Blue Cross and Blue Shield of Florida

Companion Document for Availity® Health Information Network Users
837 – Health Care Claim Institutional
November 17, 2009

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 INSTITUTIONAL
AVAILITY
Trading Partner Agreement Companion Document Business Requirements
Blue Cross Blue Shield of Florida and Health Options, INC.
ANSI X12 Version 004010X096A1

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

DATE OF REVISION	COMMENTS
07/12/2007	• Added NPI information (B1-B2)
04/21/2008	• Updated NPI information (B1-B2)
05/14/2008	• Corrected requirement, removed the word "and" from the Payer Name (B4) • Announcement of Corrected Claim Electronic Submission Capability (B8)
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 14-23) • Added Medicare Original Reference Number (B16) • Added Present on Admission (B10)
11/17/2009	• Revised verbiage for Principle Procedure and Other Procedure Information (B13-B14) • Added note for the Original Reference Number when submitting corrected claims (B6)

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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 004010X096A1 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. ***Note:*** *Services that span years, must not be submitted within one claim.*

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	GLOBAL INFORMATION			
G4	**1000A Submitter EDI Contact Information** Contact Function Code Name Communication Number Qualifier Communication Number	PER01 PER02 PER03 PER04	65	**PER01** **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####).
G5	**2010BA** Subscriber Name Qualifier Identification Code	NM108 NM109	110	**NM108** **MI** – Member Identification Number BCBSF requests the submission of the above qualifier in this data field. **NM109** BCBSF requires the 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.

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	GLOBAL INFORMATION			
G6	**2300 Claim Supplemental Information** Paperwork **2300 Claim Note** Note /Special Instructions Billing Note **2300 Home Health Care Information** Home Health Care Certification **2305 Home Heath Care Plan Information** Home Health Treatment Plan Certification	PWK NTE CR6 CR7	173 205, 208 210 314	At this time, BCBSF will not be utilizing information submitted in these segments for electronic claim processing.
G7	**Sender ID in 1000A NM109**	NM109	61	BCBSF requires the submission of the BCBSF assigned Sender Code in this data element.

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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	116	**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	122	**Blue Cross Blue Shield of Florida** _____ BCBSF requires the submission of the above name in this data element.
B3	**2010BC Payer Name** Qualifier Identification Code	NM108 NM109	127,128	**NM108** **PI –** Payer Identification BCBSF requires submission of the above qualifier value in this field. **NM109** **090 –** Blue Cross of Florida Plan Code ID. BCBSF of Florida requires submission of the above value in this data field for 837 Institutional claims.
B4	**2010CA Patient Demographic Information** Gender Code	DMG03	152	**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.

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	BUSINESS REQUIREMENTS			
B5	**2300 Claim Information** Monetary Amount Line Item Charge Amount	CLM02 SV203	159 448	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)**.
B6	**2300 Claim Information** Claim Frequency Type	CLM05-3	159	**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 should be sent in loop 2300 REF. (REF01 = F8 qualifier for Original Reference Number, REF02 = Original Claim Number) **Inpatient** Values 0, 1, 5, 7 or 8 will be processed by BCBSF *Exception:* Values 0 – 5 or 7 - 9 will be processed by BCBSF for bill types that begin with a 2 or 8. **Outpatient** Values 0 – 5 or 7 - 9 will be processed by BCBSF. Non-Payment/Zero Claim = 0 Admit thru Discharge Claim = 1 Interim - First Claim = 2 Interim - Continuing Claim = 3 Interim - Last Claim = 4 Late Charge(s) = 5

