider that was on the claim that the capitated entity received for processing
2010AB	N4	Pay to City, State, Zip		PO Box City, State, Zip for the Billing Provider that was on the claim that the capitated entity received for processing
2010BA	NM1	Subscriber Name		
2010BA	NM101	Entity Identifier Code	IL	Insured or Subscriber
2010BA	NM109	Subscriber Primary ID		Subscriber ID from Blue Shield of California ID Card, MBI or HICN. Subscriber ID is recommended. **Any other type of ID# will not be recognized and will be rejected as unable to identity the member.** **HICN will not be recognized if a member has provided BSC their MBI ID.**
2010BB	REF01	Billing Provider Secondary Identification	G2	
2010BB	REF02	Reference Identification	IP00#	Unique Blue Shield of CA IPA number (assigned by Blue Shield Provider Relations)

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM	Claim Information		
2300	CLM05-03	Claim Frequency Type Code		Used only for Replacement or Void 7 = Replacement *8 = Void *Note: (note on Void) Only send if voiding an entire encounter with No replacement ***Do not send Negative Values***
2300	REF	Payer Claim Control Number		Used only for Replacement or Void
2300	REF01	Reference Identification Qualifier	F8	Used only for Replacement or Void
2300	REF02	Reference Identification		Used only for Replacement or Void BSC Facets Claim ID or Payer Claim Control Number
2310B	NM1	Rendering Provider Name		Note: Required when the rendering provider is different than the billing provider in loop 2010AA
2310B	NM103	Rendering Provider Last Name		Last Name of the Rendering Provider that was submitted on the claim that was processed by the capitated entity
2310B	NM104	Rendering Provider First Name		First Name of the Rendering Provider that was submitted on the claim that was processed by the capitated entity
2310B	NM109	Rendering Provider NPI		Rendering Provider NPI that was submitted on the claim that was processed by the delegated medical group
2310B	PRV	Rendering Provider Taxonomy		Rendering Provider Taxonomy that was submitted on the claim that was processed by the delegated medical group
2310C	NM1	Service Facility Location		Note: Required when the location of the healthcare service is different than the billing provider in loop 2010AA
2310C	NM103	Name Last or Organization Name		Name of Service Facility Location that was submitted on the claim that was processed by the capitated entity
2320	CAS	Claim Level Adjustments		CAS*PR*1*9*7.93~ CAS*OA*93*15.06~

Loop ID	Reference	Name	Codes	Notes/Comments
				CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility
2320	CAS02	Claim Adjustment Reason Code		Use appropriate adjustment reason codes **Examples**: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Note: Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2330A	NM1	Other Subscriber Name		
2330A	NM108	Identification Code Qualifier	MI	MI = Member Identification Number
2330A	NM109	Identification Code		Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	Other Payer Name		Send Capitated entity data
2330B	NM103	Name Last or Organization Name		Name of Delegated Medical Group
2330B	NM108	Identification Code Qualifier	PI	
2330B	NM109	Identification Code		Please check with your clearinghouse or plan for specific identification code that must be used for electronic claims Tax ID / NPI for Loop 2330B NM103
2330B	REF	Other Payer Claim Control Number		Always send - Use to provide capitated entity's unique claim number. Data will later be used if/when a void or replacement claim is sent
2330B	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number
2330B	REF02	Reference Identification		Capitated entity's unique claim number

Loop ID	Reference	Name	Codes	Notes/Comments
2400	HCP*	Line Pricing / Repricing Information		Used for Allowed Amount
2400	HCP01	Pricing Methodology		Note: See Implementation Guide for codes
2400	HCP02	Monetary Amount		Allowed Amount
2430	SVD*	Line Adjudication Information		
2430	SVD01	Identification Code		Must match Loop 2330B NM109
	SVD02	Monetary Amount		Paid Amount Note: Loop 2400 SV103 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary
2430	CAS*	Line Level Adjustments		
2430	CAS02	Line Adjustment Reason Code		Use appropriate adjustment reason codes **Examples**: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Note: Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

