

Electronic Claim Submission Guidelines

On August 14, 2000, the Department of Health and Human Services (DHHS) issued a Final Rule for Standards for Electronic Transmissions. A summary of the rule is: “This rule adopts standards for eight electronic transactions and for code sets to be used in those transactions. It also contains requirements concerning the use of these standards by health plans, health care clearinghouses, and certain health care providers.

The use of these standard transactions and code sets will improve the Medicare and Medicaid programs and other Federal health programs and private health programs, and the effectiveness and efficiency of the health care industry in general, by simplifying the administration of the system and enabling the efficient electronic transmission of certain health information. It implements some of the requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996.”

These rules go into effect no later than October 11, 2003. Delaware Medical Assistance Program (DMAP) will implement these electronic standards on July 1, 2002. If the provider is using the EDS supplied Provider Electronic Solution (PES) software, the software is HIPAA compliant and has all of the requirements that are outlined below already incorporated.

The ASC X12 standards required by the Final Rule are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure.

The HIPAA implementation guides provide assistance in developing and executing the electronic transfer of health encounter and health claim data. With a few exceptions, the implementation guide does not contain payer-specific instructions. Payers are required by law to have the capability to send/receive all HIPAA transactions. However, that does not mean that the payer is required to bring that data into their adjudication system. The payer, acting in accordance with policy and contractual agreements, can ignore data within the data set.

The following items that are specific for the Delaware Medical Assistance Program should be taken into consideration when implementing the HIPAA.

All Transactions

Unless otherwise noted, loops, segments and data elements are not used by the adjudication system and no specific values are required.

ISA01 – Value “00” is expected in this field.

ISA02 – No data is expected in this field, as there is no authorization information present per ISA01

ISA03 - Value “00” is expected in this field.

ISA04 - No data is expected in this field as there is no authorization information present per ISA03

ISA05 – Value “ZZ” is expected in this field.

ISA06 - The ETIN number assigned to the submitter is expected in this field. This is the same as your ECMS Bulletin Board ID.

ISA07 - Value “ZZ” is expected in this field.

ISA08 – EDS’ ETIN number “345724166” is expected in this field.

ISA14 – Value “0” is expected in this field.

ISA16 – A colon (:) is expected as the component element separator.

All PRV segments should be included with the appropriate NM and REF segments for all instances. The Delaware Medical Assistance Program requires a taxonomy for claim processing.

837 Professional – Transaction Standard for Health Care Claims or Equivalent Encounter Information: Professional – This transaction is used to submit professional claims from FFS providers and encounter data information from the Managed Care Organizations (MCOs).

- Claims will be processed and payments issued based on the billing provider information in the 2010AA loop. Payments will not issued to the information listed in the 2010AB loop.
- Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.
- Professional, Dental and Institutional transactions cannot be mixed within the same ST-SE envelope.
- Electronic Transmitter Identification Number (ETIN) – This is the number that is assigned to a provider/submitter to uniquely identify their electronic transactions. This may also be referred to as the Trading Partner Agreement (TPA) Number. This number should be provided in the transaction in the following location:

Loop	Segment Field
	ISA06
1000A	NM109

- Loop 1000B, NM109 must contain the value of EDS’ ETIN “345724166”

NPI Revision – 3/23/2007

- Loop 2010AA - Field NM108 is required and the valid qualifiers are XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2010AA REF segment is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.

- Loop 2010BA must contain the value “MI” for Member ID Number; and NM109 should be the ten digit Delaware Medical Assistance Identification Number as listed on the Delaware Medical Assistance Program card.

- There is a maximum of 9 digits for dollar amount values including the cents field.

- There is a maximum of three (3) 2320 loops plus one (1) Medicare 2320 loop.

- There is a maximum of 80 bytes of text in the 2300 loop, NTE02 field of the segment.

- Loop 2010A is to be used to report the billing provider and the pay to provider. Loop 2010AB is not to be used.

- Loop 2300, CLM01 is limited to a maximum of 20 bytes for the Patient Account Number.

