HIPAA Transaction
Companion Guide
837 – Institutional Health Care Claim

Refers to the Implementation Guides
Based on X12 version 005010
Companion Guide Version Number: 1.2
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Disclaimer Statement

The Health Insurance Portability and Accountability Act (HIPAA), sections 160 and 162, require that health care providers, health plans, and health care clearing houses comply with the EDI standards for health care. The HIPAA implementation specifications for ASC X12N standards may be obtained through the Washington Publishing Company on the Internet at http://www.wpc-edi.com. The complete Implementation Guide is derived from the 5010 version for use under the HIPAA regulation. Our version is referred in this document as the X12N 5010.

The purpose of this companion guide is solely to supplement the HIPAA ASC X12N standards, to provide clarification to the ASC X12N standards, and should not be interpreted as a contract, amendment to a contract or an addendum to a contract. In any instance where this companion guide differs from the HIPAA ASC X12N Implementation Guides, the HIPAA ASC X12N standards shall govern.

Substantial effort has been taken to minimize errors; however, Apex Health Solutions, its agents, employees, directors and shareholders shall not be liable or responsible for any errors, omissions or expenses resulting from the use of the information in this document.

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1 Introduction

1.1 Overview

The purpose of this Companion Guide is to provide support for the submission of the HIPAA compliant 837 Institutional claim and ensure the proper processing of claims submitted to Apex Health Solutions. This Companion Guide identifies unique information processing or adjudication needs specific to Apex Health Solutions in its implementation of the 837 Institutional Health Care Claim transaction and should be used in conjunction with the HIPAA Implementation Guide. Throughout this document, “Apex Health Solutions” represents Apex Health Solutions.

This companion guide contains three categories of information:

- General information applicable to the processing of claims and business edits performed by Apex Health Solutions.
- The transaction table outlining specific requests for data format or content within the transaction, or describing Apex Health Solutions handling of specific data types.
- Additional information containing a sample scenario and frequently asked questions (FAQ).

While Apex Health Solutions accepts all ASCX12 compliant transactions, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices. Understanding Apex Health Solutions business practices may expedite claims processing for trading partners as they exchange EDI transactions with Apex Health Solutions.

Electronics submission of claims will follow these guidelines:

- Claims currently filed on CMS-1500 format will be sent as an 837P.
- Claims currently filed on ADA format will be sent as an 837D.
- Claims currently filed on UB-92 format will be sent as an 837I.

1.2 EDI Registration

As of May 23, 2007, any provider that submits claims using their National Provider ID (NPI) and Tax Identification Number (TIN) at the required levels specified in section five of this guide is not required to go through the registration process.

1.3 NPI Implementation

Beginning October 1, 2010, Apex Health Solutions will reject claims that do not contain a NPI(at the Billing, Paid To or Rendering level). The lone exception for this will be provider submitting a claim with a valid taxonomy exception. We will reject a claim containing an invalid NPI number based on check digit validation.

1.4 Testing Prior to Production

All Trading Partners must complete transaction testing prior to submission of transactions in production. This process is detailed separately in the Communication Companion Guide and on the Apex Health Solutions Website. Prior to submitting production claims electronically, all providers or their designated vendor must complete successful transaction testing. Providers must maintain a successful level of transaction submission to remain in production.

2 Claims Processing

2.1 Special Billing Situations

2.1.1 Service Lines
Any claim submitted that contains more than 97 service lines will be split into two claims by Apex Health Solutions for payment.

2.1.2 Coordination of Benefits
When submitting an 837 transaction for members after billing their other insurance sources, the other payer's adjudication details that were provided on the 835 Remittance transaction must be supplied to Apex Health Solutions. The other payer's adjudication details, both at the line level and the claim level, are required to process the claim. Trading partners should review the Implementation Guides for both the 837 HealthCare Claim transaction and the 835 HealthCare Claim Payment/Advice transaction plus the crosswalks provided to fully understand the COB process. Reviewing section 1.4.5 of the 837 Implementation Guides will explain where to place the data within the 2320 loop.

2.1.3 Sending Attachments or Paperwork to Support a Claim
Apex Health Solutions accepts supporting documentation by mail only. Illegible information will delay processing. All documentation and Attachment Cover Sheets must be received within 14 calendar days of the electronic transmission otherwise the claim will be denied.

