AmeriHealth (Pennsylvania Only)

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 Implementation Guides, version 005010

July 2023

Preface

This Companion Guide (“Companion Guide”) refers to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA and clarifies and specifies the data content when exchanging electronically with AmeriHealth HMO, Inc. (“AmeriHealth”) for Pennsylvania business only. Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12 IG, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12 IG adopted for use under HIPAA. This Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
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1. Introduction

1.1 Scope

The Provider EDI Companion Guide addresses how providers, or their business associates, conduct the following HIPAA standard electronic transactions: Health Care Claim: Professional (837P), Health Care Claim: Institutional (837I), Health Care Claim Acknowledgment (277CA), Health Care Eligibility/Benefit (270/271) and Health Care Claim Payment/Advice (835) with AmeriHealth through the Highmark Gateway.

This Companion Guide also applies to the above referenced transactions that are being transmitted to AmeriHealth through the Highmark Gateway by a health care clearinghouse.

An Electronic Data Interchange (EDI) trading partner is defined for this Companion Guide as any entity (provider, billing service, software vendor, employer group, or financial institution) that utilizes the Highmark Gateway to transmit to, or receive electronic data to or from, AmeriHealth.

The Highmark Gateway supports standard electronic transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this Companion Guide.

Highmark EDI Operations supports transactions for multiple payers, including AmeriHealth.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with AmeriHealth through the Highmark Gateway. This information is organized into the following sections:

- **Getting Started:** This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information about trading partner authorization and an overview of the trading partner testing process is also included in this section.
- **Testing with the Payer:** This section includes detailed transaction testing information and other relevant information needed to complete transaction testing with AmeriHealth on the Highmark Gateway, if applicable.
- **Connectivity with the Payer/Communications:** This section includes information on the Highmark Gateway transmission procedures and communication and security protocols.
- **Contact Information:** This section includes telephone numbers and email addresses for support from Highmark EDI Operations.
- **Control Segments/Envelopes:** This section contains information needed to create the ISA-IEA, GS-GE, and ST-SE control segments for transactions to be submitted to the Highmark Gateway.

- **Payer-Specific Business Rules and Limitations:** This section contains information describing the AmeriHealth business rules.
- **Acknowledgments and Reports:** This section contains information on all transaction acknowledgments. These include the Interchange Acknowledgment (TA1), Health Care Claim Acknowledgment (277CA), and the Implementation Acknowledgment for Health Care Insurance (999).
- **Trading Partner Agreements:** This section contains general information about and links to Provider and Clearinghouse/Vendor Trading Partner Agreements (collectively referred to herein as "Trading Partner Agreements").
- **Transaction-Specific Information:** This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that has additional information that might supplement the IGs.

1.3 References

Trading partners must use the IGs adopted under the HIPAA Administrative Simplification Electronic Transaction rule and this Companion Guide for development of the EDI transactions. These documents will be made available through the EDI Trading Partner Business Center:

edi.highmark.com/edi-amerihealth

Trading partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the Washington Publishing Company website:

www.wpc-edi.com

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice [835])
- Claim Status Category Codes and Claim Status Codes (005010X214 Health Care Claim Acknowledgment [277CA])
- Provider Taxonomy Codes (ASC X12/005010X222A1Health Care Claim: Professional [837P] and ASC X12/005010X223A2 Health Care Claim: Institutional [837I])

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working with Highmark, Inc. (“Highmark”)

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

It is highly recommended that trading partners transmit any test data during the hours that Highmark EDI Operations is available, 8:00 a.m. through 5:00 p.m. EST, Monday through Friday.

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Highmark and/or AmeriHealth may require access to the records at any time.

The Trading Partner’s automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Trading Partner documents are acceptable. The trading partner, not the billing agent, is held accountable for accurate records.

The audit conducted by AmeriHealth consists of verifying a sample of automated claim input against medical records. Retention of records might also be checked. Compliance with reporting requirements is sample-checked to ensure proper coding technique is employed. Signature(s) on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark can request for itself and AmeriHealth, and the trading partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, “string”, Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex Value
!	Exclamation Point	(21)
>	Greater than	(3E)
^	Caret	(5E)
|	Pipe	(7C)
~	Tilde	(7E)

These five characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing. Use of these characters can cause problems if encountered in the transaction data.

As described in the ASC X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters are left justified. Leading spaces, when they

occur, are presumed to be significant characters. In the actual data stream, trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality/Security/Privacy

Trading partners, including health care clearinghouses, must comply with the HIPAA Electronic Transaction and Code Set standards and HIPAA Privacy and Security standards for all EDI transactions and confidentiality requirements as outlined in the Trading Partner Agreement.

Authorized Release of Information

When contacting Highmark EDI Operations concerning any EDI transactions, you will be required to confirm your trading partner information.

2.2 Trading Partner Registration

An Electronic Data Interchange (EDI) trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) utilizing the Highmark Gateway to transmit or receive electronic standard transactions to or from AmeriHealth.

While Highmark EDI Operations accepts HIPAA-compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure is established to secure access to data. As a result, Highmark has a process in place to establish a trading partner relationship. That process has the following steps:

- The trading partner must identify Trading Partner Administrator and Delegate roles (see page 13 of this Companion Guide). AmeriHealth uses role-based security for transactions related to the maintenance of a trading partner relationship.
- The Trading Partner Administrator must complete an online application to receive from Highmark a Trading Partner ID associated with submitting transactions on behalf of AmeriHealth.
- The Trading Partner Administrator must agree to and electronically accept or otherwise submit the Trading Partner Agreement to Highmark. The Trading Partner Agreement establishes the legal relationship and requirements. This is separate from a participating provider agreement.

Once the Trading Partner Agreement is received by Highmark, the trading partner is sent a logon ID and password combination associated with the Trading Partner ID for use when accessing the Highmark Gateway for submission or retrieval of AmeriHealth transactions (“logon ID and password”). This logon ID is also used within EDI Interchanges as the ID of the trading partner. The Confidentiality/Security/Privacy section of this Companion Guide provides more detail about the maintenance of the logon ID and password by the trading partner.

Authorization Process

New trading partners that want to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application process includes review and acceptance of the appropriate EDI Trading Partner Agreement. Submission of the EDI Transaction Application indicates compliance with specifications set forth by Highmark for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark can terminate the Trading Partner Agreement after a sixty (60) day suspension period, without notice, if the trading partner's account is inactive for a period of six (6) consecutive months, pursuant to the terms of the Trading Partner Agreement.

Complete and accurate reporting of information on the EDI Transaction Application ensures that the authorization process is completed in a timely manner. If you need assistance in completing the EDI Transaction Application, contact your company's technical support area, your software vendor, or Highmark EDI Operations.

Upon completion of the authorization process, a logon ID and password are assigned to the trading partner. Highmark EDI Operations will authorize, in writing, the trading partner to submit production AmeriHealth EDI transactions.

Trading Partner Administrator and Trading Partner Delegate Roles

This section explains the Trading Partner Administrator ("Administrator") and Trading Partner Delegate ("Delegate") roles. Highmark EDI Operations will only make changes to the trading partner record if the change request is received from the authorized Administrator or Delegate.

- The "Administrator" is the primary representative of the trading partner entity (provider office, billing service, clearinghouse, etc.) that is authorized by the trading partner to conduct all electronic business on behalf of the trading partner, including entering into Trading Partner Agreements, modifying trading partner capabilities, and conducting inquiries about electronic transactions.
- The "Delegate" is a representative of the Trading Partner Administrator that has been authorized by the trading partner/Trading Partner Administrator to conduct certain activities on behalf of the trading partner such as, requesting the addition or deletion of affiliated providers or conducting inquiries about electronic transactions.
- The provider is a physician or allied health care provider credentialed and approved by AmeriHealth to provide covered services to AmeriHealth members and submit standard electronic transactions for such services to AmeriHealth for processing.
- The Administrator is required to submit a security question and an answer to this question when registering. The security answer is used to confirm and verify the identity of the Administrator prior to Highmark making any

form changes on behalf of the trading partner.

