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ELECTRONIC MEDIA CLAIMS TECHNICAL LETTER NO. 28H

TO: All Electronic Media Claims Submitters
FROM: William Longenbaker, Bureau Chief
Bureau of Information Systems Support
DATE: June 28, 2006
SUBJECT: NATIONAL STANDARD FORMAT CARTRIDGE SPECIFICATIONS

TECHNICAL LETTER NUMBER (NO) 28H is being issued to notify all submitters of electronic media claims of a revision to the NATIONAL STANDARD FORMAT (NSF) for the submission of a Date of Discharge Field beginning July 1, 2006.

APPLICABLE OHIO ADMINISTRATIVE CODE (OAC) RULES CAN BE VIEWED ON THE ODJFS WEBSITE <http://emanuals.odjfs.state.oh.us/emanuals> FOR HOME HEALTH AND PRIVATE DUTY NURSING. THE RULES ARE FROM 5101:3-12-01 TO 5101:3-12-06 OF THE ADMINISTRATIVE CODE.

For the NSF format, the location of the field for the Date of Discharge is in the CA0 record, field location is 6.0, and this detail line is left justified in position 55-60 for 6 positions. Home Health and Private Duty Nursing services for up to 60 days after a post hospital stay requires the date of discharge to be present when the level of services exceeds the current state plan levels. The new specifications are also located at <http://hipaa.oh.gov/odjfs/>.

ODJFS encourages you to test this new date of discharge status field before submitting these claims to the Production environment. Please send all correspondence, production/test cartridges to the Data Scheduling Unit at the following address:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
Data Scheduling Unit
4200 East Fifth Ave. 1st Fl.
Columbus, Ohio 43219

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES CARTRIDGE BILLING
INSTRUCTIONS

Table of Contents

I	General	I-I
II.	Cartridge Specifications, Testing Requirements and Procedures, Cartridge Rejection Criteria	
	Technical Cartridge Specifications	II-2
	Electronic Media Claim Cartridge Rejection Criteria	II-3
III.	Electronic Media Claims National Standard Format	III-1
IV.	Appendices	
	Instructions for completing ODJFS 06312 Letter of Certification/Batch Recap Form	IV-3
	Letter of Certification/Batch Recap Form	IV-4
	Health Insurance Claim Form HCFA-1500	IV-5

PREFACE

Attached are specifications for the submission of electronic media claim billing cartridges for the National Standard Format to the Ohio Medicaid Program. Please review these instructions and familiarize yourself with the various issues before you attempt to submit a cartridge.

If you have any questions regarding **billing** instructions or **policies**, please contact:

Ohio Department of Job and Family Services
Bureau of Plan Operations/Provide Network Management
P.O. Box 1461
Columbus, OH 43216-1461
VOICE RESPONSE UNIT: 1-800-686-1516, operational 24 hours per day, 7 days a week
TELEPHONE: 1-800-686-1516
FAX: 1-614-728-3264

686-1516 Operational 24 hours per day, 7 days a week.

Ohio Department of Job and Family Services
Bureau of Plan Operations/Provider Relations Section
P.O. Box 1461
Columbus, Ohio 43266-0161
TELEPHONE: 1-800-686-1516
FAX: 1-614-728-3264

To obtain a **hardcopy of specific billing** instructions, contact:

Ohio Department of Job and Family Services
Warehousing Service/Forms Distribution Section
2098 Integrity Drive, North
Columbus, Ohio 43209
FAX: 1-614-728-7724

To request **provider training**:

Ohio Department of Job and Family Services
Bureau of Plan Operations/Provider Network Management
Provider Training Unit
P.O. Box 1461
Columbus, Ohio 43266-0161
TELEPHONE: 1-614-752-9551

If you have any **technical** questions regarding cartridge submission or the specifications, please contact:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
MIS EDI Support
4200 East Fifth Avenue 1st Floor
Columbus, Ohio 43219
TELEPHONE: 1-614-387-1212
Data_Scheduling_Unit@ODJFS.state.oh.us

The attached specifications are the **technical specifications**. In order to submit claims on magnetic cartridge you **must know how to bill on hardcopy**. Hardcopy billing for the HCFA-1500 claim form instructions can be found in **Chapter 3334, of the General Information Handbook**.

GENERAL INFORMATION

Authorized providers and electronic media claim submitters can submit Clinic, Medicare Cross-Over, Dental, Independent Laboratory, Medial Supply, Physician/Podiatrist/Limited Practitioner/Waiver Service, Transportation and Vision Care claims in machine readable (magnetic cartridge) format.

A provider or electronic media claim submitter will become authorized to submit claims electronically (magnetic cartridge) only after a submitted cartridge has **passed the acceptance testing procedures** and all **enrollment forms** have been completed and returned to the Data Scheduling Unit and updated on the file.

Each submission **must be** accompanied by an **ODJFS 06312 Letter of Certification/Batch Recap** form, and signed by the electronic media claim submitter.

Electronic media claim submitters may submit claims as often as **once per week**, however, these submissions must have a **minimum** count of **250 Claims**. Different types of claim submissions (National Standard Format) will be consolidated to reach the 250 submission. There is **no minimum** requirement for **monthly** submissions. All claims submitted must be received within **365 days** from the actual date-of-service for all claims.

The Medicaid provider is ultimately responsible for the accuracy and validity reporting of all Medicaid claims submitted for payment. A provider using an electronic media claim submitter should ensure through a legal contract that the electronic media claim submitter reports claim information only as directed by the provider. A copy of all contracts between the provider and electronic media claim submitter must be made available to ODJFS upon request. Both the individual provider and the electronic media claim submitter must maintain a record of all Medicaid claims submitted for payment.

The electronic media claim submitter must abide by the provisions of 45 CFR 205.50 which states the requirements for the safeguarding of recipient information. All information pertaining to an individual recipient, supplied by ODJFS or collected internally within the computing and accounting systems for an electronic media claim submitter, can only be used in the accurate billing and accounting of claims or the for purposes of obtaining reimbursement.

Submission must be received by the Unit no later than **1:00 p.m. every Wednesday**. **The creation date on the file processor data record, record type (AA0) (processing date) must be the Wednesday the submission is received and any cartridges received after the date entered on the file header record will be returned unprocessed.**

The system cannot handle multiple volume files. For multi cartridge submissions, each file must contain one header record and one trailer record.

Production cartridges should be sent to:
Ohio Department of Job and Family Services
Bureau of Information Systems Support
MMIS-EDI-Support
4200 East Fifth Avenue 1st Floor
Columbus, Ohio 43219

DEFINITIONS RELATED TO ELECTRONIC MEDIA CLAIM SUBMISSION

Provider Any individual or institution licensed or approved for participation in the Medicaid program by ODJFS.

Provider Agreement Is a contract between ODJFS and a provider of MEDICAL ASSISTANCE services in which the provider agrees to comply with the terms of the “Provider Agreement,” state statutes and ODJFS administrative code rules, and federal statutes and rules.

Electronic Media Claim Submitter An individual or company who prepares invoices or receives payments on behalf of the provider. A provider who prepares electronic media claim submissions is also considered to be an electronic media claim submitter.

Electronic Media Claims Submission A complete electronic media claims submission consists of cartridges prepared as described in the electronic media claim specification publication appropriate to each provider type, and a hard copy of the “Letter of Certification/Batch Recap” form signed by the electronic media claim submitters.

Billing Date Date of invoice preparation.

Service Date Date service was provided to recipient.

The National Standard Format will accommodate the following providers:

- (1) Clinic
 - (a) Comprehensive - (Fee for service)
 - (b) Diagnostic
 - (c) Dialysis
 - (d) Family Planning (Planned Parenthood)
 - (e) Federally Qualified Health Center (FQHC)
 - (f) Outpatient Health Facility (OHF)
 - (g) Public Health Departments
 - (h) Rehabilitation (Physical, Speech and Hearing Therapy)
 - (i) Rural Health Facility (RHF)
 - (j) Mental, Drug and Alcohol Clinic

- (2) Cross-Over

- (3) Dental
 - Dentist (Individual/Group)

- (4) Independent Laboratory
 - (a) Independent Laboratory
 - (b) Physiology Laboratory
 - (c) X-Ray Laboratory

- (5) Medical Supply
 - (a) Durable Equipment
 - (b) Medical Equipment
 - (c) Orthotic Equipment
 - (d) Prosthetic Equipment
 - (e) Supplies

- (6) Physician/Podiatrists/Limited Practitioners
 - (a) Ambulatory Surgery Center
 - (b) Chiropractor (Individual/Group)
 - (c) Hospital Based Physician (Individual/Group)
 - (d) Midwife Nurse
 - (e) Osteopath Physicians (Individual/Group)
 - (f) Physical Therapy
 - (g) Physician (Individual/Group)
 - (h) Podiatrist (Individual/Group)
 - (i) Private Nurse
 - (j) Psychologist (Individual/Group)
 - (k) Home and Community Based Waivers Services

TECHNICAL SPECIFICATIONS FOR CARTRIDGES

Specifications for submission of Clinic, Medicare Cross-Over, Dental, Independent Laboratory, Medical Supply, Physician/Podiatrist/Limited Practitioner/Waiver Service, Transportation and Vision Care claims on magnetic cartridge follow:

- (l) Compatible with IBM 3090 system/3480 or 3490E cartridge.
- (m) Recording Density – 3800 characters per inch.
- (n) Recording Code for Claims - Extended Binary Coded Decimal Interchange Code (EBCDIC, 18 Track or 36 track).
- (o) File labels - None.
- (p) Logical Record Length - 320 characters.
- (q) Physical Record Length - 32000 characters, i.e., a blocking factor of 100.
- (r) The outside surface of the cartridge must be clearly labeled with the **provider's/agent's name, agent's address, agent's ID and the Julian submission day.**
- (s) **DO NOT PAD THE END OF THE FILE WITH NINES OR BLANKS, INSTEAD, USE A SHORT BLOCK**
- (t) Standard IBM CARTRIDGE.

The vendor shall use chromium dioxide as the active recording element in the cartridges.

The oxide coating strength shall meet or exceed the IBM specification of 0.7 foot-pounds per square inch.

ELECTRONIC MEDIA CLAIM CARTRIDGE REJECTION CRITERIA

The following errors will cause your entire Cartridge submission to be rejected. To prevent your submission from being rejected, we recommend that the electronic media claim submitter subject their file to these edits.

- (A) Rejections common to all invoices:
- (1) Agent's number is incorrect.
 - (2) Batch number is incorrect or out of sequence.
 - (3) File claim count in file trailer record does not match number of claims in file.
 - (4) Claim count in any batch trailer record does not match number of claims in batch.
 - (5) Provider number is invalid or missing.
 - (6) File claim count in file trailer record does not equal the amount stated on the ODJFS 06312 Letter of Certification/Batch Recap form.
 - (7) Any violation of the National Standard Format record ID and/or record ID sequence.
 - (8) Line items for a claim exceeds limit of 21.
 - (9) File extends over one cartridge.

