

Item No.	Narrative	ANSI 837 version 4010A1	Loop	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements
1	Provider Name, Address and Telephone number	NM103 N301, N302 N401, 02, 03 PER04, 06 N404	2010AA	NM103 N301, N401	2000AA	Billing Provider Organizational Name Billing Provider Address Billing Provider City, State, Zip Code	R R R	The Billing Provider Address must be a street address. Post Office Box of Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID-2010AB), if necessary
2	Pay To Name and Address (Required when different from locator 1)	NM103, 04, 05, 07 N301 N401, 02, 03	2010AB	NM103, 04, 05, 07 N301 N401 N402 N403	2010AB	Not Required for 5010 Pay-to Address Line Pay-to Address City Name Pay-to Address State Code Pay-to Address Postal Zone or Zip Code	R R S S	Required when the address is in the United States of America, including its territories, or Canada Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404
3a	Patient Control Number (unique claim number)	CLM01	2300	CLM01	2300	Patient Account Number	R	The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim. When Loop ID-2010AC is present, CLM01 represents the subrogated Medicaid agency's claim number (ICN/DCN) from their original 835 CLP07 – Payer Claim Control Number. See Section 1.4.1.4 of the front matter for a description of post payment recovery claims for subrogated Medicaid agencies. The maximum number of characters to be supported for this field is "20". Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.
3b	Medical/Health Record Number	REF02	2300	REF02	2300	Medical Record Number	R	
4	Type of Bill	CLM05 -1 CLM05 -3	2300	CLM05 - 1 CLM05 – 3	2300	Facility Type Code Claim Frequency Code	R R	

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5	Federal Tax ID Pay-to-provider is = to the Billing Provider	NM109 REF02	2010AA	NM109 REF02	2010AA	Billing Provider Identifier Billing Provider Additional Identifier	S R	If 2010AA.NM108 is present, 2010AA.NM109 must be present.
	Pay-to-provider is not = to the Billing Provider	NM109 REF02	2010AB	NM109 REF02	2010AB	Pay-to Provider Identifier « Not Required for 5010 »	R	Must not be present.
6	Statement Covers Period (MMDDYY)	DTP03	2300	DTP03	2300	Statement From or To Date	R	
7	Reserved							
8a	Patient Name	When Patient = Subscriber: NM103,04,05,07 When patient is not = Subscriber NM103,04,05,07	2010BA	NM103	2010BA	Subscriber Last Name	R	Required when NM102 = 1 (person) and the person has a first name. Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. Required when NM102 = 1 (person) and the name suffix of the person is needed to identify the individual.
				NM104		Subscriber First Name	S	
				NM105		Subscriber Middle Name	S	
			NM107	Subscriber Name Suffix	S			
2010CA	NM103	2010CA	Patient Last Name	R	Required when the person has a first name. Required when the middle name or initial of the person is needed to identify the individual. Required when the name suffix is needed to identify the individual.			
	NM104		Patient First Name	S				
	NM105		Patient Middle Name	S				
NM107	Patient Name Suffix	S						
8b	Patient Identifier	When patient = Subscriber 2010BA NM109 When Patient is not = Subscriber 2010CA NM109	2010BA	NM109	2010BA	Subscriber Primary Identifier	R	Must not be present.
			2010CA	NM109	2010CA	Patient Primary Identifier	R	
9a - e	Patient Address	When patient = Subscriber 2010BA N301: N401,02,03,04 When Patient is not = Subscriber 2010CA N301: N401,02,03,04	2010BA	N301	2010BA	Subscriber Address Line	R	If 2010BA.N404 is not present, 2010BA.N402 must be present. If 2010BA.N404 is not present, 2010BA.N403 must be present. 2010BA.N404 must be a valid 2 character Country Code. Must not be present. Must not be present. Must not be present. Must not be present. Must not be present.
				N401		Subscriber City Name	R	
2010CA	N402	2010CA	Subscriber State Code	R				
	N403		Subscriber Postal Zone or Zip Code	S				
N404	N404	N301	Subscriber Country Code	S				
	N301		Patient Address Line	R				
N401	N401	N401	Patient City Name	R				
	N402		Patient State Code	R				
N403	N403	N403	Patient Postal Zone or Zip Code	R				
	N404		Patient Country Code	R				

