
Electronic Transaction Manual for UNICARE Dental Claims

HIPAA Transaction with NPI
Standard Companion Guide
Section 2

**Refers to the X12N Implementation Guide
004010X097A1: 837 – Health Care Claim –
Dental**

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.

HIPAA Standard Electronic Claims – 837 Professional, Institutional, and Dental Claims			
	Dual Receipt Period (Now through 05/22/07)	Contingency Period (05/23/07 – 05/22/08)	Full Implementation (Post 05/23/08)
Provider submits a transaction with...			(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 (X097A) file specification to submission for UNICARE Dental 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.5	Header	ISA08	Receiver ID			Receiver ID should be 'UNICARE'
B.7	Header	ISA14	Acknowledgment Request			To receive a 997, please request it from us, we will not process this field to determine whether or not a 997 should be returned.
B.8	Header	GS	Function Group Header			
B.8	Header	GS03	Application Receiver's Code			Send 'UNICARE'
B.9 (46)	Header	GS08	Version/Release/Industry Identifier Code			Send '004010X097A1'
54	Header	BHT	Transaction Set Header			
56	Header	BHT06	Transaction Type Code	CH		This value is required to indicate that the batch contains all claims. Please refer to the 837 Dental Encounters Sections 2 for submission of encounters.
57	Header	REF	Transmission Type ID			
57 (11)	Header	REF02	Functional Category			Send '004010X097A1'
59	1000A	NM1	Submitter Name			
61	1000A	NM109	Submitter ID		20	Submitter ID same as GS02
66	1000B	NM1	Receiver Name			
67	1000B	NM103	Receiver Name			Send 'UNICARE'
68	1000B	NM109	Receiver Payer ID		20	Send '80314'
71 (12)	2000A	PRV	Provider Information			This segment is not required
84	2010AA	NM1	Billing Provider Name			
86	2010AA	NM108	Billing Provider ID code qualifier	24 XX		"24" indicates Employer's Identification Number "XX" Health Care Financing Administration National Provider Identifier

						*If XX is used, then either the Employer's Identification Number (EI) or Social Security Number (SY) of the provider must be carried in the REF in this loop
83	2010AA	REF	Billing Provider Secondary ID		5	Use this segment to Report Billing Provider Secondary ID
83	2010AA	REF01	Reference Identification Qualifier	1E 0B EI SY	2	<p>"1E" (Dentist License Number) or 0B (State License Number) "0B" indicates Provider State License Number. "EI" indicates Employer's Identification Number "SY" 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>
99	2000B	SBR	Subscriber Information			
100	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.
100	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.
103	2010BA	NM1	Subscriber Name			
104	2010BA	NM102	Entity Type Qualifier	1		A value of '2' is not applicable
105	2010BA	NM108	Identification Code Qualifier	MI		Required
105	2010BA	NM109	Subscriber Member ID		20	Required. Subscriber ID will be between 9 and 12 bytes, however to allow for future expansion, we recommend your internal software supports 20 bytes.
117	2010BB	NM1	Payer Name			
118	2010BB	NM103	Payer Name			Send 'UNICARE'
118	2010BB	NM109	Payer ID			Send '80314'
149	2300	CLM	Health Claim			
149	2300	CLM01	Patient Account Number			Required
155	2300	CLM19	Claim Submission Reason	PB		Required when the claim is a

			Code			pre-determination claim.
183	2300	REF	Claim ID for Clearinghouses and other Transmission Intermediaries			
183	2300	REF01	Claim Number Qualifier	D9		
184	2300	REF02	Clearinghouse Trace Number		15	If a clearinghouse trace number is submitted it will be returned on the PCO097-02 report in the Clearinghouse ID column
	2310B		RENDERING PROVIDER NAME			
		NM108	Rendering 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 (EI) or Social Security Number (SY) of the provider must be carried in the REF in this loop</p>
		REF	Rendering Provider Secondary ID			
		REF01	Reference Identification Qualifier	1E 0B EI SY	2	<p>“1E” (Dentist License Number) or 0B (State License Number)</p> <p>“0B” indicates Provider State License Number.</p> <p>“EI” indicates Employer’s Identification Number</p> <p>“SY” 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>
213	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
213	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.

213	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.
213	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.
220	2320	AMT	COB Payer Paid Amount			
220	2320	AMT01	Payer Paid Amount Qualifier code	D		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.
222	2320	AMT	COB Allowed Amount			
222	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.
225	2320	AMT	COB Discount Amount			
225	2320	AMT01	Discount Amount Qualifier code	D8		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.
415	2330B	DTP	Claim Adjudication Date			
416	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.
266	2400	SV3	Dental Service Line			
270	2400	SV306	Service Unit Count		9	
273	2400	DTP	Service Date			Line item service dates are required unless claim service dates are submitted or if the claim is a predetermination claim.
285	2400	REF	Line Item Control Number			
286	2400	REF01	Line Item Control Number	6R		

			Qualifier			
286	2400	REF02	Line Item Control Number		20	If the line item control number is sent, it will be stored on UNICARE systems and be returned on the 835 when the provider is setup to receive them.