II-2
ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

NATIONAL VERSION 001.03

**OHIO MEDICAID
LOCAL VERSION 001.03**

ISSUE DATE - 07/01/1993

IMPLEMENTATION DATE - 10/01/1993

LOCAL ISSUE DATE - 09/15/1993

LOCAL IMPLEMENTATION DATE - 02/01/94

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD DESCRIPTIONS

Page

AA0 - File Header Record - Submitter	AA0.01
BA0 - Batch Header Record - Provider	BA0.01
CA0 - Claim Header Record - Patient	CA0.01
DA0 - Insurance Information Record - Payer	DA0.01
DA1 - Insurance Information Record - Payer	DA1.01
EA0 - Claim Detail Record - Claim Level	EA0.01
FA0 - Service Line Detail Record - Root	FA0.01
FB0 - Service Line Detail Record - Medical	FB0.01
FD0 - Service Line Detail Record - Dental	FD0.01
GA0 - Certification Record - Ambulance	GA0.01
HA0 - Cert. Record - Narrative Data	HA0.01
XA0 - Claim Trailer Record - Claim Totals	XA0.01
YA0 - Batch Trailer Record - Batch Totals	YA0.01
ZA0 - File Trailer Record - File Totals	ZA0.01

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

FILE LAYOUT

-----AA0 - File Header Record.....Submitter
|
| -----BA0 - Batch Header RecordProvider
| |
| | -----CA0 - Claim Header RecordPatient
| | |
| | | -----DA0 - Insurance Info RecordsPayer(s)
| | | -----DA1 - Insurance Info RecordsPayer(s)
| | |
| | | -----EA0 - Claim Record
| | |
| | | -----FA0 - Service Line Detail Records
| | | -----FB0 - Service Line Detail Records
| | | -----FD0 - Service Line Detail Records
| | |
| | | -----GA0 - Ambulance Certification Record
| | |
| | | -----HA0 - Extra Narrative Record
| | |
| | -----XA0 - Claim Trailer RecordClaim Totals
| |
| -----YA0 - Batch Trailer RecordBatch Totals
|
-----ZA0 - File Trailer RecordFile Totals

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT
GENERAL INSTRUCTIONS

The general instructions define the validation requirements for classes of fields as well as some standard abbreviations that are utilized.

ABBREVIATIONS:

Standard abbreviations used throughout the document:

ABBREVIATION	DESCRIPTION
-----	-----
ADDR	Address (street address)
ANES	Anesthesia
APPL	Appliance
ASSIGN	Assignment
CONT	Containment
CUR	Current
DT	Date
EMPL	Employment
EMPLR	Employer
FUNCTNL	Functional
ID	Identifier OR Identification
IMPRESS	Impression
IND	Indicator
INFO	Information
INSERT	Inserted
LOC	Location
MEASURE	Measurement
MI	Middle Initial
MIN	Minutes
MOS	Months
N/A	Not Applicable OR None
NO	Number
ORTHO	Orthodontic
PAT	Patient
PERM	Permanent
PHONE	Telephone
PLACE	Placement
PRESCRIPT	Prescription
PROV	Provider
PUR	Purchased
REL	Relationship
REP	Representative
REPLACE	Replaced
REQ	Requirement
RETIRE	Retirement
SER	Series

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

Standard abbreviations (continued):

ABBREVIATION	DESCRIPTION
SPNSR	Sponsor
SUB	Submitter
SUPV	Supervising
SVC	Service
SYMP	Symptom
TREAT	Treatment
1ST	First

DATA ELEMENT REQUIREMENT:

REQ codes:

R = required O = optional C = conditional

VALIDATION REQUIREMENTS:

Some Date Element description pages state:

"See GENERAL INSTRUCTIONS for 'xxxxxxxxxxxxxxxx' entry".

Where 'xxxxxxxxxxxxxxxx' is one of the following data elements.

ELEMENT	PAGE #
ADDRESS	GI0.03
DATE	GI0.04
IDENTIFICATION NUMBERS	GI0.04
NAME 1 (INDIVIDUAL NAMES)	GI0.05
NAME 2 (COMPANY NAMES)	GI0.05
PATIENT CONTROL NUMBER	GI0.06
TELEPHONE	GI0.07

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

ADDRESS:

ADDRESS-1 and ADDRESS-2:

- a) ADDRESS-1 may not contain a blank in the first position.
- b) If entered, ADDRESS-2 may not contain a blank in the first position.
- c) Must contain at least one embedded blank.
- d) May contain:
 - A-Z
 - 0-9
 - forward slash (/)
 - period (.)
 - comma (,)
 - number sign (#)
 - ampersand (&)
 - parentheses '()'
 - percent sign (%) - for: "in care of"
 - blank ()
- e) No other special characters are allowed.

CITY:

- a) First position must not be blank.
- b) May contain:
 - A - Z
 - period (.)
 - comma (,)
 - ampersand (&)
 - blank ()
- c) No other special characters are allowed.

STATE: Must be a valid code from EXHIBIT 1.

ZIP:

- a) Position 1-3 must be a code from EXHIBIT 1.
Position 4-5 must be numeric.
Position 6-9 is optional but must be numeric if entered.
- b) If the STATE code is a foreign country, ZIP is not required.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

DATE:

Format: CCYYMMDD

- a) CC (century) must have a value of '19' or '20'.
exception: may have a value of '18', '19' or '20'
for birth dates.
- b) YY (year) must have a value of '00' through '99'.
- c) MM (month) must have a value of '01' through '12'.
- d) DD (day) must have a value of '01' through '31'
dependent on MM.

MM (month) value	DD (day) value
01, 03, 05, 07, 08, 10, 12	01 through 31
04, 06, 09, 11	01 through 30
02	01 through 29 if YY is divisible by 4
02	01 through 28 if YY NOT divisible by 4

IDENTIFICATION NUMBERS:

- a) If entered, first position may not be blank.
- b) May contain: A - Z
0 - 9
- c) No embedded blanks are allowed.
- d) Special characters may be used at the discretion of
the receiver/payer.

MEDICAID

NOTES: If special characters are allowed in a field, it will be specified in the instructions on that field.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT
GENERAL INSTRUCTIONS

NAME 1 (INDIVIDUAL NAMES):

LAST NAME and FIRST NAME

- a) First position must be A-Z.
- b) May contain: A-Z
hyphen (-)
blank ()
- c) No other special characters are allowed.
- d) Titles such as 'Mr.', 'Dr.', 'Jr.' are not allowed.
- e) Must be at least two (2) positions in length.

MIDDLE INITIAL

- a) Must contain A-Z or blank.

NAME 2 (COMPANY NAMES):

- a) First position must be A-Z.
- b) May contain:
A-Z
period (.)
comma (,)
hyphen (-)
ampersand (&)
blank ()
- c) No other special characters are allowed.
- d) Must be at least two (2) positions in length.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT
GENERAL INSTRUCTIONS

PATIENT CONTROL NUMBER:

- a) First position must not be blank.
- b) May contain:
 - A-Z
 - 0-9
 - forward slash (/)
 - period (.)
 - comma (,)
 - hyphen (-)
 - number sign (#)
 - blank ()
- c) No other special characters are allowed.

MEDICAID

NOTES: This is a required field used to link all records for a single claim.
The entire claim will be denied without this information.

Only the first nine digits of this field is used by the Medicaid payment system. These first nine digits of the Patient Control Number will be used as the Medical Record Number and will be reflected as such on the printed Remittance Advice and the electronic PAY/REJECT file.

If this number is not available on hardcopy claims, the Scanner/Data Entry departments will insert the last nine digits of the Billing Number.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

TELEPHONE:

- a) Format: AAAXXXSSSS
AAA = area code
XXX = exchange
SSSS = station number
- b) Must contain 0-9 only.
- c) No special characters or blanks are allowed.
- d) Valid area codes may be found in EXHIBIT 1.

MEDICAID

NOTES:

BATCH:

**Each submission is composed of multiple batches.
Each batch is composed of multiple claims.**

With respect to electronic submissions coming from providers and intermediaries, our use of the term "batch" relates to the entire submission or file. The batches that exist within that submission have individual batch numbers but they are not used by the Medicaid payment system. Therefore, these submissions are balanced in total by using the total number of claims in the file.

With respect to submission from internal departments, the batches within the submission or file are used by the Medicaid payment system for balancing. Therefore, individual batches within a submission may be rejected.

MISCELLANEOUS (NOT OTHERWISE SPECIFIED) CATEGORIES

The use of any code category that is considered miscellaneous or not specific in description requires the provider to maintain hardcopy documentation in the patient's file to support the submission of that claim. When these types of codes are used, it is advisable to use the Narrative (HA0) record for their explanation.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

GENERAL INSTRUCTIONS

MEDICAID NOTES (CONTINUED):

CLAIMS NOT TO BE BILLED ELECTRONICALLY

The following types of claims cannot be billed electronically. They must be billed on hardcopy and sent to the Ohio Department of Job and Family Services.

- 1) Abortion, sterilization and hysterectomy claims.
- 2) Service dates over 365 days old.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT
FILE HEADER RECORD

RECORD TYPE: AA0

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD

RECORD TYPE: AA0

LEVEL: FILE

PURPOSE: The first record of any file submitted electronically, it contains information pertinent to the submitter of the claim file. A submitter could be a provider of medical services (i.e. physician, lab, clinic...) or a billing agency. The information contained in this record will be the determining factor in whether or not the file will be allowed system access.

REQUIREMENTS: A "AA0" record is required for every submission.

ORDER:	Preceding Record Type ----- NONE	Following Record Type ----- BA0
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NOTES:

MEDICAID NOTES: Filler fields will not be read by the Medicaid processing system. Other information may be provided in these areas but they will not affect the processing of these claims.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD TYPE: AA0

FIELD NO.	FIELD NAME	LENGTH	FIELD TYPE	POSITIONS FROM	THRU
-----	-----	-----	-----	-----	-----
01.0	RECORD ID "AA0"	3	X	1	3
02.0	SUBMITTER IDENTIFIER	16	X	4	19
	FILLER	9	X	20	28
04.0	SUBMISSION TYPE	6	X	29	34
	FILLER	178	X	35	212
15.0	CREATION DATE	8	X	213	220
	FILLER	33	X	221	253
21.0	TEST/PROD IND	4	X	254	257
	FILLER	63	X	258	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-01.0

DATA ELEMENT: Record Identifier

(RECORD ID "AA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "Submitter Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "AA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-02.0

DATA ELEMENT: Submitter Identifier (SUB ID)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
02.0	X(16)	LEFT	SPACES	04	19	R

DEFINITION: Identifies the submitter as defined by the receiver.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the SUBMITTER ID entered in the File Trailer Record (ZA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: May be a federally assigned Employer Identification Number (EIN). EIN is also referred to as a Tax Identification Number (TIN) depending on the receiver's requirements.

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NOTES: This field is composed of the three-character alphabetic submitter ID (agent ID) number and the three digit numeric submitter number (agent's number). (Example ABC123).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-04.0

DATA ELEMENT: Submission Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(06)	LEFT	SPACES	29	34	R

DEFINITION: Identifies the input medium or method used to transmit the data to the receiver.

CODE VALUES:	ASYNC	BISYNC	RJE	FAX	CARTRIDGE
	ASY	BSY	RJE	FAX	TP
	ASY003	BYS024	RJE024		TPCRTG
	ASY012	BYS048	RJE048		TP0800
	ASY024	BSY096	RJE096		TP1600
	ASY048	BSY192	RJE192		TP6250
	ASY096				

DISKETTE			SCANNER	CPU
DSK8SS	DSK5SS	DSK3SS	SCN	CPU
DSK8SD	DSK5SD	DSK3SD	SCNOCR	
DSK8DD	DSK5DD	DSK3DD	SCNICR	
DSK5HD	DSK3HD			

VALIDATION: At a minimum, must be a valid code from the above lists. At the receiver's option, there may be more specific code requirements.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES:

For providers and intermediaries who are submitting their claims on cartridges, use the "TP" code. Do not use the other codes under "Cartridge".

