

AULTCARE
837 HIPAA
Companion
Guide

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INTRODUCTION

The objective of the guide is not to report all of the required data in the implementation guide. The HIPAA implementation guide contains many optional data specifications. This companion guide will indicate what optional data requirements must be met to quickly adjudicate the claim. The companion guide will also describe additional data information clarifications that will assist in adjudicating the claim upon receipt.

Note: Loops supplied within the 837 file are required to be in the sequence as defined in the HIPAA implementation guide. Segments within the loops are expected to follow the sequence in which the HIPAA implementation guide defines the segments within each loop.

Note: The HIPAA implementation guide recommends a limit of 5000 CLM segments. AultCare adheres to this limit and cannot accept file that exceed this transmission size.

The following sections are contained within the guide.

- 1. Envelope Data Requirements** – This chapter explains how to fill out the ISA and GS segment.
- 2. Professional Claim Data Requirements** – The data requirements for Professional Claims are explained.
- 3. Institutional Claim Data Requirements** – The data requirements for Hospital Claims are explained.
- 4. Dental Claim Data Requirements** – The data requirements for Dental Claims are explained.
- 5. Trading Partner Requirements** – This chapter defines the testing and production procedures to be followed by providers and vendors intending to send files via electronic file transmission.
- 6. Appendix A** – This chapter lists changes made to the companion guide.
- 7. Appendix B** – Facts you should know about AultCare Electronic Claims
- 8. Appendix C** – AultCare Product Lines for Electronic Claims

If there are additional questions, please contact our HIPAA 837 Transaction Coordinator.



837 COMPANION GUIDE

AulCare Information Systems

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1. ENVELOPE DATA REQUIREMENTS

T

he ISA and GS segments make up the header information for the 837 transaction . The information in the tables in this chapter show what information is expected.

Within the ISA is the Test/Production indicator. This indicator must be filled in properly. Test files must be sent with the “T” for test. After testing is successfully completed, the indicator changes to “P” for production processing.

ISA – Interchange Control Header

Location	Data Element Description	Expected Value
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	Blank
ISA03	Security Information Qualifier	00
ISA04	Security Information	Blank
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	Client Federal Tax ID
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	AultCare Federal Tax ID: 341488123
ISA09	Interchange Date	YYMMDD
ISA10	Interchange Time	HHMM

ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Increment by 1 with each submission
ISA14	Acknowledgment Requested	0 or 1
ISA15	Usage Indicator	T or P
ISA16	Component Element Separator	Recommend colon (:)

Note: An asterisk (*) is recommended as the data element separator.

A tilde (~) is recommended as the segment terminator.

GS – Functional Group Header

Location	Data Element Description	Expected Value
GS01	Functional Identifier Code	HC
GS02	Application Sender's Code	Client Federal Tax ID
GS03	Application Receiver's Code	AultCare Federal Tax ID: 341488123
GS04	Date	CCYYMMDD
GS05	Time	HHMM
GS06	Group Control Number	Provider Assigned
GS07	Responsible Agency Code	X
GS08	Version / Release / Industry Identifier Code	Varies depending on file type being sent: 004010X096A1 or 004010X097A1 or 004010X098A1

2. Professional Claim Data Requirements

The tables in this chapter cover the data that is required for a professional claim. The data presented is not all of the data required for a claim, **only** the data that needs clarification or further description of the expected data.

For more information about each piece of data and the different locations, please refer to the HIPAA Implementation Guide for the 837 Health Care Claim: Professional.

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000A	NM109	Identification Code	Provider Federal Tax ID Number
1000B	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000B	NM109	Identification Code	AultCare Federal Tax ID Number: 341488123

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	Reference Identification Qualifier	ZZ
2000A	PRV03	Reference Identification	If the rendering provider is the same as the bill-to and pay-to provider and a provider suffix is not supplied, the taxonomy code is required in this loop.
2010AA	NM101	Entity Identifier Code	85 – Billing Provider
2010AA	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AA	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AA	NM109	Identification Code	Billing Provider National Provider Identifier Note: Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	Billing Provider Address	Billing Provider Address information required when rendering provider/facility is

			the same as the Bill-to provider.
2010AA	N4	Billing Provider Location City/State/Zip	Billing Provider location information required when rendering provider/facility is the same as the Bill-to provider.
2010AA	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AA	REF02	Reference Identification	Provider Federal Tax ID Number Note: The provider suffix will be accepted when supplied, but is not required.
2010AB	NM101	Entity Identifier Code	87 – Pay-to Provider
2010AB	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AB	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AB	NM109	Identification Code	Pay-to National Provider Identifier Note: Pay-to Provider Tax Identification Number is required in the 2010AB REF Segment.
2010AB	N3	Pay-To Provider Address	Pay-to Provider Address information required when rendering provider/facility is

			the same as the Pay-to provider.
2010AB	N4	Pay-to Provider Location City/State/Zip	Pay-to Provider location information required when rendering provider/facility is the same as the Pay-to provider.
2010AB	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AB	REF02	Reference Identification	Pay-to Provider Federal Tax ID Number Note: The provider suffix will be accepted when supplied, but is not required.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	SBR03	Reference Identification	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	Name	The Group Name is not required, but is recommended.
2010BA	NM103	Name Last or Organization Name	Subscriber Last Name
2010BA	NM104	Name First	Subscriber First Name
2010BA	NM108	Identification Code Qualifier	MI – Member Identifier
2010BA	NM109	Identification Code	<p>Provide the subscriber’s SSN or Member ID.</p> <p>When <u>both</u> Member ID and social security number are being supplied: Supply SSN in Loop 2010BA NM1 segment and the Member ID in Loop 2010BA REF segment.</p> <p>When only <u>one</u> ID is being supplied: Supply the Member ID or SSN in the Loop 2010BA NM109</p>

			field.
2010BA	N301	Address Information	Subscriber's Street Address Recommended for all claims to facilitate claim processing.
2010BA	N401	City Name	Subscriber's City Recommended for all claims to facilitate claim processing.
2010BA	N402	State or Province Code	Subscriber's Postal State Code Recommended for all claims to facilitate claim processing.
2010BA	N403	Postal Code	Subscriber's Postal Code Recommended for all claims to facilitate claim processing.
2010BA	DMG02	Date Time Period	Subscriber's Date of Birth. Required when patient is the same as the subscriber. Recommended for all claims to facilitate claim processing.
2010BA	DMG03	Gender Code	Subscriber's Gender Code. Required when patient is the same as the subscriber. Recommended for

			all claims to facilitate claim processing.
2010BA	REF01	Reference Identification Qualifier	IG – Insurance Policy Number
2010BA	REF02	Reference Identification	Member ID
2010BB	NM103	Name Last or Organization Name	Populate the field with the payer name. Populate this field with AULTCARE.
2010BB	NM108	Identification Code Qualifier	PI – Payer Identifier
2010BB	NM109	Identification Code	Populate the field with the AultCare federal tax id: 341488123.
2010BB	N3	Address Information	Populate the N3 segment with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710

Patient (Dependent)

The patient information should be provided when the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	Name Last or Organization Name	Patient Last Name
2010CA	NM104	Name First	Patient First Name

2010CA	NM108	Identification Code Qualifier	MI
2010CA	NM109	Identification Code	If patient is a dependent supply patient's SSN.
2010CA	N301	Address Information	Patient's Street Address
2010CA	N401	City Name	Patient's City
2010CA	N402	State or Province Code	Patient's Postal State Code
2010CA	N403	Postal Code	Patient's Postal Code
2010CA	DMG02	Date Time Period	Patient's Date of Birth.
2010CA	DMG03	Gender Code	Patient's Gender Code.