- If the Prior Authorization number is submitted in 2300, REF02, then REF01 should be submitted with “G1”.

- Loop 2330B should contain the Carrier Code in NM109. The expected values will be the National Electronic Insurance Codes (NEIC). These codes can be found at <http://www.envoy.com>. If the provider is unable to locate the appropriate carrier code they should contact EDS Provider Relations.

- Units are accepted in whole numbers only.

- The detail Rendering/Performing Providers must be the same on one claim. If there are separate Rendering/Performing Providers for a single date of service, separate claims must be submitted for each service.

- Beginning of Hierarchical Transaction BHT06 should contain a CH if the transmission contains FFS claims and RP if the transmission contains encounter data claims from the MCO.

- Dependent loops of transactions will not be processed with the exception of Third Party claims where the DMAP client is a dependent on other primary insurance.

NPI Revision – 3/23/2007

- In loop 2400 – Professional Service Line, If a drug is being billed, an appropriate J-code or other drug-related HCPCS codes must be used within the SV01-2 segment.
- In loop 2410 – This loop is required if the procedure code in 2400 SV101-2 is a J-code or other drug-related HCPCS codes. The LIN02 Qualifier ID should equal N4. The LIN03 value should contain the 11 digit NDC. There is a maximum of 3 NDC's allowed per service line.
- If the Referring Provider is sent in the 2310A loop, NM101 should be submitted with "DN". Field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2310A REF segment is needed and it should contain a qualifier of 'ID' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- If the Rendering/Performing Provider is sent in the 2310B or 2420A loop, field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the REF segment for the corresponding loop is needed and it should contain a qualifier of 'ID' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- On claim submissions where Medicare is primary, the following information is expected:
 - Medicare paid amount in 2320, AMT02, COB payer paid amount
 - Medicare allowed amount in 2320, AMT02, COB allowed amount
 - Medicare ID number in 2330A, NM109, Other subscriber name
 - Medicare paid date in 2330B, DTP03, Claim adjudication date
 - Medicare claim number in 2330B, REF02, Other payer secondary identifier
 - Medicare detail approved amount in 2400, AMT02, Approved Amount
 - Medicare coinsurance and deductible in 2430, CAS segment

837 Dental – Transaction Standard for Health Care Claims or Equivalent Encounter Information: Dental - This transaction is used to submit dental claims from FFS providers and encounter data information from the Managed Care Organizations (MCOs).

- Claims will be processed and payments issued based on the billing provider information in the 2010AA loop. Payments will not issued to the information listed in the 2010AB loop.
- Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.

- Professional, Dental and Institutional transactions cannot be mixed within the same ST-SE envelope.
- Electronic Transmitter Identification Number (ETIN) – This is the number that is assigned to a provider/submitter to uniquely identify their electronic transactions. This may also be referred to as the Trading Partner Agreement (TPA) Number. This number should be provided in the transaction in the following location:

Loop	Segment	Field
	ISA	06
1000A	NM	109

- Loop 1000B, NM109 must contain the value of EDS' ETIN "345724166".

NPI Revision – 3/23/2007

- Loop 2010AA - Field NM108 is required and the valid qualifiers are XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2010AA REF segment is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- There is a maximum of 9 digits for dollar amount values including the cents field.
- Loop 2010BA, NM108 should be submitted with "MI" for Member ID Number and NM109 should be the ten digit Delaware Medical Assistance Identification Number as listed on the Delaware Medical Assistance Program card.
- There is a maximum of three (3) 2320 loops plus one (1) Medicare 2320 loop.
- There is a maximum of 80 bytes of text in the 2300 loop, NTE02 field of the segment.
- Loop 2010AA is to be used to report the billing provider and the pay to provider. Loop 2010AB is not to be used.
- Loop 2300, CLM01 is limited to a maximum of 20 bytes for the Patient Account Number.
- Loop 2330B should contain the Carrier Code in NM109. The expected values will be the National Electronic Insurance Codes (NEIC). These codes can be found at <http://www.envoy.com/lists/lists.cfm>. If the provider is unable to locate the appropriate carrier code they should contact EDS Provider Relations.
- Units are accepted in whole numbers only.