2.1.4 Late Charges/Corrected Bills
The Claim Frequency Type Code located in segment CLM05-03 determines the processing of late charges or corrected bills.

- A late charge is indicated by placing a "5" in this field. Please do not combine the amount of the late charge with the amount of the original charge.
- A corrected bill is indicated by placing a "7" in this field.

2.2 Code Sets
When entering codes in an 837 Institutional transaction, carefully follow the 837 Institutional Implementation Guide (IG). Use HIPAA-Compliant codes from the current versions of the sources listed in the 837 Institutional IG, Appendix C: External Code Sources

- Only use standard CPT/HCPCS Codes that are valid at the date of service.
- Currently use only ICD-9-CM diagnosis codes. No decimal point should be used for diagnosis codes. The decimal point is assumed. This is consistent with the specifications of the 837 Institutional IG.
- Apex Health Solutions will accept all HIPAA standard codes, however acceptance of these codes or modifiers will not alter the plan's covered benefits or current payment policies, guidelines or processes.

2.3 Data Format/Content
Apex Health Solutions accepts all compliant data elements on the 837 Institutional Claim. Follow the points outlined below for consistent data format and content issues:

2.3.1 Dates
- 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.
- Future dates will be rejected.

2.3.2 Decimals
- No decimals should be used in a diagnosis code.

2.3.3 Monetary Amounts, Unit Amounts, and Numeric Values

The transaction will be rejected if the monetary amounts do not balance. Apex Health Solutions accepts monetary amounts only in US dollars. If codes related to foreign currencies are used, the claim will be denied.

Unit amounts must be in whole numbers only. Negative values for monetary or unit amounts may not be processed and may result in the claim being rejected if submitted in the following segments, Loop 2400, Loop 2320:

- SV203 Monetary amount – Line Item Charged Amount
- SV205 Quantity – Service Unit Count
- SV Monetary amount – Line Item Charge of Non-Covered Charge Amount
- AMT02 Monetary amount – COB Allowed Amount
- AMT02 Monetary amount – COB Payer Prior Payment

2.3.4 Phone Numbers

Telephone numbers should be presented as contiguous number strings. Do not use dashes or parenthesis markers. Area codes should always be used.

2.4 HIPAA Compliance Checking and Business Edits

997 Acknowledgement will be returned at the file level. The 997 will return a status reflecting accepted, rejected and accepted with error. 277CA will return a status reflecting each claim submitted in the 837 file.

2.5 Data Retention

All claims data will be held for seven years.

2.6 Time Frames for Processing

All claim files received by 7:00 PM EST will be processed the day received. Any claim files received after 7:00 PM EST will be processed the next business day.

2.7 Batch Volume

There are no limits placed on volumes.

3 Identification Codes and Numbers

3.1 Provider Identifiers

Apex Health Solutions requires all submitters to use one of the following combinations of identifiers until further notice:

- Combination of the NPI or Taxonomy_Exception with the TIN.

Failure to use the correct number will result in the claim being rejected, denied or paid to the incorrect provider.

3.1.1 Facilities in a Health System

If you are a facility in a Health System and your checks are issued to the Parent Company, please use the NPI number specifically assigned to your facility. If you use another facility's NPI number under the Parent Company, it will result in the check being issued correctly to the Parent Company, however, the Explanation of Payment (EOP) or the 835 Health Care Payment Advice will indicate the incorrect facility. An example follows:

XYZ Skilled Nursing is part of ABC Health System, which uses the NPI Number of the system. If the 837 Health Care Claim Institutional is submitted with the incorrect NPI, which is assigned to New Ambulatory Center in the same system, the payment will be issued to the ABC Health System, but the EOP or 835 Health Care Payment Advice will list New Ambulatory Center as the servicing facility.

If you are a facility in a Health System and your checks are issued to the individual facility, please use the NPI number assigned to you specifically. If you use another facility's NPI number, the claim will be processed erroneously. The EOP or 835 Health Care Payment Advice will be issued to the facility associated with the RNPI that was submitted. An example follows:

ABC Skilled Nursing has its own NPI Number. New Ambulatory Center has its own NPI Number. If ABC Skilled Nursing submits a claim using the NPI number assigned to New Ambulatory Center. The EOP or 835 Health Care Payment Advice will be returned to New Ambulatory Center along with the payment.

