Blue Cross and Blue Shield of Florida

Companion Document for Availity® Health Information Network Users
837 – Health Care Claim Professional
January 22, 2010

BlueCross BlueShield of Florida
Health Options®

About Availity, L.L.C. – Patients. Not paperwork.®
Availity optimizes the flow of information between health care professionals, health plans, and other health care stakeholders through a secure internet-based exchange. The Availity® Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the Web and electronic data interchange (EDI), and is HIPAA compliant. Availity is the recipient of several national and regional awards, including Consumer Directed Health Care, A.S.A.P. Alliance Innovation, eHealthcare Leadership, Northeast Florida Excellence in IT Leadership, E-Fusion, Emerging Technologies and Healthcare Innovations Excellence (TETHIE), and AstraZeneca-NMHCC Partnership. For more information, including an online demonstration, visit www.availity.com or call 1.800.AVAILITY (282.4548).

[1] Availity, L.L.C., is an independent company formed as a joint venture between Navigy, Inc., a wholly owned subsidiary of Blue Cross and Blue Shield of Florida, Inc., Health Care Service Corporation, and HUM-e-FL, Inc., a subsidiary of Humana, Inc. Blue Cross and Blue Shield of Florida has business arrangements with Availity with the goal of reducing costs in the Florida health care marketplace, simplifying provider workflow, improving patient experience and in providing HIPAA-AS compliant solutions. For more information or to register, visit Availity's website at *www.availity.com*.

837 HEALTH CARE CLAIM PROFESSIONAL

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Trading Partner Agreement Companion Document Business Requirements

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ANSI X12 Version 004010X098A1

NOTE: These instructions are to be used in addition to the implementation guide.

DATE OF REVISION	COMMENTS
09/27/2007	• Added NPI information (B1, B2, B14 & B21)
04/21/2008	• Updated NPI information (B1-B2, B13-B15 & B21)
05/14/2008	• Corrected requirement, removed the word "and" from the Payer Name (B4) • Modified Plan Code ID from 590 to 090 (B5) • Announcement of Corrected Claim Electronic Submission Capability (B10)
06/02/2008	• Corrected Plan Code ID from 090 to 590 (B5)
10/24/2008	• In the Business Requirements section, the individual references to provider identifier loops were removed and the rows were renumbered due to the addition of the NPI Companion Guide • Added NPI Companion Guide (pages 12-21) • Added Medicare Original Reference Number (B11)
11/17/2009	• Added note for the Original Reference Number when submitting corrected claims (B8) • Added verbiage for Drug Identification (B16)
01/22/2010	• Added Billing Requirements for BlueMedicareSM Non-Participating Providers 2310D Service Facility Location. Rows B11-B21 renumbered (B11)

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	GLOBAL INFORMATION			
G1	**All Segments**			Only loops, segments, and data elements valid for the 837 HIPAA-AS Implementation Guide 004010X098A1 will be used for processing.
G2	**Negative Values**			Submission of any negative values in the 837 transactions will not be processed or forwarded.
G3	**Date fields**			All dates submitted on an incoming 837-claim transaction must be a valid calendar date (not future date) in the appropriate format based on the respective implementation guide qualifier. Failure to do so will result in a rejection of the claim or transaction.
G4	**1000A Submitter EDI Contact Information** Contact Function Code Name Communication Number Qualifier Communication Number	PER01 PER02 PER03 PER04	72, 73	**PER01**- Second Iteration **IC** – Information Contact BCBSF requires submission of the above qualifier for each inbound transmission file. **PER02** BCBSF requires submission of the Vendor Company Name in this data element. **PER03** **ED** – Electronic Data Interchange Access Number. BCBSF requires submission of the above qualifier in this data element. **PER04** BCBSF requires submission of the BCBSF assigned vendor number in this data element (V####).

