

5.8 837R (Hospital) Reporting Claim Submissions

Uploaded files are not limited in total size, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.

This document notes only the loops and elements relevant to WHAIC data collection specifications as defined by the State Statute. It is not intended to serve as a complete 837 reference, and not all requirements for a valid 837 file are specified. **Elements not mentioned in this document will be discarded by WHAIC prior to the file processing in Wlpop, if supplied.**

Fields defined, created, or added by WHAIC from the 837 claims file

Patient Type (Inpatient, outpatient surgery)	Type of Encounter (INP =1) (OutPt = 2)	Place of Service
Principal Procedure on OP Records	Principal Procedure Date	Additional Procedures on OPS records
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	Leave of Absence Days

Legend

Name	Data Edit/ Name	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank
S	Situational	Required based upon values in the claim/EMR or other elements
O	Optional	Element not required and may be left blank, however, if submitted, it will be edited.
Gray shade	Wlpop Name / Field #	Data is not stored, but may be sent, and may be used to route data in Wlpop

837R sample file: <https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837R-Sample-File.pdf>

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	Optional field
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. See Appendix 7.1 Facility List Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID	ISA06, GS02 and 1000A/NM109 must match.
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	Optional field
0000	ST03	Implementation Guide Version	R	005010X223A2	Required but not stored

LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail

LOOP 1000A: SUBMITTER NAME

NM1*41*2*SAMPLE HOSPITAL*****46*333~

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
PER*IC*SUBMITTER NAME*TE*614222222~ LOOP 1000B: RECEIVER NAME NM1*40*2*WHAIC*****46*WHAIC 837~					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	Vendor name, Hospital or ASC name	
1000A	NM108	Identification Code Qualifier	R	46	
1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Facility ID - Appendix 7.1 Facility List	ISA06, GS02 and 1000A/NM109 must match.
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	Use WHAIC – This identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	(837R – uses SJ = Service Provider)
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility NPI Number (Billing Provider NPI) WHAIC has on File.	Notify WHAIC of all subpart NPI's to allow us time to update our tables.
Patient and/or Subscriber Detail: Patient Detail Required when the patient <i>is different</i> from the Subscriber. If not required by this Implementation Guide, do not send. DO NOT SEND 2010CA <i>IF</i> PATIENT IS SUBSCRIBER					
Patient / Subscriber details cannot be determined until processing of UCID					
Required v. Situational <i>depends on</i> if the patient is the subscriber. LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~ SBR*P**CERTNUM2222SJ~ LOOP 2010BA: SUBSCRIBER NAME NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~ N3*236 N MAIN ST~ N4*MADISON*WI*53717~ DMG*D8*19830501*F*M*5:2~					
2000B	SBR03	Policy Number – Insurance	R/S	Send "NULL" if Self-pay	Do not default to all zeroes.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
		SBR03 is Policy, Group Number, Member ID, Certificate Number.		The <u>term policy number or group number is synonymous</u> with insurance ID, member ID, insurance code, Plan number, etc. <i>any number on the card or in the file that identifies the patient to the carrier.</i> *SEE FAQ – for more info 837R Users – SB03 may require a Form Override to send Subscriber ID / Policy or Group number that would otherwise be sent in NM109.	NULL is necessary because that element is required in the 837 spec, and we are trying to conform to the rules as much as we can.
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim Appendix 7.3.1 – list of codes	New Field Q12020: See Appendix 7.3.1 for codes
2010BA	NM103	Subscriber Last Name	R/S	Subscriber names are not accepted. Send “NULL.” NM104 – NM107 must be blank.	Patient Detail Required when the patient <i>is different</i> from the Subscriber
2010CA	NM103	Patient Last Name	R/S	Patient names are not accepted. Send “NULL.” NM104 – NM107 must be blank.	Send “NULL.” NM104 – NM107 must be blank.
2010BA	NM109	Subscriber UCID	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is UCID UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name.
2010CA	NM109	Patient UCID	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name.
2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient’s census block group. The block group, but not the address, will be saved in Wlpop. Physical address discarded.	Census Block Group - Typically, the block group number populate in Wlpop during overnight processing. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Address, City, State and Zip will be used to find the patient’s census block group. The block group, but not the address, will be saved in Wlpop.	Census Block Group - Typically, the block group number populate in Wlpop during overnight processing. Files rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC	Value not stored

