New Jersey Medicaid

HIPAA 5010

state of newjersey

HMO Encounters Systems Guide

NCPDP 1.2 & D.0 Transaction Sets

December 2023

gainwell

TABLE OF CONTENTS

TABLE OF CONTENTS

VERSION HISTORY

This section lists the changes made to this **December 2023** Version of the HMO Systems Guide compared to previous versions. The following changes indicate payer-specific requirements for the submission of HMO encounters and the interpretation of the 834 Enrollment, 820 Premium Payment and 835 Remittance Advice interchanges:

Page	Change	December 2023 Version
171	Changed HMO Plan Code Name from Amerigroup to Wellpoint in Section 17-6 Capitation Codes.	
172	Changed HMO Plan Code Name from Wellcare to Fidelis Care in Section 17-6 Capitation Codes.	
Page	**Change**	**November 2023 Version**
142	Changed requirements for field 420-DK in the AM07 Claim Segment.	
Page	**Change**	**July 2023 Version**
3	Added Section 17.22 Special Program Codes to the Table of Contents.	
174, 176	In Section 17.10 Program Status Codes of the Data Element Dictionary changed descriptions for Program Status Codes 293, 294, 591, 592, 593, 594 which can be expected to be seen in field HD04 of Loop 2300 of the Managed Care Enrollment File.	
186 - 188	Added Condition Code 84 to Section 17.21 Institutional Condition Codes. Also added Section 17.22 Special Program Codes to the Data Element Dictionary. Special Program Codes can be expected to be seen in field REF02 of the 2300 Loop of the Managed Care Enrollment File.	
Page	**Change**	**June 2023 Version**
2 - 3	Added Section 17.20 Disenrollment Reason Codes and Section 17.21 Institutional Condition Codes to the Table of Contents.	
18, 19, 20, 21	Added HCP Claim Pricing/Repricing Information Loops to Section 1 Loop/Segment Table.	
49	Changed the number of Condition Codes captured by the NJMMIS in Loop 2300 for the HI Condition Information Segment in Section 4 HIPAA 837 Institutional Encounters and added a link to the Institutional Condition Codes in the Data Element Dictionary.	
50	Added HCP Claim Pricing/Repricing Information Loop 2300 and segments HCP01 and HCP02 to Section 4 HIPAA 837 Institutional Encounters.	
57	Added HCP Claim Pricing/Repricing Information Loop 2400 and segments HCP01 and HCP02 to Section 4 HIPAA 837 Institutional Encounters.	
67	Added HCP Claim Pricing/Repricing Information Loop 2300 and segments HCP01 and HCP02 to Section 5 HIPAA 837 Dental Encounters.	
72	Added HCP Claim Pricing/Repricing Information Loop 2400 and segments HCP01 and HCP02 to Section 5 HIPAA 837 Dental Encounters.	
81	Added HCP Claim Pricing/Repricing Information Loop 2300 and segments HCP01 and HCP02 to Section 6 HIPAA 837 Professional Encounters.	
88	Added HCP Claim Pricing/Repricing Information Loop 2400 and segments HCP01 and HCP02 to Section 6 HIPAA 837 Professional Encounters.	
106	Added special requirement to submit diagnosis code Z00.8 as Primary Diagnosis for CAPT records in field HI01-2 of Loop 2300 in Section 8 HIPAA 837 Capitation Detail Records.	
121 – 135	Changed references of “LogistiCare” to “Modivcare” in Section 10 HIPAA 837 Capitated Transportation Encounters due to Transportation Encounters Plan name change.	
155	Corrected hyperlink for Eligibility Termination Code and added hyperlink for Disenrollment Reason Codes for field HD04 Health Coverage (Medicaid Coverage) Segment of Loop 2300 in Section 14 – HIPAA 384 Managed Care Enrollment.	
184 - 185	Added Section 17.20 Disenrollment Reason Codes and Section 17.21 Institutional Condition Codes to the Data Element Dictionary.	

Page	Change	March 2023 Version
174	In Section 17.10 Program Status Codes of the Data Element Dictionary changed descriptions for Program Status Codes 291 and 292 which can expected to be seen in field HD04 of Loop 2300 of the Managed Care Enrollment File.	
Page	**Change**	**February 2023 Version**
170 & 171	Added Cover All Kids Capitation Code 19499 / S2000 for all HMO Plans in Section 17.6 Capitation Codes and removed HMO Plan Healthfirst.	
Page	**Change**	**September 2022 Version**
186 & 187	Changed references for WebSphere to IBM's Integrated Transformation Extender (ITX) in Section 18.2 Translator Reports And Edits.	
Page	**Change**	**May 2022 Version**
54	Changed requirements for field DTP03 in Section 4 Institutional Encounters in Loop 2330B.	
56	Changed requirements for field DTP03 in Section 4 Institutional Encounters in Loop 2330B.	
Page	**Change**	**May 2022 Version - continued**
61	Changed requirements for field DTP03 in Section 4 Institutional Encounters in Loop 2430.	
62	Changed requirements for field DTP03 in Section 4 Institutional Encounters in Loop 2430.	
191	Changed special characters used in Section 18.7 Interchange Naming Convention. Removed (& and +) as allowable special characters.	
Page	**Change**	**October 2021 Version**
140	Changed requirements for field 420-DK in the AM07 Claim Segment.	
Page	**Change**	**September 2021 Version**
140	Changed requirements for field 420-DK in the AM07 Claim Segment.	
145	Changed e-mail addresses from NJMMISEDI@DXC.COM or NJMMISEDI@GAINWELLTECHNOLOGIES.COM.	
Page	**Change**	**January 2021 Version**
140	Changed requirements for field 420-DK in the AM07 Claim Segment.	
141	Added AM8 DUR/PPS Segment and added requirements for field 440-E5. Added field 438-E3 and requirements for this field in the AM11 Pricing segment.	
Page	**Change**	**November 2020 Version**
Throughout document	Changed references from DXC Technology to Gainwell Technologies.	
Page	**Change**	**September 18, 2020 Version**
140	Changed requirements for fields 403-D3, 405-D5, 4-14-DE and 415-DF in the AM07 Claim Segment. Also added fields 460-ET, 343-HD, 344-HF, 345-HG in Section 11 – NCPDP Pharmacy Encounters.	
Page	**Change**	**September 2020 Version**
145	Changed e-mail addresses from NJMMISEDI@MOLINAHEALTHCARE.COM or NJMMISEDI@DXC.COM.	
Page	**Change**	**April 2020 Version**
81	Added field HI09-1, HI09-2, HI10-1, HI10-2, HI11-1, HI11-2, HI12-1, HI12-2 in Health Care Diagnosis Code Loop 2300 in Section 6 – Professional Encounters.	
126	Added field HI09-1, HI09-2, HI10-1, HI10-2, HI11-1, HI11-2, HI12-1, HI12-2 in Health Care Diagnosis Code Loop 2300 in Section 10 – HIPAA Capitated Transportation Encounters.	
Page	**Change**	**April 2019 Version**
141	Added comments to Section 12 – NCPDP Pharmacy Reversals requesting to not submit segments that are not required for reversals.	

Page	Change	February 2019 Version
144	Changed field length for field CLP11 in Loop 2100 in Section 13 – HIPAA 835 Remittance Advice.	
Page	**Change**	**January 2019 Version**
26	Added REF – Other Claim Related segment to Section 1 Loop/Segment Table.	
146	Changed data requirements for REF "F8" segment in Loop 2100, fields REF00 and REF02 in Section 13 - HIPAA 835 Remittance Advice.	
147	Added REF "9C" segment, fields REF00, REF01 and REF02 in Loop 2100 for ICN of the submitted debit adjustment.	
169 - 170	Updated descriptions for Payment Codes in Section 17.8 - Payment Codes.	
Page	**Change**	**October 2018 Version**
Throughout document	Changed references from Molina Medicaid Solutions to DXC Technology.	
Page	**Change**	**August 2018 Version**
39	Changed data requirements for field HI01-2 for Loop 2300 in Section 4 – Institutional Encounters regarding use of 4-digit APR-DRG code.	
Page	**Change**	**February 2018 Version**
52	Changed data requirements for field AMT02 for Loop 2320 in Section 4 – Institutional Encounters.	
59	Changed data requirements for field SVD02 for Loop 2430 in Section 4 – Institutional Encounters.	
69	Changed data requirements for field AMT02 for Loop 2320 in Section 5 – Dental Encounters.	
73	Changed data requirements for field SVD02 for Loop 2430 in Section 5 – Dental Encounters.	
83	Changed data requirements for field AMT02 for Loop 2320 in Section 6 – Professional Encounters.	
90	Changed data requirements for field SVD02 for Loop 2430 in Section 6 – Professional Encounters.	
127	Changed data requirements for field AMT02 for Loop 2320 in Section 10 – Capitated Transportation Encounter Records.	
133	Changed data requirements for field SVD02 for Loop 2430 in Section 10 – Capitated Transportation Encounter Records.	
138	Changed data requirements for field 431-DV for AM05 in Section 11 - NCPDP Pharmacy Encounters.	
140	Changed data requirements for field 409-D9 in Section 11 – NCPDP Pharmacy Encounters.	
141	Replaced data requirements for field 993-A7 in Section 12 – NCPDP Pharmacy Reversals.	
Page	**Change**	**August 2017 Version**
181 – 182	Added County of Supervision Codes 072, 076, 078 and 079.	
Page	**Change**	**March 2017 Version**
138	Changed data requirements for 420-DK Submission Clarification Code in the AM07 Claim Segment in Section 11 – NCPDP Pharmacy Encounters for submitting 340B Claims.	
147	Changed data requirements for REF02 Line Item Control Number for Loop 2110 in Section 13 – 835 Remittance Advise.	
Page	**Change**	**February 2017 Version**
2	Added Section 17.19 – County of Supervision Codes to Table Of Contents.	
152	Changed data requirements for HD Health Coverage (Medicaid Coverage), adding County of Supervision for field HD04 in Loop 2300 of Section 14 – HIPAA 834 Managed Care Enrollment.	
179 - 182	Added Section 17.19 – County of Supervision Codes to Section 17 Data Element Dictionary.	
Page	**Change**	**July 2016 Version**
50	Changed data requirements for NM100 Referring Provider Name and REF00 Referring Provider Secondary Identification for Loop 2310F in Section 4 - Institutional Encounters.	

Page	Change
	July 2016 Version - continued
57	Changed data requirements for NM100 Referring Provider Name for Loop 2420D noting the NJMMIS does not capture any data from this segment.
58	Changed data requirements for REF00 Referring Provider Secondary Identification for Loop 2420D noting the NJMMIS does not capture any data from this segment.
66	Changed data requirements for NM100 Referring Provider Name, REF00 Referring Provider Secondary Identification and NM100 for Primary Care Provider iteration for Referring Provider Name for Loop 2310A in Section 5 – Dental Encounters.
80	Changed data requirements for NM100 Referring Provider Name and REF00 Referring Provider Secondary Identification for Loop 2310A in Section 6 – Professional Encounters.
81	Changed data requirements for NM100 for Primary Care Provider iteration for Referring Provider Name for Loop 2310A noting the NJMMIS does not capture any data from this segment.
88	Changed data requirements for NM100 Referring Provider Name, REF00 Referring Provider Secondary Identification and NM100 for Primary Care Provider iteration for Referring Provider Name for Loop for Loop 2420F.
124	Changed data requirements for NM100 Referring Provider Name, REF00 Referring Provider Secondary Identification and NM100 for Primary Care Provider iteration for Referring Provider Name for Loop 2310A in Section 10 – Capitated Transportation Encounter Records.
131	Changed data requirements for NM100 Referring Provider Name for Loop 2420F
132	Changed data requirements for REF00 Referring Provider Secondary Identification and NM100 for Primary Care Provider iteration for Referring Provider Name for Loop for Loop 2420F.
Page	**Change**
	February 2016 Version
180 & 181	Changed “Mercator” to “WebSphere” as the translator being used for HIPAA 837 transactions.
170 - 171	In Section 17.8 Payment Codes made changes to descriptions for codes B, C, E, H, J, L, M, 1, 2, 3, 4 and removed payment codes 7 and Y.
Page	**Change**
	December 2015 Version
171	In Section 17.8 Payment Codes added payment codes for Cystic Fibrosis.
Page	**Change**
	October 2015 Version
34	Changed data requirements for HI Principal Diagnosis segment for Loop 2300 in Section 4 – Institutional Encounters stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for field HI01-9.
35	Changed data requirements for HI External Cause Of Injury segment for Loop 2300 stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for field HI01-9.
36	Changed data requirements for HI External Cause Of Injury segment for Loop 2300 stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for fields HI02-9, HI03-9, HI04-9, HI05-9, HI06-9, HI07-9 & HI08-9.
37	Changed data requirements for HI External Cause Of Injury segment for Loop 2300 stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for fields HI09-9, HI10-9, HI114-9 & HI12-9. Also changed data requirements for HI00 Other Diagnosis Information segment for Loop 2300 stating the NJMMIS will capture a total of 17 Diagnosis Codes and Present on Admission Indicators from the previous 5.
38	Changed data requirements for HI00 Other Diagnosis Information segment for Loop 2300 stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for fields HI01-9., HI02-9, HI03-9, HI04-9, HI05-9, HI06-9 & HI07-9.
39	Changed data requirements for HI00 Other Diagnosis Information segment for Loop 2300 stating “If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to “1”.” for fields HI08-9, HI09-9, HI10-9, HI114-9 & HI12-9.

Page	Change	October 2015 Version - continued
40	Changed data requirements for HI00 Other Procedure Information segment for Loop 2300 stating the NJMMIS will capture a total 6 surgical procedure codes, including the primary surgical code from the previous 3.	
43	Changed data requirements for HI00 Occurrence Information segment for Loop 2300 stating the NJMMIS will only capture the 1st 8 occurrence codes from the previous 4.	
49	Changed previous statement regarding capturing of Referring Provider data for NM100 and REF00 for Loop 2310F.	
96	Changed data requirements for HI Principal Diagnosis segment for Loop 2300 in Section 7 – Capitation Summary Records stating "If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1"." for field HI01-9.	
Page	**Change**	**April 2015 Version**
25	Added HD – Health Coverage (Special Program Code), DTP – Health Coverage Dates, DTP – Health Coverage Dates & REF – Health Coverage Policy segments to Section 1 Loop/Segment Table.	
136	Corrected field ID for 335-2C Pregnancy Indicator in the AM01 Patient Segment in Section 11 – NCPDP Pharmacy Encounters.	
150	Remove all fields for REF – Member Supplemental Identifier segments from Loop 2000 in Section 14 – HIPAA 834 Managed Care Enrollment.	
153 to 154	Added additional Health Coverage (Special Program Code) segments for Loop 2300 in Section 14 – HIPAA 834 Managed Care Enrollment.	
Page	**Change**	**February 2015 Version**
32	Changed data requirements for CLM05-1 for Loop 2300 in Section 4 - Institutional Encounters.	
62	Changed data requirements for CLM05-1 for Loop 2300 in Section 5 – Dental Encounters.	
77	Changed data requirements for CLM05-1 for Loop 2300 in Section 6 – Professional Encounters.	
85	Changed data requirements for SV105 for Loop 2400 in Section 6 – Professional Encounters removing reference to the Facility Type Codes/Place of Service Codes table in Section 17 - Data Element Dictionary.	
121	Changed data requirements for CLM05-1 for Loop 2300 in Section 10 – Capitated Transportation Encounter Records.	
129	Changed data requirements for SV105 for Loop 2400 in Section 10 – Capitated Transportation Encounter Records removing reference to the Facility Type Codes/Place of Service Codes table in Section 17 - Data Element Dictionary.	
163	Removed Facility Type Codes/Place of Service Codes table from Section 17 - Data Element Dictionary.	
Page	**Change**	**October 2014 Version**
47	Changed data requirements for first iteration of SBR00 & SBR01 fields for Loop 2320.	
49	Changed data requirements for second iteration of SBR00 & SBR01 fields for Loop 2320.	
51	Changed data requirements for NM109 field for Loop 2330B.	
65	Changed data requirements for first iteration of SBR00 & SBR01 fields for Loop 2320 in Section 5 – Dental Encounters.	
66	Changed data requirements for second iteration of SBR00 & SBR01 fields for Loop 2320.	
67	Changed data requirements for NM109 field for Loop 2330B.	
80	Changed data requirements for first iteration of SBR00 & SBR01 fields for Loop 2320 in Section 6 – Professional Encounters.	
82	Changed data requirements for second iteration of SBR00 & SBR01 fields for Loop 2320.	
83	Changed data requirements for NM109 field for Loop 2330B.	
90	Added statement "HIPAA 837 capitation summary records are no longer required and should not be submitted after June 30, 2013".	
100	Changed data requirements for SBR01 field for Loop 2000B in Section 8 – Capitation Detail Records.	

Page	Change October 2014 Version - continued
102	Changed delimiter for HI01-2 field and removed data requirements for HI01-9 field for Loop 2300. Also changed data requirements for first iteration of SBR00 & SBR01 fields for Loop 2320.
103	Changed data requirements for AMT02 field in Loop 2320.
104	Changed data requirements for second iteration of SBR01 field for Loop 2320.
105	Changed data requirements for NM109 field for Loop 2330B.
124	Changed data requirements for first iteration of SBR00 & SBR01 fields for Loop 2320 in Section 10 – Capitation Transportation Encounter Records.
126	Changed data requirements for second iteration of SBR00 & SBR01 fields for Loop 2320.
127	Changed data requirements for NM109 field for Loop 2330B.
184	Changed 1st paragraph for section 18.7 removing reference to CD-ROM.
186	Deleted sections 18.7 CD-ROM Specifications & 18.8 Mailing Address For CD-ROM Submissions.
Page	**Change July 2014 Version**
19	Added 2320 – SBR – Other Subscriber Information, AMT – Coordination Of Benefits (COB) Pater Paid Amount, OI – Other Insurance Coverage Information, 2330A – NM1 – Other Subscriber Name, 2330B – NM1 – Other Payer Name, DTP – Claim Check Or Remittance Date, 2430 – SVD – Line Adjudication Information & DTP – Line Check Or Remittance Date loops and segments to Section 1 Loop/Segment Table.
30	Changed data requirements for SBR01 field for Loop 2000B in Section 4 – Institutional Encounters.
31	Changed data requirements for CLM01 fields in the CLM – Claim Information segment for Loop 2300 in Section 4 – HIPAA 837 Institutional Encounters and Section 6 – HIPAA 837 Professional Encounters adding “M” designation for reimbursable Maternity and Drug encounters.
33, 34, 36, 38	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Principal Diagnosis, HI – Admitting Diagnosis, HI – Patient's Reason For Visit, HI – External Cause Of Injury, HI – Other Diagnosis Information, HI – Principal Procedure Information, HI – Other Procedure Information segment in Section 4 – Institutional Encounters for Loop 2300.
59	Changed data requirements for SBR01 field for Loop 2000B in Section 5 – Dental Encounters.
61	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Health Care Diagnosis Code segment for Loop 2300.
64 & 65	Changed data requirements for SBR01 field for Loop 2320.
74	Changed data requirements for SBR01 field for Loop 2000B in Section 6 – Professional Encounters.
75	Changed data requirements for CLM01 field in the CLM – Claim Information segment for Loop 2300 adding “M” designation for reimbursable Maternity and Drug encounters.
76	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Health Care Diagnosis Code segment for Loop 2300.
79 & 81	Changed data requirements for SBR01 field for Loop 2320.
92	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Principal Diagnosis segment in Section 7 - Capitation Summary Records for Loop 2300.
99	Changed data requirements for SBR01 field for Loop 2000B in Section 8 – Capitation Detail Records.
101	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Principal Diagnosis segment for Loop 2300. And changed data requirements for SBR01 field for Loop 2320.
102	Added additional iteration of SBR - Other Subscriber Information segment for Loop 2320.

Page	Change
	July 2014 Version - continued
103	Added additional iterations of AMT – Coordination Of Benefits (COB) Pater Paid Amount and OI – Other Insurance Coverage Information segments for Loop 2320. Added additional iterations of NM1 – Other Subscriber Name segment for Loop 2330A. Added additional iteration of NM1 – Other Payer Name and DTP – Claim Check Or Remittance Date segments for Loop 2330B.
107	Added additional iterations of SVD – Line Adjudication Information & DTP – Line Check Or Remittance segments for Loop 2430.
112	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Principal Diagnosis segment In Section 9 - Capitation True-Up Records for Loop 2300.
118	Changed data requirements for SBR01 field for Loop 2000B in Section 10 – Capitation Transportation Encounter Records.
120	Changed previous ICD-10 implementation date of 10/1/2014 to 10/1/2015 for the HI – Health Care Diagnosis Code segment in Section 10 – Capitated Transportation Encounter Records for Loop 2300.
134 & 138	Changed data requirements for 332-CY fields in the AM01 Segments in Section 11 – NCPDP Pharmacy Encounters and Section 12 – NCPDP Pharmacy Reversals adding "M" designation for reimbursable Maternity and Drug encounters.
136	Removed data requirements for calculating total payment amount for field 426-DQ in Segment AM11.
166 – 167	In Section 17.7 Capitation Codes of the Data Element Dictionary added new MLTSS HBI Code L2014 and associated CAP Codes for each HMO. Also added HMO/Plan Code, CAP Codes and HBI Codes for Aetna.
168	In Section 17.8 HBI Codes of the Data Element Dictionary added HBI Code L2014 with description of Managed Long Term Services and Support (MLTSS) to the list of HBI Codes which can be expected to be seen in field HD04 in Loop 2300 of the Managed Care Enrollment File.
Page	**Change**
	April 2014 Version
11	Added AMT – Patient Estimated Amount Due segment to Section 1 Loop/Segment Table.
14	Added AMT – Patient Amount Paid segment to Section 1 Loop/Segment Table.
21	Added "(Medicaid Coverage)" to the segment title for Loop 2300 – HD Health Coverage and an additional Health Coverage Loop for (Patient Liability) in the Section 1 Loop/Segment Table.
27	Changed the data requirements for field NM108 in the Billing Provider Name segment of Loop 2010AA.
30	Added AMT – Patient Estimated Amount Due segment to Loop 2300 for MLTSS recipient Patient Responsibility Amount.
71	Changed the data requirements for field NM108 in the Billing Provider Name segment of Loop 2010AA.
74	Added AMT – Patient Amount Paid segment to Loop 2300 for MLTSS recipient Patient Responsibility Amount.
145	Added "(Medicaid Coverage)" to the segment title for Health Coverage for the Managed Care Enrollment 834.
146	Added Health Coverage (Patient Liability) segments for the Managed Care Enrollment 834.
162	Added HMO/Plan Code, CAP Code and HBI Code for WellCare.
174, 177, 178	Changed HIPAA Claims link to HIPAA Submitter Login and revised 1st sentence of last paragraph.
178	Changed last sentence in 1st bulleted paragraph following paragraph #4 and added file naming conventions for 835 files.
179	Added bullet item at top of page regarding 835s.
Page	**Change**
	February 2014 Version
93	Changed requirements for field CN104 for Contract Information Loop 2400 adding additional Capitation Provider Types for Capitation Summary Records.
101	Changed requirements for field CN104 for Contract Information Loop 2400 adding additional Capitation Provider Types for Capitation Detail Records.

Page	Change
	February 2014 Version - continued
173	Revised 3rd paragraph indicating that test 835 E-RA files are also produced as part of the testing process.
174	Changed the word "comma" with "semi-colon" in the paragraph preceded by #3.
176	Revised 1st paragraph changing the word "mailed" to "e-mailed" indicating Pharmacy EMC Proof Reports are e-mailed to the NCPDP 1.2 batch submitters and changed the scheduled maintenance windows for the website.
177	Changed the word "comma" with "semi-colon" in the 2nd bulleted paragraph following the paragraph preceded by #4.
180	Changed the word "comma" with "semi-colon" in the 3rd paragraph and removed the paragraph regarding 835 Health Care Claim Payment/Advices on CD-ROM will be mailed.
Page	**Change**
	October 2013 Version
31	Changed requirements and field lengths in Principal Diagnosis Loop 2300 for fields HI01-01 & HI01-2 and for Admitting Diagnosis Loop 2300 for fields HI01-01 & HI01-2.
32	Changed requirements and field lengths in Patient's Reason For Visit Loop 2300 for fields HI01-01 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2, and for External Cause of Injury Loop 2300 for fields HI01-01 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2.
33	Changed requirements and field lengths in External Cause of Injury Loop 2300 for fields HI04-1 & HI04-2, HI05-1 & HI05-2, HI06-1 & HI06-2, HI07-1 & HI07-2, HI08-1 & HI08-2, HI09-1 & HI09-2, HI10-1 & HI10-2, and HI11-1 & HI11-2, HI12-1
34	Changed requirements and field lengths in External Cause of Injury Loop 2300 for fields HI12-2 and for Other Diagnosis Information Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2, HI04-1 & HI04-2, HI05-1 & HI05-2.
35	Changed requirements and field lengths in Other Diagnosis Information Loop 2300 for fields HI06-1 & HI06-2, HI07-1 & HI07-2, HI08-1 & HI08-2, HI09-1 & HI09-2, HI10-1 & HI10-2, HI11-1 & HI11-2, HI12-1 & HI12-2.
36	Changed requirements and field lengths in Principal Procedure Information Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2 and for Other Procedure Information Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2, HI04-1 & HI04-2.
37	Changed requirements and field lengths in Other Procedure Information Loop 2300 for fields HI05-1 & HI05-2, HI06-1 & HI06-2, HI07-1 & HI07-2, HI08-1 & HI08-2, HI09-1 & HI09-2, HI10-1 & HI10-2, HI11-1 & HI11-2, HI12-1 & HI12-2.
59	Changed requirements and field lengths in Healthcare Diagnosis Code Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2.
74	Changed requirements and field lengths in Healthcare Diagnosis Code Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2, HI04-1 & HI04-2.
75	Changed requirements and field lengths in Healthcare Diagnosis Code Loop 2300 for fields HI05-1 & HI05-2, HI06-1 & HI06-2, HI07-1 & HI07-2, HI08-1 & HI08-2.
90	Changed requirements and field lengths in Principal Diagnosis Loop 2300 for fields HI01-01 & HI01-2.
99	Changed requirements and field lengths in Principal Diagnosis Loop 2300 for fields HI01-01 & HI01-2.
107	Changed requirements and field lengths in Principal Diagnosis Loop 2300 for fields HI01-01 & HI01-2.
115	Changed requirements and field lengths in Healthcare Diagnosis Code Loop 2300 for fields HI01-1 & HI01-2, HI02-1 & HI02-2, HI03-1 & HI03-2, HI04-1 & HI04-2, HI05-1 & HI05-2.
116	Changed requirements and field lengths in Healthcare Diagnosis Code Loop 2300 for fields HI06-1 & HI06-2, HI07-1 & HI07-2, HI08-1 & HI08-2.
160 – 161	In Section 17.7 Capitation Codes of the Data Element Dictionary added HBI Code E2014 and Cap Codes 59099 and 57499 for each HMO.
161	In Section 17.8 HBI Codes of the Data Element Dictionary added HBI Code E2014 with description of Medicaid Alternative Benefit Plan to the list of HBI Codes which can expect to be seen in field HD04 in Loop 2300 of the Managed Care Enrollment File.

Page	Change	July 15, 2013 Version
164 – 167	In Section 17.11 Program Status Codes of the Data Element Dictionary changed descriptions for Program Status Codes which can expect to be seen in field HD04 of Loop 2300 of the Managed Care Enrollment File.	
2	Added Section 17.19 Enrollment Type Codes to the Table of Contents.	
20	Added REF – Member Policy Number and Ref – Member Supplemental Identifier segments to Section 1 Loop/Segment Table.	
Page	**Change**	**July 15, 2013 Version - continued**
139	Changed delimiter for field INS05 in Loop 2000 and added requirements for field INS08. Also added requirements for REF segments; Member Policy Number and Member Supplemental Identifier.	
140	Changed delimiter for field PER01 in 2100A Loop.	
141	Changed requirements for field HD04 in Loop 2300.	
151 & 152	Changed Facility Type Codes/Place of Service Codes table adding columns for Professional and Dental NJMMIS Place of Service Codes.	
167	Added Section 17.19 Enrollment Type Codes to the Data Element Dictionary (DED).	
Page	**Change**	**July 2013 Version**
13	Added CAS – Line Adjustment Loop to Section 1 Loop/Segment Table.	
32	Changed field length requirements for field HI01-2 in Loop 2300.	
61	Changed requirements for field AMT02 in Loop 2320.	
62	Changed requirements for field NM109 in Loop 2330B.	
65	Changed requirements for field SVD02 in Loop 2430.	
66	Added CAS – Line Adjustment Loop and associated CAS segments due to requirements for Claim Adjustment Reason Code “59” for interim Dental encounters.	
76	Changed requirements for field SBR01 in Loop 2320.	
77	Changed requirements for fields AMT02 in Loop 2320 and NM109 in Loop 2330B.	
82	Changed requirements for field SVD01 in Loop 2430.	
126	Changed requirements for field 431-DV in AM05 segment.	
Page	**Change**	**April 2013 Version**
3	Added Section 18.1 NJ Specific Requirements Testing to the Table of Contents and renumbered subsequent sections.	
18	Added AM15 Facility Segment to Section 1 Loop/Segment Table.	
47	Changed note for fields LIN03 and CTP04 in Loop 2410 indicating this field will now be captured for Outpatient Encounters.	
77	Changed note for fields LIN03 and CTP04 in Loop 2410 indicating this field will now be captured for Professional Encounters.	
124	Changed requirements for fields 340-7C, 431-DV, 471-5E, 472-6E, 353-NR, 351-NP, 352-NQ, 392-MU and 393-MV in segment AM05 for COB with DSNP/Part D and other payers.	
125	Changed requirements for fields 442-E7, 408-D8, 354-NX, 420-DK, 308-C8, 600-28 and 461-EU in segment AM07 for capturing of drug information on Encounters.	
126	Added AM15 Facility Segment for LTC facility services.	
132	Changed length of field from 16 to 1-20 for field REF02 in 2100 Loop when REF01 = “EA” and added statement at the end of the data requirements for the field for pharmacy encounters indicating the 332-CY field is returned on the 835.	
166	Added Section 18.1 NJ Specific Requirements Testing and.	

