ForwardHealth
Wisconsin serving you

Instructions Related to 837 Health Care Claim/Encounter: Institutional (837I) Transactions Based on ASC X12 Implementation Guide

Companion Guide Version Number: 2.0 April 28, 2025

Preface

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 Implementation Guide (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every companion guide. The components may be published as separate guides or as a single guide.

The Communications/Connectivity component is included in the companion guides when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the companion guides when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

Table of Contents

837 Health Care Claim/Encounter: Institutional Transaction Instructions

1 Transaction Instructions Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions for administrative simplification. This requires the Secretary of the federal Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

1.1.2 Compliance According to HIPAA

The HIPAA regulations at 45 C.F.R. § 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance According to ASC X12

The ASC X12 requirements include specific restrictions that prohibit trading partners from modifying any:

- Defining, explanatory, or clarifying content contained in the implementation guide.
- Requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements guides. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with the ASC X12 Implementation Guide's Fair Use and Copyright statements.

1.3 Companion Guide Audience

This companion guide applies to all 837I claims and encounters submitted to ForwardHealth for processing and thus applies to the following types of 837I submitters:

- Providers submitting claims for BadgerCare Plus and Wisconsin Medicaid, including related limited-benefit programs
- Providers submitting claims for the Wisconsin Well Woman Program (WWWP)
- Providers submitting claims for the Wisconsin Chronic Disease Program (WCDP)
- HMOs submitting encounters for the BadgerCare Plus and SSI Medicaid Managed Care programs

The guidance in Section 3, Instruction Tables, applies to all submitters unless otherwise indicated in the following table.

If the guidance in the Notes/ Comments column is preceded by:	Then that guidance only applies to:
For Claims,	• Providers
For Encounters,	• BadgerCare Plus/SSI HMOs • Long-term care (LTC) managed care organizations (MCOs) • IRIS (Include, Respect, I Self-Direct) fiscal employer agents (FEAs)
For HMO Encounters,	• BadgerCare Plus/SSI HMOs
For LTC Encounters,	• LTC MCOs • IRIS FEAs
For MCO Encounters,	• LTC MCOs
For IRIS Encounters,	• IRIS FEAs

Companion guides are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal HIPAA regulations.

1.4 Purpose of Companion Guides

The purpose of the companion guides is to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The companion guides provide trading partners with a guide to communicate ForwardHealth-specific information required to successfully exchange transactions electronically with ForwardHealth.

ForwardHealth will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain ForwardHealth-specific information, though processed, may be denied for payment. For example, a compliant 837 Health Care Claim/Encounter (837) created without a ForwardHealth member ID number will be processed by ForwardHealth but will be denied payment. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the ForwardHealth Online Handbook.

Companion guides highlight the data elements significant for ForwardHealth. For transactions created by ForwardHealth, companion guides explain how certain data

elements are processed. Refer to the companion guide first if there is a question about how ForwardHealth processes a HIPAA transaction. For further information, contact the ForwardHealth Electronic Data Interchange (EDI) Department at 866-416-4979.

1.5 Acceptable Characters

All alpha characters used in 837 transactions must be in an uppercase format. The 837 transaction must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream.

1.6 Acknowledgements

An accepted 999 Implementation Acknowledgement rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the web to determine the status of their files.

1.7 Examples

Refer to Section 4.1 of this guide for examples.

2 Referenced ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and are included in Section 3 of this guide.

Unique ID	Name
005010X223A2	837 Health Care Claim: Institutional (837I)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “loops” and “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

3.1 05010X223A2—837 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA03	Interchange Control Security Information Qualifier	**00** (No Security Information Present)	Enter “00”.
	ISA05	Interchange ID (Sender) Qualifier	**ZZ** (Mutually Defined)	Enter “ZZ”.
	ISA06	Interchange Sender ID		Enter the nine-digit numeric Trading Partner ID assigned by ForwardHealth.
	ISA07	Interchange ID (Receiver) Qualifier	**ZZ** (Mutually Defined)	Enter “ZZ”.
	ISA08	Interchange Receiver ID	WISC_DHFS	Enter “WISC_DHFS”.