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
				Loop 2010CA, NM102 = 1	
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	*File rejected if more than 10% of records missing address
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	*File rejected if more than 10% of records missing address
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Zip Code Stored in Wlpop
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in Wlpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender / Sex Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	F, M, X, U and O (U or O requires Cond Code 45)
2010CA	DMG03	Patient Gender / Sex Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	F, M, X, U and O (U or O requires Cond Code 45)
2010BA	DMG04	Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Marital Status Codes	Marital Status optional field, supply if collected.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Marital Status Codes	Marital Status optional field, supply if collected.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 7.2	RS	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of 5:2:3 is treated as Race = 5, Ethnicity = 2, Race2 = 3 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. The first character is either R (race) or E (ethnicity).	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for Wlpop fields RACE and RACE2.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
				Second character is the race or ethnicity code. DMG*D. 9830501*F*M*:RET:R3^:RET:E1~	The first entry for ethnicity will be used for field ETHN. File rejected if >25% of records are declined/unknown
2010CA	DMG05-1	Patient Race Code1 See Appendix 7.2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 For each entry: DMG05-1: Leave empty DMG05-2: Value is RET (race or ethnicity) DMG05-3: Two-character value. First character is either R (race) or E (ethnicity). Second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, repeats up to 10 times. The first two entries for race will be used for Wlpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN. File rejected if >25% of records are declined/unknown
2010BA	DMG05-2	Subscriber Ethnicity Code See Appendix 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	File rejected if >25% of records are declined/unknown
2010CA	DMG05-2	Patient Ethnicity Code See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	File rejected if >25% of records are declined/unknown
2010BA	DMG05-3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Report only if more than one race is collected.
2010CA	DMG05-3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Report only if more than one race is collected.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined	DMG10 = ZZ
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined	DMG10 = ZZ
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	See Appendix 7.3.1 for Code List Mapping
LOOP ID - 2010BB Payer Detail					
LOOP 2010BB: PAYER NAME					

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
NM1*PR*1*PRIMARY PAYER NAME*****PI*A21-09~					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	S	Name of Payer Organization as provided on the claim.	.
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code *Self-pay requires OTH-61	R	WHAIC Values in Appendix 7.3 Element format is AAA-99 Example A21-09 Primary Source of Payment ID	SOPID is characters 1-3 - SOPTYPE is characters 5-6 The dash is preferred, but not required
2010BB	REF01	REF ID Qualifier for Payer ID#	S	NF = Payer ID number See Appendix 7.3.2 for more information.	New Q32019: Payer Identifier on EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID #	S	Enter the Value of the Payer ID# See Appendix 7.3.2 for more information.	Refer to Appendix 7.3.2 for additional info.
<p>LOOP ID – 2300 CLAIM INFORMATION</p> <p>LOOP 2300: CLAIM INFORMATION</p> <p>CLM*PCTRL535*2500.50***11:A:1**A*Y*Y~</p> <p>DTP*096*DT*201702032359~</p> <p>DTP*434*RD8*20170202-20170203~</p> <p>DTP*435*DT*201702022359~</p> <p>CL1*2*1*20~</p> <p>REF*LU*MN~</p> <p>REF*EA*MRN123~</p> <p>HI*ABK:G9782:.....Y~</p> <p>HI*ABJ:G9389~</p> <p>HI*APR:G9389*APR:N179~</p> <p>HI*ABF:A4152:.....N*ABF:G918:.....Y*ABF:N179:.....Y*ABF:B370:.....N~</p>					
2300	CLM01	Patient Control Number	R	Use Patient Control Number *File rejected for Duplicate Patient control numbers. IF duplicates are found, resubmit file with this phrase anywhere in the file name: Exclude_duplicates Ex: Q322hospitalname exclude_duplicates	PCONTROL or PCTRL Do not use special characters <> IF duplicates are found, resubmit file and add exclude_duplicates anywhere in file name.

