



ANSI ASC X12N
837
Version 4010A1
Companion
Document

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PLEASE NOTE: The *ANSI ASC X12N 837 v4010A1 Companion Document* is subject to change. We will post updated versions of this and other EDI-related documents on our Web site. Please visit us regularly at <http://www.trailblazerhealth.com>. Select the EDI topic to check for updates to EDI-specific documentation.

Introduction

ANSI Transaction Sets

The Health Insurance Portability and Accountability Act of 1996 is referred to by the acronym HIPAA. This legislation includes several provisions, including the Administrative Simplification Act. This Act mandates new standard formats for electronically submitted health care transactions. These transaction standards were developed by the American National Standard Institute (ANSI). The Medicare-applicable transaction sets include the following:

ANSI	Transaction
270 / 271	Eligibility Request / Response
276 / 277	Claim Status Request / Response
835	Remittance Advice
837	Claim and COB
997	Acknowledgement

The Department of Health and Human Services is the branch of the federal government overseeing the Administration Simplification Act. The Centers for Medicare & Medicaid Services is responsible for providing guidelines for how HIPAA and the Administrative Simplification Act will impact the Medicare program.

Getting Your Implementation Guides

HIPAA Implementation Guides may be downloaded from the Washington Publishing Company (WPC) Web site. The guides are also available as bound copies and on CD-ROM. For more information, visit the WPC Web site (www.wpc-edi.com/HIPAA).

Communications

TrailBlazer Health Enterprises will continue to use GPNet as the EDI gateway for submitting claims electronically. For more information, please refer to the *GPNet Communications Manual* located at <http://www.trailblazerhealth.com/Electronic Data Interchange/Software - Manuals>.

EDI Updates

We will post updated versions of this and other EDI-related documents on our Web site as well as send email notification through the EDI listserv as available. Please visit us regularly at <http://www.trailblazerhealth.com>. Select EDI from the left navigation to check for updates to EDI-specific documentation.

To sign up for the TrailBlazer Part A/B EDI listserv, visit the TrailBlazer Web site, select "register" if you are a new user or login, and click on "edit profile." Click on the LISTSERV tab and select "Part A/B EDI."

Technical Support

If you have questions regarding HIPAA and its implementation requirements, please contact the appropriate TrailBlazer Technology Support Center at 1-866-749-4302. You can also receive additional information on this supplement and on how you can begin or expand your use of electronic transactions.

ANSI-837 v4010A1 Completion Information

To ensure that your claim files are processed correctly, please include the following information in the appropriate ANSI fields:

ANSI Field																					
ISA06	Enter your Submitter ID.																				
ISA08	Enter the appropriate Payer ID:																				
	<table border="1"> <tbody> <tr> <td>Colorado Part A</td> <td>04001</td> </tr> <tr> <td>Colorado Part B</td> <td>04102</td> </tr> <tr> <td>New Mexico Part A</td> <td>04001</td> </tr> <tr> <td>New Mexico Part B</td> <td>04202</td> </tr> <tr> <td>Oklahoma Part A</td> <td>04301</td> </tr> <tr> <td>Oklahoma Part B</td> <td>04302</td> </tr> <tr> <td>Texas Part A</td> <td>04001</td> </tr> <tr> <td>Texas Part B</td> <td>04402</td> </tr> <tr> <td>Virginia Part B</td> <td>00904</td> </tr> <tr> <td>J4 WPS Part A</td> <td>52280</td> </tr> </tbody> </table>	Colorado Part A	04001	Colorado Part B	04102	New Mexico Part A	04001	New Mexico Part B	04202	Oklahoma Part A	04301	Oklahoma Part B	04302	Texas Part A	04001	Texas Part B	04402	Virginia Part B	00904	J4 WPS Part A	52280
Colorado Part A	04001																				
Colorado Part B	04102																				
New Mexico Part A	04001																				
New Mexico Part B	04202																				
Oklahoma Part A	04301																				
Oklahoma Part B	04302																				
Texas Part A	04001																				
Texas Part B	04402																				
Virginia Part B	00904																				
J4 WPS Part A	52280																				
ISA13	Please ensure the nine-digit File ID field is a unique number that has not been submitted within the past 12 months.																				
ISA15	Enter T when submitting a test claim file. Enter P when submitting a production claim file.																				
REF02	Institutional Claims (Part A) Enter 004010X096A1 when submitting a test or production claim file. Professional Claims (Part B) Enter 004010X098A1 when submitting a test or production claim file.																				
LIN03	The format for National Drug Codes (NDC) is 5-4-2 (11 positions with no dashes). Claims that contain NDC codes in any other format will be rejected.																				

For more information on submitting test claim files, please refer to the *EDI Enrollment Packet*.