- The detail Rendering/Performing Providers must be the same on one claim. If there are separate Rendering/Performing Providers for a single date of service, separate claims must be submitted for each service.
- Beginning of Hierarchical Transaction BHT06 should contain a CH if the transmission contains FFS claims and RP if the transmission contains encounter data claims from the MCO.
- Dependent loops of transactions will not be processed with the exception of Third Party claims where the DMAP client is a dependent on other primary insurance.

NPI Revision – 3/23/2007

- If the Referring Provider is sent in the 2310A loop, NM101 should be submitted with "DN". Field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2310A REF segment is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- If the Rendering/Performing Provider is sent in the 2310B or 2420A loop, field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the REF segment for the corresponding loop is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.

837 Institutional – Transaction Standard for Health Care Claims or Equivalent Encounter Information: Institutional - This transaction is used to submit institutional claims from FFS providers and encounter data information from the Managed Care Organizations (MCOs).

- Claims will be processed and payments issued based on the billing provider information in the 2010AA loop. Payments will not issued to the information listed in the 2010AB loop.
- Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.
- Professional, Dental and Institutional transactions cannot be mixed within the same ST-SE envelope.
- Electronic Transmitter Identification Number (ETIN) – This is the number that is assigned to a provider/submitter to uniquely identify their electronic transactions. This may also be referred to as the Trading Partner Agreement (TPA) Number. This number should be provided in the transaction in the following location:

Loop	Segment	Field
	ISA06	
1000A	NM109	

- Loop 1000B, NM109 must contain the value of EDS' ETIN "345724166".

NPI Revision – 3/23/2007

- Loop 2010AA - Field NM108 is required and the valid qualifiers are XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2010AA REF segment is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- Loop 2010BA, NM108 should be submitted with "MI" for Member ID Number and NM109 should be the ten digit Delaware Medical Assistance Identification Number as listed on the Delaware Medical Assistance Program card.
- There is a maximum of 9 digits for dollar amount values including the cents field.\
- There is a maximum of three (3) 2320 loops plus one (1) Medicare 2320 loop.
- There is a maximum of 80 bytes of text in the 2300 loop, NTE02 field of the segment.
- Loop 2010AA is to be used to report the billing provider and the pay to provider. Loop 2010AB is not to be used.
- Loop 2300, CLM01 is limited to a maximum of 20 bytes for the Patient Account Number.
- If the Prior Authorization number is submitted in 2300, REF02, then REF01 should be submitted with "G1".
- Loop 2330B should contain the Carrier Code in NM109. The expected values will be the National Electronic Insurance Codes (NEIC). These codes can be found at <http://www.envoy.com/lists/lists.cfm>. If the provider is unable to locate the appropriate carrier code they should contact EDS Provider Relations.
- Units are accepted in whole numbers only.
- Beginning of Hierarchical Transaction BHT06 should contain a CH if the transmission contains FFS claims and RP if the transmission contains encounter data claims from the MCO.
- Dependent loops of transactions will not be processed with the exception of Third Party claims where the DMAP client is a dependent on other primary insurance.

- There can be up to 8 other diagnosis codes in the HI segment of the 2300 loop.
- There can be up to 5 procedure codes in the HI segment of the 2300 loop.
- There can be up to 2 Occurrence Span Code/Dates in the HI segment of the 2300 loop.
- There can be up to 8 Occurrence Codes/Dates in the HI segment of the 2300 loop.
- There can be up to 7 Condition Codes in the HI segment of the 2300 loop.
- The Operating Physician information will be reported in the 2310B loop and not in the 2410 loop.
- If a claim or an encounter data claim is submitted with more than **999 detail lines**, multiple claims will be created that contain no more than **999** detail lines per claim or encounter. The claim or encounter will be returned on an 835 transaction or paper RA in **999** detail segments.