The following table lists the rights that an Administrator, a Delegate, and a provider are authorized to perform:

AmeriHealth Trading Partner Role-Based Security Matrix

Rights	Administrator	Delegate	Provider
EDI Trading Partner Business Center Permissions			
New trading partner registration	✓		
New trading partner request	✓		
Update a trading partner's address information	✓		
Delete a trading partner	✓		
Update claim transactions	✓		
Update Administrator	✓		

Rights	Administrator	Delegate	Provider
Establish Delegate	✓		
Update Delegate	✓	✓	
Request for production	✓	✓	
Provider changes	✓	✓	✓
Update software vendor	✓	✓	
Other Permissions			
Receive EDI transaction support	✓	✓	✓
Request password change	✓	✓	

Where to Get Authorization Forms to Request a Trading Partner ID

To receive a Trading Partner ID, you must complete an online EDI Transaction Application and agree to the terms of the EDI Trading Partner Agreement. The EDI Transaction Application and all other EDI request forms are available through the *Sign-Up* section of the EDI Trading Partner Business Center website. You may access the online application from the page accessed by the link below:

www.highmark.com/edi-amerihealth

Receiving ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)

To receive Health Care Claim Payment/Advice (835 remittance transactions) generated from the payment cycle in a batch process, trading partners need to request 835 remittance transactions by completing an *ERA Enrollment* form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

Adding a New Provider to an Existing Trading Partner

Trading partners currently using electronic claims submission who wish to add a new provider to their Trading Partner ID should complete the *Provider Changes* form in the *Update Trading Partners* section on the EDI Trading Partner Business Center website and select the option to *Add Provider to an existing Trading Partner*.

Deleting Providers from an Existing Trading Partner

Trading partners who wish to delete an existing provider from their Trading Partner ID should complete the *Provider Change request* in the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

Reporting Changes in Status

If trading partners need to change any other trading partner information, they must inform Highmark EDI Operations by completing the appropriate trading partner update form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website an include all information that is to be updated.

edi.highmark.com/edi-amerihealth

2.3 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

Testing Policy

AmeriHealth does not currently require the testing or certification of any electronic claim or inquiry transactions through the Highmark Gateway. It is highly recommended, however, that all Practice Management Software (PMS) Vendors ensure their software complies with all current transaction requirements.

AmeriHealth through Highmark Transactional Testing

Highmark does not allow Trading Partners to send test claim transaction files to our production environment. A TA1 will be generated for any transaction file that has "test" indicated in the ISA15 element.

3. Testing with the Payer

AmeriHealth does not currently require or provide for testing of any electronic transactions. It is highly recommended, however, that all Practice management Software (PMS) Vendors test their software for HIPAA compliance on behalf of all of their clients. Any questions about the requirements contained within this Guide may be directed to EDI Operations at 1-800-992-0246.

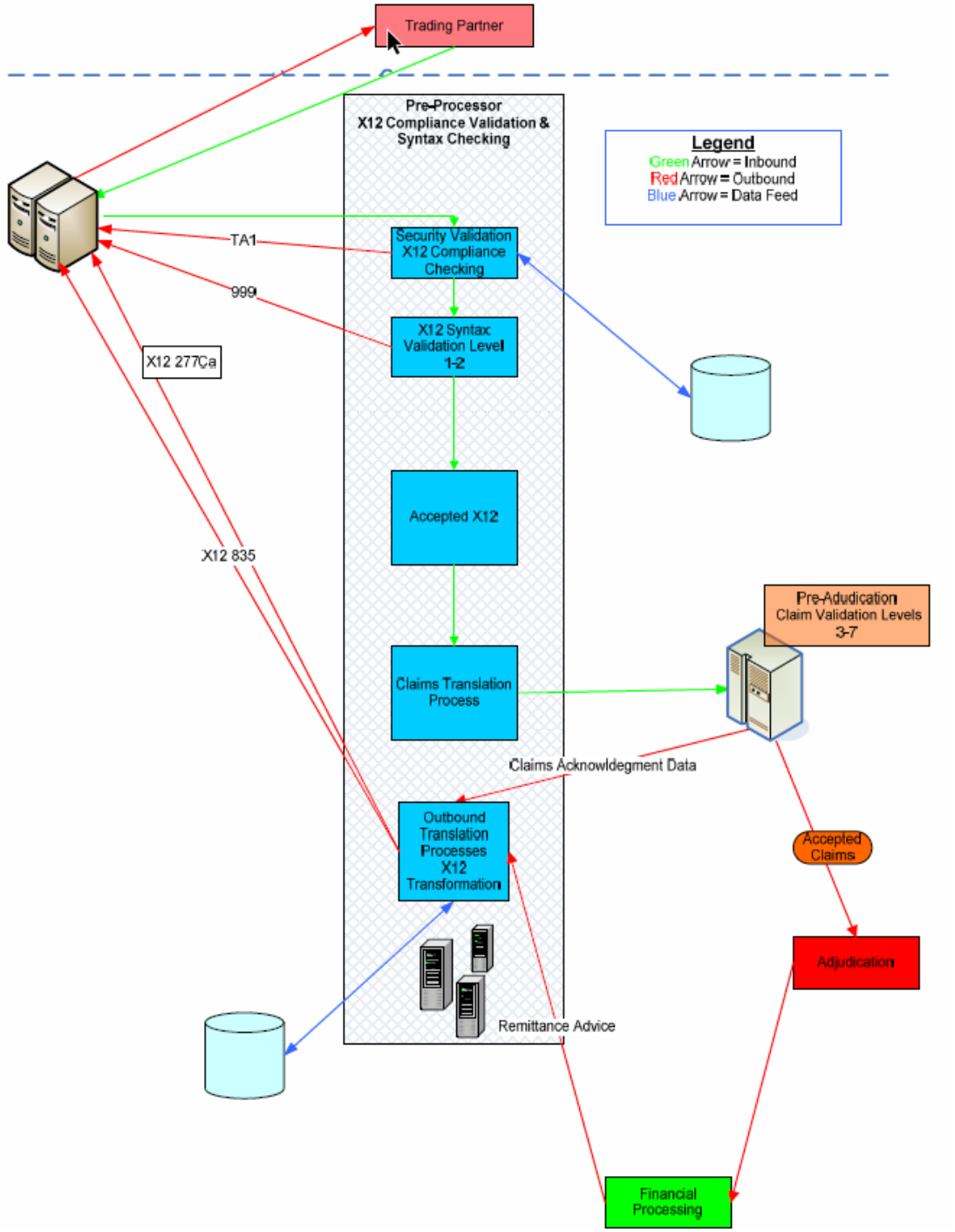
4. Connectivity with the Payer/Communications

Highmark offers AmeriHealth trading partners the following communication method for transferring data electronically: **Secure File Transfer Protocol (SFTP)** through a secure https Internet connection (Secure File) is available for transaction in batch mode.

4.1 Process Flows

Trading partners will submit and receive all transactions through the Highmark Gateway. The 999 Implementation Acknowledgment for Health Care Insurance transaction, TA1 Transaction Acknowledgment transaction, 277CA Health Care Claim Acknowledgment transaction, and 835 Health Care Payment/Advice transaction are all returned to trading partners through the Highmark Gateway.

High Level Batch Transaction Flow



4.2 Transmission Administrative Procedures

This information will be communicated to the trading partner upon Highmark's receipt of the agreed-to Trading Partner Agreement.