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10	Patient Birth Date	When patient = Subscriber DMG02	2010BA	DMG02	2010BA	Subscriber Birth Date	R	2010BA.DMG02 must be present.
		When Patient is not = Subscriber DMG02	2010CA	DMG02	2010CA	Patient Birth Date	R	Must not be present
11	Patient Sex	When patient = Subscriber DMG03	2010BA	DMG02	2010BA	Subscriber Gender Code	R	2010BA.DMG03 must be present.
		When Patient is not = Subscriber DMG03	2010CA	DMG02	2010CA	Patient Gender Code	R	Must not be present.
12	Admission/Start of care Date	2300 DTP03	2300	DTP03	2300	Admission Date and Hour	R	
13	Admission Hour	2300 DTP03	2300	DTP03	2300	Discharge Hour	R	
14	Priority (Type) of Visit	2300 CL101	2300	CL101	2300	Admission Type Code	S	2300.CL101 must be present when 2300.CLM05-1 is "11", "12", "18", "21", "22" or "41".
15	Source of Admission	2300 CL102	2300	CL102	2300	Admission Source Code	S	Required for all inpatient and outpatient services.
16	Discharge Hour	2300 DTP03	2300	DTP03	2300	Discharge Hour	R	
17	Institutional Claim Code	2300 CL103	2300	CL103	2300	Patient Status Code	R	

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Item No.	Narrative	ANSI 837 version 4010A1	Loop	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements
18-28	Condition Codes	2300 HI01-2 (HI01-1=BG), 2300HI02-2 (HI02-1=BG), 2300HI03-2 (HI03-1=BG), 2300HI04-2 (HI04-1=BG), 2300HI05-2 (HI05-1=BG), 2300HI06-2 (HI06-1=BG), 2300HI07-2 (HI07-1=BG)	2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2 HI06-2 HI07-2	2300	Condition Code Condition Code Condition Code Condition Code Condition Code Condition Code Condition Code	R R R R R R R	If 2300.HI01-1 is "BG" then 2300.HI01-2 must be a valid Condition code. If 2300.HI02-1 is "BG" then 2300.HI02-2 must be a valid Condition code If 2300.HI03-1 is "BG" then 2300.HI03-2 must be a valid Condition code If 2300.HI04-1 is "BG" then 2300.HI04-2 must be a valid Condition code. If 2300.HI05-1 is "BG" then 2300.HI05-2 must be a valid Condition code If 2300.HI06-1 is "BG" then 2300.HI06-2 must be a valid Condition code. If 2300.HI07-1 is "BG" then 2300.HI07-2 must be a valid Condition code.
29	Auto State	2300 CLM11-4	2300	CLM11-4	2300	Auto Accident State or Province Code	S	If 2300.CLM11-1 or 2300.CLM11-2 is "AA", then 2300.CLM11-4 must be present.
30	Reserved							

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Item No.	Narrative	ANSI 837 version 4010A1	Loop	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements
31-34	Occurrence Information	2300 HI01-2 (HI01-1 = BH) HI01-4, 2300HI02-2 (HI02-1 = BH) HI102-4, 2300 HI03-2 (HI03-1 = BH) HI03-4, 2300HI04-2 (HI04-1 = BH) HI04-4, 2300HI05-2 (HI05-1 = BH) HI05-4, 2300HI06-2 (HI06-2 = BH) HI06-4, 2300HI07-2 (HI07-1 = BH) HI07-4, 2300HI08-2 (HI08-1 = BH) HI08-4.	2300	HI01-2 HI01-4 HI02-2 HI02-4 HI03-2 HI03-4 HI04-2 HI04-4 HI05-2 HI05-4 HI06-2 HI06-4 HI07-2 HI07-4 HI08-2 HI08-4	2300	Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date Occurrence Code Occurrence Code Date	S S S S S S S S S	Required when there is an Occurrence Code that applies to this claim. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes.
	R Required.	Any data element that is needed in order to process a claim (e.g., date of service)						
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35-36	Occurrence Span Information	2300 HI01-2 (HI01-1 =BI) HI01-4, 2300HI02-2 (HI02-1 = BI) HI02-4, 2300HI03-2 (HI03-1 = BI) HI03-4, 2300HI04-2 (HI04-1 = BI) HI04-2	2300	HI01-2 HI01-4 HI02-2 HI02-4 HI03-2 HI03-4 HI04-2 HI04-4	2300	Occurrence Span Code Occurrence Span Code Date Occurrence Span Code Occurrence Span Code Date Occurrence Span Code Occurrence Span Code Date Occurrence Span Code Occurrence Span Code Date	S S S S	Required when there is an Occurrence Span Code that applies to this claim. Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes
37	Reserved							
38	Not Required for 5010 Not Required for 5010 Not Required for 5010 Payer Name	2010BD NM103, 04, 05, 07 2010BD N301 2010BD N302 2010BB N401, N402, N403	2010BD 2010BD 2010BD 2010BB	Not Required for 5010 Not Required for 5010 Not Required for 5010 N401 N402 N403	2010BB	Payer City Name Payer State Code Payer Postal Zone or Zip Code	R R R	

