When a HIPAA compliant ANSI 837 Institutional or Reporting formatted file with the additional required fields, including all mapped fields listed below, is submitted the data file should pass the WIpop Edits. Data elements listed as "Situational" or "Not Used" in the ANSI 837 Institutional Guide but REQUIRED by WHAIC are listed below.

WHAIC file and technical support is available Monday through Friday, 8:00 a.m. to 4:00 p.m. The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day. The secure electronic system for notification is available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

If you cannot find the answers to your questions within this manual, FAQ, or other available resources, please use the contact information below. All file issues will be addressed during normal business hours within 24-48 hours.

Cindy Case Director, Data Management & Integrity ccase@wha.org whainfocenter@wha.org All things WIpop or file submission related.	Justin Flory Health Care Data Programmer 837 Technical and File related. jflory@wha.org whainfocenter@wha.org	Heather Scambler Program Specialist hscambler@wha.org whainfocenter@wha.org General WIpop or redirected questions.

5.6 **837I** (Hospital) Institutional Claims Data Specifications

837I Crosswalk and WIpop Map - Summary Table of required elements

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 WIpop, if supplied.

Fields defined, created, or updated in WIpop by WHAIC from the 837 claims file.

Patient Type (`1' Inpatient & `2' outpatient)	Place of Service (Blank if INP)	Principal Procedure on OP Records
Principal Procedure Date	Additional Procedures	
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	This element is not required and may be left blank, however, if submitted, it will be edited.
Gray shade	WIpop Field Notes	Data is not stored, but may be sent, and may or may not be used to route data in WIpop.

837I sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837I_Sample-File.pdf

Loop	Element / Reference	Field Description	R, S, O	Values/Mapping Comments	WIpop 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 Facility ID - Appendix 7.1 Facility List	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 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~** **PER*IC*SUBMITTER NAME*TE*6142222222~** **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	
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.	**To avoid edits, notify WHAIC of all subpart NPI's**

					to update our tables.
Patient and/or Subscriber Detail: **Patient Detail Required when the patient *is different* from the Subscriber.** **If not required by this Implementation Guide, do not send.** **DO NOT SEND 2010CA *IF* PATIENT IS SUBSCRIBER**					
Patient / Subscriber details cannot be determined until processing of UCID occurs – Use of Windows Program may be required					
Required v. Situational *depends on* 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~** **DO NOT SEND 2010CA *IF* PATIENT IS SUBSCRIBER**					
2000B	SBR03	Policy Number – Insurance SBR03 is Policy, Group Number, Member ID, Certificate Number.	R/S	Send "NULL" if Self-pay The term policy number or group number is synonymous with insurance ID, member ID, insurance code, Plan number, etc. *any number on the card or in the file that identifies the patient to the carrier.* *SEE FAQ – for more info	Self-pay is required. Do not default to all zeroes. 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.	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 *is different* 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 encrypt the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
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. Provide Patient

					UCID if different from subscriber.
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 WIpop. Physical address discarded.	Census Block Group - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 WIpop. Physical address is discarded.	Census Block Group - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 Loop 2010CA, NM102 = 1	Value not stored
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	*File rejected if > 10% of records missing address
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	*File rejected if > 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 WIpop
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
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, U (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, U (U or O requires Cond Code 45)
2010BA	DMG04	Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Marital Status optional field, supply if collected.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Marital Status optional - supply if collected.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 2	R/S	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). The second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN.
2010CA	DMG05-1	Patient Race Code1 See Appendix 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. The first character is either R (race) or E (ethnicity). The second character is the race or ethnicity code. DMG*D8*19830501*F*M*:RET:R3^:RET:E1~	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2. The first entry for ethnicity will be used for field ETHN.
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 = declined/unkwn
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 = declined/unkwn
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 DMG 10 = ZZ	Primary Language collected from patient. New field Q32019
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined DMG 10 = ZZ	Primary language collected from patient. New field Q32019
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** **NM1*PR*1*Aetna*****PI*A10-09~** **REF*NF*60054**					
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	R/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/NAIC#	S	NF	Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID	S	Enter the Value of the Payer ID. This value is found on the patient's insurance ID card. This value directs the claim to the correct payer or plan type (commercial, Medicare, ACA plan, etc.)	Refer to Appendix 7.3.2 for additional info.
LOOP 2300: CLAIM INFORMATION **CLM*PCTRL535*2500.50***11:A:1**A*Y*Y~** **DTP*096*DT*201702032359~** **DTP*434*RD8*20170202-20170203~**					

DTP*435*DT*201702022359~ CL1*2*1*20~ REF*LU*MN~ REF*EA*MRN123~ HI*ABK:G9782:::::::Y~ HI*ABJ:G9389~ HI*APR:G9389*APR:N179~ HI*ABF:A4152:::::::N*ABF:G918:::::::Y*ABF:N179:::::::Y*ABF:B370:::::::N~					
2300	CLM01	Patient Control Number	R	Use Patient Control Number *File rejected for Duplicate Patient control numbers. IF response email indicates duplicates are found, resubmit file with this phrase anywhere in the file name: exclude_duplicates	PCONTROL or PCTRL Do not use special characters <>
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 WIpop
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 WIpop 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 *Cannot provide Admission date w/o discharge date.	Discharge Date required for INP & ED. Discharge Time required for INP May be provided on other record types.

