HIPAA Transaction
Companion Guide
837 – Professional Health Care Claim
Refers to the Implementation Guides
Based on X12 version 005010
Companion Guide Version Number: 1.1
February 2024

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.wpcedi.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 Professional 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 Professional 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-04 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 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 Corrected Bills
The Claim Frequency Type Code located in segment CLM05-03 determines the processing of corrected bills.

- A corrected bill is indicated by placing a "7" in this field.

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

- Only use standard CPT/HCPCS Codes that are valid at the date of service. Currently use only ICD-10-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 Professional IG.
- Apex Health Solutions will accept all HIPAA standard codes, however acceptance of these codes or modifier 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 Professional 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
Decimals should not 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 2300, Loop 2320 and Loop 2400:

- CLM02 Monetary amount – Total Submitted Changes
- SV102 Monetary amount – Line Item Charge Amount
- SV104 Quantity – Service Unit Count
- AMT02 Monetary amount – COB Payer Paid Amount
- AMT02 Monetary amount – COB Allowed Amount

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 Providers in a Group Practice

If you are a Rendering Provider in a Group Practice and your checks are issued to the Group Practice, please use your individual NPI number. If you use another provider's individual NPI number within the Group Practice, it will result in the check being issued correctly to the Group Practice, however, the Explanation of Payment (EOP) or the 835 Health Care Payment Advice will indicate the incorrect rendering provider. An example follows:

Dr. Smith is part of Radiology Group. He uses the Tax Identification Number (TIN) of the group. If the 837 Health Care Claim Professional is submitted with the incorrect NPI, which is assigned to Dr. Jones in the same practice, the payment will be issued to the Radiology Group, but the EOP or 835 Health Care Payment Advice will list Dr. Jones as the rendering provider.

3.1.2 Individual Providers & Individually Paid Providers

If you are an individual provider or a provider in a Group Practice and your checks are issued to the individual physician, please use your individual NPI number. If you use another provider's individual NPI, the claim will be processed incorrectly. The EOP or 835 Health Care Payment Advice will be issued to the physician associated with the NPI that was submitted. An example follows:

If Dr. Smith submits a claim using the NPI number assigned to Dr. Jones), the claim will be processed as submitted and the EOP or 835 Health Care Payment Advice will be returned to Dr. Jones 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 as a corrected claim file. Rejected 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 Professional Health Care Claim file.

5 Data Element Table: Professional

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 Professional 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 Professional Claims. All alpha characters should be formatted as UPPERCASE only.

5.1 837 Professional 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 Professional 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 Professional 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	BI - Billing Provider
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	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 details 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	82	82 - Rendering Provider If this segment is submitted, then the REF01 and REF02 segments with the specified data requested must also be submitted. Failure to submit the combination of these segments will result in the claim being rejected.
Individual or Organizational Name	NM102	Entity Type Qualifier	1, 2	1 - Person 2 - Non-Person Entity
Individual or Organizational Name	NM103	Last Name or Organization Name	Rendering Provider's Last Name or Name of the Organization	Represents the Rendering Provider's Last Name or Name of the Organization
Individual or Organizational Name	NM104	First Name	Rendering Provider's First Name	Represents the Rendering Provider'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****
Rendering Provider Secondary Identification	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
Rendering Provider Secondary Identification	REF02	Reference Identification Qualifier	Rendering 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****
Individual or Organizational Name	NM101	Entity Identifier Code	77	77 – Service Facility This is **Required** for all Professional claims when the location code is **NOT** one of the following - ('03','11','12','41','42','81','20','60','71','49','65','72') Failure to submit this segment will result in the claim being rejected.
Individual or Organizational Name	NM102	Entity Type Qualifier	2	Non-Person Entity
Individual or Organizational Name	NM103	Last Name or Organization Name	Last Name or Organization Name	Service Facility Location Name
Individual or Organizational Name	NM108	Identification Code Qualifier	XX	National Provider ID (NPI)
Individual or Organizational Name	NM109	Identification Code	NPI Number	Enter the Service Facility's NPI Number. ****Please do not send dashes or leading zeroes****
Party Location	N301	Address Information	Facility Address	This is **Required** for all Professional claims when the location code is **NOT** one of the following - ('03','11','12','41','42','81','20','60','71','49','65','72') Failure to submit this segment will result in the claim being rejected.
Geographic Location	N401	City Name	Facility City Name	This is **Required** for all Professional claims when the location code is **NOT** one of the following - ('03','11','12','41','42','81','20','60','71','49','65','72') Failure to submit this segment will result in the claim being rejected.
Geographic Location	N402	State	Facility Location State	This is **Required** for all Professional claims when the location code is **NOT** one of the following - ('03','11','12','41','42','81','20','60','71','49','65','72') Failure to submit this segment will result in the claim being rejected.
Geographic Location	N403	Postal Code	Facility Location Postal Code	This is **Required** for all Professional claims when the location code is **NOT** one of the following - ('03','11','12','41','42','81','20','60','71','49','65','72') Failure to submit this segment will result in the claim being rejected.