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
2300	CLM02	Total Claim Charge	R	Total Charges in SV2 must match this number. The total amount of all submitted charges of service for this claim. **Exclude Professional fees**	Total charges from revenue line-item details must match claim detail in Wlpop
2300	CLM05-1	Type of Bill – Facility Type Code	R	WHAIC mapping required: Appendix 7.4 TOB Exclusions and special mapping apply.	Leading zero not required in 837 claims file.
2300	CLM05-02	Facility Code Qualifier	O	A – Uniform Billing Claim Form Bill Type	Ignored in the Wlpop data
2300	CLM05-3	Type of Bill – Claim Frequency Code	R	WHAIC Exclusions Apply: Appendix 7.4 TOB Do not send values from 5-9 or alpha characters “1” – Admit through Discharge claim includes bills representing total confinement or course of tx. “2” - indicates Interim – first claim “3” – indicates interim – continuing claim “4” – indicates interim – Last Claim – used for the last of a series of bills, for the same confinement or course of treatment. Claim Frequency Code ‘0’ must be used on non-payment zero charge claims.	Ex: 131 1 (hospital) 3 (outpatient) 1 (admit/discharge claim) Claim Frequency Code ‘0’ must be used on non-payment zero charge claims.
2300	DTP01	Discharge Date Qualifier	S	096	
2300	DTP02	Discharge Date Format Qualifier	S	DT	
2300	DTP03	Discharge Date/ Time	S	CCYYMMDDHHMM DDAT is first 8 characters DTIME is last 4 characters Required on INP and ED records only	Discharge Date required for INP & ED. Discharge Time required for INP May be provided on other record types. Cannot provide Admission date w/o discharge date.
2300	DTP01	Statement Dates Qualifier	R	434	
2300	DTP02	Statement Date / Time Format Qualifier	R	RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Use RD8 (range of dates) to indicate the “from and through (To)” date of the statement. When the statement is for a single date of service, the ‘from and through’ date are the same.	Required on Outpatient Records / Encounters
2300	DTP03	Statement From and Through (To) Dates	S	CCYYMMDD-CCYYMMDD STPERODF is first 8 characters STPERODT is last 8 characters	Required = Outpatient (observation, lab/rad therapies, etc.)

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	Wlpop Field Name/ Field Notes
2300	DTP01	Admission Date / Time Qualifier	S	435 Required on Inpatient and Emergency Dept. Only	May be provided on other record types. Cannot provide Admission date w/o discharge date.
2300	DTP02	Admission Time Period	S	DT Required on Inpatient	ER records can use 12:00 if not collected
2300	DTP03	Admission Date and Hour	S	CCYYMMDDHHMM ADAT is first 8 characters ADMTIME is last 4 characters Admission Date Required on Inpatient and ER/ED claims.	Wlpop: Admission Date/Time Admission Time – Req on INP
2300	CL101	Priority (Type) of Admission or visit / Admission Type Code	R	National Uniform Billing Codes *Appendix is included, see 7.7.1 for code list.	Wlpop: Admit Type
2300	CL102	Point of Origin for Admission or Visit	R	NUBC Codes – Required on all Bill Types except 014X See Appendix 7.7	Wlpop: Point of Origin See Appendix 7.7
2300	CL103	Discharge (Patient) Status	R	Per NUBC: Required on all institutional claims.	Wlpop: Discharge Status See Appendix 7.8
2300	REF01	Auto Accident State Qualifier	S	LU = Location Number	
2300	REF02	Auto Accident State	S	Use valid 2- digit U.S. State code	Accident State – where the accident occurred

Service Facility and Provider-base Location (PBL) Details:

****Note – In the 837R:** Segment NTE may be used as alternate means to supply the service facility/provider-based location (PBL) ID.

Use only if your vendor software will not allow you to send loop 2310E. If both are supplied, the value in 2310E will be used.

PBL NOTE: The 837R “Reporting” specification does not include the 2310E Loop. Developers programming the Provider Based Location (PBL) detail must use the NTE segment and send PBL ID in Loop 2300 - NTE02, as noted below.

At the time of this release: The 2310E section is grayed out for the 837R, but users are not discouraged from usage in loop 2310E if available in program.

2300	NTE01	Service Facility Location Identifier	S	UPI = Service Facility Location Identifier *** Send only if this visit applies to a PBL*** See NTE segment above if not using this to report PBL	*Epic use NTE segment.
2300	NTE02	Service Facility Location Value	S	Set to PBL ID Number Provider Based Location ID Leading zero will be discarded.	Set to PBL ID Off-campus hospitals & facilities that share the same Medicare # must report ALL