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	GLOBAL INFORMATION			
G5	**2010BA** Subscriber Name Qualifier Identification Code	NM108 NM109	119 Addenda 17	**NM108** **MI** – Member Identification Number BCBSF requires the submission of the above qualifier in this data element. **NM109** BCBSF requires submission of the ID number (#) exactly as it appears on the BCBS ID card **without using any embedded spaces** (this includes any out of state Blue Card ID's) including any applicable alpha prefix or suffix.
G6	**2300 Claim Supplemental Information** Paperwork **2300 Claim Note** Note /Special Instructions **2300 Ambulance Transport Information** Ambulance Certification **2300 Spinal Manipulation Service** Information Chiropractic Certification **2300 Home Health Care Plan Information** Home Health Treatment Plan Certification	Addenda 33-35 and 61-63 PWK NTE CR1 CR2 CR7	 214 246 248 251 276	At this time, BCBSF will not be utilizing information submitted in these segments for electronic claim processing.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

Trading Partner Agreement Companion Document Business Requirements

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	GLOBAL INFORMATION			
G7	**Sender ID in 1000A NM109**	NM109	67	BCBSF requires the submission of the **BCBSF assigned Sender Code** in this data element.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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ANSI X12 Version 004010X098A1

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B1	**2010BA Subscriber Demographic Information** Gender Code	DMG03	125	**F –** Female **M-** Male BCBSF prefers that either the "F" or "M" gender code be submitted. If any other gender code is submitted, this may cause processing delays.
B2	**2010BB Payer Name** Name Last or Organization	NM103	130	**Blue Cross Blue Shield of Florida** BCBSF requires the submission of the above name for this data element.
B3	**2010BB Payer Name** Qualifier Identification Code	NM108 NM109	131	**NM108** **PI –** Payer Identification. BCBSF requires submission of the above qualifier value in this data element. **NM109** **590 –** Blue Shield of Florida Plan Code ID. BCBSF of Florida requires submission of the above value for this data element for 837 Professional claims.
B4	**2000C Patient Information** Patient Hierarchical Level Patient Relationship code	PAT01	154,155	BCBSF requires submission of this data when the subscriber is not the patient.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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ANSI X12 Version 004010X098A1

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B5	**2010CA Patient Demographic Information** Gender Code	DMG03	165	**F –** Female **M-** Male BCBSF prefers that either the "F" or "M" gender code be submitted. If any other gender code is submitted, this may cause processing delays.
B6	**2300 Claim Information** Monetary Amount Line Item Charge Amount	CLM02 SV102	172 402	The total claim charge must equal the sum of all submitted line items. Failure to do so will result in claim rejection. **Note:** If whole dollar amounts are sent in monetary elements, do not include the decimal or trailing zero **(e.g. $30 = 30)**. When indicating dollars and cents, the decimal must be indicated **(e.g. $30.12 = 30.12)**.
B7	**2300 Claim Information** Facility Code Value	CLM05-1	173	**41 – Ambulance Land** **42 – Ambulance Air or Water** BCBSF defines ambulance services by place of service codes 41 and 42. When reporting ambulance services, follow implementation guide instructions.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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Blue Cross Blue Shield of Florida and Health Options, INC.

ANSI X12 Version 004010X098A1

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	BUSINESS REQUIREMENTS			
B8	**2300 Claim Information** Claim Frequency Type Code	CLM05-3	173,174 Addenda 22	**As of 5/19/08,** providers will be able to electronically submit corrected claims. **Note:** When submitting a corrected claim, the Original Reference Number (ICN/DCN) also known as the Original Claim Number is required to be sent in loop 2300 REF. (REF01 = F8 qualifier for Original Reference Number, REF02 = Original Claim Number) **0** - Non-Payment/Zero Claim **1** - Original (Admit thru Discharge Claim) **7** - Replacement (Replacement of Prior Claim) **8** - Void (Void/Cancel of Prior Claim)
B9	**2300 Health Care Code Information** Health Care Diagnosis Codes	HI	265-270	BCBSF requires that you do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.
B10	**2300 Claim Information** Health Care Diagnosis Code(s) 1-8	Hl01-2 Hl02-2 H103-2 H104-2 Hl05-2 Hl06-2 Hl07-2 Hl08-2	266,267,268,269,270	At least one (1) diagnosis code is required for all professional services. However, you may send up to 8 diagnosis codes per claim.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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ANSI X12 Version 004010X098A1