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	Claim Submitter's Identifier	The provider should attempt to make this number unique. This number will be echoed back in the 835. A unique number will make it easier to identify the claim.
2300	CLM06	Yes/No Condition or Response Code	Supplying provider signature on file information may facilitate claim adjudication.
2300	CLM07	Provider Accept Assignment Code	Supplying the Medicare assignment code

			may facilitate claim adjudication.
2300	CLM08	Yes/No Condition or Response Code	Supplying benefits assignment information may facilitate claim adjudication.
2300	DTP01	Date/Time Qualifier	454 – Initial Treatment
2300	DTP03	Date Time Period	The date of the initial treatment may speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	431 – Onset of current illness or symptom
2300	DTP03	Date Time Period	The date of the illness or incident that caused the illness may speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	439 – Accident
2300	DTP03	Date Time Period	If the claim is for an accident, then the accident date is required.
2300	DTP01	Date/Time Qualifier	484 – Last Menstrual Period
2300	DTP03	Date Time Period	Required when claim involves pregnancy.
2300	DTP01	Date/Time Qualifier	435 – Date of Admission
2300	DTP03	Date Time Period	If the claim is associated with a hospital stay, then the date of admission should

			be included.
2300	DTP01	Date/Time Qualifier	455- Last X-Ray
2300	DTP03	Date Time Period	Required for chiropractor claims; and claims involving spinal manipulation.
2300	DTP01	Date/Time Qualifier	471- Prescription
2300	DTP03	Date Time Period	Required when a prescription has been written for hearing devices or vision frames and lenses and is included with this claim.
2300	DTP01	Date/Time Qualifier	360- Disability Begin
2300	DTP03	Date Time Period	The disability begin date may speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	361- Disability End
2300	DTP03	Date Time Period	The disability end date may speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	297- Date Last Worked
2300	DTP03	Date Time Period	The last work date may speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	296- Return to Work Date
2300	DTP03	Date Time Period	The return to work date may

			speed up the processing of the claim for certain types of claims.
2300	DTP01	Date/Time Qualifier	435- Admission Date
2300	DTP03	Date Time Period	Required on all claims/encounters that involve a patient hospital admission.
2300	DTP01	Date/Time Qualifier	096- Discharge Date
2300	DTP03	Date Time Period	Required for inpatient claims; this field indicates when a patient is discharged from a facility.
2300	DTP01	Date/Time Qualifier	090-Assumed Care Date
2300	DTP03	Date Time Period	Required for Medicare claims.
2300	DTP01	Date/Time Qualifier	091-Relinquished Care Date
2300	DTP03	Date Time Period	Required for Medicare claims.
2300	AMT01	Amount Qualifier Code	F5 – Patient Amount Paid
2300	AMT02	Monetary Amount	For correct payment, please indicate any amounts the patient paid toward the service.
2300	AMT01	Amount Qualifier Code	NE – Net Billed
2300	AMT02	Monetary Amount	Required if there are purchased service components to this claim; use this segment with vision claims.

2300	REF01	Reference Identification Qualifier	G1 – Prior Authorization Number
2300	REF02	Reference Identification	If the service had prior authorization, then include the authorization number for faster processing.
2300	REF01	Reference Identification Qualifier	4N – Service authorization exception code
2300	REF02	Reference Identification	Required when providers are required by state law. (e.g. Medicaid in some states)
2300	REF01	Reference Identification Qualifier	F5 – Mandatory Medicare Crossover indicator
2300	REF02	Reference Identification	Required only for Medicare Crossover claims.
2300	NTE02	Description	<p>Note: Text should not be sent unless absolutely necessary to explain the claim.</p> <p>Note: Injury details should be supplied when applicable (e.g. when, where, how, etc.)</p> <p>AultCare highly recommends accident detail in the NTE segment to expedite claim consideration for accident related</p>

			claims.
2300	HI01-1	Code List Qualifier Code	BK – Principle Diagnosis
2300	HI01-2	Industry Code	ICD-9 Primary Diagnosis required, additional diagnosis codes supplied as needed. Note: Codes beginning with an E (E-codes) can be provided to supply accident information.
2300	HCP	Claim Pricing / Repricing Information	Supply when applicable.
2310A	NM101	Entity Identifier Code	DN – Referring Provider
2310A	NM103	Name Last or Organization Name	Referring Provider Last Name
2310A	NM104	Name First	Referring Provider First Name
2310A	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310A	NM109	Identification Code	Referring Provider National Provider Identifier Note: Referring Provider Tax Identification Number is required in the 2310A REF Segment.
2310A	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310A	REF02	Reference Identification	Referring Provider Federal Tax ID Number

			Note: The provider suffix will be accepted when supplied, but is not required.
2310B	NM101	Entity Identifier Code	82 – Rendering Provider
2310B	NM103	Name Last or Organization Name	Rendering Provider Last Name
2310B	NM104	Name First	Rendering Provider First Name
2310B	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310B	NM109	Identification Code	Rendering Provider National Provider Identifier Note: Rendering Provider Tax Identification Number is required in the 2310B REF Segment.
2310B	PRV01	Provider Code	PE – Performing
2310B	PRV02	Reference Identification Qualifier	ZZ – Health Care Provider Taxonomy Code
2310B	PRV03	Reference Identification	When a provider suffix is not supplied, the taxonomy code is required in this loop.
2310B	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310B	REF02	Reference Identification	Rendering Provider Federal Tax ID Number

			<p>Note: The provider suffix will be accepted when supplied, but is not required.</p>
2310D	NM101	Entity Identifier Code	<p>FA - Facility</p> <p>Note: Only the value of FA will be recognized by the AultCare claims system.</p>
2310D	NM103	Name Last or Organization Name	Laboratory or Service Facility Name
2310D	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310D	NM109	Identification Code	<p>Laboratory or Service Facility National Provider Identifier</p> <p>Note: Laboratory or Service Facility Tax Identification Number is required in the 2310D REF Segment.</p>
2310D	N3	Service Facility Address	Service Facility address information required for claim adjudication.
2310D	N4	Service Facility Location City/State/Zip	Service Facility location information required for claim adjudication.
2310D	REF01	Reference Identification Qualifier	TJ – Employer’s Identification Number