Envelope/Section Label	Segment	Description	Value Options for Apex Health Solutions	Description/Comments
Other Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	P - Primary S - Secondary T - Tertiary ***See complete list on Implementation Guide***	Usage of 'S' requires that 'P' be present Usage of 'T' requires that both 'P' and 'S' be present
Other Payer Name	NM108	Amount Qualifier Code	FI	Submitters are required to send all known information on other payers in Loop ID-2330
Other Payer Name	NM109	Other Payer Primary	Self-Assigned	This number must be identical to SVD01 (Loop 2430) for COB. If COB submitted, NM109 is required and must be unique from any other 2330B/NM109 value.
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.
Professional Services	SV101-3	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.
Professional Services	SV101-4	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.
Professional Services	SV101-5	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.
Professional Services	SV101-6	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.
Professional Services	SV102	Monetary Amount	(Line Item Charge Amount)	The sum of the service lines charges reported in this field must be equal to the Total Claim Charge Amount in Loop 2300/CLM02
Professional Services	SV103	Units or Basis for Measurement Code	MJ, UN	MJ - Minutes ****(Required for Anesthesia Claims)**** UN - Units
Professional Services	SV104	Quantity	Service Unit/Minute Count	Apex Health Solutions accepts values greater than or equal to 1. The service unit count may not exceed 999. If the quantity exceeds 999 the claim will be rejected.
Line Adjudication Info	SVD01	Identification Code	Other Payer Identifier	Value is required when segment sent and must match a previous 2330B/NM109 value

6 837 Professional Health Care Claim Sample

6.1 Claim Scenario

Apex Health Solutions member, Johnny Doe, went to his PCP, Dr. Joel Smith at Smith's Family Practice, on September 15, 2022. Dr. Smith submitted the claim to a clearinghouse. The clearinghouse transmitted the claim to Apex Health Solutions in the 837P file format.

Claim Information:

Claim Date: 7/17/2022
Claim Time: 9:39 am

Sender: Clearinghouse
Sender Electronic Transmitter ID: Type 46, 999999999

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

Professional Claim: 005010X222

Billing Provider: Smiths Family Practice
Tax Identification Number: Type XX (NPI), 1234567890
Provider Address: 123 Med Center Drive Akron, OH 44308
Provider Contact Information: Smiths Family Practice Phone (330) 555-5555

Subscriber: Jonathan Doe
Subscriber ID: 98765432100
Group #: V99999
Birth date: 4/5/74
Sex: M
Insurance/Payer ID: Apex Health Solutions, 34196

Patient: Johnny Doe
Patient ID: 98765432102
Patient Address: 100 Patient RD Akron, OH 44308
Date of Birth: 10/28/02
Sex: M

Provider's Patient Account Number at Claim level: 0027833
Clearinghouse Claim Reference Number: Type D9, 01234567890
Diagnosis: ICD-10, R509 - Fever

Rendering Provider at Claim level: Dr. Joel C. Smith, DO
Rendering Provider ID at Claim level: Type 24 (TIN), 34-1131413

Service Procedure CPT: 99212 – 0ffice visit, unfocused, 15 minutes
Charged Amount: $50.00
Units: 1
Date of Service: 07/15/22