Page	Change	April 2013 Version - continued
166 – 174	Renumbered subsequent sections of section 18 due to addition of section 18.1.	
171	Changed paragraph 5, 2nd bullet item; no more than three hours after the TA1 has been received.	
172	Changed 1st paragraph, 2nd sentence; changed file naming convention allowing additional characters to be used in the prefix of the file name.	
173	Changed 2nd Paragraph, 1st sentence; no more than three hours after the TA1 has been received.	
174	Changed the prefix of the file name used in the example.	
Page	**Change**	**February 2013 Version**
35	Changed requirements for field HI00 in 2300 Loop noting number of occurrence span code captured. Also changed requirements for fields HI01-2, HI02-2, HI03-2 & HI04-2 For reporting ICF, Residential or SNF facility type days.	
38	Changed requirements for fields HI01-2 & HI01-5 in 2300 Loop for reporting birth weight.	
46	Changed requirements for field SV201 in 2400 Loop for reporting Acute days.	
59	Changed requirements for field SBR01 in 2320 Loop. Also changed requirements for field AMT02 in 2320 Loop with regards to Sub-Capitation reporting.	
60	Changed requirements for fields SBR01 & AMT02 in 2320 Loop with regards to FQHC Sub-Capitation reporting.	
61	Changed requirements for field NM109 in 2330B Loop with regards to FQHC Sub-Capitation reporting.	
64	Changed requirements for fields SVD01 & SVD02 in 2430 Loop with regards to FQHC Sub-Capitation reporting.	
73	Changed requirements for field SBR01 in Loop 2320. Also changed requirements for field AMT02 in 2320 Loop with regards to Sub-Capitation reporting.	
74	Changed requirements for field SBR01 in Loop 2320.	
75	Changed requirements for field AMT02 in Loop 2320 with regards to Sub-Capitation reporting. Also changed requirements for field NM109 in Loop 2330B with regards to FQHC Sub-Capitation reporting.	
80	Changed requirements for fields SVD01 & SVD02 in Loop 2430 with regards to FQHC Sub-Capitation reporting.	
Page	**Change**	**October 2012 Version**
Through-out document	Deleted references to previous HIPAA format of 4010.	
2	Added Section 10 – HIPAA 837 Capitated Transportation Encounters to Table Of Contents.	
15 – 16	Added Section 10 – HIPAA 837 Capitated Transportation Encounters to Section 1 Loop/Segment Table.	
25, 54, 68	Changed delimiter for SBR02 fields.	
25, 39, 40, 41, 42, 44, 46, 47, 53, 54, 57, 58, 59, 61, 63, 67, 69, 71, 72, 74, 75, 77, 79, 85, 87, 92, 93, 95,	Changed field length for NM103 & NM104 fields.	
100, 101, 103, 131, 137, 142	Changed field length for NM103 & NM104 fields.	

Page	Change October 2012 Version - continued
25, 39, 40, 54, 69, 131	Changed field length for NM105 fields.
26	Changed delimiter for CLM05-1 & CLM05-2 fields in Loop 2300.
34 – 35	Changed requirements for HI##-4 fields for Loop 2300.
39, 53, 57, 58, 63, 67, 72, 78	Changed field length for PRV02 fields.
55, 69, 86, 94, 102	Changed field length for CLM05-1 & changed delimiter for CLM05-1 & CLM05-2 fields in Loop 2300.
56, 62, 77, 88, 96, 104	Changed field length for DTP02 fields.
71	Changed references to the 2400/SV101-2 segments in NM100 fields in Loop 2310A.
72	Changed Loop # from 2301A to 2310A.
76	Changed field length for field SV105 & changed delimiter in field SV107-4 in Loop 2400.
106 – 122	Added Section 10 – HIPAA 837 Capitated Transportation Encounters.
133	Changed field length for SVC01-2 & SVC05 fields in Loop 2110.
136	Changed field length for N102 field in Loop 1000A.
Page	**Change July 2012 Version**
15	Added AM05 COB/Other Payments Segment and Other Claim Related Identification REF segment for Loop 2100 in Section 1 Loop/Segment Table.
36	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2310A.
37	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) and changed Length of field to 10 in Loops 2310B and 2310C.
38	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) and changed Length of field to 10 in Loops 2310B and 2310F.
44	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loops 2420A and 2420B.
45	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) and changed Length of field to 10 in Loop 2420D.
54	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2310A.
55	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2310B.
60	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2420A.
68	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2310A.
69	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2310B.
75	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2420A.
76	Changed requirements for field REF02 10-digit EIN (E1234567890) to 9-digit EIN (E123456789) in Loop 2420F.
92	Changed the SBR02 delimiters listed increasing these to 7 asterisks (*) and changed SBR05 with “HM” to SBR09 in Loop 2320 in Section 8 - Capitation Detail Records.

Page	Change	July 2012 Version - continued
100	Changed the SBR02 delimiters listed increasing these to 7 asterisks (*) and changed SBR05 with "HM" to SBR09 Loop 2320 in Section 9 – Capitation True-Up Records (for FirstHealth NJ only).	
105	Added Benefit Stage fields 392-MU, 393-MV & 394-MW in AM05 COB/Other Payments Segment.	
107	Added 993-A7 Internal control Number field to the AM05 COB/Other Payments Segment for Reversals.	
108	Removed AM11 Pricing Segment for Reversals.	
112	Added another REF segment after the existing "F8" information in Loop 2100 for HMO Category of Service.	
Page	**Change**	**April 2012 Version**
16	Changed name of Section 14 for 834 D-SNP (Dual Eligible Special Needs Plan) Enrollment. Also added HD Health Coverage and DTP Health Coverage Dates segments for Loop 2300 in Section 1 Loop/Segment Table.	
84	Changed delimiter for field SBR02 and changed field SBR05 with "HM" to SBR09.	
85	Changed field length and delimiter for field SV104. Changed field SV109 with "1" to SV107 and changed the field's format and delimiter.	
93	Changed field length and delimiter for field SV104. Changed field SV109 with "1" to SV107 and changed the field's format.	
94	Changed requirements for field CN102 and the field's length. Changed requirements for field CN104 in 2400 Loop.	
96	Added statement "HIPAA 837 capitation "True-Up" records can only be submitted by HealthFirst NJ."	
101	Changed field length and delimiter for field SV104. Changed field SV109 with "1" to SV107 and change the field's format.	
110	Changed requirements for field CLP07 and the field's length.	
121	Changed name of Section 14 for 834 D-SNP (Dual Eligible Special Needs Plan) Enrollment and changed plan name in field BGN08 from SNP to D-SNP. Clarified requirements for field ST03, made changes to the format for field N103, changed the length for field N104 in Loop 1000A. Also made changes to the format for field N103 in Loop 1000B.	
122	Changed delimiters for fields INS03 and INS05. Added requirements for fields INS04 and INS08 in Loop 2000. Also added HD Health Coverage and DTP Health Coverage Dates segments in Loop 2300.	
123	Changed requirements for field DTP02 and added statement to indicate open-ended disenrollment date for field DTP02 in Loop 2300.	
126 – 129	Added additional Other Payer Codes to Data Element Dictionary Section.	
132	Added Patient Status Code 70 to Data Element Dictionary Section.	
134	Replaced Capitation Codes chart with a revised table.	
135	Added additional HBI Code to Data Element Dictionary Section.	
136	Added additional Payment Codes 1, 2, 3, & 4 to Data Element Dictionary Section.	
Page	**Change**	**December 2011 Version**
2	Added Section 9 – HIPAA 837 Capitation True-Up Records to Table of Contents	
8	Added HI Health Care Diagnosis Code to Section 1 Loop/Segment Table.	
11	Added REF Billing Provider Tax Identification segment and corrected DTP segment names for Loops 2330B and 2430 in Section 1 Loop/Segment Table.	
12 – 13	Corrected DTP segment name for Loop 2330B and added Section 9 – HIPAA 837 Capitation True-Up Records to Section 1 Loop/Segment Table.	
20	Changed requirements for fields NM108 and NM109 in Loop 2010AA.	
22	Removed Billing Provider Secondary Identification REF segment in Loop 2010BB and changed type of code to be entered in field and corrected name of code type in CLM05-1 in Loop 2300.	

Page	Change December 2011 Version - continued
37	Changed requirements for field AMT02 in Loop 2320.
39	Changed requirements for field DTP03 in Loop 2330B.
40	Changed requirements for field AMT02 in Loop 2320.
41	Changed requirements for field DTP03 in Loop 2330B.
42	Changed requirements for field SV204 in Loop 2400.
43	Changed requirements for field REF02 in Loop 2410.
45	Changed requirements for fields SVD02 and DTP03 in Loop 2430.
46	Changed requirements for field SVD02 in Loop 2430.
47	Changed requirements for field DTP03 in Loop 2330B.
49	Corrected value to be entered for field PRV02 in Loop 20000A and changed requirements for fields NM108 and NM109 in Loop 2010AA.
51	Removed requirements for REF segment in Loop 2010BB.
52	Added HI Health Care Diagnosis Code segment in Loop 2300.
56	Changed requirements for DTP segment in Loop 2330B.
57	Changed requirements for DTP segment in Loop 2330B.
60	Changed requirements for field DTP03 in Loop 2430.
61	Changed requirements for field DTP03 in Loop 2430.
63	Changed requirements for fields NM108 and NM109 in Loop 2010AA.
70	Changed requirements for field DTP03 in Loop 2330B.
72	Changed requirements for DTP segment in Loop 2330B.
74	Changed loop referenced in NM1 segment in Loop 2420C.
77	Changed requirements for field DTP03 in Loop 2430.
78	Changed requirements for field DTP03 in Loop 2430.
80	Changed requirements for fields NM108 and NM109 in Loop 2010AA.
81	Added REF Billing Provider Tax Identification Number segment in Loop 2010AA.
82	Changed requirements for field HI01-2 in Loop 2300.
84	Changed Loop name to Claim Check or Remittance Date and changed requirements for DTP segment in Loop 2330B.
86	Changed Loop name to Line Check or Remittance Date and changed requirements for field DTP03 for Loop 2430 removing last sentence.
88	Changed requirements for fields NM108 and NM109 in Loop 2010AA.
89	Changed requirements for field REF01in Loop 2010AA.
91	Changed requirements for field HI01-2 in Loop 2300.
92	Changed Loop name to Claim Check or Remittance Date and changed requirements for DTP segment in Loop 2330B.
93	Changed requirements for fields CN102 and CN104 in Loop 2400.
94	Changed Loop name to Line Check or Remittance Date and changed requirements for field DTP03 for Loop 2430 removing last sentence.
95 – 101	Added Section 9 – HIPAA 837 Capitation True-Up Records.
103	Changed requirements and field length for field 201-B1 in the Batch Transaction Header Segment.
104	Added 993-A7 Internal control Number field to the AM05 COB/Other Payments Segment.

Page	Change	December 2011 Version - continued
115	Changed name of section 13 to HIPAA 834 Managed Care Enrollment.	
118	Changed delimiter for field HD04 in Loop 2300.	
119 – 120	Added Section 14 – HIPAA 834 Special Needs Plan Enrollment.	
121	Changed requirements for fields BPR10 and BPR11.	
Page	**Change**	**June 2011 Version**
18	Changed requirements for field N301 in Loop 2010AA.	
46	Changed requirements for field N301 in Loop 2010AA.	
Page	**Change**	**June 2011 Version - continued**
60	Changed requirements for field N301 in Loop 2010AA.	
Page	**Change**	**April 2011 Version**
All	1st Production version of the HMO Encounters Systems Guide for the HIPAA 5010 and NCPDP 1.2 Batch and D.0 version transaction sets.	

SECTION 1 – LOOP/SEGMENT TABLE

SECTION 2 – INTRODUCTION

The purpose of this manual is to provide the HMOs and their vendors with the New Jersey Medicaid payer-specific electronic data requirements for the submission of HMO 837 and NCPDP 1.2/D.0 Pharmacy Encounters and interpretation of the 834 Enrollment, 820 Premium Payment and 835 Remittance Advice interchanges.

The loops, segments, and fields that are required for the construction of valid HIPAA 837 and NCPDP Encounters, 834 Enrollment, 820 Premium Payment and 835 Remittance Advice interchanges are identified in the HIPAA and NCPDP standards. Therefore, loops, segments, and fields that are required per HIPAA and NCPDP standards but do not have data requirements specific to New Jersey Medicaid are not included in this manual. Version 5010 claim transactions will capture and edit the following new fields – Billing Provider Zip Code (required on all claims/encounters), Attending Physician Taxonomy Code (Institutional only, if sent), and Referring Physician Taxonomy Code (Dental only, if sent).

The information for each of the transaction types is presented in a tabular format. A tabular table of contents (SECTION 2 – LOOP/SEGMENT TABLE) can be used to quickly find information by loop. The requirements for the fields in each loop/segment are preceded by the segment name. Both loop and segment names are provided in the loop/segment table.

The "FORMAT" column of the tables indicates the data format (i.e., data type) of each field. Although the specified data formats will generally comply with the HIPAA standard, they may be more specific for New Jersey Medicaid. The value of "A" in this column indicates that the field must contain alphanumeric data. The value of "N" in this column indicates that the field must contain numeric data. The value of "SN" in this column indicates that the field must contain signed-numeric data.

The "LENGTH" column of the tables indicates the required length, maximum length, or length range for each field. Some of the length requirements specified in this manual are the same as those specified in the HIPAA ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3), but some are less than those specified in the HIPAA TR3s, and reflect the maximum lengths of fields defined for use by New Jersey Medicaid. A length specified in the format "X.X" indicates the maximum length of the field, specified as the maximum number of digits to the left and right of the decimal point (Example: A numeric length specification of 7.2 indicates a maximum length of nine digits, with a maximum of seven whole number digits and two decimal digits).

The delimiters specified in the "DELIMITER" column indicate the New Jersey Medicaid standard delimiters for composite sub-fields (:), fields (*), and segments (~). Where more than one delimiter is required to separate a required field from the next required field in the segment (i.e., the two fields are not contiguous within the segment), a string of delimiters is specified.

SECTION 3 – HIPAA ENVELOPE

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
			INTERCHANGE CONTROL HEADER			
	ISA	ISA00	"ISA"	A	3	*
		ISA01	"03"	N	2	*
		ISA02	Enter the 7-position NJ Medicaid Submitter ID followed by 3 spaces.	A	10	*
		ISA03	"00"	N	2	*
		ISA04	"NONE" followed by 6 spaces.	A	10	*
		ISA05	"ZZ"	A	2	*
		ISA06	Enter the 7-position NJ Medicaid Submitter ID followed by 8 spaces.	A	15	*
		ISA07	"ZZ"	A	2	*
		ISA08	"610515"	A	15	*
		ISA09	Enter the interchange (ISA) date (YYMMDD).	N	6	*
		ISA10	Enter the interchange (ISA) time (HHMM).	N	4	*
		ISA11	"^"	A	1	*
		ISA12	"00501"	N	5	*
		ISA13	Enter a unique control number for each interchange (ISA), which must be 9-position numeric value with leading zeros. This field is used by Gainwell Technologies to edit against duplicate interchanges.	N	9	*
		ISA14	"1"	N	1	*
		ISA15	Enter "P" for production. Only upon pre-approval by the Encounter Data Monitoring Unit and Gainwell Technologies is an HMO permitted the use of "T" to signify a test interchange.	A	1	*
		ISA16	A colon is required as the delimiter for data element components. Enter ":" for ISA16. In addition, and for all HIPAA transactions, a carat (^) is the required value for a repetition separator, an asterisk (*) is the required field delimiter and a tilde (~) is the required segment terminator value. It is important that each carat, colon, asterisk, and tilde be used solely as delimiters and not be included in any data value. The use of carriage return, and line feed characters is not permitted in the file.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
FUNCTIONAL GROUP HEADER						
	GS	GS00	"GS"	A	2	*
		GS01	"HC"	A	2	*
		GS02	Enter the 7-position NJ Medicaid Submitter ID.	N	7	*
		GS03	"610515"	N	6	*
		GS04	Enter the functional group (GS) date (CCYYMMDD).	N	8	*
		GS05	Enter the functional group (GS) time (HHMM).	N	4	*
		GS06	Enter a unique control number for each functional group (GS), which must be a 1 to 9-position numeric value. This field value is referenced on the 999 Acknowledgement for reconciliation purposes and MUST match the ISA13 minus the leading zeros.	N	9	*
		GS07	"X"	A	1	*
		GS08	Enter the version number of the 837 transaction contained between the GS and GE segments. For the 837 Professional, enter "005010X222A1". For the 837 Institutional, enter "005010X223A2. For the 837 Dental, enter "005010X224A2". This envelope is not used for NCPDP transactions.	A	12	~
837 TRANSACTION SET						
Please see the 837P, 837I, or 837D specifications included in the other sections of the HMO Systems Guide. Only one type of 837 can be included between each GS and GE segment.						
FUNCTIONAL GROUP TRAILER						
	GE	GE00	"GE"	A	2	*
		GE01	Enter the number of transaction sets (count of SE segments) included in the functional group between the GE and GS segments.	N	6	*
		GE02	Enter the same value used in GS06.	N	9	~
INTERCHANGE CONTROL TRAILER						
	IEA	IEA00	"IEA"	A	3	*
		IEA01	Enter the number of functional groups (count of GS segments) included in the interchange between the ISA and IEA segments.	N	5	*
		IEA02	Enter the same value used in ISA13.	N	9	~

SECTION 4 – HIPAA 837 INSTITUTIONAL ENCOUNTERS

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4-8	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	1-12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER SPECIALTY INFORMATION						
2000A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"BI"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the billing provider.	A	10	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the provider's group provider name.	A	1-35	*****
		NM108	Enter "XX" if the provider is a NPI covered entity. Otherwise, if the provider is a non-covered entity and present on the NPI Non-Covered Entity File submitted by the HMO to the New Jersey EDMU, or the procedure code or procedure code and modifier = S5111, S5120, S5121, S5165, S5170, T1005, T1028, T2002, T2003, T2038, T2038U6, T2039, T2039U7, do not send if a NPI is not available.	A	2	*
		NM109	If NM108 is XX, enter the provider's 10-digit NPI. Otherwise, do not send.	N	10	~
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the provider identified in the NM1 segment.	A	1-55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	1-55	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider.	A	2-30	*
		N402	Enter the state code of the provider.	A	2	*
		N403	Enter the postal code of the provider.	A	9	~
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	"EI"	A	2	*
		REF02	Enter the provider's tax identification number.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SUBSCRIBER DEMOGRAPHIC INFORMATION						
2010BA	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Enter the client's birth date (CCYYMMDD).	N	8	*
		DMG03	Enter the client's gender ("M" for male, "F" for female, "U" for unknown).	A	1	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"012"	N	6	~
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". When submitting an encounter for a reimbursable Maternity service, the last/rightmost position of the submitted ICN/PAN must be an "M". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the total charge amount, which is the sum of all line item charges reported in all SV202 fields in loop 2400.	N	7.2	***
		CLM05-1	Enter the Facility Type Code as referenced in the 837 Institutional TR3.	A	2	:
		CLM05-2	"A"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	**
		CLM07	Enter the appropriate code per the 837 Institutional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Institutional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Institutional TR3.	A	1	**********
		CLM20	Enter the appropriate code per the 837 Institutional TR3.	N	1-2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
DISCHARGE HOUR						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"096"	N	3	*
		DTP02	"TM"	A	2	*
		DTP03	For inpatient encounters, enter the discharge time (HHMM).	N	4	~
STATEMENT DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"434"	N	3	*
		DTP02	"RD8"	A	3	*
		DPT03	Enter the statement covers date (CCYYMMDD-CCYYMMDD).	N	17	~
ADMISSION DATE/HOUR						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"435"	N	3	*
		DTP02	"DT"	A	2	*
		DPT03	For inpatient encounters, enter the admission date and time (CCYYMMDDHHMM).	N	12	~
INSTITUTIONAL CLAIM CODE						
2300	CL1	CL100	"CL1"	A	3	*
		CL101	Enter the Priority Type of Admission Code per the Data Element Dictionary (DED) section.	N	1	*
		CL102	Enter the Point of Origin for Admission or Visit Code per the Data Element Dictionary (DED) section.	N	1	*
		CL103	Enter the Patient Status Code per the Data Element Dictionary (DED) section.	N	2	~
PATIENT ESTIMATED AMOUNT DUE						
2300	AMT	AMT00	"AMT"	A	3	*
		AMT01	"F3"	A	1	*
		AMT02	Enter the Patient Responsibility Amount paid to the MCO by the MLTSS recipient if AMT01 is "F3". (Maximum amount of 99,999.99) Otherwise, do not send.	N	5.2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies 15-digit ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~
MEDICAL RECORD NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"EA"	A	2	*
		REF02	Enter the Medical Record Number. New Jersey Medicaid will only capture the first/leftmost 16 characters of the Medical Record Number.	A	1-16	~
PRINCIPAL DIAGNOSIS						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service/discharge dates before 10/1/2015, use "BK". For service/discharge dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Use ICD-9 principle diagnosis codes for service/discharge dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service/discharge dates on or after 10/1/2015.	A	5-7	::::::
		HI01-9	Enter the Present on Admission Indicator per the 837 Institutional TR3. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	~
ADMITTING DIAGNOSIS						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BJ" or "ABJ" For service/discharge dates before 10/1/2015, use "BJ". For service/discharge dates on or after 10/1/2015, use "ABJ".	A	2-3	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI01-2	For inpatient encounters, enter the admitting diagnosis code. Otherwise, skip. Although this is a required field the NJMMIS will not be capturing this field. Use ICD-9 admitting diagnosis codes for service/discharge dates before 10/1/2015. Use ICD-10 admitting diagnosis codes for service/discharge dates on or after 10/1/2015.	A	5-7	~
PATIENT'S REASON FOR VISIT						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"PR" or "APR" For service dates before 10/1/2015, use "PR". For service dates on or after 10/1/2015, use "APR".	A	2-3	:
		HI01-2	For outpatient encounters, enter the patient reason for visit code. Otherwise, skip. Although this is a required field the NJMMIS will not be capturing this field. Use ICD-9 patient's reason for visit codes for service dates before 10/1/2015. Use ICD-10 patient's reason for visit codes for service dates on or after 10/1/2015.	A	5-7	*
		HI02-1	"PR" or "APR"	A	2-3	:
		HI02-2	If applicable, enter and additional patient reason for visit code. Otherwise, skip. Although this is a required field the NJMMIS will not be capturing this field.	A	5-7	*
		HI03-1	"PR" or "APR"	A	2-3	:
		HI03-2	If applicable, enter and additional patient reason for visit code. Otherwise, skip. Although this is a required field the NJMMIS will not be capturing this field.	A	5-7	~
EXTERNAL CAUSE OF INJURY						
2300	HI	HI00	"HI" The NJMMIS will not capture any data from this segment.	A	2	*
		HI01-1	"BN" or "ABN" For service dates before 10/1/2015, use "BN". For service dates on or after 10/1/2015, use "ABN".	A	2-3	:
		HI01-2	For outpatient encounters, enter the external cause of injury. Otherwise, skip. Use ICD-9 external cause of injury codes for service dates before 10/1/2015. Use ICD-10 external cause of injury codes for service dates on or after 10/1/2015.	A	5-7	::::::
		HI01-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI02-1	"BN" or "ABN"	A	2-3	:
		HI02-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI02-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI03-1	"BN" or "ABN"	A	2-3	:
		HI03-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI03-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI04-1	"BN" or "ABN"	A	2-3	:
		HI04-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI04-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI05-1	"BN" or "ABN"	A	2-3	:
		HI05-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI05-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI06-1	"BN" or "ABN"	A	2-3	:
		HI06-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI06-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI07-1	"BN" or "ABN"	A	2-3	:
		HI07-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI07-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI08-1	"BN" or "ABN"	A	2-3	:
		HI08-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI08-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI09-1	"BN" or "ABN"	A	2-3	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI09-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI09-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI10-1	"BN" or "ABN"	A	2-3	:
		HI10-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI10-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI11-1	"BN" or "ABN"	A	2-3	:
		HI11-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI11-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI12-1	"BN" or "ABN"	A	2-3	:
		HI12-2	If applicable, enter and additional external cause of injury. Otherwise, skip.	A	5-7	::::::
		HI12-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	~
DIAGNOSIS RELATED GROUP (DRG) INFORMATION						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"DR"	A	2	:
		HI01-2	Enter the diagnosis related group (DRG) code. Enter the 3 digit AP-DRG code for claims for service thru/discharge dates before 10/1/2018. Enter the 4-digit APR-DRG code for service thru/discharge dates after 09/30/2018.	A	4	~
OTHER DIAGNOSIS INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 occurrences of diagnosis codes. The NJMMIS will only capture a total of 17 diagnosis codes and present on admission indicators, including the primary diagnosis code.	A	2	*
		HI01-1	"BF" or "ABF" For service/discharge dates before 10/1/2015, use "BF". For service/discharge dates on or after 10/1/2015, use "ABF".	A	2-3	:
		HI01-2	If applicable, enter an additional diagnosis code. Otherwise, skip. Use ICD-9 other diagnosis codes for service/discharge dates before 10/1/2015. Use ICD-10 other diagnosis codes for service/discharge dates on or after 10/1/2015.	A	5-7	::::::