For hardcopy claims that are being scanned, use the "SCN" code.

For hardcopy claims that are being keyed by the Data Entry department, use the "KD" code.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-15.0

DATA ELEMENT: Creation Date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
15.0	X(08)	LEFT	SPACES	213	220	R

DEFINITION: Identifies the date the submitter created the file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

Must not be later than the date the file is received.

FORM LOCATION: N/A

REMARKS: N/A CCYYMMDD

MEDICAID

NOTES: Submission must be received by the Data Scheduling Unit no later than 1:00 p.m. every Wednesday. The date must be the Wednesday the submission is received and any cartridges received after the date entered on the file header record will be returned unprocessed.

9/93

Production cartridges should be sent to:

9/98 Ohio Department of Job and Family Services
Bureau of Information Systems Support
Data Scheduling Unit
4200 E. Fifth Avenue,. 1st Floor
Columbus, Ohio 43219

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE HEADER RECORD
"SUBMITTER DATA"

RECORD/FIELD: AA0-21.0

DATA ELEMENT: Test/Production Indicator

(TEST/PROD IND)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----- 21.0	----- X(04)	----- LEFT	----- SPACES	----- 254	----- 257	----- C

DEFINITION: A code indicating whether the file is to be used for test or production purposes.

CODE VALUES: TEST = file should be run through a test system.

PROD = file should be run through a production system.

VALIDATION: Must be entered if required by receiver.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

BATCH HEADER RECORD

RECORD TYPE: BA0

"PROVIDER DATA 1"

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD TYPE: BA0

LEVEL: BATCH

PURPOSE: To identify and provide information regarding the
provider of services indicated in this batch.

REQUIREMENTS: This record is required.
A "BA0" record is required for every submission.

ORDER:	Preceding Record Type ----- AA0 or YA0	Following Record Type ----- BA1 or CA0
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NOTES: Only one BA0 record is allowed for each batch.

MEDICAID

NOTES: See **GENERAL INSTRUCTIONS** for "Batch" definition.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD TYPE: BA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "BA0"	3	X	1	3
	FILLER	18	X	4	21
04.0	BATCH NUMBER	4	N	22	25
	FILLER	49	X	26	74
12.0	PROVIDER MEDICAID NUMBER	15	X	75	89
	FILLER	45	X	90	134
16.0	PROVIDER OTHER NUMBER 1	15	X	135	149
	FILLER	171	X	150	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD/FIELD: BA0-01.0

DATA ELEMENT: Record Type (RECORD ID 'BA0')

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----- 01.0	----- X(03)	----- LEFT	----- SPACES	----- 1	----- 3	----- R

DEFINITION: This field is used to identify the "PROVIDER DATA 1" record.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be BA0.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD/FIELD: BA0-04.0

DATA ELEMENT: Batch Number

(BATCH NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----- 04.0	----- 9(04)	----- RIGHT	----- ZEROS	----- 22	----- 25	----- R

DEFINITION: This is a sequential number assigned by the submitter, to each batch of claims.

CODE VALUES: Must be equal to 0001 through 9999.

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be 0001.

Whenever the "EMC Provider Identifier", BA0 - 02.0, or "Type of Batch", BA0 - 03.0, changes from those previously entered, the "Batch Number" must be reset to 01.

If the previous "EMC Provider Identifier", BA0 - 02.0 and "Type of Batch", BA0 - 03.0 are identical with those currently being processed, the "Batch Number" must be one greater than the previous "Batch Number".

FORM LOCATION: N/A

REMARKS: N/A

**MEDICAID
NOTES:**

For providers and intermediaries, this field identifies a batch for their own purposes but the Medicaid payment system does not use it.

For Scanning and Data Entry departments, only three digits are accepted by the Medicaid payment system.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD RECORD/FIELD: BA0-12.0
"PROVIDER DATA 1"

DATA ELEMENT: Provider Medicaid Number (PROV MEDICAID NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
12.0	X(15)	LEFT	SPACES	75	89	C

DEFINITION: The number assigned to the Provider by a Medicaid State Agency for identification purposes.

CODE VALUES: N/A

VALIDATION: If entered:

This field must contain the Medicaid Provider Number as it appears on the Payer's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: HCFA-1500 Block 33

REMARKS: If the Medicaid Provider Number is not entered or entered incorrectly all Medicaid claims contained within the batch may be rejected.

REQUIREMENTS: The Medicaid Provider Number must be entered if the batch contains any claims that are to be processed by a Medicaid payer.

MEDICAID

NOTES: This is the pay-to Medicaid provider number. This field MUST ALWAYS contain a seven digit provider number for the provider receiving payment.

In the case of a group practice or hospital, this is the group's number. In other instances, it is the rendering provider number.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD RECORD/FIELD: BA0-12.0
"PROVIDER DATA 1"

DATA ELEMENT: Provider Medicaid Number (PROV MEDICAID NO)

(CONTINUED)

MEDICAID

NOTES: If the Medicaid Provider Number is not entered or entered incorrectly, all Medicaid claims contained within the batch may be deleted from the system or they may cause payment to the wrong provider.

Billing agencies should validate the digits of the provider number by using the following procedure:

The last digit is the "check" digit and is verified by a routine that takes the first six digits of the provider number and calculates a number that is compared to the seventh digit of the provider number.

The check digit is calculated as follows:

- 1) add together the first three odd position number digits and multiply the result by 2
- 2) add together the first three even position number digits
- 3) add together the results of step 1 and 2, then subtract from 100
- 4) the low order digit from the result of step 3 should be the check digit

For example:

Provider Number 8321597

- 1) $(8 + 2 + 5) \times 2 = 30$
- 2) $3 + 1 + 9 = 13$
- 3) $100 - (30 + 13) = 57$
- 4) 7 should be the check digit

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH HEADER RECORD
"PROVIDER DATA 1"

RECORD/FIELD: BA0-16.0

DATA ELEMENT: Provider Other Number 1

(PROV NO 1)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
16.0	X(15)	LEFT	SPACES	135	149	C

DEFINITION: The number assigned to the provider by the receiver for other identification purposes.

CODE VALUES: N/A

VALIDATION: Must be entered as required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Example: Specific number assigned for Workmen's Compensation, Health Maintenance Organization (HMO) or Additional Commercial Number.

MEDICAID

NOTES: In the case of a group practice, this field is the servicing provider's individual provider number. This field **MUST ALWAYS** contain the seven digit provider number of the servicing provider.

It can be found on the HCFA-1500 form in Block 33 as the "PIN#".

It has the same check digit routine as Provider Medicaid Number, Record BA0, Field 12.0.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

CLAIM HEADER RECORD

RECORD TYPE: CA0

"PATIENT DATA"

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD TYPE: CA0

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the patient who received the services indicated in this claim.

REQUIREMENTS: A CA0 record is required for every claim.

ORDER:	Preceding Record Type -----	Following Record Type -----
	BA0, BA1 or XA0	CB0 or DA0

NOTES: Only one CA0 record is allowed for each claim.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
 "PATIENT DATA"

RECORD TYPE: CA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "CA0"	3	X	1	3
	FILLER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
04.0	PATIENT LAST NAME	20	X	23	42
05.0	PATIENT FIRST NAME	12	X	43	54
06.0	DATE OF DISCHARGE	6	9	55	60
	FILLER	121	X	61	181
22.0	OTHER INSURANCE INDICATOR	1	X	182	182
	FILLER	13	X	183	195
27.0	PAYER CLAIM CONTROL NO.	17	X	196	212
	FILLER	108	X	213	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD RECORD/FIELD: CA0-01.0
"PATIENT DATA"

DATA ELEMENT: Record Identifier (RECORD ID "CA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Code used to identify the "Patient Data" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "CA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD RECORD/FIELD: CA0-03.0
"PATIENT DATA"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payers' systems will record and return seventeen characters on remittance advices or other documents. Consult the Matrix/Usage document supplied by the Payer/Receiver for additional information.

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD RECORD/FIELD: CA0-04.0
"PATIENT DATA" CA0-05.0

DATA ELEMENT: Patient Last Name (PAT LAST NAME)
Patient First Name (PAT FIRST NAME)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(20)	LEFT	SPACES	23	42	R
05.0	X(12)	LEFT	SPACES	43	54	R

DEFINITION: The name of the individual to whom the services were provided.

CODE VALUES N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: HCFA-1500 Block 2

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-06.0

DATA ELEMENT: Date of Discharge

(MMDDYY)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
06.0	9(6)	N/A	ZEROS	55	60	C

DEFINITION: Enter the six digit (MMDDYY) date of discharge when billing services provided for 60 days after a post-hospital stay for home health and private duty nursing services. The date of discharge can never be greater than 60 days from the date of service.

CODE VALUES N/A

VALIDATION: Must be in a valid date format.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-22.0

DATA ELEMENT: Other Insurance Indicator

(OTHER INSURANCE IND)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----- 22.0	----- X(01)	----- N/A	----- SPACE	----- 182	----- 182	----- C

DEFINITION: A code which indicates the patient has other insurance which may or may not be reflected on this claim.

CODE VALUES: 1 = Yes, patient has other insurance.
2 = Yes, patient has other insurance not reflected on this bill.
3 = No, patient does not have other insurance.

VALIDATION: Must be entered if required by payer/receiver.

If entered, must be a valid code from the above list.

FORM LOCATION: HCFA-1500 Block 11d

REMARKS: 1. Patient has declared that he/she has other insurance which may pay a portion of this claim and provided the necessary insurance information. (Not all insurance companies require the other insurance fields to be completed.)

2. Patient has declared that he/she has other insurance which may pay a portion of this claim but did not furnish the insurance information for this claim.

3. The provider has asked the patient if he/she has other insurance, and the patient has stated that they do not.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD RECORD/FIELD: CA0-22.0
"PATIENT DATA"

DATA ELEMENT: Other Insurance Indicator (OTHER INSURANCE IND)

(CONTINUED)

MEDICAID NOTES:

This field is required if other insurance is involved. This is a one character field, either alphabetic or numeric which indicates if an insurance payment other than Medicare has been received or has not been received from the third party insurer. For Ohio Medicaid, the acceptable codes are as follows:

If you have received payment, please enter one of the following:

- 1 = Self/Family**
- 2 = Blue Cross/Blue Shield**
- 3 = Private Carrier**
- 4 = Employer or Union**
- 5 = Public Agency**
- 6 = Other**

If you have not received payment, please enter one of the following:

R = No Response From Carrier. Means no response from the insurance carrier for 90 days. A claim with this code may not be submitted until 91 days after the date of treatment.

P = No Coverage for This Recipient Number. Means that the provider has confirmed that there is health insurance for some members of the Medicaid case, but the particular patient is not covered.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-22.0

DATA ELEMENT: Other Insurance Indicator

(OTHER INSURANCE IND)
(CONTINUED)

MEDICAID NOTES:

F = No Coverage for All Recipient Numbers. Means that there is no health insurance for any member of the Medicaid case.