***See **Appendix A** for examples

837 Institutional [005010x223A1] - Encounters

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT 06	Transaction Type Code	RP	Use RP when the entire ST-SE envelope contains only capitated encounters
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV03	Provider Taxonomy Code		Taxonomy Code for the billing provider on the claim that was received by the capitated entity for processing
2010AA	NM1	Billing Provider		Send original billing provider, do not send capitated entity data
2010AA	NM103	Billing Provider Last or Organizational Name		Name of the provider that was received on the claim that the capitated entity received for processing
2010AA	NM104	Billing Provider First Name		First Name of the provider that was received on the claim that the capitated entity received for processing
2010AA	NM109	Identification Code		NPI for the billing provider that was received on the claim that the capitated entity received for processing
2010AA	N3	Billing Provider Address		Physical Address for the Billing Provider that was received on the claim that the capitated entity received for processing PO Box information should be sent in the Pay To Address Loop 2010AB if Necessary
2010AA	N4	Billing Provider City, State, Zip		City, State, Zip for the Billing Provider that was received on the claim that the capitated entity received for processing
2010AB	NM1	Pay to Address Name		Billing Provider PO Box Information
2010AB	N3	Pay to Address		PO Box Address for the Billing Provider that was on the claim that the capitated entity received for processing
2010AB	N4	Pay to City, State, Zip		PO Box City, State, Zip for the Billing Provider that was on the claim that the capitated entity received for processing
2010BA	NM1	Subscriber Name		
2010BA	NM101	Entity Identifier Code	IL	Insured or Subscriber
2010BA	NM109	Subscriber Primary ID		Subscriber ID from Blue Shield of California ID Card, MBI or HICN. Subscriber ID is recommended. **Any other type of ID# will not be recognized and will be rejected as unable to identity the member.** **HICN will only be used if a member has not received an MBI ID.**

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	REF01	Billing Provider Secondary Identification	G2	
2010BB	REF02	Reference Identification	IP00#	Unique Blue Shield of CA IPA number (assigned by Blue Shield Provider Relations)
2300	CLM	Claim Information		
2300	CLM05-03	Claim Frequency Type Code		Used only for Replacement or Void 7 = Replacement *8 = Void *Note: (note on Void) Only send if voiding an entire encounter with No replacement ***Do not send Negative Values***
2300	REF	Payer Claim Control Number		Used only for Replacement or Void
2300	REF01	Reference Identification Qualifier	F8	Used only for Replacement or Void
2300	HCP	Claim Pricing / Repricing Information		Used for Claim Level Allowed Amount
2300	HCP01	Pricing Methodology		Note: See Implementation Guide for codes
2300	HCP02	Monetary Amount		Allowed Amount
2300	REF02	Reference Identification		Used only for Replacement or Void BSC Facets Claim ID or Payer Claim Control Number
2320	SBR	Other Subscriber Information		
2320	SBR01	Payer Responsibility Sequence	P	P = Primary

Loop ID	Reference	Name	Codes	Notes/Comments
2320	CAS	Claim Level Adjustments		CAS*PR*1*9*7.93~ CAS*OA*93*15.06~ CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility
2320	CAS02	Claim Adjustment Reason Code		Use appropriate adjustment reason codes **Examples**: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Note: Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2330A	NM1	Other Subscriber Name		
2330A	NM108	Identification Code Qualifier	MI	MI = Member Identification Number
2330A	NM109	Identification Code		Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	Other Payer Name		**Send Capitated entity data**
2330B	NM103	Name Last or Organization Name		Name of Delegated Medical Group
2330B	NM108	Identification Code Qualifier	PI	
2330B	NM109	Identification Code		Please check with your clearinghouse for specific identification code that must be used

Loop ID	Reference	Name	Codes	Notes/Comments
2330B	REF	Other Payer Claim Control Number		Always send - Use to provide capitated entity's unique claim number. Data will later be used if/when a void or replacement claim is sent
2330B	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number
2330B	REF02	Reference Identification		Capitated entity's unique claim number
2400	HCP*	Line Pricing / Repricing Information		Used for Line Level Allowed Amount
2400	HCP01	Pricing Methodology		Note: See Implementation Guide for codes
2400	HCP02	Monetary Amount		Allowed Amount
2430	SVD*	Line Adjudication Information		
2430	SVD01	Identification Code		Must match Loop 2330B NM109
2430	SVD02	Monetary Amount		Paid Amount NOTE: Loop 2400 SV203 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02
2430	CAS*	Line Adjustment		
2430	CAS02	Line Adjustment Reason Code		Use appropriate adjustment reason codes **Examples**: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Note: Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