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42	Institutional Service Line	2400 SV201	2400	SV201	2400	Service Line Revenue Code	R	
43	Drug Identification	2410 LIN03 2410 REF02 2410 CTP05-1 2410 CTP04 2410 CTP03	2410	2410 LIN03 2410 REF02 2410 CTP05-1 2410 CTP04 2410 CTP03	2410	National Drug Code Prescription Number Code Qualifier Unit of Basis of Measurement Code Multiplier	S S R R R	Required when government regulation mandates that prescribed drugs and biologics are reported with NDC numbers. OR Required when the provider or submitter chooses to report NDC numbers to enhance the claim reporting or adjudication process. Required when dispensing of the drug has been done with an assigned prescription number. OR Required when the provided medication involves the compounding of two or more drugs being reported and there is no prescription number.
44	Institutional Service Line	2400 SV202-2 2400 SV206	2400	SV202-2 SV206	2400	Procedure Code Unit Rate	R R	
45	Service Date	2400 DTP03	2400	DTP03	2400	Service Date	S	Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day. OR Required on service lines where a drug is being billed and the payer's adjudication is known to be impacted by the drug duration or the date the prescription was written.
46	Quantity	2400 SV205	2400	SV205	2400	Service Unit Count	R	
47	Monetary Amount	2400 SV203	2400	SV203	2400	Line Item Charge Amount	R	
48	Monetary Amount	2400 SV207	2400	SV207	2400	Line Item Denied Charge or Non-Covered Charge Amount	S	Required if needed to report line specific non-covered charge amount.
49	Reserved							
50a-c	Name Last or Organization Name	2010BC NM103 2330B NM103	2010BC 2330B	Not Required for 5010 NM103	 2330B	 Other Payer Last or Organization Name	 R	 .

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51	Identification Code	2010BC NM109 2330B NM109	2010BC 2330B	Not Required for 5010 NM109	2330B	Other Payer Primary Identifier	R	When sending Line Adjudication information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID 2430 (Line Adjudication Information) must match this value.
52	Provider Accept Assignment Code	2300 CLM07	2300	CLM07	2300	Assignment of Plan Participation Code	R	Within this element the context of the word assignment is related to the relationship between the provider and payer. This is NOT the field for reporting whether the patient has or has not assigned benefits to the provider. The benefit assignment indicator is in CLM08.
53	Yes/No Condition or Response Code	2300 CLM08 2320 OI03	2300 2320	CLM08 OI03	2300 OI03	Benefits Assignment Certification Indicator Benefits Assignment Certification Indicator	R R	This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider. This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.
54	Coordination Of Benefits (COB) Payer Paid Amount	2320 AMT02	2320	AMT02	2320	Payer Paid Amount	S	Required when the claim has been adjudicated by the payer identified in Loop ID-2330B of this loop. OR Required when Loop ID-2010AC is present. In this case, the claim is a post payment recovery claim submitted by a subrogated Medicaid agency.
55a-c	Patient Estimated Amount Due Remaining Patient Liability	2300 AMT02 2320 AMT02	2300 2320	AMT02 AMT02	2300 2320	Patient Responsibility Amount Remaining Patient Liability	S S	Required when the Patient Responsibility Amount is applicable to this claim. Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim and provided claim level information only. OR Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim and the provider received a paper remittance advice and the provider does not have the ability to report line item information.
56	Identification Code	2010AA NM109	2010AA	NM109	2010AA	Billing Provider Identifier	S	Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. OR Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI. OR Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.