L = Disputed or Contested Liability. Means that the provider has confirmed that there is health insurance, but the coverage for the billed service is disputed or contested by the insurance carrier.

S = Non-Covered Services. Means that the provider has confirmed that there is health insurance, but that the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.

E = Insurance Benefits Exhausted. Means that the provider has confirmed that there is health insurance, but the policy benefits for the billed services have been exhausted.

X = Non-Cooperative Recipient. Means that the provider has confirmed that there is health insurance, but the patient refused to cooperate in collection effort.

7/01/2001

8 = Other Insurance Indicator. Other source code of "8" Supplemental (wraparound) payment (for FQHCs or RHCs only). For FQHCs or RHCs, enter other source code of "8" if the provider is submitting for the managed care supplemental payment.

If you have not received payment from another source and there is no indication of health insurance coverage for the case, leave this item blank.

04/19/04

MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:

Enter "M" if the Medicare Part C panel provider is not capitated.
Enter "H" if the Medicare Part C panel provider is capitated.

When an "M" is entered in item CA0-22.0 the amount collected by the provider from all other insurance sources must be entered in item XA0-19.0.

When and "H" is entered in item CA0-22.0 the amount entered in item XA0-19.0 can be a zero. The Medicare Part C managed care plan copayment amount is entered in item DA1-13.0.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-27.0

DATA ELEMENT: Payer Claim Control Number

(PAYER CLM CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----- 27.0	----- X(17)	----- LEFT	----- SPACES	----- 196	----- 212	----- R

DEFINITION: A number assigned by the Payer/Receiver to identify the claim.

CODE VALUES: Blanks / Spaces are only valid values.

VALIDATION: Must be blank / space filled.

FORM LOCATION: N/A

REMARKS: For Payer/Receiver usage only.

For assignment of an Internal / Document /
Claim Control Number (ICN/DCN/CCN) that the Payer/
Receiver will pass to an adjudication system.

MEDICAID

NOTES:

This field should not be used by the provider or electronic submission intermediary. This field is for use by the Ohio Medicaid payment system only.

Known within the system as the Transaction Control Number, it has two versions, one for cartridge/computer submitted claims and one for OCR/Data Entry/Exam Entry claims. They are defined as follows:

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD
"PATIENT DATA"

RECORD/FIELD: CA0-27.0

DATA ELEMENT: Payer Claim Control Number

(PAYER CLM CONTROL NO)

(CONTINUED)

OCR/DATA ENTRY/EXAM ENTRY FORMAT

abbbbbcdeeeffggghh

a = Input Medium Indicator

OLD FORMS (UB-82, 6780, ETC.):

- 0 = Exam Entry**
- 1 = Keyed**
- 2 = Cartridge/Computer Billed**
- 3 = OCR**
- 4 = Computer Generated Credit or Adjustment**

NEW FORMS (UB-92, HCFA-1500, ETC.):

- 5 = Exam Entry**
- 6 = Keyed**
- 7 = Cartridge/Computer Billed**
- 8 = OCR**
- 9 = Computer Generated Credit or Adjustment**

- bbbbb = Batch Date in Julian format (YYDDD)**
- c = Microfilm Machine Number**
- d = Microfilm Roll Number**
- eee = Batch Number**
- f = Claim Accounting Code**
 - 0 = Original Claim**
 - 1 = Credit Adjustment**
 - 2 = Debit Adjustment**
- ggg = Document Number**
- hh = Document Line Number**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM HEADER RECORD RECORD/FIELD: CA0-27.0
"PATIENT DATA"

DATA ELEMENT: Payer Claim Control Number (PAYER CLM CONTROL NO)

(CONTINUED)

ELECTRONIC SUBMISSION FORMAT

abbbbccccdeeeee

a = Input Medium Indicator

OLD FORMS (UB-82, 6780, ETC.):

- 0 = Exam Entry**
- 1 = Keyed**
- 2 = Cartridge Billed**
- 3 = OCR**
- 4 = Computer Generated Credit or Adjustment**

NEW FORMS (UB-92, HCFA-1500, ETC.):

- 5 = Exam Entry**
- 6 = Keyed**
- 7 = Cartridge Billed**
- 8 = OCR**
- 9 = Computer Generated Credit or Adjustment**

bbbbbb = Batch Date in Julian format (YYDDD)

cccc = Batch Number

d = Claim Accounting Code

- 0 = Original Claim**
- 1 = Credit Adjustment**
- 2 = Debit Adjustment**

eeee = Document Number

For all claims except pharmacy, Document Number and Document Line Number are treated as a single field with each claim incrementing the number by one. For pharmacy claims, each form increments the document number by one and each line on the form increments the Document Line Number by one, up to a maximum of ten.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

INSURANCE INFORMATION RECORD

RECORD TYPE: DA0

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
 "PAYER DATA 1"

RECORD TYPE: DA0

FIELD NO. -----	FIELD NAME -----	FIELD LENGTH -----	TYPE -----	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA0"	3	X	1	3
02.0	SEQUENCE NUMBER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
	FILLER	46	X	23	68
10.0	GROUP NUMBER	20	X	69	88
11.0	GROUP NAME	33	X	89	121
	FILLER	16	X	122	137
14.0	PRIOR AUTHORIZATION NUMBER	15	X	138	152
	FILLER	4	X	153	156
18.0	INSURED ID NO	25	X	157	181
19.0	INSURED LAST NAME	20	X	182	201
20.0	INSURED FIRST NAME	12	X	202	213
21.0	INSURED MI	1	X	214	214
	FILLER	106	X	215	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-01.0
"PAYER DATA 1"

DATA ELEMENT: Record Identifier (RECORD ID "DA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "INSURANCE INFORMATION"- "PAYER DATA 1" record.

CODE VALUES: N/A

VALIDATION: A claim must have at least one "DA0" record and may have up to three.

Must be "DA0".

FORM LOCATION: N/A

REMARKS: N/A

DA0.3

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-02.0
"PAYER DATA 1"

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA0" records and to associate "DA0" records with "DA1" and "DA2" records.

CODE VALUES: 01 - Identifies the primary payer record.
02 - Identifies the secondary payer record.
03 - Identifies the tertiary payer record.

VALIDATION: Must be entered.

Must be a valid code from the above list.

A claim must have at least one "DA0" record and may have up to three. All "Dan" records must be grouped as "DA0", "DA1", "DA2" by sequence number.

The first (or only) record must be identified by a sequence number of '01'.

FORM LOCATION: N/A

REMARKS: Multiple DA0 records should be sequenced according to national and state coordination of benefits rules. The primary payer should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be PRIMARY followed by SECONDARY insurance (if applicable) and then TERTIARY insurance (if applicable). The CLAIM FILING INDICATOR (DA0-04.0) should be used to direct the claim to the appropriate payer(s).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-02.0
 "PAYER DATA 1"

DATA ELEMENT: Sequence Number (SEQUENCE NO)

(CONTINUED)

MEDICAID

NOTES: **Since Medicaid is the payer of last resort and
that the records are submitted in sequence,
it will be assumed that the last record in the
sequence will relate to Medicaid information.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-03.0
"PAYER DATA 1"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"
(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account
Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-10.0
"PAYER DATA 1"

DATA ELEMENT: Group Number (GROUP NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
10.0	X(20)	LEFT	SPACES	69	88	C

DEFINITION: The identification number assigned by the payer to the group or plan through which insurance is provided.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

If entered, must only contain 0-9, A-Z, forward slash (/), period (.), comma (,), hyphen (-), number sign (#), ampersand (&) and blank (). No other characters are allowed.

Must NOT equal the PAYER ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ().

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces (). EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following laterals: "UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-10.0
"PAYER DATA 1"

DATA ELEMENT: Group Number (GROUP NO)
(CONTINUED)

Must NOT equal the GROUP NAME (DA0-11.0).

FORM LOCATION: HCFA-1500 Blocks 9a, 11

REMARKS: Some payers require this information for all claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payers since it's presence may expedite the processing of the claim.

This information is required for processing a Medicare secondary claim.

MEDICAID

NOTES: This field is required when other insurance is involved. It contains the group number of the other insurance.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-11.0
"PAYER DATA 1"

DATA ELEMENT: Group Name

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
11.0	X(33)	LEFT	SPACES	89	121	C

DEFINITION: The name of the group or plan through which insurance is being provided.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

See GENERAL INSTRUCTIONS for "Name 2" (company name) entry.

Must NOT equal the PAYER ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ().

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces () EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following literals: "UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

Must NOT equal the GROUP NUMBER (DA0-10.0).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
"PAYER DATA 1"

RECORD/FIELD: DA0-11.0

DATA ELEMENT: Group Name

(CONTINUED)

FORM LOCATION: HCFA-1500 Blocks 9d, 11

REMARKS: Some payers require this information for all claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payers since it's presence may expedite the processing of the claim.

This information is required for processing Medicare secondary claims.

MEDICAID

NOTES: This field is required when other insurance is involved. It is the plan name or program name of the other insurance.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-14.0
"PAYER DATA 1"

DATA ELEMENT: Prior Authorization Number (PRIOR AUTH NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
14.0	X(15)	LEFT	SPACES	138	152	C

DEFINITION: A number, code or other indicator that the services provided on this claim have been authorized by the payer.

CODE VALUES: N/A

VALIDATION: Must be entered if required by the payer and prior approval has been obtained from the payer or his agent.

FORM LOCATION: HCFA-1500 Block 23

REMARKS: N/A

MEDICAID

NOTES: Complete this field only if prior/payment authorization is required for any of the services billed. Use the ODJFS assigned six (6) digit number from the approved "Prior Authorization" notification. Refer to the appropriate Medicaid Handbook to determine what services require prior authorization.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-18.0
"PAYER DATA 1"

DATA ELEMENT: Insured Identification Number (INSURED ID NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
18.0	X(25)	LEFT	SPACES	157	181	R

DEFINITION: Insured's unique identification number, by the Third Party Payer.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for identification number entry. Must not contain all zeros or all nines (9's). May not contain any of the following literals:
unknown", "individual", "self",
"1234567890" or "none"

FORM LOCATION: HCFA-1500 Blocks 1a, 9a

REMARKS: Subscriber ID
Sponsor ID
HIC ID
SSN ID
Recipient ID
Employee ID (Group self administered)

MEDICAID

NOTES: This is a required field and is an unique number assigned to each recipient.

This is the 12 digit billing number which is found in the column marked "Billing Number" on the Ohio Medical card(Medicaid, General Assistance, or Disability Assistance).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-18.0
"PAYER DATA 1"

DATA ELEMENT: Insured Identification Number (INSURED ID NO)

(CONTINUED)

The tenth digit of the number is the "check" digit and is verified by a routine that takes the first nine digits of the Billing Number and calculates a number that is compared to the tenth digit of the Billing Number. If digits 11 and 12 are equal to 80, the routine is ignored.