2310D	REF02	Reference Identification	Laboratory or Service Facility Federal Tax ID Number Note: The Laboratory or Service Facility suffix will be accepted when supplied, but is not required.
2310E	NM101	Entity Identifier Code	DQ – Supervising Provider
2310E	NM103	Name Last or Organization Name	Supervising Provider Last Name
2310E	NM104	Name First	Supervising Provider First Name
2310E	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310E	NM109	Identification Code	Supervising Provider National Provider Identifier Note: Supervising Provider Tax Identification Number is required in the 2310E REF Segment.
2310E	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310E	REF02	Reference Identification	Supervising Provider Federal Tax ID Number Note: The Supervising Provider suffix will be accepted

			when supplied, but is not required.
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Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Loop Id	Data Element	Data Element Description	Data Requirements
2400	SV101-1	Product/Service ID Qualifier	HC – CPT or HCPCS codes Note: A maximum of 99 lines can be accepted by AultCare.
2400	SV101-2	Product/Service ID	Procedure code
2400	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	Procedure Modifiers 1 – 4 are required when the reporting accuracy of the associated procedure code is improved.
2400	SV102	Monetary Amount	Line item charge amount. Note: Positive values only.
2400	SV103	Unit or Basis for Measurement Code	UN – Units, used for most cases. MJ – Minutes for

			Anesthesia claims.
2400	SV104	Quantity	Units or Minutes for this claim line.
2400	SV105	Facility Code Value	The place of service is required, unless presented at the claim level.
2400	SV107 - 1	Diagnosis Code Pointer	The first diagnosis code is required. Use remaining diagnosis pointers if needed to substantiate medical treatment.
2400	SV109	Yes/No Condition or Response Code	Emergency indicator is required when service is known to be an emergency by the provider.
2400	SV111	Yes/No Condition or Response Code	EPSDT indicator is required if Medicaid services are result of a screening referral.
2400	SV112	Yes/No Condition or Response Code	Family Planning indicator is required for Medicaid claims.
2400	SV5	Durable Medical Equipment Service	Required when reporting rental/purchase price information for DME.
2400	DTP02	Date Time Period Format Qualifier	The service date for the procedure.
2400	HCP	Line Pricing / Repricing Information	Supply when applicable.
2400	NTE02	Description	AultCare highly recommends supplying additional information

			regarding service rendered detail (e.g. for unlisted procedures, dosage, etc.)
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Service Line Segments

Information provided within the service line 2400 loop that overrides information provided within the claim level 2300 loop should follow the same guidelines defined at the claim loop level. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

3. Institutional Claim Data Requirements

The tables in this chapter cover the data that is required for an institutional or hospital claim. The data presented is not all of the data required for a claim, only the data that needs clarification or further description of the expected data. Institutional claims cover both inpatient and outpatient services.

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000A	NM109	Identification Code	Provider Federal Tax ID Number
1000B	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000B	NM109	Identification Code	AultCare Federal Tax ID Number: 341488123

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	Reference Identification Qualifier	ZZ
2000A	PRV03	Reference Identification	If the rendering provider is the same as the bill-to and pay-to provider and a provider suffix is not supplied, the taxonomy code is required in this loop.
2010AA	NM101	Entity Identifier Code	85 – Billing Provider
2010AA	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AA	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AA	NM109	Identification Code	Billing Provider National Provider Identifier Note: Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	Billing Provider Address	Billing Provider Address information required when service facility

			provider is the same as the Bill-to provider.
2010AA	N4	Billing Provider Location City/State/Zip	Billing Provider location information required when service facility provider is the same as the Bill-to provider.
2010AA	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AA	REF02	Reference Identification	Billing Provider Federal Tax ID Number Note: The Billing Provider suffix will be accepted when supplied, but is not required.
2010AB	NM101	Entity Identifier Code	87 – Pay-to Provider
2010AB	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AB	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AB	NM109	Identification Code	Pay-to Provider National Provider Identifier Note: Pay-to Provider Tax Identification Number is required in the 2010AB REF Segment.
2010AB	N3	Pay-To Provider Address	Pay-to Provider

			Address information required when service facility provider is the same as the Pay-to provider.
2010AB	N4	Pay-to Provider Location City/State/Zip	Pay-to Provider location information required when service facility provider is the same as the Pay-to provider.
2010AB	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AB	REF02	Reference Identification	Pay-to Provider Federal Tax ID Number Note: The Pay-to Provider suffix will be accepted when supplied, but is not required.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	03	Reference Identification	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	Name	The Group Name is not required, but is

			recommended.
2000B	SBR09	Claim Filing Indicator Code	AulCare accepts codes: CI: Commercial Insurance 16: HMO Medicare Risk MC: Mediplan
2010BA	NM103	Name Last or Organization Name	Subscriber Last Name
2010BA	NM104	Name First	Subscriber First Name
2010BA	NM108	Identification Code Qualifier	MI – Member Identifier
2010BA	NM109	Identification Code	Provide the subscriber’s SSN or Member ID. When <u>both</u> Member ID and social security number are being supplied: Supply SSN in Loop 2010BA NM1 segment and the Member ID in Loop 2010BA REF segment. When only <u>one</u> ID is being supplied: Supply the Member ID or SSN in the Loop 2010BA NM109 field.
2010BA	N301	Address Information	Subscriber’s Street Address Recommended for all claims to facilitate claim processing.

2010BA	N401	City Name	Subscriber's City Recommended for all claims to facilitate claim processing.
2010BA	N402	State or Province Code	Subscriber's Postal State Code Recommended for all claims to facilitate claim processing.
2010BA	N403	Postal Code	Subscriber's Postal Code Recommended for all claims to facilitate claim processing.
2010BA	DMG02	Date Time Period	Subscriber's Date of Birth. Only required if the subscriber is the patient. Recommended for all claims to facilitate claim processing.
2010BA	DMG03	Gender Code	Subscriber's Gender Code. Only required if the subscriber is the patient. Recommended for all claims to facilitate claim processing.
2010BA	REF01	Reference Identification Qualifier	IG – Insurance Policy Number
2010BA	REF02	Reference Identification	Member ID

2010BC	NM103	Name Last or Organization Name	Populate the field with the payer name. Populate this field with AULTCARE.
2010BC	NM108	Identification Code Qualifier	PI – Payer Identifier
2010BC	NM109	Identification Code	Populate the field with the AultCare federal tax id: 341488123.
2010BC	N3	Address Information	Populate the N3 segment with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710

Patient (Dependent)

The patient information should be provided when the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	Name Last or Organization Name	Patient Last Name
2010CA	NM104	Name First	Patient First Name
2010CA	NM109	Identification Code	If patient is a dependent supply patient's SSN.
2010CA	N301	Address Information	Patient's Street Address
2010CA	N401	City Name	Patient's City
2010CA	N402	State or Province Code	Patient's Postal

			State Code
2010CA	N403	Postal Code	Patient's Postal Code
2010CA	DMG02	Date Time Period	Patient's Date of Birth.
2010CA	DMG03	Gender Code	Patient's Gender Code.