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. Edits will occur if discharge dates are different than Revenue DOS.
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.)
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.	WIpop: Admission Date/Time **Admission Time** – Req on INP but would like on ER/ED too.
2300	CL101	Priority (Type) of Admission or Visit / Admission Type Code	R	National Uniform Billing Codes *Required - Inpatient and Outpatient (ED, OBS, OPS)	WIpop: Admit Type *New Edit Q22020
2300	CL102	Point of Origin for Admission or Visit	R	NUBC Codes – Required on all Bill Types except 014X See Appendix 7.7	WIpop: Point of Origin See Appendix 7.7
2300	CL103	Discharge (Patient) Status	R	Per NUBC: Required on all institutional claims.	WIpop: 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.
2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	WIpop: MRN

					(WHAIC cannot 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	Follow correct coding guidelines.
2300	HI01-9	Present on Admission (POA)	S	Y, N, U, W – **INP ONLY** Leave blank for exempt – per CMS.	WIpop: Principal Diagnosis POA. For a list of exempt codes: CDC.gov
2300	HI01-1	Admitting Diagnosis *Qualifier*	S	ABJ	
2300	HI01-2	Admitting Diagnosis ICD-10 Code	R/S	ICD-10 Code R= Inpatient ONLY	WIpop: Admitting Diagnosis
2300	HI01-1	Reason for Visit *Qualifier*	R/S	APR R = Outpatient Only	
2300	HI01-2	Reason for Visit ICD-10	R/S	ICD diagnosis codes, describing the 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 are reported.	At least one Reason for Visit Diagnosis code is required on OP records R = Outpatient Only
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 WIpop	Additional DIAGNOSIS and External Cause Codes
2300	HI0X-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	HI0X-1	External Cause of Injury Qualifier	S	ABN	
2300	HI0X-2	External Cause of Injury ICD-10 Codes	S	***Required on ICD-10 Codes in the S range*** and some in the T range – See 5.1.6 for more	Additional Diagnosis and

				information. Applies only to INP, ED, OPS and OBS records.	External Cause Codes
2300	HI0X-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	**ICD-10 Procedure codes for inpatient stays.** No decimal point. ***Do Not Hard Code CPT/HCPCS into this field.***	WHAIC populates Principal procedure code based on Rev. Code line-item detail & coding guidelines.
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.	WHAIC populates Principal Procedure Date.
2300	HI0**X**-1	Additional / Other Procedure Code Qualifier	S	BBQ – ICD-10 Procedure codes verify with addenda	
2300	HI0**X**-2	Additional Procedure Codes	S	ICD-10 Procedure codes for inpatient stays **Facility File will only have INP procedure codes** per NUBC – UB-04 Official Coding Guidelines	WHAIC populates fields for additional procedures as applicable from CPT/HCPCS in revenue section.
2300	HI0**X**-3	Additional/Other Procedure Dates	S	D8	
2300	HI0**X**-4	Additional/Other Procedure Date	S	CCYYMMDD Facility File will only have INP procedure dates.	For Outpatient, additional procedure DATE – populated by WHAIC.
2300	HI0X-1	Occurrence Span Qualifier	S	BI	
2300	HI0X-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	HI0X-3	Occurrence Span Code Date Qualifier	S	RD8	
2300	HI0X-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	HI0X-1	Occurrence Code Qualifier	S	BH	
2300	HI0X-2	Occurrence Code – Industry Standard	S	NUBC Uniform Billing Codes UB-04	

2300	HI0X-3	Occurrence Code Date Qualifier	S	D8 (meaning one date)	
2300	HI0X-4	Occurrence Code Date	S	CCYYMMDD OCCSTART and OCCEND set to same value	WHAIC will record the first 4 occurrence codes/dates, others will be discarded.
2300	HI0X-1	Value Code Qualifier	S	BE	
2300	HI0X-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	HI0X-5	Value Code Amount	S	No decimals Value Code Amounts 1 thru 4 recorded.	WHAIC will record the first 4 Value code amounts, others will be discarded.
2300	HI0**X**-1	Condition Code Qualifier	S	BG	
2300	HI0X-2	Condition Code	S	NUBC Billing Codes The first 4 condition codes will be saved in WIpop	WHAIC will record 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 on INP and ED – edits will occur if provided on other data.
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 *ASCs that only populate rendering NPI will auto copy to 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 – secondary provider.
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	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***	Off-campus hospitals & facilities that share the same Medicare # must report ALL services with Location ID.
2310E	NM108	Service Facility Location Qualifier	S	PI = Provider ID	
2310E	NM109	Service Facility Location Value	S	Service Facility/Provider Based Location (PBL) ID value as provided by WHAIC. Also referred to as provider-based clinic.	Service Facility Location ID / PBL ID assigned by WHA.
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##-99** SOPID2 is characters 1-3 - SOPTYPE2 is characters 5-6	Source of payment requires mapping. WHAIC Values in Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL **LOOP 2400: SERVICE LINE NUMBER** **LX*1~**					

SV2*01192000*DA*2~** **DTP*472*D8*20170202~**					
2400	SV201	Revenue Code	R	NUBC Billing Codes Some reporting exclusions apply .	Revenue CODE
2400	SV202-1	CPT/HCPCS Qualifier	R	HC (HCPCS) or HP (HIPPS)	
2400	SV202-2	CPT / HCPCS Procedure Code codes	R	CPT Codes (AMA) or HCPCS (CMS) required on OP claims if required by uniform billing standards.	CPT/HCPCS code *NO limit in WIpop.
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
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