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57a-c	Reference Identification	2010AA REF02	2010AA	REF02	2010AA	Billing Provider Tax Identification Number	R	
58a-c	Subscriber Name	2010BA NM103, 04, 05	2010BA	NM103 NM104 NM105	2010BA	Subscriber Last Name Subscriber First Name Subscriber Middle Name or Initial	R S S	Required when NM102 = (person) and the person has a first name. Required when NM102 = (person) and the middle name or initial of the person is needed to identify the individual.
	Other Subscriber Name	2330A NM103, 04, 05	2330A	NM103 NM104 NM105	2330A	Other Insured Last Name Other Insured First Name Other Insured Middle Name	R S S	Required when NM102 = (person) and the person has a first name. Required when NM102 = (person) and the middle name or initial of the person is needed to identify the individual.
59a-c	Individual Relationship Code	2000B SBR02	2000B	SBR02	2000B	Individual Relationship Code	S	Required when the patient is the subscriber or is considered to be the subscriber.
		2000C PAT01	2000C	PAT01	2000C	Individual Relationship Code	R	
		2320 SBR02	2320	SBR02	2320	Individual Relationship Code	S	Required when other payers are known to potentially be involved in paying on this claim.
60a-c	Subscriber Identification Code	2010BA NM109	2010BA	NM109	2010BA	Subscriber Primary Identifier	R	Required when an additional identification number to that provided in NM109 of this loop is necessary for claim processor to identify the entity. Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity.
	Subscriber Secondary Identification	2010BA REF02		REF02		Subscriber Supplemental Identifier	S	
	Other Subscriber Identification Code	2330A NM109	2330A	NM109	2330A	Other Insured Identifier	R	
	Other Subscriber Secondary Identification	2330A REF02		REF02		Other Insured Additional Identifier	S	
61a-c	Subscriber Information	2000B SBR04	2000B	SBR04	2000B	Subscriber Group Name	S	Required when SBR03 is not used and the group name is available.
	Other Subscriber Information	2320 SBR04	2320	SBR04	2320	Other Insured Group Name	S	Required when SBR03 is not used and the group name is available.
62a-c	Subscriber Information	2000B SBR03	2000B	SBR03	2000B	Subscriber Group or Policy Number	S	Required when the subscriber's identification card for the destination payer (Loop ID-2010BB) shows a group number. Required when the subscriber's identification card for the non-destination payer identified in Loop ID-2330B of this iteration of Loop ID-2320 shows a group number.
	Other Subscriber Information	2320 SBR03	2320	SBR03	2320	Insured Group or Policy Number	S	

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63a-c	Service Authorization Exception Code	2300 REF02	2300	REF02	2300	Service Authorization Exception Code	S	Required when mandated by government law or regulation to obtain authorization for specific service(s) but, for the reasons listed in REF02, the service was performed without obtaining the authorization. Required when the payer identified in this loop has assigned a prior authorization number to this claim.
	Other Payer Prior Authorization Number	2330B REF02	2330B	REF02	2330B	Other Payer Prior Authorization Number	S	
64a-c	Payer Claim Control Number	2300 REF02	2300	REF02	2300	Payer Claim Control Number	S	Required when the CLM05-3 (Claim Frequency Code) indicates this is a replacement or void to a previously adjudicated claim. Required when it is necessary to identify the Other Payer's Claim Control Number in a payer-to-payer COB situation.
	Other Payer Claim Control Number	2330B REF02	2330B	REF02	2330B	Other Payer's Claim Control Number	S	
65a-c	Employer Name	Not Cross Walked						.
66	Diagnosis and Procedure Code Qualifier	Not Cross Walked						
67	Principal Diagnosis	2300 HI01-2	2300	HI01-2 (HI01-1=BK)	2300	Principal Diagnosis Code	R	Required when ALL of the following conditions are met: <ul style="list-style-type: none"> A regulatory agency concludes it must use the K3 to meet an emergency legislative requirement; The Administering regulatory agency or other state organization has completed each one of the following steps: <ul style="list-style-type: none"> contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement X12N determines that there is no method to meet the requirement.
	File Information	2300 K3	2300	K3	2300	State Data Requirement	S	

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70a-c	Patient's Reason For Visit	2300 HI02-2 (HI02-1 = ZZ)	2300	HI02-2	2300	Patient Reason For Visit	S	Required when claim involves outpatient visits.
71	Diagnosis Related Group (DRG) Information	2300 HI01-2 (HI01-1 = DR)	2300	HI01-2 (HI01-1 = DR)	2300	Diagnosis Related Group (DRG) Code	S	Required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
72a-c	External Cause Of Injury	2300 HI03-2 (HI03-1 = BN)	2300	HI03-2 (HI03-1= BN)	2300	External Cause Of Injury Code	S	Required when the external Cause of Injury is needed to describe an injury, poisoning, or adverse effect.
73	Reserved							
74	Principal Procedure Information	2300 HI01-2 (HI01-1 = BP) 2300 HI04-4	2300 2300	HI01-2 (HI01-1 = BP) HI01-4	2300 2300	Principal Procedure Code Principal Procedure Date	S S	Required on inpatient claims when a procedure was performed. Required on inpatient claims when a procedure was performed.