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	BUSINESS REQUIREMENTS			
B11	**2310D Service Facility Location** Entity Identifier Code Identifier Code Qualifier Identification Code	 NM101 NM108 NM109	 304 305 305	**Billing Requirements for BlueMedicare℠ Non-Participating Providers** Providers who **do not participate** in the applicable BlueMedicare network for the member, should bill as they would for a Medicare member and file the claim to BCBSF. BCBSF reimburses BlueMedicare non-participating providers the prevailing Medicare rate (less the member's cost share) for the service area in which the service is rendered for a BlueMedicare members. Standard Medicare billing requirements apply including the following: • Provider name and address • **Rendering zip code for professional claims** • Rendering zip code in the value code field for ambulance pick-up • Weight and height, in proper format, in the value code fields for dialysis services **NM101** – Use **77** qualifier to indicate Service Location. **NM108** - Use **XX** qualifier to indicate National Provider Identifier. **NM109** – Submit your office's NPI value
	Service Facility Location City/State/Zip Postal Code	N403	309	**N403** – Submit your office's 9-digit zip code
B12	**2320 Other Subscriber Information** Claim Filing Indicator Code	SBR09	321-322	**SBR09**- Use **MB** qualifier to indicate Medicare Part B as the other payer.
	2330B Other Payer Secondary Identifier Medicare's Original Reference Number	REF01 REF02	368-369	**REF01**- Reference Identification Qualifier

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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	BUSINESS REQUIREMENTS			
				F8 – Original Reference Number Use to indicate Medicare's claim number for this claim **REF02** - Reference Identification Please submit the Medicare ICN also known as the Original Reference Number.
B13	**2400 Product Service ID** Product/Service ID Qualifier Product/Service ID	SV101-1 SV101-2	400,401 Addenda 54 - 57	**HC** – Health Care Financing Administration Common Procedural Coding System (HCPCS). BCBSF requires submission of the above qualifier for processing. ***Note*:** Procedures and modifiers beginning with W, X, Y & Z are invalid for BCBSF, and use of these will result in the claim being rejected.
B14	**2400 Professional Service – Service Line** Procedure Modifier(s) 1-4	SV101-3 SV101-4 SV101-5 SV101-6	401,402	Please submit the appropriate modifiers in priority order. At this time, BCBSF will only use the first modifier submitted for processing.
B15	**2400 Professional Service (Service Line)** Unit or Basis for Measurement Code	SV103 SV104	403	**MJ** – Minutes **UN** – Units _____ **F2** – Is not a valid qualifier for BCBSF processing. **MJ** – BCBSF requires total minutes for anesthesia services. **UN** - Should be used for all other services.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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ANSI X12 Version 004010X098A1