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
				Replacement of Prior Claim = 7 Void/Cancel of Prior Claim = 8 Reserved for National Assignment = 9
B7	**2300 Claim Information** Explanation of Benefits Indicator	CLM18	163	Although the 837 allows for request of a paper EOB (explanation of benefits) on a per claim basis, BCBSF has not adopted this practice and this data will not be forwarded for processing. If the Trading Partner is on file for receipt of an 835, an electronic remittance advice will be sent regardless of the presence of this indicator. BCBSF requires Trading Partner Agreements be on file indicating all electronic transactions the Trading Partner will participate in.
B8	**2300 Admission Date/Hour** Date Time Period Format Qualifier	DTP02	169	**CCYYMMDDHHMM** Admission minutes are now required for Inpatient admissions in the 837 Institutional Implementation Guide for HIPAA-AS claims transactions**.** You should provide the minutes if known, if not default to 00.
B9	**2300 Institutional Claim Code Claim Information** Patient Status Code	CL103	172	Patient Status code required for all inpatient institutional claims.
B10	**2300 File Information** Present on Admission Indicator	K301	204	According to section 5001(c) of the 2005 Deficit Reduction Act, for **discharges occurring on or after October 1, 2008**, inpatient hospitals (type of bill 11X) are required to submit a present on admission (POA) indicator for all primary and secondary diagnosis codes submitted on inpatient hospital claims. Using the ASC X12N 837 Institutional (837I), submit the POA in the segment K3 in the 2300 loop, data element K301. In order to identify this information and map it to the appropriate diagnosis code, the string should begin with POA, contain the

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	BUSINESS REQUIREMENTS			
				corresponding number of POA indicators as there are diagnosis codes and the string should end with a "Z" or an "X" depending on whether or not the inpatient hospital is included or excluded as defined by Medicare. Included hospitals submit the loop ending in a "Z" and excluded hospitals submit the loop ending in an "X". For example, the following is the K3 segment for a claim with one primary and four secondary diagnosis codes, five in total, submitted from an included hospital: "POAYYNU1Z". The valid POA values are: • Y – Yes, diagnosis present at the time of admission • N – No, diagnosis was not present at the time of admission • U – Unknown, documentation is not sufficient to determine if condition was present at the time of admission • W – Clinically undetermined, unable to clinically determine if the condition was present at the time of admission • 1 – Exempt from POA reporting, this only applies to those diagnosis codes that have been identified in the ICD 9-CM Official Guidelines for Coding and Reporting, section II. This code is the equivalent of a blank on the UB04, however, it was determined blanks were undesirable for electronic submissions. **Claims will be returned if** the POA indicator is invalid (not one of the 5 values above, if the POA is missing from a hospital acquired condition (HAC) or if the number of POA indicators does not match the number of diagnosis codes reporting on the 837I transaction.
B11	**2300 Health Care Code Information** Health Care Diagnosis Codes	HI	227	BCBSF requires that you do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

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	BUSINESS REQUIREMENTS			
B12	**2300 Health Care Code Information** Health Care Diagnosis Codes	HI01-1 Principle HI02 - Admitting HI03- E-Code	227,228	Use **BK** qualifier for Principal diagnosis Use **BJ** qualifier for Admitting diagnosis Use **BN** qualifier for E-code.
B13	**2300 Principle Procedure Information** Code List Qualifier	HI01-1	242	**BR** – ICD9-CM Required on inpatient claims or encounters when a procedure was performed.
B14	**2300 Other Procedure Information** Code List Qualifier Code	HI01 – HI12	244 – 254	**BQ** – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure. Required on inpatient claims or encounters when additional procedures must be reported.
B15	**2300 Claim Quantity** Quantity Qualifier Code Quantity	QTY01 QTY02	306,307	This segment is required for all inpatient claims.
B16	**2320 Other Subscriber Information** Claim Filing Indicator Code **2300 Original Reference Number (ICN/DCN)** **Note:** When submitting a corrected claim, the Original Reference Number (ICN/DCN) also known as the Original Claim Number should be sent.	SBR09 REF01 REF02	363-364 191-192	**SBR09-** Use **MA** qualifier to indicate Medicare Part A as the other payer. Use **MB** qualifier to indicate Medicare Part B as the other payer. **REF01**- Reference Identification Qualifier **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.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B17	**2400 Service Line Number** Assigned Number	LX01	444	For Institutional claims BCBSF will **only allow and process 450 service lines per claim**. Claims greater than 450 service lines will be rejected.
B18	**Coordination of Benefits (COB) Balancing**	2430 Loops	490	Within each Institutional claim loop (2300 CLM loop), the sum of the amounts in each 2320 AMT02 elements for Coordination of Benefits Payer Paid Amount (where AMT01='C4' or 'N1') must equal the sum of the amounts in the corresponding SVD02 elements (loop 2430) for that payer id (identified in SVD01).
B19	**2320 Coordination of Benefits (COB) Total Allowed Amount**	AMT01 AMT02	372	BCBSF requests that this information be provided to facilitate claims processing.
B20	**2320 Medicare Inpatient Adjudication Information**	MIA	392 - 396	BCBSF requests that this information be provided to facilitate claims processing.
B21	**2320 Medicare Outpatient Adjudication Information**	MOA	397 - 399	BCBSF requests that this information be provided to facilitate claims processing.
B22	**2330B Other Payer Name**	NM108	410 - 411	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.

