AmeriHealth
(Delaware business only)
HIPAA Transaction
Standard Companion Guide

**Refers to the Implementation Guides
Based on ASC X12 Implementation
Guides, version 005010**

February 2014

Preface

This Companion Guide ("Companion Guide") refers to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA and clarifies and specifies the data content when exchanging electronically with AmeriHealth HMO, Inc. for Delaware business only and QCC Insurance Company, Inc. d/b/a AmeriHealth Insurance Company ("AmeriHealth"). Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. This Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
This page is blank because major sections of a book should begin on a right-hand page.

Table of Contents

1.   Introduction

This section describes the ASC X12 Implementation Guides (IGs) adopted under HIPAA and is detailed using tables. The tables contain a row for each segment where AmeriHealth has something additional, over and above the information in the IGs. This information can:

1. Limit the repeat of loops or segments;
2. Limit the length of a simple data element;
3. Specify a subset of the IGs internal code listings;
4. Clarify the use of loops, segments, composite, and simple data elements;
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with AmeriHealth.

In addition to the row for each segment, one or more additional rows are used to describe the AmeriHealth usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the Companion Guide:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row indicates that a new segment has begun. It is shaded at 10%. Notes or comments about the segment are entered in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row limits the length of the specified data element.
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by AmeriHealth.
			Plan Network Identification Number	N6		This type of row is used when a note for a particular code value is required. For example, this note could state that value N6 is the default. Not populating the first three columns indicates that the code value belongs to the row immediately above it.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/ Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1   Scope

AmeriHealth migrated X12 transactions from its current gateway to the gateway managed and maintained by Highmark, Inc., formerly referred to as Highmark Health Services ("Highmark Gateway").

The purpose of this Companion Guide is to provide guidance when submitting standard electronic transactions for AmeriHealth business. This Companion Guide addresses how providers, or their business associates, conduct the following HIPAA standard electronic transactions: Health Care Claim: Professional (837P), Health Care Claim: Institutional (837I), and Health Care Claim Payment/Advice (835) with AmeriHealth through the Highmark Gateway. In addition, it addresses the proprietary Unsolicited 277 - Claim Acknowledgment Transaction (U277).*

This Companion Guide also applies to the above referenced transactions that are being transmitted to AmeriHealth through the Highmark Gateway by a health care clearinghouse.

An Electronic Data Interchange (EDI) trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) that utilizes the Highmark Gateway to send or receive electronic data to or from AmeriHealth.

The Highmark Gateway supports standard electronic transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and additional supporting transactions as described in this Companion Guide. Highmark EDI Operations supports transactions for multiple payers, including AmeriHealth.

005010X AmeriHealth Unsolicited 277 Claim Acknowledgment Transaction (U277) is the AmeriHealth proprietary functional acknowledgment for ANSI 837 claims transactions. A separate Specification Guide for this transaction is available at U277 Trading Partner Specification (Claim Status Notification). *AmeriHealth through the Highmark Gateway supports all listed transactions in batch mode.*

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with AmeriHealth through the Highmark Gateway. This information is organized into the following sections:

- **Getting Started:** This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information about trading partner authorization and an overview of the trading partner testing process is also included in this section.

- **Testing with the Payer:** This section includes detailed transaction testing information and other relevant information needed to complete transaction testing with AmeriHealth on the Highmark Gateway, if applicable.

- **Connectivity with the Payer/Communications:** This section includes information on the Highmark Gateway transmission procedures and communication and security protocols.

- **Contact Information:** This section includes telephone numbers and email addresses for support from Highmark EDI Operations.

- **Control Segments/Envelopes:** This section contains information needed to create the ISA-IEA, GS-GE, and ST-SE control segments for transactions to be submitted.

- **Payer-Specific Business Rules and Limitations:** This section contains information describing the AmeriHealth business rules.

- **Acknowledgments and Reports:** This section contains information on all transaction acknowledgments. These include the Interchange Acknowledgment (TA1), Unsolicited - Claim Acknowledgment Transaction (U277), and the Implementation Acknowledgment for Health Care Insurance (999).

- **Trading Partner Agreements:** This section contains general information about and links to Provider and Clearinghouse/Vendor Trading Partner Agreements (collectively referred to herein as "Trading Partner Agreements").

- **Transaction-Specific Information:** This section describes how IGs adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that has additional information that might supplement the IGs.

1.3 References

Trading partners must use the IGs adopted under the HIPAA Administrative Simplification Electronic Transaction rule and this Companion Guide for development of the EDI transactions. These documents will be made available through the EDI Trading Partner Business Center:

www.highmark.com/edi-amerihealth

Trading partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the Washington Publishing Company website:

www.wpc-edi.com

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice [835])

- Provider Taxonomy Codes (ASC X12/005010X222A1Health Care Claim: Professional [837P] and ASC X12/005010X223A2 Health Care Claim: Institutional [837I])

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working with Highmark, Inc. ("Highmark")

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

It is highly recommended that trading partners transmit any test data during the hours that Highmark EDI Operations is available, 8:00 a.m. through 5:00 p.m. EST, Monday through Friday.