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI01-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI02-1	"BF" or "ABF"	A	2-3	:
		HI02-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI02-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI03-1	"BF" or "ABF"	A	2-3	:
		HI03-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI03-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI04-1	"BF" or "ABF"	A	2-3	:
		HI04-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI04-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI05-1	"BF" or "ABF"	A	2-3	:
		HI05-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI05-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI06-1	"BF" or "ABF"	A	2-3	:
		HI06-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI06-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI07-1	"BF" or "ABF"	A	2-3	:
		HI07-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI07-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI08-1	"BF" or "ABF"	A	2-3	:
		HI08-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI08-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI09-1	"BF" or "ABF"	A	2-3	:
		HI09-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI09-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI10-1	"BF" or "ABF"	A	2-3	:
		HI10-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI10-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI11-1	"BF" or "ABF"	A	2-3	:
		HI11-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI11-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	*
		HI12-1	"BF" or "ABF"	A	2-3	:
		HI12-2	If applicable, enter an additional diagnosis code. Otherwise, skip.	A	5-7	::::::
		HI12-9	If applicable, enter the present on admission code per the 837 Institutional TR3. Otherwise, skip. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	~
PRINCIPAL PROCEDURE INFORMATION						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BR" or "BBR" For discharge dates before 10/1/2015, use "BR". For discharge dates on or after 10/1/2015, use "BBR".	A	2-3	:
		HI01-2	If applicable, enter the primary surgical procedure code. Otherwise, skip. Use ICD-9 principal procedure codes for discharge dates before 10/1/2015. Use ICD-10 principal procedure codes for discharge dates on or after 10/1/2015.	A	5-7	*
		HI01-3	"D8"	A	2	:
		HI01-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PROCEDURE INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 occurrences of surgical procedure codes. The NJMMIS will only capture a total of 6 surgical procedure codes, including the primary surgical code.	A	2	*
		HI01-1	"BQ" or "BBQ" For discharge dates before 10/1/2015, use "BQ". For discharge dates on or after 10/1/2015, use "BBQ".	A	2-3	:
		HI01-2	If applicable, enter an additional surgical procedure code. Otherwise, skip. Use ICD-9 surgical procedure codes for discharge dates before 10/1/2015. Use ICD-10 surgical procedure codes for discharge dates on or after 10/1/2015.	A	5-7	*
		HI01-3	"D8"	A	2	:
		HI01-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI02-1	"BQ" or "BBQ"	A	2-3	:
		HI02-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI02-3	"D8"	A	2	:
		HI02-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI03-1	"BQ" or "BBQ"	A	2-3	:
		HI03-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI03-3	"D8"	A	2	:
		HI03-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI04-1	"BQ" or "BBQ"	A	2-3	:
		HI04-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI04-3	"D8"	A	2	:
		HI04-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI05-1	"BQ" or "BBQ"	A	2-3	:
		HI05-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI05-3	"D8"	A	2	:
		HI05-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI06-1	"BQ" or "BBQ"	A	2-3	:
		HI06-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI06-3	"D8"	A	2	:
		HI06-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI07-1	"BQ" or "BBQ"	A	2-3	:
		HI07-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI07-3	"D8"	A	2	:
		HI07-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI08-1	"BQ" or "BBQ"	A	2-3	:
		HI08-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI08-3	"D8"	A	2	:
		HI08-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI09-1	"BQ" or "BBQ"	A	2-3	:
		HI09-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI09-3	"D8"	A	2	:
		HI09-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI10-1	"BQ" or "BBQ"	A	2-3	:
		HI10-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI10-3	"D8"	A	2	:
		HI10-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI11-1	"BQ" or "BBQ"	A	2-3	:
		HI11-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI11-3	"D8"	A	2	:
		HI11-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	*
		HI12-1	"BQ" or "BBQ"	A	2-3	:
		HI12-2	If applicable, enter an additional surgical procedure code. Otherwise, skip.	A	5-7	*
		HI12-3	"D8"	A	2	:
		HI12-4	Enter the date of the surgical procedure (CCYYMMDD).	N	8	~
OCCURRENCE SPAN INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 occurrence span codes. The NJMMIS will capture up to the first four occurrence span code and date ranges	A	2	*
		HI01-1	"BI"	A	2	:
		HI01-2	If applicable, enter an appropriate occurrence span code. For reporting ICF, Residential or SNF facility type days enter the appropriate 2 digit code: "M3" Intermediate Care Facility (ICF) Days "M4" Residential Days "75" Skilled Nursing Facility (SNF) Days"	A	5	*
		HI01-3	"RD8"	A	3	:
		HI01-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI02-1	"BI"	A	2	:
		HI02-2	If applicable, enter an appropriate 2 digit code as stated in HI01-2 above for reporting additional facility type days.	A	5	*
		HI02-3	"RD8"	A	3	:
		HI02-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI03-1	"BI"	A	2	:
		HI03-2	If applicable, enter an appropriate 2 digit code as stated in HI01-2 above for reporting additional facility type days.	A	5	*
		HI03-3	"RD8"	A	3	:
		HI03-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI04-1	"BI"	A	2	:
		HI04-2	If applicable, enter an appropriate 2 digit code as stated in HI01-2 above for reporting additional facility type days.	A	5	*
		HI04-3	"RD8"	A	3	:
		HI04-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI05-1	"BI"	A	2	:
		HI05-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI05-3	"RD8"	A	3	:
		HI05-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI06-1	"BI"	A	2	:
		HI06-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI06-3	"RD8"	A	3	:
		HI06-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI07-1	"BI"	A	2	:
		HI07-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI07-3	"RD8"	A	3	:
		HI07-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI08-1	"BI"	A	2	:
		HI08-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI08-3	"RD8"	A	3	:
		HI08-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI09-1	"BI"	A	2	:
		HI09-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI09-3	"RD8"	A	3	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI09-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI10-1	"BI"	A	2	:
		HI10-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI10-3	"RD8"	A	3	:
		HI10-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI11-1	"BI"	A	2	:
		HI11-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI11-3	"RD8"	A	3	:
		HI11-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	*
		HI12-1	"BI"	A	2	:
		HI12-2	If applicable, enter an additional occurrence span code. Otherwise, skip.	A	5	*
		HI12-3	"RD8"	A	3	:
		HI12-4	Enter the date of the occurrence span code (CCYYMMDD-CCYYMMDD).	N	17	~
OCCURRENCE INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 occurrence codes. The NJMMIS will only capture the 1st 8 occurrence codes.	A	2	*
		HI01-1	"BH"	A	2	:
		HI01-2	If applicable, enter an occurrence code. Otherwise, skip.	A	5	*
		HI01-3	"D8"	A	2	:
		HI01-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI02-1	"BH"	A	2	:
		HI02-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI02-3	"D8"	A	2	:
		HI02-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI03-1	"BH"	A	2	:
		HI03-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI03-3	"D8"	A	2	:
		HI03-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI04-1	"BH"	A	2	:
		HI04-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI04-3	"D8"	A	2	:
		HI04-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI05-1	"BH"	A	2	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI05-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI05-3	"D8"	A	2	:
		HI05-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI06-1	"BH"	A	2	:
		HI06-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI06-3	"D8"	A	2	:
		HI06-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI07-1	"BH"	A	2	:
		HI07-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI07-3	"D8"	A	2	:
		HI07-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI08-1	"BH"	A	2	:
		HI08-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI08-3	"D8"	A	2	:
		HI08-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI09-1	"BH"	A	2	:
		HI09-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI09-3	"D8"	A	2	:
		HI09-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI10-1	"BH"	A	2	:
		HI10-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI10-3	"D8"	A	2	:
		HI10-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI11-1	"BH"	A	2	:
		HI11-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI11-3	"D8"	A	2	:
		HI11-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	*
		HI12-1	"BH"	A	2	:
		HI12-2	If applicable, enter an additional occurrence code. Otherwise, skip.	A	5	*
		HI12-3	"D8"	A	2	:
		HI12-4	Enter the date of the occurrence code (CCYYMMDD).	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
VALUE INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 value codes.	A	2	*
		HI01-1	"BE"	A	2	:
		HI01-2	If applicable, enter an appropriate value code. For reporting birth weight, enter "54".	N	2	:::
		HI01-5	If applicable, enter the amount associated with the value code. Enter birth weight in grams when HI01-2 equals "54".	N	7.2	*
		HI02-1	"BE"	A	2	:
		HI02-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI02-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI03-1	"BE"	A	2	:
		HI03-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI03-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI04-1	"BE"	A	2	:
		HI04-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI04-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI05-1	"BE"	A	2	:
		HI05-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI05-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI06-1	"BE"	A	2	:
		HI06-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI06-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI07-1	"BE"	A	2	:
		HI07-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI07-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI08-1	"BE"	A	2	:
		HI08-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI08-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI09-1	"BE"	A	2	:
		HI09-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI09-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI10-1	"BE"	A	2	:
		HI10-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI10-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI11-1	"BE"	A	2	:
		HI11-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI11-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	*
		HI12-1	"BE"	A	2	:
		HI12-2	If applicable, enter an additional value code. Otherwise, skip.	N	2	:::
		HI12-5	If applicable, enter the amount associated with the value code. Otherwise, skip.	N	7.2	~
CONDITION INFORMATION						
2300	HI	HI00	"HI" This segment can be repeated a second time to submit up to 24 condition codes. The NJMMIS will only capture a total of 11 condition codes. Please refer to the Data Element Dictionary (DED) section for a list of Institutional Condition Code values.	A	2	*
		HI01-1	If applicable, enter a condition code. Otherwise, skip.	A	2	:
		HI01-2	"BG"	A	2	*
		HI02-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI02-2	"BG"	A	2	*
		HI03-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI03-2	"BG"	A	2	*
		HI04-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI04-2	"BG"	A	2	*
		HI05-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI05-2	"BG"	A	2	*
		HI06-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI06-2	"BG"	A	2	*
		HI07-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI07-2	"BG"	A	2	*
		HI08-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI08-2	"BG"	A	2	*
		HI09-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI09-2	"BG"	A	2	*
		HI10-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI10-2	"BG"	A	2	*
		HI11-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI11-2	"BG"	A	2	*
		HI12-1	If applicable, enter an additional condition code. Otherwise, skip.	A	2	:
		HI12-2	"BG"	A	2	~
CLAIM PRICING/REPRICING INFORMATION						
2300	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	A	9.2	~
ATTENDING PROVIDER NAME						
2310A	NM1	NM100	"NM1"	A	3	*
		NM101	"71"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the attending physician's last name.	A	1-35	*
		NM104	Enter the attending physician's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the attending provider's National Provider Identifier.	N	10	~
ATTENDING PROVIDER SPECIALTY INFORMATION						
2310A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"AT"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the attending physician.	A	10	~
ATTENDING PROVIDER SECONDARY IDENTIFICATION						
2310A	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
2310A		REF02	Enter "E" followed by the attending physician's or enter "S" followed by the attending physician's 9-digit SSN (S123456789).	N	10	~
OPERATING PHYSICIAN NAME						
2310B	NM1	NM100	"NM1" An operating physician is required when a surgical procedure code is present.	A	3	*
		NM101	"72"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the operating physician's last name.	A	1-35	*
		NM104	Enter the operating physician's first name.	A	1-25	****
		NM108	"XX"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2310B		NM109	Enter the operating physician's National Provider Identifier.	N	10	~
OPERATING PHYSICIAN SECONDARY IDENTIFICATION						
2310B	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the operating physician's 9-digit EIN (E123456789) or enter "S" followed by the operating physician's 9-digit SSN (S123456789).	N	10	~
OTHER OPERATING PHYSICIAN NAME						
2310C	NM1	NM100	"NM1" If applicable, enter an additional operating physician. Otherwise, skip. The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"ZZ"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the other operating physician's last name.	A	1-35	*
		NM104	Enter the other operating physician's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the other operating physician's National Provider Identifier.	N	10	~
OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION						
2310C	REF	REF00	"REF" This segment is optional when an NPI is NOT sent in the NM109 field. The NJMMIS will not capture any data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the other operating physician's 9-digit EIN (E123456789) or enter "S" followed by the other operating physician's 9-digit SSN (S123456789).	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
REFERRING PROVIDER NAME						
2310F	NM1	NM100	"NM1" A referring provider is not required, but if this segment identifies a referring provider for inpatient services, the NJMMIS will capture the data from this segment. However, if this segment identifies a referring provider for outpatient or home health services, the NJMMIS will not capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2310F	REF	REF00	"REF" A referring provider is not required, but if this segment identifies a referring provider for inpatient services, the NJMMIS will capture the data from this segment. However, if this segment identifies a referring provider for outpatient or home health services, the NJMMIS will not capture the data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" One iteration of the 2320/2330 loops is required to identify the HMO and to report the amount of the payment made to the provider by the HMO or their appointed subcontractor.	A	3	*
		SBR01	Enter the appropriate code per the 837 Institutional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, the HMO cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount that was made to the provider by the HMO or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. The payment amount is permitted to be $0 if the total claim liability is covered by other payers, or if the service is covered by a capitation arrangement/contract between the HMO and their provider. For Outpatient and Home Health, this amount must be reported at both the claim level and the service line level, and the amount reported at the claim level must equal the sum of all amounts reported at the service line level in field 2430/SVD/SVD02, where the payer ID that is specified at the claim level in field 2330B/NM1/NM109 and the service line level in field 2430/SVD/SVD01 is "HMO". For Inpatient, submit only claim level payment information.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Institutional TR3.	A	1	*
		OI06	Enter the appropriate code per the 837 Institutional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2330B		NM109	"HMO"	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	This date should reflect the reimbursement method for this claim. If the claim is paid at the document level, the claim level date should be sent in this 2330B loop. If the claim is reimbursed at the line level, the 2430 date should be sent for each line, even if they have the same date. For Inpatient claims, both the claim level payment date and the 2430 line level payment date should be submitted. Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered.	N	8	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" Additional iterations of the 2320/2330 loops are required to identify other payers and report the amount of the payments made to the provider by the other payers.	A	3	*
		SBR01	Enter the appropriate code per the 837 Institutional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, other payers cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2320		AMT02	For Outpatient and Home Health, enter the payment amount made to the provider by the other payer. This amount must be reported at both the claim level and the service line level, and the amount reported for a specific payer at the claim level must equal the sum of all amounts reported for that same payer at the service line level in field 2430/SVD/SVD02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 – 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section. For Inpatient, submit only claim level payment information.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Institutional TR3.	A	1	*
		OI06	Enter the appropriate code per the 837 Institutional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the other payer name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	Enter the appropriate payer ID. The list of "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section. NOTE: The identification of NJ Medicaid as an "other payer" is incorrect and should not be specified here.	N	3	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	This date should reflect the reimbursement method for this claim. If the claim is paid at the document level, the claim level date should be sent in this 2330B loop. If the claim is reimbursed at the line level, the 2430 date should be sent for each line, even if they have the same date. For Inpatient claims, both the claim level payment date and the 2430 line level payment date should be submitted. Enter the date (CCYYMMDD) that the provider was paid by the other payer. For Inpatient claims, submit claim level date.	N	8	~
OTHER PAYER CLAIM CONTROL NUMBER						
2330B	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	Enter the other payer's claim control number.	A	1-14	~
SERVICE LINE						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
INSTITUTIONAL SERVICE						
2400	SV2	SV200	"SV2"	A	3	*
		SV201	Enter the service line revenue code. When reporting Inpatient services, NJ Medicaid will use revenue codes 0100 – 0219 to identify charges for Acute days.	N	4	*
		SV202-1	"HC"	A	2	:
		SV202-2	Enter the national procedure code.	A	5	:
		SV202-3	If applicable, enter the first procedure code modifier. Otherwise, skip.	A	2	:
		SV202-4	If applicable, enter the second procedure code modifier. Otherwise, skip.	A	2	:
		SV202-5	If applicable, enter the third procedure code modifier. Otherwise, skip.	A	2	:
		SV202-6	If applicable, enter the fourth procedure code modifier. Otherwise, skip.	A	2	*
		SV203	Enter the service line charge amount.	N	7.2	*
		SV204	"UN" or "DA"	A	2	*
		SV205	Enter the service line units of service, which cannot exceed 999 for NJ Medicaid. For reporting of encounters, a default of 999 is permitted if the actual units on the HMO claim exceed 999.	N	4	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2400		SV207	If applicable, enter the non-covered service amount. Otherwise, skip.	N	7.2	~
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	Enter "D8" to indicate a single date of service or "RD8" to specify a range of service dates.	A	2-3	*
		DTP03	Enter a single date of service (CCYYMMDD) when DTP02 = "D8", or a range of service dates (CCYYMMDD-CCYYMMDD) when DTP02 = "RD8".	N	8-17	~
CLAIM PRICING/REPRICING INFORMATION						
2400	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	N	9.2	~
DRUG IDENTIFICATION						
2410	LIN	LIN00	"LIN" The 2410 loop is required when the "service" in SV201-2 identifies a physician-administered drug.	A	3	**
		LIN02	"N4"	A	2	*
		LIN03	Enter the National Drug Code (NDC). The NJMMIS will begin capturing this field in 2013.	A	11	~
DRUG QUANTITY						
2410	CTP	CTP00	"CTP"	A	3	****
		CTP04	Enter the drug quantity (maximum value – 9999999.999). The NJMMIS will begin capturing this field in 2013.	N	7.3	*
		CTP05	Enter "GR" for Gram, "ML" for Milliliter or "UN" for Unit.	A	2	~
PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER						
2410	REF	REF00	"REF"	A	3	*
		REF01	"XZ"	A	2	*
		REF02	Enter the prescription number. The NJMMIS does not capture this field.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OPERATING PHYSICIAN NAME						
2420A	NM1	NM100	"NM1" The 2420A loop is required when another operating physician at the service line level is different compared to the provider identified in 2310C at the claim level.	A	3	*
		NM101	"72"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the operating physician's last name.	A	1-35	*
		NM104	Enter the operating physician's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the operating physician's National Provider Identifier.	N	10	~
OPERATING PHYSICIAN SECONDARY IDENTIFICATION						
2420A	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the operating physician's 9-digit EIN (E123456789) or enter "S" followed by the operating physician's 9-digit SSN (S123456789).	N	10	~
OTHER OPERATING PHYSICIAN NAME						
2420B	NM1	NM100	"NM1" The 2420A loop is required when a surgical procedure code is listed on the claim and the operating physician at the service line level is different compared to the provider identified in 2310B at the claim level. The NJMMIS does not capture this field.	A	3	*
		NM101	"ZZ"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the other operating physician's last name.	A	1-35	*
		NM104	Enter the other operating physician's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the other operating physician's National Provider Identifier.	N	10	~
OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION						
2420B	REF	REF00	"REF" This segment is optional when an NPI is NOT sent in the NM109 field. The NJMMIS will not capture any data from this segment.	A	3	*
		REF01	"G2"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2420B		REF02	Enter "E" followed by the other operating physician's 9-digit EIN (E123456789) or enter "S" followed by the other operating physician's 9-digit SSN (S123456789). The NJMMIS does not capture this field.	N	10	~
REFERRING PROVIDER NAME						
2420D	NM1	NM100	"NM1" This segment is optional and the NJMMIS does not capture any data from this segment.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2420D	REF	REF00	"REF" This segment is optional and the NJMMIS does not capture data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	Enter "SVD". The first iteration of 2430 loop is required to identify the HMO and the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV202-2.	A	3	*
		SVD01	"HMO"	A	3	*
		SVD02	For outpatient and home health encounters, enter the payment amount that was made to the provider by the HMO or their appointed sub-contractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. The payment amount is permitted to be $0 if the total claim liability is covered by other payer(s) or if the service is covered by a capitation arrangement/contract between the HMO and their provider. For Inpatient, submit only claim level payment information.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV202-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV202-3.	A	2	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2430		SVD03-4	Enter the same value entered in 2400/SV202-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV202-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV202-6.	A	2	*
		SVD04	Enter the same value entered in 2400/SV201.	N	4	*
		SVD05	Enter the same value entered in 2400/SV204.	A	2	~
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) the provider was paid by the HMO or their appointed subcontractor. For a payment made via a check, the payment date is the check date. If the payment is being made electronically, the payment date is the date identified on the transaction that instructs the bank to allocate the funds to the provider, which is typically the date of the transaction. The payment date is permitted to be the claim adjudication date of the HMO or their appointed sub-contractor when the provider is submitting a claim, which is covered by a capitation payment made separately by the HMO or their appointed sub-contractor. In other words, the provider is not billing the claim to receive payment, but rather submitting a record of the service(s) rendered. If the 2430 loop is submitted, this segment must be submitted. For Inpatient claims, submit both the 2330B claim level date and the 2430 line level date.	N	8	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" Additional iterations of the 2430 loop is required if other payers are identified in the 2330B/NM109.	A	3	*
		SVD01	Enter the same value entered in 2330B/NM109.	A	3	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2430		SVD02	Enter the payment amount made to the provider by the other payer. For Outpatient and Home Health, this amount must be reported at both the claim level and the service line level, and the sum of all amounts reported for a specific payer at the service line level must equal the amount reported for that same payer at the claim level in field 2320/AMT*C4/AMT02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 - 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section. For Inpatient, submit only claim level payment information.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV202-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV202-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV202-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV202-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV202-6.	A	2	*
		SVD04	Enter the same value entered in 2400/SV201.	N	4	*
		SVD05	Enter the same value entered in 2400/SV204.	A	2	~
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2430		DTP03	Enter the date (CCYYMMDD) the provider was paid by the HMO or their appointed subcontractor. For a payment made via a check, the payment date is the check date. If the payment is being made electronically, the payment date is the date identified on the transaction that instructs the bank to allocate the funds to the provider, which is typically the date of the transaction. The payment date is permitted to be the claim adjudication date of the HMO or their appointed sub-contractor when the provider is submitting a claim, which is covered by a capitation payment made separately by the HMO or their appointed sub-contractor. In other words, the provider is not billing the claim to receive payment, but rather submitting a record of the service(s) rendered. For services other than inpatient, any line item that has a different payment date should be submitted here at this loop. If the 2430 loop is submitted, this segment must be submitted. For Inpatient claims, submit both the 2330B claim level date and the 2430 line level date.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction, including the ST and SE segments.	N	1-10	*
		SE02	Enter the same value entered in ST02.	N	4-9	~

SECTION 5 – HIPAA 837 DENTAL ENCOUNTERS

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER SPECIALTY INFORMATION						
2000A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"BI"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the billing provider.	A	10	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	Enter "1" if the billing provider is an individual or "2" if the billing provider is a group provider.	N	1	*
		NM103	Enter the provider's last name if NM102 = "1" or the group provider name if NM102 = "2".	A	1-35	*
		NM104	Enter the provider's first name if NM102 = "1" or skip if NM102 = "2".	A	1-25	****
		NM108	Enter "XX" if the provider is a NPI covered entity. Otherwise, if the provider is a non-covered entity and present on the NPI Non-Covered Entity File submitted by the HMO to the New Jersey EDMU, do not send.	A	2	*
		NM109	If NM108 is XX, enter the provider's 10-digit NPI. Otherwise, do not send.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the provider identified in the NM1 segment.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider identified in the NM1 segment.	A	30	*
		N402	Enter the state code of the provider identified in the NM1 segment.	A	2	*
		N403	Enter the postal code of the provider identified in the NM1 segment.	A	15	~
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	Enter "SY" to qualify the SSN in REF02, or enter "EI" to qualify the EIN in REF02.	A	2	*
		REF02	Enter the provider identifier qualified in REF01.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SUBSCRIBER DEMOGRAPHIC INFORMATION						
2010BA	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Enter the client's birth date (CCYYMMDD).	N	8	*
		DMG03	Enter the client's gender ("M" for male, "F" for female, "U" for unknown).	A	1	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the total charge amount, which is the sum of all line item charges reported in all SV302 fields in loop 2400.	N	7.2	***
		CLM05-1	See Code Source 237: Place of Service Codes for Professional Claims as referenced in the 837 Dental TR3 on the CMS website at www.cms.gov.	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	*
		CLM06	Enter the appropriate code per the 837 Dental TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Dental TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Dental TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Dental TR3.	A	1	**:::::*
		CLM12	Enter "01" if the service is a result of an EPSDT screening exam. Otherwise, skip.	N	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
DATE – SERVICE DATE						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	Enter "D8" to indicate a single date of service or "RD8" to specify a range of service dates.	A	2-3	*
		DTP03	Enter a single date of service (CCYYMMDD) when DTP02 = "D8", or a range of service dates (CCYYMMDD-CCYYMMDD) when DTP02 = "RD8". When reporting capitation payments to a HMO network provider (i.e., capitation summary or detail records), the range of service dates entered in DTP03 must represent a full service (calendar) month.	N	8-17	~
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~
HEALTH CARE DIAGNOSIS CODE						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service dates before 10/1/2015, use "BK". For service dates on or after 10/1/2015, use "ABK".	A	2-3	*
		HI01-2	Enter the principal diagnosis code. The NJMMIS does not capture this field. Use ICD-9 principal diagnosis codes for service dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service dates on or after 10/1/2015.	A	5-7	********
		HI02-1	"BF" or "ABF" For service dates before 10/1/2015, use "BF". For service dates on or after 10/1/2015, use "ABF".	A	2-3	*
		HI02-2	If applicable, enter additional diagnosis code. Up to 4 diagnosis codes can be sent including the principal diagnosis code. The NJMMIS does not capture this field. Use ICD-9 diagnosis codes for service dates before 10/1/2015. Use ICD-10 diagnosis codes for service dates on or after 10/1/2015.	A	5-7	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CLAIM PRICING/REPRICING INFORMATION						
2300	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	A	9.2	~
REFERRING PROVIDER NAME						
2310A	NM1	NM100	Enter "NM1". A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SPECIALTY INFORMATION						
2310A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"RF"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the referring provider.	A	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2310A	REF	REF00	"REF" A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
REFERRING PROVIDER NAME						
2310A	NM1	NM100	"NM1" The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"P3"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the primary care provider's last name.	A	1-35	*
		NM104	Enter the primary care provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2310A		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER NAME						
2310B	NM1	NM100	"NM1"	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER SPECIALTY INFORMATION						
2310B	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2310B	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" One iteration of the 2320/2330 loops is required to identify the HMO and to report the amount of the payment made to the provider by the HMO or their appointed subcontractor.	A	3	*
		SBR01	Enter the appropriate code per the 837 Dental TR3. For FQHC or non-FQHC sub-capitation reporting, enter "S". NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, the HMO cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount that was made to the provider by the HMO or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. The payment amount is permitted to be $0 if the total claim liability is covered by other payers, or if the service is covered by a capitation arrangement/contract between the HMO and their provider. This amount must be reported at both the claim level and the service line level, and the amount reported at the claim level must equal the sum of all amounts reported at the service line level in field 2430/SVD/SVD02, where the payer ID that is specified at the claim level in field 2330B/NM1/NM109 and the service line level in field 2430/SVD/SVD01 is "HMO". *** For Sub-Capitation, see next 2320 loop info below.**	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Dental TR3.	A	1	***
		OI06	Enter the appropriate code per the 837 Dental TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" Additional iterations of the 2320/2330 loops are required to identify other payers and report the amount of the payments made to the provider by the other payers.	A	3	*
		SBR01	Enter the appropriate code per the 837 Dental TR3. For FQHC or non-FQHC sub-capitation reporting, enter "T". NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, other payers cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount made by the Sub-Capitation Contractor to any other provider. This amount must equal the sum of all amounts in the 2430/SVD02 fields where the corresponding 2430/SVD01 is CAP and is the same as the other payer ID specified in the corresponding 2330B/NM109 field."	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Dental TR3.	A	1	***
		OI06	Enter the appropriate code per the 837 Dental TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the other payer name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	Enter the appropriate payer ID. The list of "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section. EXCEPTION: For FQHC or non-FQHC sub-capitation reporting, enter "CAP". NOTE: The identification of NJ Medicaid as an "other payer" is incorrect and should not be specified here.	A	10	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
SERVICE LINE NUMBER						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
DENTAL SERVICE						
2400	SV3	SV300	"SV3"	A	3	*
		SV301-1	"AD"	A	2	:
		SV301-2	Enter the national procedure code.	A	5	:
		SV301-3	If applicable, enter the first procedure code modifier. Otherwise, skip.	A	2	:
		SV301-4	If applicable, enter the second procedure code modifier. Otherwise, skip.	A	2	:
		SV301-5	If applicable, enter the third procedure code modifier. Otherwise, skip.	A	2	:
		SV301-6	If applicable, enter the fourth procedure code modifier. Otherwise, skip.	A	2	*
		SV302	Enter the service line charge amount.	N	7.2	*
		SV303	Enter the service line place of service if different compared the place of service specified in 2300/CLM05-1 at the claim level. Otherwise, skip.	A	2	*
		SV304	If applicable, enter the Oral Cavity Designation Code per the Data Element Dictionary (DED) section. Otherwise, skip. Only one SV304 can be used for each 2400 loop. Occurrences SVC304-2 through SVC304-5 will be ignored by New Jersey Medicaid.	N	4	**

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2400		SV306	Enter the service line units of service.	A	1	~
TOOTH INFORMATION						
2400	TOO	TOO00	"TOO"	A	2	*
		TOO01	"JP"	A	2	*
		TOO02	Enter the tooth number per the 837 Dental TR3. Otherwise, skip. When reporting a super-numerary tooth, NJ Medicaid requires that tooth numbers greater than 50 be used. Add 50 to adult tooth number to report the corresponding super-numerary tooth.	AN	30	*
		TOO03	Enter the tooth surface per the 837 Dental TR3. Otherwise, skip. If "F" Facial is entered Medicaid will convert "F" to "B" when reporting on the electronic RA.	AN	2	~
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	Enter "D8" to indicate a single date of service or "RD8" to specify a range of service dates.	A	2-3	*
		DTP03	Enter a single date of service (CCYYMMDD) when DTP02 = "D8", or a range of service dates (CCYYMMDD-CCYYMMDD) when DTP02 = "RD8". When reporting capitation payments to a HMO network provider (i.e., capitation summary or detail records), the range of service dates entered in DTP03 must represent a full service (calendar) month.	N	8-17	~
CLAIM PRICING/REPRICING INFORMATION						
2400	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	N	9.2	~
RENDERING PROVIDER NAME						
2420A	NM1	NM100	"NM1" The 2420A loop is required when the rendering provider identified at the service line level is different than the rendering provider identified at the claim level (in loop 2310B).	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RENDERING PROVIDER SPECIALTY INFORMATION						
2420A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2420A	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify the HMO and specify the amount of the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV301-2.	A	3	*
		SVD01	"HMO" **For FQHC Sub-Capitation payment reporting, use "CAP".**	A	3	*
		SVD02	Enter the payment amount that was made to the provider by the HMO or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor. The payment amount can be $0 if the total claim liability is covered by other payers, or if the service is covered by a capitation arrangement/contract between the HMO and the provider. For Sub-Capitation payment reporting, use amount paid by the Sub-Capitation Contractor.	N	7.2	*
		SVD03-1	"AD"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV301-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV301-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV301-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV301-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV301-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV304.	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" Additional iterations of the 2430 loop are required if other payers are identified in 2330B/NM109.	A	3	*
		SVD01	Enter the same value entered in 2330B/NM109.	A	10	*
		SVD02	Enter the amount of the payment made to the provider by the other payer.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV301-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV301-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV301-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV301-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV301-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV304.	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CAS - LINE ADJUSTMENT						
2430	CAS	CAS00	"CAS"	A	3	*
		CAS01	"CO"	A	2	*
		CAS02	Enter "59" when reporting an interim encounter for multiple visits/treatments but no payment is made to the provider by the HMO or their appointed subcontractor. If other CAS trios are required for this claim, adjustment reason code 59 could be submitted in any of applicable CAS trios.	A	3	*
		CAS03	Enter the amount of the adjustment.	N	7.2	**
		CAS05	If applicable, enter the HIPAA claim adjustment reason code. Otherwise, skip.	A	3	*
		CAS06	If applicable, enter the amount of the adjustment. Otherwise, skip.	N	7.2	**
		CAS08	If applicable, enter the HIPAA claim adjustment reason code. Otherwise, skip.	A	3	*
		CAS09	If applicable, enter the amount of the adjustment. Otherwise, skip.	N	7.2	**
		CAS11	If applicable, enter the HIPAA claim adjustment reason code. Otherwise, skip.	A	3	*
		CAS12	If applicable, enter the amount of the adjustment. Otherwise, skip.	N	7.2	**
		CAS14	If applicable, enter the HIPAA claim adjustment reason code. Otherwise, skip.	A	3	*
		CAS15	If applicable, enter the amount of the adjustment. Otherwise, skip.	N	7.2	**
		CAS17	If applicable, enter the HIPAA claim adjustment reason code. Otherwise, skip.	A	3	*
		CAS18	If applicable, enter the amount of the adjustment. Otherwise, skip.	N	7.2	~
LINE ADJUDICATION DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the other payer. Any line item that has a different payment date should be submitted here at this loop. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 6 – HIPAA 837 PROFESSIONAL ENCOUNTERS