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Institutional Companion Document

Overview

HIPAA requires that Medicare, and all other health benefit payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 Implementation Guides (IGs) have been established as the standards of compliance for claim transactions. The IGs for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the X12N 837 IGs adopted for national use under HIPAA. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the following TrailBlazer Health Enterprises systems:

Line of Business	Contractor Number
Texas Part A	04001
Colorado Part A	04001
New Mexico Part A	04001
Oklahoma Part A	04001

The information in this document is subject to change. Changes will be communicated in the quarterly news bulletin and on the TrailBlazer Health Enterprises Web site: www.TrailBlazerHealth.com. Separate companion documents have been or will be issued for use with other HIPAA transaction standard IGs.

Supplemental Information

GENERAL STATEMENTS

Language
The maximum size for the fields containing number of days information (covered, lifetime reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by TrailBlazer Health Enterprises.
The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitted with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Claims submitted with attending, other, or operating physician UPIN data will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more than 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises. Claims submitted with decimal data will be rounded to the closest whole number before being processed.

Language
The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.
You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.
Hospital other (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by TrailBlazer Health Enterprises.
Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)).
Since the date care starts is considered for billing purposes to be the date the beneficiary is admitted to Home Health Agency (HHA) care, HHAs must enter the Home Health Start of Care Date as Admission Date (2300 DTP Admission Date/Hour) for Medicare processing purposes. Any compliant time is acceptable in this field.
TrailBlazer Health Enterprises will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, , and:. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.
You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and 837 v. 4010A1 Inbound Institutional Claim Companion Document ATTACHMENT Description Language Page the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the intermediary's translator.
Effective January 1, 2008, the National Provider Identifier (NPI) must be submitted in all primary loops, unless under the Veteran's Administration Project.
Effective May 23, 2008, the National Provider Identifier (NPI) must be submitted in all NM109 data elements (NM108 = XX) where NM109 is required and in the Service Facility (2310E) NM109 if known, unless under the Veteran's Administration Project.
Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes/taxonomy . Claims submitted with invalid taxonomy codes will be rejected.
All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
Compression of files using PKZIP is supported for transmissions between the submitter and TrailBlazer Health Enterprises.

Language	
Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing which are not defined for use in Medicare billing may cause the claim or the transaction to be rejected	
Do not use Credit/Debit card information to bill Medicare. Credit/Debit card information will be ignored.	

INTERCHANGE CONTROL HEADER

Loop	Segment	Description	Language	Page
	ISA05	Interchange ID Qualifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain 28 in ISA05.	B.4
	ISA06	Interchange Sender ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4
	ISA07	Interchange ID Qualifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain 28 in ISA07.	B.4
	ISA08	Interchange Receiver ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain the appropriate intermediary code (see page 2) in ISA08. Each individual contractor determines this code.	B.5

FUNCTIONAL GROUP HEADER

Loop	Segment	Description	Language	Page
			TrailBlazer Health Enterprises will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).	
			TrailBlazer Health Enterprises will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	
	GS03	Application Receiver's Code	TrailBlazer Health Enterprises may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the intermediary definition.	B.8
			TrailBlazer Health Enterprises will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.	
	ST02	Transaction Control Set	TrailBlazer Health Enterprises will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	56
	BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	58
	BHT06	Claim/Encounter Identifier	TrailBlazer Health Enterprises will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable). TrailBlazer Health Enterprises will accept but will ignore a Claim or Encounter Indicator (BHT06) if 'RP' (Reporting) during adjudication.	59
	REF02	Transmission Type Identification	The 837 Institutional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 will cause the file to be rejected.	60
1000A	NM109	Submitter ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	63

Loop	Segment	Description	Language	Page
1000B	NM103	Receiver Name	TrailBlazer Health Enterprises will reject an interchange (transmission) that is not submitted with a valid intermediary name (NM1).	68
1000B	NM109	Receiver Primary Identifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual contractor determines this code.	68
2000A	PRV	Billing/Pay-To Provider Specialty Information	Providers shall be in compliance with CR 5243: Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims	Addenda 12
2000B	HL	Subscriber Hierarchical Level	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.	99
2000B	SBR02, SBR09	Subscriber Information	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.	103
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 may not be processed and may result in the claim being rejected.	159
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).	159
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing.	179
2300	HI	Health Care Diagnosis Code	Effective October 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes will be rejected.	228
2410	LIN03	Drug Identification	The format for National Drug Codes (NDC) is 5-4-2 (11 positions with no dashes). Claims that contain NDC codes in any other format will be rejected.	Addenda 37

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Loop	Segment	Description	Language	Page
			We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than 5 days after the file submission.	B.15
			TrailBlazer Health Enterprises will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	

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Professional Companion Document

Overview

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

The following information is intended to serve only as a companion document to the HIPAA X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the following TrailBlazer Health Enterprises systems:

Line of Business	Contractor Number
Colorado Part B	04102
New Mexico Part B	04202
Oklahoma Part B	04302
Texas Part B	04402
Virginia Part B	00904

The information in this document is subject to change. Changes will be communicated in the quarterly news bulletin and on the TrailBlazer Health Enterprises Web site: www.TrailBlazerHealth.com.