4.3 Re-Transmission Procedures

AmeriHealth does not have specific re-transmission procedures. Trading partners can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers a secure File Transfer Protocol (SFTP) through "Secure Transport" for conducting business with AmeriHealth. "Secure Transport" is available for trading partners who submit or receive any HIPAA-compliant EDI transactions in batch mode.

Internet Secure File Transfer Protocol (SFTP) through "Secure Transport"

The Highmark Secure FTP Server ("Secure Transport") provides an SFTP service over an encrypted data session providing "on-the-wire" privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple SFTP process in an encrypted and secure manner.

Any state-of-the-art browser can be used to access the Highmark Secure FTP Server. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.
2. Connect to the SFTP server at https://mft.hmhs.com.
3. The server prompts you for your logon ID and password. Use the logon ID/password that Highmark provided you as part of the trading partner authorization process for accessing this service. Enter the ID, tab to password field and enter the password.
4. Press "Enter" or click "OK".
5. The server places you in an individual file space on the SFTP server. Other users cannot access your space and you cannot access the space of other users. You will not be able to change out of your space.
6. You need to change into the directory for the type of file you are uploading or downloading from the server.
7. By default, the file transfer mode is binary. This mode is acceptable for all data types. However, you can change between ASCII and binary file transfer modes by clicking the *Set ASCII/ Set Binary* toggle button.

8. Send Highmark a file. The following is an example of the submission of an electronic claim[1] transaction file:
    a. Click the *hipaa-in* folder to change into that directory.
    b. Click the **browse** button to select a file from your system to send to Highmark. A file finder box appears listing the files available on your system.
    c. Select the file you want to send to Highmark and click **OK**. This returns you to the browser with the file name you selected in the filename window.
    d. Click the **Upload File** button to transfer the file to Highmark. Once completed, the file appears in your file list.
9. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:
    a. Click the *hipaa-out* directory. Your browser lists all the files available to you.
    b. Click the *ack* directory.
    c. Click the file you want to download. Your browser downloads the file. If your browser displays the file instead of downloading, click the **browser back** button and click the tools next to the file you want to receive. Select *application/octet-stream*. You might be prompted with the **Save As** file location window. Select a file location and click **Save** to download the file.

Internet/Real-Time (HTTPS – Hypertext Terminal Protocol Secure)
Highmark offers a Real-Time Web Service through a secure Internet Connection (HTTPS) for our real-time enabled transactions:

Real-Time Inquiry Transactions

- Health Care Eligibility Benefit Inquiry and Response (270/271)

Real-time inquiry transactions utilize a CORE-compliant Web Services Description Language (WSDL) Simple Object Access Protocol (SOAP). SOAP is a way for a program running in one kind of operating system to communicate with another operating system by using Extensible Markup Language (XML) for the exchange of information over the Internet. Since the Internet is being utilized to transport the data, encryption will be utilized to secure messages.

In order to take advantage of real-time transactions for AmeriHealth with Highmark, a Trading Partner will need to:

- Check with your EDI software vendor to ensure that the EDI transaction software is programmed for Highmark's real-time CORE-compliant or proprietary SOAP transactions, as appropriate. For instructions on how to program for Highmark's real-time transactions, refer to the "Real-Time Inquiry Connectivity Specifications" in the Resources section under EDI Companion Guides at the following site:

  https://www.highmark.com/edi/resources/guides/index.shtml

- Complete an EDI Transaction Application
  - Select the real-time inquiry transaction option (270/271)
  - Include your email address
  - Trading Partner must have a valid Internet enabled 'V' Logon ID.
- Download the Web Services Security Certificate as outlined in the appropriate Real-Time Connectivity Specification documents.

Real-time transactions are designed to respond to individual end-user requests for real-time enabled inquiry transactions (270/271).

Note: AmeriHealth must provide approval before a trading partner will be granted the ability to submit/receive Health Care Eligibility Benefit Inquiry and Response (270/271).

For typical inquiry requests, the average response time should be within 15 seconds. Actual response time will be dependent upon real-time transaction activity. Batched inquiries should not be submitted through the real-time process as it may impact the response time.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

4.5 Passwords

Highmark EDI Operations assigns logon IDs and passwords to trading partners. EDI transactions submitted by unauthorized trading partners will not be accepted by the Highmark Gateway.

Trading partners should protect password privacy by limiting knowledge of the password to key personnel. Passwords should be changed regularly: upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the trading partner office, or at any time the trading partner deems necessary.

Trading partners must notify Highmark immediately if there is a violation of these logon ID and password requirements as required by the Trading Partner Agreement.

Password requirements include:

- Password must be eight characters in length.
- Password must contain a combination of both numeric and alpha characters.
- Password cannot contain the logon ID.
- Password must be changed periodically.

Trading partners are directed to refer to the terms of their Trading Partner Agreement for any additional obligations they may have concerning logon IDs and passwords.

Password Change Requests

EDI Operations only performs a password reset if requested by an Administrator or Delegate.

If an Administrator or a Delegate provides the answer to their security question, EDI Operations can provide temporary passwords over the telephone. If the security answer is not provided, a temporary password is not given during the initial telephone call. In this case, the temporary password can be provided in a follow-up email or return telephone call using existing contact information on file at Highmark.

5. Contact Information

5.1 Highmark EDI Operations

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246

When contacting Highmark EDI Operations, have your Trading Partner ID and logon ID available. These numbers facilitate the handling of your questions.

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246

When contacting Highmark EDI Operations, have your Trading Partner ID and logon ID available. These numbers facilitate the handling of your questions.

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.3 Provider Services

Non-EDI related inquiries should be handled through your existing channels of communication with AmeriHealth.

5.4 Applicable Websites/Email

EDI specifications, including this Companion Guide, will be accessible online in the *Resources* section of the EDI Trading Partner Business Center website:

edi.highmark.com/edi-amerihealth

6. Control Segments/Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the IGs. The AmeriHealth expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter of the Companion Guide.

Note: Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

For 5010 claim files, the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days, the file is considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the IGs, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark EDI Operations (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that Line Feed, hex value “0A”, is an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E
!	21

Description	Hex value
“	22
%	25
&	26
‘	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^	5E
{	7B
}	7D
~	7E

Note: “^” can be used as a Data Element Separator, but is not accepted as a Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark uses the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, “!”, cannot be used in text data (type AN, Sting data element) within the transaction; refer to Section 2.1 Valid Characters in Text Data in this document.

Delimiter Type	Character Used	(Hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to AmeriHealth

Segment: ISA Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the IGs with the clarifications as follows:

Table 1: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	AmeriHealth can only support code 00 - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	AmeriHealth can only support code 00 - No Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value “ZZ” Mutually Defined to designate a payer-defined ID.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA06	Interchange Sender ID		Use the AmeriHealth assigned security logon ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value “33”. AmeriHealth only supports the NAIC code to identify the receiver.
	ISA08	Interchange Receiver ID	54704	AmeriHealth
	ISA13	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA 14	Acknow-ledgement Requested	1	A TA1 segment is always returned when the incoming interchange is rejected due to errors at the interchange or functional group envelope.
	ISA15	Usage Indicator		The value in this element is used to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from AmeriHealth

Segment: ISA Interchange Control Header (Outgoing)

Note: The following table lists clarifications of the AmeriHealth use of the ISA segment for outgoing interchanges.

Table 2: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Code 00 is sent - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA03	Security Information Qualifier	00	Code 00 is sent - no Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	33	Qualifier code value “33” is sent to designate that the NAIC code is used to identify the sender.
	ISA06	Interchange Sender ID	54704	AmeriHealth
	ISA07	Interchange ID Qualifier	ZZ	Qualifier code value “ZZ” is sent. Mutually defined to designate that an AmeriHealth-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The assigned ID is the trading partner’s security logon ID. This ID is left-justified and space filled.
	ISA 14	Acknowledgment Requested		AmeriHealth always uses a 0 (No Interchange Acknowledgment Requested).
	ISA15	Usage Indicator		AmeriHealth provides T or P as appropriate to identify the test or production nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in Section 7 (Payer-Specific Business Rules and Limitations) and Section 10 (Transaction-Specific Information) of this Companion Guide.