					services with Location ID.
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	Wlpop: MRN (WHAIC does not locate record using MRN)
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	
2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code Do not use the decimal point	Principal Diagnosis – follow correct coding guidelines.
2300	HI01-9	Present on Admission (POA)	S	Y, N, U, W – INP ONLY Leave blank for exempt – per CMS.	Wlpop: Principal Diagnosis POA. For a list of exempt codes: see CDC.gov
2300	HI01-1	Admitting Diagnosis Qualifier	S	ABJ	
2300	HI01-2	Admitting Diagnosis ICD-10 Code	R/S	ICD-10 Code – Decimals not allowed R= Inpatient ONLY	Wlpop: Admitting Diagnosis required on INP only.
2300	HI01-1	Reason for Visit Qualifier	R/S	APR R = Outpatient Only	
2300	HI01-2	Reason for Visit ICD-10	S	ICD diagnosis codes describes patient's stated reason for visit at the time of outpatient registration. R = Outpatient Required on TOB 013X, 078X, and 085X when: type of admission or visit codes 1, 2 or 5 are reported; and Rev codes 045X, 0516, 0526 or 0762 reported.	Reason for Visit Diagnosis 1 – required on OP records
2300	HI02-1	Reason for Visit Qualifier	S	APR	
2300	HI02-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded	Reason for Visit Diagnosis 2 – required on OP records if documented
2300	HI03-1	Reason for Visit Qualifier	S	APR	
2300	HI03-2	Reason for Visit ICD-10	S	ICD-10 Code R = Outpatient if applicable and coded	Reason for Visit Diagnosis 3 – required if coded
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 Codes *Additional Diagnosis in Wlpop	Additional DIAGNOSIS and External Cause Codes

2300	HIOX-9	Other Diagnosis - Present on Admission Indicator	S	Y, N, U, W – INP only Leave blank for exempt – per CMS	Additional Diagnosis and External Cause Codes
2300	HIOX-1	External Cause of Injury Qualifier	S	ABN	
2300	HIOX-2	External Cause of Injury ICD-10 Codes	S	Required on ICD-10 Codes in the S range and some in the T range –Applies only to INP, ED, OPS and OBS records.	Additional Diagnosis and External Cause Codes
2300	HIOX-9	External Cause Present on Admission	S	Y, N, U, W – INP only	Additional Diagnosis and External Cause Codes
2300	HI01-1	Principal Procedure Qualifier	S	BBR for ICD-10 Procedure Codes	
2300	HI01-2	Principal Procedure Code	S	Hospital supplies ICD-10 Procedure codes for inpatient stays. No decimal point. Do Not Hard Code CPT/HCPCS into this field.	WHAIC populates OP Procedure codes based on Revenue Code detail
2300	HI01-3	Principal procedure Date qualifier	S	D8	
2300	HI01-4	Principal procedure Date	S	CCYYMMDD – Required when a Principal Procedure is provided on INP records	Principal Procedure Date WHAIC will populate Outpatient Records based on revenue line-item details
2300	HIOX-1	Additional / Other Procedure Code Qualifier	S	BBQ – ICD-10 Procedure codes verify with addenda	
2300	HIOX-2	Additional Procedure Codes	S	ICD-10 Procedure codes for inpatient stays.	Additional Procedures are populated by WHAIC from revenue codes in rev line item
2300	HIOX-3	Additional/Other Procedure Dates	S	D8	
2300	HIOX-4	Additional/Other Procedure Date	S	CCYYMMDD Facility File will only have INP procedure dates.	Additional / Other Procedure DATE WHAIC populates
2300	HIOX-1	Occurrence Span Qualifier	S	BI	
2300	HIOX-2	Occurrence Span Code	S	Occurrence Code 1-4: NUBC Billing Codes	WHAIC will record the first 4 occurrence codes, others will be discarded.
2300	HIOX-3	Occurrence Span Code Date Qualifier	S	RD8	
2300	HIOX-4	Occurrence Span Code Range of Dates	S	CCYYMMDD-CCYYMMDD OCCSTART is first 8 characters OCCEND is last 8 characters	Occurrence Code 1 Start / End. Follow 837 file layout