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	Claim Submitter's Identifier	The provider should attempt to make this number unique. This number will be echoed back in the 835. A unique number will make it easier to identify the claim.
2300	CLM06	Yes/No Condition or Response Code	Supplying provider signature on file information may facilitate claim adjudication.
2300	CLM07	Provider Accept Assignment Code	Supplying the Medicare assignment code may facilitate claim adjudication.
2300	CLM08	Yes/No Condition or Response Code	Supplying benefits assignment information may facilitate claim adjudication.
2300	DTP01	Date/Time Qualifier	434 – Statement
2300	DTP03	Date Time Period	Required statement from or to date.
2300	DTP01	Date/Time Qualifier	096 – Discharge
2300	DTP03	Date Time Period	Discharge Hour required for final inpatient claims/encounters.
2300	DTP01	Date/Time Qualifier	435 – Date of

			Admission
2300	DTP03	Date Time Period	Admission date required for all inpatient claims.
2300	CL1	Institutional Claim Code Segment	Required when reporting hospital based admissions and Medicare outpatient registrations on claims/encounters.
2300	AMT01	Amount Qualifier Code	F5 – Patient Amount Paid
2300	AMT02	Monetary Amount	For correct payment, please indicate any amounts the patient paid toward this service.
2300	REF01	Reference Identification Qualifier	G1 – Prior Authorization
2300	REF02	Reference Identification	If the service had prior authorization, then include the authorization number for faster processing.
2300	REF01	Reference Identification Qualifier	4N – Service authorization code
2300	REF02	Reference Identification	Required when providers are required by state law (e.g. Medicaid in some states)
2300	NTE02	Description	Note: Text should not be sent unless absolutely necessary to explain the claim. Note: Injury details should be

			<p>supplied when applicable (e.g. when, where, how, etc.)</p> <p>AultCare highly recommends accident detail in the NTE segment to expedite claim consideration for accident related claims.</p>
2300	HI	Principal, Admitting, E-Code and Patient Reason, for Visit Diagnosis Information	Required except as noted in HIPAA implementation guide.
2300	HI	Diagnosis Related Group Information	Required when inpatient is under DRG contract.
2300	HI	Principal Procedure Information	Required on inpatient claims or encounters when a procedure was performed.
2300	HCP	Claim Pricing / Repricing Information	Supply when applicable.
2310A	NM101	Entity Identifier Code	71 – Attending Physician
2310A	NM103	Name Last or Organization Name	Attending Physician Last Name
2310A	NM104	Name First	Attending Physician First Name
2310A	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310A	NM109	Identification Code	<p>Attending Physician National Provider Identifier</p> <p>Note: Attending Physician Tax Identification</p>

			Number is required in the 2310A REF Segment.
2310A	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310A	REF02	Reference Identification	Attending Physician Federal Tax ID Number Note: The Attending Physician suffix will be accepted when supplied, but is not required.
2310B	NM101	Entity Identifier Code	72 – Operating Physician
2310B	NM103	Name Last or Organization Name	Operating Physician Last Name
2310B	NM104	Name First	Operating Physician First Name
2310B	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310B	NM109	Identification Code	Operating Physician National Provider Identifier Note: Operating Physician Tax Identification Number is required in the 2310B REF Segment.
2310B	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310B	REF02	Reference Identification	Operating Physician Federal Tax ID Number

			Note: The Operating Physician suffix will be accepted when supplied, but is not required.
2310C	NM101	Entity Identifier Code	73 – Other Physician
2310C	NM103	Name Last or Organization Name	Other Physician Last Name
2310C	NM104	Name First	Other Physician First Name
2310C	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310C	NM109	Identification Code	Other Physician National Provider Identifier Note: Other Physician Tax Identification Number is required in the 2310C REF Segment.
2310C	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310C	REF02	Reference Identification	Other Physician Federal Tax ID Number Note: The Other Physician suffix will be accepted when supplied, but is not required.
2310E	NM101	Entity Identifier Code	FA – Facility
2310E	NM103	Name Last or Organization Name	Service Facility Name
2310E	NM108	Identification Code Qualifier	XX – National Provider Identifier

2310E	NM109	Identification Code	Service Facility National Provider Identifier Note: Service Facility Tax Identification Number is required in the 2310E REF Segment.
2310E	N3	Service Facility Address	Service facility address information required for claim adjudication.
2310E	N4	Service Facility Location City/State/Zip	Service Facility location information required for claim adjudication.
2310E	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310E	REF02	Reference Identification	Service Facility Federal Tax ID Number Note: The Service Facility suffix will be accepted when supplied, but is not required.
2320	AMT	Payer Prior Payment	Required when present payer has paid an amount towards this bill.
2320	AMT	Coordination of Benefits : Allowed amount Total Submitted Medicare Paid Medicare Paid 100% Medicare Paid 80% Medicare A Trust Fund	Provide COB and Medicare amounts when applicable to the claim

		Medicare B Trust Fund COB Not Covered COB Denied Medicare Inpatient Adjudication Medicare Outpatient Adjudication	
2320	AMT	Diagnostic Related Group Outlier Amount	Supply the DRG outlier amount when applicable to the claim.

Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Loop Id	Data Element	Data Element Description	Data Requirements
2400	SV201-1	Product/Service ID Qualifier	42 – Revenue Code
2400	SV202	Composite Medical Procedure Identifier	Required when an appropriate HCPCS code and modifiers exist for this service line item.
2400	SV203	Monetary Amount	Line item charge amount.
2400	SV204	Unit or Basis for Measurement Code	Specify the way units will be supplied.
2400	SV205	Quantity	Supply quantity of units.
2400	SV206	Unit Rate	Supply when required by the revenue code.
2400	SV207	Monetary Amount	Supply non-covered money

			amount when line item is not covered.
2400	DTP	Service Line Date	Supply when required by revenue, procedure, drug codes, or HIEC code.
2400	DTP	Assessment Date	Supply as required to meet Medicare requirements.
2400	HCP	Line Pricing / Repricing Information	Supply when applicable.
2410	LIN	Drug Identification	Supply drug information as needed for claim adjudication.

Service Line Segments

Information provided within the service line 2420 loop that overrides information provided within the claim level 2300 loop should follow the same guidelines defined at the claim loop level. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

4. Dental Claim Data Requirements

The tables in this chapter cover the data that is required for a dental claims.