6.3 ST-SE

AmeriHealth has no requirements outside the national transaction IGs.

7. Payer-Specific Business Rules and Limitations (837P, 837I, 277CA, 835, 270/271 and 999)

7.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 IG, as modified by the July 2010 Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the Companion Guide for submitting Health Care Claim: Professional (837P) claims for patients with AmeriHealth benefit plans. Accurate reporting of the AmeriHealth NAIC code is critical for claims submitted to AmeriHealth through the Highmark Gateway.

Claims Resubmission

Frequency Type codes that tie to “prior claims” or “finalized claims” refer to a previous claim that has completed processing in the payer’s system and produced a final paper or electronic remittance or explanation of benefits.

Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim”. An 837 professional claim transaction is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.2 005010X223A2 Health Care Claim: Institutional (837I)

The Health Care Claim: Institutional (837I) transaction is used for institutional claims. The May 2006 ASC X12 005010X223 IG, as modified by the August 2007 and the July 2010 Type 1 Errata documents, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with the revisions in the errata; the transaction version must be identified as 005010X223A2.

This Companion Guide supplements the ASC X12 Implementation Guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction detail make up the Companion Guide for submitting Health Care Claim: Institutional (837I) claims for patients with AmeriHealth benefit plans, including Health Maintenance Organization (HMO), Point of Service (POS). Accurate reporting of the AmeriHealth NAIC code 54704 in the ISA08 along with associated prefixes and suffixes is critical for claims submission.

Claims Resubmission

Frequency Type codes that tie to “prior claims” or “finalized claims” refer to a previous claim that has completed processing in the payer’s system and produced a final paper or electronic remittance or explanation of benefits.

Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claims”. An 837 claim transaction is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.3 005010X214 Health Care Claim Acknowledgment (277CA)

The 277 Claim Acknowledgment (277CA) transaction is a business application level acknowledgment for the Health Care Claim (837) transaction(s). This transaction acknowledges the validity and acceptability of claims for adjudication. The January 2007 X12 005010X214 Implementation Guide is the primary source for definitions, data usage, and requirements.

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a Health Care Claim Acknowledgement (277CA) transaction within 24 hours after AmeriHealth Pennsylvania receives the electronic claims[1], subject to processing cutoffs. The 277CA files (ISA-IEA) will be grouped by the 277CA transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837 transaction. Each 277CA grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA-IEA) has two Functional Groups (GS-GE) and each Functional Group has two 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each with a Functional Group that contains two 277CA transactions (ST-SE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

There is a one-to-one relationship between an 837 (ST-SE) and the corresponding 277CA (ST-SE). In the event system issues are encountered and all claims from a single 837 transaction cannot be acknowledged in a single 277CA transaction, it may be necessary to retrieve multiple 277CA transactions related to an electronic claims transaction. See Section 4.4 Communication Protocol Specifications in this Companion Guide for information on retrieving the batch Health Care Claim Acknowledgment (277CA).

7.4 005010X221A1 Health Care Claim Payment/Advice (835)

The 835 transaction is used to provide an explanation of claims payment. The April X12 005010X221 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Availability of Payment Cycle 835 Transactions (Batch)

Health Care Claim Payment/Advice (835) transactions are created on a weekly or daily basis to correspond with the AmeriHealth weekly or daily payment cycles. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete and remain available for seven days. If a Health Care Claim Payment/Advice (835) transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact Highmark EDI Operations for assistance.

Reassociation of the 835 and EFT Payment

Providers have the ability to automate their patient account posting and reconciliation with the associated electronic payment through use of an Electronic Remittance Advice (ERA/835) and Electronic Funds Transfer (EFT). Providers who receive payment for claims via EFT and also receive the 835 transaction must contact their financial institution to arrange for the delivery of the EFT payment data that is needed for re-association of the payment and the 835. The table below defines the payment data needed for reassociation and where that data is located in both the banking system's CCD+ (EFT) format file and the 835 transaction:

EFT Payment Data	Banking System's CCD+ Format File	835 Transaction Data
Effective Entry Date	Record 5, Field 9	BPR16
EFT Amount	Record 6, Field 6	BPR02
Payment Related Information	Record 7, Field 3	TRN Segment (Payment/EFT Trace Number)

Missing or Late 835 or EFT Payment

If an ERA/835 file has not been received after 4 business days of receipt of the corresponding EFT payment, you can research it by contacting Highmark EDI Operations.

If an EFT payment has not been received after 4 business days of receipt of the corresponding ERA/835 file, you can research it by contacting AmeriHealth through Provider eBusiness Inquiry form at https://fhnportal.amerihealth.com/providerinquiry/ahpa/dashboard

AmeriHealth defines business days as Monday through Friday, excluding holidays. A holiday schedule is published on a yearly basis. For Electronic Funds Transfer (EFT), AmeriHealth follows the bank holiday schedule. The electronic funds will be available the next business day following the bank holiday.

For additional details, user guides are available on our Provider News Center at www.amerihealth.com/pnc. Click on *Resources* at the top of the page and then *EFT Resources* under User Guides & Pages.

Limitations

Paper claims might not provide all data utilized in the Health Care Claim Payment/Advice (835). Therefore, some data segments and elements may be populated with "default data" or not available as a result of the claim submission mode.

- Administrative checks are issued from a manual process and are not part of the weekly or daily payment cycles. Therefore, they will not be included in the Health Care Claim Payment/Advice (835) transaction. A letter or some form of documentation usually accompanies the check. An administrative check does not routinely contain an Explanation of Benefits notice.

- The following information will be populated with data from internal databases:
  - Payer name and address
  - Payee name and address

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

Claim Overpayment Refunds

Member Facility Institutional Claims

The Reversal and Correction methodology is used to recoup immediate refunds for overpayments identified by the provider or by AmeriHealth. The change in payment details is reflected by a reversal claim (CLP02 = 22) and a corrected claim (CLP02 = 1, 2, 3, or 4). The payment amount of the check/EFT is reduced by the overpayment amount, after any outstanding provider offsets are applied from previous checks/EFTs.

If AmeriHealth is unable to recoup all or a portion of the refund money from the current check/EFT, the remaining refund amount to be offset on a future check will be shown as a negative amount in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835) using the Provider Adjustment Reason code of FB – Forward Balance. The negative PLB dollars allow the Health Care Claim Payment/Advice (835) payment to balance and essentially delay or move the refund balance forward to a future Health Care Claim Payment/Advice (835), when money is available to be offset from a check/EFT.

When the refund dollars are eventually offset in a subsequent check/EFT, the money is only reflected in the Health Care Claim Payment/Advice (835) PLB segment with the dollar amount being offset from that specific check/EFT. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835).

AmeriHealth claims uses the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.

Professional and Non-Member Facility Claims

When overpayment of a professional claim is identified by the provider, and verified by AmeriHealth, the reversal/correction/offset mechanism described above for member facility institutional claims is followed.

When overpayment of a professional claim is identified by AmeriHealth, the provider's payment will not be immediately reduced. This delay is intended as an opportunity for the provider to appeal the AmeriHealth overpayment determination. Due to the timing of the appeal review and actual check/ EFT reduction, providers are encouraged to NOT wait to appeal the refund request.

With the exception of difficult refund cases, this new process will eliminate the form letters.

