

Companion Document For
ANSI ASC X12N 837 4010A1 Claim Submission To
Blue Cross and Blue Shield of Alabama
For Dental Claims
March 15, 2008

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States, comply with the EDI standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837 implementation guides have been established as the standards of compliance for electronic claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI ASC X12N 837 implementation guides. The table contains specific requirements to be used for processing data in the Blue Cross and Blue Shield of Alabama dental claims processing system.

The use of this document is solely for the purpose of clarification. This document supplements, but does not contradict any requirements in the ANSI ASC X12N implementation guides. Additional companion documents are available for Professional 837, Institutional 837 and other HIPAA standards.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
1.	----	----	The maximum number of characters to be submitted in a dollar amount field is nine characters. Claims in excess of 9,999,999.99 will be rejected.
2.	----	----	Blue Cross and Blue Shield of Alabama will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Dental processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
3.	----	----	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
4.	----	----	The incoming 837 transactions utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), (pipe), and ^ (carrot). Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected. Preferred delimiters are: ~ (tilde) for segment separators, * (asterisk) for data element separators and : (colon) or > (greater than) for component data element separators. The usage of these characters within text data elements in the incoming 837 transaction may cause problems with creation of subsequent transactions, including the outbound 837 and the 835.
5.	----	----	Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected and not sent for processing consideration.
6.	----	----	All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).

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7.	-----	-----	Blue Cross and Blue Shield of Alabama will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).
8.	-----	-----	Blue Cross and Blue Shield of Alabama will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
9.	-----	-----	Blue Cross and Blue Shield of Alabama will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
10.	-----	-----	Blue Cross and Blue Shield of Alabama will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Dental Implementation Guide.
11.	-----	-----	We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission. A TA1 segment (Interchange Acknowledgment) will be returned in the 997.
12.	-----	-----	Compression of files is supported for transmissions between the submitter and Blue Cross and Blue Shield of Alabama. Any compression software compatible with PKZIP by PKWARE, Inc. is supported.
13.	-----	-----	Use the following format when submitting Blue Cross and Blue Shield of Alabama provider numbers: 0(leading zero) + plan code + provider number (i.e. 051012345).
14.			When submitting text in free format fields, such as name and address, a hyphen (-) is the only special character allowed. Any names with apostrophes (') can be submitted with or without a space in the place of the apostrophe.
15.	-----	Interchange Control Header	Use your 8-character CLIENTID followed by 7 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID.
16.	-----	Interchange Control Header	Use ZZ in ISA07 as the Interchange ID Qualifier.

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17.	-----	Interchange Control Header	Use 00510DN followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID.
18.	-----	Functional Group Header	Use your 8 character CLIENTID in GS02 as the Application Sender's Code.
19.	-----	Functional Group Header	Use 00510DN in GS03 as the Application Receiver's Code.
20.	2000B	Subscriber Hierarchical Level	The HL segment must be in order from one, by one (+1) and must be numeric.
21.	2010AA	Billing Provider Name	Use XX in NM108 and the appropriate NPI number in NM109.
22.	2010AA	Billing Provider Address	Include address information for the billing provider in N3.
23.	2010AA	Billing Provider City/State/Zip Code	Include the city, 2-character state code, and 9-digit zip code for the billing provider in N4.
24.	2010AA	Billing Provider Secondary Identification Number	Use TJ or EI in REF01 and Tax ID in REF02.
25.	2010AB	Pay-to Provider Name	Use XX in NM108 and the appropriate NPI number in NM109.
26.	2010AB	Pay-to Provider Address	Include address information for the pay-to provider in N3.
27.	2010AB	Pay-to Provider City/State/Zip Code	Include the city, 2-character state code, and 9-digit zip code for the pay-to provider in N4.
28.	2010AB	Pay-to Provider Secondary Identification Number	Use TJ or EI in REF01 and Tax ID in REF02.
29.	2300	Claim Information	The only valid values for CLM05-3 (Claim Frequency Type Code) of the Health Care Service Information data element are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.
30.	2300	Claim Total Submitted Charge	CLM02 must be equal to the sum of the line items.
31.	2310B	Rendering Provider Name	Use XX in NM108 and the appropriate NPI number in NM109.

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32.	2310B	Rendering Provider Secondary Identification Number	Use TJ or EI in REF01 and Tax ID in REF02.
33.	2310C	Service Facility Location	Use XX in NM108 and the appropriate NPI number in NM109.
34.	2310C	Service Facility Location Secondary Identification Number	Use TJ in REF01 and Tax ID in REF02.
35.	2320	Claim Deductible Amount	CAS03 with CAS01=PR and CAS02=1, if line item data is not available, report this data at the claim level.
36.	2320	Claim Co-payment Amount	CAS06 with CAS05=3, if the line item data is not available, report this data at the claim level.
37.	2320	Claim Primary Payer Paid Amount	AMT02, where AMT01=D, if the line item data is not available, report this data at the claim level.
38.	2320	Claim Primary Payer Allowed Amount	AMT02, where AMT01=B6, if the line item data is not available, report this data at the claim level.
39.	2320	Claim Primary Payer Discount Amount	AMT02, where AMT01=D8, if line item data is not available, report this data at the line level.
40.	2400	Professional Service	Service unit counts (units or minutes) cannot exceed 9999 (SV104).
41.	2400	Line Submitted Charge	SV102 will be the monetary amount.
42.	2400	Line Primary Payer Allowed Amount	AMT02, where AMT01=AAE, if line item data is not available, report this data at the line level.
43.	2420A	Rendering Provider Name	If this loop is submitted use XX in NM108 and the appropriate NPI number in NM109.
44.	2420A	Rendering Provider Secondary Identification Number	If this loop is submitted use TJ or EI in REF01 and Tax ID in REF02.

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45.	2430	Line Primary Payer Paid Amount	SVD02, if line item data is not available, report this data at the line level.
46.	2430	Line Deductible Amount	CAS03, with CAS01=PR and CAS02=1, if line item data is not available, report this data at the line level.
47.	2430	Line Co-payment Amount	CAS06, with CAS05=3, if line item data is not available, report this data at the line level.
48.	2430	Line Primary Payer Discount Amount	CAS03, with CAS01=CO and CAS02=131, if line item data is available, report this data at the line level
49.	Multiple (2300, 2400)	Paperwork	Any data submitted in the PWK (Paperwork) segment will not be considered for processing.