Audit Procedures

For purposes of conducting an audit for itself and/or AmeriHealth, Highmark may require access to the medical records used by the trading partner for submitting claims in accordance with the Trading Partner Agreement. The trading partner must ensure that input documents and medical records are retained and available for every automated claim for purposes of an audit. Copies of trading partner documents are acceptable. The trading partner, not the billing agent, is held accountable for accurate records.

The audit conducted by Highmark consists of verifying a sample of automated claim input against medical records. Retention of records might also be checked. Compliance with reporting requirements is sample-checked to ensure proper coding technique is employed. Signature(s) on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark can request for itself and AmeriHealth, and the trading partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex Value
!	Exclamation Point	(21)
>	Greater than	(3E)
^	Caret	(5E)
|	Pipe	(7C)
~	Tilde	(7E)

These five characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing. Use of these characters can cause problems if encountered in the transaction data.

As described in the ASC X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters are left justified. Leading spaces, when they occur, are presumed to be significant characters. In the actual data stream, trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality/Security/Privacy

Trading partners, including health care clearinghouses, must comply with the HIPAA Electronic Transaction and Code Set standards and HIPAA Privacy and Security standards for all EDI transactions and confidentiality requirements as outlined in the Trading Partner Agreement.

Authorized Release of Information

When contacting Highmark EDI Operations concerning any EDI transactions, you will be required to confirm your trading partner information.

2.2   Trading Partner Registration

An Electronic Data Interchange (EDI) trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) utilizing the Highmark Gateway to transmit or receive electronic standard transactions to or from AmeriHealth.

While Highmark EDI Operations accepts HIPAA-compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure is established to secure access to data. As a result, Highmark has a process in place to establish a trading partner relationship. That process has the following steps:

- The trading partner must identify Trading Partner Administrator and Delegate roles (see page 13 of this Companion Guide). AmeriHealth uses role-based

security for transactions related to the maintenance of a trading partner relationship.

- The Trading Partner Administrator must complete an online application to receive from Highmark a DataStream Trading Partner ID associated with submitting transactions on behalf of AmeriHealth.

- The Trading Partner Administrator must agree to and electronically accept or otherwise submit the Trading Partner Agreement to Highmark. The Trading Partner Agreement establishes the legal relationship with Highmark and the requirements of that relationship. This is separate from a participating provider agreement.

- Once the Trading Partner Agreement is received by Highmark, the trading partner is sent a logon ID and password combination associated with the DataStream Trading Partner ID for use when accessing the Highmark Gateway for submission or retrieval of AmeriHealth transactions ("DataStream logon ID and password"). This DataStream logon ID is also used within EDI Interchanges as the ID of the trading partner. The Security section of this Companion Guide provides more detail about the maintenance of the DataStream logon ID and password by the trading partner.

Authorization Process

New trading partners that want to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application and the Trading Partner Agreement must be completed, electronically accepted and submitted by the Trading Partner Administrator who is an authorized representative of the organization submitting the EDI Transaction Application.

Highmark can terminate the Trading Partner Agreement after a sixty (60) day suspension period, without notice, if the trading partner's account is inactive for a period of six (6) consecutive months, pursuant to the terms of the Trading Partner Agreement.

Complete and accurate reporting of information on the EDI Transaction Application ensures that the authorization process is completed in a timely manner. If you need assistance in completing the EDI Transaction Application contact your company's technical support area, your software vendor, or Highmark EDI Operations.

Upon completion of the authorization process, a DataStream logon ID and password are assigned to the trading partner. Highmark EDI Operations will authorize, in writing, the trading partner to submit production AmeriHealth EDI transactions.

Trading Partner Administrator and Trading Partner Delegate Roles

This section explains the Trading Partner Administrator ("Administrator") and Trading Partner Delegate ("Delegate") roles. Highmark EDI Operations will only make changes to the trading partner record if the change request is received from the authorized Administrator or Delegate.

- The "Administrator" is the primary representative of the trading partner entity (provider office, billing service, clearinghouse, etc.) that is authorized by the trading partner to conduct all electronic business on behalf of the trading partner, including entering into Trading Partner Agreements, modifying trading partner capabilities, and conducting inquiries about electronic transactions.

- The "Delegate" is a representative of the Trading Partner Administrator that has been authorized by the trading partner/Trading Partner Administrator to conduct certain activities on behalf of the trading partner such as, requesting the addition or deletion of affiliated providers or conducting inquiries about electronic transactions.

- The provider is a physician or allied health care provider credentialed and approved by AmeriHealth to provide covered services to AmeriHealth members and submit standard electronic transactions for such services to AmeriHealth for processing.

- The Administrator is required to submit a security question and an answer to this question when registering. The security answer is used to confirm and verify the identity of the Administrator prior to Highmark making any form changes on behalf of the trading partner.