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	BUSINESS REQUIREMENTS			
B16	**2400 Claim Information** Professional Service – Service Line Diagnosis Code Pointer	SV107-1 Required SV107-2-4 Situational	405	Each service line must point to the appropriate diagnosis for that service.
B17	**2410 Drug Identification**	LIN CTP	Addenda 71-76	**DME Providers** Effective July 2007, DME Providers will be required to submit the CTP segment in addition to the LIN segment when billing unlisted drug codes. **All Providers (except Specialty Pharmacy Providers – T9XXX*)** Effective November 8, 2009, all providers will be required to submit the National Drug Code (NDC) in the LIN segment and the NDC Quantity (in the SV1 segment or the CTP segment) when billing unlisted drug codes. The NDC Quantity should be submitted in the CTP segment. However, if your electronic format has not been upgraded to send the NDC Quantity in the CTP segment, BCBSF will ensure the NDC Quantity is populated correctly using the value sent in the HCPCS units. This was done to allow time for electronic senders to upgrade the electronic transaction format and to accommodate electronic senders who do not have the capability of sending both the HCPCS units and the NDC Quantity. *Specialty Pharmacy providers must submit the NDC Quantity in the CTP segment.
B18	**Coordination of Benefits (COB) Balancing**	2300 2320	170 332	Within each Professional claim loop (2300 CLM loop), the sum of the amounts in each 2320 AMT02 elements for Coordination of Benefits Payer Paid Amount (where AMT01= 'D' must equal the sum of the amounts in the corresponding SVD02 elements (loop 2430) for that payer id (identified in SVD01).

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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	BUSINESS REQUIREMENTS			
B19	**2320 Coordination of Benefits (COB) Allowed Amount**	AMT01 AMT02	334	BCBSF requests that this information be provided to facilitate claims processing.
B20	**2320 Medicare Outpatient Adjudication Information**	MOA	347 - 349	BCBSF requests that this information be provided to facilitate claims processing.
B21	**2330B Other Payer Name**	NM108	359 - 361	BCBSF requests that the "PI" qualifier and the National Association of Insurance Commissioners (NAIC) code until the Health Care Financing Administration Plan ID is implemented.

837 HEALTH CARE CLAIM PROFESSIONAL

AVAILITY

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Tips for Sending Coordination of Benefits Information on Electronic Claims
837 Professional Health Care Claims

When Blue Cross and Blue Shield of Florida (BCBSF) is secondary, please remember to include coordination of benefits (COB) data on your claim as outlined below. All HIPAA mandated fields are required. The business requirements and corresponding 837 fields listed below are necessary to process COB information on BCBSF claims.

R=Required S=Situational	837 Fields	Business Requirement
S	Loop 2320 CAS 01-19, as needed	Submission of other insurance payment information requires claim adjustment group codes and associated monetary amounts. Please be sure to submit any differences between the paid and charge amounts in the CAS segments. BCBSF requires the CAS segments and the AMT segments equal the charge amount.
R	Loop 2320 AMT 02, Qualifiers: D - Payer Amount Paid AAE - Approved Amount B6 - Allowed-Actual F2 - Patient Responsibility, Actual AU - Coverage Amount D8 - Discount Amount DY - Per Day Limit	When BCBSF is secondary, submit the primary insurer payment information to support correct processing of COB information.
R	• Loop 2430 CAS segments • Loop 2430 SVD 02	When Medicare is primary and BCBSF is secondary, BCBSF requires: All line level adjustment reason codes & Payment amounts.

Last Revision of Tips Document - September 2007

NPI Companion Guide

Field	Locator	
Primary Identifier Qualifier	NM108	Key “XX” for NPI submission.
Primary Identifier	NM109	Key 10-digit NPI. Tax Identification number or SSN will be required in the REF segment when NPI is reported in NM109 locator.
Secondary Identifier Qualifier	REF01	Key “EI” (Tax Identification) or “SY” [Social Security Number (SSN)]
Secondary Identifier	REF02	Key your provider Tax ID or SSN
Secondary Identifier Qualifier (New REF Segment)	REF01	Optional: Key “1B” or “1A” 1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
Secondary Identifier	REF02	Optional: Your current provider identification number (Legacy ID).

Listed below are the loop IDs, loop names, element and segment details used for submitting NPI information. This is reference information. It does not replace the American National Standards Institute (ANSI) X12N 837 professional or institutional implementation guides, companion documents or trading partner agreements.