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000A	NM109	Identification Code	Provider Federal Tax ID Number
1000B	NM108	Identification Code Qualifier	46 – Electronic Transmitter Identification Number
1000B	NM109	Identification Code	AultCare Federal Tax ID Number: 341488123

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	Reference Identification Qualifier	ZZ
2000A	PRV03	Reference Identification	If the rendering provider is the same as the bill-to and pay-to provider and a provider suffix is not supplied, the taxonomy code is required in this loop.
2010AA	NM101	Entity Identifier Code	85 – Billing Provider
2010AA	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AA	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AA	NM109	Identification Code	Billing Provider National Provider Identifier Note: Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	Billing Provider Address	Billing Provider Address information required when rendering

			provider/facility is the same as the Bill-to provider.
2010AA	N4	Billing Provider Location City/State/Zip	Billing Provider location information required when rendering provider/facility is the same as the Bill-to provider.
2010AA	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AA	REF02	Reference Identification	Billing Provider Federal Tax ID Number Note: The Billing Provider suffix will be accepted when supplied, but is not required.
2010AB	NM101	Entity Identifier Code	87 – Pay-to Provider
2010AB	NM103	Name Last or Organization Name	Provider Name or Group Name
2010AB	NM108	Identification Code Qualifier	XX – National Provider Identifier
2010AB	NM109	Identification Code	Pay-to Provider National Provider Identifier Note: Pay-to Provider Tax Identification Number is required in the 2010AB REF Segment.
2010AB	N3	Pay-To Provider Address	Pay-to Provider Address information

			required when rendering provider/facility is the same as the Pay-to provider.
2010AB	N4	Pay-to Provider Location City/State/Zip	Pay-to Provider location information required when rendering provider/facility is the same as the Pay-to provider.
2010AB	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2010AB	REF02	Reference Identification	Pay-to Provider Federal Tax ID Number Note: The Pay-to Provider suffix will be accepted when supplied, but is not required.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	SBR03	Reference Identification	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	Name	The Group Name is not required, but is recommended.
2010BA	NM103	Name Last or Organization Name	Subscriber Last Name
2010BA	NM104	Name First	Subscriber First Name
2010BA	NM108	Identification Code Qualifier	MI – Member Identifier
2010BA	NM109	Identification Code	<p>Provide the subscriber's SSN or Member ID.</p> <p>When <u>both</u> Member ID and social security number are being supplied: Supply SSN in Loop 2010BA NM1 segment and the Member ID in Loop 2010BA REF segment.</p> <p>When only <u>one</u> ID is being supplied: Supply the Member ID or SSN in the Loop</p>

			2010BA NM109 field.
2010BA	N301	Address Information	Subscriber's Street Address Recommended for all claims to facilitate claim processing.
2010BA	N401	City Name	Subscriber's City Recommended for all claims to facilitate claim processing.
2010BA	N402	State or Province Code	Subscriber's Postal State Code Recommended for all claims to facilitate claim processing.
2010BA	N403	Postal Code	Subscriber's Postal Code Recommended for all claims to facilitate claim processing.
2010BA	DMG02	Date Time Period	Subscriber's Date of Birth. Only required if the subscriber is the patient. Recommended for all claims to facilitate claim processing.
2010BA	DMG03	Gender Code	Subscriber's Gender Code. Only required if the subscriber is the patient.

			Recommended for all claims to facilitate claim processing.
2010BA	REF01	Reference Identification Qualifier	IG – Insurance Policy Number
2010BA	REF02	Reference Identification	Member ID
2010BB	NM103	Name Last or Organization Name	Populate the field with the payer name. Populate this field with AULTCARE.
2010BB	NM108	Identification Code Qualifier	PI – Payer Identifier
2010BB	NM109	Identification Code	Populate the field with the AultCare federal tax id: 341488123.
2010BB	N3	Address Information	Populate the N3 segment with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710

Patient (Dependent)

The patient information should only be provided if the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	Name Last or Organization Name	Patient Last Name
2010CA	NM104	Name First	Patient First Name

2010CA	NM109	Identification Code	If patient is a dependent supply patient's SSN.
2010CA	N301	Address Information	Patient's Street Address
2010CA	N401	City Name	Patient's City
2010CA	N402	State or Province Code	Patient's Postal State Code
2010CA	N403	Postal Code	Patient's Postal Code
2010CA	DMG02	Date Time Period	Patient's Date of Birth.
2010CA	DMG03	Gender Code	Patient's Gender Code.

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	Claim Submitter's Identifier	The provider should attempt to make this number unique. This number will be echoed back in the 835. A unique number will make it easier to identify the claim.
2300	DTP01	Date/Time Qualifier	096 – Discharge
2300	DTP03	Date Time Period	Discharge Hour required for final inpatient claims /encounters.
2300	DTP01	Date/Time Qualifier	439 – Accident
2300	DTP03	Date Time Period	If the claim is for an accident, then the accident date is required.
2300	DTP01	Date/Time Qualifier	330 – Date of Referral
2300	DTP03	Date Time Period	Supply referral date.
2300	DTP01	Date/Time Qualifier	452 – Appliance Placement
2300	DTP03	Date Time Period	Supply appliance placement date.
2300	DN1	Quantity	Indicate the number of months of orthodontic treatment.
2300	DN2	Reference Identification	Tooth number needed for

			services other than preventative care.
2300	DN2	Tooth Status Code	Required for services other preventative care.
2300	REF01	Reference Identification Qualifier	G3 - Predetermination of Benefits Identification Number
2300	REF02	Reference Identification	If the request is for predetermination of benefits, then enter the code here.
2300	REF01	Reference Identification Qualifier	9F- Referral Number
2300	REF02	Reference Identification	If the service was the result of a referral, please enter the referral number.
2300	REF02	Reference Identification	The state license number of the rendering dentist should be supplied.
2300	NTE02	Description	<p>Note: Text should not be sent unless absolutely necessary to explain the claim.</p> <p>Note: Injury details should be supplied when applicable (e.g. when, where, how, etc.)</p> <p>AultCare highly recommends accident detail in the NTE segment</p>

			to expedite claim consideration for accident related claims.
2310B	NM101	Entity Identifier Code	82 – Rendering Provider
2310B	NM103	Name Last or Organization Name	Rendering Provider Last Name
2310B	NM104	Name First	Rendering Provider First Name
2310B	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310B	NM109	Identification Code	Rendering Provider National Provider Identifier Note: Rendering Provider Tax Identification Number is required in the 2310B REF Segment.
2310B	PRV01	Provider Code	PE – Performing
2310B	PRV02	Reference Identification Qualifier	ZZ – Health Care Provider Taxonomy Code
2310B	PRV03	Reference Identification	If a provider suffix is not supplied, the taxonomy code is required in this loop.
2310B	REF01	Reference Identification Qualifier	EI – Employer’s Identification Number
2310B	REF02	Reference Identification	Rendering Provider Federal Tax ID Number Note: The Rendering Provider suffix

			will be accepted when supplied, but is not required.
2310B	REF01	Reference Identification Qualifier	0B - State License Number
2310C	NM101	Entity Identifier Code	FA - Facility Note: Only the value of FA will be recognized by the AultCare claims system.
2310C	NM103	Name Last or Organization Name	Facility Name
2310C	NM108	Identification Code Qualifier	XX – National Provider Identifier
2310C	NM109	Identification Code	Facility Name National Provider Identifier Note: Facility Name Tax Identification Number is required in the 2310C REF Segment.
2310C	N3	Service Facility Address	Service Facility address information required for claim adjudication.
2310C	N4	Service Facility Location City/State/Zip	Service Facility location information required for claim adjudication.
2310C	REF01	Reference Identification Qualifier	TJ – Employer’s Identification Number
2310C	REF02	Reference Identification	Service Facility Federal Tax ID Number

			Note: The Service Facility suffix will be accepted when supplied, but is not required.
2310C	REF01	Reference Identification Qualifier	0B - State License Number

Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Service line information is consistent with the HIPAA implementation guide. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

5. Trading Partner Requirements

The information in this chapter explains the procedures a provider or vendor follows to establish electronic file transmission with AultCare.