NDC Revision -7/1/2008

- **If a drug is being billed, the NDC will be entered in the 2400 loop — SERVICE LINE NUMBER in the LIN03 transaction data element Product Service ID. This is a required loop on outpatient claims when revenue, procedure, or drug codes are reported in the SV2 segment. . The LIN02 Qualifier ID should equal N4. The LIN03 value should contain the 11 digit NDC. There is a maximum of 3 NDCs allowed per service line.**

NPI Revision – 3/23/2007

- If the Attending Provider is sent in the 2310A loop, NM101 should be submitted with "71". Field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2310A REF segment is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- If the Operating / Other Provider is sent in the 2310B or the 2310C, field NM108 uses the valid qualifiers of XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the REF segment for the corresponding loop is needed and it should contain a qualifier of '1D' - Medicaid Provider Number. The REF02 should contain the DMAP Atypical Provider Number.
- On claim submissions where Medicare is primary, the following information is expected:

- Medicare paid amount in 2320, AMT02, COB total Medicare paid amount
 - Medicare allowed amount in 2320, AMT02, COB total allowed amount
 - Medicare ID number in 2330A, NM109, Other subscriber name
 - Medicare paid date in 2330B, DTP03, Claim adjudication date
 - Medicare claim number in 2330B, REF02, Other payer secondary identification and reference number
 - Medicare detail approved amount in 2400, AMT02, Approved Amount
 - Medicare coinsurance and deductible in 2430, CAS segment
- **Loop 2300, HI segment, Principal Admitting and E-Code Diagnosis Information is required for all home health care claims.**

NCPDP 5.1 – Transaction Standard for Health Care Claims or Equivalent Encounter Information: Pharmacy - This transaction is used to submit retail pharmacy claims from FFS providers and encounter data information from the Managed Care Organizations (MCOs).

NPI Revision – 3/23/2007 POS will be shut down for conversion.

- As of 3/25/2007 all POS claims must contain, in all segments, the NPI for the following fields:
 - 202-B2 Service Provider ID Qualifier – 01 = NPI
 - 202-B1 Service Provider ID - 10 digit assigned NPI
 - 466-EZ Prescriber ID Qualifier may be one of the following – 01 = NPI or 12 = DEA.
 - 411-DB Prescriber ID will need to correspond to the 466-EZ qualifier - 10 digit assigned NPI or DEA.
- Please refer to the Pharmacy Billing Manual 2.3, located on our website @ www.dmap.state.de.us/downloads/manuals.html, for submission requirements.

270/271 Healthcare Eligibility Benefit Inquiry/Response – Transaction Standard for Eligibility for a Health Plan - This transaction is used by FFS providers and the MCO's to receive eligibility information about a subscriber.

- The BHT02 segment can contain only the value 13 – Request.

NPI Revision – 3/23/2007

- Loop 2100B, NM108 must contain the value of either XX = NPI or SV = Service Provider Number. NM109 will need to contain either the NPI number or the DMAP Atypical Provider Number that corresponds with the qualifier in NM108.
- Loop 2100B, REF01 must contain the value “EO” and REF02 must contain the ETIN.
- In the EQ segment, EQ01 must equal 30 and will be processed accordingly. Requests will not be processed where EQ02 is used at the detail level.

- Loop 2100B, REF01 the value of “EO” and the ETIN in REF02 will be returned. The REF segment in 2100C may repeat three times. The first occurrence may report the clients SSN in REF02. The second occurrence will return the patient account number if submitted on the request. The third occurrence will report the DMAP card number.
- Loop 2110C, EB05 will contain the Plan Coverage Description.
- If applicable, the MCO information will be reported in the 2120C loop in the NM segment. A contact phone number will be provided in the PER segment if applicable.

NPI Revision – 3/23/2007

- Loop 2120C in the 271 response, NM108 will contain the value of either XX = NPI or SV = Service Provider Number. NM109 will contain either the NPI number or the DMAP Atypical Provider Number that corresponds with the qualifier in NM108.

276/277 Health Care Claim Status – Transaction Standard for Health Care Claim Status and Response – This transaction is used by the FFS provider to get the status of a claim. The 277 Unsolicited Claims Status Response is used to report pended claim information when the provider chooses to receive an electronic remittance advice (835).