3.2 Subscriber Identifiers

Submitters should be careful to use the member's identification number as it appears on their Apex Health Solutions member ID card. If the member's identification number is not submitted, the claim may be rejected or denied. Each member of the family is listed on the member identification card. Make sure the name of the patient is the same as the name on the identification card.

4 Reporting

4.1 Audit Report

TA1 (Interchange Acknowledgement)
When the HIPAA Compliant 837 claims file is submitted it is checked for ASC X12 syntax and HIPAA compliance errors. The TA1 report allows us to notify you of problems that were encountered in the interchange control structure. When the compliance check is completed, the TA1 (Interchange Acknowledgement) acknowledges that we have received or rejected an entire transmission. TA1 will be sent if your 837 file rejects or if the ISA14 (Sent in the 837 file) =1

997
When the HIPAA Compliant 837 claims file is submitted it is checked for ASC X12 syntax and HIPAA compliance errors. When the compliance check is complete, a 997 Acknowledgement will be sent to the Trading Partner informing them if the file has been accepted or rejected. If multiple transaction sets (ST-SE) are sent within a functional group (GS-GE), the entire functional group (GS-GE) will be rejected when an ASC X12 or HIPAA compliance error is found.

277CA
Once the HIPAA Compliant 837 claims file is submitted into our claims processing system, a 277CA will be sent back to the Trading Partner (along with the 997) that submitted the claim file to us.

The purpose of the 277CA Acknowledgement is to report the status of the interchange envelope for the 837 transaction that you submitted. This acknowledgement can either be accepted or rejected depending on whether the envelope was accepted or rejected.

An accepted acknowledgement occurs when the envelope is set up correctly. A rejected acknowledgement occurs when the envelope is set up incorrectly or the information in the envelope does not match the information that is contained within our claims processing system.

The 277CA will advise you of accepted and rejected claims. Review the rejected claims, correct the errors, and resubmit the 837, then the claims associated with this transaction will not be processed and therefore will not be considered for payment.

Both the 277CA and 997 will be sent the day following the receipt of the 837 Institutional Health Care Claim file.

5 Data Element Table: Institutional

After the claim transmissions have passed Implementation Guide compliance checks for acceptance into the Apex Health Solutions system, business edits, specific to Apex Health Solutions, are then applied to the incoming HIPAA compliant claims. The business edits include security validation and the verification of proprietary business requirements. The following 837 Institutional Health Care Claim – Detail Data Element Table contain only data elements that require instructions to efficiently enhance the claims processing through Apex Health Solutions systems. If a data element does not need specific information for Apex Health Solutions processing, then it is not documented in this Data Element Table. Use this table in conjunction with the ASC X12N 837 Implementation Guide (837 IG) for Institutional Claims. All alpha characters should be formatted as UPPERCASE only.

5.1 837 Institutional Health Care Claim - Header

The 837 Header identifies the start of a transaction, the specific transaction set, and the transaction's business purpose. Also, when a transaction set uses a hierarchical data structure, a data element in the header, BHT01 (Hierarchical Structure Code) relates the type of business data expected within each level.
The BHT - Beginning of Hierarchical Transaction is required.

- BHT01 Hierarchical Structure Code
- BHT02 Transaction Set Purpose Code
- BHT03 Reference Identification
- BHT04 Date of Transaction
- BHT05 Time of Transaction
- BHT06 Transaction Type Code

5.1.1 837 Institutional Health Care Claim - Submitter/Receiver Details

Loop 1000A/1000B contains Submitter and Receiver information.

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Individual or Organizational Name	NM109	Identification Code	Sender/Submitter Identifier	Enter the EDI Sender ID assign to you by Apex Health Solutions. This Sender ID should be identical to the value in ISA06 and GS02.
Individual or Organizational Name	NM103	Last Name or Organization Name	Apex Health Solutions	Represents the Receiver Name as Apex Health Solutions
Individual or Organizational Name	NM109	Identification Code	34196	The Receiver Primary Identifier (Apex Health Solutions Payer Identification Number)

5.2 837 Institutional Health Care Claim - Detail

The 837 Detail level has a hierarchical level (HL) structure based on the participants involved in the transaction. The three levels for the participant types include:

- Information Source (Billing provider)
- Subscriber (can be the patient when the subscriber is the patient)
- Dependent (when the patient is not the subscriber)

5.2.1 837 Detail: Information Source/Provider Hierarchical Level

The first hierarchical level (HL) of the 837 details is the Information Source HL, also known as the Billing/Pay-to Provider HL.