*See **Appendix A** for examples

835 [005010X221] Health Care Claim Payment Advice

Loop ID	Reference	Name	Length	Notes/Comments
		Interchange Control Header (ISA)		
	ISA05	Interchange ID Qualifier	2	BSC will send "30", Federal Tax ID number
	ISA06	Interchange Sender ID	15	BSC will send "940360524"
	ISA07	Interchange ID Qualifier	2	BS will send "ZZ", Mutually Defined
	ISA08	Interchange Receiver ID	15	BSC will send mutually defined value
	ISA16	Component Element Separator	1	BSC will send "*" as the Data Element Separator, ">" as the Composite Element Separator, and "~" as the Segment Terminator
		Functional Group Header (GS)		
	GS02	Application Sender's code	15	BSC will send the same value as ISA06, "940360524"
	GS03	Application Receiver's code	15	BSC will send the same value as ISA08
	GS08	Version/Release/Industry Identifier code	12	BSC will send "005010X221A1"
		Financial Information (BPR)		
	BPR01	Transaction Handling Code	1-2	BSC will send either "H" or "I" only
	BPR04	Payment Method Code	3	BSC will send either "ACH", "CHK", or "NON
	BPR05	Payment Format Code	1-10	The value will always be "CCP" if BPR04 = "ACH", else it will not be sent.
	BPR06	(DFI) ID Number Qualifier	2	The value will always be "01" if BPR04 = "ACH", else it will not be sent.
1000A		**Payer Identification**		
1000A	N102	Payer Name	1-60	CALIFORNIA PHYSICIANS SERVICES DBA BLUE SHIELD CA
1000A	N301	Payer Address Information	1-56	If BPR04 = "NON", BSC will send "PO Box 272560". If BPR04 = "ACH" or "CHK", BSC will send PO Box 769025
1000A	N401	City Name	1-56	If BPR04 = "NON", BSC will send Chico. If BPR04 = "ACH" or "CHK", BSC will send "Woodland"
1000A	N403	Postal Code	3-15	If BPR04 = "NON", BSC will send "959272560". If BPR04 = "ACH" or "CHK". BSC will send "957769025"
1000B		**Payee Identification**		
1000B	N103	Identification Code Qualifier	1-2	BSC will send "XX" when the National Provider Identifier (NPI) has been received from claims submission.
1000B	N104	Identification Code	2-80	BSC will send the NPI provided from the claim submitted.

Loop ID	Reference	Name	Length	Notes/Comments
2100		**Claim Payment Information**		
2100	CLP01	Patient Control Number		For claims received via 837, BSC will return the data from loop 2300 CLM01. For claims received in a non-837 format, BSC will return the patient control number if included. If not included on the claim, BSC will send "0".
2100	CLP08	Facility Code Value	1-2	Will be sent when included on the claim
2100	CLP09	Claim Frequency Type Code	1	Will be sent when included on the claim
		Patient Name		
2100	NM101	Entity Identifier Code	2-3	BSC will send "QC"
2100	NM108	Identification Code Qualifier	1-2	BSC will send "MI"
2100	NM109	Patient Identifier	2-80	BSC will send the Patient Control Number
		Insured Name		
2100	NM101	Entity Identifier Code	2-3	BSC will send "IL"
2100	NM108	Identification Code Qualifier	1-2	BSC will send "MI"
2100	NM109	Subscriber Identifier	2-80	BSC will send the BSC Subscriber Number

Appendix A

Data Elements	Loop	Segment Position	Example
Allowed Amount	2400	HCP02	HCP*10*100~
Paid Amount	2430	SVD02	SVD*IPA*60~
Any other Adjudicated Amounts (Not part of balancing, only shown here as an example that CAS segments are used for non-Member Out of Pockets as well)	2430	CAS03 where CAS02, CAS05, etc. does not = 1, 2, 3, 66, 241, 247, 248	CAS*CO*45*50~
Member Out of Pockets			
Deductible	2430	CAS03 where CAS02, CAS05, etc. = 1, 66, 247	CAS*PR*1*10
Coinsurance	2430	CAS03 where CAS02, CAS05, etc. = 2, 248	CAS*PR*2*10
Copayment	2430	CAS03 where CAS02, CAS05, etc. = 3, 241	CAS*PR*3*10
Any other Patient Responsibility Amounts	2430	CAS03 where CAS01, CAS04, etc. = PR	CAS*PR*96*10