2300	HIOX-1	Occurrence Code Qualifier	S	BH	
2300	HIOX-2	Occurrence Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04	
2300	HIOX-3	Occurrence Code Date Qualifier	S	D8 (meaning one date)	
2300	HIOX-4	Occurrence Code Date	S	CCYYMMDD OCCSTART and OCCEND set to same value	WHAIC will record the first 4 occurrence codes/dates.
2300	HIOX-1	Value Code Qualifier	S	BE	
2300	HIOX-2	Value Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04 The first 4 value codes will be saved in Wipop	WHAIC will record the first 4 Value Codes, others will be discarded.
2300	HIOX-5	Value Code Amount	S	No decimals Value Code Amounts 1 thru 4 recorded.	WHAIC will record the first 4 Value code amounts.
2300	HIOX-1	Condition Code Qualifier	S	BG	
2300	HIOX-2	Condition Code	S	NUBC Billing Codes The first 4 condition codes will be saved in Wipop	WHAIC stores the first 4 Condition Codes.
LOOP ID 2310 (A – F) PROVIDER Information LOOP 2310A: ATTENDING PHYSICIAN NAME NM1*71*1*ATTENDING*****XX*9876543210~ LOOP 2310B: OPERATING PHYSICIAN NAME NM1*72*1*OPERATING*****XX*9876543211~					
2310A	NM101	Attending ID Code	S	71 = Attending Physician/Provider	
2310A	NM108	Attending Provider ID Qualifier	S	XX = NPI	
2310A	NM109	Attending Provider ID NPI	S	Use Attending Provider NPI Number Provider = Any Qualified Health Care Provider NPI –	Wipop: Attending NPI Required INP and ED
2310B	NM101	Operating Entity ID Code	S	72 = Operating Provider	
2310B	NM108	Operating ID Code Qualifier	S	XX = NPI	
2310B	NM109	Operating Provider NPI Number	S	Use Operating Provider NPI Number Required on Outpatient Surgery (OPS)	Wipop: Operating NPI
2310C	NM101	Other Operating Code Qualifier	S	ZZ = Other Operating Provider	
2310C	NM108	Other Operating ID Qualifier	S	XX = NPI	
2310C	NM109	Other Operating Provider NPI	S	Use Other Operating provider NPI Number	Wipop: Other Operating NPI
2310D	NM101	Rendering ID code	S	82 = Rendering Provider	
2310D	NM108	Rendering ID Code Qualifier	S	XX = NPI	
2310D	NM109	Rendering Provider NPI number	S	Use Rendering Provider NPI number	Most often used on the 837P

2310E	NM101	Service Facility Location Identifier	S	77 = Service Facility Location *** applies to Hospitals that have off-campus hospitals and outpatient facilities that share the same Medicare number as the main hospital***	837R – see the 2300 / NTE segment above.
2310E	NM108	Service Facility Location Qualifier	S	PI = Provider ID	
2310E	NM109	Service Facility Location Value	S	Service Facility / Provider Based Location (PBL) ID A leading zero is not necessary and will be discarded.	Service/Provider-Based Location ID is assigned by WHAIC.
2310F	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310F	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310F	NM109	Referring Provider NPI	S	Use Referring Provider NPI *This is not the billing provider – sometimes PCP*	The individual who directed the patient for care to the provider that rendered the services.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if applicable					
2320	SBR01	Payer Responsibility Sequence Code	R/S	S = Secondary Include only if secondary payer applies	
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	S	PI = Payer ID	
2330B	NM109	Payer Identifier Code	S	Mapping required: Secondary Source of Payment ID: Format is A##-09 Expected Source of Payment ID is characters 1-3 – Pay TYPE is characters 5-6	Source of payment requires mapping to WHAIC Values in Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL LOOP 2400: SERVICE LINE NUMBER LX*1~ SV2*0119**2000*DA*2~ DTP*472*D8*20170202~					
2400	SV201	Revenue Codes	R	NUBC Billing Codes – leading zero required when applicable. Some exclusions for reporting apply - see 5.1.5	Revenue codes identify specific accommodation, or service
2400	SV202-1	CPT/HCPCS Qualifier	R	HC (HCPCS) or HP (HIPPS)	
2400	SV202-2	CPT / HCPCS Procedure Code codes Or HIPPS Code for INP	R	CPT Codes (AMA) or HCPCS (CMS) required on OP claims if required by uniform billing standards. HIPPS rate appropriate for INP claims if available.	HIPPS rate for INP CPT/HCPCS code for OP

2400	SV202-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	CPT/HCPCS
2400	SV202-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	CPT/HCPCS
2400	SV202-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	CPT/HCPCS
2400	SV202-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	CPT/HCPCS
2400	SV203	Monetary amount - Revenue Code Charge – Line-Item Charge Amount	R	Line-Item Charge Amount – Zero 0\$ is a valid amount	Charge
2400	SV204	Unit or Basis for Measurement Code	R	DA = Days UN = Units	
2400	SV205	Service Unit Count	R	Quantity – positive whole numbers	Units value must be 1 or >
2400	DTP01	Service Date Qualifier	S	472	
2400	DTP02	Service Date Qualifier	S	D8 – one date is acceptable	
2400	DTP03	Service Date on Revenue Line Item	S	CCYYMMDD	SERVICE DATE

837R– Click here for [Sample File](#)