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Provider Information	PRV01	Provider Code	BI or BT	BI - Billing Provider PT - Pay-to
Currency	CUR02	Currency Code	USD or "Blank"	USD - US Dollars Apex Health Solutions recognizes monetary amounts as US dollars only.
Billing Provider Name	NM108	Identification Code Qualifier	XX	National Provider ID (NPI)
Billing Provider Name	NM109	Identification Code	NPI number	The Billing Provider's NPI Number. Only send the 9 digit TAX Identification Number ****Please do not send dashes or leading zeroes****
Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
Billing Provider Secondary Identification	REF02	Reference Identification	Billing Provider's Employer's Identification Number	The Employer's Identification Number must be sent when the provider's NPI is sent in the NM108/ NM109 segment. Only send the 9 digit TAX Identification Number ****Please do not send dashes or leading zeroes****

5.2.2 837 Detail: Subscriber Hierarchical Level

The second hierarchical level (HL) of the 837 detail is the Subscriber HL. Apex Health Solutions encourages our Trading Partners to submit one claim per transaction set (ST-SE) to eliminate the impact of errors on other clean claims within the same interchange; our X12 and HIPAA compliance edits will reject the entire transaction set if an error is found.

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	P, S, T	P - Primary S - Secondary T - Tertiary Usage of 'S' or 'T' requires that information be populated in loop 2320. This will give us the other payer's information.
Subscriber Information	SBR02	Individual Relationship Code	18	18 - Self
Subscriber Information	SBR03	Reference Identification	Contract Holder's Member ID Number	Enter the ID number exactly as it appears on the front of the contract holder's ID card, including the two-digit suffix.
Individual or Organization Name	NM108	Identification Code Qualifier	MI	Member Identification Number
Individual or Organization Name	NM109	Identification Code	Patient's Member ID Number	Enter the ID number exactly as it appears on the front of the contract holder's ID card, including the two-digit suffix.

5.2.3 837 Detail: Patient Hierarchical Level

The third hierarchical level (HL) of the 837 detail is the Patient HL. Apex Health Solutions encourages our Trading Partners to submit one claim per transaction set (ST-SE) to eliminate the impact of errors on other clean claims within the same interchange; our X12 and HIPAA compliance edits will reject the entire transaction set if an error is found.

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Claim Information	CLM01	Patient Control Number	Provider's Patient Account Number	As indicated in the IG, Apex Health Solutions supports a maximum of 20 characters in this data element. This number is echoed back to the Submitter in the 835 and other transactions.
Claim Information	CLM02	Monetary Amount	Total Claim Charge Amount	This field must equal the total amount of submitted charges in Loop 2400, SV102.
Claim Supplemental Information	PWK02	Report Transmission Code	BM	Apex Health Solutions accepts supporting documentation by mail only. All documentation and Attachment Cover Sheets must be received within 14 calendar days of the electronic transmission otherwise the claim will be denied. **Note**-Illegible information will delay processing.
Claim Supplemental Information	PWK05	Identification Code	AC	Attachment Control Number
Claim Supplemental Information	PWK06	Identification Code	Self-Assigned	This Field is reserved for a unique self-assigned attachment Control Number
Claim Identifier Number for Transmission Intermediaries	REF01	Reference Identification Qualifier	D9	Unique number assigned by the clearinghouse/ submitter of claims
Claim Identifier Number for Transmission Intermediaries	REF02	Reference Identification	Self-Assigned	Clearinghouse Trace Number. The value carried in this element is limited to a maximum of 20 positions.
Claim Note	NTE01	Note Reference Code	ADD	General claim notes/remarks must be submitted with this qualifier
Claim Note	NTE02	Description	Claim Note Text	Claim Notes/Remarks
Individual or Organizational Name	NM101	Entity Identifier Code	71	71 - Attending Physician If this segment is submitted, then the REF01 and REF02 segments with the specified data requested must also be submitted.
Individual or Organizational Name	NM102	Entity Type Qualifier	1, 2	1 - Person 2 - Non-person Entity
Individual or Organizational Name	NM103	Last Name	Attending Physician's Last Name	Represents the Attending Physician's Last Name
Individual or Organizational Name	NM104	First Name	Attending Physician's First Name	Represents the Attending Physician's First Name