Scenario A: No member out of pocket dollars: Paid at 100% of Allowance

LX*1~
SV1*HC>88305>>>>>TISSUE EXAM BY PATHOLOGIST*3000*UN*12***1~ *[BILLED AMOUNT: $3000]*
DTP*472*D8*20200219~
REF*6R*4038349309Z1~
HCP*10*883.73~ *[ALLOWED AMOUNT: $888.73]*
SVD*IPA*883.73*HC>88305**12~ *[PAID AMOUNT: $888.73]*
CAS*CO*45*2116.27~ *[OTHER ADJUDICATED AMOUNTS: $2116.27]*
DTP*573*D8*20200318~

Scenario B: Member out of pocket: Member Out of Pocket Amounts + Paid Amount = Allowance

Variation 1: ($5 + $76.73 = $81.73)
LX*1~
SV1*HC>99214>>>>>OFFICEOUTPATIENT VISIT, EST*178.14*UN*1***1~ *[BILLED AMOUNT: $178.14]*
DTP*472*D8*20200206~
REF*6R*4038378969Z1~
HCP*10*81.73~ *[ALLOWED AMOUNT: $81.73]*
SVD*IPA*76.73*HC>99214**1~ *[PAID AMOUNT: $76.73]*
CAS*CO*45*96.41~ *[OTHER ADJUDICATED AMOUNTS: $96.41]*
CAS*PR*3*5~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAY AMOUNT: $5]*
DTP*573*D8*20200227~

Variation 2: ($222.32 + $871.47 = $ 1093.79)
LX*1~
SV1*HC>E0483>RR>KX>KJ>>HI FREQ CHST WALL AIR-PULSE GEN EA*1642.5*UN*1***1~ *[BILLED AMOUNT: $1642.5]*
DTP*472*D8*20200207~
REF*6R*403835709Z1~
HCP*10*1093.79~ *[ALLOWED AMOUNT: $1093.79]*
SVD*IPA*871.47*HC>E0483**1~ *[PAID AMOUNT: $871.47]*
CAS*OA*45*548.71~ *[OTHER ADJUDICATION AMOUNT: $548.71]*
CAS*PR*2*222.32~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COINSURANCE AMOUNT: $222.32]*
DTP*573*D8*20200228~

Appendix A (continued)

Scenario B (continued):

Variation 3: ($35 + $35 = $70)
LX*1
SV1*HC>99212*80*UN*1***1 *[BILLED AMOUNT: $80]*
DTP*472*D8*20200129
REF*6R*398877979 6Z1
HCP*10*70~ *[ALLOWED AMOUNT: $70]*
SVD*95414204477*35*HC>99212**1 *[PAID AMOUNT: $35]*
CAS*CO*45*10 *[OTHER ADJUDICATION AMOUNT: $10]*
CAS*PR*3*35 *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAYMENT AMOUNT: $35]*
DTP*573*D8*20200228

Scenario C: Service is denied, Billed Amount equals Patient Responsibility

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ *[ALLOWED AMOUNT: $0]*
SVD*002*0*HC>90691**1~ *[PAID AMOUNT: $0]*
CAS*PR*96*313~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR": $313]*
DTP*573*D8*20200228~

13. Trading Partner Information Change Summary

This section details the changes between this version and the previous version. The initial entry should start with version 1.0. Each entry should include the date of the change in mm/dd/yyyy format, a list of the section or sections changed, and a description of the change. Old entries can be removed to avoid making the table too long.

Version	Date	Section(s) changed	Change Summary
2.0	04/3/2020	837P, 837I, 837P Encounters, 837I Encounters	Added Loop 2010BA, Added Loop 2400, HCP segment, Added Appendix A
1.9	02/20/2017	Inst. and Prof	PRV Segments and REF*F8 segments
1.8	11/16/2017	6, 7 and 10	Various changes to update the companion guide
1.7	01/28/2016	All	Revised all sections. Added 835 tables
1.6	10/13/2014	837P, 837I	Updated GS03 to 940360524
1.5	5/20/2014	837P, 837I	Added 837P and 837I tables for Medicare Advantage Encounters
1.4	3/24/2014	837P, 837I	Removal of reference to Ramp Manager Update UB-92 to UB-04
1.3	1/16/2013	837P, 837I	Referring Provider Name: Self Referral
1.2	10/10/2012	837P	Encounters: BHT 2010AA 2010AB 2010BB
1.1	2/21/2012	837P	ISA11 Self Referral
1	6/25/2011		