The following table lists the rights that an Administrator, a Delegate, and a provider are authorized to perform:

AmeriHealth Trading Partner Role-Based Security Matrix

Rights	Administrator	Delegate	Provider
EDI Trading Partner Business Center Permissions			
New trading partner registration	✓		
New trading partner request	✓		
Update a trading partner's address information	✓		
Delete a trading partner	✓		
Update claim transactions	✓		
Update Administrator	✓		
Establish Delegate	✓		
Update Delegate	✓	✓	
Request for production	✓	✓	
Provider changes	✓	✓	✓
Update software vendor	✓	✓	

Rights	Administrator	Delegate	Provider
Other Permissions			
Receive EDI transaction support	✓	✓	✓
Request password change	✓	✓	

Where to Get Authorization Forms to Request a DataStream Trading Partner ID

To receive a DataStream Trading Partner ID, you must complete an online EDI Transaction Application and electronically agree to the terms of the Trading Partner Agreement. The EDI Transaction Application form and all other EDI request forms are available through the *Sign Up* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-amerihealth

Receiving ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)

To receive Health Care Claim Payment/Advice (835 remittance transactions) generated from the payment cycle in a batch process, trading partners need to request 835 remittance transactions by completing an *Update Claims Transactions* form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-amerihealth

Adding a New Provider to an Existing Trading Partner

Trading partners currently using electronic claims submission who wish to add a new provider to their DataStream Trading Partner ID should complete the *Provider Changes* form in the *Update Trading Partners* section on the EDI Trading Partner Business Center website, and select the option to *Add Provider*.

www.highmark.com/edi-amerihealth

Deleting Providers from an Existing Trading Partner

Trading partners who wish to delete a provider from their DataStream Trading Partner ID should complete the *Provider Changes* form in the *Update Trading Partners* section of the EDI Trading Partner Business Center website, and select the option to *Delete Provider*.

www.highmark.com/edi-amerihealth

Reporting Changes in Status

If trading partners need to change any other trading partner information, they must inform Highmark EDI Operations by completing the appropriate trading partner update form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-amerihealth

2.3 Certification and Testing Overview

AmeriHealth through Highmark Transactional Testing

Detailed payer testing requirements and procedures to be determined.

Claims Transactions

Detailed payer testing requirements and procedures to be determined.

3. Testing with the Payer

Detailed payer testing requirements and procedures to be determined.

4. Connectivity with the Payer/Communications

Highmark offers AmeriHealth trading partners the following communication method for transferring data electronically:

* A secure https Internet connection available for transactions in batch mode.

4.1 Process Flows

In the fourth quarter of 2013, AmeriHealth migrated all X12 transactions to the Highmark Gateway as illustrated in the diagram below:

Trading partners now submit and receive all transactions through the Highmark Gateway. The 999 Implementation Acknowledgment for Health Care Insurance transaction, TA1 Transaction Acknowledgment transaction, U277 Claim Acknowledgment transaction and 835 Health Care Payment/Advice transaction are all returned to trading partners through the Highmark Gateway.

4.2 Transmission Administrative Procedures

This information will be communicated to the trading partner upon Highmark's receipt of the agreed-to Trading Partner Agreement.

4.3 Re-Transmission Procedures

AmeriHealth does not have specific re-transmission procedures. Trading partners can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers a secure File Transfer Protocol (SFTP) through "eDelivery" for conducting business with AmeriHealth. "eDelivery" is available for trading partners who submit or receive any HIPAA-compliant EDI transactions in batch mode.

Internet File Transfer Protocol (SFTP) through "eDelivery"

The Highmark Secure FTP Server ("eDelivery") provides an SFTP service over an encrypted data session providing "on-the-wire" privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple SFTP process in an encrypted and secure manner.

Any state-of-the-art browser can be used to access the Highmark Secure FTP Server. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.

2. Connect to the SFTP server at https://ftp.highmark.com.

3. The server prompts you for your DataStream logon ID and password. Use the DataStream logon ID/password that Highmark provided you as part of the trading partner authorization process for accessing this service. Enter the ID, tab to password field and enter the password.

4. Press "Enter" or click "OK".

5. The server places you in an individual file space on the SFTP server. Other users cannot access your space and you cannot access the space of other users. You cannot change your space.

6. You need to change into the directory for the type of file you are uploading or downloading from the server.

7. By default, the file transfer mode is binary. This mode is acceptable for all data types. However, you can change between ASCII and binary file transfer modes by clicking the "Set ASCII"/ "Set Binary" toggle button.

8. Send Highmark a file. The following is an example of the submission of an electronic claim[1] transaction file:

    a. Click the "hipaa-in" folder to change into that directory.

    b. Click the **browse** button to select a file from your system to send to Highmark. A file finder box appears listing the files available on your system.

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[1]Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

c. Select the file you want to send to Highmark and click **OK**. This returns you to the browser with the file name you selected in the filename window.

d. Click the **Upload File** button to transfer the file to Highmark. Once completed, the file appears in your file list.

9. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:

a. Click the "hipaa-out" directory. Your browser lists all the files available to you.

b. Click the "ack" directory.

c. Click the file you want to download. Your browser downloads the file. If your browser displays the file instead of downloading, click the **browser back** button and click the tools next to the file you want to receive. Select application/ octet-stream. You might be prompted with the **Save As** file location window. Select a file location and click **Save** to download the file.

4.5 Passwords

Highmark EDI Operations assigns DataStream logon IDs and passwords to trading partners. EDI transactions submitted by unauthorized trading partners will not be accepted by the Highmark Gateway.