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Individual or Organizational Name	NM108	Identification Code Qualifier	XX	National Provider ID (NPI)
Individual or Organizational Name	NM109	Identification Code	NPI number	Enter the Rendering Provider's NPI Number. ****Please do not send dashes or leading zeroes****
Attending Physician Secondary Identification	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
Attending Physician Secondary Identification	REF02	Reference Identification	Attending Physician's Employer's Identification Number	The Employer's Identification Number must be sent when the provider's NPI is sent in the NM108/ NM109 segment. Only send the 9 digit TAX Identification Number ****Please do not send dashes or leading zeroes****
Individual or Organizational Name	NM101	Entity Identifier Code	FA	FA -Facility If this segment is submitted, then the REF01 and REF02 segments with the specified data requested must also be submitted
Individual or Organizational Name	NM102	Entity Type Qualifier	1, 2	2 - Non-person Entity
Individual or Organizational Name	NM103	Last Name or Organization Name	Facility Name	Represents the Facility's Name
Individual or Organizational Name	NM108	Identification Code Qualifier	XX	National Provider ID (NPI)
Individual or Organizational Name	NM109	Identification Code	NPI	Enter the Facility's NPI. ****Please do not send dashes or leading zeroes****
Service Facility Secondary Identification	REF01	Reference Identification Qualifier	EI	Employer's Identification Number.
Service Facility Secondary Identification	REF02	Reference Identification	Service Facility Employer's Identification Number	The Employer's Identification Number must be sent when the provider's NPI is sent in the NM108/ NM109 segment. Only send the 9 digit TAX Identification Number ****Please do not send dashes or leading zeroes****
Other Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	S,P,T	Usage of 'S' requires that 'P' be present Usage of 'T' requires that both 'P' and 'S' be present **See loop 2320 in the Implementation Guide for more Information**
Other Payer Name	NM108	Amount Qualifier Code	PI	Submitters are required to send all known information on other payers in this Loop ID-2330.
Other Payer Name	NM109	Other Payer Primary Identifier	Self-Assigned	This number must be identical to SVD01 (Loop ID-2430) for COB. If COB submitted, NM109 is required and must be unique from any other 2330B/NM109 value.

Envelope/ Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Service Line Number	LX01	Assigned Number	Service Line LX segment must begin with 1 and increase in increments of 1 for each additional service line on the claim	Any claim submitted that contains more than 97 service lines will be split into to two claims by Apex Health Solutions for payment.
Institutional Service line	SV201	Product/Service ID	Revenue Code	Enter the service line revenue code
Institutional Service line	SV202-1	Product/Service ID Qualifier	HC	HC - health care financing administration common procedural coding system
Institutional Service line	SV202-2	Product/Service ID	Procedure Code	Apex Health Solutions requires the use of CPT and HCPCS from the current manuals to be compliant.
Institutional Service line	SV202-3	Procedure Modifier	Procedure Modifier 1	Apex Health Solutions considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.
Institutional Service line	SV202-4	Procedure Modifier	Procedure Modifier 2	Apex Health Solutions considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.
Institutional Service line	SV202-5	Procedure Modifier	Procedure Modifier 3	Apex Health Solutions considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.
Institutional Service line	SV202-6	Procedure Modifier	Procedure Modifier 4	Apex Health Solutions considers the modifiers listed in the CPT and HCPCS manuals to be compliant. An anesthesia modifier must be used with any anesthesia service to correctly identify the service as anesthesia.
Institutional Service line	SV203	Monetary Amount	Line Item Charge Amount	The sum of the service lines charges reported in this field must be equal the Total Claim Charge Amount in Loop 2300/CLM02
Institutional Service line	SV204	Unit or Basis of Measurement Code	DA or UN	DA – Days UN - Units
Institutional Service line	SV205	Quantity	1-999	Apex Health Solutions accepts values greater than or equal to one The service unit count may not exceed 999. If the quantity exceeds 999 the claim will be rejected.
Line Adjustment Info	SVD01	Identification Code	Other Payor Identifier	Value is required when segment sent and must match a previous 2330B/NM109 value

6 837 Institutional Claim Transaction Sample

6.1 Claim Scenario

On September 2, 2022, Jonathan Doe was experiencing pain in his leg and ankle. He was taken to Healthy Hospital for an x-ray of his foot and ankle. The hospital submitted the bill to their clearinghouse. The Clearing House transmitted the claim to Apex Health Solutions in the 837I file format.

