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# **Electronic Transaction Manual for UniCare Institutional Claims**

HIPAA Transaction with NPI  
Standard Companion Guide  
Section 2

**Refers to the X12N Implementation Guide  
004010X096A1:  
837 – Health Care Claim – Institutional**

**Companion Guide Version Number: 5.0**

## Preface

This Companion Document to the ASCX12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with UNICARE. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both the 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.

## 1 NPI Implementation

For your convenience, UniCare has provided a timeline that illustrates our NPI approach going forward. We have designed the information in a portable and easy to read format.

<b>HIPAA Standard Electronic Claims – 837 Professional, Institutional, and Dental Claims</b>			
	<b>Dual Receipt Period</b> (Now through 05/22/07)	<b>Contingency Period</b> (05/23/07 – 05/22/08)	<b>Full Implementation</b> (Post 05/23/08)
<b>Provider submits a transaction with...</b>			(A notification will be sent 60 days before requiring the use of NPI only on transactions)
Legacy ID Only (Provider License# or Medicare ID or APIN)	Accept Transaction	Accept Transaction	Reject Transaction
NPI & Legacy ID (Provider License# or Medicare ID or APIN)	Accept Transaction (Dual Receipt)	Accept Transaction (NPI must be in primary loops)	Reject Transaction
NPI Only	Reject (unless testing is completed with EDI area)	Accept Transaction (NPI must be registered with us)	Accept Transaction

### **Don't forget to Register NPI's with UniCare\***

Registering your NPI(s) with us helps to ensure a seamless conversion to NPI, and minimizes any potential payment disruptions. Register your NPI(s) on our NPI Registration web site located at <https://npi.wellpoint.com>. For provider offices with many NPI's, a bulk submission process is available and instructions can be found on our NPI Registration web site.

\*If you have already registered your NPI, thank you.

If you haven't already, we recommend that you apply for your NPI as soon as possible in order to comply with this claims submission process change. For more information on applying and obtaining an NPI, please visit the Centers for Medicare and Medicaid Services (CMS) Web site at <https://nppes.cms.hhs.gov>.

## 2 Introduction

The following table describes the requirements and recommendations of implementing an 837 4010 Addenda (X096A) file specification to submission for UNICARE Institutional Claims.

Pages listed are from the May 2000 implementation guides with addenda pages in parenthesis if applicable.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
B.3	Header	ISA	Interchange Control Header			
B.4	Header	ISA05	Interchange ID Qualifier	ZZ		
B.4	Header	ISA07	Interchange ID Qualifier	ZZ		
B.5	Header	ISA08	Receiver ID			Receiver ID should be 'UNICARE'
B.8 (48)	Header	GS	Function Group Header			
B.8 (48)	Header	GS03	Application Receiver's Code			Send 'UNICARE'
B.9 (49)	Header	GS08	Version/Release/Industry Identifier Code			Send '004010X096A1'
57	Header	BHT	Transaction Set Header			
59	Header	BHT06	Transaction Type Code	CH		This value is required to indicate that the batch contains all claims.
60 (11)	Header	REF	Transmission Type ID			
60 (11)	Header	REF02	Functional Category			Send '004010X096A1'
61	1000A	NM1	Submitter Name			
63	1000A	NM109	Submitter ID		20	Submitter ID same as GS02
67	1000B	NM1	Receiver Name			
68	1000B	NM103	Receiver Name			Send 'UNICARE'
69	1000B	NM109	Receiver Payer ID		20	Send '80314'
71 (12)	2000A	PRV	Provider Information			This segment is not required
76	2010AA	NM1	Billing Provider Name			
77	2010AA	NM102	Billing Provider Type Qualifier	2		Required
77	2010AA	NM108	Billing Provider ID code qualifier	24 XX		<p>"24" indicates Employer's Identification Number</p> <p>"XX" Health Care Financing Administration National Provider Identifier</p> <p>*If XX is used, then either the Employer's Identification Number or Social Security Number of the provider must be carried in the REF in this loop</p>
82	2010AA	REF	Billing Provider Secondary ID			
	2010AA	REF01	Reference Identification Qualifier	1C 1D G2		<p>"1C" indicates Medicare Provider Number.</p> <p>"1D" indicates Medicaid Number</p>