6.2 837P – NPI Claim Example ANSI X12

ST*837*000000001*005010X222~
BHT*0019*00*000000001*20220715*0939*CH~
NM1*41*2*CLEARINGHOUSE*****46*999999999~
PER*IC*CLEARINGHOUSE*TE*8005555555~
NM1*40*2*APEX HEALTH SOLUTIONS*****46*34196~
HL*1**20*1~
NM1*85*2*SMITHS FAMILY PRACTICE***XX*1234567890~**
N3*123 MED CENTER DRIVE~
N4*AKRON*OH*44308~
REF*EI*111223333~
PER*IC*SMITHS FAMILY PRACTICE*TE*3305555555~
HL*2*1*22*1~
SBR*P**V99999******CI~
NM1*IL*1*DOE*JONATHAN****MI*98765432100~
DMG*D8*19740405*M~
NM1*PR*2*APEX HEALTH SOLUTIONS*****PI*34196~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*DOE*JOHNNY****MI*98765432102~
N3*100 PATIENT RD~
N4*AKRON*OH*44308~
DMG*D8*20021028*M~
CLM*0027833*50***22::1*Y*A*Y*Y*C~
REF*D9*01234567890~
HI*ABK:R509~
NM1*82*1*SMITH*JOEL*C**DO*XX*9876543210~
REF*EI*44455666~
NM1*77*2*SUMMA HEALTH SYSTEMS***XX*1234567890~**
N3*123 SUMMA DRIVE~
N4*AKRON*OH*44308~
LX*1~
SV1*HC:34196*50*UN*1***1~
DTP*472*D8*20220715~
SE*35*000000001~

6.3 837P – COB Claim Example ANSI X12

ST*837*0001*005010X222~
BHT*0019*00*1*20220715*08280000*CH~
NM1*41*2*SUGARHILL BILLING SERVICE*****46*00123~
PER*IC*TECHNOLOGY SUPPORT CENTER*TE*3305554321~
NM1*40*2*APEX HEALTH SOLUTIONS*****46*34196~
HL*1**20*1~
NM1*85*2*JACK SPRAT INC*****XX*300300123~
N3*PO BOX 1687~
N4*FOREST HILL*OH*441234107~
REF*1C*0123456789~
PER*IC* BARBIE*TE*2165552020~
HL*2*1*22*0~
SBR*S*18*731062******ZZ~
NM1*IL*1*GREEN*MARY****MI*98799432100~
N3*1506 MAGIC DR~
N4*AKRON*OH*44308~
DMG*D8*19220101*F~
REF*IG*012345678D~
NM1*PR*2*APEX HEALTH SOLUTIONS*****PI*34196~
N3*17 TECHNOLOGY~
N4*COLUMBIA*SC*29219~
CLM*TV12345678987654*59.28***12::1*Y*A*Y*Y*C~
REF*F5*N~
HI*ABK:R509~
NM1*82*2*LINUS INC*****XX*300300123~
REF*1C*0123456789~
SBR*P*18*MB****MB~**
AMT*D*24.46~
AMT*AAE*30.57~
AMT*B6*30.57~
DMG*D8*19220101*F~
OI*Y*C**Y~**
NM1*IL*1*GREEN*MARY****MI*270123456D~
N3*1506 MAGIC DR~
N4*AKRON*OH*443081234~
NM1*PR*2*XYZ HEALTH PLAN, INC *****PI***00123**~
PER*IC*COORDINATION OF BENEFITS*TE*8885551105*FX*8885550008~
REF*F8*0123456789000~
NM1*82*2~
REF*1C*1234567890~
LX*1~
SV1*HC:E0434:RR*59.28*UN*1*12**1~
DTP*472*D8*20220715~
AMT*AAE*30.57~
NM1*DK*1*JOHNSON*DAVID~
N3*2400 MONTY RD~
N4*NORFOLK*VA*245510687~
REF*1G*B01234~
SVD*00123*24.46*HC:E0434:RR**1~
CAS*CO*96*28.71~
CAS*PR*2*6.11~
DTP*573*D8*20220715~
SE*54*0001~
GE*1*1~
IEA*1*000000001~

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
1.0	August 2017	**Loop 2310C** 77 – Service Facility/Service Facility Address This is Required for all Professional claims when the location code is **NOT** one of the following -('03','11','12','41','42','81','20','60','71','49','65','72'). Failure to submit this segment will result in the claim being rejected.
1.1	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 **-** 5.1 837 Professional Health Care Claim - Header Section **-** Updated Questions 2 and 6 **-** Removed Question 7 **Added:** **-** 5.1.1 837 Professional Health Care Claim - Submitter/Receiver Details Section **- New** Question 7

7 Frequently Asked Questions

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