- The 276 will be processed at the claim level. The requests will be processed at claim detail level. An inquiry needs to be made at the claim level rather than requesting the status of one detail line within the claim.

NPI Revision – 3/23/2007

- The value of "46" is required in the NM108 in the 2100B loop. NM109 must contain the ETIN or the trading partner ID assigned by EDS.
- Loop 2100C, NM108 will contain the value of “SV” when the NM109 is an Atypical Delaware Provider Number. The NM108 will be a value of “XX” when NM109 contains an NPI.

278 Referral Certification and Authorization – Transaction Standard for Referral Certification and Authorization – This transaction is used by FFS providers to request prior authorization for clients receiving services from a FFS provider.

NPI Revision – 3/23/2007

- Loop 2010B, Request Name, Field NM108 is required and the valid qualifiers are XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2010B REF segment is needed and it should contain a qualifier of 'ZH' - Carrier Assigned

Reference Number. The REF02 should contain the DMAP Atypical Provider Number.

- Loop 2010E, Service Provider Name, Field NM108 is required and the valid qualifiers are XX, 24 and 34. XX = NPI, 24 = Employers Tax ID, and 34 = Social Security Number. NM109 should contain the appropriate value that corresponds with NM108. Note: If field NM108 contains a 24 or a 34 qualifier, then the 2010E REF segment is needed and it should contain a qualifier of 'ZH' - Carrier Assigned Reference Number. The REF02 should contain the DMAP Atypical Provider Number.

820 Payment Order/Remittance Advice – Transaction Standard for Health Plan Premium Payments – This transaction will be sent by the fiscal agent to the MCO or Prescription Drug Plan (PDP) and will contain the capitated payment summary for the month.

- BPR03 will contain a value of “C”.
- When BPR04 is ACH, BPR05 will contain a value of CCP.
- TRN01 will contain a value of “1”.
- TRN04 will contain the value “DE Medical Assistance Program”.
- CUR01 will contain the value “PR”.
- CUR02 will contain the value “USD”.
- The Premium Receivers Identification Key, REF01 will contain a value of “14” and REF02 will contain your MCO or PDP MMIS provider number.
- The Coverage Period, DTM06 will contain the capitation month enrollment period.
- Loop 1000A, N103 will contain a value of EQ; N014 will contain your MCO or PDP MMIS provider number.
- Loop 1000B, N102 will contain the value “EDS/DMAP”; N103 will contain the value “FI”; N104 will contain EDS’ TIN.
- Loop 2310A, IT101 will contain the value “1”.
- Loop 2000B, ENT03 will contain the value “EI”; ENT04 will contain the value of the client’s Medicaid Identification number.
- Loop 2100B, NM1 will contain the value “EY”; NM103 will contain the client’s last name; NM104 will contain the client’s first name; NM108 will contain the value of “N”; and NM109 will contain the client’s Medicaid Identification number.

- If the provider is an MCO, then Loop 2300B, RMR01 will contain the value “CT”; RMR02 will contain the client’s tier level.
- If the provider is a PDP, then Loop 2300B, RMR01 will contain the value of spaces; RMR02 will also contain the value of spaces.
- Loop 2300B, DTM06 will contain the month capitation payment is being made or the month a capitation payment adjustment is being made.

834 Benefit Enrollment and Maintenance – Transaction Standard for Enrollment and Disenrollment in a Health Plan – This transaction is sent to the MCO by the fiscal agent and will contain enrollment information for the MCO.