				EI SY		<p><b>"G2"</b> APIN  <b>"EI"</b> indicates Employer's Identification Number  <b>"SY"</b> indicates Social Security Number</p> <p>*As of May 23, 2008 NPI will require either the Employer's Identification Number (EI) or Social Security Number (SY) to be carried in this segment.</p>
	2010AA	REF02	Reference Identification			(Billing Provider Additional Identifier)
101	2000B	SBR	Subscriber Information			
102	2000B	SBR01	Payer Responsibility Sequence Code	S, T		If values of 'S' or 'T' are sent it is recommended that the corresponding 2320 and 2330 loops containing the COB adjudication information are sent along with the claim. Absence of this data will delay processing of the claim.
102	2000B	SBR03	Group Number		10	This field is required. The group number on the card or from eligibility check should be submitted. If group number is unknown, '999999' may be submitted.
108	2010BA	NM1	Subscriber Name			
109	2010BA	NM102	Entity Type Qualifier	1		A value of '2' is not applicable
110	2010BA	NM108	Identification Code Qualifier	MI		Required
110	2010BA	NM109	Subscriber Member ID		20	Required. Subscriber ID will be between 9 and 15 bytes, however to allow for future expansion, we recommend your internal software supports 20 bytes.
126	2010BC	NM1	Payer Name			
127	2010BC	NM103	Payer Name			Send 'UNICARE'
128	2010BC	NM109	Payer ID			Send '80314'
187	2300	REF	Claim ID for Clearinghouses and other Transmission Intermediaries			
188	2300	REF01	Claim Number Qualifier	D9		
188	2300	REF02	Clearinghouse Trace Number		15	If a clearinghouse trace number is submitted it will be returned on the Level 2 report in the Clearinghouse ID column
365	2320	CAS	Claim Level Adjustments			Multiple Adjustments should be sent as they apply on COB claims. COB claims submitted without other payer

						adjudication information will delay the processing of the claim
367	2320	CAS02, 5, etc	Claim Adjustment Reason Code	1		A code of '1' should be sent in the CAS02, 05 etc when there is a Deductible amount. The corresponding amount should be sent in CAS03, 06 etc.
367	2320	CAS02, 5, etc	Claim Adjustment Reason Code	2		A code of '2' should be sent in the CAS02, 05 etc when there is a Coinsurance amount. The corresponding amount should be sent in CAS03, 06 etc.
367	2320	CAS02, 5, etc	Claim Adjustment Reason Code			Other adjustments reason codes should be sent if they apply with the corresponding amounts in CAS03, 06 etc.
371	2320	AMT	COB Prior Payment Amount			
371	2320	AMT01	Prior Payment--Acual Qualifier code	C4		This should be sent with the corresponding amount in AMT02 when it applies. This is the amount the other payer has paid to the provider on this claim. COB claims submitted without other payer adjudication information will delay the processing of the claim.
372	2320	AMT	COB Allowed Amount			
372	2320	AMT01	Allowed Amount Qualifier code	B6		This should be sent with the corresponding amount in AMT02 when it applies. COB claims submitted without other payer adjudication information will delay the processing of the claim.
386	2320	AMT	COB Non-Covered Amount			
386	2320	AMT01	Non-Covered Amount Qualifier code	A8		This should be sent with the corresponding amount in AMT02 when it applies. This would be the amount the other payer deemed as disallowed or not a covered benefit. COB claims submitted without other payer adjudication information will delay the processing of the claim.
387	2320	AMT	COB Total Denied Amount			
387	2320	AMT01	Total Denied Amount Qualifier code	YT		This should be sent with the corresponding amount in

