837 PROFESSIONAL COMPANION GUIDE

This document is being provided for the purposes of 837 Professional testing. Any provider that wishes to submit claims via an 837 must follow this testing process prior to submission.

If you have already been certified by Alpha, you do NOT have to go through the testing process. Once the live system is up, please verify that your agency has been marked as "EDI Certified". This can be seen in the Provider Base tile.

Please contact the Helpdesk at (919) 651-8500 to request information on additional 837 Testing and FTP Client setup instructions, and/or next steps. You may also submit this request via email to Alliance837Support@AllianceBHC.org.

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, ASC X12N 837 (005010X222A1)**. It contains data clarifications authorized by Alliance Health. The clarifications include:

- Identifiers to use when a national standard has not been adopted [and]
- Parameters in the implementation guide that provide options.

The Implementation Guides may be found at the Washington Publishing Company's website (http://www.wpc-edi.com), for current HIPAA transaction standards for the 837, Health Care Claim: Professional (ASC X12N, version **005010X222A1**).

Critical Additional Notes:

- **You are responsible for keeping track of your file names and contents.**

This document specifically does not address every data element, whether required or optional, nor every scenario nor situation that the National Implementation Guides address. It is vital that you, your software vendor, or claim service provider conform to the specifications as detailed in the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional. The purpose of this document is to assist you in the proper completion for submission to Alliance. Information provided in this guide is subject to change.

Acknowledgements

A 999 Acknowledgement report will be sent to the trading partner's or provider's DOWNLOAD area for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement reports are available within moments of submission. **Please note that you are responsible for troubleshooting any errors that may be produced.**

Page	Loop	Segment	Data Element	Comments
	Header	ISA	ISA03	**use "00" – No Security Information Present.**
			ISA05	**use "ZZ" – Mutually Defined.**
			ISA06	**use the Provider Number assigned to you by Alliance. For testing purposes, please use any 5 digit number. Once live, this number will be the SFTP username you will receive.**
			ISA07	**use "ZZ" – Mutually Defined.**
			ISA08	**use "23071"**
	Header	GS	GS02	**use the 5 digit Submitter ID/Mailbox # issued by Alliance. This is the same value as provided in the ISA06.**
			GS03	**use "23071"**
	1000A		NM108	**use "46" - Electronic Transmitter Identification Number (ETIN) established by a trading partner agreement**
			NM109	**use the Provider Number assigned to you by Alliance. This is the same value as provided in the ISA06.**
	1000B	NM1	NM103	**use "ALLIANCE"**
			NM109	**use "23071"**
	2000A	PRV	PRV01	**use "BI" to indicate billing provider**
			PRV02	**use qualifier "PXC" – Health Care Provider Taxonomy Code. Note: not required for atypical providers.**
			PRV03	**Provider Taxonomy Codes, as maintained by the National Uniform Claim Committee, can be obtained from www.wpc-edi.com/hipaa. Submit the Provider Taxonomy that best fits provider type and specialty for the billing provider.**
	2000B	SBR	SBR09	**use "11" for State claims , use "MC" for Medicaid**
	2010BA	NM1	NM102	**use "1" to indicate the subscriber is a person.**
			NM108	**use "MI" -Member Identification Number Qualifier**
			NM109	**enter the member's identification number assigned by Alliance. Or the Medicaid ID for Medicaid Clients**
	2010BB	NM1	NM108	**use "PI"**
			NM109	**use "23071"**
		REF	REF01	**use "G2" to report Atypical provider data.**
			REF02	**Used by atypical providers to report Medicaid Provider number.**
	2300	DTP		**this segment used to report date of first treatment/date first seen.** **DTP*454*D8*20121001~**
		PWK	PWK01	**submit OZ – Support Data for Claim – only to be used in combination with PWK02 to indicate Medicare does not cover the service submitted Follow rules of implementation guide for other claim paperwork**
			PWK02	**submit "AA" – Available on Request at Provider Site – only to be used to indicate Medicare does not cover the service. NC DMA billing instructions for Medicare Overrides, or Medicare voucher indicating the service was not covered by Medicare must be kept on file at the provider's site. Follow rules of implementation guide for other claim paperwork**

Page	Loop	Segment	Data Element	Comments
	Not required		PWK06	**provider 10-digit Control number Not required.**
	Not required			
	Not required			
		CRC	CRC03	**use to report EPSDT, Health Check, referral status**
			CRC04	**use to report EPSDT, Health Check, referral status**
			CRC05	**use to report EPSDT, Health Check, referral status**
	2310A	NM		**use to report Carolina Access primary care provider, local management entity, or a psychiatrist authorization information, as required by DMA policy.**
	2310A	NM	NM103	**When referring provider is a group or office, please provide name of organization as the provider last name or UNKNOWN**
			NM109	**For NC Medicaid this element is used to report the NPI of the Carolina ACCESS primary care provider, local management entity, or psychiatrist.**
		REF		**For NC Medicaid, used to report Carolina Access Override information when required.**
			REF01	**For NC Medicaid, use a value of "G2" – to report Carolina Access Override number.**
			REF02	**For NC Medicaid, use Carolina Access issued override number.**
	2310B	REF	REF01	**use "G2" to report Atypical provider data.**
			REF02	**use the NC Medicaid issued provider number.**
	2320	AMT	AMT01	**uses "D" – Payer Amount qualifier code in this AMT segment, no other qualifiers used in claims processing.**
			AMT02	**Enter the amount collected from private insurance.**
	2400	SV1	SV101-01	**use "HC" – HCFA HCPC Codes**
	2410	LIN		**this loop is required when submitting a drug related HCPCS procedure code.**
			LIN03	**enter the National Drug code in this field when applicable.**
		CTP	CTP04	**enter the numeric quantity in this field**
			CTP05-1	**enter the unit of measurement that corresponds to the value enter in the CTP04.**
		REF	REF01	**use "VY" for a link sequence number of the compound drug.**
			REF02	**only the first ten bytes of the reference number will be used.**
	2420A		REF01	**use "G2" - when billing for Atypical providers.**
			REF02	**used by atypical providers to report Medicaid issued provider number**