The check digit is calculated as follows:

- 1) take the first five odd position number digits and treat it as a single number**
- 2) multiply the result of step 1 by 2**
- 3) add together each digit of the result of step 2 with the first four even position number digits**
- 4) subtract the result of step 3 from 100**
- 5) the low order digit from the result of step 4 should be the check digit**

For example:

Billing Number 736285914701

- 1) (76894) X 2 = 153788**
- 2) (1+5+3+7+8+8) + (3+2+5+1) = 43**
- 3) 100 - (43) = 57**
- 4) 7 should be the check digit**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA0-19.0
"PAYER DATA 1" DA0-20.0
DA0-21.0

DATA ELEMENT: Insured Last Name (INSURED LAST NAME)
Insured First Name (INSURED FIRST NAME)
Insured Middle Initial (INSURED MI)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
19.0	X(20)	LEFT	SPACES	182	201	C
20.0	X(12)	LEFT	SPACES	202	213	C
21.0	X(01)	LEFT	SPACES	214	214	C

DEFINITION: The last, first, middle name of the insured individual.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for Name 1 (individual names) entry.

FORM LOCATION: HCFA-1500 Blocks 4, 9

REMARKS: N/A

MEDICAID

NOTES: This field is required when other insurance is involved. It is the Other Insured's Name from Block 9 of the HCFA-1500.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

INSURANCE INFORMATION RECORD

RECORD TYPE: DA1

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION
 "PAYER DATA 2"

RECORD TYPE: DA1

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA1"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
	FILLER	105	X	23	127
11.0	ALLOWED AMOUNT	7	N	128	134
12.0	DEDUCTIBLE AMOUNT	7	N	135	141
13.0	COINSURANCE AMOUNT	7	N	142	148
	FILLER	104	X	149	252
26.1	DATE PAID BY MEDICARE	6	X	253	258
	FILLER	62	X	259	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-01.0
"PAYER DATA 2"

DATA ELEMENT: Record Identifier (RECORD ID "DA1")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "INSURANCE INFORMATION" - "PAYER DATA 2" record.

CODE VALUES: N/A

VALIDATION: A claim may have up to three "DA1" records. Each must have a corresponding "DA0" record.
Must be "DA1".

FORM LOCATION: N/A

REMARKS: Multiple "DA1" records must have corresponding "DA0" records. The records are 'matched' by SEQUENCE NO (DA0-02.0 and DA1-02.0).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-02.0
"PAYER DATA 2"

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA1" records and to associate "DA1" records with "DA0" and "DA2" records.

CODE VALUES: 01 - Identifies the primary payer record.
02 - Identifies the secondary payer record.
03 - Identifies the tertiary payer record.

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (DA0-02.0) submitted in the preceding "DA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page DA0.04.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-03.0
"PAYER DATA 2"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"
(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account
Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-11.0
 "PAYER DATA 2"

DATA ELEMENT: Allowed Amount

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----	-----	-----	-----	-----	-----	-----
11.0	9(5)V99	RIGHT	ZEROS	128	134	C

DEFINITION: The maximum amount determined by the payer as being "allowable" under the provisions of the contract prior to the determination of actual payment.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES:

USE FOR MEDICARE CROSSOVER CLAIMS ONLY

- 04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:**
 Enter the Medicare Part C managed care plan "approved/allowed/covered" amount found on the Medicare managed care plan's EOB remittance advice. The "approved/allowed/covered" amount is provided on the HIPAA compliant 835 Remittance Advance, as well as on many NSF and paper claims remittance advices; if the specific "approved/allowed/covered" amount is not given, then information is available on the remittance advice that providers can use in order to calculate this amount.
- For example, if the Medicare managed care plan's EOB does not provide a place on the remittance for "allowed/approved/covered" amount, the provider will be able to calculate this amount by subtracting the "provider discount/contract adjustment" amount from the "charged/billed/claimed" amount.
- (2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:**
 Enter the total dollar amount approved by Medicare indicated on the Summary Notice from Medicare.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-12.0
"PAYER DATA 2"

DATA ELEMENT: Deductible Amount

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
12.0	9(5)V99	RIGHT	ZEROS	135	141	C

DEFINITION: The amount deducted, by the payer, from the allowed amount. This amount will meet the contract "deductible" provisions.

The amount applied toward the deductible by this payer.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount of deductible on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:

Enter the Medicare Part C managed care plan deductible amount found on the Medicare managed care plan's EOB remittance advice. If the Medicare managed care plan has bundled the deductible, coinsurance and copayment amounts enter the bundled amount in the DA1-13.0 field. If there is no amount listed leave this item blank.

Note: Providers paid under a capitation arrangement may submit the deductible amount set forth in their agreement with the Part C plan.

(2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:

Enter the dollar amount shown in the Deductible column on the Summary Notice from Medicare. If there is no deductible amount listed leave this item blank.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-13.0
"PAYER DATA 2"

DATA ELEMENT: Coinsurance Amount

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
13.0	9(5)V99	RIGHT	ZEROS	142	148	C

DEFINITION: The amount deducted, by the payer, from the allowed amount in order to meet the "coinsurance" provisions of the contract.

The amount applied toward the coinsurance by this payer.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payer requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field may be used to report the total amount coinsurance on the claim for Medicare Secondary Payer submission purposes.

Consult the Matrix/User Guide document supplied by the payer/receiver to determine usage of this data element.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:

Enter the Medicare Part C managed care plan coinsurance and/or copayment amount found on the Medicare managed care plan's EOB remittance advice. If the Medicare managed care plan has bundled the deductible, coinsurance and copayment amounts enter the bundled amount in this field. If there is no amount listed leave this item blank.

Note: Providers paid under a capitation arrangement may submit the coinsurance and/or copayment amounts set forth in their agreement with the Part C plan.

(2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:

Enter the dollar amount shown in the Co-insurance column on the Summary Notice from Medicare. If there is no coinsurance amount listed leave this item blank.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: INSURANCE INFORMATION RECORD/FIELD: DA1-26.1
"PAYER DATA 2"

DATA ELEMENT: Date Paid by Medicare

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
26.1	X(6)	LEFT	ZEROS	253	258	C

DEFINITION: This field is the date that this claim was paid by Medicare.

CODE VALUES: N/A

VALIDATION: Logical date edit: MMDDYY

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payer.

REMARKS: This field is only used for Medicare Secondary Payer purposes.

MEDICAID NOTES:

04/19/04 (1) MEDICARE PART C (MEDICARE ADVANTAGE PLANS) CROSSOVERS:

For providers not paid under a capitation arrangement: Enter the date paid by the Medicare Part C managed care plan found on the Medicare managed care plan's EOB remittance advice.

For providers paid under a capitation arrangement: Enter the date of submission to Medicaid . This date may not be older than 365 days from the date of service.

(2) TRADITIONAL MEDICARE PART A/B CROSSOVERS:

Enter the payment date shown in the upper right hand corner of the Summary Notice from Medicare.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

CLAIM RECORD

RECORD TYPE: EA0

"CLAIM DATA"

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD TYPE: EA0
"CLAIM DATA"

LEVEL: CLAIM

PURPOSE: To identify claim level information.

REQUIREMENTS: One EA0 is required on every claim.

ORDER:	Preceding Record Type ----- DA0, DA1 or DA2	Following Record Type ----- EA1 or FA0
--------	--	---

NOTES: Only one EA0 record is allowed on each claim.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD

RECORD TYPE: EA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
01.0	RECORD ID "EA0"	3	X	1	3
	FILLER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
	FILLER	1	X	23	23
05.0	ACCIDENT INDICATOR	1	X	24	24
	FILLER	1	X	25	25
07.0	ACCIDENT/SYMPTOM DATE	8	X	26	33
	FILLER	46	X	34	79
20.0	REFERRING PROVIDER ID NUMBER	15	X	80	94
	FILLER	25	X	95	119
22.0	REFER PROV LAST	20	X	120	139
23.0	REFER PROV FIRST	12	X	140	151
24.0	REFER PROV MI	1	X	152	152
	FILLER	26	X	153	178
30.0	DIAGNOSIS CODE-1 (PRIMARY)	5	X	179	183
31.0	DIAGNOSIS CODE-2 (SECONDARY)	5	X	184	188
	FILLER	132	X	189	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-01.0
"CLAIM DATA"

DATA ELEMENT: Record Identification (RECORD ID "EA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: This is the record identifier for the Claim Detail Record - EA0.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "EA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-03.0
"CLAIM DATA"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"
(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control
Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-05.0
"CLAIM DATA"

DATA ELEMENT: Accident Indicator (ACCIDENT IND)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
05.0	X(01)	LEFT	SPACE	24	24	R

DEFINITION: A code to indicate whether the patient's condition was the result of an accident.

CODE VALUES: A = Auto accident
O = Other, non-auto accident
N = No accident

VALIDATION: Must be entered.

Must be a valid code from above list.

If "A" or "O" is entered, EA0-07.0 thru EA0-11.0
must be completed according to payer requirements.

FORM LOCATION: HCFA-1500 Blocks 10b, 10c

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-07.0
"CLAIM DATA"

DATA ELEMENT: Accident/Symptom Date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
07.0	X(08)	LEFT	SPACES	26	33	C

DEFINITION: The date of the accident or the date that patient first experienced symptoms of illness or the date of the last menstrual period (LMP).

CODE VALUES: N/A

VALIDATION: If "Symptom Indicator" (EA0-06.0) equals "1" or "2", this field must be completed according to payer requirements.

If "Accident Indicator" (EA0-05.0) equals "A" or "O", this field must be completed according to payer requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-1500 Block 14

REMARKS: N/A

MEDICAID NOTES: This field is only used for the Last Menstrual Period Date (LMP).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD
"CLAIM DATA"

RECORD/FIELD: EA0-20.0

DATA ELEMENT: Referring Provider Identification Number

(REFER PROV ID NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
20.0	X(15)	LEFT	SPACES	80	94	C

DEFINITION: The Identification Number assigned by the Payer to the Referring Physician.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: HCFA-1500 Block 17a

REMARKS: N/A

MEDICAID

NOTES:

For physicians, podiatrists, clinics and private duty nurses, if the patient was referred to you, enter the referring physician's provider number. If the referring physician's provider number is not available, enter 9111115 in this space and enter the referring physician's name and address (Record EA0, Fields 22, 23 and 24). This field must be completed when you are billing for consultative or referral services or billing for services provided to a Pact recipient for whom you are not the designated physician.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-20.0
"CLAIM DATA"

DATA ELEMENT: Referring Provider Identification Number (REFER PROV ID NO)

(CONTINUED)

MEDICAID

NOTES:

For Medical Suppliers, enter the seven (7) digit Medicaid provider number of the prescribing physician or podiatrist. If the referring provider does not have a Medicaid provider number or you are unable to obtain the provider number, enter 9111115 in the space and the referring provider's name and address.

For Laboratories, please leave blank unless the procedure code is one designated as code requiring a referring physician number.

For Transportation, except in instances of Ambulance Transportation to a hospital emergency room in an emergency situation; e.g., as a result of accident, injury or acute illness, all ambulance and ambulette services must be certified by a physician as medically necessary. Enter the Medicaid provider number of the attending or ordering physician.

Please refer to the check digit routine for the Provider Medicaid Number field (number 12.0) on Record BA0.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-22.0
 "CLAIM DATA" EA0-23.0
 EA0-24.0

DATA ELEMENT: Referring Provider Last Name (REFER PROV LAST)
 Referring Provider First Name (REFER PROV FIRST)
 Referring Provider Middle Initial (REFER PROV MI)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
22.0	X(20)	LEFT	SPACES	120	139	C
23.0	X(12)	LEFT	SPACES	140	151	C
24.0	X(01)	LEFT	SPACES	152	152	C

DEFINITION: Name of Provider who referred the patient to the provider of service on this claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: HCFA-1500 Block 17

REMARKS: N/A

MEDICAID

NOTES: These fields should be used if the Referring Provider Identification Number is equal to 9111115.