Trading partners should protect password privacy by limiting knowledge of the password to a key Administrator or their Delegates. Passwords should be changed regularly: upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the trading partner office, or at any time the trading partner deems necessary. Trading partners must notify Highmark immediately if there is a violation of these DataStream logon ID and password requirements as required by the Trading Partner Agreement.

Password requirements include:

- Password must be eight characters in length.
- Password must contain a combination of both numeric and lower case alpha characters.
- Password cannot contain the logon ID.
- Password must be changed periodically.

Trading partners are directed to refer to the terms of their Trading Partner Agreement for any additional obligations they may have concerning logon IDs and passwords.

Password Change Requests

EDI Operations only performs a password reset if requested by an Administrator or Delegate.

If an Administrator or a Delegate provides the answer to their security question, EDI Operations can provide temporary passwords over the telephone. If the security answer is not provided, a temporary password is not given during the initial telephone call. In this case, the temporary password can be provided in a follow-up email or return telephone call using existing contact information on file at Highmark.

5.   Contact Information

5.1   Highmark EDI Operations

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246
- Email Address: edisupport@highmark.com

When contacting Highmark EDI Operations, have your DataStream Trading Partner ID and DataStream logon ID available. These numbers facilitate the handling of your questions.

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.2   EDI Technical Assistance

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246
- Email Address: edisupport@highmark.com

When contacting Highmark EDI Operations, have your DataStream Trading Partner ID and DataStream logon ID available. These numbers facilitate the handling of your questions.

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.3   Provider Services

Non-EDI related inquiries should be handled through your existing channels of communication with AmeriHealth.

5.4   Applicable Websites/Email

EDI specifications, including this Companion Guide, will be accessible online in the *Resources* section of the EDI Trading Partner Business Center website:

www.highmark.com/edi-amerihealth

6. Control Segments/Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the IGs. The AmeriHealth expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter of the Companion Guide.

Note: Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

For 5010 claim files, the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days, the file is considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the IGs, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark EDI Operations (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that Line Feed, hex value "0A", is an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E

Description	Hex value
!	21
"	22
%	25
&	26
'	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^	5E
{	7B
}	7D
~	7E

Note: "^"can be used as a Data Element Separator, but is not accepted as a Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark uses the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, "!", cannot be used in text data (type AN, Sting data element) within the transaction; refer section 2.1 Valid Characters in Text Data in this document.

Delimiter Type	Character Used	(Hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to AmeriHealth

Segment: ISA Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the IGs with the clarifications as follows:

Table 1: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	AmeriHealth can only support code 00 - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	AmeriHealth can only support code 00 - No Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value "ZZ" Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the AmeriHealth assigned security logon ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value "33". AmeriHealth only supports the NAIC code to identify the receiver.
	ISA08	Interchange Receiver ID	54704	AmeriHealth
	ISA13	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA 14	Acknow-ledgment Requested	1	A TA1 segment is always returned when the incoming interchange is rejected due to errors at the interchange or functional group envelope.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA15	Usage Indicator		The value in this element is used to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from AmeriHealth

Segment: ISA Interchange Control Header (Outgoing)

Note: The following table lists clarifications of the AmeriHealth use of the ISA segment for outgoing interchanges:

Table 2: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Code 00 is sent - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Code 00 is sent - no Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	33	Qualifier code value "33" is sent to designate that the NAIC code is used to identify the sender.
	ISA06	Interchange Sender ID	54704	AmeriHealth
	ISA07	Interchange ID Qualifier	ZZ	Qualifier code value "ZZ" is sent. Mutually defined to designate that an AmeriHealth-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The assigned ID is the trading partner's security logon ID. This ID is left-justified and space filled.
	ISA 14	Acknowledgment Requested		AmeriHealth always uses a 0 (No Interchange Acknowledgment Requested).

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA15	Usage Indicator		AmeriHealth provides T or P as appropriate to identify the test or production nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific.

6.3 ST-SE

AmeriHealth has no requirements outside the national transaction IGs.

7. Payer-Specific Business Rules and Limitations (837P, 837I, U277, 835, and 999)

7.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 IG, as modified by the July 2010 Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the Companion Guide for submitting Health Care Claim: Professional (837P) claims for patients with AmeriHealth benefits plans. Accurate reporting of the AmeriHealth NAIC code is critical for claims submitted to AmeriHealth through the Highmark Gateway.

Claims Resubmission

Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a "prior claim" or "finalized claim". An 837 professional claim transaction is not an appropriate response to a payer's request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.2 005010X223A2 Health Care Claim: Institutional (837I)

The Health Care Claim: Institutional (837I) transaction is used for institutional claims. The May 2006 ASC X12 005010X223 IG, as modified by the August 2007 and the July 2010 Type 1 Errata documents, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with

the revisions in the errata; the transaction version must be identified as 005010X223A2.

This Companion Guide supplements the ASC X12 Implementation Guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction detail make up the Companion Guide for submitting Health Care Claim: Institutional (837I) claims for patients with AmeriHealth benefit plans, including Health Maintenance Organization (HMO), Point of Service (POS). Accurate reporting of the AmeriHealth NAIC code 54704 in the ISA08 along with associated prefixes and suffixes is critical for claims submission.