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER SPECIALTY INFORMATION						
2000A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"BI"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the billing provider.	A	10	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	Enter "1" if the billing provider is an individual or "2" if the billing provider is a group provider.	N	1	*
		NM103	Enter the provider's last name if NM102 = "1" or the group provider name if NM102 = "2".	A	1-35	*
		NM104	Enter the provider's first name if NM102 = "1" or skip if NM102 = "2".	A	1-25	****
		NM108	Enter "XX" if the provider is a NPI covered entity. Otherwise, if the provider is a non-covered entity and present on the NPI Non-Covered Entity File submitted by the HMO to the New Jersey EDMU, or the procedure code or procedure code and modifier = S5111, S5120, S5121, S5165, S5170, T1005, T1028, T2002, T2003, T2038, T2038U6, T2039, T2039U7, do not send if a NPI is not available.	A	2	*
		NM109	If NM108 is XX, enter the provider's 10-digit NPI. Otherwise, do not send.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the provider identified in the NM1 segment.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider identified in the NM1 segment.	A	30	*
		N402	Enter the state code of the provider identified in the NM1 segment.	A	2	*
		N403	Enter the postal code of the provider identified in the NM1 segment.	A	15	~
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	Enter "SY" to qualify the SSN in REF02, or enter "EI" to qualify the EIN in REF02.	A	2	*
		REF02	Enter the provider identifier qualified in REF01.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SUBSCRIBER DEMOGRAPHIC INFORMATION						
2010BA	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Enter the client's birth date (CCYYMMDD).	N	8	*
		DMG03	Enter the client's gender ("M" for male, "F" for female, "U" for unknown).	A	1	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". When submitting an encounter for a reimbursable Drug, the last/rightmost position of the submitted ICN/PAN must be an "M". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the total charge amount, which is the sum of all line item charges reported in all SV102 fields in loop 2400.	N	7.2	***
		CLM05-1	See Code Source 237: Place of Service Codes for Professional Claims as referenced in the 837 Professional TR3 on the CMS website at www.cms.gov.	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	*
		CLM06	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Professional TR3.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PATIENT AMOUNT PAID						
2300	AMT	AMT00	"AMT"	A	3	*
		AMT01	"F5"	A	1	*
		AMT02	Enter the Patient Responsibility Amount paid to the MCO by the MLTSS recipient if AMT01 is "F5". (Maximum amount of 99,999.99) Otherwise, do not send.	N	5.2	~
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~
MEDICAL RECORD NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"EA"	A	2	*
		REF02	Enter the Medical Record Number. New Jersey Medicaid will only capture the first/leftmost 16 characters of the Medical Record Number.	A	16	~
HEALTH CARE DIAGNOSIS CODE						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service dates before 10/1/2015, use "BK". For service dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Enter the primary diagnosis code. Use ICD-9 principle diagnosis codes for service/discharge dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service/discharge dates on or after 10/1/2015.	A	5-7	*
		HI02-1	"BF" or "ABF" For service dates before 10/1/2015, use "BF". For service dates on or after 10/1/2015, use "ABF".	A	2-3	:
		HI02-2	If applicable, enter an additional diagnosis code. Use ICD-9 diagnosis codes for service dates before 10/1/2015. Use ICD-10 diagnosis codes for service dates on or after 10/1/2015.	A	5-7	*
		HI03-1	"BF" or "ABF"	A	2-3	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI03-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI04-1	"BF" or "ABF"	A	2-3	:
		HI04-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI05-1	"BF" or "ABF"	A	2-3	:
		HI05-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI06-1	"BF" or "ABF"	A	2-3	:
		HI06-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI07-1	"BF" or "ABF"	A	2-3	:
		HI07-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI08-1	"BF" or "ABF"	A	2-3	:
		HI08-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI09-1	"BF" or "ABF"	A	2-3	:
		HI09-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI10-1	"BF" or "ABF"	A	2-3	:
		HI10-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI11-1	"BF" or "ABF"	A	2-3	:
		HI11-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI12-1	"BF" or "ABF"	A	2-3	:
		HI12-2	If applicable, enter an additional diagnosis code.	A	5-7	~
CLAIM PRICING/REPRICING INFORMATION						
2300	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	N	9.2	~
REFERRING PROVIDER NAME						
2310A	NM1	NM100	Enter "NM1". A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2310A	REF	REF00	"REF" A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~
REFERRING PROVIDER NAME						
2310A	NM1	NM100	"NM1" The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"P3"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the primary care provider's last name.	A	1-35	*
		NM104	Enter the primary care provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER NAME						
2310B	NM1	NM100	"NM1"	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER SPECIALTY INFORMATION						
2310B	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2310B	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SERVICE FACILITY LOCATION NAME						
2310C	NM1	NM100	"NM1"	A	3	*
		NM101	"77"	N	2	*
		NM102	"2"	N	1	******
		NM108	"XX"	A	2	*
		NM109	Enter the service facility name's National Provider Identifier.	N	10	~
SERVICE FACILITY LOCATION ADDRESS						
2310C	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the facility where the service was provided.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	*
SERVICE FACILITY LOCATION CITY/STATE/ZIP CODE						
2310C	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the facility where the service was provided.	A	30	*
		N402	Enter the state code of the facility where the service was provided.	A	2	*
		N403	Enter the postal code of the facility where the service was provided.	A	15	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" One iteration of the 2320/2330 loops is required to identify the HMO and to report the amount of the payment made to the provider by the HMO or their appointed subcontractor.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. For FQHC or non-FQHC sub-capitation reporting, enter "S". NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, the HMO cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount that was made to the provider by the HMO or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. This amount must be reported at both the claim level and the service line level, and the amount reported for a specific payer at the claim level must equal the sum of all amounts reported for that same payer at the service line level in field 2430/SVD/SVD02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 – 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section. ***For Sub-Capitation, see next 2320 loop info below.**	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" Additional iterations of the 2320/2330 loops are required to identify other payers and report the amount of the payments made to the provider by the other payers.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. For FQHC or non-FQHC sub-capitation reporting, enter "T". NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, other payers cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount made by the Sub-Capitation Contractor to any other provider. This amount must equal the sum of all amounts in the 2430/SVD02 fields where the corresponding 2430/SVD01 is CAP and is the same as the other payer ID specified in the corresponding 2330B/NM109 field.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the other payer name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	Enter the appropriate payer ID. The list of "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) Section. EXCEPTION: For FQHC or non-FQHC sub-capitation reporting, enter "CAP". NOTE: The identification of NJ Medicaid as an "other payer" is incorrect and should not be specified here.	A	10	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
SERVICE LINE NUMBER						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PROFESSIONAL SERVICE						
2400	SV1	SV100	"SV1"	A	3	*
		SV101-1	"HC"	A	2	:
		SV101-2	Enter the national procedure code.	A	5	:
		SV101-3	If applicable, enter the first procedure code modifier. Otherwise, skip. When reporting a transportation service in SV101-2, a pseudo procedure code modifier is required to report the origin (first character of the modifier) and the destination (second character of the modifier). Please see the Data Element Dictionary (DED) section (Transportation Origin/Destination Code) for the list of codes.	A	2	:
		SV101-4	If applicable, enter the second procedure code modifier. Otherwise, skip.	A	2	:
		SV101-5	If applicable, enter the third procedure code modifier. Otherwise, skip.	A	2	:
		SV101-6	If applicable, enter the fourth procedure code modifier. Otherwise, skip.	A	2	*
		SV102	Enter the service line charge amount.	N	7.2	*
		SV103	"UN" or "MJ"	A	2	*
		SV104	Enter the service line units of service with the "UN" qualifier in SV103. For anesthesia services, bill the exact number of minutes with the "MJ" qualifier in SV103.	N	4	*
		SV105	Enter the service line place of service code if different than the claim level place of service code (entered in loop 2300, segment CLM, field CLM05-1).	A	2	**
		SV107-1	If diagnosis codes are reported at the claim level (entered in Loop 2300, Segment HI), enter the diagnosis pointer ("1" through "8"). Otherwise, skip. A specific diagnosis pointer can only be used once in SV107-1 through SV107-4.	N	2	:
		SV107-2	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	:
		SV107-3	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	:
		SV107-4	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	**
		SV109	Enter "Y" if the service provided was emergency related. Otherwise, skip.	A	1	**
		SV111	Enter "Y" if the service is the result of an EPSDT screening. Otherwise, skip.	A	1	*
		SV112	Enter "Y" if the service is a family planning service. Otherwise, skip.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	Enter "D8" to indicate a single date of service or "RD8" to specify a range of service dates.	A	2-3	*
		DTP03	Enter a single date of service (CCYYMMDD) when DTP02 = "D8", or a range of service dates (CCYYMMDD-CCYYMMDD) when DTP02 = "RD8".	N	8-17	~
CLAIM PRICING/REPRICING INFORMATION						
2300	HCP	HCP00	"HCP"	A	3	*
		HCP01	Ener the Pricing Methodology Code.	A	2	*
		HCP02	Enter the allowed amount.	N	9.2	~
DRUG IDENTIFICATION						
2410	LIN	LIN00	"LIN" The 2410 loop is required when the "service" in SV101-2 identifies a physician-administered drug.	A	3	**
		LIN02	"N4"	A	2	*
		LIN03	Enter the National Drug Code (NDC). The NJMMIS will begin capturing this field in 2013.	A	11	~
DRUG PRICING						
2410	CTP	CTP00	"CTP"	A	3	****
		CTP04	Enter the drug quantity (maximum value – 9999999.999). The NJMMIS will begin capturing this field in 2013.	N	7.3	*
		CTP05	Enter "GR" for Gram, "ML" for Milliliter or "UN" for Unit.	A	2	~
RENDERING PROVIDER NAME						
2420A	NM1	NM100	"NM1" The 2420A loop is required when the rendering provider identified at the service line level is different than the rendering provider identified at the claim level (in loop 2310B).	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RENDERING PROVIDER SPECIALTY INFORMATION						
2420A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2420A	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
SERVICE FACILITY LOCATION NUMBER						
2420C	NM1	NM100	"NM1" The 2420C loop is required when service facility address at the service line level is different than the service facility address at the claim level (in loop 2310C).	A	3	*
		NM101	"77"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the service facility name.	A	1-35	*****
		NM108	"XX"	A	2	*
		NM109	Enter the service facility name's National Provider Identifier.	N	10	~
SERVICE FACILITY LOCATION ADDRESS						
2420C	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the facility where the service was provided.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
SERVICE FACILITY LOCATION CITY/STATE/ZIP CODE						
2420C	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the facility where the service was provided.	A	30	*
		N402	Enter the state code of the facility where the service was provided.	A	2	*
		N403	Enter the postal code of the facility where the service was provided.	A	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
REFERRING PROVIDER NAME						
2420F	NM1	NM100	"NM1" A referring provider is required at the service line level when the referring provider identified at the servcie line level is different than the referring provider identified at the claim level (in loop 2310A). If a referring provider is identified, the NJMMIS will capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2420F	REF	REF00	"REF" A referring provider is not required, but if a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~
REFERRING PROVIDER NAME						
2420F	NM1	NM100	"NM1" The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"P3"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the primary care provider's last name.	A	1-35	*
		NM104	Enter the primary care provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify the HMO and specify the amount of the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV101-2.	A	3	*
		SVD01	"HMO" or "CAP" For FQHC or Non-FQHC Sub-Capitation payment reporting, use "CAP".	A	3	*
		SVD02	Enter the payment amount that was made to the provider by the HMO or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. This amount must be reported at both the claim level and the service line level, and the sum of all amounts reported at the service line level must equal the amount reported at the claim level in field 2320/AMT*D/AMT02, where the payer ID that is specified at the claim level in field 2330B/NM1/NM109 and the service line level in field 2430/SVD/SVD01 is "HMO" or "CAP" for FQHC Sub-Capitation payment reporting.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV101-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV101-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV101-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV101-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV101-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV104.	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" Additional iterations of the 2430 loop are required if other payers are identified in 2330B/NM109.	A	3	*
		SVD01	Enter the same value entered in 2330B/NM109.	A	10	*
		SVD02	Enter the payment amount made to the provider by the other payer. This amount must be reported at both the claim level and the service line level, and the sum of all amounts reported for a specific payer at the service line level must equal the amount reported for that same payer at the claim level in field 2320/AMT*D/AMT02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 field must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 - 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV101-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV101-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV101-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV101-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV101-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV104.	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE ADJUDICATION DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the other payer. Any line item that has a different payment date should be submitted here at this loop. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 7 – HIPAA 837 CAPITATION SUMMARY RECORDS

HIPAA 837 capitation summary records are no longer required and should not be submitted after June 30, 2013

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*
		NM108	Enter "XX" if the provider is a NPI covered entity. Otherwise, if the provider is a non-covered entity and present on the NPI Non-Covered Entity File submitted by the HMO to the New Jersey EDMU, do not send.	A	2	*
		NM109	If NM108 is XX, enter the provider's 10-digit NPI. Otherwise, do not send.	N	10	~
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the HMO's street address.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the HMO's city name.	A	30	*
		N402	Enter the HMO's state code.	A	2	*
		N403	Enter the HMO's zip code.	A	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	Enter "SY" to qualify the SSN in REF02, or enter "EI" to qualify the EIN in REF02.	A	2	*
		REF02	Enter the provider identifier qualified in REF01.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	"SUMMARY"	A	7	*
		NM104	"CAP"	A	3	*
		NM108	"MI"	A	2	*
		NM109	"999999999999"	N	12	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the amount reported in 2320/AMT02.	N	7.2	***
		CLM05-1	"99"	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	**
		CLM06	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM20	Enter the appropriate code per the 837 Institutional TR3.	N	1-2	~
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies 15-digit ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PRINCIPAL DIAGNOSIS						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service dates before 10/1/2015, use "BK". For service dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Submit any valid diagnosis code. This field is not captured. Use ICD-9 principle diagnosis codes for service dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service dates on or after 10/1/2015.	A	5-7	::::::
		HI01-9	Enter the Present on Admission Indicator per the 837 Institutional TR3. If a diagnosis is submitted and no corresponding POA is entered the NJMMIS will default the POA to "1".	A	1	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"HM"	A	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	"SUMMARY"	A	7	*
		NM104	"CAP"	A	3	***
		NM108	"MI"	A	2	*
		NM109	"999999999999"	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" Do not submit this segment. Submit 2430 line level segment instead.	A	3	*
SERVICE LINE						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
PROFESSIONAL SERVICE						
2400	SV1	SV100	"SV1"	A	3	*
		SV101-1	"HC"	A	2	:
		SV101-2	"G9012"	A	5	:
		SV102	Enter the amount reported in 2320/AMT02.	N	7.2	*
		SV103	"UN"	A	2	*
		SV104	"1"	N	1	***
		SV107	"1"	N	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	"RD8"	A	3	*
		DTP03	Enter the date of service (CCYYMMDD-CCYYMMDD) for the capitation payment specified in 2320/AMT02.	N	17	~
CONTRACT INFORMATION						
2400	CN1	CN100	"CN1"	A	3	*
		CN101	"05"	N	2	*
		CN102	Enter the number of beneficiaries represented by the capitation summary code specified in CN104.	N	7	**
		CN104	Enter an 8-digit code, which is the combination of the 5-digit beneficiary capitation code (assigned by OIT), and the 3-digit provider type required by the HMO contract. The valid provider types are: 100 – Medical, Primary Care 200 – Medical, Specialty 300 – Dental, Primary Care 400 – Dental, Specialty 500 – Vision 600 – Pharmacy 700 – Mental Health 800 – Care Management 900 – Laboratory 910 – Therapies (PT, ST, OT) 920 – Radiology 930 – Hearing 940 -- Reserved for future use 950 – Reserved for future use 960 – Reserved for future use 970 – Reserved for future use 980 – Reserved for future use 990 – Other	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify the HMO and specify the amount of the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV101-2.	A	3	*
		SVD01	"HMO"	A	3	*
		SVD02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	"G9012"	A	5	:
		SVD05	"1"	N	4	~
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 8 – HIPAA 837 CAPITATION DETAIL RECORDS

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	~
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	Enter "1" if the provider being issued a capitation payment is an individual or "2" if the provider being issued a capitation payment is a group provider.	N	1	*
		NM103	Enter the provider's last name if NM102 = "1" or the group provider name if NM102 = "2".	A	1-35	*
		NM104	Enter the provider's first name if NM102 = "1" or skip if NM102 = "2".	A	1-25	****
		NM108	Enter "XX" if the provider is a NPI covered entity. Otherwise, if the provider is a non-covered entity and present on the NPI Non-Covered Entity File submitted by the HMO to the New Jersey EDMU, do not send.	A	2	*
		NM109	If NM108 is XX, enter the provider's 10-digit NPI. Otherwise, do not send.	N	10	~
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the provider's street address.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider identified in the NM1 segment.	A	30	*
		N402	Enter the state code of the provider identified in the NM1 segment.	A	2	*
		N403	Enter the postal code of the provider identified in the NM1 segment.	A	15	~
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	Enter "SY" to qualify the SSN in REF02, or enter "EI" to qualify the EIN in REF02.	A	2	*
		REF02	Enter the provider's tax identification number.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	*
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SUBSCRIBER DEMOGRAPHIC INFORMATION						
2010BA	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Enter the client's birth date (CCYYMMDD).	N	8	*
		DMG03	Enter the client's gender ("M" for male, "F" for female, "U" for unknown).	A	1	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the amount reported in 2320/AMT02.	N	7.2	***
		CLM05-1	"99"	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	**
		CLM06	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM20	Enter the appropriate code per the 837 Institutional TR3.	N	1-2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~
PRINCIPAL DIAGNOSIS						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service/discharge dates before 10/1/2015, use "BK". For service/discharge dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Submit any valid diagnosis code. This field is not captured. Use ICD-9 principle diagnosis codes for service/discharge dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service/discharge dates on or after 10/1/2015. For CAPDT records, submit diagnosis code Z00.8 - Encounter for general examination or any similar general ICD-10 diagnosis codes that align with the sub-capitation type, when applicable.	A	5-7	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" One iteration of the 2320/2330 loops is required to identify the HMO and report the amount of the capitation payment made to the provider by the HMO or their appointed subcontractor.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, the HMO cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"HM"	A	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03. For D-SNP, the HMO capitation payment reported here must not include the portion that was paid by Medicare, as the Medicare portion is reported separately in the 2320/2330 loops that identify Medicare as an "other payer". Also for D-SNP, the HMO capitation payment may be $0 if fully paid by Medicare.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" An additional iteration of the 2320/2330 loops is required to identify Medicare and report the portion of a D-SNP capitation payment that was paid my Medicare.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, Medicare cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"HM"	A	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the portion of a D-SNP capitation payment that was paid by Medicare.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the Medicare payer name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	Enter the appropriate payer ID. The list of "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) Section. NOTE: The identification of NJ Medicaid as an "other payer" is incorrect and should not be specified here.	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
SERVICE LINE						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
PROFESSIONAL SERVICE						
2400	SV1	SV100	"SV1"	A	3	*
		SV101-1	"HC"	A	2	:
		SV101-2	"G9012"	A	5	:
		SV102	Enter the amount reported in 2320/AMT02.	N	7.2	*
		SV103	"UN"	A	2	*
		SV104	"1"	N	1	***
		SV107	"1"	N	1	~
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	"RD8"	A	3	*
		DTP03	Enter the date of service (CCYYMMDD-CCYYMMDD) for the capitation payment specified in 2320/AMT02.	N	17	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CONTRACT INFORMATION						
2400	CN1	CN100	"CN1"	A	3	*
		CN101	"05"	N	2	*
		CN102	"1"	N	1	**
		CN104	Enter an 8-digit code, which is the combination of the 5-digit beneficiary capitation code (assigned by OIT), and the 3-digit provider type required by the HMO contract. The valid provider types are: 100 – Medical, Primary Care 200 – Medical, Specialty 300 – Dental, Primary Care 400 – Dental, Specialty 500 – Vision 600 – Pharmacy 700 – Mental Health 800 – Care Management 900 – Laboratory 910 – Therapies (PT, ST, OT) 920 – Radiology 930 – Hearing 940 – Reserved for future use 950 – Reserved for future use 960 – Reserved for future use 970 – Reserved for future use 980 – Reserved for future use 990 – Other	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify the HMO and specify the amount of the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV101-2.	A	3	*
		SVD01	"HMO"	A	3	*
		SVD02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	"G9012"	A	5	:
		SVD05	"1"	N	4	~
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered.	N	8	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" An additional iteration of the 2430 loop is required to identify Medicare and report the portion of a D-SNP capitation payment that was paid by Medicare.	A	3	*
		SVD01	Enter the same value entered in the 2330B/NM109 used for the Medicare D-SNP Payer ID.	A	3	*
		SVD02	Enter the portion of a D-SNP capitation payment that was paid by Medicare.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	"G9012"	A	5	:
		SVD05	"1"	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the HMO was paid by Medicare. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 9 – HIPAA 837 CAPITATION TRUE-UP RECORDS

HIPAA 837 Capitation "True-Up" records can only be submitted by HealthFirst NJ

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	Enter the HMO name.	A	1-60	*
		PER03	"TE"	A	2	*
		PER04	Enter the HMO telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	Enter "1" if the provider being issued a capitation payment is an individual or "2" if the provider being issued a capitation payment is a group provider.	N	1	*
		NM103	Enter the provider's last name if NM102 = "1" or the group provider name if NM102 = "2".	A	1-35	*
		NM104	Enter the provider's first name if NM102 = "1" or skip if NM102 = "2".	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the provider's 10-digit NPI.	N	10	~
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the provider's street address.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider identified in the NM1 segment.	A	30	*
		N402	Enter the state code of the provider identified in the NM1 segment.	A	2	*
		N403	Enter the postal zip code of the provider identified in the NM1 segment.	A	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF" This segment is required when NM108 = "XX".	A	3	*
		REF01	"EI" or "SY"	A	2	*
		REF02	When REF01 = "EI", enter the provider's tax identification number. When REF01 = "SY", enter the provider's social security number.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	"TRUEUP"	A	6	*
		NM104	"HF"	A	2	*
		NM108	"MI"	A	2	*
		NM109	"999999999999"	N	12	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter the HMO Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a HMO-denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". New Jersey Medicaid will only capture the first/leftmost 20 characters of the HMO Internal Claim Number.	A	20	*
		CLM02	Enter the amount reported in 2320/AMT02.	N	7.2	***
		CLM05-1	"99"	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	**
		CLM06	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM10	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM11	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM12	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM20	Enter the appropriate code per the 837 Professional TR3.	N	1-2	~
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies 15-digit ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PRINCIPAL DIAGNOSIS						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK" or "ABK" For service dates before 10/1/2015, use "BK". For service dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Submit any valid diagnosis code. This field is not captured. Use ICD-9 principle diagnosis codes for service dates before 10/1/2015. Use ICD-10 principal diagnosis codes for service dates on or after 10/1/2015.	A	5-7	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"HM"	A	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	"TRUEUP"	A	6	*
		NM104	"HF"	A	2	****
		NM108	"MI"	A	2	*
		NM109	"999999999999"	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the HMO name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~
CLAIM ADJUDICATION DATE						
2330B	DTP	DTP00	"DTP" Do not submit this segment. Submit 2430 line level segment instead.	A	3	*
SERVICE LINE						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
PROFESSIONAL SERVICE						
2400	SV1	SV100	"SV1"	A	3	*
		SV101-1	"HC"	A	2	:
		SV101-2	"G9012"	A	5	:
		SV102	Enter the amount reported in 2320/AMT02.	N	7.2	*
		SV103	"UN"	A	2	*
		SV104	"1"	N	1	***
		SV107	"1"	N	1	~
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	"RD8"	A	3	*
		DTP03	Enter the date of service (CCYYMMDD-CCYYMMDD) for the capitation payment specified in 2320/AMT02.	N	17	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
CONTRACT INFORMATION						
2400	CN1	CN100	"CN1"	A	3	*
		CN101	"05"	N	2	*
		CN102	Enter the number of clients in the provider's organization (P-ORG).	N	7	**
		CN104	Enter an 8-digit code, which is a default of five 9's (99999) followed by a three-digit code identifying the provider type. The valid provider types are: 997 – Professional, 998 – Inpatient, and 999 – Outpatient.	N	8	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify the HMO and specify the amount of the payment made to the provider by the HMO or their appointed subcontractor for the service identified in SV101-2.	A	3	*
		SVD01	"HMO"	A	3	*
		SVD02	Enter the total capitation payment amount made to the provider by the HMO or their appointed subcontractor for the provider type and beneficiary capitation code specified in 2400/CN104 and the service month specified in 2400/DTP03.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	"G9012"	A	5	:
		SVD05	"1"	N	4	~
LINE ADJUDICATION DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the HMO or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by the HMO or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by the HMO or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered.	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 10 – HIPAA 837 CAPITATED TRANSPORTATION ENCOUNTERS

HIPAA 837 Capitated Transportation Encounter record can only be submitted by Modivcare Solutions