In the Health Care Claim Payment/Advice (835) transaction, the AmeriHealth - identified overpayment reversal and correction claims will be separated to a second LX loop (LX01 = 2). Because the resulting overpayment amounts for the claims in this LX loop are not being deducted from this check/EFT, a negative amount which cancels out the reversal and correction overpayment claims is reported in the Provider Adjustment PLB segment. The PLB segment will have the following codes and information:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim followed by the word "DEFER" with no space. Example: '06123456789DEFER.'

  Claim Interest – If an interest payment was made in connection with the original claim payment, recoupment of the interest corresponding to the overpayment will also be deferred. Deferred Interest will be individually detailed in the PLB segment to assist the provider with account reconciliation. The PLB segment will reflect the following codes and information:

  - Provider Adjustment Reason Code L6, Interest Owed
  - Reference Identification will contain the claim number from the impacted claim followed by the word "DEFER" with no space. Example: '06123456789DEFER.'
  - Both a positive and negative interest (L6) adjustment will be shown in order to not financially impact the current Health Care Claim Payment/Advice (835) payment.

If an appeal is not filed, AmeriHealth will assume the provider agrees with the refund request. The overpayment refund will then be deducted from a current check/EFT, and that refund amount will be reflected in a Provider Adjustment PLB segment. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835).

The following codes and information will be used in the PLB segment for this purpose:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim.
- If Interest related to this claim was previously deferred, the current refund amount being collected will include the interest amount.

In the event the full refund amount cannot be deducted from the current check/EFT, then the remaining balance will be 'moved forward' to a subsequent check/EFT using the Provider Adjustment Reason code of FB – Forward Balance in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835).

AmeriHealth uses the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.

7.5 00501X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

The 270 transaction is used to request the health care eligibility for a subscriber or dependent. The 271 transaction is used to respond to that request. The May 2006 X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Requests per Transaction Mode

The eligibility Inquiry process for the payers in this Reference Guide is limited to one Information Source and Information Receiver per ST-SE transaction.

Real-time mode: If multiple requests are sent, the transaction is rejected.

Patient Search Criteria

In addition to the Required Primary and Required Alternate Search options mandated by the 270/271 implementation guide, AmeriHealth will search for the patient if only the following combinations of data elements are received on the 270 request:

- Subscriber ID, Patient First Name, and Patient Date of Birth
- Subscriber ID and Patient Date of Birth

7.6 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA-IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.) The location and reason for errors are identified in one or more of the following segments:

- IK3 - segment errors
- IK4 - data element errors
- IK5 - transaction errors
- AK9 - functional group errors

Rejection codes are contained in the ASC X12 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) IG. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA-IEA) and Functional Group (GS-GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be "005010X231A1." Note that this will not match the IG identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment for Health Care Insurance (999) guide.

As part of your trading partner agreement, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values supplied in the trading partner agreement, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter.

In the following example the IK404 value 'TRADING PARTNER PROFILE' indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

```
ISA^00^          ^00^          ^33^54771          ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
```

IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627

8. Acknowledgments and Reports

8.1 Report Inventory

AmeriHealth has no proprietary reports within this Companion Guide.

8.2 X12 Acknowledgments

AmeriHealth has no proprietary reports within this Companion Guide.

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance
277CA Acknowledgment	Claim Acknowledgment to the Electronic Claim[1]

Outgoing Interchange Acknowledgment TA1 Segment

The Highmark Gateway returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA-IEA) must be rejected.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the 999 Implementation Guide. Each Highmark Gateway TA1 will have an Interchange Control Envelope (ISA-IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

The Highmark Gateway returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA-IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to Sections 7.6 and 10.6: 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) of this Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The 277CA Claim Acknowledgment Transaction is used to return a reply of “accepted” or “not accepted” for claims or encounters processed by AmeriHealth submitted via the electronic claim[1] transaction in batch mode. The 277CA files (ISA-IEA) will be grouped by the 277CA transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837 transaction. Each 277CA grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA-IEA) has two Functional Groups (GS-GE) and

each Functional Group has two 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each with a Functional Group that contains two 277CA transactions (ST-SE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

Acceptance at this level is based on the electronic claim.[1] Implementation Guides and front-end edits will apply to individual claims within an electronic claim[1] transaction.

For those claims not accepted, the Health Care Claim Acknowledgment (277CA) will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to the Health Care Claim Acknowledgment (277CA) in Section 7.3 of this Companion Guide.

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[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

9. Trading Partner Agreements

Provider Trading Partner Agreement

For use by professionals and institutional providers.

Clearinghouse/Vendor Trading Partner Agreement

For use by software vendors, billing services, or clearinghouses.

Trading Partners

An EDI trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) utilizing the Highmark Gateway to transmit or receive electronic data to or from AmeriHealth.

Payers have Trading Partner Agreements that accompany the standard IGs 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 with an entity or a part of a larger Agreement, between each party to the Agreement.

For example, a Trading Partner Agreement specifies, among other things, the roles and responsibilities of each party to the Agreement in conducting standard electronic transactions.

10. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that AmeriHealth has something additional, over and above the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with AmeriHealth.

In addition to the row for each segment, one or more additional rows are used to describe the AmeriHealth usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table lists the IGs for which specific transaction instructions apply and which are included in Section 10 of this Companion Guide:

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010221A1	Health Care Claim Payment/Advice
005010X279A1	Health Care Eligibility Benefit Inquiry and Response*
005010X231A1	Implementation Acknowledgment for Health Care Insurance

AmeriHealth through the Highmark Gateway supports all listed transactions marked with an “*” in real-time only. All other listed transactions are supported in batch mode.

10.1 005010X222A1 Health Care Claim: Professional (837P)

Refer to Section 7.1 for AmeriHealth business rules and limitations for this specific transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's assigned Trading Partner ID. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	95044	**95044** AmeriHealth POS AmeriHealth HMO
1000A	NM1	Payer Identification		
	NM109	Submitter Identifier		Sender's Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		AmeriHealth will use contact information on internal files for initial contact.
	PER01	Contact Function Code	BL	Technical Department
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth
	NM109	Receiver Primary Identifier	95044	Identifies AmeriHealth as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
	N301	Address Informati on		The Billing Provider Address must be a street address of a practice location. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address loop (Loop ID 2010AB), if necessary.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	N4	Billing Provider Address		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N301	Address Information		The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID 2010AB), if necessary.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2010AA	REF	Billing Provider Tax Identification Number		
2100AA	PER	Billing Provider Contact Information		AmeriHealth uses contact information on internal files for initial contact.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AB	NM1	Pay-To Address Name		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E. F, G, H, P, S, T, U	If value other than “P” (Primary) is populated, then the following Loops/Segments are required: • **2320 or 2430/CAS:** With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • **2320/AMT:** With AMT01 = ‘D’ and AMT02 Payer Paid Amount • **2320 or 2430/AMT:** With AMT01 = ‘AEF’ and AMT02 Payer Paid Amount • **2330A/NM1:** With Other Subscriber information
	SBR09	Claim Filing Indicator Code	BL	AmeriHealth Products
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which AmeriHealth does not process.
	NM109	Subscriber Primary Identifier		This is the identifier from the Subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BA	REF	Subscriber Secondary Identification		AmeriHealth does not need secondary identification to identify the Subscriber.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which AmeriHealth does not process.
2010CA	NM1	Patient Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which AmeriHealth does not process.
2010BB	NM1	Payer Name		
	NM103	Payer Name		AmeriHealth
	NM109	Payer Identifier	95044	**95044** AmeriHealth POS AmeriHealth HMO
2010BB	REF	Payer Secondary Identification		AmeriHealth does not need secondary identification to identify the payer.
2300	CLM	Claim Information		
2300	CLM101	Claim Submitter’s Identifier		Do not enter values more than 20 characters.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains ‘7’ or ‘8’, prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = ‘F8’ and AmeriHealth Claim Number in REF02) • NTE – Billing Note (NTE01 = ‘ADD’ and detailed description regarding the adjustment in NTE02)
2300	REF	Payer Claim Control Number		
2300	REF01	Reference Identification Qualifier	F8	If CLM05-3 contains ‘7’ or ‘8’, prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = ‘F8’ and AmeriHealth Claim Number in REF02)
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment. If CLM05-3 contains ‘7’ or ‘8’, prior claim information is required in the following Segments are required in Loop 2300: • NTE – Billing Note (NTE01 = ‘ADD’ and detailed description regarding the adjustment in NTE02)