7/01/01 For FQHCs (type 12) or Rural Health Clinics (type 5), if the provider is billing for the managed care supplemental payment effective for dates of service , enter the seven digit Ohio Medicaid identification number of the Managed Care Plan (MCP) which paid the provider for managed care services. For a current list of Managed Health Care Provider numbers call the Bureau of Managed Health Care at 614-466-4693 and submit an information request.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD RECORD/FIELD: EA0-30.0
"CLAIM DATA" EA0-31.0

DATA ELEMENT: Diagnosis Code-1 Diagnosis Code-2

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
30.0	X(05)	LEFT	SPACES	179	183	R
31.0	X(05)	LEFT	SPACES	184	188	C

DEFINITION: An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition resulting in a line item service.

CODE VALUES: ICD-9-CM Diagnosis Codes.

VALIDATION: Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

The submission of "V", "E" and/or "M" Diagnosis Codes may or may not be accepted by a payer.

FORM LOCATION: HCFA-1500 Block 21

REMARKS: The Diagnosis Code should correspond with the age and sex of the patient.

MEDICAID

NOTES: Diagnosis Code-1 is considered the Primary Diagnosis.
Diagnosis Code-2 is considered the Secondary Diagnosis.

PRIMARY DIAGNOSIS CODE: For Physicians, Podiatrists, Vision, Ambulatory Surgical Centers, Clinics and Medical Suppliers, enter the appropriate diagnosis code from the Internal Classification of Diseases,

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD
"CLAIM DATA"

RECORD/FIELD: EA0-30.0
EA0-31.0

DATA ELEMENT: Diagnosis Code-1

Diagnosis Code-2

(CONTINUED)

9th Edition, Clinical Modification (ICD-9-CM) for the primary diagnosis. Note: Some diagnosis codes in the ICD-9-CM are 3 or 4 digits. If the diagnosis is 5 digits, you must enter all 5 digits. "V" are acceptable. "E" and "M" codes are not acceptable as a primary diagnosis.

SECONDARY DIAGNOSIS CODE: Enter the 3, 4 or 5 digit ICD-9-CM code which corresponds to the secondary diagnosis for the patient. If there is no secondary diagnosis, leave this field blank. "V" and "M" codes are acceptable.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FA0

"CLAIM - ROOT SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD TYPE: FA0

LEVEL: CLAIM - ROOT SEGMENT

PURPOSE: To provide information related to the medical/dental services rendered to the patient by the provider.

REQUIREMENTS: This record is required on all claims.

ORDER:	Preceding Record Type	Following Record Type
	EA0, EA1, EA2, FA0, FB0, FB1, FB2, FD0, CERT Records, or HA0	FB0, FB1, FB2, FD0, CERT Records, HA0 or XA0

- NOTES: 1. There must be at least 1 record type FA0 entered for a claim.
2. There may be up to 99 record type FA0's entered for a claim.

**MEDICAID
NOTES**

**There must be at least one but not more than twenty-one
line items per document.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
 ROOT SEGMENT

RECORD TYPE: FA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FA0"	3	X	1	3
02.0	SEQUENCE NUMBER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	SERVICE FROM DATE	8	X	40	47
	FILLER	8	X	48	55
07.0	PLACE OF SERVICE	2	X	56	57
	FILLER	2	X	58	59
09.0	HCPCS PROCEDURE CODE	5	X	60	64
10.0	HCPCS MODIFIER 1	2	X	65	66
	FILLER	4	X	67	70
13.0	LINE CHARGES	7	N	71	77
	FILLER	4	X	78	81
18.0	UNITS OF SERVICE	4	N	82	85
19.0	ANESTHESIA/OXYGEN MINUTES	4	N	86	89
	FILLER	141	X	90	230
39.1	EG ORDER SHIPPING DATE	8	X	231	238
	Filler	3	X	239	241
39.2	HCPCS Modifier 2	2	X	242	243
39.3	HCPCS Modifier 3	3	X	244	245
39.4	HCPCS Modifier 4	4	X	246	247
40.0	Filler	73	X	248	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: This is the record identifier for the Service Line Detail Record - FA0.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be 'FA0'.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

All Fxx records must be grouped as FA0, FB0, FB1 followed by any applicable CERT record(s) and/or Narrative record(s) (or for Dental claims, FA0, FD0) by Sequence Number.

FORM LOCATION: N/A

REMARKS: Consult the Matrix/User Guide document supplied by the payer/receiver to determine the maximum number (sequences) of "FA0" records allowed.

MEDICAID NOTES:

There can be no duplicate line numbers for a document (claim or invoice). Line numbers must be in ascending sequence. There must be at least one but not more than twenty-one line items per document.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the **GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(17)	LEFT	SPACES	23	39	C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-05.0

DATA ELEMENT: Service From Date (SVC FROM DATE)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
05.0	X(08)	LEFT	SPACES	40	47	R

DEFINITION: The date the service was initiated.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-1500 Block 24a

REMARKS: N/A

MEDICAID

NOTES:

**Enter the dates of service in chronological order (first to last).
Each date of service must be A separate FA0 record. FAILURE TO ENTER A DATE WILL
CAUSE THE CLAIM TO REJECT.**

**Since Medicaid does not pay for spanned billing dates, the Service To Date should be left
blank.**

Note: All services must be billed to Medicaid within 365 days of the date of service.

**01/01/2002 Order Received Date for eye glass orders denotes date the Optical
laboratory received the eyeglass order for processing.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-07.0

DATA ELEMENT: Place of Service (PLACE OF SVC)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
07.0	X(02)	LEFT	SPACES	56	57	R

DEFINITION: The code that identifies where the service was performed.

CODE VALUES:

00-09	Unassigned
11	Office
12	Home
10, 13-19	Unassigned
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
20, 27-29	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
30, 35-39	Unassigned
41	Ambulance - Land
42	Ambulance - Air or Water
40, 43-49	Unassigned
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
50, 57-59	Unassigned

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-07.0

DATA ELEMENT: Place of Service (PLACE OF SVC)

(CONTINUED)

61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
60, 63, 64	Unassigned
66-69	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
70, 73-79	Unassigned
81	Independent Laboratory
80, 82-89	Unassigned
99	Other Unlisted Facility
90-98	Unassigned

VALIDATION: Must be entered

Must be a valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24b

REMARKS: N/A

MEDICAID

NOTES: An additional code is available:

73 Clinic NOS

All claims, other than those submitted by independent laboratories, portable x-ray suppliers and independent physiological laboratories, require a place of service. Please check your Billing Instructions for details.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-09.0

DATA ELEMENT: HCPCS Procedure Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
09.0	X(05)	LEFT	SPACES	60	64	R

DEFINITION: This is the HCPCS/CPT-4 code that describes the service.

CODE VALUES: HCPCS/CPT-4 code set.

VALIDATION: Must be entered.

Must be a valid HCPCS/CPT-4 procedure code.

FORM LOCATION: HCFA-1500 Block 24d

REMARKS: N/A

MEDICAID

NOTES: Enter the 5 character/digit Health Care Financing Administration Common Procedure Coding System (HCPCS) code which corresponds to the service being rendered.

Encounter/Procedure Codes - ONLY provider types (04) OHF, (05) RHF, and (12) FQHC must bill the appropriate five (5) digit encounter code followed immediately on the next record by the HCPCS code(s) that corresponds to the services rendered. HCPCS CODES MUST FOLLOW THE ENCOUNTER CODE TO WHICH THEY RELATE.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FA0-09.0

DATA ELEMENT: HCPCS Procedure Code

(CONTINUED)

Modifiers (all providers) - In certain instances, a 2 character/digit modifier will be required depending on the service. When entering a code with the modifier, enter the 2 character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes. The following services must always be billed using a modifier:

Healthcheck evaluation and management codes (99381-99395)

Anesthesia

Assistant at Surgery

Ambulance/Ambulette

Oxygen

Other services may require a modifier based on the type and/or place of service. The appropriate Medicaid Handbook should be referenced for further details regarding the use of modifiers.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-10.0

DATA ELEMENT: HCPCS Modifier 1

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
10.0	X(02)	LEFT	SPACES	65	66	C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID

NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at surgery, laboratory, transportation, radiology, durable medical equipment, etc.).
Please refer to the Medicaid Handbook for proper usage.

Please refer to the ODJFS web site Electronic Manuals [http:// emanuals.odjfs.state.oh.us/emanuals](http://emanuals.odjfs.state.oh.us/emanuals) Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E- Collection. Look for the services your billing, e.g. physicians, or FQHC's , or transportation. Find the approved modifiers for the services you need to use in your program.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FA0-13.0

DATA ELEMENT: Line Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
13.0	9(05)V99	RIGHT	ZEROS	71	77	R

DEFINITION: The charges related to this service.

CODE VALUES: N/A

VALIDATION: Must be positive unsigned numeric value.

FORM LOCATION: HCFA-1500 Block 24f

REMARKS: N/A

MEDICAID

NOTES: This field is the usual and customary fee for the service listed on this record.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-18.0

DATA ELEMENT: Units Of Service (UNITS OF SVC)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
18.0	9(03)V9	RIGHT	ZEROS	82	85	C

DEFINITION: The number of services rendered in days or units.

CODE VALUES: N/A

VALIDATION: Must be Positive unsigned numeric value.

FORM LOCATION: HCFA-1500 Block 24g

REMARKS: In order to capture fractional services, the fourth position with an assumed decimal position.

MEDICAID

NOTES: This field contains the number of units of service if more than one.
Only numbers 1 to 999 are accepted.
The digit to the right of the decimal must be zero (0).

5/01/01 NOTE: Multiple units of service on a single record is limited to anesthesia time, allergy services, transportation (number of loaded miles), medical supplies (number of items dispensed), private duty nursing (hours of personal care) and waiver services.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-39.1

DATA ELEMENT: Eyeglass Order Shipping Date (EG ORDER SHIPPING DATE)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
39.1	X(08)	LEFT	SPACES	231	238	C

DEFINITION: The date the eyeglasses were shipped.

CODE VALUES: N/A

VALIDATION: Must be entered for eyeglass orders.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field only applies to Medicaid vision contractors.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-39.2

DATA ELEMENT: HCPCS Modifier 2

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
39.2	X(02)	LEFT	SPACES	242	243	C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

Please refer to the ODJFS web site Electronic Manuals <http://emanuals.odjfs.state.oh.us/emanuals>
Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E- Collection. Look for the services your billing, e.g. physicians, or FQHC's , or transportation. Find the approved modifiers for the services you need to use in your program.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-39.3

DATA ELEMENT: HCPCS Modifier 3

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
39.3	X(02)	LEFT	SPACES	244	245	C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID

NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at-surgery, laboratory, transportation, radiology, durable medical equipment, etc.).
Please refer to the Medicaid Handbook for proper usage.

Please refer to the ODJFS web site Electronic Manuals <http://emanuals.odjfs.state.oh.us/emanuals> Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E- Collection. Look for the services your billing, e.g. physicians, or FQHC's , or transportation. Find the approved modifiers for the services you need to use in your program.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FA0-39.4

DATA ELEMENT: HCPCS Modifier 4

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
39.4	X(02)	LEFT	SPACES	246	247	C

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper of the service.