Claim Information
Claim Date: 9/18/2022
Claim Time: 9:33 am

Sender: Clearing House
Sender Electronic Transmitter ID: Type 46, 999999999

Receiver: Apex Health Solutions
Receiver Electronic Transmitter ID: Type 46 – 34196

Institutional Claim: 005010X223

Facility: Healthy Hospital
Facility TIN: 123456789

Provider Address: 789 Hospital Drive, Akron, OH 44308
Provider Phone Number: 330-555-5555

Patient: Jonathan Doe
Patient Address: 100 Patient RD Akron, OH 44308
Sex: M
Date of Birth: 2/5/1974
Patient ID: 98765432103
Group #: V99999
Patient Account #: 330866922

Diagnosis: Primary 719.7 – difficulty walking; Secondary 729.5 - pain in limb

Attending Physician: Dr. John Smith
Attending Physician TIN: 123456789

CPT Codes: 73610 – X-ray exam of ankle; 73630 – X-ray exam of foot Revenue Codes: 320

Date of Service: 9/2/2022

6.2 837I – NPI Claim Example ANSI X12

ST*837*000000004*005010X223
BHT*0019*00*1*20220918*0933*CH
NM1*41*2*CLEARINGHOUSE*****46*999999999
PER*IC*CLEARINGHOUSE*TE*8005555555
NM1*40*2*APEX HEALTH SOLUTIONS*****46*34196
HL*1**20*1
PRV*BI*PXC*208D00000X
NM1*85*2*HEALTHY HOSPITAL*****XX*1234567890
N3*789 HOSPITAL DRIVE
N4*AKRON*OH*44308
REF*EI*11122333
PER*IC*HEALTHY HOSPITAL*TE*3305555555
HL*2*1*22*0
SBR*P*18*V99999*USPO*****CI
NM1*IL*1*DOE*JONATHAN****MI*98765432103
N3*100 PATIENT RD
N4*AKRON*OH*44308
DMG*D8*19740205*M
NM1*PR*2*APEX HEALTH SOLUTIONS*****PI*34196
CLM*330866922*583.70***13<A<1***Y*Y
DTP*434*D8*20220902
CL1*3*1*01
AMT*C5*583.70
REF*D9*091703003980700
REF*EA*221109
HI*BK:7917
HI*BF:7295
HI*BH:11<D8<20030902
HI*BE:A3:::583.70
NM1*71*2*SMITH*JOHN****24*123456789
REF*G2*1234
LX*1
SV2*0320*HC:73610*297.40*UN*1
DTP*472*D8*20030902~
LX*2
SV2*0320*HC:73630*286.30*UN*1
DTP*472*D8*20030902
SE*42*000000004

6.3 837I – COB Claim Example ANSI X 12

ST*837*000000459*005010X222A1
BHT*0019*00*0000A8795*20220625*211533*CH
NM1*41*2*STARKE*****46*123456789
PER*IC*STARKE CUSTOMER SOLUTIONS*TE*8008456592
NM1*40*2*APEX HEALTH SOLUTIONS*****46*34196
HL*1**20*1
PRV*BI*PXC*200D00000X~
NM1*85*2*DUCK PHYSICIANS CENTER INC*****XX*1467400929
N3*3515 ANYTOWN ROAD*SUITE 150
N4*TOWNE*OH*446857819
REF*EI*123456789
PER*IC*EDI SUPPORT*TE*5088363663
HL*2*1*22*1
SBR*S**G0259816OS******CI
NM1*IL*1*DOE*JANE*S***MI*A1234567801
NM1*PR*2*APEX HEALTH SOLUTIONS*****PI*34196
REF*FY*NOCD
HL*3*2*23*0
PAT*01
NM1*QC*1*DOE*JOHN
N3*10976 THORN CIR NW
N4*TOWNE*OH*44685
DMG*D8*19001029*M
CLM*1440112*302***81:B:1*Y*A*Y*Y
REF*X4*36D0339480
REF*D9*062514757253118
HI*BK:78079*BF:7906*BF:V7791*BF:V7644
NM1*DN*1*TAYLOR*MATTHEW*S***XX*5555552555
NM1*77*2* DUCK PHYSICIANS CENTER
LAB*****XX*123456789
N3*65 COMMUNITY RD*SUITE A
N4*TALLMADGE*OH*442782357
SBR*P*18*241547201******CI
AMT*D*36.77
OI***Y*P**Y
NM1*IL*1*DOE*JOHN****MI*000000000000
N3*10976 THORN CIR NW
N4*TOWNE*OH*44685
NM1*PR*2*OTHER PRIMARY INSURACE CO*****PI***29076**
LX*1
SV1*HC:82306*84*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-01
SVD***29076***0*HC:82306**1*1
CAS*PR*1*50.9
CAS*CO*45*33.1
DTP*573*D8*20220610
LX*2
SV1*HC:84153*53*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-02
SVD*29076*0*HC:84153**1*2
CAS*PR*1*31.61
CAS*CO*45*21.39
DTP*573*D8*20220610