Separate companion documents have been or will be issued for use with other HIPAA transaction standard IGs. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Supplemental Information

GENERAL STATEMENTS

Language
The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
Claims that contain percentage amounts with values in excess of 99.99 will be rejected.
Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.
TrailBlazer Health Enterprises will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
Only loops, segments, and data elements valid for the HIPAA Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, , and :. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.

Language
You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator.
Effective March 1, 2008, the National Provider Identifier (NPI) must be submitted in the primary loops, unless under the Veteran's Administration Project
Effective May 23, 2008, the National Provider Identifier (NPI) must be submitted in all of the NM109 segment (NM108=XX) unless under the Veteran's Administration Project
Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes/taxonomy . Claims submitted with invalid taxonomy codes will be rejected.
All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
TrailBlazer Health Enterprises may reject an interchange (transmission) submitted with more than 9,999 loops.
TrailBlazer Health Enterprises may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
Compression of files using PKZIP is supported for transmissions between the submitter and TrailBlazer Health Enterprises.
Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing may cause the claim to be rejected.
TrailBlazer Health Enterprises will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides.

INTERCHANGE CONTROL HEADER

Loop	Segment	Description	Language	Page
	ISA05	Interchange ID Qualifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain 27 in ISA05.	B.4
	ISA06	Interchange Sender ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4
	ISA07	Interchange ID Qualifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain 27 in ISA07.	B.4
	ISA08	Interchange Receiver ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that does not contain the appropriate carrier code (see page 2) in ISA08. Each individual Contractor determines this code.	B.5

FUNCTIONAL GROUP HEADER

Loop	Segment	Description	Language	Page
			TrailBlazer Health Enterprises will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).	
	GS03	Application Receiver's Code	TrailBlazer Health Enterprises may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.	B.8

TRANSACTION SET

Loop	Segment	Description	Language	Page
			TrailBlazer Health Enterprises will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.	
	ST02	Transaction Control Set	TrailBlazer Health Enterprises will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	62
	BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	64
	BHT06	Claim/Encounter Identifier	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).	65
	REF02	Transmission Type Identification	The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 will cause the file to be rejected.	66
1000A	NM109	Submitter ID	TrailBlazer Health Enterprises will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	69
1000B	NM109	Receiver Primary Identifier	TrailBlazer Health Enterprises will reject an interchange (transmission) that is not submitted with a valid carrier code (NM1). Each individual Contractor determines this code.	75
2000B	HL	Subscriber Hierarchical Level	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.	108
2000B	SBR02, SBR09	Subscriber Information	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.	111
2010BD		Credit/Debit Card Information	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).	150

CLAIM INFORMATION

Loop	Segment	Description	Language	Page
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 will not be processed and will result in the claim being rejected.	172
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).	172
2300	CLM05-3	Claim Frequency Type Code	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected.	173
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing.	179
2300	PWK	Claim Supplemental Information	Any data submitted in the PWK (Paperwork) segment may not be considered for processing.	214
2300	AMT01	Credit/Debit Card Maximum Amount	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).	219
2300	AMT02	Patient Amount Paid	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	220
2300	AMT02	Total Purchased Service Amount	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	221

Loop	Segment	Description	Language	Page
2300	REF02	Prior Authorization and Referral Number	Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) will be ignored.	227
2300	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: CR102, CR106.	249, 250
2300	HI	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.	265
2300	HI	Health Care Diagnosis Code	Effective October 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected.	265
2300	HI	Health Care Diagnosis Code	You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes may not be considered in processing.	265
2320	AMT02	Coordination of Benefits Amounts	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	332, 333
2400	SV102	Line Item Charge Amount	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: SV102.	402
2400	SV104	Professional Service	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)	403
2400	SV104	Professional Service	The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	403
2400	SV104	Professional Service	The max value for units (qualifier UN) cannot exceed three bytes numeric with one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)	403
2400	SV104	Professional Service	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9.	403
2400	SV104	Professional Service	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: SV104	403
2400	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: CR102, CR106.	413, 414
2400	PS1	Purchased Service	Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims for PDT services that are submitted without the PS1 segment data at the 2400 loop may be rejected.	489
2400	PS102	Purchased Service	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: PS102	490
2410	CTP04	Professional Service	The max value for international units (qualifier F2), in the CTP segment, cannot exceed seven bytes numeric with three decimal places. Claims for drugs that exceed this value will be rejected.	403

997 - FUNCTIONAL ACKNOWLEDGEMENT

Loop	Segment	Description	Language	Page
			We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.	B.15
			TrailBlazer Health Enterprises will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	