FORM LOCATION: HCFA-1500 Block 24D

REMARKS: N/A

MEDICAID

**NOTES: In certain instances, a modifier is required depending on the service (e.g., anesthesia, assistant-at-surgery, laboratory, transportation, radiology, durable medical equipment, etc.).
Please refer to the Medicaid Handbook for proper usage.**

Please refer to the ODJFS web site Electronic Manuals <http://emanuals.odjfs.state.oh.us/emanuals>
Under the Ohio Health Plans Manual. Click on the right hand side Ohio Health Plans Provider E- Collection. Look for the services your billing, e.g. physicians, or FQHC's , or transportation. Find the approved modifiers for the services you need to use in your program.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FB0

"MEDICAL SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD TYPE: FB0

LEVEL: CLAIM - MEDICAL SEGMENT

PURPOSE: To provide information related to the medical services rendered to the patient by the provider.

REQUIREMENTS: If required by the payer, this record must be submitted.

ORDER:	Preceding Record Type	Following Record Type
	----- FA0	----- FA0, FB1, CERT records, HA0 or XA0

NOTES: There may be up to 99 record type FB0's entered for a claim.

MEDICAID

NOTES: There must be at least one but not more than twenty-one line items per document.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
 MEDICAL SEGMENT

RECORD TYPE: FB0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
----	-----	-----	-----	-----	-----
01.0	RECORD ID "FB0"	3	X	1	3
02.0	SEQUENCE NUMBER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
	FILLER	88	X	40	127
17.0	PRESCRIPTION NUMBER	15	X	128	142
	FILLER	12	X	143	154
22.0	EPSDT INDICATOR	1	X	155	155
23.0	FAMILY PLANNING INDICATOR	1	X	156	156
	FILLER	164	X	157	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FB0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: This is the record identifier for the Service Line Detail Record - FB0.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be 'FB0'.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the **GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(17)	LEFT	SPACES	23	39	C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID

NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-17.0

DATA ELEMENT: Prescription Number (PRESCRIPTION NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
17.0	X(15)	LEFT	SPACES	128	142	C

DEFINITION: The unique identification number assigned by the pharmacy or supplier.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payer.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: Only the first 10 positions of this field are used by the Medicaid payment system.

For Medical Supplies, enter the prescription number or invoice number of the dispensed item.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-22.0

DATA ELEMENT: EPSDT Indicator (EPSDT IND)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
22.0	X(01)	LEFT	SPACE	155	155	C

DEFINITION: An indicator of whether or not "Early and Periodic Screen for Diagnosis and Treatment of children" services are involved with this detail line.

CODE VALUES: Y – Yes for, EPSDT involvement

N – no for, EPSDT not involved

R- referral for, EPSDT and other services

VALIDATION: Must be entered if required by Payer.

If entered, must be valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24h

REMARKS: N/A

MEDICAID

NOTES: This field is required by the Medicaid payment system.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FB0-23.0

DATA ELEMENT: Family Planning Indicator (FAMILY PLANNING IND)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
23.0	X(01)	LEFT	SPACE	156	156	C

DEFINITION: An indicator of whether or not Family Planning Services are involved with this detail line.

CODE VALUES: Y - Yes, family planning involved

N - No, family planning not involved

VALIDATION: Must be entered if required by Payer.

If entered, must be valid code from the above list.

FORM LOCATION: HCFA-1500 Block 24h

REMARKS: N/A

MEDICAID

NOTES: This field is required by the Medicaid payment system.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

SERVICE LINE DETAIL RECORD

RECORD TYPE: FD0

"DENTAL SEGMENT"

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD TYPE: FD0

LEVEL: CLAIM - DENTAL SEGMENT

PURPOSE: To provide information related to dental services rendered to the patient by the provider.

REQUIREMENTS: If required by the payer, this record must be submitted for dental claims.

ORDER:	Preceding Record Type ----- FA0, FB0, FB1 FB2 or FD0	Following Record Type ----- FD0, HA0 or XA0
--------	--	--

NOTES: There may be up to 99 record type FD0's entered for a claim.

MEDICAID

NOTES: There must be at least one but not more than twenty-one line items per document.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL
DENTAL SEGMENT

ORD TYPE: FD0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FD0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	TOOTH CODE NUMBER 1	2	X	40	41
06.0	TOOTH SURFACE(S) 1	5	X	42	46
	FILLER	274	X	47	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FD0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FD0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: This is the record identifier for the Service Line Detail Record - FD0.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "FD0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FD0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the "Sequence Number" (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FD0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES:

This field is used to link all records for a single claim. The entire claim will be denied without this information

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FD0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(17)	LEFT	SPACES	23	39	C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: If accepted by Payer, it should be returned on the EMC electronic remittance to facilitate the provider's posting of line item adjudication information.

MEDICAID

NOTES: This field is currently not returned on the Ohio Medicaid Pay/Reject file.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL

RECORD/FIELD: FD0-05.0

DATA ELEMENT: Tooth Code Number 1

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
05.0	X(02)	LEFT	SPACES	40	41	C

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent

10 Through 32 - Permanent

A Through T - Primary

SN - Supernumerary

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: SERVICE LINE DETAIL RECORD/FIELD: FD0-06.0

DATA ELEMENT: Tooth Surface(s) 1

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
06.0	X(05)	LEFT	SPACES	42	46	C

DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

06/01 Date eyeglass order received.

CODE VALUES:

M	-	Mesial
O	-	Occlusal
D	-	Distal
L	-	Lingual
F	-	Facial
I	-	Incisal
B	-	Buccal

VALIDATION: If entered must be a valid code or combination of up to five codes from the above table.

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

AMBULANCE CERTIFICATION RECORD

RECORD TYPE: GA0

NATIONAL VER. 001.02 - 09/01/1992

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

RECORD TYPE: GA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	FROM	POSITIONS THRU
-----	-----	-----	-----	-----	-----
01.0	RECORD ID "GA0"	3	X	1	3
02.0	SEQUENCE NUMBER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
	FILLER	31	X	23	53
17.0	MILES	4	X	54	57
	FILLER	250	X	58	307
23.1	TIME PATIENT WAS PICKED UP	4	X	308	311
	FILLER	9	X	312	320

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD RECORD/FIELD: GA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"
(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control
Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES:

**This field is used to link all records for a single
claim. The entire claim will be
denied without this information**

**For further information, refer to the GENERAL
INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID
NOTES, page GI0.6.**

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD

RECORD/FIELD: GA0-23.1

DATA ELEMENT: Time patient was picked up

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
23.1	X(4)	LEFT	SPACES	308	311	R

DEFINITION: This is the hour and minute that the patient was picked up by the ambulance. The hour is represented in the military (24 hour clock) fashion.

CODE VALUES: N/A

VALIDATION: Only required for Transportation type claims.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for Transportation claims.

The time is required for each line item and must be expressed in military time. As an example, military time is represented as follows:

8:30 a.m. = 0830

2:15 p.m. = 1415

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

EXTRA NARRATIVE RECORD

RECORD TYPE: HA0

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD RECORD TYPE: HA0

LEVEL: SERVICE LINE

PURPOSE: To provide additional information related to the service rendered to the patient by the provider.

REQUIREMENTS: If required by the payer, this record must be submitted.

ORDER:	Preceding Record Type -----	Following Record Type -----
	FA0, FB0, FB1, FB2, FD0, GA0, GC0, GD0, GD1, GE0, GP0, GU0, GX0, GX1 or GX2	FA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1, FB2, FD0, GA0, GC0, GD0, GE0, GP0, GU0, GX0, GX1 or GX2 record related to this service.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD

RECORD TYPE: HA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "HA0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	CO-PAYMENT REMARKS	10	X	40	49
06.0	EXTRA NARRATIVE DATA	271	X	50	320

MEDICAID NOTES:

Field number 05.0 should only be used for co-payment remarks.

Field number 06.0 should only be used for:

- 1. Multiple Surgeries**
- 2. By-Report Procedures**
- 3. Multiple passengers for transportation claims**
- 4. Service codes 10000 thru 69999**

Only 5 HA0 records per claim is allowed

01/01/06

HA0.2

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD
"CLAIM DATA"

RECORD/FIELD: HA0-01.0

DATA ELEMENT: Record Identification (RECORD ID "HA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: This is the record identifier for the Narrative Record - HA0.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "HA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD RECORD/FIELD: HA0-02.0
"CLAIM DATA"

DATA ELEMENT: Sequence Number (SEQUENCE NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
02.0	X(02)	LEFT	SPACES	04	05	R

DEFINITION: A numeric value from 01 through 99 used to sequence the "HA0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid value from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD RECORD/FIELD: HA0-03.0
"CLAIM DATA"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"
(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES:

This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD
"CLAIM DATA"

RECORD/FIELD: HA0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	X(17)	LEFT	SPACES	23	39	C

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payer allowed.

If entered, value must match the "Line Item Control Number" submitted in the preceding FA0-04.0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is currently not returned on the Ohio Pay/Reject file.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: NARRATIVE RECORD RECORD/FIELD: HA0-05.0

"CLAIM DATA"
RECORD NAME: CLAIM CONTROL SCREEN

DATA ELEMENT: COPAY REMARKS

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
05.0	X(10)	LEFT	SPACES	40	49	R

DEFINITION: This field is used to for reporting a co-payment exclusion.

Use the following table to indicate that a co-payment exclusion applies.

Note: The caret denotes a space between the word COPAY and the 4-digit alpha exclusion code. The space must exist if billing for a co-payment exclusion.

Exclusion Description	Exclusion Code – Denotes a Co-payment Should Not Be Taken
Pregnant or pregnancy ended recently (up to 90 days ago)	COPAY PREG ^
If Receiving Hospice Services	COPAY HSPC ^
Vision or Dental Services Rendered on an Emergency Basis	COPAY EMER ^

VALIDATION: This field is required.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

DATA ELEMENT: Extra Narrative Data
DEFINITION: Free form narrative record to submit additional information that may assist in the adjudication of the Service Line Item in the preceding FA0 record.

DATA ELEMENT: Extra Narrative Data

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
06.0	X(271)	LEFT	SPACES	50	320	C

DEFINITION: Free form narrative record to submit additional information that may assist in the adjudication of the Service Line Item in the preceding FA0 record.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payer.

FORM LOCATION: N/A

REMARKS: This field may be used as follows:

1. To describe the service being submitted as an Unlisted/NOC HCPCS Procedure Code in the preceding FA0 record.
2. To report "Secondary" Diagnosis Codes that exceeded the number that could be submitted on the preceding FA0 record.
3. To report the substitute physician's UPIN (six bytes in length, alpha numeric) for "Reciprocal" or "Locum Tenens" billing arrangements.

Consult the Matrix/Users Guide supplied by the Payer/Receiver for additional details regarding submission instructions.

**MEDICAID
NOTES:**

These records are required when miscellaneous codes are used, such as Places of Service "0-9", "10", "13-19", "20", "27-99", "30", "35-39", "40", "43-49", "50", "57-59", "60", "63-64", "66-69", "70", "74-79", "80", "82-89", "90-99", Other Source of Insurance "6", or when special types of claims are submitted, such as:

- 1) HCPCS, CPT, drug and supply codes that need special handling, pricing or any miscellaneous codes needing an explanation.
- 2) Transportation claims requiring an explanation for the need for service (when the referring physician number is not available).
- 3) Claims with multiple surgeries.
- 4) Transportation claims for multiple passengers or air flight.