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	HI	Health Care Diagnosis Code		
2300	HI	Anesthesia Related Procedure		Send the procedure code for the surgery or other service related to the anesthesia, if known. If the only applicable code is a Not Otherwise Classified code, send a description in the Procedure Code Description element SV101-7.
2310A	NM1	Referring Provider		With the implementation of the Ancillary Claim Filing mandate, the referring provider is required on Specialty Pharmacy and Independent Laboratory claims.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the Provider's contractual business arrangements with AmeriHealth.
2310C		Service Facility Location Name		This 2310C loop should only be used when the service is rendered at a location other than the Billing Provider's office (submitted in loop 2010AA). Service Facilities examples are hospitals, Skilled Nursing Facilities, Surgical Centers, etc. They are not provider offices.

2310C	N3	Service Facility Location Address		When the 2310C Service Facility Location Name loop us sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.
2310C	N4	Service Facility Location City/State/ Zip		
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2320	CAS	Claims Level Adjustment		If SBR01 is a value other than “P” (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2320	AMT	COB Payer Paid Amount		If SBR01 is a value other than “P” (Primary), this segment is required.
2320	AMT	Remaining Patient Liability		If SBR01 is a value other than “P” (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2330B	NM1	Other Payer Name		If SBR01 is a value other than “P” (Primary), this segment is required.
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter’s system. If the submitter’s system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state, and ZIP information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state, and ZIP, send the Billing Provider address information as the default.
2400	SV1	Service Line		
	SV101-1	Product/Service ID Qualifier		Qualifier value HC, HCPCS, is the only value AmeriHealth will accept in this element.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2400	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer's adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer's adjudication process; therefore, it is not required.
2410	LIN	Drug Identification		• NDC codes are required when specified in the Provider's agreement with AmeriHealth. • AmeriHealth encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the Provider's contractual business arrangements with AmeriHealth.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2420C	N3	Service Facility Location Address		When the 2420C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.
2430	CAS	Claims Level Adjustment		If SBR01 is a value other than “P” (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.
2430	COB Payer Paid Amount	Remaining Patient Liability		If SBR01 is a value other than “P” (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.

10.2 005010X223A2 Health Care Claim: Institutional (837I)

Refer to Section 7.2 for AmeriHealth business rules and limitations for this specific transaction.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Trading Partner ID. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	95044	**95044** AmeriHealth POS AmeriHealth HMO
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		AmeriHealth uses contact information on internal files for initial contact.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth
	NM109	Receiver Primary Identifier	95044	**95044** AmeriHealth POS AmeriHealth HMO
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners; therefore, U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	NM108	Identification Code Qualifier		When the organization is not a health care Provider (is an "atypical" Provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" Provider must submit their TIN in the REF segment and their assigned AmeriHealth Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AA	NM109	Identification code		When the organization is not a health care Provider (is an “atypical” Provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The “atypical” Provider must submit their TIN in the REF segment and their assigned AmeriHealth Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).
2010AA	N3	Billing Provider Address		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		AmeriHealth will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	SBR01	Payer Responsibility Sequence Number Code		If value other than “P” (Primary) is populated, then the following Loops/Segments are required: • **2300/HI:** If AmeriHealth secondary to Medicare, appropriate Value Codes if applicable • **2300/CAS:** With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • **2300/AMT:** With AMT01 = ‘D’ and AMT02 Payer Paid Amount • **2330A/NM1:** With Other Subscriber information
2000B	SBR09		CI	**CI** for AmeriHealth Products
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which AmeriHealth does not process.
	NM104	Subscriber First Name		Subscriber’s first name is required when NM102 = 1 and the person has a first name. If the subscriber has a Single Legal Name, NM102 must = 1 and Single Legal Name must be populated in NM103 and NM104 must not be populated.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Subscriber Primary Identifier		This is the identifier from the Subscriber's identification card (ID Card), including alpha characters. Spaces, dashes, and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction. When the Subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.
2010BA	REF	Subscriber Secondary Identification		AmeriHealth does not need secondary identification to identify the Subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		AmeriHealth (based on values submitted in GS03)
	NM109	Payer Identifier	95044	**95044** AmeriHealth POS AmeriHealth HMO
2010BB	REF	Payer Secondary Identification		AmeriHealth does not need Secondary Identification to identify the payer.
2300	CLM	Claim Information		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CLM05-1	Facility Type Code	84	AmeriHealth considers Free Standing Birthing Center to be Outpatient when applying data edits. Note that this is a variation from the Inpatient.indication in the NUBC Data Specifications Manual as of the time of this document.
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains ‘5’, ‘7’, or ‘8’, prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = ‘F8’ and AmeriHealth Claim Number in REF02) • REF – Medical Records Number (REF01 = ‘EA’ and Medical Record Number in REF02) • NTE – Billing Note (NTE01 = ‘ADD’ and detailed description regarding the adjustment in NTE02)
2300	DTP	Discharge Hour		
	DTP03	Discharge Time		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	DTP	Admission Date/Hour		
	DTP03	Admission Date and Hour		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.

2300	REF	Payer Claim Control Number		AmeriHealth requires the Payer Claim Control Number segment when Loop 2300/CLM05-3 is ‘5’, ‘7’, or ‘8’.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	REF02	Payer Claim Control Number		AmeriHealth Claim Number of the previously adjudicated claim associated with the Late Charge, Replacement or Void noted by Loop 2300/CLM05-3
2300	REF	Medical Record Number		AmeriHealth requires the Medical Record Number segment when Loop 2300/CLM05-3 is ‘5’, ‘7’, or ‘8’.
	REF01	Reference Identification Qualifier	EA	
2300	NTE	Billing Note		NTE segment required for AmeriHealth when Loop 2300/CLM05-3 is ‘5’, ‘7’, or ‘8’
	NTE02	Original Reference Number		Enter a detail description regarding the adjustment request.
2300	K3	File Information		Present on Admission (POA) codes are not reported in the K3. Claims with POA codes in the K3 will not be accepted for processing. POA codes are reported in the appropriate HI segment along with the appropriate diagnosis code.
2300	HI	Principal Diagnosis		
2300	HI	Admitting Diagnosis		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	HI	Patient's Reason for Visit		
2300	HI	Other Diagnosis		
2300	HI	Principal Procedure Information		
2300	HI	Other Procedure Information		
	HI01-1	Code List Qualifier Code		Until further notification from AmeriHealth, Advanced Billing Concepts (ABC) codes will not be accepted.
2300	HI	Occurrence Information		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
2300	HI	Value Information		When AmeriHealth is secondary to Medicare, Value Code information is required as necessary.
	HI01-01		BE	