Continued Below

LX*3
SV1*HC:84443*40*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-03
SVD*29076*0*HC:84443**1*3
CAS*PR*1*28.89
CAS*CO*45*11.11
DTP*573*D8*20220610
LX*4
SV1*HC:80061*36*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-04
SVD*29076*0*HC:80061**1*4
CAS*PR*1*21.86
CAS*CO*45*14.14
DTP*573*D8*20220610
LX*5
SV1*HC:83036*27*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-05
SVD*29076*0*HC:83036**1*5
CAS*PR*1*16.68
CAS*CO*45*10.32
DTP*573*D8*20220610
LX*6
SV1*HC:85025*23*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-06
SVD*29076*13.3*HC:85025**1*6
CAS*PR*1*.06
CAS*CO*45*9.64
DTP*573*D8*20220610
LX*7
SV1*HC:80048*21*UN*1***1:2:3:4
DTP*472*D8*20220519
REF*6R*EP062514757253118-07
SVD*29076*12.61*HC:80048**1*7
CAS*CO*45*8.39
DTP*573*D8*20220610
LX*8
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DTP*472*D8*20220519
REF*6R*EP062514757253118-08
SVD*29076*10.86*HC:80076**1*8
CAS*CO*45*7.14
DTP*573*D8*20220610
SE*100*000000459

7 Version History

The following Version History is provided to easily identify updates from the last version of this Companion Guide.

Version	Date Updated	Update
1.1	September 2014	Add Notes to segment to NOT add leading zero's or dashes to NPI Numbers
1.2	February 2024	**Update:** - Any claim submitted that contains more than 97 Service Lines (was 85 Service Lines) will be split into to two claims by Apex Health Solutions for payment (LX01) - 5.1 837 Institutional Health Care Claim - Header Section - Updated Questions 2 and 6 - Removed Question 7 **Added:** - 5.1.1 837 Institutional Health Care Claim - Submitter/Receiver Details Section - New Question 7

7 Frequently Asked Questions – FAQ

1. What is Electronic Data Interchange?
Electronic Data Interchange (EDI) is the computer-to-computer exchange of business documents in a standard electronic format between business Partners. By moving from a paper-based exchange of business document to one that is electronic, businesses enjoy major benefits such as reduced cost, increased processing speed, reduced errors and improved relationships with business Partners.

2. How many claims do you currently receive electronically?
Approximately 98% of our claims today are received electronically.

3. Why submit claims electronically?
Electronic claims are not subject to postal delays and may be transmitted 24 hours a day seven days a week. Submitting electronically reduces costs, increases processing speeds and reduces errors.

4. Will Apex Health Solutions reject claims submitted electronically without the NPI number?
Yes, unless the claim is sent with a Taxonomy Exception.

5. Do you accept secondary claims electronically?
Yes, we accept secondary claims electronically. However, the Explanation of Benefits information is required. It should be sent with the claim electronically, detailing the COB information at the line level.

6. Which claims may be submitted electronically?
We accept all claims electronically. However, Apex Health Solutions only accepts supporting documentation by mail. All documentation and attachment cover sheets must be received within 14 calendar days of the electronic claim being transmitted, otherwise the claim will be denied.

Note: Illegible information will delay processing of that claim.

7. Can Participating Provider receive Paper Remits (EOP)?
No, all Participating Providers that submit claims electronically, will be asked to review their Remits through their Plan Central Account or have their Remits sent to a Clearing House of their choice. Providers can register for a Plan Central Account using the below link and then clicking on 'Provider Forms & Resources' and then 'Plan Central'.
https://www.apex-healthsolutions.com/forms-and-resources