Item #3 in the above Remarks section is concerned with "Reciprocal" and "Locum Tenens" billing arrangements. These arrangements are not currently being Recognized by Ohio Medicaid.

NATIONAL VER. 001.01 - 03/01/1992
LOCAL VER. 001.03 - 09/15/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

CLAIM TRAILER RECORD

RECORD TYPE: XA0

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD TYPE: XA0

LEVEL: CLAIM

PURPOSE: The last record of every claim submitted electronically, it contains information pertinent to the balancing of each claim (i.e. claim record counts, claim charges) within a batch.

REQUIREMENTS: An 'XA0' Record is a REQUIRED record since it is the CLAIM TRAILER

ORDER:	Preceding Record Type -----	Following Record Type -----
	FA0, FB0, FB1, FB2, FD0, GA0 (CERT RECORDS), HA0 (NARRATIVE RECORD)	CA0, YA0

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type FA0 (SERVICE LINE DETAIL RECORD).

There may be multiple claims per batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD TYPE: XA0
 "RECORD SUMMARY"

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "XA0"	3	X	1	3
	FILLER	2	X	4	5
03.0	PATIENT CONTROL NUMBER	17	X	6	22
	FILLER	12	X	23	34
10.0	CLAIM RECORD COUNT	3	N	35	37
	FILLER	40	X	38	77
12.0	TOTAL CLAIM CHARGES	7	N	78	84
	FILLER	42	X	85	126
19.9	PATIENT AMOUNT PAID	7	N	127	133
	FILLER	187	X	134	320

NOTE: Only positive numeric values are accepted as input, values are not allowable.

2/95 Only 500 Batches Per Cartridge.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD/FIELD: XA0-01.0
"RECORD SUMMARY"

DATA ELEMENT: Record Identifier (RECORD ID "XA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "Claim Trailer Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "XA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD/FIELD: XA0-03.0
"RECORD SUMMARY"

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
03.0	X(17)	LEFT	SPACES	06	22	R

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the PATIENT CONTROL NUMBER found in Claim Header Record (CA0-03.0).

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: HCFA-1500 Block 26

REMARKS: N/A

MEDICAID NOTES:

This field is used to link all records for a single claim. The entire claim will be denied without this information.

For further information, refer to the GENERAL INSTRUCTIONS, PATIENT CONTROL NUMBER: MEDICAID NOTES, page GI0.6.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD/FIELD: XA0-10.0
"RECORD SUMMARY"

DATA ELEMENT: Claim Record Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
10.0	9(03)	RIGHT	ZEROS	35	37	R

DEFINITION: The total number of records submitted for this claim excluding this record.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be numeric.
Must be the computed sum of all records processed from the Claim Header Record (CA0) to the Claim Trailer Record (XA0).

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD/FIELD: XA0-12.0
"RECORD SUMMARY"

DATA ELEMENT: Total Claim Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
12.0	9(05)V99	RIGHT	ZEROS	78	84	R

DEFINITION: The sum of all line item charges included within this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all LINE CHARGES fields (FA0-13.0) included for this claim.

FORM LOCATION: HCFA-1500 Block 28

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM TRAILER RECORD RECORD/FIELD: XA0-19.0
"RECORD SUMMARY"

DATA ELEMENT: Patient Amount Paid (PAT AMOUNT PAID)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
19.0	9(05)V99	RIGHT	ZEROS	127	133	R

DEFINITION: The amount the provider has received from the patient (or insured) toward payment of this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must not exceed TOTAL CLAIM CHARGES (XA0-12.0).

FORM LOCATION: HCFA-1500 Block 29

REMARKS: N/A

MEDICAID NOTES:

04/19/04 (1) MEDICARE CROSSOVERS:

Enter the amount collected from all insurance sources including the amount paid the Medicare Part C managed care plan (Medicare Advantage plan). Leave this item blank for Medicare Part A/B claims.

(2) NON-MEDICARE CLAIMS:

Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment.

05/01 (3) For (Federally Qualified Health Centers FQHCs) and Rural health Clinics (RHCs) only:

If billing for the Medicaid managed care supplemental payment, enter the sum of the dollar amount the provider was paid by the Medicaid managed care plan for services provided to a Medicaid managed care consumer and any amount the FQHC or RHC was paid from any other third party insurance.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

BATCH TRAILER RECORD

RECORD TYPE: YA0

NATIONAL VER. 001.03 - 07/01/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD TYPE: YA0

LEVEL: BATCH

PURPOSE: The last record of any batch submitted electronically, it contains information pertinent to the balancing of each batch (i.e. batch record count, batch charges) within a file.

REQUIREMENTS: A 'YA0' Record is a REQUIRED record since it is the BATCH TRAILER.

ORDER:	Preceding Record Type ----- XA0	Following Record Type ----- BA0, ZA0
--------	--	---

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type XA0 (CLAIM TRAILER RECORD).

There may be multiple batches per file.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD

RECORD TYPE: YA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "YA0"	3	X	1	3
	FILLER	18	X	4	21
04.0	BATCH NUMBER	4	N	22	25
	FILLER	21	X	26	46
08.0	BATCH SERVICE LINE COUNT	7	N	47	53
09.0	BATCH RECORD COUNT	7	N	54	60
10.0	BATCH CLAIM COUNT	7	N	61	67
11.0	BATCH TOTAL CHARGES	9	N	68	76
	FILLER	244	X	77	320

NOTE: Only positive numeric values are acceptable as input, values are not allowable.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD/FIELD: YA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "YA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "Provider Batch Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "YA0".

FORM LOCATION: N/A

REMARKS:

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD/FIELD: YA0-04.0

DATA ELEMENT: Batch Number (BATCH NO)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
04.0	9(04)	RIGHT	Zero	22	25	R

DEFINITION: A sequential number assigned by the submitter to each batch of claims.

CODE VALUES: Must be "0001" through "9999".

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be "0001".

Must be identical to the BATCH NUMBER entered in the corresponding Batch Header Record (BA0-04.0).

FORM LOCATION: N/A

REMARKS:

MEDICAID

NOTES:

For submission coming from providers and electronic intermediaries, the Medicaid payment system will accept up to 9,999 batches in a submission.

For submissions coming from Scanning and Data Entry, Medicaid payment system will accept up to 999 batches in a submission.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD/FIELD: YA0-08.0

DATA ELEMENT: Batch Service Line Count (BATCH SVC LINE COUNT)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
08.0	9(07)	RIGHT	ZEROS	47	53	R

DEFINITION: The number of line items included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Type
FA0's within this batch.

FORM LOCATION: N/A

REMARKS:

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD/FIELD: YA0-09.0

DATA ELEMENT: Batch Record Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
09.0	9(07)	RIGHT	ZEROS	54	60	R

DEFINITION: The number of records included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Types
BA0 through YA0.

FORM LOCATION: N/A

REMARKS:

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD

RECORD/FIELD: YA0-10.0

DATA ELEMENT: Batch Claim Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
10.0	9(07)	RIGHT	ZEROS	61	67	R

DEFINITION: The number of claims that are included within this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all the Record Type CA0's included between this Batch Trailer Record (YA0) and the preceding Batch Header Record (BA0).

FORM LOCATION: N/A

REMARKS:

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: BATCH TRAILER RECORD RECORD/FIELD: YA0-11.0

DATA ELEMENT: Batch Total Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
-----	-----	-----	-----	-----	-----	-----
11.0	9(07)V99	RIGHT	ZEROS	68	76	R

DEFINITION: The sum of all "Total Claim Charges" fields included within this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the TOTAL CLAIM CHARGES fields (XA0-12.0) included within this batch.

FORM LOCATION: N/A

REMARKS:

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

NATIONAL VER. 001.01 - 03/01/1992
LOCAL VER. 001.03 - 09/15/1993

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

FILE TRAILER RECORD

RECORD TYPE: ZA0

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD TYPE: ZA0

LEVEL: FILE

PURPOSE: The last record of any file submitted electronically, it contains information pertinent to the balancing of the file (i.e. file record counts, file charges).

REQUIREMENTS: A "ZA0" Record is a REQUIRED record since it is the FILE TRAILER RECORD. 0

ORDER:	Record Type	Record Type
	-----	-----
	YA0	NONE

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type YA0 (BATCH TRAILER RECORD).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD

RECORD TYPE: ZA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "ZA0"	3	X	1	3
02.0	SUBMITTER ID NUMBER	16	X	04	19
	FILLER	25	X	20	44
05.0	FILE SERVICE LINE COUNT	7	N	45	51
06.0	FILE RECORD COUNT	7	N	52	58
07.0	FILE CLAIM COUNT	7	N	59	65
08.0	BATCH COUNT	4	N	66	69
09.0	FILE TOTAL CHARGES	11	N	70	80
	FILLER	240	X	81	320

NOTE: positive numeric values are accepted as input, values are not allowable.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "ZA0")

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
01.0	X(03)	LEFT	SPACES	01	03	R

DEFINITION: Field used to identify the "File Trailer Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "ZA0".

FORM LOCATION: N/A

REMARKS: N/A

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-02.0

DATA ELEMENT: Submitter Identifier (SUB ID)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
02.0	X(16)	LEFT	SPACES	04	19	R

DEFINITION: Identifies the submitter as defined by receiver.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the SUBMITTER ID entered in the File Header Record (AA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: May be a Federally assigned Employer Identification Number (EIN). EIN is also referred to as Tax Identification Number (TIN) depending on the receiver's requirements.

MEDICAID

NOTES: This field is required.

Please refer to the Medicaid Notes on Record AA0, Field Number 2.0, Submitter Identifier.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-05.0

DATA ELEMENT: File Service Line Count (FILE SVC LINE COUNT)

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
05.0	9(07)	RIGHT	ZEROS	45	51	R

DEFINITION: The number of service lines included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH SERVICE LINE COUNT fields (YA0-08.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-06.0

DATA ELEMENT: File Record Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
06.0	9(07)	RIGHT	ZEROS	52	58	R

DEFINITION: The number of records included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH RECORD
COUNT fields (YA0-09.0) within this file.

FORM LOCATION: N/A

REMARKS: This field does not include any count of the AA0 or the ZA0 records.

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-07.0

DATA ELEMENT: File Claim Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
07.0	9(07)	RIGHT	ZEROS	59	65	R

DEFINITION: The number of claims included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH CLAIM COUNT fields (YA0-10.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-08.0

DATA ELEMENT: Batch Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
08.0	9(04)	RIGHT	ZEROS	66	69	R

DEFINITION: The number of batches included within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Type YA0's within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission.

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: FILE TRAILER RECORD RECORD/FIELD: ZA0-09.0

DATA ELEMENT: File Total Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
09.0	9(09)V99	RIGHT	ZEROS	70	80	R

DEFINITION: The sum of all total charges from each batch contained within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all BATCH TOTAL CHARGES fields (YA0-11.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This field is required for the Medicaid payment system.

For provider or intermediary submissions, incorrect totals in this field would not reject the entire submission. This amount must equal the total claim amount on the Letter of Certification/Batch Recap Form (ODJFS06312).

For scanner/data entry submissions, incorrect totals in this field would not reject the entire batch.