7.3 005010X AmeriHealth Unsolicited 277 - Claim Acknowledgment Transaction (U277)

Detailed transaction information for the U277 transaction as well as business rules and/or limitations can be found in the independent AmeriHealth Unsolicited 277 Trading Partner Specification.

7.4 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on AmeriHealth Platform

The 835 is utilized to send an electronic Statement of Remittance (SOR) from health care payer to health care provider. Health care providers that receive the 835 include but are not limited to hospitals, nursing homes, laboratories, physicians, dentists, and allied professional groups.

Availability of Payment Cycle 835 Transactions (Batch)

Payment Health Care Claim Payment/Advice (835) transactions are created on a weekly or daily basis to correspond with the AmeriHealth weekly or daily payment cycle. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete, and remain available for 7 days. This section describes business rules specific to the 835 remittance transaction generated on the AmeriHealth platform.

7.5 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

AmeriHealth returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA-IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.)

The location and reason for errors are identified in one or more of the following segments:

- IK3 - segment errors
- IK4 - data element errors
- IK5 - transaction errors
- AK9 - functional group errors

Rejection codes are contained in the ASC X12 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) IG. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA-IEA) and Functional Group (GS-GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be "005010X231A1." Note that this will not match the IG identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment for Health Care Insurance (999) guide.

When you were issued your DataStream Trading Partner ID, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values on record for your DataStream Trading Partner ID, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter. In the following example the IK404 value 'TRADING PARTNER PROFILE' indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

```
ISA^00^        ^00^        ^33^54771      ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627
```

8.   Acknowledgments and Reports

8.1   Report Inventory

AmeriHealth has no proprietary reports within this Companion Guide.

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance
U277 Acknowledgment	Unsolicited Claim Acknowledgment Transaction, generated by AmeriHealth

Outgoing Interchange Acknowledgment TA1 Segment

The Highmark Gateway returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA-IEA) must be rejected.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the 999 Implementation Guide. Each Highmark Gateway TA1 will have an Interchange Control Envelope (ISA-IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

The Highmark Gateway returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA-IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to Sections 7.5 and 10.6: 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) of this Companion Guide.

Outgoing Unsolicited 277 Claim Acknowledgment (U277 Transaction)

The Unsolicited Claim Acknowledgment Transaction (U277) is used to return a reply of "accepted" or "not accepted" for claims or encounters processed by AmeriHealth submitted via the electronic claim[2] transaction in batch mode. Acceptance at this level is based on the electronic claim[2] IGs and front-end edits, and will apply to individual claims within an electronic claim[2] transaction. For those claims not accepted by AmeriHealth for processing, U277 transaction will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to the independent [AmeriHealth Unsolicited 277 Trading Partner Specification Guide](#).

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[2]Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

9. Trading Partner Agreements

Provider Trading Partner Agreement

For use by professionals and institutional providers.

Clearinghouse/Vendor Trading Partner Agreement

For use by software vendors, billing services, or clearinghouses.

Trading Partners

An EDI trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) utilizing the Highmark Gateway to transmit or receive electronic data to or from AmeriHealth.

Payers have Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the Trading Partner Agreement is with an entity or a part of a larger Agreement, between each party to the Agreement.

For example, a Trading Partner Agreement might specify the roles and responsibilities of each party to the Agreement in conducting standard electronic transactions.

10. Transaction-Specific Information

This section describes how ASC X12 IGs adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that AmeriHealth has something additional, over and above the information in the IGs. That information can:

1. Limit the repeat of loops, or segments

2. Limit the length of a simple data element

3. Specify a sub-set of the IGs internal code listings

4. Clarify the use of loops, segments, composite and simple data elements

5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with AmeriHealth.

In addition to the row for each segment, one or more additional rows are used to describe the AmeriHealth usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row indicates a new segment for notes and comments. It is shaded at 10%.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row limits the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by AmeriHealth
			Plan Network Identification	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

The following table lists the IGs for which specific transaction instructions apply and which are included in Section 10 of this Companion Guide:

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010221A1	Health Care Claim Payment/Advice
005010X231A1	Implementation Acknowledgment for Health Care Insurance

AmeriHealth through the Highmark Gateway supports all listed transactions in batch mode.

10.1 005010X222A1 Health Care Claim: Professional (837P)

Refer to Section 7.1 for AmeriHealth business rules and limitations for this specific transaction.

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's assigned DataStream Trading Partner ID. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	95044 93688	**95044** AmeriHealth POS AmeriHealth HMO **93688** AmeriHealth PPO
1000A	NM1	Payer Identification		
	NM109	Submitter Identifier		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		AmeriHealth will use contact information on internal files for initial contact.
	PER01	Contact Function Code	BL	Technical Department
	PER02	Name Communication Number		Payer Contact Name
	PER03	Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth
	NM109	Receiver Primary Identifier	54704	Identifies AmeriHealth as the receiver of the transaction and corresponds to the value in GS03 Application Receiver Code.

The header row "005010X222A1 Health Care Claim: Professional" spans all columns.