837 Electronic Claims Procedures for Providers and/or Vendors:

AultCare has established the following procedures for the implementation of the 837 electronic claims file for HIPAA compliance.

Providers and vendors that follow these 837 guidelines will benefit by smooth transition to HIPAA electronic claims submission with minimal interruption of claims processing.

Guidelines:

- Providers should submit a National Provider ID (NPI) and Tax Identification Number (TIN) to insure prompt claims processing.
- Use of the AultCare unique alpha modifier will be accepted when supplied in the 837 file, but is not required.
- A trading partner agreement must be signed and returned to AultCare before an 837 file will be accepted for production file processing.
- Successful 837 testing should be completed and approved by AultCare prior to submitting a production file.

Please forward questions to AultCare-IS@AultCare.com.

The following testing procedures must be completed by providers and/or vendors prior to implementing the 837 electronic claims file.

Testing Procedures:

- Successful testing must be completed before files will be accepted for production processing.
- A trading partner agreement must be signed and returned to AultCare before an 837 file will be accepted for production file processing. A copy of the trading partner agreement is available on the AultCare.com website.
- The test file should contain only twenty records with matching paper claims. The paper claims should contain one claim per page, and when possible be in subscriber name alpha sequence.
- Test file naming convention.
 - For professional - HCFA.
 - “H837P(-company name-)MMDD(-month and day-).txt”
 - For Institutional - (UB92).
 - “H837I (-company name-)MMDD(-month and day-).txt”
 - For Dental.
 - “H837D (-company name-)MMDD(-month and day-).txt”
 - Documents contain DOC after the H837 prefix.
 - “H837PDOC (-company name-)MMDD.txt” – (HCFA)
 - “H837IDOC (-company name-)MMDD.txt” – (UB92)
 - “H837DDOC (-company name-)MMDD.txt” – (Dental)
- Send the test file to the AultCare website at www.aultcare.com.
 - A non-disclosure form will need to be completed before a test file can be sent to the website.
 - A login and password will be provided after the non-disclosure form is completed.
- The 837 Companion Guide is online at www.aultcare.com. From the AultCare.com Home page click on the AultCare Providers link; then click on the Forms and Guidelines drop down menu option to navigate to the companion guide selection.

Please contact AultCare-IS@AultCare.com with any questions.

Production Submission Procedures:

- Change Usage Indicator (ISA15) from **T** to **P**.
- Production files are distinguished from test files by the file name. Use the following naming convention when submitting production files:

PH837fxxxxxxxxMMDDCCYYX.txt

Encrypted production file naming convention:

PH837fxxxxxxxxMMDDCCYYX.txt.pgp

PH837 – File name prefix

f - Indicates file type I, P, or D (Institutional, Professional, or Dental)

xxxxx – Company name

MMDD - Month and Day

CCYY - Century and Year

X - This suffix value is required only when multiple files are transmitted for the same day. The value begins with **A** and increments with each file.

Single File Example: PH837PNCMF10272003.txt

Multiple Files Example: PH837PNCMF10272003A.txt
PH837PNCMF10272003B.txt

- Place files on the website: www.aultcaregateway.com
OR
AultCare FTP Site, ftp url: www.aultcare.com
Note: Files sent to ftp site must be encrypted.

Refer to the File Transfer Instructions at the end of this section for additional file transfer information.

- Files received by 4:00 p.m. Monday thru Friday will be processed on the same day they are sent. Files received after 4:00 p.m. may not be processed until the next day.
- The 997 Functional Acknowledgment is to be picked up the next day, also by using the website www.aultcaregateway.com
OR
AultCare FTP site.
- It is the sender's responsibility to pickup the 997 Functional Acknowledgment and verify whether the file was accepted or rejected.

Note: When a file is rejected, it is the sender's responsibility to correct and resend the file.

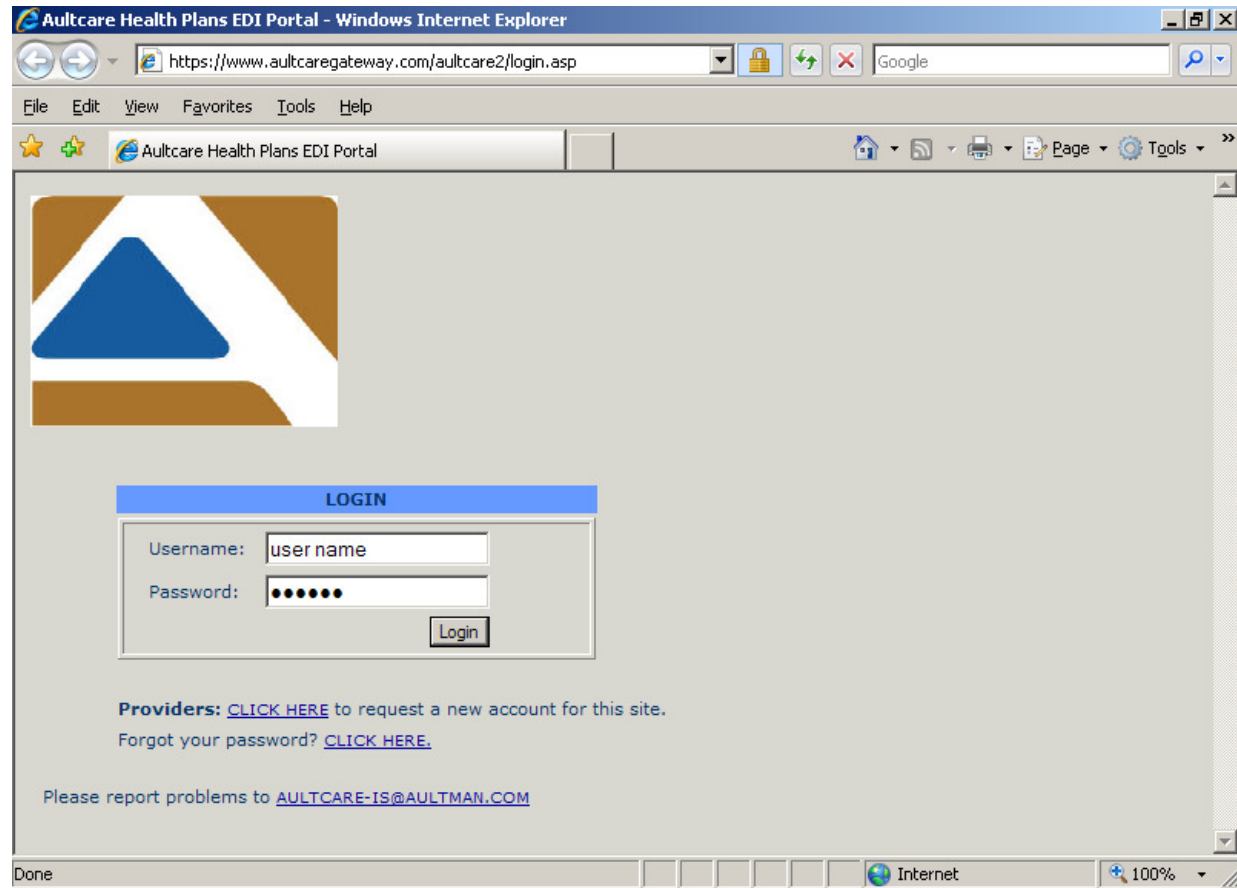
- The 837 Companion Guide is online at www.aultcare.com. From the AultCare.com Home page click on the AultCare Providers link; then click on the Forms and Guidelines drop down menu option to navigate to the companion guide selection.