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"837"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	A	4-9	*
		ST03	Enter the same value used in GS08.	A	12	~
BEGIN HIERARCHICAL TRANSACTION						
	BHT	BHT00	"BHT"	A	3	*
		BHT01	"0019"	N	4	*
		BHT02	"00"	N	2	*
		BHT03	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BHT04	Enter the file creation date (CCYYMMDD).	N	8	*
		BHT05	Enter the file creation time (HHMM).	N	4	*
		BHT06	"RP"	A	2	~
SUBMITTER NAME						
1000A	NM1	NM100	"NM1"	A	3	*
		NM101	"41"	N	2	*
		NM102	"2"	N	1	*
		NM103	"MODIVCARE SOLUTIONS"	A	21	*****
		NM108	"46"	N	2	*
		NM109	Enter the 7-position NJ Medicaid Submitter ID.	N	7	~
SUBMITTER EDI CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	*
		PER02	"MODIVCARE SOLUTIONS"	A	21	*
		PER03	"TE"	A	2	*
		PER04	Enter Modivcare Solutions' telephone number.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RECEIVER NAME						
1000B	NM1	NM100	"NM1"	A	3	*
		NM101	"40"	N	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"46"	N	2	*
		NM109	"610515"	N	6	~
BILLING PROVIDER HIERARCHICAL LEVEL						
2000A	HL	HL00	"HL"	A	2	*
		HL01	Each HL01 value must be unique within a transaction set, including the HL01 value reported in the 2000B loop. The first HL01 value in the first HL segment must be set to "1", and the HL01 value in each subsequent HL segment must be incremented by "1", for both the 2000A and 2000B loops.	N	12	**
		HL03	"20"	N	2	*
		HL04	"1"	N	1	~
BILLING PROVIDER SPECIALTY INFORMATION						
2000A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"BI"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the billing provider.	A	10	~
BILLING PROVIDER NAME						
2010AA	NM1	NM100	"NM1"	A	3	*
		NM101	"85"	N	2	*
		NM102	Enter "1" if the billing provider is an individual or "2" if the billing provider is a group provider.	N	1	*
		NM103	Enter the provider's last name if NM102 = "1" or the group provider name if NM102 = "2".	A	1-35	*
		NM104	Enter the provider's first name if NM102 = "1" or skip if NM102 = "2".	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the provider's 10-digit NPI.	N	10	~
BILLING PROVIDER ADDRESS						
2010AA	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the provider identified in the NM1 segment.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
BILLING PROVIDER CITY/STATE/ZIP CODE						
2010AA	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the provider identified in the NM1 segment.	A	30	*
		N402	Enter the state code of the provider identified in the NM1 segment.	A	2	*
		N403	Enter the postal code of the provider identified in the NM1 segment.	A	15	~
BILLING PROVIDER TAX IDENTIFICATION						
2010AA	REF	REF00	"REF"	A	3	*
		REF01	Enter "SY" to qualify the SSN in REF02, or enter "EI" to qualify the EIN in REF02.	A	2	*
		REF02	Enter the provider identifier qualified in REF01.	N	10	~
SUBSCRIBER HIERARCHICAL LEVEL						
2000B	HL	HL00	"HL"	A	2	*
		HL01	Enter the next incremental HL01 value (see Data Requirement for 2000A/HL01).	N	12	*
		HL02	Enter the 2000A/HL01 value to which this HL segment is subordinate.	N	12	*
		HL03	"22"	N	2	*
		HL04	"0"	N	1	~
SUBSCRIBER INFORMATION						
2000B	SBR	SBR00	"SBR"	A	3	*
		SBR01	"P"	A	1	*
		SBR02	"18"	N	2	*******
		SBR09	"MC"	A	2	~
SUBSCRIBER NAME						
2010BA	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SUBSCRIBER DEMOGRAPHIC INFORMATION						
2010BA	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Enter the client's birth date (CCYYMMDD).	N	8	*
		DMG03	Enter the client's gender ("M" for male, "F" for female, "U" for unknown).	A	1	~
PAYER NAME						
2010BB	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"NEW JERSEY MEDICAID"	A	19	*****
		NM108	"PI"	A	2	*
		NM109	"610515"	N	6	~
CLAIM INFORMATION						
2300	CLM	CLM00	"CLM"	A	3	*
		CLM01	Enter Modivcare Solutions' Internal Claim Number (i.e., ICN, Patient Account Number/PAN). When submitting an encounter for a denied claim, the last/rightmost position of the submitted ICN/PAN must be a "D". New Jersey Medicaid will only capture the first/leftmost 20 characters of the submitter's Internal Claim Number.	A	20	*
		CLM02	Enter the total charge amount, which is the sum of all line item charges reported in all SV102 fields in loop 2400.	N	7.2	***
		CLM05-1	See Code Source 237: Place of Service Codes for Professional Claims as referenced in the 837 Professional TR3 on the CMS website at www.cms.gov.	A	2	:
		CLM05-2	"B"	A	1	:
		CLM05-3	Enter "1" for an original transaction, "7" for an adjustment transaction or "8" for a void transaction.	N	1	*
		CLM06	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM07	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM08	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		CLM09	Enter the appropriate code per the 837 Professional TR3.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PAYER CLAIM CONTROL NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"F8"	A	2	*
		REF02	When CLM05-3 = "7", enter the Gainwell Technologies ICN for the encounter being adjusted. When CLM05-3 = "8", enter the Gainwell Technologies ICN for the encounter being voided. When an encounter must be voided, the void should be submitted in one week and the replacement encounter should be submitted the following week. If the void and the replacement encounters are both submitted in the same week, the replacement encounter will be denied as a duplicate.	N	15	~
MEDICAL RECORD NUMBER						
2300	REF	REF00	"REF"	A	3	*
		REF01	"EA"	A	2	*
		REF02	Enter the Medical Record Number. New Jersey Medicaid will only capture the first/leftmost 16 characters of the Medical Record Number.	A	16	~
HEALTH CARE DIAGNOSIS CODE						
2300	HI	HI00	"HI"	A	2	*
		HI01-1	"BK or "ABK" For service dates before 10/1/2015, use "BK". For service dates on or after 10/1/2015, use "ABK".	A	2-3	:
		HI01-2	Enter the primary diagnosis code. Use ICD-9 primary diagnosis codes for service dates before 10/1/2015. Use ICD-10 primary diagnosis codes for service dates on or after 10/1/2015.	A	5-7	*
		HI02-1	"BF" or "ABF" For service dates before 10/1/2015, use "BF". For service dates on or after 10/1/2015, use "ABF".	A	2-3	:
		HI02-2	If applicable, enter an additional diagnosis code. Use ICD-9 diagnosis codes for service dates before 10/1/2015. Use ICD-10 diagnosis codes for service dates on or after 10/1/2015.	A	5-7	*
		HI03-1	"BF" or "ABF"	A	2-3	:
		HI03-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI04-1	"BF" or "ABF"	A	2-3	:
		HI04-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI05-1	"BF" or "ABF"	A	2-3	:
		HI05-2	If applicable, enter an additional diagnosis code.	A	5-7	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2300		HI06-1	"BF" or "ABF"	A	2-3	:
		HI06-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI07-1	"BF" or "ABF"	A	2-3	:
		HI07-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI08-1	"BF" or "ABF"	A	2-3	:
		HI08-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI09-1	"BF" or "ABF"	A	2-3	:
		HI09-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI10-1	"BF" or "ABF"	A	2-3	:
		HI10-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI11-1	"BF" or "ABF"	A	2-3	:
		HI11-2	If applicable, enter an additional diagnosis code.	A	5-7	*
		HI12-1	"BF" or "ABF"	A	2-3	:
		HI12-2	If applicable, enter an additional diagnosis code.	A	5-7	~
REFERRING PROVIDER NAME						
2310A	NM1	NM100	Enter "NM1". A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2310A	REF	REF00	"REF" A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
REFERRING PROVIDER NAME						
2310A	NM1	NM100	Enter "NM1". The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"P3"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the primary care provider's last name.	A	1-35	*
		NM104	Enter the primary care provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER NAME						
2310B	NM1	NM100	"NM1"	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~
RENDERING PROVIDER SPECIALTY INFORMATION						
2310B	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2310B	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
SERVICE FACILITY LOCATION NAME						
2310C	NM1	NM100	"NM1"	A	3	*
		NM101	"77"	N	2	*
		NM102	"2"	N	1	******
		NM108	"XX"	A	2	*
		NM109	Enter the service facility name's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
SERVICE FACILITY LOCATION ADDRESS						
2310C	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the facility where the service was provided.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	*
SERVICE FACILITY LOCATION CITY/STATE/ZIP CODE						
2310C	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the facility where the service was provided.	A	30	*
		N402	Enter the state code of the facility where the service was provided.	A	2	*
		N403	Enter the postal code of the facility where the service was provided.	A	15	~
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" One iteration of the 2320/2330 loops is required to identify Modivcare Solutions and report the amount of the payment made to the provider by Modivcare Solutions or their appointed subcontractor.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, Modivcare Solutions cannot be identified as the primary payer.	A	1	*
		SBR02	"18"	N	2	~
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount that was made to the provider by Modivcare Solutions or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. This amount must be reported at both the claim level and the service line level, and the amount reported at the claim level must equal the sum of all amounts reported at the service line level in field 2430/SVD/SVD02, where the payer ID that is specified at the claim level in field 2330B/NM1/NM109 and the service line level in field 2430/SVD/SVD01 is "HMO".	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	"MODIVCARE SOLUTIONS"	A	21	*****
		NM108	"PI"	A	2	*
		NM109	"HMO"	A	3	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date need to be reflected for each line item in the 2430 loop.	A	3	*
OTHER SUBSCRIBER INFORMATION						
2320	SBR	SBR00	"SBR" Additional iterations of the 2320/2330 loops are required to identify other payers and report the amount of the payments made to the provider by the other payers.	A	3	*
		SBR01	Enter the appropriate code per the 837 Professional TR3. NOTE: Since NJ Medicaid is identified as the primary payer in the 2000B loop, other payers cannot be the primary payer.	A	1	*
		SBR02	"18"	N	2	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT						
2320	AMT	AMT00	"AMT"	A	3	*
		AMT01	"D"	A	1	*
		AMT02	Enter the payment amount made to the provider by the other payer. This amount must be reported at both the claim level and the service line level, and the amount reported for a specific payer at the claim level must equal the sum of all amounts reported for that same payer at the service line level in field 2430/SVD/SVD02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 – 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section.	N	7.2	~
OTHER INSURANCE COVERAGE INFORMATION						
2320	OI	OI00	"OI"	A	2	***
		OI03	Enter the appropriate code per the 837 Professional TR3.	A	1	*
		OI04	Enter the appropriate code per the 837 Professional TR3.	A	1	**
		OI06	Enter the appropriate code per the 837 Professional TR3.	A	1	~
OTHER SUBSCRIBER NAME						
2330A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the client's last name.	A	1-35	*
		NM104	Enter the client's first name.	A	1-25	*
		NM105	Enter the client's middle initial, if known. Otherwise, skip.	A	1	***
		NM108	"MI"	A	2	*
		NM109	Enter the NJ Medicaid recipient ID assigned to the client.	N	12	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER PAYER NAME						
2330B	NM1	NM100	"NM1"	A	3	*
		NM101	"PR"	A	2	*
		NM102	"2"	N	1	*
		NM103	Enter the other payer name.	A	1-35	*****
		NM108	"PI"	A	2	*
		NM109	Enter the appropriate payer ID. The list of "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) Section. NOTE: The identification of NJ Medicaid as an "other payer" is incorrect and should not be specified here.	A	10	~
CLAIM CHECK OR REMITTANCE DATE						
2330B	DTP	DTP00	"DTP" This segment should not be submitted as claim payment and date needs to be reflected for each line item in the 2430 loop.	A	3	*
SERVICE LINE NUMBER						
2400	LX	LX00	"LX"	A	2	*
		LX01	Each LX01 value must be unique within a claim. The first LX01 value in the first LX segment must set to "1" and the LX01 value in each subsequent LX segment (each additional service line for the claim) must be incremented by "1".	N	6	~
PROFESSIONAL SERVICE						
2400	SV1	SV100	"SV1"	A	3	*
		SV101-1	"HC"	A	2	:
		SV101-2	Enter the national procedure code.	A	5	:
		SV101-3	If applicable, enter the first procedure code modifier. Otherwise, skip. When reporting a transportation service in SV101-2, a pseudo procedure code modifier is required to report the origin (first character of the modifier) and the destination (second character of the modifier). Please see the Data Element Dictionary (DED) section (Transportation Origin/Destination Code) for the list of codes.	A	2	:
		SV101-4	If applicable, enter the second procedure code modifier. Otherwise, skip.	A	2	:
		SV101-5	If applicable, enter the third procedure code modifier. Otherwise, skip.	A	2	:
		SV101-6	If applicable, enter the fourth procedure code modifier. Otherwise, skip.	A	2	*
		SV102	Enter the service line charge amount.	N	7.2	*
		SV103	"UN" or "MJ"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2400		SV104	Enter the service line units of service with the "UN" qualifier in SV103. For anesthesia services, bill the exact number of minutes with the "MJ" qualifier in SV103.	N	4	*
		SV105	Enter the service line place of service code if different than the claim level place of service code (entered in loop 2300, segment CLM, field CLM05-1).	A	2	**
		SV107-1	If diagnosis codes are reported at the claim level (entered in Loop 2300, Segment HI), enter the diagnosis pointer ("1" through "8"). Otherwise, skip. A specific diagnosis pointer can only be used once in SV107-1 through SV107-4.	N	2	:
		SV107-2	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	:
		SV107-3	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	:
		SV107-4	If applicable, enter the diagnosis pointer ("1" through "8"). Otherwise, skip.	N	2	**
		SV109	Enter "Y" if the service provided was emergency related. Otherwise, skip.	A	1	**
		SV111	Enter "Y" if the service is the result of an EPSDT screening. Otherwise, skip.	A	1	*
		SV112	Enter "Y" if the service is a family planning service. Otherwise, skip.	A	1	~
SERVICE DATE						
2400	DTP	DTP00	"DTP"	A	3	*
		DTP01	"472"	N	3	*
		DTP02	Enter "D8" to indicate a single date of service or "RD8" to specify a range of service dates.	A	2-3	*
		DTP03	Enter a single date of service (CCYYMMDD) when DTP02 = "D8", or a range of service dates (CCYYMMDD-CCYYMMDD) when DTP02 = "RD8".	N	8-17	~
RENDERING PROVIDER NAME						
2420A	NM1	NM100	"NM1" The 2420A loop is required when the rendering provider identified at the service line level is different than the rendering provider identified at the claim level (in loop 2310B).	A	3	*
		NM101	"82"	N	2	*
		NM102	"1"	N	1	*
		NM103	Enter the rendering provider's last name.	A	1-35	*
		NM104	Enter the rendering provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the rendering provider's National Provider Identifier.	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
RENDERING PROVIDER SPECIALTY INFORMATION						
2420A	PRV	PRV00	"PRV"	A	3	*
		PRV01	"PE"	A	2	*
		PRV02	"PXC"	A	3	*
		PRV03	Enter the HIPAA taxonomy code for the rendering provider.	A	10	~
RENDERING PROVIDER SECONDARY IDENTIFICATION						
2420A	REF	REF00	"REF" This segment is required when an NPI is NOT sent in the NM109 field.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the rendering provider's 9-digit EIN (E123456789) or enter "S" followed by the rendering provider's 9-digit SSN (S123456789).	N	10	~
SERVICE FACILITY LOCATION NUMBER						
2420C	NM1	NM100	"NM1" The 2420C loop is required when service facility address at the service line level is different than the service facility address at the claim level (in loop 2310C).	A	3	*
		NM101	"77"	N	2	*
		NM102	"2"	N	1	*
		NM103	Enter the service facility name.	A	1-35	*****
		NM108	"XX"	A	2	*
		NM109	Enter the service facility name's National Provider Identifier.	N	10	~
SERVICE FACILITY LOCATION ADDRESS						
2420C	N3	N300	"N3"	A	2	*
		N301	Enter the street address of the facility where the service was provided.	A	55	*
		N302	If applicable, enter the second line of the street address. Otherwise, skip.	A	55	~
SERVICE FACILITY LOCATION CITY/STATE/ZIP CODE						
2420C	N4	N400	"N4"	A	2	*
		N401	Enter the city name of the facility where the service was provided.	A	30	*
		N402	Enter the state code of the facility where the service was provided.	A	2	*
		N403	Enter the postal code of the facility where the service was provided.	A	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
REFERRING PROVIDER NAME						
2420F	NM1	NM100	"NM1" A referring provider is required at the service line level when the referring provider identified at the servcie line level is different than the referring provider identified at the claim level (in loop 2310A). If a referring provider is identified, the NJMMIS will capture the data from this segment. If a referring provider is identified, the NPI of the referring provider must be provided.	A	3	*
		NM101	"DN"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the referring provider's last name.	A	1-35	*
		NM104	Enter the referring provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
REFERRING PROVIDER SECONDARY IDENTIFICATION						
2420F	REF	REF00	"REF" A referring provider is not required, but if a referring provider is identified, the NJMMIS will capture the data from this segment.	A	3	*
		REF01	"G2"	A	2	*
		REF02	Enter "E" followed by the referring provider's 9-digit EIN (E123456789) or enter "S" followed by the referring provider's 9-digit SSN (S123456789).	N	10	~
REFERRING PROVIDER NAME						
2420F	NM1	NM100	"NM1" The NJMMIS will not capture any data from this segment.	A	3	*
		NM101	"P3"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the primary care provider's last name.	A	1-35	*
		NM104	Enter the primary care provider's first name.	A	1-25	****
		NM108	"XX"	A	2	*
		NM109	Enter the referring provider's National Provider Identifier.	N	10	~
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" The first iteration of the 2430 loop is required to identify Modivcare Solutions and specify the amount of the payment made to the provider by Modivcare Solutions or their appointed subcontractor for the service identified in 2400/SV101-2.	A	3	*
		SVD01	"HMO"	A	3	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2430		SVD02	Enter the payment amount that was made to the provider by Modivcare Solutions or their appointed subcontractor/vendor. The payment amount should reflect only the amount that was paid to the provider and should not include administrative costs or fees paid to the subcontractor/vendor. This amount must be reported at both the claim level and the service line level, and the sum of all amounts reported at the service line level must equal the amount reported at the claim level in field 2320/AMT*C4/AMT02, where the payer ID that is specified at the claim level in field 2330B/NM1/NM109 and the service line level in field 2430/SVD/SVD01 is "HMO".	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV101-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV101-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV101-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV101-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV101-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV104.	N	4	~
LINE CHECK OR REMITTANCE DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by Modivcare Solutions or their appointed subcontractor. For payment that was made via check, the payment date is the check date. For payment that was made electronically, the payment date is the date on the transaction that instructed the bank to allocate funds to the provider, which is typically the transaction date. The payment date can be the date of claim adjudication by Modivcare Solutions or their appointed subcontractor if the provider submitted a claim that was covered by a capitation payment made separately by Modivcare Solutions or their appointed subcontractor. Such a claim is not submitted for payment, but rather to provide a record of the service(s) rendered. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
LINE ADJUDICATION INFORMATION						
2430	SVD	SVD00	"SVD" Additional iterations of the 2430 loop are required if other payers are identified in 2330B/NM109.	A	3	*
		SVD01	Enter the same value entered in 2330B/NM109.	A	10	*
		SVD02	Enter the payment amount made to the provider by the other payer. This amount must be reported at both the claim level and the service line level, and the sum of all amounts reported for a specific payer at the service line level must equal the amount reported for that same payer at the claim level in field 2320/AMT*D/AMT02 (i.e., the payer ID that is specified at the claim level in field 2330B/NM1/NM109 field must be the same as the payer ID that is specified at the service line level in field 2430/SVD/SVD01, and that payer ID must be numeric and in the range 001 - 999). The list of valid "Other Payer Codes" that can be used as payer IDs is presented in the Data Element Dictionary (DED) section.	N	7.2	*
		SVD03-1	"HC"	A	2	:
		SVD03-2	Enter the same value entered in 2400/SV101-2.	A	5	:
		SVD03-3	Enter the same value entered in 2400/SV101-3.	A	2	:
		SVD03-4	Enter the same value entered in 2400/SV101-4.	A	2	:
		SVD03-5	Enter the same value entered in 2400/SV101-5.	A	2	:
		SVD03-6	Enter the same value entered in 2400/SV101-6.	A	2	**
		SVD05	Enter the same value entered in 2400/SV104.	N	4	~
LINE ADJUDICATION DATE						
2430	DTP	DTP00	"DTP"	A	3	*
		DTP01	"573"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the date (CCYYMMDD) that the provider was paid by the other payer. Any line item that has a different payment date should be submitted here at this loop. When the 2430 loop is submitted, this segment must be submitted and the 2330B DTP segment must not be submitted.	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	10	*
		SE02	Enter the same value entered in ST02.	A	4-9	~

SECTION 11 – NCPDP PHARMACY ENCOUNTERS

SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	POSITIONS
BATCH TRANSACTION HEADER SEGMENT				
	880-K4	Hex 02 (Stx)	HEX	1
	701	"00"	N	2-3
	880-K6	"T"	A	4
	880-K1	Enter the 7-position NJ Medicaid Submitter ID followed by 17 spaces.	N	5-28
	806-5C	Enter a unique 7-digit number assigned by sender. The same value will be entered in field 806-5C of the trailer.	N	29-35
	880-K2	Enter the file creation date (CCYYMMDD).	N	36-43
	880-K3	Enter the file creation time (HHMM).	N	44-47
	702	Enter "P" for production. Only upon pre-approval by the Encounter Data Monitoring Unit and Gainwell Technologies is a HMO permitted the use of "T" to signify a test interchange.	A	48
	102-A2	"12"	N	49-50
	880-K7	"610515"	N	51-74
	880-K4	Hex 03 (Etx)	HEX	75
DETAILED DATA RECORD				
	880-K4	Hex 02 (Stx)	HEX	1
	701	"G1"	A	2-3
	880-K5	Enter a 10-digit Transaction Reference Number.	N	4-13
See the NCPDP D.0 DATA RECORD and NCPDP D.0 REVERSAL RECORD segments for Original B1, B2 Reversal (Void) and B3 Adjustment transactions.				
	880-K4	Hex 03 (Etx)	HEX	1
TRAILER RECORD				
	880-K4	Hex 02 (Stx)	HEX	1
	701	"99"	N	2-3
	806-5C	Enter the same value as is in field 806-5C in the batch header segment.	N	4-10
	751	Enter the count of records in file including the header and trailer.	N	11-20
	504-F4	Enter 35 spaces in this field.	A	21-55
	880-K4	Hex 03 (Etx)	HEX	56

NCPDP D.0 DATA RECORD				
SEGMENT	**FIELD**	**DATA REQUIREMENT**	**FORMAT**	**LENGTH**
BATCH TRANSACTION HEADER SEGMENT				
	101-A1	"610515"	N	6
	102-A2	"D0" (Dzero)	N	2
	103-A3	Enter "B1" for original transactions or "B3" for adjustment transactions.	A	2
	104-A4	Enter NJE plus the 7-position NJ Medicaid Submitter ID. (e.g. NJE7700000). The same value will be entered in field 110-AK.	A	10
	109-A9	"1"	N	1
	202-B2	"01"	N	2
	201-B1	Enter 10-position National Provider Identifier (NPI) followed by 5 spaces.	N	15
	401-D1	Enter the date of service (CCYYMMDD).	N	8
	110-AK	Enter the same value as is in field 104-A4.	A	10
PATIENT SEGMENT				
AM01	111-AM	"01"	N	2
	332-CY	For paid claims enter the internal control number (ICN) or patient account number (PAN). For denied claims enter the ICN/PAN followed by a "D". When submitting an encounter for a reimbursable Drug, the last/rightmost position of the submitted ICN/PAN must be an "M".	A	20
	304-C4	Enter client's birth date (CCYYMMDD).	N	8
	305-C5	Enter the client's gender ("1" for Male, "2" for Female).	N	1
	310-CA	Enter the client's full first name.	A	12
	311-CB	Enter the client's full last name.	A	15
	335-2C	Enter "1" for Non-Pregnant or "2" for Pregnant.	N	1
	384-4X	Please refer to PATIENT RESIDENCE CODES in the Data Element Dictionary (DED) section for a list of values.	N	2
PRESCRIBER SEGMENT				
AM03	111-AM	"03"	N	2
	466-EZ	Enter "01" for National Provider Identifier (NPI), or "08" for State License Number.	N	2
	411-DB	If 466-EZ = "01" Enter the 10-position National Provider Identifier (NPI). HIPAA NON-COVERED ENTITIES ONLY: If 466-EZ = "08" enter State License Number, at your option, proceed with 2-character state code. (e.g.NJMA123456) Omit entry of spaces and special characters in this field.	A	10
INSURANCE SEGMENT				
AM04	111-AM	"04"	N	2
	302-C2	Enter the first 10 digits of the Beneficiary ID (see 303-C3).	N	10-16
	303-C3	Enter the last 2 digits of the Beneficiary ID.	N	2

SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH
COB/OTHER PAYMENTS SEGMENT				
AM05	111-AM	"05"	N	2
	338-5C	Please refer to OTHER PAYER COVERAGE TYPE CODES in the Data Element Dictionary (DED) section for a list of values. Code "HMO" payment as "Primary".	N	2
	339-6C	"99"	N	2
	340-7C	"HMO" and "OTH" when COB with other insurance. "HMO" and "MED" and "OTH" when COB with DSNP/Part D and other insurance. "HMO" and "MED" when COB with DSNP/Part D. The value of "HMO" is to be entered to identify the payment made by the HMO to a provider for the service. The value of "OTH" represents payments made by other insurance. The value of "MED" represents payments made by the DSNP or Part D plan.	A	3
	443-E8	Enter the date the HMO payment was made to the provider for the HMO-covered service (CCYYMMDD). (Not required for other insurance.)	N	8
	993-A7	Enter the number assigned by the HMO system to identify an adjudicated claim.	A	30
	342-HC	Enter appropriate qualifier representing the actual amount of the payment(s) made by the third party health plan(s) when applicable.	N	2
	431-DV	Enter the payment amount that was made to a pharmacy provider by the HMO or their appointed subcontractor/PBM, or by a third party health plan (including DSNP/Part D when applicable). The payment amount should reflect only the amount that was paid to the pharmacy provider and should not include administrative costs or fees paid to the subcontractor/PBM.	N	6.2
	471-5E	Enter Other Payer Reject Count. Mandatory if Other Payer Reject Codes 472-6E are present.	N	2
	472-6E	Enter Other Payer Reject Code(s). Mandatory when 340-7C "MED" or "OTH" payer has rejected the claim.	A	3
	353-NR	Enter Other Payer-Patient Responsibility Amount Count. Mandatory when claim is not rejected by 340-7C "MED" or "OTH" payer.	N	2
	351-NP	Enter Other Payer-Patient Responsibility Amount Qualifier. Mandatory when claim is not rejected by 340-7C "MED" or "OTH" payer.	A	2
	352-NQ	Enter Other Payer-Patient Responsibility Amount in S9(8)V99 format. Mandatory when applicable/including Part D COB claims. When 351-NP = 9 the amount must be submitted as a negative value or zero.	N	8.2
	392-MU	Enter Benefit Stage Count. Mandatory for DSNP/Part D approved claims, i.e. when 340-7C = "MED".	N	2
	393-MV	Enter appropriate Benefit Stage Qualifier. Mandatory for DSNP/Part D approved claims, i.e. when 340-7C = "MED".	A	2
	394-MW	Enter Benefit Stage Amount in S9(6)V99 format. Mandatory if 393-MV is present.	N	6.2

SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH
		CLAIM SEGMENT		
AM07	111-AM	"07"	N	2
	402-D2	If Prescription Number is less than 12 positions it must be entered as left zero filled so as to provide a 12-digit value. (e.g. If Pharmacy's Rx # is 7 digits it must be submitted as 000001234567) Plan B ® OTC claims enter a Service Reference Number up to 12 digits, left zero filled.	N	12
	407-D7	Enter the 11-digit NDC. (For compounds enter 11 zeros or 1 zero.)	N	11
	442-E7	Enter Quantity Dispensed in 9(7)V999 format. Mandatory.	N	7.3
	408-D8	Enter Dispense as Written (DAW)/Product Selection Code. Mandatory: "0" = NOT DAW; "1" = DAW	N	1
	354-NX	Enter Submission Clarification Code Count. Mandatory when 420-DK is present.	N	2
	420-DK	Enter Submission Clarification Code. Mandatory if PA used to pay claim: "10" = PA Used. "8" is acceptable for compound claims, i.e. ingredient not covered. Mandatory for 340B Claims submitted for dates of service 4/1/2017 or later if applicable: "20" = 340 Claim. Mandatory for vaccine administration claims: "02" = first dose of vaccine claim, "06" = second dose of vaccine claim, "07" = additional or booster dose of COVID19 vaccine. NOTE: Until further notice, please submit only "07" for additional dose of COVID19 vaccine, and "07" and "10" for booster dose of COVID19 vaccine. NOTE: Effective 9/11/2023, claims for the new COVID vaccine NDCs will not require a Submission Clarification Code.	N	2
	308-C8	Enter Other Coverage Code when submitted by pharmacy.	N	2
	600-28	Enter Unit of Measure. Mandatory.	A	2
	461-EU	Enter Prior Authorization Type Code "00" = none, "05" = Exempt. Mandatory.	N	2
	403-D3	Enter fill number, up to 2 digits. Mandatory.	N	2
	405-D5	Enter days supply, up to 3 digits. Mandatory.	N	3
	406-D6	Enter "1" if Not a Compound or "2" if a Compound.	N	1
	414-DE	Enter date the prescription was written (CCYYMMDD). Mandatory.	N	8
	415-DF	Enter up to 2 digits in 2-digit field reflecting number of refills authorized by Prescriber. Mandatory.	N	2
	460-ET	Enter the quantity prescribed. Mandatory.	N	7.3
	343-HD	Enter the Dispensing Status Value with "P" for partial fill; "C" for completion of a previous partial fill; blank if neither.	A	1
	344-HF	Quantity Intended To Be Dispensed. Mandatory for partial fill or completion of previous paid partial fill. Must be greater than 442-E7 when 343-HD = "P" or "C".	N	7.3
	345-HG	Days Supply Intended To Be Dispensed. Mandatory for partial fill or completion of previous paid partial fill. Must be greater than 405-D5 when 343-HD = "P" or "C".	N	3

SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH
		DUR/PPS SEGMENT		
AM08	111-AM	"08"	N	2
	440-E5	Professional Service Code – Value with "MA" (Medication Administration) for vaccine Administration Claim.	A	2
		COMPOUND SEGMENT		
AM10	111-AM	"10"	N	2
	451-EG	Enter "1" for Each, "2" for Gram or "3" for Milliliter.	N	1
	447-EC	Enter up to 2 digits 1, 2,…24, 25 A maximum of 25 ingredients will be accepted. Identifies the ingredient within a compound (i.e. Ingredient Number 12)	N	2
	488-RE	"03"	N	2
	489-TE	Enter 11-digit NDC.	N	11
	448-ED	Enter ingredient quantity in 9(7)V999 format.	N	7.3
	449-EE	Enter ingredient cost in S9(6)V99 format.	S	6.2
SEGMENT	**FIELD**	**DATA REQUIREMENT**	**FORMAT**	**LENGTH**
		PRICING SEGMENT		
AM11	111-AM	"11"	N	2
	409-D9	Enter in S9(6)V99 format. Enter ingredient amount paid (see 426-DQ). Value entered must be greater than 0.	SN	6.2
	412-DC	Enter in S9(6)V99 format. Enter the Dispensing fee paid. Value entered must be greater than 0.	SN	6.2
	426-DQ	Enter in S9(6)V99 format. Provider usual and customary charge. For compounds, report usual and customary charge for entire compound.	SN	6.2
	438-E3	Incentive Amount Submitted – Mandatory when 440-E5 submitted with "MA".	N	6.2
		FACILITY SEGMENT		
AM15	111-AM	"15" (Segment mandatory for LTC setting only.)	N	2
	336-8C	Report the NPI of the LTC Facility where the Medicaid Beneficiary resides.	A	10
	385-3Q	Report the Facility name where the Medicaid Beneficiary resides.	A	30

SECTION 12 – NCPDP PHARMACY REVERSALS

The following tables outline the NCPDP D.0 Reversal segment and field specifications for submitting NCPDP reversal (void) transactions to New Jersey Medicaid. Please do not submit segments that are not required for reversals. If segments are submitted that are not required, they will be parsed for NCPDP compliance and could result in rejected transactions.