- BGN01 will contain the value of “00”.
- REF02 will contain the MCO’s MMIS provider number.
- Loop 1000A, N102 will contain the value “Delaware Medical Assistance Program”; N104 will contain the State’s tax identification number.
- Loop 1000B, N102 will contain the value “EDS”; N103 will contain the value “FI”; N104 will contain EDS’ tax identification number.
- Loop 2000 – Member Level Detail, INS01 will contain the value “Y”; INS02 will contain the value “18”; INS03 will contain the value “021”; INS04 will contain the value “07”; INS05 will contain the value “A”; INS08 will contain the value “FT”; INS10 will contain the value “Y” if the client’s AID category is 51 or 61.
- Loop 2000 – Subscriber Name, REF02 will contain the value client’s Medicaid Identification Number.
- Loop 2000 – Member Identification will repeat twice. The first occurrence of REF01 will contain the value “17” and REF02 will contain the client’s AID category. The second occurrence of REF01 will contain the value “ZZ” and REF02 will contain the value “DSHP” or “DHCP”.
- Loop 2000 – Member Level Dates will be repeated twice – first for the MCO begin date in DTP01 that will contain the value “473” and second for the MCO end date in DTP01 that will contain the value “474”.
- Loop 2100A – Member Name, NM101 will contain the value of “IL”; NM103 will contain the client’s last name and NM104 will contain the client’s first name; NM108 will contain the value “34” and NM109 will contain the client’s social security number.

- Loop 2100A – Member Communications Numbers, PER03 will contain the value of “TE” and PER04 will contain the client’s telephone number.
- Loop 2100A – Member Residence, N405 will contain the value “CY” and N406 will contain the client’s county code.
- Loop 2100A – Member Language, LUI01 will contain the value “LD” and the language codes reported in LUI02 will be the NISO (National Information Standards Organization) codes.
- Loop 2100C – Member Mailing Address, NM101 will contain the value “31”.
- Loop 2300 – Health Coverage, HD01 will contain the value “030” and HD03 will contain the value “HMO”.
- Loop 2300 – Health Coverage Date, DTP01 will occur twice. The first occurrence will contain the MCO enrollment begin date with value “348” and the second occurrence will contain the MCO enrollment end date with the value “349”; DTP03 will contain the MCO enrollment end date (either the end of time date or the last day of the month when eligibility ended).
- Loop 2300 – Health Coverage Policy Number, REF01 will contain the value “1L” and REF02 will contain the client’s case number.

NPI Revision – 3/23/2007

- Loop 2310 – Provider Name, NM101 will contain the value “P3”; NM102 will contain the value “1”; NM103 will contain the client’s PCP last name and NM104 will contain the client’s PCP first name; NM108 will contain the value XX = NPI or SV = Service Provider Number. NM109 will need to contain either the NPI number or the DMAP Atypical Number that corresponds with the qualifier in NM108.
- Loop 2320 – Coordination of Benefits, COB01 will contain the value “U” and COB03 will contain the value “5”.
- Loop 2320 – Additional Coordination of Benefits, REF01 will contain the value “6P” and REF02 will contain the client’s TPL group number or policy number.
- Loop 2320B – Other Insurance Company Name, N103 will contain the value “NI” and N104 will contain the NEIC code. These codes can be found at <http://www.envoy.com/lists/lists.cfm>. If the provider is unable to locate the appropriate carrier code they should contact EDS Provider Relations.

835 Remittance Advice – Transaction Standard for health Care Payment and Remittance Advice - This transaction is used by FFS providers and the MCO’s to retrieve an electronic remittance advice from the bulletin board system if they so choose to receive an RA in this fashion.

- The number of CLP segments will not be limited to 10,000 in the ST-SE envelope as suggested in the Implementation Guide.

NPI Revision – 3/23/2007

- Loop 1000B, N103 will contain either the qualifier of XX = NPI or FI = Federal Taxpayers Identification, (SSN/FEIN). N104 will contain the appropriate number that corresponds with the qualifier in N103.
- Loop 1000B, REF segment - If the FI qualifier is used in the 1000B N103 segment, then the REF01 will contain the value of '1D' – Medicaid Provider Number and the REF02 will contain the DMAP Atypical Provider Number.
- Loop 2100, Service Provider Name, NM108 will be populated with an 'MC' when the value in NM109 is a Delaware Medicaid Atypical Provider Number (value starts with 'A') otherwise NM108 will be an 'XX' for NPI.
- Loop 2100, Corrected Priority Payer Name Loop, NM and REF segment will contain other payer information when DMAP has determined that there is other insurance that is primary.