						AMT02 when it applies. This would be the amount the other payer identified as exceeding existing benefits. COB claims submitted without other payer adjudication information will delay the processing of the claim.
415	2330B	DTP	Claim Adjudication Date			
415	2330B	DTP	Claim Adjudication Date Qualifier	573		The Claim Adjudication Date Qualifier should be sent along with the adjudication or payment date of the claim in DTP03. COB claims submitted without other payer adjudication information will delay the processing of the claim.
445	2400	SV2	Institutional Service Line			
446 (24)	2400	SV202	Composite Medical Procedure Identifier			Required on outpatient claims when an appropriate code exists
446 (24)	2400	SV201-1	Product/Service ID Qualifier	HC		Required
448	2400	SV204	Units or Basis for Measurement Code	DA, UN		Required
449	2400	SV205	Service Unit Count		9	

# Addendum

## NPI and Taxonomy Codes

In order to make the use of the National Provider Identifier (NPI) as seamless as possible, providers should follow the instructions as outlined in HIPAA Implementation Guides and Anthem Central Regions Companion documents as it describes usage of the National Provider Identifier (NPI), UniCare Legacy Provider Identifier, and Taxonomy codes. It is strongly recommended when submitting claims with NPI to also include the Taxonomy code for: UniCare.

### Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are alphanumeric and are 10 positions in length. These codes are not “assigned” to health care providers; rather, health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

Refer to the CMS website for a listing of Taxonomy codes at: [www.wpc-edi.com/taxonomy](http://www.wpc-edi.com/taxonomy).

<p><b><u>837I – Institutional Claims</u></b></p> <p>For 837I Institutional claims the taxonomy should be populated in Loops 2000A and 2310A PRV segment for all applicable claims that you are filing.</p> <p><b>PRV loop 2000A</b> Billing/Pay-to <b>PRV01</b> = Provider Code BI – Billing Provider Specialty Information PT= Pay to Provider Specialty Information <b>PRV02 = ZZ</b> is used to indicate the “Health Care Provider Taxonomy” code <b>PRV03</b> = Reference Identification (<b>ProviderTaxonomy Code</b>) Strongly recommended to include a taxonomy on all applicable claims that you are filing (<b>NOTE</b> to Clearinghouses – DO NOT USE Defaults)</p> <p><b>Example:</b> <b>PRV*BI*ZZ*203BA0200N~</b></p> <p><b>PRV loop 2310A</b> Attending Provider</p>	<p><b><u>837P – Professional Claims</u></b></p> <p>For 837P Professional claims the taxonomy should be populated in Loops 2000A and 2310B PRV segment for all applicable claims that you are filing.</p> <p><b>PRV loop 2000A</b> Billing/Pay-to <b>PRV01</b> = Provider Code BI – Billing Provider Specialty Information PT= Pay to Provider Specialty Information <b>PRV02 = ZZ</b> is used to indicate the “Health Care Provider Taxonomy” code <b>PRV03</b> = Reference Identification (<b>ProviderTaxonomy Code</b>) Strongly recommended to include a taxonomy on all applicable claims that you are filing (<b>NOTE</b> to Clearinghouses – DO NOT USE Defaults)</p> <p><b>Example:</b> <b>PRV*BI*ZZ*203BA050N~</b></p> <p><b>PRV loop 2310B</b> Rendering Provider</p>
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<p><b>PRV01</b> = Provider Code AT – Attending Provider Specialty Information</p> <p><b>PRV02 = ZZ</b> is used to indicate the “Health Care Provider Taxonomy” code</p> <p><b>PRV03</b> = Reference Identification (<b>ProviderTaxonomy Code</b>)</p> <p>Strongly recommended to include a taxonomy on all applicable claims that you are filing (<b>NOTE</b> to Clearinghouses – DO NOT USE Defaults)</p> <p><b>Example:</b> <b>PRV*AT*ZZ*363LP0200N~</b></p>	<p><b>PRV01</b> = Provider Code PE – Performing Provider Specialty Information</p> <p><b>PRV02 = ZZ</b> is used to indicate the “Health Care Provider Taxonomy” code</p> <p><b>PRV03</b> = Reference Identification (<b>ProviderTaxonomy Code</b>)</p> <p>Strongly recommended to include a taxonomy on all applicable claims that you are filing (<b>NOTE</b> to Clearinghouses – DO NOT USE Defaults)</p> <p><b>Example:</b> <b>PRV*PE*ZZ*203BA0200N~</b></p>
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