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74a-c	Other Procedure Information	2300 HI01-2 (HI01-1 = BO) HI01-4 (HI01-1 = BO) HI02-2 (HI02-1 = BO) HI02-4 (HI02-1 = BO) HI03-2 (HI03-1 = BO) HI03-4 (HI03-1 = BO) HI04-2 (HI04-1 = BO) HI04-4 (HI04-1 = BO) HI05-2 (HI05-1 = BO) HI05-4 (HI05-1 = BO)	2300	HI01-2 HI01-4 HI02-2 HI02-4 HI03-2 HI03-4 HI04-2 HI04-4 HI05-2 HI05-4	2300	Procedure Code Procedure Date Procedure Code Procedure Date Procedure Code Procedure Date Procedure Code Procedure Date Procedure Code Procedure Date	S S S S S S S S S S	<i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i> <i>Required on inpatient claims when additional procedures must be reported.</i>
75	Reserved							.

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76	Attending Provider Name	2310A NM109	2310A	NM109	2310A	Attending Provider Primary Identifier	S	Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. OR Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI. OR Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it. Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when the identification number other than the NPI is necessary for the receiver to identify the provider. OR Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. Required when the claim contains any services other than non-scheduled transportation claims. Required when the person has a first name.
	Attending Provider Secondary Identification	2310A REF01, 02	2310A	REF01 REF02	2310A	Reference Identification Qualifier Reference Identification	S S	
	Attending Provider Name	2310A NM103, 04	2310A	NM103 NM104	2310A	Attending Provider Last Name Attending Provider First Name	S S	
77	Operating Physician Name	2310B NM109	2310B	NM109	2310B	Operating Physician Primary Identifier	S	Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. OR Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI. OR Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it. Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider. OR Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and the identification number other than the NPI is necessary for the receiver to identify the provider. Required when the person has a first name.
	Operating Physician Secondary Identification	2310B REF01, 02	2310B	REF01 REF02	2310B	Reference Identification Qualifier Operating Physician Secondary Identifier	S S	
	Operating Physician Name	2310B NM103,04	2310B	NM103 NM104	2310B	Operating Physician Last Name Operating Physician First Name	R S	

R Required. Any data element that is needed in order to process a claim (e.g., date of service)

S Situational. Any data element that must be completed if other conditions exist (e.g., if the insured differs from the patient, the insured's name must be entered on the claim)

Item No.	Narrative	ANSI 837 version 4010A1	Loop	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements
78	Other Operating Physician Name	2310C NM109	2310C	NM109	2310C	Other Operating Physician Identifier	S	Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. OR Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI. OR Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it. Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider. OR Required on or after the mandated NPI implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. Required when another Operating Physician is the individual performing a secondary surgical procedure or assisting the Operating Physician. Required when the person has a first name.
	Other Operating Physician Secondary Identification	2310C REF01, 02	2310C	REF01 REF02	2310C	Other Provider Reference Identification Qualifier Other Provider Secondary Identifier	S S	
	Other Operating Physician Name	2310C NM103, 04	2310C	NM103	2310C	Other Operating Physician Last Name	S	
				NM104		Other Operating Physician First Name	S	
79	Not Crosswalked							
80	Claim Note	2300 NTE01, NTE02	2300	NTE01 NTE02	2300	Note Reference Code Claim Note Text	S S	Required when in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set. OR Required when in the judgment of the provider, narrative information from the forms "Home Health Certification and Plan of Treatment" or "Medical Update and Patient Information" is needed to substantiate home health services.
81a-d	Code-Code	Paper Only					S	This is where you can put additional codes required if not enough space in the designated form locator id condition codes, occurrence codes, value code span.

R Required. Any data element that is needed in order to process a claim (e.g., date of service)

S Situational. Any data element that must be completed if other conditions exist (e.g., if the insured differs from the patient, the insured's name must be entered on the claim)