Please contact AultCare-IS@AultCare.com with any questions.

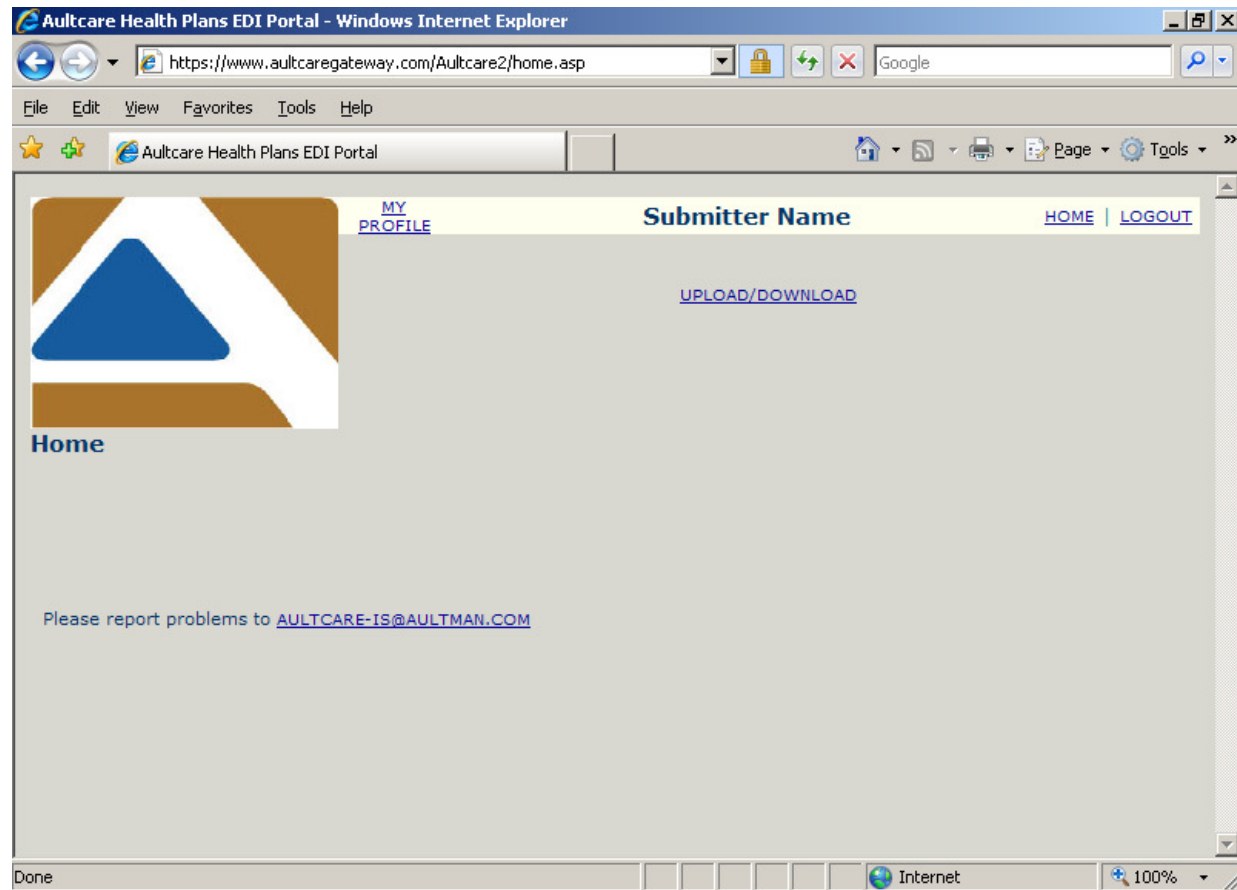
File Transfer Instructions:

Instructions for transferring a file to www.aultcaregateway.com:

Navigate to www.aultcaregateway.com; Type your Username and Password:



Click on Upload/Download:



Upload 837 File:

Click on browse and select file to upload. After the file is uploaded, the file display in the Upload Pending Processing section. The file will remain in this section until the file is processed by AultCare.

Download 997 File:

Click on the file name to save and view the file. After the file has been saved, the file can be deleted. To delete the file, click on the check box, and then click on the Delete Selected button

When finished click on Logout.

6. Appendix A: Revision Summary

The information in this chapter lists the date and changes made to the AultCare 837 Companion Guide.

AultCare 837 HIPAA Companion Guide Change Summary:

Refer to the Data Requirements column within the document for details of the updates listed below.

Note: Segment changes listed below apply to professional, institutional, and dental 837 files unless the segment is not used within one of the files per the national 837 implementation guide.

Date	Updated Loop	Updated Data Element	Data Requirements
06/13/08	N/A	N/A	Wording added to Introduction section to regarding transmission size and limitation to 5000 CLM segments.
10/15/07	N/A	N/A	Revised Section 5 Trading Partner Requirements: Daily file submission time changed from 5 p.m. to 4 p.m.; File Transfer Instructions added.
08/01/07	N/A	N/A	Wording added to Introduction section to regarding loop sequencing.
05/07/07	2310D	REF	Changed Servicing Facility Location Secondary Identification, Reference Identification Qualifier from EI to TJ in Professional guidelines.
05/07/07	2310C	REF	Changed Servicing Facility Location Secondary Identification, Reference Identification Qualifier from EI to TJ in Dental guidelines.
02/06/07	2010AA	NM1	Added NPI to Billing provider guidelines for Professional, Institutional, and Dental guidelines.
02/06/07	2010AA	REF	Updated TIN Billing provider guidelines for Professional, Institutional, and Dental guidelines
02/06/07	2010AB	NM1	Added NPI to Pay-to provider guidelines for Professional, Institutional, and Dental guidelines.