NCPDP D.0 REVERSAL RECORD				
SEGMENT	**FIELD**	**DATA REQUIREMENT**	**FORMAT**	**LENGTH**
BATCH TRANSACTION HEADER SEGMENT				
	101-A1	"610515"	N	6
	102-A2	"D0" (Dzero)	N	2
	103-A3	"B2" = Reversal	A	2
	104-A4	Enter NJE plus the 7-position NJ Medicaid Submitter ID. (e.g. NJE7700000). The same value will be entered in field 110-AK.	A	10
	109-A9	"1"	N	1
	202-B2	"01"	N	2
	201-B1	Enter 10-position National Provider Identifier (NPI).	N	10
	401-D1	Enter date of service (CCYYMMDD).	N	8
	110-AK	Enter the same value as is in field 104-A4.	A	10
PATIENT SEGMENT				
AM01	111-AM	"01"	N	2
	332-CY	For paid claims enter the internal control number (ICN) or patient account number (PAN). For denied claims enter the ICN/PAN followed by a "D". When submitting an encounter for a reimbursable Drug, the last/rightmost position of the submitted ICN/PAN must be an "M".	A	20
	304-C4	Enter client's birth date (CCYYMMDD).	N	8
	305-C5	Enter the client's gender. ("1" = Male, "2" = Female)	N	1
	310-CA	Enter the client's full first name.	A	12
	311-CB	Enter the client's full last name.	A	15
COB/OTHER PAYMENTS SEGMENT				
AM05	111-AM	"05"	N	2
	993-A7	Enter the number assigned by the HMO system to identify an adjudicated claim (i.e., the HMO ICN). The HMO ICN will be used to identify the target encounter to be voided and therefore must match the HMO ICN submitted in this same field in the accepted original encounter.	A	30

SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH
CLAIM SEGMENT				
AM07	111-AM	"07"	N	2
	402-D2	If Prescription Number is less than 12 positions it must be entered as left zero filled so as to provide a 12-digit value. (e.g. If Pharmacy's Rx # is 7 digits it must be submitted as 000001234567). Plan B ® OTC claims enter a Service Reference Number up to 12 digits, left zero filled.	N	12
	407-D7	Enter the 11-digit NDC. (For compounds enter 11 zeros or 1 zero.)	N	11

SECTION 13 – HIPAA 835 REMITTANCE ADVICE

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"835"	N	3	*
		ST02	Gainwell Technologies-assigned sequential ID starting with "0001" and incremented for each subsequent ST segment.	N	4-9	~
FINANCIAL INFORMATION						
	BPR	BPR00	"BPR"	A	3	*
		BPR01	"H"	A	1	*
		BPR02	"0"	N	1	*
		BPR03	"C"	A	1	*
		BPR04	"NON"	N	3	**********
		BPR16	Gainwell Technologies cycle date (CCYYMMDD) which is typically the Friday of the weekly encounter cycle.	N	8	~
REASSOCIATION TRACE NUMBER						
	TRN	TRN00	"TRN"	A	3	*
		TRN01	"1"	N	1	*
		TRN02	Gainwell Technologies cycle date (CCYYMMDD) which is concatenated with a sequence number beginning with "1", and incremented for each subsequent TRN segment.	N	1-30	*
		TRN03	Gainwell Technologies IRS number.	N	10	~
RECEIVER IDENTIFICATION						
	REF	REF00	"REF"	A	3	*
		REF01	"EV"	A	2	*
		REF02	Gainwell Technologies-assigned encounter submitter ID for the HMO, which begins with "77".	N	7	~
PRODUCTION DATE						
	DTM	DTM00	"DTM"	A	3	*
		DTM01	"405"	N	3	*
		DTM02	Gainwell Technologies cycle date (CCYYMMDD) which is typically the Friday of the weekly encounter cycle.	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PAYER IDENTIFICATION						
1000A	N1	N100	"N1"	A	2	*
		N101	"PR"	A	2	*
		N102	"NEW JERSEY MEDICAID"	A	19	*
		N103	"XV"	A	2	*
		N104	"012"	N	3	~
PAYER ADDRESS						
1000A	N3	N300	"N3"	A	2	*
		N301	"3705 QUAKERBRIDGE ROAD, SUITE 101"	A	33	~
PAYER CITY, STATE, ZIP CODE						
1000A	N4	N400	"N4"	A	2	*
		N401	"TRENTON"	A	7	*
		N402	"NJ"	A	2	*
		N403	"086191288"	N	9	~
PAYER CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"CX"	A	2	*
		PER02	"NEW JERSEY MEDICAID PROVIDER SERVICES"	A	37	*
		PER03	"TE"	A	2	*
		PER04	"1-800-776-6334"	N	14	~
PAYER TECHNICAL CONTACT INFORMATION						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"BL"	A	2	*
		PER02	"NEW JERSEY EDI UNIT"	A	19	*
		PER03	"TE"	A	2	*
		PER04	"6095886051"	N	10	*
		PER05	"EM"	A	2	*
		PER06	"NJMMISEDI@GAINWELLTECHNOLOGIES.COM"	N	30	*
		PER07	"FX"	A	2	*
		PER08	"6095848268"	N	10	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PAYER WEB SITE						
1000A	PER	PER00	"PER"	A	3	*
		PER01	"IC"	A	2	**
		PER03	"UR"	A	2	*
		PER04	"WWW.NJMMIS.COM"	N	14	~
PAYEE IDENTIFICATION						
1000B	N1	N100	"N1"	A	2	*
		N101	"PE"	A	2	*
		N102	HMO name.	A	1-60	*
		N103	"FI"	A	2	*
		N104	HMO IRS number.	N	10	~
CLAIM PAYMENT INFORMATION						
2100	CLP	CLP00	"CLP"	A	3	*
		CLP01	HMO-reported patient account number (non-pharmacy) or prescription number (pharmacy).	N	1-38	*
		CLP02	Gainwell Technologies-assigned claim status: "1" (approved original or adjustment debit), "22" (approved void or adjustment credit), or "4" (denied).	N	2	*
		CLP03	HMO-reported charge amount.	N	7.2	*
		CLP04	"0"	N	1	**
		CLP06	"MC"	A	2	*
		CLP07	This field will be valued with the 15-digit Internal Control Number (ICN) assigned to the claim by the New Jersey MMIS system followed by a hyphen (-) and then up to 8 4-digit NJMMIS edit codes posted on the claim.	N	15-48	*
		CLP08	For non-pharmacy, the HMO-reported value from CLM05-1. Blank for pharmacy.	N	1	*
		CLP09	For non-pharmacy, the HMO-reported value from CLM05-2. Blank for pharmacy.	N	1	**
		CLP11	For inpatient, the Gainwell Technologies-assigned DRG code. Blank for all other claim types.	N	4	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PATIENT NAME						
2100	NM1	NM100	"NM1"	A	3	*
		NM101	"QC"	A	2	*
		NM102	"1"	N	1	*
		NM103	If present, the HMO-reported client's last name. Otherwise "No Name Submitted".	A	1-35	*
		NM104	If present, the HMO-reported client's first name. Otherwise "No Name Submitted".	A	1-25	*
		NM105	If present, the HMO-reported client's middle initial name. Otherwise "No Name Submitted".	A	1-17	***
		NM108	"MR"	A	2	*
		NM109	HMO-reported client's Medicaid ID.	N	12	~
CORRECTED PATIENT/INSURED NAME						
2100	NM1	NM100	"NM1" This segment is only sent when Gainwell Technologies has assigned a different Medicaid ID for the client.	A	3	*
		NM101	"74"	N	2	*
		NM102	"1"	N	1	*
		NM103	If present, the HMO-reported client's last name. Otherwise "No Name Submitted".	A	1-35	*
		NM104	If present, the HMO-reported client's first name. Otherwise "No Name Submitted".	A	1-25	*
		NM105	If present, the HMO-reported client's middle initial name. Otherwise "No Name Submitted".	A	1-17	***
		NM108	"MR"	A	2	*
		NM109	Gainwell Technologies-assigned client's Medicaid ID.	N	12	~
SERVICE PROVIDER NAME						
2100	NM1	NM100	"NM1"	A	2	*
		NM101	"82"	N	2	*
		NM102	HMO-reported entity type code: "1" (individual) or "2" (non-individual).	N	1	*
		NM103	HMO-reported provider name or provider last name.	A	1-35	*
		NM104	HMO-reported provider first name. Otherwise "No Name Submitted".	A	1-25	****
		NM108	If the HMO reported a NPI for the provider, then "XX". Otherwise, if the HMO reported an IRS Number, then "FI".	A	2	*
		NM109	HMO-reported NPI or IRS number depending on qualifier in NM108.	N	10	~
OTHER CLAIM RELATED IDENTIFICATION						
2100	REF	REF00	"REF" If applicable, this REF segment will be present to report the medical record number.	A	3	*
		REF01	"EA"	A	2	*

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2100		REF02	HMO-reported medical record number. For non-pharmacy encounters, contains the HMO-reported medical record number with a maximum of 16 characters. For pharmacy encounters, contains the internal control number (ICN) or patient account number (PAN) submitted in the 332-CY field with a maximum of 20 characters on the original pharmacy encounter.	A	1-20	~
OTHER CLAIM RELATED IDENTIFICATION						
2100	REF	REF00	"REF" If applicable, this REF segment will be present to report the NJMMIS-assigned Internal Control Number (ICN) of an encounter transaction for one of the conditions listed below in the REF02 field description.	A	3	*
		REF01	"F8"	A	2	*
		REF02	NJMMIS-assigned Internal Claim Number (ICN). The specific ICN will be one of the following: 1. ICN of the historical encounter that matches this encounter if this encounter was denied as a duplicate. 2. ICN of the historical (target) encounter identified in the submitted debit adjustment. 3. ICN of the historical (target) encounter identified in the submitted void that was denied. 4. ICN of the submitted void that was accepted.	N	15	~
OTHER CLAIM RELATED IDENTIFICATION						
2100	REF	REF00	"REF" If applicable, this REF segment will be present to report the HMO Category of Service assigned to the encounter.	A	3	*
		REF01	"BB"	A	2	*
		REF02	HMO Category of Service, if applicable.	N	15	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
OTHER CLAIM RELATED IDENTIFICATION						
2100	REF	REF00	"REF" If applicable, this REF segment will be present only for a credit adjustment transaction.	A	3	*
		REF01	"9C"	A	2	*
		REF02	This field will report the NJMMIS-assigned Internal Control Number (ICN) of the corresponding debit adjustment transaction.	N	15	~
RENDERING PROVIDER INFORMATION						
2100	REF	REF00	"REF"	A	3	*
		REF01	"1D"	A	2	*
		REF02	New Jersey Medicaid provider ID.	N	7	~
STATEMENT FROM OR TO DATE						
2100	DTM	DTM00	"DTM"	A	3	*
		DTM01	"232"	N	3	*
		DTM02	HMO-reported date of service from (CCYYMMDD).	N	8	~
STATEMENT FROM OR TO DATE						
2100	DTM	DTM00	"DTM"	A	3	*
		DTM01	"233"	N	3	*
		DTM02	HMO-reported date of service through (CCYYMMDD).	N	8	~
SERVICE PAYMENT INFORMATION						
2110	SVC	SVC00	"SVC"	A	3	*
		SVC01-1	"AD" (dental procedure code), or "HC" (other procedure code), or "N4" (NDC), or "NU" (revenue code).	A	2	:
		SVC01-2	HMO-reported service code per the qualifier in SVC01-1. For pended claims or denied claims when a service code is not available for reporting, the following values will be returned. When SVC01-1 = Value Returned AD "00001" for Dental procedure codes HC "00001" for other procedure codes N4 "000000000001" for NDC NU "001" for Inpatient	A	3-11	:
		SVC01-3	If applicable, the first HMO-reported procedure code modifier. Otherwise, blank.	A	2	:
		SVC01-4	If applicable, the second HMO-reported procedure code modifier. Otherwise, blank.	A	2	:
		SVC01-5	If applicable, the third HMO-reported procedure code modifier. Otherwise, blank.	A	2	:

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2110		SVC01-6	If applicable, the fourth HMO-reported procedure code modifier. Otherwise, blank.	A	2	*
		SVC02	HMO-reported service line charge amount.	N	7.2	*
		SVC03	"0"	N	1	*
		SVC04	If applicable and not reported in SVC01-2, the HMO-reported revenue code.	N	3	*
		SVC05	The HMO-reported service units (non-pharmacy) or metric quantity (pharmacy).	N	1-10	*
		SVC07	For void transactions, the negative of the units present in SVC05.	N	7.3	~
SERVICE DATE						
2110	DTM	DTM00	"DTM"	A	3	*
		DTM01	"150" (service period start, multi-day services) or "472" (single day services).	N	3	*
		DTM02	HMO-reported date of service from for the service line (CCYYMMDD).	N	8	~
SERVICE DATE						
2110	DTM	DTM00	"DTM"	A	3	*
		DTM01	"151" (service period end, multi-day services).	N	3	*
		DTM02	HMO-reported date of service through for the service line (CCYYMMDD).	N	8	~
SERVICE ADJUSTMENT						
2110	CAS	CAS00	"CAS"	A	3	*
		CAS01	For approved encounters with no edits posted, CAS01 will equal "CO" and CAS02 will equal "24". For approved encounters with one or more edits posted or for denied encounters, CAS01 will equal "OA". Each CAS segment can report up to six claim adjustment reason codes, each of which has a matching remark code in the LQ segment. However, the LQ segment only contains one remark code per segment. As such, a separate LQ segment is required for each edit posted to the encounter. Please refer to the NJMMIS website (www.njmmis.com) for a mapping of the claim adjustment reason code and remark code combinations for the equivalent NJMMIS edit code.	A	2	*
		CAS02	HIPAA claim adjustment reason code	A	3	*
		CAS03	"0"	N	1	**
		CAS05	If applicable, the HIPAA claim adjustment reason code. Otherwise, blank.	A	3	*
		CAS06	If applicable, "0". Otherwise, blank.	N	1	**
		CAS08	If applicable, the HIPAA claim adjustment reason code. Otherwise, blank.	A	3	*
		CAS09	If applicable, "0". Otherwise, blank.	N	1	**
		CAS11	If applicable, the HIPAA claim adjustment reason code. Otherwise, blank.	A	3	*
		CAS12	If applicable, "0". Otherwise, blank.	N	1	**
		CAS14	If applicable, the HIPAA claim adjustment reason code. Otherwise, blank.	A	3	*
		CAS15	If applicable, "0". Otherwise, blank.	N	1	**

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
2110		CAS17	If applicable, the HIPAA claim adjustment reason code. Otherwise, blank.	A	3	*
		CAS18	If applicable, "0". Otherwise, blank.	N	1	~
LINE ITEM CONTROL NUMBER						
2110	REF	REF00	"REF"	A	3	*
		REF01	"6R"	A	2	*
		REF02	The value in this field contains the REF*6R value for the line item, if sent, otherwise it contains the LX01 value. For Inpatient, it will contain the LX01 value of the first line item only, normally "1".	N	15	~
HEALTH CARE REMARK CODES						
2110	LQ	LQ00	"LQ"	A	2	*
		LQ01	"HE" or "RX"	A	2	*
		LQ02	HIPAA remark code or NCPDP code.	A	4	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction, including the ST and SE segments.	N	1-10	*
		SE02	Enter the same value entered in ST02.	N	4-9	~

SECTION 14 – HIPAA 834 MANAGED CARE ENROLLMENT

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"834"	N	3	*
		ST02	OIT-assigned identifier.	N	4-9	*
		ST03	005010X220A1	A	12	~
BEGINNING SEGMENT						
	BGN	BGN00	"BGN"	A	3	*
		BGN01	"00" for the initial transaction set, "15" for a replacement transaction set.	N	2	*
		BGN02	OIT-assigned plan code for the HMO.	A	1-30	*
		BGN03	OIT-assigned file creation date (CCYYMMDD).	N	8	*
		BGN04	OIT-assigned file creation time (HHMM).	N	4	*
		BGN05	"ET"	A	2	***
		BGN08	"2" for daily transactions or "4" for the weekly roster.	N	1	~
FILE EFFECTIVE DATE						
	DTP	DTP00	"DTP"	A	3	*
		DTP01	"007"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	OIT-assigned cycle date (CCYYMMDD).	N	8	~
SPONSOR NAME						
1000A	N1	N100	"N1"	A	2	*
		N101	"P5"	A	2	*
		N102	"NEW JERSEY MEDICAID"	A	19	*
		N103	"94"	A	2	*
		N104	"610515"	N	6	~
PAYER						
1000B	N1	N100	"N1"	A	2	*
		N101	"IN"	A	2	*
		N102	HMO name.	A	1-60	*
		N103	"FI"	A	2	*
		N104	HMO IRS number.	N	6	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
MEMBER LEVEL DETAIL						
2000	INS	INS00	"INS"	A	3	*
		INS01	"Y"	A	1	*
		INS02	"18"	N	2	*
		INS03	New Jersey Medicaid will use values "001" (change), "021" (add) and "024" (enrollment termination or client deletion) when BGN08 = "2", or value "030" (audit or compare) when BGN08 = "4". When "024" is used in this field, the HMO must refer to HD01 to further determine if the transaction is a termination or a deletion.	N	3	**
		INS05	"A"	A	1	***
		INS08	"FT"	A	2	~
SUBSCRIBER NUMBER						
2000	REF	REF00	"REF"	A	3	*
		REF01	"0F"	A	2	*
		REF02	New Jersey Medicaid client's ID.	N	12	~
MEMBER POLICY NUMBER						
2000	REF	REF00	"REF"	A	3	*
		REF01	"1L"	A	2	*
		REF02	New Jersey Medicaid client's ID.	N	12	~
MEMBER NAME						
2100A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Client's last name.	A	1-35	*
		NM104	Client's first name.	A	1-25	*
		NM105	If present, the client's middle initial. Otherwise blank.	A	1	***
		NM108	"34"	N	2	*
		NM109	Client's SSN.	N	9	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
MEMBER COMMUNICATIONS NUMBERS						
2100A	PER	PER00	"PER" This segment will be present if a telephone number is available for the client.	A	3	*
		PER01	"IP"	A	2	**
		PER03	"TE"	A	2	*
		PER04	Client's telephone number.	N	10	~
MEMBER RESIDENCE STREET ADDRESS						
2100A	N3	N300	"N3"	A	2	*
		N301	New Jersey Medicaid carries up to five lines for a client's address. N301 will be valued with the concatenation of the first address line on file, the second address line on file, and the first 11 characters of the third address line on file, in a fixed-width format.	A	1-55	*
		N302	New Jersey Medicaid carries up to five lines for a client's address. N302 will be valued with the concatenation of the last 11 characters of the third address line on file, and fourth address line on file, and fifth address lines on file in a fixed-width format.	A	1-55	~
MEMBER RESIDENCE CITY, STATE, ZIP CODE						
2100A	N4	N400	"N4"	A	2	*
		N401	Client's address city.	A	1-30	*
		N402	Client's address state code.	A	2	*
		N403	Client's address postal code.	N	9	~
MEMBER DEMOGRAPHICS						
2100A	DMG	DMG00	"DMG"	A	3	*
		DMG01	"D8"	A	2	*
		DMG02	Client's birth date (CCYYMMDD).	N	8	*
		DMG03	Client's gender code ("F" for female, "M" for male, "U" for unknown).	A	1	**
		DMG05-1	Client's Race/Ethnicity Code. Please refer to the Data Element Dictionary (DED) section for a list of values.	A	1	::~
MEMBER LANGUAGE						
2100A	LUI	LUI00	"LUI"	A	3	*
		LUI01	"LD"	A	2	*
		LUI02	Client's Language Code. Please refer to the Data Element Dictionary (DED) section for a list of values.	A	2-80	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
HEALTH COVERAGE (MEDICAID COVERAGE)						
2300	HD	HD00	"HD"	A	2	*
		HD01	The values specified in HD01 will be the same as those specified in 2000/INS03 except for deletions, which will be valued with "002" in HD01, but will be valued with "024" in 2000/INS03.	N	3	**
		HD03	"HMO"	A	3	*
		HD04	HD04 will be valued with the following fields, delimited by commas: HBI Code, Capitation Code, Payment Code, Eligibility Termination Code, Program Status Code, Extension Code, County Of Residence, Enrollment Type, County of Supervision Enrollment Source and Disenrollment Reason Code. Please refer to the Data Element Dictionary (DED) section for a list of values.	A	1-50	*
		HD05	"IND"	A	3	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"348"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enrollment effective date (CCYYMMDD).	N	8	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"349"	N	3	*
		DTP02	Enrollment end date (CCYYMMDD).	N	8	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP" If HD01 = "001" (change), a second occurrence of the enrollment dates is present and represents the previous enrollment period prior to the change.	A	3	*
		DTP01	"348"	N	3	*
		DTP02	Prior enrollment effective date (CCYYMMDD).	N	8	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"349"	N	3	*
		DTP02	Prior enrollment end date (CCYYMMDD).	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
HEALTH COVERAGE (PATIENT LIABILITY)						
2300	HD	HD00	"HD"	A	2	*
		HD01	The values specified in HD01 will be the same as those specified in 2000/INS03 except for deletions, which will be valued with "002" in HD01, but will be valued with "024" in 2000/INS03.	N	3	**
		HD03	"HMO"	A	3	*
		HD04	"PATIENT LIABILITY"	A	1-50	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"348"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Effective date (CCYYMMDD).	N	8	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"349"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	End date (CCYYMMDD).	N	8	~
HEALTH COVERAGE POLICY						
2300	AMT	AMT00	"AMT"	A	3	*
		AMT01	'B9' for assisted living 'C1' for nursing facility.	A	2	*
		AMT02	Monetary amount.	N	7	~
HEALTH COVERAGE (SPECIAL PROGRAM CODE)						
2300	HD	HD00	"HD"	A	2	*
		HD01	The values specified in HD01 will be the same as those specified in 2000/INS03 except for deletions, which will be valued with "002" in HD01, but will be valued with "024" in 2000/INS03.	N	3	**
		HD03	"HMO"	A	3	*
		HD04	"SPECIAL PROGRAM CODE"	A	1-50	*
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"348"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enrollment effective date (CCYYMMDD).	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"349"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enrollment end date (CCYYMMDD).	N	8	~
HEALTH COVERAGE POLICY						
2300	REF	REF00	"REF"	A	3	*
		REF01	"XX1"	A	3	*
		REF02	Special Program Code.	N	2	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	1-10	*
		SE02	Enter the same value entered in ST02.	N	4-9	~

SECTION 15 – HIPAA 834 D-SNP (DUAL ELIGIBLE SPECIAL NEEDS PLAN) ENROLLMENT

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
TRANSACTION SET HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"834"	N	3	*
		ST02	Enter a unique control number for the transaction set. This control number must be unique within the current functional group and interchange.	N	4-9	*
		ST03	Enter "005010X220A1".	A	12	~
BEGINNING SEGMENT						
	BGN	BGN00	"BGN"	A	3	*
		BGN01	"00" for the initial transaction set, "15" for a replacement transaction set.	N	2	*
		BGN02	Enter a batch control number for the transaction set. This batch control number can be equal to the value specified in ST02.	A	1-30	*
		BGN03	Enter the file creation date (CCYYMMDD).	N	8	*
		BGN04	Enter the file creation time (HHMM).	N	4	*
		BGN05	"ET"	A	2	***
		BGN08	Enter "4". Each 834 submitted is considered a full file replacement of the previously submitted 834 and must always include all members currently and previously enrolled in D-SNP.	N	1	~
SPONSOR NAME						
1000A	N1	N100	"N1"	A	2	*
		N101	"P5"	A	2	*
		N102	Enter the HMO name.	A	1-60	*
		N103	"94"	N	2	*
		N104	Enter the seven digit encounter submitter ID assigned to the HMO by Gainwell Technologies (begins with "77").	N	7	~
PAYER						
1000B	N1	N100	"N1"	A	2	*
		N101	"IN"	A	2	*
		N102	"NEW JERSEY MEDICAID".	A	19	*
		N103	"94"	N	2	*
		N104	"610515".	N	6	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
MEMBER LEVEL DETAIL						
2000	INS	INS00	"INS"	A	3	*
		INS01	"Y"	A	1	*
		INS02	"18"	N	2	*
		INS03	"030"	N	3	*
		INS04	"XN"	A	2	*
		INS05	"A"	A	1	***
		INS08	Enter "AC" for an active enrollment or "TE" for a terminated enrollment.	A	2	~
SUBSCRIBER IDENTIFIER						
2000	REF	REF00	"REF"	A	3	*
		REF01	"0F"	A	2	*
		REF02	Enter the New Jersey Medicaid ID.	N	12	~
MEMBER NAME						
2100A	NM1	NM100	"NM1"	A	3	*
		NM101	"IL"	A	2	*
		NM102	"1"	N	1	*
		NM103	Enter the member's last name.	A	1-35	*
		NM104	Enter the member's first name.	A	1-25	*
		NM105	If present, the member's middle initial. Otherwise blank.	A	1	***
		NM108	"34"	N	2	*
		NM109	Enter the member's social security number.	N	9	~
HEALTH COVERAGE						
2300	HD	HD00	"HD"	A	2	*
		HD01	"030"	N	3	**
		HD03	"HMO"	A	3	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"300"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the D-SNP enrollment application date (CCYYMMDD).	N	8	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"348"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the D-SNP enrollment date (CCYYMMDD).	N	8	~
HEALTH COVERAGE DATES						
2300	DTP	DTP00	"DTP"	A	3	*
		DTP01	"349"	N	3	*
		DTP02	"D8"	A	2	*
		DTP03	Enter the D-SNP disenrollment date (CCYYMMDD). To indicate an open-ended disenrollment date, enter "99991231".	N	8	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction set, including the ST and SE segments.	N	1-10	*
		SE02	Enter the same value entered in ST02.	N	4-9	~

SECTION 16 – HIPAA 820 PREMIUM PAYMENT

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
820 HEADER						
	ST	ST00	"ST"	A	2	*
		ST01	"820"	N	3	*
		ST02	Gainwell Technologies-assigned sequential ID starting with "0001" and incremented for each subsequent ST segment.	N	4-9	*
		ST03	"005010X218"	A	10	~
FINANCIAL INFORMATION						
	BPR	BPR00	"BPR"	A	3	*
		BPR01	"I"	A	1	*
		BPR02	"999999999.99"	N	1-18	*
		BPR03	"C"	A	1	*
		BPR04	"ACH"	N	3	*
		BPR05	"CCP"	A	3	*
		BPR06	"01"	N	2	*
		BPR07		A	1-3	*
		BPR08	"DA"	A	2	*
		BPR09	State Account Number	A	1-35	*
		BPR10	"State Payer Identifier"	A	10	*
		BPR11	"State Supplemental Code"	A	9	*
		BPR12	"01"	N	2	*
		BPR13	ACH routing number of HMO.	A	3-12	*
		BPR14	"DA"	A	2	*
		BPR15	Bank Account number of HMO.	A	1-35	*
		BPR16	Gainwell Technologies cycle date (CCYYMMDD) which is typically the Friday of the weekly encounter cycle.	N	8	~
REASSOCIATION TRACE NUMBER						
	TRN	TRN00	"TRN"	A	3	*
		TRN01	"1"	N	1	*
		TRN02		N	1-30	~

LOOP	SEGMENT	FIELD	DATA REQUIREMENT	FORMAT	LENGTH	DELIMITER
PREMIUM RECEIVER'S NAME						
1000A	N1	N100	"N1"	A	2	*
		N101	"PE"	A	2	*
		N102	HMO name.	A	1-60	*
		N103	"FI"	A	2	*
		N104	HMO IRS number.	N	10	~
PREMIUM PAYER'S NAME						
1000B	N1	N100	"N1"	A	2	*
		N101	"PR"	A	2	*
		N102	"NEW JERSEY MEDICAID"	A	19	~
ORGANIZATION SUMMARY REMITTANCE						
2000A	ENT	ENT00	"ENT"	A	3	*
		ENT01	"1"	N	1	*
		ENT02	"2L"	A	2	*
		ENT03	"FI"	A	2	*
		ENT04		N	10	~
ORGANIZATION SUMMARY REMITTANCE DETAIL						
2300A	RMR	RMR00	"RMR"	A	3	*
		RMR01	"IK"	A	2	*
		RMR02		A	1-30	*
		RMR04		N	1-18	~
TRANSACTION SET TRAILER						
	SE	SE00	"SE"	A	2	*
		SE01	Enter the total number of segments in the transaction, including the ST and SE segments.	N	1-10	*
		SE02	Enter the same value entered in ST02.	N	4-9	~

SECTION 17 – DATA ELEMENT DICTIONARY

17.1 – OTHER PAYER CODES

OTHER PAYER CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2330B	NM1	NM109	122	Advantra Freedom (Medicare HMO)
			071	Aetna Health Plans
			006	Aetna US Healthcare
			094	Aetna US Healthcare HMO
			104	Aetna US Healthcare Inc.
			007	Allstate
			112	Americhoice (Medicare HMO)
			008	American Association of Retired Persons (AARP)
			009	American General Insurance
			010	American National
			054	American Postal Workers Union (APWU)
			121	Amerigroup (Medicare HMO)
			105	Amerihealth HMO, Inc.
			012	Benefit Trust Life
			128	Bravo Health (Medicare HMO)
			017	CAN
			043	Capital Enterprises, Inc.
			034	CIGNA Healthcare HMO
			107	CIGNA Healthcare of Northern NJ, IN
			106	CIGNA Healthcare of Southern NJ, IN
			018	Colonial Life and Accident
			047	Colonial Penn
			019	Columbia Life Insurance
			093	Co-Med HMO (CIGNA)
			020	Continental General (CIGNA)
			022	Continental Insurance
			116	Empire Medicare HMO BC/BS
			024	Employer's Health Insurance
			025	Equicorp, Inc.
			026	Equitable

OTHER PAYER CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2330B	NM1	NM109	127	Evercare (Medicare HMO)
			027	Federal Blue Cross
			052	Federal Express
			028	Fireman's Fund
			088	First Health
			029	Garden State Hospitalization, NJ
			030	GHI Claims Department
			031	Great West Life & Annuity
			032	Guardian Life
			063	Hartford Insurance
			123	Healthfirst NJ (Medicare HMO)
			087	HIP
			089	HIP Health Plan of New Jersey
			033	HIP Health Plan of NJ
			091	HMO Blue
			109	Horizon Medicare Blue
			115	Humana Medicare HMO Plan
			035	Independent Life
			037	Inter County Health Plan
			036	Intercontinental
			038	John Hancock, L.I.C.
			118	Kaiser Permanente (Medicare HMO)
			113	Keystone (Senior Blue)
			039	Liberty Mutual
			040	Life Insurance Corporation of America
			059	Local 798 Welfare Fund
			086	MagnaCare (through Local 274)
			042	Mail Handlers Benefit Plan
			044	Massachusetts Mutual
			132	Medicare HMO (Out Of State Carrier)
			100	Medicare Part A
			101	Medicare Part B
			045	Metropolitan

OTHER PAYER CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2330B	NM1	NM109	076	Monarch Life
			048	Mutual Benefit
			049	Mutual of New York
			050	Mutual of Omaha
			051	National Association of Letter Carriers
			053	National Maritime Union
			001	New Jersey Blue Cross/Blue Shield
			002	New York Blue Cross/Blue Shield
			057	New York Life/NYLCARE
			058	New York Shipping Association
			060	Northwestern National Life
			061	Occidental Life Insurance
			085	OmniCare
			110	Oxford Health Plans (New Jersey), Inc.
			062	Pacific Mutual
			064	Penn Mutual
			013	People's Benefit Life Insurance
			065	Philadelphia American Life
			003	Philadelphia Blue Cross/Blue Shield
			108	Physicians Health Services (Medicare)
			066	Physicians Mutual Life
			011	Principal Financial Group
			067	Provident Life and Accident
			092	PruCare
			068	Prudential
			046	Qualcare
			069	Railroad Retirement
			070	Reliance
			072	Reliastar
			096	Saint Barnabas System Health Plan
			124	Secure Horizons (Medicare HMO)
			074	Security Mutual
			117	Senior Partners/Health Partners Inc.