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	HI01-02		09, 11, 08, 10, 06, 80, 81, 82, 83	• 09 (Coinsurance Amount in 1st calendar year) • 11 (Coinsurance Amount in 2nd calendar year) • 08 (Lifetime Reserve Amount in 1st year) • 10 (Lifetime Reserve Amount in 2nd year) • 06 (Medicare Blood Deductible) • 80 (Covered Days) • 81 (Non-covered Days) • 82 (Coinsurance Days) • 83 (Lifetime Reserve Days) *Note:* **For Medicare Part A:** Coinsurance amounts use Value Codes 9-11 (CAS segments are not required). **For Medicare Part A:** Deductible (previously identified by Value Codes A1, B1, C1) are to be reported in the CAS (Claim Adjustment Group Code “PR” = Patient Responsibility) segment.
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider’s National Provider Identifier (NPI) is associated with more than one AmeriHealth contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider’s contractual business arrangements with AmeriHealth.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2310E	N3	Service Facility Location Address		When the 2310E Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.
2310E	N4	Service Facility Location City/State/ZIP		
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
2320	CAS	Other Subscriber Information		AmeriHealth requires this information either at this 2320/CAS (claim level) or the 2430/CAS (service line) when the Loop 2000B/SBR01 is other than 'P'. *Note:* **For Medicare Part A:** Deductible (previously identified by Value Codes A1, B1, and C1) should be reported as follows in the 2320 loop: • CAS01 = "PR" (Patient Responsibility) • CAS02 = 1 (Deductible) **For Medicare Part A:** Coinsurance amounts (previously identified by Value Codes A2, B2, C2) use Value codes 09-11 (CAS Segment is not required). **For Medicare Part B:** Coinsurance amounts should be submitted at the 2430 loop. • CAS01 = "PR" (Patient Responsibility) • CAS02 = 2 (Coinsurance)

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CAS01	Claim Adjustment Group Code	CO CR OA PI PR	**CO** (Contractual Obligations) **CR** (Corrections and Reversals) **OA** (Other Adjustments) **PI** (Payer Initiated Reductions) **PR** (Patient Responsibility)
	CAS02	Claim Adjustment Reason Code		Enter Adjustment Reason Code at the claim level
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2410	LIN	Drug Identification		AmeriHealth requires submission of Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Populate LIN01 with 'N4' and LIN02 with the National Drug Code (NDC).
2410	CPT	Pricing Information		AmeriHealth requires the submission of Loop ID 2410 and the provision of a price specific to the NDC provided in LIN03 that is different from the price reported in SV102.
	CPT04	Quantity		Enter National Drug Unit Count
	CPT05-1	Unit or Basis for Measurement	F2 GR ME ML UN	**F2** for International Unit **GR** for Gram **ME** for Milligram **ML** for Milliliter **UN** for Unit

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2410	REF	Reference Identification		AmeriHealth requires the submission of Loop ID 2410 if dispensing of the drug has been done with an assigned Rx number.
	REF01	Reference Identification Qualifier	XZ	
	REF02	Reference Identification		Prescription Number

10.3 005010X214 Health Care Claim Acknowledgment (277CA)

Refer to Section 7.4 for AmeriHealth business rules and limitations for this specific transaction.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	95044	This matches the ID in the GS03 of the claim transaction.
	GS03	Application Receiver's Code		This is the Trading Partner ID for the entity receiving this transaction.
2100A	NM1	Information Source Name		
	NM109	Information Source Identifier	95044	This matches the payer ID in the GS03 of the claim transaction.
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This is the assigned Trading Partner number for the entity that submitted the original 837 transaction.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge receipt of the claim transaction by the payer. It does not mean all of the claims have been accepted for processing. We will not report rejected claims at this level.
	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
	STC01-2	Health Care Claim Status Code	19	Default value for this status level.
	STC01-3	Entity Identifier Code	PR	Default value for this status level.
	STC03	Action Code	WQ	This element is set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
	STC04	Total Submitted Charges		In most instances this is the sum of all claim dollars (CLM02) from the 837 being acknowledged. In instances where the claim dollars do not match, an exception process occurred. See Section 7.3 about the exception process.
2200C		Provider of Service Information Trace Identifier		The 2200C loop is used. Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Relational edits between claim and line level data will be reported at the service level.
	STC01-2	Health Care Claim Status Code	247	Health Care Claim Status Code '247 - Line Information' will be used at the claim level when the reason for the rejection is line specific.
2200D	DTP	Claim Level Service Date		
	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Claim Service Period		The earliest and latest service line dates will be used as the claim level range date for professional claims. When the service line is a single date of service, the same date will be used for the range date.
2220D	STC	Service Line Level Status Information		Relational edits between claim and line level data will be reported at the service level.
2220D	DTP	Service Line Date		
	DTP02	Date Time Period Format Qualifier	RD8	RD8 is used
	DTP03	Service Line Date		When the service line date is a single date of service, the same date will be used for the range date.

10.4 005010X221A1 Health Care Claim Payment/Advice (835)

Refer to Section 7.4 for AmeriHealth business rules and limitations for this specific transaction.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	95044	This should be a hardcoded value for AmeriHealth business.
	GS03	Application Receiver's Code		This will always be the Trading Partner number for the entity receiving this transaction.
	BPR	Financial Information		

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	BPR01	Transaction Handling Code	H	**The 837 contains the remittance details only. Payment is sent separately (EFT or check).**
	BPR04	Payment Method Code	ACH or CHK	**ACH is used when provider is set up for EFT. CHK is used when provider is set up to receive a check.**
	REF	Receiver Identification		
	REF02	Receiver Identification		This will be the Trading Partner number assigned by Highmark's EDI Operations for transmission of Health Care Claim Payment/Advice (835) transactions
1000A	REF	Additional Payer Identification		
	REF01	Reference Identification Qualifier	NF	This value will always be used.
	REF02	Additional Payer Identification	95044	AmeriHealth
1000B	REF	Additional Payee Identification		
	REF01	Additional Payee Identification Qualifier	TJ	The Provider's Tax Identification Number will be sent when the Provider's NPI is sent in the 1000 Payee Identification in N104
	REF02	Additional Payee Identifier		Additional Payee Number
2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.

	LX01	Assigned Number	1	All claims except AmeriHealth-identified overpayment reversal and correction claims where refund offset is delayed.
	LX01	Assigned Number	2	AmeriHealth-identified overpayment reversal and correction claims where refund offset is delayed. Refer to Section 7.4 of this document for further information.
2100	CAS	Claim Adjustment		

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CAS01	Claim Adjustment Group Code	OA	**Health Care Spending Account use:** This Group Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.
	CAS02	Claim Adjustment Reason Code	23	**Health Care Spending Account use:** This Reason Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.
2100	NM1	Crossover Carrier Name		This segment will only be used to report a situation when AmeriHealth indicates the claim has been processed by AmeriHealth and is being transferred to a second AmeriHealth coverage.
2100	NM1	Corrected Priority Payer Name		
	NM108	Identification Code Qualifier	PI	AmeriHealth uses this value
	NM109	Identification Code		Other payer IDs are not currently retained therefore a default value of 99999 will be used in this element.
2100	REF	Other Claim Related Identification		
	REF01	Reference Identification Qualifier	CE	

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	REF02	Other Claim Related Identifier		**Professional claims:** This value is used to provide the payer's Class of Contract Code and code description. **Institutional claims:** This value is used to provide the Reimbursement Method Code.
2110	SVC	Service Payment Information		
	SVC01-2	Adjudicated Procedure Code		The applicable Unlisted Code will be returned in this data element when a paper professional or institutional claim was submitted without a valid procedure or revenue code: • 99199 – Unlisted HCPCS Procedure code (SVC01-1 qualifier is HC) • 0949 – Unlisted Revenue code (SVC01-1 qualifier is NU)
	PLB	Provider Adjustment		
	PLB01	Reference Identification		When the Provider is a covered health care provider under HIPAA, the National Provider Identifier (NPI) assigned to the Provider is required.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	CS	This value will be used for financial arrangement adjustments such as Bulk Adjustments, Cost Rate Adjustments, etc. Supporting identification information will be provided in the Reference Identification element.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	FB	This value will be used to reflect balance forward refund amounts between weekly Health Care Claim Payment/Advice (835) transactions. Refer to Section 7.4 for more information.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	L6	This value will be used to reflect the interest paid or refunded for penalties incurred as a result of legislated guidelines for timely claim processing. Refer to Section 7.4 of this document for more information on interest related to deferred refunds.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	WO	This value will be used for recouping claim overpayments and reporting offset dollar amounts. Refer to Section 7.4 for more information.
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Provider Adjustment Reason Code is “FB” the Provider Adjustment Identifier will contain the applicable 835 Identifier as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Adjustment Reason Code is “WO”, the Provider Adjustment Identifier will contain the AmeriHealth Claim Number for the claim associated to this refund recovery. For AmeriHealth-identified overpayments, the claim number will be followed by the word “DEFER” (example: 06123456789DEFER) when the reversal and correction claims are shown on the current Health Care Claim Payment/Advice (835), but the refund amount will not be deducted until after the appeal period. Refer to Section 7.5 for more information on Claim Overpayment Refunds.