02/06/07	2010AB	REF	Updated TIN Pay-to provider guidelines for Professional, Institutional, and Dental guidelines
02/06/07	2310A	NM1	Added NPI to Referring provider guidelines for Professional and Dental guidelines.
02/06/07	2310A	REF	Updated TIN Referring provider guidelines for Professional and Dental guidelines
02/06/07	2310A	NM1	Added NPI to Attending provider guidelines for Institutional guidelines.
02/06/07	2310A	REF	Updated TIN Attending provider guidelines for Institutional guidelines
02/06/07	2310B	NM1	Added NPI to Rendering provider guidelines for Professional and Dental guidelines.
02/06/07	2310B	REF	Updated TIN Rendering provider guidelines for Professional and Dental guidelines
02/06/07	2310B	NM1	Added NPI to Operating provider guidelines for Institutional guidelines.
02/06/07	2310B	REF	Updated TIN Operating provider guidelines for Institutional guidelines
02/06/07	2310C	NM1	Added NPI to Other provider guidelines for Institutional guidelines.
02/06/07	2310C	REF	Updated TIN Other provider guidelines for Institutional guidelines
02/06/07	2310C	NM1	Added NPI to Facility guidelines for Dental guidelines.
02/06/07	2310C	REF	Updated TIN Facility provider guidelines for Dental guidelines
02/06/07	2310D	NM1	Added NPI to Facility guidelines for Professional guidelines.
02/06/07	2310D	REF	Updated TIN Facility provider guidelines for Professional guidelines
02/06/07	2310E	NM1	Added NPI to Supervisor guidelines for Professional guidelines.
02/06/07	2310E	REF	Updated TIN Supervisor provider guidelines for Professional guidelines
02/06/07	2310E	NM1	Added NPI to Facility guidelines for Institutional guidelines.
02/06/07	2310E	REF	Updated TIN Facility provider guidelines for Institutional guidelines
02/06/07	N/A	N/A	Updated guidelines listed in the 837

			Electronic Claims Procedures for Providers section; added production submission information
02/06/07	N/A	N/A	Updated Appendix C: AultCare Product Line Information
09/21/05	2010BA	REF02	Added Member ID clarification in subscriber secondary reference segment in 837 Dental guidelines.
08/25/05	2010BB	NM1	Added payer identification submission information to Professional and Dental guidelines.
08/25/05	2010BB	NM3	Added payer address submission information to Professional and Dental guidelines.
08/25/05	2010BC	NM1	Added payer submission information to Institutional guidelines.
08/25/05	2010BC	NM3	Added payer address submission information to Institutional guidelines.
07/28/05	N/A	N/A	Updated Appendix C Product Lines.
07/01/05	2010BA	NM109	Text added for Member ID submission.
07/01/05	2010BA	REF01	Added IG Insurance Policy Number.
07/01/05	2010BA	REF02	Added Reference Identification for Member ID.
06/01/05	N/A	N/A	Updated guidelines listed in the 837 Electronic Claims Procedures for Providers section.
06/01/05	2000A	PRV03	Text updated.
06/01/05	2010A	NM109	Text updated.
06/01/05	2010AB	NM109	Text updated.
06/01/05	2010BA	N301	Text updated.
06/01/05	2010BA	N402	Text updated.
06/01/05	2010BA	N403	Text updated.
06/01/05	2010BA	DMG02	Text updated.
06/01/05	2010BA	DMG03	Text updated.
06/01/05	2300	DTP01	Added 454 Initial Treatment.
06/01/05	2300	DTP01	Added 431 Onset of Current Illness.
06/01/05	2300	HCP	Added Claim Repriced / Repricing Information.
06/01/05	2300	NTE02	Added Claim note reference.
06/01/05	2300	HI	Text Updated.
06/01/05	2310A	NM109	Text Updated.
06/01/05	2310B	NM109	Text Updated.
06/01/05	2310B	PRV03	Text Updated.
06/01/05	2310D	NM101	Text Updated.

06/01/05	2310E	NM109	Added Supervising Provider reference.
06/01/05	2400	SV101-1	Text Updated.
06/01/05	2400	HCP	Added Line Repriced / Repricing Information.
06/01/05	2400	NTE02	Added Line Note Reference
06/01/05	N/A	N/A	Added Appendix A: Revision Summary
06/01/05	N/A	N/A	Added Appendix B: Facts you should know about AultCare Electronic Claims
06/01/05	N/A	N/A	Added Appendix C: AultCare Product Lines for Electronic Claims

7. Appendix B: Facts you should know about AultCare Electronic Claims

- To get started: view the AultCare 837 companion guide located at www.aultcare.com under the HIPAA tab.
- Before sending an 837 claims file, the AultCare non-disclosure and trading partner agreement must be completed. These are used to protect data confidentially and can be found at www.aultcare.com under the HIPAA tab.
- Testing of the 837 claims file must be completed before sending production files.
- Before going live with 837 files, the claim data will be validated with test scenarios. This quality process ensures a high rate of accurate claim processing in the production environment.
- Test files should contain twenty test claims. Send a hard copy of the twenty claims to facilitate the test validation process.
- Using the document '837 HCFA Test Scenario Form.doc', fill out the provider/vendor comment column with comments to clarify testing issues or questions you have and return the document to AultCare. This form gives a list of the different testing scenarios that AultCare reviews before approving a file for production.
- When creating the test file not all of the claims scenarios are applicable to every practice, but you are encouraged to test as many variables as possible.
- AultCare does not accept secondary claims electronically at this time, but eventually will. Secondary payer information is reviewed during testing. Supply a primary claim with other coverage information supplied in the test file.
- AultCare, AultCare HMO, McKinley Life Insurance, Primetime Medical Insurance, Primetime Health plan, Mediplan, and Cardinal Administrative Service's claims can all be submitted in the same 837 file.
- Your claims will process faster if you supply accurate and complete eligibility information. For example, member ID, complete names, birthdates, and gender.
- The 837 claims file provides the capacity to supply prior payment, first consult date, line and claim notes, COB, and other coverage information.

- Remember to inform AultCare regarding changes that affect submission. Some examples would be change in vendor, software version, submission method, and tax id changes.

8. Appendix C: AultCare Product Lines for Electronic Claims

AultCare administers pays claims for those products listed below. Paper claims mailed to the addresses below can also be sent electronically to AultCare using the 837 file layout. All of the claims for the different product lines can be combined into one Professional or Institutional file.

New files must still be tested as noted in the AultCare 837 companion guide. We still need to be notified when a provider is added to an existing file, so we can verify that they are setup in our system before the provider sends claims to AultCare.

AultCare Product Lines:

AULTCARE
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

MCKINLEY LIFE INSURANCE CO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

AULTCARE HMO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

PRIMETIME MEDICAL INSURANCE CO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

AULTRA ADMINISTRATIVE SERVICES*
P O BOX 6060
CANTON, OH 44706-6060

PRIMETIME HEALTH PLAN
P O BOX 6905
CANTON, OH 44706-0905

*Formerly CARDINAL ADMINISTRATIVE SERVICES