OTHER PAYER CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2330B	NM1	NM109	075	Sentry Life
			073	State Mutual Insurance
			119	Sterling Life (Medicare HMO)
			125	Today's Options (Medicare HMO)
			077	Travelers Insurance
			014	Tri Care Region 1 – Claims
			081	U.S. Life
			126	Unicare (Medicare HMO)
			023	Union Fidelity Life Insurance
			078	Union Labor Life
			079	Union Mutual Benefits
			114	United Healthcare Medicare Complete
			111	United Healthcare Of New Jersey, Inc.
			015	Unity Mutual Life
			082	Veterans Administration
			041	Virginia Health Network
			083	Washington National
			120	Wellcare (Medicare HMO Only)
			084	Wellmark Community
			099	ALL OTHER INSURANCE PLANS

17.2 – PRIORITY TYPE OF ADMISSION CODES

PRIORITY TYPE OF ADMISSION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	CL1	CL101	1	Emergency
			2	Urgent
			3	Elective
			4	Newborn
			5	Trauma
			9	Information not available

17.3 – POINT OF ORIGIN FOR ADMISSION OR VISIT CODE

POINT OF ORIGIN FOR ADMISSION OR VISIT CODE				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	CL1	CL102		**If "Type of Admission" (form locator 14) equals 1, 2, 3 or 9, the valid admission source codes are as follows:**
			1	Physician referral
			2	Clinic referral
			3	HMO referral
			4	Transfer from a hospital (acute)
			5	Transfer from a skilled nursing facility
			6	Transfer from another health care facility
			7	Emergency room
			8	Court/Law enforcement
			9	Information not available
				If "Type of Admission" (form locator 14) equals 4, the valid admission source code are as follows:
			5	In hospital
			6	Out of hospital
			9	Information not available

17.4 – PATIENT STATUS CODE

Patient Status Code				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	CL1	CL103		**Inpatient**
			01	Discharged to home or self-care (routine discharge)
			02	Discharged/transferred to another short term general hospital for inpatient care
			03	Discharged/transferred to skilled nursing facility (SNF)
			04	Discharged/transferred to an intermediate care facility (ICF)
			05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
			06	Discharged/transferred to home under care of organized home health service organization
			07	Left against medical advice or discontinued care
			08	Discharged/transferred to home under care of a Home IV provider
			20	Expired
			30	Still patient or expected to return for outpatient services

Patient Status Code				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	CL1	CL103	43	Discharged/transferred to a Federal Health Care Facility
			50	Hospice - Home
			51	Hospice - Medical Facility
			61	Discharged/transferred to hospital-based Medicare approved swing bed
			62	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF)
			63	Discharge/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
			64	Discharged/transferred to a Nursing Facility certified by Medicaid but not Medicare
			65	Discharged/transferred to a psychiatric hospital
			66	Discharged/transferred to a critical access hospital
				*If interim billing, the patient status code must be "30", (frequency code 2 or 3 entered in "Type of Bill").
			70	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
				Outpatient
			01	Discharged (routine)
			20	Expired
			30	Still patient

17.5 – TRANSPORTATION ORIGIN AND DESTINATION CODES

TRANSPORTATION ORIGIN AND DESTINATION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2400	SV1	SV101-3	D	Diagnosis or therapeutic site other than P or H
			E	Residential, domiciliary, custodial facility
			G	Hospital-based dialysis facility (hospital or hospital related)
			H	Hospital
			I	Site of transfer (e.g. airport or helicopter pad) between modes of transport
			J	Non hospital-based dialysis facility
			N	Skilled nursing facility
			P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
			R	Residence
			S	Scene of accident or acute event
			X	Destination code only (Intermediate stop at physician's office, enroute to hospital (includes HMO non-hospital facility)

17.6 –CAPITATION CODES

CAPITATION CODES			
LOOP	SEGMENT	FIELD	
2300	HD	HD04	

HMO / PLAN CODE	CAP CODE	HBI CODE
WELLPOINT		
078	10399	S2000
078	19399	S2000
078	19499	S2000
078	39499	S2000
078	17399	S2000
078	37399	S2000
078	79599	S2000
078	79699	K2000
078	77399	S2000
078	80399	S2000
078	89599	S2000
078	87399	S2000
078	81299	S2000
078	49499	S2000
078	90399	K2000
078	99399	K2000
078	59499	K2000
078	59099	E2014
078	57499	E2014
078	79399	L2014
078	89399	L2014
078	78199	L2014
078	88199	L2014
078	78399	L2014
078	88399	L2014
078	78499	L2014
078	88499	L2014
201	89999	M2012

HMO / PLAN CODE	CAP CODE	HBI CODE
UNITED HEALTHCARE		
082	10399	S2000
082	19399	S2000
082	19499	S2000
082	39499	S2000
082	17399	S2000
082	37399	S2000
082	79599	S2000
082	79699	K2000
082	77399	S2000
082	80399	S2000
082	89599	S2000
082	87399	S2000
082	81299	S2000
082	49499	S2000
082	90399	K2000
082	99399	K2000
082	59499	K2000
082	59099	E2014
082	57499	E2014
082	79399	L2014
082	89399	L2014
082	78199	L2014
082	88199	L2014
082	78399	L2014
082	88399	L2014
082	78499	L2014
082	88499	L2014
200	89999	M2012

HMO / PLAN CODE	CAP CODE	HBI CODE
HORIZON		
086	10399	S2000
086	19399	S2000
086	19499	S2000
086	39499	S2000
086	17399	S2000
086	37399	S2000
086	79599	S2000
086	79699	K2000
086	77399	S2000
086	80399	S2000
086	89599	S2000
086	87399	S2000
086	81299	S2000
086	49499	S2000
086	90399	K2000
086	99399	K2000
086	59499	K2000
086	59099	E2014
086	57499	E2014
086	79399	L2014
086	89399	L2014
086	78199	L2014
086	88199	L2014
086	78399	L2014
086	88399	L2014
086	78499	L2014
086	88499	L2014
202	89999	M2012

Additional HMO Plans continued on next page

CAPITATION CODES - continued			
LOOP	SEGMENT	FIELD	
2300	HD	HD04	

HMO / PLAN CODE	CAP CODE	HBI CODE
FIDELIS CARE		
092	10399	S2000
092	19399	S2000
092	19499	S2000
092	39499	S2000
092	17399	S2000
092	37399	S2000
092	79599	S2000
092	79699	K2000
092	77399	S2000
092	80399	S2000
092	89599	S2000
092	87399	S2000
092	81299	S2000
092	49499	S2000
092	90399	K2000
092	99399	K2000
092	59499	K2000
092	59099	E2014
092	57499	E2014
092	79399	L2014
092	89399	L2014
092	78199	L2014
092	88199	L2014
092	78399	L2014
092	88399	L2014
092	78499	L2014
092	88499	L2014
204	89999	M2012

HMO / PLAN CODE	CAP CODE	HBI CODE
AETNA		
097	10399	S2000
097	19399	S2000
097	19499	S2000
097	39499	S2000
097	17399	S2000
097	37399	S2000
097	79599	S2000
097	79699	K2000
097	77399	S2000
097	80399	S2000
097	89599	S2000
097	87399	S2000
097	81299	S2000
097	49499	S2000
097	90399	K2000
097	99399	K2000
097	59499	K2000
097	59099	E2014
097	57499	E2014
097	79399	L2014
097	89399	L2014
097	78199	L2014
097	88199	L2014
097	78399	L2014
097	88399	L2014
097	78499	L2014
097	88499	L2014
205	89999	M2012

17.7 – HBI CODES

HBI CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	H2000	Plan H Service Package
			K2000	Kidcare Plan D Service Package
			S2000	Standard Service Package
			M2012	Dual Eligible Special Needs Plan (D-SNP) Service Package
			E2014	Medicaid Alternative Benefit Plan
			L2014	Managed Long Term Services and Support (MLTSS)

17.8 – PAYMENT CODES

PAYMENT CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	A	AIDS – Discontinued 7/1/2015
			B	AIDS and DDD – Discontinued 7/1/2015
			C	HIV+ and DDD – Discontinued 7/1/2015
			D	DDD
			E	DYFS and ABD and HIV+ and Blood Factor and DDD – Discontinued 7/1/2015
			F	Blood Factor
			G	Blood Factor and AIDS – Discontinued 7/1/2015
			H	HIV+ – Discontinued 7/1/2015
			I	Blood Factor and DDD and AIDS – Discontinued 7/1/2015
			I	SMA or DMD
			J	Blood Factor and DDD and HIV+ – Discontinued 7/1/2015
			K	Blood Factor and DDD
			L	Blood Factor and HIV – Discontinued 7/1/2015
			M	DYFS and ABD
			P	DYFS and ABD and AIDS – Discontinued 7/1/2015
			Q	DYFS and ABD and Blood Factor
			R	DYFS and ABD and DDD
			S	DYFS and ABD and AIDS and Blood Factor – Discontinued 7/1/2015
			T	DYFS and ABD and AIDS and DDD – Discontinued 7/1/2015
			U	DYFS and ABD and HIV+ and Blood Factor – Discontinued 7/1/2015
			V	DYFS and ABD and HIV+ and DDD – Discontinued 7/1/2015
			W	DYFS and ABD and AIDS and Blood Factor and DDD – Discontinued 7/1/2015

PAYMENT CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	X	DYFS and ABD and Blood Factor and DDD
			Z	DYFS and ABD and AIDS – Discontinued 7/1/2015
			1	High Cost Drugs (Angioedema/Pompe/Gaucher's) only
			2	High Cost Drugs (Angioedema/Pompe/Gaucher's) and AIDS/HIV – Discontinued 7/1/2015
			3	High Cost Drugs (Angioedema/Pompe/Gaucher's) and Blood Factor
			4	High Cost Drugs (Angioedema/Pompe/Gaucher's) and DDD
			5	Cystic Fibrosis
			6	Cystic Fibrosis and DDD
			7	Cystic Fibrosis and Blood Factor
			8	SMA or DMD and DDD
			9	SMA or DMD and Blood Factor

17.9 –ELIGIBILITY TERMINATION CODES

ELIGIBILITY TERMINATION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	00	Case Record Closed Due To Death With Potential Recoverable Assets
			01	Failure To Appear For Re-determination
			02	Voluntary Disenrollment
			03	Case Record Closed Due To Non-Utilization
			04	Case Record Closed Due To Duplicate Eligibility Record
			05	Case Record Closed Due To Death
			06	Case Record Closed Due To Transfer To Other County
			07	Case Record Closed Due To Transfer To Another Program
			08	Case Record Closed Due To Ineligibility
			09	Case Record Closed For Other Reasons
			10	TPL Coverage
			11	Failure To Pay Premium
			12	Exceeded HCFA Financial Cap
			13	Eligible for the Premium Support Program (PSP), but did not comply with all of the requirements
			14	Recipients with Program Status Codes 486 and 497 have not selected an HMO within four (4) months of eligibility effective date
			15	Case Record Closed as a result of going into a Long Term Care Facility (LTCF)

ELIGIBILITY TERMINATION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	16	Recipient record closed due to non-use of EBT benefits
			17	Recipient record closed due to no eligible child on the case (the last or only child aged out)
			50	Change Of Program Status

17.10 – PROGRAM STATUS CODES

PROGRAM STATUS CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04		**PROGRAM 10 OLD AGE ASSISTANCE**
			110	OAA CN-SSI Money Payment (MP)
			120	OAA CN - Medicaid only, No Money Payment (NMP)
			130	OAA CN - Categorically Related - NMP - No Federal Match (NFM)
			140	OAA CN - Institutional Resident – NFM
			150	PRUCOL (Permanent Residents Under the Color of Law) – Aged
			160	OAA CN - HCEP - Home Care Expansion Program
			190	NJC - Aged, OCN - Optional Categorically Needy
				PROGRAM 15 MEDICALLY NEEDY AGED
			170	Aged MN - No Spenddown
			180	Aged MN – Spenddown
				PROGRAM 20 DISABILITY ASSISTANCE
			210	DA - CN SSI MP
			220	DA - CN Medicaid only-NMP
			230	DA - CN Categorically Related, NMP, NFM
			240	DA - CN Institutional Resident, NFM
			250	PRUCOL – Disabled
			260	DA - CN HCEP
			290	NJC-Disabled, Optional Categorically Needy
			291	Working Disabled Members Ages 16-64 and up to 250% FPL
			292	Working Disabled Members Ages 65 and older with up to 250% FPL
			293	Working disabled members with 251 – 350% FPL (Tier 1)
			294	Working disabled members with 351 – 450% FPL (Tier 2)
			295	Breast and Cervical Cancer

PROGRAM STATUS CODES				
LOOP	**SEGMENT**	**FIELD**	**CODE**	**DESCRIPTION**
2300	HD	HD04		**PROGRAM 25 MEDICALLY NEEDY DISABLED**
			270	DA - MN - No Spenddown
			280	DA - MN – Spenddown
				PROGRAM 30 AID TO FAMILIES WITH DEPENDENT CHILDREN
			300	FC HealthAccess, 0-150% Plan D Services 100% State Funds
			301	FC HealthAccess, 151-250% Plan D Services 100% State Funds
			310	AFDC Children 0-18 – FM
			320	AFDC Parents – FM
			330	AFDC-C - CN Regular-Categorically Related – NM
			390	PEPW - Presumptively Eligible Pregnant Women
			391	NJ Suppl Prenatal Care Program - Other Pregnant Women
			410	AFDC-F - CN MP - Federal Match (FM) – Categorically
			420	AFDC-F - CN NMP – FM
			430	AFDC-C - CN Regular - NMP - NFM – REACH
			440	AFDC-F - CN NMP - NFM – REACH
			450	AFDC-N - CN Adults - MP/NMP – NFM
			460	AFDC-N - CN Children - MP/NMP - Categorically Related-FM
			470	AFDC-N - CN Child/Adult - NM - NF - REACH - TDI/UIB, no 3/6
			480	NJC-Child, Optional Categorically Needy – FM
			481	Child 1-5, > AFDC ≥ 142% FPL – FM
			490	Pregnant Women 0-194% FPL – FM
			491	NJC-Pregnant Women, OCN, to 133% FPL – FM
			499	AFDC Pregnant Women, 194-200% FPL – FM
				PROGRAM 30 NEW JERSEY CARE
			482	Newborn <1>, ADFC ≤ 194% FPL – FM
			483	Child 6-18, >AFDC ≤ 107% FPL – FM
			492	NJC - Pregnant Women, 133%-185% FPL – FM
				PROGRAM 30 WELFARE REFORM
			451	AFDC-N Adults and Temporary Assistance Needy Family (TANF) Approved
			452	AFDC-N Adults but no TANF Approval
			461	Child 6-18, 107-142% FPL – FM
			462	Medicaid Special 19-21 – FM

PROGRAM STATUS CODES				
LOOP	**SEGMENT**	**FIELD**	**CODE**	**DESCRIPTION**
2300	HD	HD04		**PROGRAM 30 NJ CARE EXPANSION AND NJ KIDCARE**
			484	NJC - Child born before 10/01/83, but < or equal to 19, < or equal to 100% FPL - FM
			485	Uninsured Child 6-18, 107-142% FPL – FM
			486	Plan B - Child 142-150% FPL – FM
			487	Child 1-18, 150-185% FPL, Plan C – FM
			488	Child 1-18, 194-200% FPL, Newborn 194-200% FPL Plan C – FM
			493	Child 0-18, 200-250% FPL, Plan D – FM
			489	NJFC FFS Newborns > 194% to ≤ 200% FPL - FM
			494	Child 0-18, 250-300% FPL, Plan D – FM
			495	Child 0-18, 300-350% FPL, Plan D – FM
			496	NJFC FFS Newborn 201-350% FPL – FM
				PROGRAM 30 FAMILYCARE
			380	Parent 19-64, > AFDC ≤ 133% FPL – FM
			497	Plan D Parent 134-150% FPL – FM
			498	Plan D Parent 150-200% FPL – FM
				PROGRAM 35 MEDICALLY NEEDY CHILDREN/PREGNANT WOMEN
			340	MN - Pregnant Women-no Spenddown
			350	MN - Pregnant Women-Spenddown
			360	MN - Child-no Spenddown
			370	MN - Child-Spenddown
				PROGRAM 50 ASSISTANCE FOR BLIND
			510	AB - CN SSI MP
			520	AB - CN NMP
			530	AB - CN Categorically Related - NMP - NFM
			540	AB - CN Institutional Resident - NFM
			550	PRUCOL-Blind
			560	AB - CN HCEP
			590	NJC - Blind - Optional Categorically Needy
			591	Working disabled members with 451 – 550% FPL (Tier 3)
			592	Working disabled members with 551 – 650% FPL (Tier 4)
			593	Working disabled members with 651 – 750% FPL (Tier 5)
			594	Working disabled members with greater than 750% FPL (Tier 6)

PROGRAM STATUS CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04		**PROGRAM 55 MEDICALLY NEEDY BLIND PROGRAM**
			570	Blind - MN - no Spenddown
			580	Blind - MN – Spenddown
				PROGRAM 60, (COUNTY <22) DIVISION OF YOUTH AND FAMILY SERVICES
			600	DCP&P - Optional Foster Care and Adoption Assistance
			620	DCP&P - Medicaid Extension for Young Adults
			630	DCP&P - Title IV-E Foster Children
			650	DCP&P - State Program – NFM
				PROGRAM 60, (COUNTY >21) DIVISION OF PUBLIC WELFARE BLO ISS
			600	ISS - SSI MP - FM
			620	ISS - Medicaid Only - SSI Related
			630	ISS - AFDC Related AFDC Recipient
			640	ISS - Institutional Resident - NFM
			641	CSOCI - Children's System of Care Initiative
				PROGRAM 70 MEDICAL ASSISTANCE FOR THE AGED STATE PROGRAM
			710	MAA - NFM - Age 65 and over
				PROGRAM 70 FAMILYCARE - OTHER ADULTS
				FamilyCare
			700	FC HealthAccess, 0-150% Plan D Services 100% State Funds
			701	FC HealthAccess, 151-250% Plan D Services 100% State Funds
			761	NJFC, other adults, 0-23% FPL
			762	Single Adult/Childless Couple 19-64, 0-133% FPL – FM
			763	NJFC, other adults, 51-100% FPL
				Cystic Fibrosis
			770	Cystic Fibrosis
				ADDP
			780	ADDP, NFM
				PAAD PHARMACEUTICAL ASSISTANCE TO AGED/DISABLED
			730	PAAD under 65, Disabled Casino Fund
			740	PAAD over 65, Upper Income Casino Fund
			750	PAAD over 65, Lower Income General Fund
				SENIOR GOLD
			830	Senior Gold, Disabled

PROGRAM STATUS CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	840	Senior Gold, Aged
				GA GENERAL ASSISTANCE
			760	General Assistance Program
				PROGRAM 80 JUVENILE SERVICES
			800	Juvenile Services - Not Refugee
			810	County Juvenile Services
				Department of Corrections
			801	DOC (Department of Corrections)

17.11 – EXTENSION CODES

EXTENSION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	A	up to 6 months extension, due to loss of eligibility, non- REACH
			B	up to 6 months extension, due to loss of eligibility, non- REACH (to follow extension type A when applicable)
			C	12 month extension
			D	up to 4 month extension (current CSP collection but not TANF) (C/F/N)
			E	up to 12 months extension for newborns, up to 60 days for mother of newborn, but not TANF (C/F/N)
			F	up to 12 months extension (no longer used as of 7/1/1997)
			G	up to 12 months extension, Family Development Program (FDP) (no longer used as of 7/1/1997)
			H	up to 12 months extension (no longer used as of 7/1/1997)
			I	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			J	up to 12 months extension (N segment or does not meet 3/6), and TANF (C/F/N)
			K	up to 12 months extension (N segment or does not meet 3/6), and TANF (C/F/N)
			L	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			M	up to 12 months extension (no longer used as of 7/1/1997)
			N	up to 6 months extension, Family Support Act (no longer used as of 7/1/1997)
			O	up to 12 months extension, FDP (no longer used as of 7/1997)
			P	up to 6 months extension (no longer used as of 7/1/1997)
			Q	up to 6 months extension (no longer used as of 7/1/1997)
			R	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			S	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			T	up to 12 months extension, REACH (no longer used as of 7/1/1997)

EXTENSION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	U	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			V	up to 12 months extension, due to TDI/UIB and TANF (C/F)
			W	up to 12 months extension, due to TDI/UIB and TANF (C/F)
			X	up to 12 months extension, FDP (no longer used as of 7/1/1997)
			Y	up to 6 months extension, Family Support Act (no longer used as of 7/1/1997)
			Z	up to 6 months extension, income exceeds 185% of poverty, Family Support Act (no longer used as of 7/1/1997)
			1	balance of guarantee, HMO enrollments (no longer used)
			2	GSHP extension (no longer used)
			3	Good Faith extension

17.12 – COUNTY OF RESIDENCE CODES

COUNTY OF RESIDENCE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	01	Atlantic
			02	Bergen
			03	Burlington
			04	Camden
			05	Cape May
			06	Cumberland
			07	Essex
			08	Gloucester
			09	Hudson
			10	Hunterdon
			11	Mercer
			12	Middlesex
			13	Monmouth
			14	Morris
			15	Ocean
			16	Passaic
			17	Salem
			18	Somerset
			19	Sussex

COUNTY OF RESIDENCE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	20	Union
			21	Warren

17.13 – LANGUAGE CODES

LANGUAGE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2100A	LUI	LUI02	ARA	Arabic
			CHI	Chinese
			ENG	English
			FRE	French
			GER	German
			GRE	Greek
			HEB	Hebrew
			HIN	Hindi
			HUN	Hungarian
			ITA	Italian
			JPN	Japanese
			JOR	Korean
			PER	Persian
			POL	Polish
			POR	Portuguese
			RUS	Russian
			SPA	Spanish
			TAG	Tagalong
			TUR	Turkish
			VIE	Vietnamese
			UND	Undisclosed

17.14 –RACE CODES

RACE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2100A	DMG	DMG05	C	White
			B	Black
			I	American Indian
			H	Latin American
			7	Other or not provided

17.15 – PATIENT RESIDENCE CODES

PATIENT RESIDENCE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
AM01	01	384-4X	00	Not Specified
			01	Home
			02	Skilled Nursing Facility (For Medicare Part B use only)
			03	Nursing Facility (To be used for Nursing Homes)
			04	Assisted Living Facility (To be used for Assisted Living Facilities)
			05	Custodial Care Facility (For Medicare Part B use only)
			06	Group Home
			09	Intermediate Care Facility/Mentally Retarded
			11	Hospice
			15	Correctional Institution

17.16 – OTHER PAYER COVERAGE TYPE CODES

OTHER PAYER COVERAGE TYPE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
AM05	05	338-5C	blank	Not Specified
			01	Primary – First
			02	Secondary – Second
			03	Tertiary – Third
			04	Quaternary – Fourth
			05	Quinary – Fifth
			06	Senary – Sixth
			07	Septenary – Seventh

OTHER PAYER COVERAGE TYPE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
AM05	05	338-5C	08	Octonary – Eighth
			09	Nonary – Ninth

17.17 – ORAL CAVITY DESIGNATION CODES

ORAL CAVITY DESIGNATION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2400	SV3	SV304	00	Entire Oral Cavity
			01	Maxillary Area
			02	Mandibular Area
			09	Other Area of Oral Cavity
			10	Upper Right Quadrant
			20	Upper Left Quadrant
			30	Lower Left Quadrant
			40	Lower Right Quadrant
			L	Left
			R	Right

17.18 – ENROLLMENT TYPE CODES

ENROLLMENT TYPE CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	A	Central Office
			E	Individual exempt from HMO enrollment (MHC Plan Code 99)
			S	HMO Selected by Individual

17.19 – COUNTY OF SUPERVISION CODES

COUNTY OF SUPERVISION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04		**The following codes Identify the County Welfare Agency (CWA), DYFS District Office, Medical Assistance Customer Care (MACC) office, ISS Office, or Eligibility Vendor which has supervisory responsibility for the individual.**
			001	Atlantic
			002	Bergen

COUNTY OF SUPERVISION CODES				
LOOP	**SEGMENT**	**FIELD**	**CODE**	**DESCRIPTION**
2300	HD	HD04	003	Burlington
			004	Camden
			005	Cape May
			006	Cumberland
			007	Essex
			008	Gloucester
			009	Hudson
			010	Hunterdon
			011	Mercer
			012	Middlesex
			013	Monmouth
			014	Morris
			015	Ocean
			016	Passaic
			017	Salem
			018	Somerset
			019	Sussex
			020	Union
			021	Warren
				Institutional Codes
			010	(600,000 series) Sen. Garrett W. Hagedorn Center for Geriatrics (LTC)
			031	Greystone Park Psychiatric Hospital (2)
			032	Trenton Psychiatric Hospital (4)
			032	(300,000 series) Forensic Psychiatric Hospital
			032	(600,000 series) Sen. Garrett W. Hagedorn Center for Geriatric
			033	Marlboro Psychiatric Hospital (2)
			033	(300,000 series) Edison Habilitation Center Melmark ICF/MR
			034	Ancora Psychiatric Hospital (4)
			034	(800,000 series) Ancora Development Center (Program Number = 10, 20 or 60 and Person Number = 02)
			035	North Princeton Developmental Center (4)
			035	Behavioral Health (cases starting with 3560)
			036	Arthur Brisbane Child Treatment Center (2)

COUNTY OF SUPERVISION CODES				
LOOP	**SEGMENT**	**FIELD**	**CODE**	**DESCRIPTION**
2300	HD	HD04	037	Bergen Pines Hospital (2)
			037	(600,000 series) Meadowview Psychiatric Hospital
			038	Essex County Hospital Center (2)
			039	Camden County Health Services Center (4)
			041	Vineland Development Center (4)
			042	North Jersey Development Center (2)
			043	Green Brook Regional Center (2)
			044	Woodbine Development Center (4)
			045	New Lisbon Development Center (2)
			046	Obsolete (used to be Johnstone (4))
			047	Woodbridge Development Center (2)
			048	Hunterdon Development Center (4)
			050	General Assistance Program (GA)
			051	NJ Veterans' Memorial Home (Vineland)
			051	(100,000 series) NJ Veterans' Memorial Home (Menlo Park) (Program Number = 10 or 20)
			051	(200,000 series) NJ Veterans' Memorial Home (Paramus) (Program Number = 10 or 20)
			052	57 General Assistance Program (GA)
			058	Cystic Fibrosis Program
			059	AIDS Drug Distribution Program (ADDP)
			090	Division of Developmental Disabilities (4)
				ISS Offices
				ISS Offices maintain enrollment for the institutionalized population and are noted above in ().
			2	Central (Paterson/Marlboro)
			4	South (Trenton/Hammonton)
				DMAHS Offices
			055	Retroactive Eligibility
			056	Good Faith Eligibility
				Family Care
			023	Family Care Plan A, HBC Vendor
			024	Family Care Plan B and C and D, HBC Vendor
			025	PE for Family Care
				Medical Assistance Customer Care (MACC)Offices
			070	Passaic, Bergen, Morris, Sussex, Warren

COUNTY OF SUPERVISION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	071	Atlantic, Cape May, Cumberland
			072	Burlington, Mercer (merged with 073)
			073	Camden, Gloucester, Salem, Burlington, Mercer
			074	Essex
			075	Hudson
			076	Middlesex, Hunterdon, Somerset, Union (merged with 077)
			077	Monmouth, Middlesex, Hunterdon, Somerset, Union, Ocean (Case number '33' with county of supervision 079 are Household of One)
			078	Morris, Sussex, Warren (merged with 070)
			079	Ocean (merged with 077)
			099	General Assistance