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2000A Billing/Pay-To Provider Specialty Information	**S**	**S**	PRV01	BI = Billing or PT = Pay-To
(837P) *Required if the Rendering Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.* **(837I)** *Required if the Service Facility Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Service Facility Provider is being identified at this level for all subsequent claims in this HL batch and Loop ID-2310E is not used. If the Billing or Pay-to Provider is also the Service Facility Provider, and Loop 2310E is not used, this PRV segment is required.*	R	R	PRV02	ZZ
	R	R	PRV03 **TIP:** If multiple provider numbers share a NPI and/or Tax ID, the submission of the taxonomy (specialty) is useful for identifying the correct provider.	Provider Taxonomy Code
2010AA Billing Provider	**R**	**R**	NM101	85
Required	R	R	NM108	XX
	R	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2010AB Pay-To-Provider	**S**	**S**	NM101	87
Required if the pay-to-provider is different than the billing provider	R	R	NM108	XX
	R	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#
2310A Referring Provider (837P) / Attending Physician (837I)	**S**	**S**	NM101	837P use DN, 837I use 71
(837P) *Required if claim involved a referral. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.* **(837I)** *Required on all inpatient claims or encounters. Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.*	S	R	NM108	XX
	S	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2310B Rendering Provider (837P) / Operating Physician (837I)	**S**	**S**	NM101	837P use 82, 837I use 72
(837P) *Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.* **(837I)** *This segment is required when any surgical procedure code is listed on this claim. Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.*	R	R	NM108	XX
	R	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#
2310B Specialty Information - Rendering Provider (837P) / Operating Physician (837I)	**S**	**S**	PRV01	PE
The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.	R	R	PRV02	ZZ
	R	R	PRV03 **TIP:** If multiple provider numbers share an NPI and/or Tax ID, the submission of the taxonomy (specialty) is useful for identifying the correct provider.	Provider Taxonomy Code

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2310C Purchased Service Provider (837P) / Other Provider (837I)	**S**	**S**	NM101	837P use QB, 837I use 73
(837P) *Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.* **(837I)** *Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) that rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here. Required when the Other Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider in the 2010AA/AB loops. Required on non-outpatient (e.g. inpatient, SNF, ICF etc.) claims or encounters to indicate the physician who rendered service for the principal procedure if other than the operating physician reported in Loop 2310B. Not required on non-outpatient claims or encounters if no principal procedure was performed. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.*	S	R	NM108	XX
	S	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2310D Service Facility Location (837P)	**S**	**N/A**	NM101	837P use 77, FA or LI *77 = Service Location* *FA = Facility* *LI = Independent Lab*
(837P) *This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.* **(837I)** *This loop was deleted in the Addenda*	S		NM108	XX
	S		NM109	NPI
	S			
	R		REF01= TJ	TJ
	R		REF02= EIN	Tax ID
	O		REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O		REF02= Legacy Provider #	Your Current Provider ID#
2310E Supervising Provider (837P) / Service Facility (837I)	**S**	**S**	NM101	837P use DQ, 837I use FA
(837P) *Required when the rendering provider is supervised by a physician. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.* **(837I)** *This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.*	S	S	NM108	XX
	S	S	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY (837P), EI (837I)	EI or SY (837P), EI (837I)
	R	R	REF02= EIN or SSN (837P) or EIN (837I)	Tax ID or SSN (837P) Tax ID (837I)
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2420A Rendering Provider (837P) / Attending Physician (837I)	**S**	**S**	NM101	837P use 82, 837I use 71
***(837P)** Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.* ***(837I)** Required if the Attending Provider NM1 information is different than that carried in the 2310A (claim) loop.*	R	R	NM108	XX
	R	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#
2420B Purchased Service Provider (837P) / Operating Physician (837I)	**S**	**S**	NM101	837P use QB, 837I use 72
***(837P)** Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations.* ***(837I)** Required if the Operating Physician NM1 information is different than that carried in the 2310B (claim) loop.*	S	R	NM108	XX
	S	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2420C Service Facility Location (837P) / Other Provider (837I)	**S**	**S**	NM101	837I use 73 837P use 77, FA, LI or TL *77 = Service Location* *FA = Facility* *LI = Independent Lab* *TL = Testing Laboratory*
(837P) *Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB (Pay-to Provider), or 2310D Service Facility Location loops.* **(837I)** *Required if the Other Provider NM1 information is different than that carried in the 2310C (claim) loop. Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) that rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here. Required on non-outpatient (e.g. Inpatient, SNF, ICF, etc) claims or encounters to indicate the physician who rendered the service for the principal procedure if other than the operating physician reported in Loop ID-2420B.*	S	R	NM108	XX
	S	R	NM109	NPI
	S	**S**		
	R	R	REF01= EI or SY	EI or SY
	R	R	REF02= EIN or SSN	Tax ID or SSN
	O	O	REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O	O	REF02= Legacy Provider #	Your Current Provider ID#
2420D Supervising Provider (837P)	**S**	**N/A**	NM101	837P use DQ
(837P) *Required when rendering provider is supervised by a physician and the supervising physician is different than that listed at the claim level for this service line.* **(837I)** *This loop was deleted in the Addenda*	S		NM108	XX
	S		NM109	NPI
	S			
	R		REF01= EI or SY	EI or SY
	R		REF02= EIN or SSN	Tax ID or SSN
	O		REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O		REF02= Legacy Provider #	Your Current Provider ID#