Loop ID	Reference	Name	Codes	Notes/Comments
		005010X222A1 Health Care Claim: Professional		
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	N3	Billing Provider Address		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N301	Address Information		The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID 2010AB), if necessary.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.

**005010X222A1 Health Care Claim: Professional**
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AA	REF	Billing Provider Tax Identification Number		
2100AA	PER	Billing Provider Contact Information		AmeriHealth uses contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E. F, G, H, S, T, U	If value other than "P" (Primary) is populated, then the following Loops/Segments are required: • 2320 or 2430/CAS: With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • 2320/AMT: With AMT01 = 'D' and AMT02 Payer Paid Amount • 2320 or 2430/AMT: With AMT01 = 'AEF' and AMT02 Payer Paid Amount • 2330A/NM1: With Other Subscriber information
	SBR09	Claim Filing Indicator Code	BL	AmeriHealth Products
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.

**005010X222A1 Health Care Claim: Professional**
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Subscriber Primary Identifier		This is the identifier from the Subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BA	REF	Subscriber Secondary Identification		AmeriHealth does not need secondary identification to identify the Subscriber.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.
2010CA	NM1	Patient Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.
2010BB	NM1	Payer Name		
	NM103	Payer Name		AmeriHealth
	NM109	Payer Identifier	95044 93688	**95044** AmeriHealth POS AmeriHealth HMO **93688** AmeriHealth PPO
2010BB	REF	Payer Secondary Identification		AmeriHealth does not need secondary identification to identify the payer.
2010BB	REF01	Identification Code Qualifier	G2	AmeriHealth
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
2300	CLM	Claim Information		

005010X222A1 Health Care Claim: Professional				
Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM101	Claim Submitter's Identifier		Do not enter values more than 20 characters.
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and AmeriHealth Claim Number in REF02) • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)
2300	REF	Payer Claim Control Number		
2300	REF01	Reference Identification Qualifier	F8	If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and AmeriHealth Claim Number in REF02)
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment. If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)

		005010X222A1 Health Care Claim: Professional		
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	HI	Health Care Diagnosis Code		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the Provider's contractual business arrangements with AmeriHealth.
2310B	REF	Rendering Provider Secondary Identification		
	REF01	Identification Code Qualifier	G2	AmeriHealth
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
2310C	REF	Service Facility Secondary Identification		
2310C	REF01	Identification Code Qualifier	G2	AmeriHealth
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2320	CAS	Claims Level Adjustment		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2320	AMT	COB Payer Paid Amount		If SBR01 is a value other than "P" (Primary), this segment is required.

		005010X222A1 Health Care Claim: Professional		
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2320	AMT	Remaining Patient Liability		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2330B	NM1	Other Payer Name		If SBR01 is a value other than "P" (Primary), this segment is required.
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state, and ZIP information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state, and ZIP, send the Billing Provider address information as the default.
2400	SV1	Service Line		
	SV101-1	Product/Service ID Qualifier		Qualifier value HC, HCPCS, is the only value AmeriHealth will accept in this element.
2400	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer's adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer's adjudication process; therefore, it is not required.

005010X222A1 Health Care Claim: Professional				
Loop ID	Reference	Name	Codes	Notes/Comments
2410	LIN	Drug Identification		• NDC codes are required when specified in the Provider's agreement with AmeriHealth. • AmeriHealth encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	REF	Rendering Provider Secondary Identification		
2420A	REF01	Identification Code Qualifier	G2	AmeriHealth
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the Provider's contractual business arrangements with AmeriHealth.
2420C	N3	Service Facility Location Address		When the 2420C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.
2430	CAS	Claims Level Adjustment		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.

005010X222A1 Health Care Claim: Professional				
Loop ID	Reference	Name	Codes	Notes/Comments
2430	COB Payer Paid Amount	Remaining Patient Liability		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.

10.2 005010X223A2 Health Care Claim: Institutional (837I)

Refer to Section 7.2 for AmeriHealth business rules and limitations for this specific transaction.

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	95044 93688	**95044** AmeriHealth POS AmeriHealth HMO **93688** AmeriHealth PPO
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		AmeriHealth uses contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth
	NM109	Receiver Primary Identifier	95044 93688	**95044** AmeriHealth POS AmeriHealth HMO **93688** AmeriHealth PPO

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners; therefore, U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	NM108	Identification Code Qualifier		When the organization is not a health care Provider (is an "atypical" Provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" Provider must submit their TIN in the REF segment and their assigned AmeriHealth Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).
2010AA	NM109	Identification code		When the organization is not a health care Provider (is an "atypical" Provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" Provider must submit their TIN in the REF segment and their assigned AmeriHealth Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AA	N3	Billing Provider Address		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		AmeriHealth will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The Provider's address on AmeriHealth internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Sequence Number Code		If value other than "P" (Primary) is populated, then the following Loops/Segments are required: • **2300/HI:** If AmeriHealth secondary to Medicare, appropriate Value Codes if applicable • **2300/CAS:** With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • **2300/AMT:** With AMT01 = 'D' and AMT02 Payer Paid Amount • **2330A/NM1:** With Other Subscriber information
2000B	SBR09		CI	CI for AmeriHealth Products
2010BA	NM1	Subscriber Name		

		005010X223A2 Health Care Claim: Institutional		
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.
	NM104	Subscriber First Name		Subscriber's first name is required when NM102 = 1 and the person has a first name. If the subscriber has a Single Legal Name, NM102 must = 1 and Single Legal Name must be populated in NM103 and NM104 must not be populated.
	NM109	Subscriber Primary Identifier		This is the identifier from the Subscriber's identification card (ID Card), including alpha characters. Spaces, dashes, and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction. When the Subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.
2000B	SBR09		CI	CI for AmeriHealth Products
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.