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Tips for Sending Coordination of Benefits Information on Electronic Claims
837 Institutional 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 information is required. The business requirements and corresponding 837 elements listed below are necessary to process COB information on BCBSF claims.

NOTE: When the charges, payment amount, deductible, coinsurance, co-pay or adjustment is zero, the AMT or CAS segment must still be submitted. Indicate the zero amounts as "0".

R=Required S=Situational	837 Fields	Business Requirement
R	Total Charges	Loop 2300 CLM02 or 2320 AMT01 = T3, AMT02 = Total Charges
R	Allowed Amount	Loop 2320 AMT01 = B6, AMT02 = Allowed Amount
R	Paid Amount	Loop 2320 AMT01 = C4 (Prior Payment – Actual) or Loop 2320 AMT01 = N1 (Net Worth for Total Medicare Paid Amount)
S	Total Non-covered Amount	Loop 2320, AMT01 = A8, AMT02 = Non-covered Amount
S	Total Denied Amount	Loop 2320, AMT01 = YT, AMT02 = Denied Amount
S	Medicare Paid Amount 100%	Loop 2320, AMT01 = KF, AMT02 = Paid Amount
S	Medicare Paid Amount 80%	Loop 2320, AMT01 = PG, AMT02 = Paid Amount
S	Diagnostic Related Group (DRG) Outlier Amount	Loop 2320, AMT01 = ZZ, AMT02 = Outlier Amount

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S	Contractual Adjustment	Loop 2320, CAS01 = CO or CAS02 = 42 or A2, CAS03 = Adjustment Amount
R	Patient Responsibility	Loop 2320, CAS01 = PR and CAS02 = 1–Deductible, 2–Coinsurance, 3–Copay, CAS03 = Amount Or Loop 2430, CAS01 = PR and CAS02 = 1–Deductible, 2–Coinsurance, 3–Copay, CAS03 = Amount Or Loop 2300 HI01-1 = BE, HI01-2 = Value Code (A1- Deductible, A2 – Coinsurance and A7 – Copay) and HI01-5 = Amount *Note: The first value code will be reported as HI01, the second will be HI02 and will continue up to 12 value codes.
S	Medicare Denial Codes	Loop 2320, CAS01 = OA, CAS02 = Adjustment Reason Code, CAS03 = Adjustment Amount
S	Medicare Inpatient Adjudication Information	Used to submit Medicare Remittance Remarks Codes. Refer to Implementation Guide, pages 392-396 for details.
S	Medicare Outpatient Adjudication Information	Used to submit Medicare Remittance Remarks Codes. Refer to Implementation Guide, pages 397-399 for details.
S	Medicare ICN	Loop 2330B, REF01 = F8, REF02 = Medicare Internal Control Number or Original Reference Number

Last Revision of Tips Document - April 2007

BlueCross BlueShield of Florida
Health Options®

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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.