Loop ID	Professional 837 P R = Required S = Situational O = Optional	Institutional 837 I R = Required S = Situational O = Optional	Reference	Qualifiers / Identifiers
2420E Ordering Provider (837P)	**S**	**N/A**	NM101	DK
Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line.	S		NM108	XX
	S		NM109	NPI
	S			
	R		REF01= EI or SY	EI or SY
	R		REF02= EIN or SSN	Tax ID or SSN
	O		REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O		REF02= Legacy Provider #	Your Current Provider ID#
2420F Referring Provider (837P)	**S**	**N/A**	NM101	DN
Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A).	S		NM108	XX
	S		NM109	NPI
	S			
	R		REF01= EI or SY	EI or SY
	R		REF02= EIN or SSN	Tax ID or SSN
	O		REF01= 1B or 1A	1B (Professional BCBSF #) or 1A (Institutional BCBSF #)
	O		REF02= Legacy Provider #	Your Current Provider ID#

Helpful Hints

BCBSF Billing Instructions	Visit www.bcbsfl.com, click on Physicians & Providers, Tools & Resources and Manuals & Billing Instructions to locate the Manual for Physicians and Providers.
Register your National Provider Identifier (NPI) with BCBSF	Visit to www.bcbsfl.com, click on Physicians & Providers, Tools & Resources, Forms and select the National Provider Identifier (NPI) Notification Form. ***Type-1 Individual NPI*** If you are contracted with BCBSF as an individual provider, please register and use your Type-1 Individual NPI. ***Type-2 Organization NPI*** If you are contracted with BCBSF as a group, please register and use your Type-2 Organization NPI.
Billing with your National Provider Identifier (NPI) with BCBSF	***Type-1 Individual NPI*** If you are submitting your Type-1 Individual NPI in the NM1 segment, please submit your Individual Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) in the corresponding REF segment. ***Type-2 Organization NPI*** If you are submitting your Type-2 Organization NPI in the NM1 segment, please submit your Employer Identification Number (EIN) or Tax Identification Number (TIN) in the corresponding REF segment.
1500 Health Insurance Claim Form NUCC Instruction Manual	Visit www.nucc.org, under 1500 Claim Form, click on 1500 Instructions then click on the current version of the instructions.
UB04 Claim Form Information	Visit www.nubc.org. The Official UB-04 Data Specifications Manual is available for subscribers. Additional information can be found under Other Resources.
National Plan and Provider Enumeration System (NPPES)	Visit https://nppes.cms.hhs.gov to apply for a National Provider Identifier (NPI), search the NPI Registry and locate additional information resources.