Loop ID	Reference	Name	Codes	Notes/Comments
		005010X223A2 Health Care Claim: Institutional		
	NM104	Subscriber First Name		Subscriber's first name is required when NM102 = 1 and the person has a first name. If the subscriber has a Single Legal Name, NM102 must = 1 and Single Legal Name must be populated in NM103 and NM104 must not be populated.
	NM109	Subscriber Primary Identifier		This is the identifier from the Subscriber's identification card (ID Card), including alpha characters. Spaces, dashes, and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction. When the Subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.
2000B	SBR09		CI	CI for AmeriHealth Products
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which AmeriHealth does not process.
	NM104	Subscriber First Name		Subscriber's first name is required when NM102 = 1 and the person has a first name. If the subscriber has a Single Legal Name, NM102 must = 1 and Single Legal Name must be populated in NM103 and NM104 must not be populated.

		005010X223A2 Health Care Claim: Institutional		
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains '5', '7', or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and AmeriHealth Claim Number in REF02) • REF – Medical Records Number (REF01 = 'EA' and Medical Record Number in REF02) • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)
2300	DTP	Discharge Hour		
	DTP03	Discharge Time		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	DTP	Admission Date/Hour		
	DTP03	Admission Date and Hour		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	REF	Payer Claim Control Number		AmeriHealth requires the Payer Claim Control Number segment when Loop 2300/CLM05-3 is '5', '7', or '8'.
	REF02	Payer Claim Control Number		AmeriHealth Claim Number associated with the Late Charge, Replacement or Void noted by Loop 2300/CLM05-3

| 005010X223A2 Health Care Claim: Institutional |
Loop ID	Reference	Name	Codes	Notes/Comments
2300	REF	Medical Record Number		AmeriHealth requires the Medical Record Number segment when Loop 2300/CLM05-3 is '5', '7', or '8'.
	REF01	Reference Identification Qualifier	EA	
2300	NTE	Billing Note		NTE segment required for AmeriHealth when Loop 2300/CLM05-3 is '5', '7', or '8'
	NTE02	Original Reference Number		Enter a detail description regarding the adjustment request.
2300	K3	File Information		Present on Admission (POA) codes are not reported in the K3. Claims with POA codes in the K3 will not be accepted for processing. POA codes are reported in the appropriate HI segment along with the appropriate diagnosis code.
2300	HI	Principal Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Admitting Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Patient's Reason for Visit		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Other Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Principal Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Other Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing AmeriHealth implementation of the ICD-10 mandate will be issued in the future.
	HI01-1	Code List Qualifier Code		Until further notification from AmeriHealth, Advanced Billing Concepts (ABC) codes will not be accepted.
2300	HI	Occurrence Information		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
2300	HI	Value Information		When AmeriHealth is secondary to Medicare, Value Code information is required as necessary.
	HI01-01		BE	

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
	HI01-02		09, 11, 08, 10, 06, 80, 81, 82, 83	• 09 (Coinsurance Amount in 1st calendar year) • 11 (Coinsurance Amount in 2nd calendar year) • 08 (Lifetime Reserve Amount in 1st year) • 10 (Lifetime Reserve Amount in 2nd year) • 06 (Medicare Blood Deductible) • 80 (Covered Days) • 81 (Non-covered Days) • 82 (Coinsurance Days) • 83 (Lifetime Reserve Days) ***Note:*** For Medicare Part A: Coinsurance amounts use Value Codes 9-11 (CAS segments are not required). For Medicare Part A: Deductible (previously identified by Value Codes A1, B1, C1) are to be reported in the CAS (Claim Adjustment Group Code "PR" = Patient Responsibility) segment.
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider's National Provider Identifier (NPI) is associated with more than one AmeriHealth contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with AmeriHealth.
2310E	N3	Service Facility Location Address		When the 2310E Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
2310E	N4	Service Facility Location City/State/ZIP		
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
2320	CAS	Other Subscriber Information		AmeriHealth requires this information either at this 2320/CAS (claim level) or the 2430/CAS (service line) when the Loop 2000B/SBR01 is other than 'P'. ***Note:*** For Medicare Part A: Deductible (previously identified by Value Codes A1, B1, and C1) should be reported as follows in the 2320 loop: • CAS01 = "PR" (Patient Responsibility) • CAS02 = 1 (Deductible) For Medicare Part A: Coinsurance amounts (previously identified by Value Codes A2, B2, C2) use Value codes 09-11 (CAS Segment is not required). For Medicare Part B: Coinsurance amounts should be submitted at the 2430 loop. • CAS01 = "PR" (Patient Responsibility) • CAS02 = 2 (Coinsurance)
	CAS01	Claim Adjustment Group Code	CO CR OA PI PR	CO (Contractual Obligations) CR (Corrections and Reversals) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility)