10.5 00501279XA1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Refer to Section 7.5 for AmeriHealth business rules and limitations.

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		The receiver's assigned Trading Partner Number will be used, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54704	
BHT02		Transaction Set Purpose Code	01	AmeriHealth does not process this code if received.
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use this code to indicate that AmeriHealth is a payer.
	NM103	Information Source Last or Organization Name		The information in this element will not be captured and used in the processing.
	NM108	Identification Code Qualifier	NI	Use this code to indicate the NAIC value is being sent in NM109.
	NM109	Information Source Primary Identifier	54704	AmeriHealth
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	2B 36 P5	AmeriHealth business practices do not allow for eligibility inquiries from Third Party Administrators (2B), Employers (36), or Plan Sponsors (P5).
	NM108	Identification Code Qualifier	XX PI	Provider Request Payer Request
	NM109	Identification Code		
2100B	REF	Information Receiver		The information in this segment will not be

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
		Additional Identification		captured and used in the processing.
2100B	N3	Information Receiver Address		The information in this segment will not be captured and used in the processing.
2100B	N4	Information Receiver City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		Enter ID Number from the Patient's current ID card Example: AmeriHealth HMO-Q3C1234567800-
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help AmeriHealth identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100C	N3	Subscriber Address		The information in this segment will not be captured and used in the processing.
2100C	N4	Subscriber City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	HI	Subscriber Health Care Diagnosis Code		AmeriHealth does not process eligibility responses at the Diagnosis level. Do not send.
2100C	DTP	Subscriber Date		
	DTP03	Date Time Period		AmeriHealth will respond to requests up to 24 months prior to the current date and will respond with current coverage if the requested date is up to 6 months in the future. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth will

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
				use the first date of the date range for processing
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Enter code value: The service types where AmeriHealth is able to provide specific benefit limitations and details.
	EQ01	Service Type Code	35	AmeriHealth only provides coverage for medical services. Dental inquiries must be forwarded to the subscriber's dental plan accordingly.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BK, BE, BJ, BK, BL, BM, BN, BP, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	AmeriHealth does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code.
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, AmeriHealth will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, BZ and MH.
	EQ02	Composite Medical Procedure Identifier		AmeriHealth does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01.
	EQ03	Coverage Level Code	FAM	AmeriHealth does not process inquiries at the contract, or family, level. The 271 response will include only subscriber eligibility information.
2110C	III	Subscriber Eligibility or Benefit Additional		AmeriHealth does not consider the information in the III segment for processing.

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
		Inquiry Information		
2110C	DTP	Subscriber Eligibility/ Benefit Date		
	DTP03	Date Time Period		AmeriHealth will respond to requests up to 24 months prior to the current date and will respond with current coverage if the requested date is up to 6 months in the future. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth will use the first date of the date range for processing.
2100D	REF	Dependent Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help AmeriHealth identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100D	N3	Dependent Address		The information in this segment will not be captured and used in the processing.
2100D	N4	Dependent City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	HI	Dependent Health Care Diagnosis Code		AmeriHealth does not process eligibility responses at the Diagnosis level. Do not send.
2100D	DTP	Dependent Date		
	DTP03	Date Time Period		AmeriHealth will respond to requests up to 24 months prior to the current date and will respond with current coverage if the requested date is up to 6 months in the future. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth will use the first date of the date range for processing.

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110D	EQ	Dependent Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		AmeriHealth will accept this as a repeating element when applicable.
	EQ01	Service Type Code	35	AmeriHealth only provides coverage for medical services. Dental inquiries must be forwarded to the subscriber's dental plan accordingly.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BE, BJ, BK, BL, BM, BN, BP, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	AmeriHealth does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code.
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, AmeriHealth will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, BZ and MH.
	EQ02	Composite Medical Procedure Identifier		AmeriHealth does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01.
2110D	III	Dependent Eligibility or Benefit Additional Inquiry Information		AmeriHealth does not consider the information in the III segment for processing.
2110D	DTP	Dependent Eligibility/ Benefit Date		
	DTP03	Date Time Period		AmeriHealth will respond to requests up to 24 months prior to the current date and will respond with current coverage if the requested

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
				date is up to 6 months in the future. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth will use the first date of the date range for processing.
	GS	Functional Group Header		
	GS02	Application Sender's Code	54704	This will match the payer ID in the GS03 of the 270 transaction.
	GS03	Application Receiver's Code		The receiver's assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
2100C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		AmeriHealth will accept up to 60 characters on the 270 Inquiry.
	NM104	Subscriber First Name		AmeriHealth will accept up to 35 characters on the 270 Inquiry.
	NM108	Identification Code Qualifier	MI	This is the only qualifier AmeriHealth will return on the 271 Response.
	NM109	Subscriber Primary Identifier		If a contract ID that is not a Unique Member ID (UMI) is submitted, AmeriHealth will return the corrected UMI in this element. The submitted ID will be returned in a REF segment with a Q4 qualifier.
2110C	EB	Subscriber Eligibility or Benefit Information		AmeriHealth will populate this segment with the Eligibility Benefit Information Code(s) R or 30 as applicable and Insurance code type GP as well as Plan Coverage Description when a member is found to have greater than one active policy.

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110C	DTP	Subscriber Eligibility/ Benefit Date		
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re-certification date	AmeriHealth will return the Coordination of Benefits eligibility, effective, cancel, or certification dates, if applicable.
2110C	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".
2100D	NM1	Dependent Name		
	NM103	Dependent Last Name		AmeriHealth will accept up to 60 characters on the 270 Inquiry.
	NM104	Dependent First Name		AmeriHealth will accept up to 35 characters on the 270 Inquiry.
2110D	EB	Dependent Eligibility or Benefit Information		
	EB03	Service Type Code		AmeriHealth will return this as a repeating element when applicable.
2110D	DTP	Dependent Eligibility/ Benefit Date		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re-certification date	AmeriHealth will return the Coordination of Benefits eligibility, effective, cancel, or certification dates, if applicable.
2110D	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".

10.6 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Refer to Section 7.6 for AmeriHealth business rules and limitations for this transaction.

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		For AmeriHealth, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be
2100	CTX	Business Unit Identifier		For AmeriHealth, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment; therefore, when there are errors in the submitted GS, “TRADING PARTNER PROFILE” will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		For AmeriHealth, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.

Appendices

1. Implementation Checklist

AmeriHealth does not have an Implementation Checklist.

2. Business Scenarios

No business scenarios at this time.

3. Transmission Examples

No examples at this time.

4. Frequently Asked Questions

No FAQs at this time.

5. Change Summary

The items listed in the chart below were revised from the September 2021 version to this July 2023 version of the Companion Guide. Please note that there were no changes to transaction-specific information or codes.

Page(s)	Section	Description
27	7.4	Updated navigation for EFT Resources
29	7.4	Removed information regarding provider payment from member health care accounts