17.20 – DISENROLLMENT REASON CODES

DISENROLLMENT REASON CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HD	HD04	DI	DDD Institution (Plan 099 Only)
			IN	Institutionalized
			PI	Psychiatric Institution (Plan 099 Only)

17.21 – INSTITUTIONAL CONDITION CODES

INSTITUTIONAL CONDITION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HI	HI01-2	01	Military Service Related
			02	Condition is Employment Related
			03	Patient Covered by Insurance Not Reflected Here
			05	Lien Has Been Filed
			08	Beneficiary Would Not Provide Insurance Coverage Information
			10	Patient and/or Spouse is Employed But No EGHP Coverage Exists
			40	Same Day Transfer
			41	Partial Hospitalization
			81	Medically Necessary C-Section or Induction
			82	Second Newborn*

INSTITUTIONAL CONDITION CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	HI	HI01-2	83	Third Newborn*
			84	Dialysis for Acute Kidney Injury
			M4	Fourth Newborn
			A0	CHAMPUS External Partnership Program
			A1	EPSDT/CHAP
			A2	Physically Handicapped Children's Program
			A3	Special Federal Funding
			A4	Family Planning
			A5	Disability
			A6	Vaccines/Medicare 100% Payment
			A9	Second Opinion Surgery
			AA	Abortion Performed due to Rape
			AB	Abortion Performed due to Incest
			AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality
			AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from Or Exacerbated by the Pregnancy Itself
			AE	Abortion Performed due to Physical Health of the Mother that is not Life Endangering
			AF	Abortion Performed due to Emotional/Psychological Health of the Mother
			AG	Abortion Performed due to Social or Economic Reasons
			AH	Elective Abortion

17.22 – SPECIAL PROGRAM CODES

SPECIAL PROGRAM CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	REF	REF02	03	CRPD - Private Duty Nursing (PDN) (no longer effective after 7/1/14)
			04	CRPD - not used (old Model Waiver I)
			05	ACCAP Waiver (no longer effective after 7/1/14)
			06	CRPD - no PDN (no longer effective after 7/1/14)
			07	DDD Community Care Waiver
			08	CCPED Waiver
			09	HCEP Waiver
			10	Ineligible Alien
			11	Alien Undocumented (no longer effective as of 10/1/15)

SPECIAL PROGRAM CODES				
LOOP	**SEGMENT**	**FIELD**	**CODE**	**DESCRIPTION**
2300	REF	REF02	12	Cover All Kids (CAK) (No federal match)
			13	Transfer of Assets
			14	Reserved for Qualified Income Trust (QIT)
			15	Hospice (no longer effective after 7/1/15)
			16	ABC DYFS Waiver
			17	TBI Waiver (no longer effective after 7/1/14)
			18	Illegal Alien (no longer effective as of 10/1/15)
			19	CSS-Generic SH
			20	CSS-RIST (Residential Intensive Support Team)
			21	CSS-DD/MI
			22	ALT Family Care
			23	CSS-MESH (Medically Enhanced Supportive Housing)
			24	CSS-Forensically Involved
			25	CSS-ESH (Enhanced Supportive Housing)
			26	CSS-RIST MESH (Residential Intensive Support Team-Medically Enhanced Supportive Housing)
			27	DDD IDD/OOS (Intellectual Developmental Disability/Out of State NJ residents (reserved for future initiative)
			28	Alternate/CPCH
			29	Asst. Liv. Residence
			30	Asst. Living Program
			31	CAP Waiver
			32	Global Option (no longer effective after 7/1/14)
			33	Fast Track Eligibility for Global Options
			34	AL/AFC Reserved 34
			35	AL/AFC Reserved 35
			36	AL/AFC Reserved 36
			37	DCF/CSOC SED CSOC Enrolled - Y or S
			38	DCF/CSOC IDD/MI CSOC Enrolled - I
			39	CSS At Risk Supportive Housing
			40	Restricted Alien
			41	ADDP Limited Coverage
			45	Reserved for Supports+PDN
			46	DDD Support
			47	DCF/CSOC ASD Waiver (9K Fed Match Cap) CSOC Enrolled = L
			48	DCF/CSOC ASD Waiver (18K Fed Match Cap) CSOC Enrolled = M

SPECIAL PROGRAM CODES				
LOOP	SEGMENT	FIELD	CODE	DESCRIPTION
2300	REF	REF02	49	DCF/CSOC ASD Waiver (27K Fed Match Cap) CSOC Enrolled = H
			50	Premium Support (Large Employer no FFS wraps)
			51	Premium Support Plan A
			52	Premium Support Plan B
			53	Premium Support Plan C
			54	Premium Support Plan D
			55	Reserved for Premium Support
			56	Reserved for Premium Support
			58	Reserved for Premium Support
			59	Premium Support Transitional
			60	Home and Community (effective 7/1/14)
			61	Nursing Facility (effective 7/1/14)
			62	Assisted Living (effective 7/1/14)
			63	Skilled Nursing Facility Upper (Pediatric and Vent) (effective 7/1/14)
			64	Skilled Nursing Facility Lower (Other) (effective 7/1/14)
			65	Managed Care Exemption: NF Members (effective 7/1/14)
			66	Managed Care Exemption: SNF Upper Members (effective 7/1/14)
			67	Managed Care Exemption: SNF Lower Members (effective 7/1/14)
			75	Money Follows Person (MFP) Grant
			76	MFP (SPC 75) & CRPD Waiver (SPC 03)
			77	MFP (SPC 75) & CRPD Waiver (SPC 06)
			78	MFP (SPC 75) & CCP Waiver (SPC 07)
			79	MFP (SPC 75) & TBI Waiver (SPC 17)
			80	MFP (SPC 75) & Global Options (SPC 32)
			81	MFP (SPC 75) & MLTSS Community (SPC 60) or Asst. Living (SPC 62)
			98	Incarcerated - State Prison
			99	Incarcerated - County Prison

SECTION 18 – DATA TRANSMISSION AND RETRIEVAL

18.1 – NJ SPECIFIC REQUIREMENTS TESTING

New Jersey Medicaid offers testing for NJ specific requirements as stated in the NJ Medicaid HMO Encounters Systems Guide. Submitters wishing to test the NJ specific requirements must have an approved EDI Agreement on file with Gainwell Technologies including a valid HIPAA Certification for the transaction type they wish to test.

Test files must be submitted using the **HIPAA Submitter Login** link on the NJMMIS website at www.njmmis.com and may contain a maximum of 1,000 claims. Files containing more than 1,000 claims will be rejected. Refer to section 18.6 Logging In To Website for instructions on submitting files via the website.

Summary and detail test result files in a semi-colon delimited format will be available for downloading from the download link on the "Upload or download HIPAA files" prompt on the website. Test 835 E-RA files are also produced as part of the testing process. These files will be available after 09:00 a.m. Eastern Time the following morning the test files are sent.

18.2 – TRANSLATOR REPORTS AND EDITS

New Jersey Medicaid will be using IBM's Integrated Transformation Extender (ITX) (formerly WebSphere) as our translator for HIPAA 837 transactions submitted as production data. HIPAA Transactions submitted as test data (ISA15 Usage Indicator entered as "T"); will only be edited at the first level of validation as described below.

Validation of HIPAA interchanges will be done at four different levels of processing. The type of notification to the submitter will depend on where in the process the editing is executed.

1. The first level of 837 interchange editing will be at the point of receipt. A TA1 Interchange Acknowledgement will be sent to the EDI Submitter upon completion of uploading (dropping-off) their 837 interchanges. If the submitter disconnects immediately after uploading and does not receive the TA1 then a TA1 status is available on the Web site indicating the TA1 status of the file. Conveyed in this acknowledgement will indicate whether the transmitted interchange was accepted for further processing or rejected. A rejection at this level will indicate the interchange needs immediate correction before additional processing can commence. Please refer to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 for details of the TA1 error codes.

   Interchanges will reject at this level for the following conditions:

   - Duplicate Interchange Control Number received for same Submitter (duplicate file received)
   - Interchanges containing Carriage Return/Line Feed characters following the Segment Terminator
   - Invalid Segment Terminator
   - Invalid Subsequent Separator
   - Invalid Interchange Content
   - Submitter ID is not the same in ISA and GS records
   - Receiver ID is not the same in the ISA or GS Records

2. The second level of 837 interchange editing will be performed as part of the ITX translator processing and will result in the creation of a 999 Implementation Acknowledgement for the EDI Submitter to retrieve indicating additional validation of the interchange. Validation is done on a one-to-one correspondence between the functional group, transactions sets or segments within the interchange. Data elements in error will be identified in these acknowledgements and will indicate whether the transmitted interchange is accepted or rejected and if correction and resubmission is required before additional processing is commenced. HIPAA Transactions submitted as test data (ISA15 Usage Indicator entered as "T") will not be processed thru this level of editing and will not receive a 999 Acknowledgement. Please refer to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 for details.

3. The third level of 837 interchange editing will be performed in the NJMMIS preprocessing after the ITX translator processing and will be related to the EDI Submitter/Provider relationship information. Errors found in this level of editing will be identified on the HIPAA Claims Rejected Report. The HIPAA Claims Rejected Report in a semi-colon delimited file is sent to the Web site for the EDI Submitter to retrieve and import to a spreadsheet application. For those that do not have Internet capabilities the error report produced at this level of editing will be sent to the EDI Submitter via USPS mail for correction of the transaction sets in which the error was encountered. Samples of the HIPAA Claims Rejected Reports produced are provided later in this section.

3rd Level Of Editing - NJMMIS Preprocessing
HIPAA Claims Rejected Report
Pre-Processing Edit and Description
Billing Provider Not Valid
Provider Not Valid For Submitter
Transaction Type, Effective Date, Media Type Not Valid For This Submitter
Acute Days Validation (Cannot Exceed 999)
ICF Days Validation (Cannot Exceed 999)
SNF Days Validation (Cannot Exceed 999)
Residential Days Validation (Cannot Exceed 999)
Revenue Units Validation (Cannot Exceed 999)
Units Of Service Validation (Cannot Exceed 999)
Revenue Code Validation (Cannot Exceed 999 And Cannot Equal 0)

```
REPORT ID: WC033R03          STATE OF NEW JERSEY                              PAGE  1
RUN DATE:  12/31/2010     DEPARTMENT OF HUMAN SERVICES
                  DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

                        ENCOUNTER  HIPAA CLAIMS REJECTED REPORT

SUBMITTER ID: 7700000    SUBMITTER NAME:  EDI TRADING PARTNER NAME
                       INTERCHANGE CONTROL NBR:  032880001

 PROVIDER ID:  1234567    PROVIDER NAME:   NJ MEDICAID PROVIDER NAME       *

 CLM # 5  EDIT: 435 UNABLE TO DEFINE CLM TYP
          PAT ACC # 000000000001 CLM TYP: 99 RCN: 0328853730801 CLM CHRG: 14,143.00
 CLM # 6  EDIT: 435 UNABLE TO DEFINE CLM TYP
          PAT ACC # 000000000002 CLM TYP: 99 RCN: 0328853730901 CLM CHRG: 64,273.00

                       NBR CLMS GENERATED:         6     CLAIM CHRGS:      144,936.00
                       NBR CLMS ACCEPTED :         4     CLAIM CHRGS:       66,520.00
                       NBR CLMS REJECTED :         2     CLAIM CHRGS:       78,416.00

  >>   INTERCHANGE TOTALS: TOT CLMS =         6     TOT CHRGS =       144,936.00
       TOTAL PROVIDERS =       1
```

```
 RUN DATE ;SUBM ID;   SUBM NAME  ;INTERCHNG; PROV NPI ;PROV ID;          PROV NAME ;CLM # ;REJ CODE;          REJ DESC           ;CLM TYPE;       PAT #     ;   REJ #     ;CLM CHARGES;
12/31/2010;7700000;SUBMITTER NAME;000001234;0770000089;1234567;PROVIDER     NAME,MD; 1,458;   271  ;SUB/PRV INELIG ON CLM-ACTV-DT;   02   ;PATIENT ACCOUNT #;0908253435901;       0.00;
          ;       ;              ;         ;0770000089;1234567;TOTAL CLAIMS        ;     1;        ;                              ;        ;                 ;TOTAL CHARGES;       0.00;
          ;       ;              ;         ;          ;       ;                    ;      ;        ;                              ;        ;                 ;             ;            ;
 RUN DATE ;SUBM ID;   SUBM NAME  ;INTERCHNG; PROV NPI ;PROV ID;          PROV NAME ;CLM # ;REJ CODE;          REJ DESC           ;CLM TYPE;       PAT #     ;   REJ #     ;CLM CHARGES;
12/31/2010;7700000;SUBMITTER NAME;100001234;1111111111;       ;PROVIDER NOT ON FILE;   403;   206 ;BILLING PROVIDER NOT ON FILE ;   01   ;PATIENT ACCOUNT #;0908254648901;     189.00;
12/31/2010;7700000;SUBMITTER NAME;100001234;1111111111;       ;PROVIDER NOT ON FILE;   404;   206 ;BILLING PROVIDER NOT ON FILE ;   03   ;PATIENT ACCOUNT #;0908254649001;     250.00;
          ;       ;              ;         ;1111111111;       ;TOTAL CLAIMS        ;     2;        ;                              ;        ;                 ;TOTAL CHARGES;     439.00;
          ;       ;              ;         ;          ;       ;                    ;      ;        ;                              ;        ;                 ;             ;            ;
 RUN DATE ;SUBM ID;   SUBM NAME  ;INTERCHNG; PROV NPI ;PROV ID;          PROV NAME ;CLM # ;REJ CODE;          REJ DESC           ;CLM TYPE;       PAT #     ;   REJ #     ;CLM CHARGES;
12/31/2010;7700000;SUBMITTER NAME;110001234;1100000123;       ;PROVIDER NOT ON FILE;    61;  1240 ;PROVIDER NOT MAPPED - BILLING;   04   ;PATIENT ACCOUNT #;0908254374401;     126.00;
12/31/2010;7700000;SUBMITTER NAME;110001234;1100000123;       ;PROVIDER NOT ON FILE;    79;  1240 ;PROVIDER NOT MAPPED - BILLING;   13   ;PATIENT ACCOUNT #;0908254374901;     132.36;
12/31/2010;7700000;SUBMITTER NAME;110001234;1100000123;       ;PROVIDER NOT ON FILE;    80;  1240 ;PROVIDER NOT MAPPED - BILLING;   13   ;PATIENT ACCOUNT #;0908254374902;     132.36;
12/31/2010;7700000;SUBMITTER NAME;110001234;1100000123;       ;PROVIDER NOT ON FILE;    81;  1240 ;PROVIDER NOT MAPPED - BILLING;   04   ;PATIENT ACCOUNT #;0908254375001;     273.60;
12/31/2010;7700000;SUBMITTER NAME;110001234;1100000123;       ;PROVIDER NOT ON FILE;    82;  1240 ;PROVIDER NOT MAPPED - BILLING;   04   ;PATIENT ACCOUNT #;0908254375101;     508.91;
          ;       ;              ;         ;1100000123;       ;TOTAL CLAIMS        ;     5;        ;                              ;        ;                 ;TOTAL CHARGES;   1,173.23;
          ;       ;              ;         ;          ;       ;                    ;      ;        ;                              ;        ;                 ;             ;            ;
 RUN DATE ;SUBM ID;   SUBM NAME  ;INTERCHNG; PROV NPI ;PROV ID;          PROV NAME ;CLM # ;REJ CODE;          REJ DESC           ;CLM TYPE;       PAT #     ;   REJ #     ;CLM CHARGES;
12/31/2010;7700000;SUBMITTER NAME;111001234;7700000890;1234567;PROVIDER     NAME,MD;    15;   271  ;SUB/PRV INELIG ON CLM-ACTV-DT;  11   ;PATIENT ACCOUNT #;0908254375461;     148.00;
          ;       ;              ;         ;0770000089;1234567;TOTAL CLAIMS        ;     1;        ;                              ;        ;                 ;TOTAL CHARGES;     148.00;
          ;       ;              ;         ;          ;       ;                    ;      ;        ;                              ;        ;                 ;             ;            ;
 RUN DATE ;SUBM ID;   SUBM NAME  ;INTERCHNG; PROV NPI ;PROV ID;          PROV NAME ;CLM # ;REJ CODE;          REJ DESC           ;CLM TYPE;       PAT #     ;   REJ #     ;CLM CHARGES;
12/31/2010;7700000;SUBMITTER NAME;000011234;0770000089;1234567;PROVIDER     NAME,MD;     4;   271  ;SUB/PRV INELIG ON CLM-ACTV-DT;  07   ;PATIENT ACCOUNT #;0908254375611;     130.00;
          ;       ;              ;         ;0770000089;1234567;TOTAL CLAIMS        ;     1;        ;                              ;        ;                 ;TOTAL CHARGES;     130.00;
```

The fourth level of 837 interchange editing will be performed in the NJMMIS Claims Adjudication Cycle, which is performed over the weekend. Errors found at this level of editing will be conveyed as Adjustment Reason and Remark Codes in the 835 Health Care Claim Payment/Advice file and on the hard copy remittance advice.

18.3 – PHARMACY EMC PROOF REPORTS

Pharmacy EMC Proof Reports are error reports that are e-mailed to the NCPDP 1.2 batch submitters to report an error(s) found for a particular transaction(s) within the NCPDP 1.2 batch file processed by the NJMMIS System. The error message, "Parsing error for segment(s)" will be reported in the response file for the transaction(s) that contained an error in the format structure for a particular transaction(s) disallowing the transaction to adjudicate. The transaction containing the error will be reported in the Record Number column of the error report.

```
REPORT ID: WC020R03                          STATE OF NEW JERSEY                          PAGE:   1
RUN DATE:  12/30/2011                    DEPARTMENT OF HUMAN SERVICES
                              DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
                                       PHARMACY EMC ENCOUNTER PROOF REPORT

FILE NAME : 7700000_0001234.dat    SUBMITTER ID : 7700000  DATE PROCESSED : 12/30/2011

    RECORD NUMBER         SEGMENT NUMBER          FIELD NAME
   ---------------        --------------          ----------
               91               HD

RECORDS RECEIVED -       753   RECORDS ON TRAILER -      753   CLAIMS ADJUDICATED -    750
NUMBER OF FORMAT ERRORS -             1    FORMAT ERRORS FOUND ON THIS FILE
```

Transactions containing errors should be corrected and resubmitted in the next batch for processing.

18.4 – INTERNET SPECIFICATIONS

New Jersey Medicaid and Gainwell Technologies have deployed an Internet-based solution that will allow the electronic exchange of HIPAA transactions through the **HIPAA Submitter Login** link on the NJMMIS Web site (www.njmmis.com). HIPAA interchanges can be sent seven days a week, Sunday thru Saturday, with the following exceptions, which have been scheduled as maintenance windows.

- Thursdays, 8 p.m. thru Friday 12.00 a.m. and
- Saturdays, 8 p.m. thru Sundays 4 a.m., Eastern time

EDI Submitters using the Web site will drop-off 837 5010 and NCPDP 1.2 & D.0 transactions and pick-up TA1, 999 and 835 transactions through a secure area of the New Jersey Medicaid Web site. A valid username and password is required before access is granted for drop-off and pick-up.

18.5 – SUBMITTER REGISTRATION - OBTAINING A USERNAME AND PASSWORD

EDI Submitters will receive their Username and Password via the United States Postal Service mail upon verification of their HIPAA Certification for the specified HIPAA transaction sets. EDI Submitters will be registered on the submitter database via their EDI Submitter Agreement and certification documentation.

Submitters are expected to maintain their own passwords and will be able to change their password thru a link on the **HIPAA Submitter Login** page of the NJMMIS Web site. Within 5 business days, your username and password will be sent to the Submitter information listed on the NJMMIS Gainwell Technologies Submitter database, via the United States Postal Service mail.

18.6 – LOGGING IN TO WEB SITE

1. After receiving your username and password, access the Web site (www.njmmis.com) and select the **HIPAA Submitter Login** link from the menu options on left side of screen.

2. Enter your username and password and click on Submit.

3. On the **Welcome to the New Jersey Medical Assistance Program Transaction Services Home** screen click on the upload link at the "• Upload or download HIPAA files" prompt to upload files for processing.

   - Only files in the approved HIPAA and NCPDP formats may be uploaded.
   - You can upload up to five files at a time. All files being submitted must be of the same type as indicated in the file type selection area. (i.e. Up to five NCPDP 1.2 batch files can be submitted at one time. If you wish to also submit 837 – 5010X222A1 Professional files these must be sent after the previous file type has been submitted.)
   - Users should allow 30 seconds or more before submitting additional files allowing for the TA1 to be created and returned to the user.
   - The optimal file size recommendation for efficient 837 and NCPDP 1.2 file transfers, processing, and analysis by Gainwell Technologies EDI staff is 5MB or less.
   - 837 files are recommended to not exceed a maximum file size of 40MB. And, in agreement with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, it is recommended that submitters limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments.
   - NCPDP 1.2 files are recommended to not exceed a maximum file size of 20MB.
   - While files up to a maximum size of 40MB for 837 and 20MB for NCPDP 1.2 may be submitted, Gainwell Technologies will not perform detailed analysis on files in excess of 5MB when assisting submitters in resolving errors resulting in the full or partial rejection of a submission. Submitters requiring the technical assistance of Gainwell Technologies EDI staff will be requested to resubmit the encounters in question with one or more files where the file size does not exceed 5MB.
   - If multiple 837 files are being submitted at one time within a compressed file, the combined file sizes must not exceed 40 MB.
   - The combined file size for zipped files must not exceed 20MB for NCPDP 1.2 batch files and 40MG for 837 files. (i.e. If multiple files are being submitted at one time the combined file sizes must not exceed 40MG for 837 files and 20MB for NCPDP 1.2 files.
   - Files can be in ZIP or DAT format only. Please refer to the section on Interchange Naming Convention discussed later in this section for additional information regarding compressed files and naming conventions.

4. Click on the download link at the "• Upload or download HIPAA files" prompt to download (pick-up) your 835 remittance files and HIPAA Claims Rejected Report files.

   - 835 Health Care Claim Payment/Advice remittance files are available for downloading the following Wednesday after your file has been submitted as long as your submission is received and accepted for processing within the published submission deadlines. Please refer to the EDI Submission Deadlines discussed later in this section. 835 files are split into separate files using the following naming convention with each file containing remittance data per the associated file name.

     <submitter id>_PROF_<mm>-<dd>-<yy>.ZIP <submitter id>_PHRM_<mm>-<dd>-<yy>.ZIP
     <submitter id>_INST_<mm>-<dd>-<yy>.ZIP <submitter id>_DENT_<mm>-<dd>-<yy>.ZIP

- 835 and Remittance interchanges are retained on the web site for 6 weeks.
- HIPAA Claims Rejected Report files in a semi-colon delimited format are available for downloading the next morning following the nightly preprocessing of your file as long as your submission is received and accepted for processing.

5. Click on the Recent Uploads link of the "• View a list of Recent Uploads" prompt to view TA1 and NCPDP acknowledgments and to download (pick-up) 999 acknowledgements.

   - TA1 acknowledgements are displayed as text messages indicating Accepted; No Error or Rejected; indicating type of error detected. These are not available for downloading.
   - 999 acknowledgements are available for downloading no more than three hours after the TA1 has been received.
   - NCPDP acknowledgements are displayed as text messages indicating Accepted; No Error or Rejected; indicating type of error detected. These are not available for downloading.

18.7 – INTERCHANGE NAMING CONVENTION

Regardless of the transaction type HIPAA 837 or NCPDP D.0/1.2 transactions, New Jersey Medicaid will support the DOS file-naming convention of 8-characters followed by a 3-character extension. The file name format MUST be **one alphabetic character (A – Z)** or **one numeric character (0 – 9)** or **one of the following six special characters (~, @, #, $, %, ^),** followed by **the 7-digit EDI Submitter ID Number** (assigned by Gainwell Technologies) with **the REQUIRED 3-character extension of .DAT**. The eight special characters listed are the only special characters that will be allowed. If any other special characters are used, the file will be rejected at the time of submission.

Example: A7700000.DAT or 07700000.DAT or #7700000.DAT

Any interchanges that do not follow this naming convention will NOT be processed. The EDI Submitter number in the interchange name MUST match the EDI Submitter number in the ISA. An EDI submitter may reuse the same file name used for a file previously submitted on the same day after the EDI submitter has received the TA1 acknowledgement for the previously submitted file.

As stated in the TR3 it is recommend that trading partners limit the size of the transaction sets (ST-SE envelope) to a maximum of 5,000 CLM segments.

Regardless of the media of submission, New Jersey Medicaid also recommends that EDI submissions NOT exceed 40 megabytes for 837 interchanges and 20 megabytes for NCPDP 1.2 files. **EDI submissions with file properties set to "READ ONLY" will NOT be accepted.**

Multiple interchanges may be sent daily however an EDI Submitter is NOT to exceed more than **999** interchanges in a day (from the period of midnight to midnight).

Only one ISA must be contained within a file and the file must contain only one file type, Professional, Institutional, Dental or NCPDP 1.2 per file. If the Submitter sends multiple file types they must be sent as separate submissions. (i.e. one file containing one ISA including encounters in the 837 – 005010X223A2 Institutional format only; one file containing one ISA including encounters in the 837 – 005010X224A2 Dental format only; one file containing one ISA including encounters in the 837 – 005010X222A1 Professional format only; one file containing NCPDP 1.2 encounters only.)

Multiple files may be submitted in a compressed format with a .zip file extension, but again the .zip file must contain only one file type, all Institutional, Dental, Professional or NCPDP 1.2 format encounters only. (i.e. multiple files within one .zip file, all files containing only one ISA and all included encounters are in one 837 – 005010 or NCPDP 1.2 format only.)

- #7700000.zip - Compressed file
- A7700000.dat – 1st file in compressed file, all Institutional encounters
- B7700000.dat – 2nd file in compressed file, all Institutional encounters
- C7700000.dat – 3rd file in compressed file, all Institutional encounters

18.8 –EDI SUBMISSION VERIFICATION

TA1 Interchange Acknowledgements will be available to the EDI Submitter upon completion of uploading (dropping-off) their interchanges on the Web site as long as the submitter stays connected. If the submitter disconnects immediately after dropping-off their interchange and does not receive their TA1, the TA1 acknowledgement will be displayed as a text message indicating Accepted; No Error or Rejected; indicating type of error detected.

999 Implementation Acknowledgements will be available for downloading to the EDI Submitter no more than three hours after the TA1 has been received. **999 Implementation Acknowledgements are retained for 30 days.**

HIPAA Claims Rejected Report files in a semi-colon delimited format will be available for downloading to the EDI Submitter the morning following the nightly preprocessing. **HIPAA Claims Rejected Reports are retained for 6 weeks.**

835 Health Care Claim Payment/Advices from the Web site will be available for downloading to the EDI Submitter the following Wednesday after the file has been submitted as long as your submission is received within the published submission deadlines. **835 Remittance files are retained for 6 weeks.**

Submitters will NOT be able to retrieve "paper format" Remittance Advice data from the Web site. **Only approved Providers will be allowed to retrieve "Paper Format" Remittance Advice data from the Web site.**

It is strongly recommended that for accurate reconciliation of your 999 Acknowledgements to the corresponding 837 Interchange that the Group Control Numbers entered in the GS/GE segments be unique for each interchange submitted by an EDI Submitter. The GS06/GE02 - Group Control Number from the incoming 837 is returned in the outgoing 999. If it is your practice to have only one GS segment in an interchange we suggest the GS06/GE02 - Group Control Number be the same as the ISA13/IEA02 – Interchange Control Number. When the same value (0001) is entered as the GS06/GE02 - Group Control Number, it is impossible to reconcile.

Below are examples of this situation:

- One zip file is submitted containing six (6) Interchanges
- Each ISA/IEA Interchange Control Number is unique for each Interchange included within the file
- All Interchanges have the same GS06/GE02 number
- 999 Acknowledgements are returned back to the Submitter for each of the six (6) Interchanges included within the zip file

- Five 999 Acknowledgements report as Accepted
- One 999 Acknowledgement reports as Rejected
- All 999 Acknowledgement reports are returned with the originator's GS06/GE02 - Group Control Numbers (00001)

#7700000.ZIP

Interchange	GS06/GE02 #	Interchange	GS06/GE02 #	Interchange	GS06/GE02 #
A7700000.dat	00001	B7700000.dat	00001	C7700000.dat	00001
D7700000.dat	00001	E7700000.dat	00001	F7700000.dat	00001

999 Acknowledgement	ST02/SE02- GS06/GE02 #	999 Acknowledgement	ST02/SE02- GS06/GE02 #	999 Acknowledgement	ST02/SE02- GS06/GE02 #
9990000.dat	00001	9990000.dat	00001	9990000.dat	00001
9990000.dat	00001	9990000.dat	00001	9990000.dat	00001

- Which Interchange with GS06/GE02 - Group Control Numbers (00001) Rejected?

It is for this reason that we have determined that the uniqueness of the GS06/GE02 - Group Control Numbers is mandatory for the accuracy of 999 Acknowledgement processing and reconciliation and have added this to our HIPAA Companion Guide as a Trading Partner requirement.

18.9 – EDI SUBMISSION DEADLINES

All EDI submissions must be received no later than close of business (5:00 p.m., Eastern time) on the Wednesday before the upcoming Adjudication Cycle to be included in that week's adjudication cycle. Exceptions may be made for weeks containing a Gainwell Technologies holiday. Please refer to the FAQ link on the www.njmmis.com Web site for the Submission Deadline Schedule.