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2410	LIN	Drug Identification		AmeriHealth requires submission of Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Populate LIN01 with 'N4' and LIN02 with the National Drug Code (NDC).
2410	CPT	Pricing Information		AmeriHealth requires the submission of Loop ID 2410 and the provision of a price specific to the NDC provided in LIN03 that is different from the price reported in SV102.
	CPT04	Quantity		Enter National Drug Unit Count
	CPT05-1	Unit or Basis for Measurement	F2 GR ME ML UN	F2 for International Unit GR for Gram ME for Milligram ML for Milliliter UN for Unit
2410	REF	Reference Identification		AmeriHealth requires the submission of Loop ID 2410 if dispensing of the drug has been done with an assigned Rx number.
	REF01	Reference Identification Qualifier	XZ	
	REF02	Reference Identification		Prescription Number

10.3 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on AmeriHealth Platform

Refer to Section 7.4 for AmeriHealth business rules and limitations for this specific transaction.

This section describes the transaction generated on the AmeriHealth platform.

Loop ID	Reference	Name	Codes	Notes/Comments
		005010X221A1 Health Care Claim Payment/Advice		
	GS	Functional Group Header		
	GS02	Application Sender's Code	54704	This should be a hardcoded value for AmeriHealth business.
	GS03	Application Receiver's Code		This will always be the DataStream Trading Partner ID for the entity receiving this transaction.
2100	DTM	Coverage Expiration Date		
	DTM01	Date/Time Qualifier	036	Expiration Date: This is the expiration date of the patient's coverage.
	DTM02	Date		Date expressed as CCYYMMDD
1000A	PER	Payer Technical Contact Information		
	PER01	Contact Functional Code	BL	Technical Department
	PER02	Name		Payer Contact Name
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
	PLB	Provider Level Adjustment		
	PLB01	Reference Identification		When the provider is a covered health care provider under HIPAA, the National Provider Indicator (NPI) assigned to the provider must be provided.
2110	SVC	Service Payment Information		
	SVC01-1	Product/Service ID Qualifier	HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
2100	REF	Service Identification		

Loop ID	Reference	Name	Codes	Notes/Comments
	REF01	Payee Additional Identification Qualifier	APC	Ambulatory Payment Classification
2110		Service Payment Information		
	REF01	Reference Identification Qualifier	6R	Provider Control Number – new data element for Facility Claims
1000A	PER	Payer Contact Information		
	PER01	Contact Function Code	CX	Payers Claim Office
	PER02	Name		Payer Contact Name
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
Header	DTM			
	DTM01	Date/Time Qualifier	405	Production
	DTM02	Date		Date expressed as CCYYMMDD
2100	REF	Rendering Provider Identification		
	REF01	Payee Additional Identification Qualifier	1A	AmeriHealth Provider Number
	REF02	Rendering Provider Identifier		Rendering Provider Identifier
1000B	N1	Payee Identification		
	N103	Identification Code Qualifier	XX	National Provider ID
	N104	Payee Identification Code		National Provider ID Number
1000B	REF	Payee Additional Identification		
	REF01	Payee Additional Identification Qualifier	PQ TJ	**PQ:** AmeriHealth Provider Number **TJ:** Federal Tax ID
	REF02	Additional Payee Identifier		Additional Payee Number

005010X221A1 Health Care Claim Payment/Advice

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	NM1	Service Provider Name		
	NM108	Payee Additional Identification Qualifier	BD FI XX	**BD:** AmeriHealth Provider Number **FI:** Federal Tax ID **XX:** National Provider ID
	NM109	Rendering Provider Identifier		Rendering Provider Identifier
2110	REF	Rendering Provider Identification		
	REF01	Payee Additional Identification Qualifier	1A	AmeriHealth Provider Number
	REF02	Rendering Provider Identifier		Rendering Provider Identifier

10.4 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Refer to Section 7.5 for AmeriHealth business rules and limitations for this transaction.

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		

| | IK404 | Copy of Bad Data Element | | The 005010 version of the 999 transaction does not support codes for errors in the GS segment; therefore, when there are errors in the submitted GS, "TRADING PARTNER PROFILE" will be placed in this element to indicate that one or more invalid values were submitted in the GS. |
| | 2110 | CTX | Element Context | | Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time. |

Appendices

1.   Implementation Checklist

AmeriHealth does not have an Implementation Checklist.

2.   Business Scenarios

No business scenarios at this time.

3.   Transmission Examples

No examples at this time.

4.   Frequently Asked Questions

No FAQs at this time.

5.   Change Summary

The items listed in the chart below were revised from the December 2013 version to this February 2014 version of the Companion Guide.

Page(s)	Section	Description
23-25	Payer-Specific Business Rules and Limitations (837P, 837I, 835, and 999)	Added business rules and limitations
26	Acknowledgments and Reports	Added requirements
27-51	Transaction – Specific Information	Added requirements