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Enter the same value as ISA06, the nine-digit Trading Partner ID assigned by ForwardHealth.
	GS03	Application Receiver's Code	WISC_TXIX WISC_WWWP WISC_WCDP	For Claims, enter: • "WISC_TXIX" for Wisconsin Medicaid and BadgerCare Plus. • "WISC_WWWP" for WWWP. • "WISC_WCDP" for WCDP. For Encounters, enter "WISC_TXIX".
	BHT	Beginning of Hierarchical Transaction		
	BHT06	Claim Identifier	**CH** (Chargeable) **RP** (Reporting)	For Claims, enter "CH". For Encounters, enter "RP".
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		Enter the same value as ISA06, the nine-digit Trading Partner ID assigned by ForwardHealth
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name	FORWARDHEALTH	Enter "FORWARDHEALTH".
1000B	NM109	Receiver Primary Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	For Claims, enter: • "WISC_TXIX" for Wisconsin Medicaid and BadgerCare Plus. • "WISC_WWWP" for WWWP. • "WISC_WCDP" for WCDP. For Encounters, enter "WISC_TXIX".
2000A	PRV	Billing Provider		If the billing provider's National Provider Identifier (NPI) is associated

Loop ID	Reference	Name	Codes	Notes/Comments
		Specialty Information		with multiple ForwardHealth enrollment files, use this segment to provide the taxonomy code associated with the enrollment file under which the claims/encounters should process. If the billing provider's NPI is associated with only one ForwardHealth enrollment file or if the billing provider does not have an NPI, do not use this segment.
2010AA	NM1	Billing Provider Name		Submit the Billing Provider's name and, when applicable, the provider's NPI.
2010AA	N3	Billing Provider Address		Enter the billing provider's physical address as reported on the billing provider's ForwardHealth enrollment file. Do not submit a P.O. Box in this segment.
2010AA	N4	Billing Provider City, State, ZIP Code (Geographic Location)		Enter the city, state, and zip+4 code of the billing provider's physical address as indicated on the provider's ForwardHealth enrollment file.
2010AB		Pay-to Address Name		Note for Claims: ForwardHealth does not use this loop to determine where to send the provider Remittance Advice (RA) and/or 835 Health Care Claim Payment/Advice (835). ForwardHealth sends the RA and/or the 835 to the location identified during provider enrollment.
2010BA		Subscriber Name		Enter information about the member in this loop. Note: For claims/encounters submitted to ForwardHealth, the member is always treated as the subscriber.
2010BA	NM102	Entity Type Qualifier	1 (Person)	Enter "1" to indicate the member is a person.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM103	Subscriber Last Name		Enter the member's last name. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the member's ID card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber First Name		Enter the member's first name. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the member's identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM108	Identification Code Qualifier	**MI** (Member Identification Number)	Enter "MI".
2010BA	NM109	Subscriber Primary Identifier		Enter the member's 10-digit ForwardHealth ID number. Do not use any other numbers or letters. Use the ForwardHealth ID card or the EVS to obtain the correct identification number.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name	FORWARDHEALTH	Enter "FORWARDHEALTH".
2010BB	NM109	Payer Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	For Claims, enter: • "WISC_TXIX" for Wisconsin Medicaid and BadgerCare Plus. • "WISC_WWWP" for WWWP. • "WISC_WCDP" for WCDP. For Encounters, enter "WISC_TXIX".
2010BB	REF	Billing Provider Secondary Identification		Include this segment when the billing provider in Loop 2010AA is enrolled in ForwardHealth but is a non-healthcare (atypical) provider without an NPI, and thus an NPI was not submitted in Loop 2010AA, element NM109.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	REF01	Reference Identification Qualifier	**G2** (Provider Commercial Number)	Enter “G2”.
2010BB	REF02	Billing Provider Secondary Identifier		Enter the billing provider’s eight- or nine-digit ForwardHealth provider number.
2010CA	REF	Property and Casualty Claim Number		Note: ForwardHealth does not use this segment.
2300	CLM	Claim Information		
2300	CLM01	Patient Control Number		For Claims, enter the claim identifier assigned by the provider. For Encounters, enter the claim identifier assigned by the HMO, MCO, or FEA. Note: ForwardHealth processes identifiers up to 20 characters in length.
2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter. Note*:* ForwardHealth process claims/ encounters submitted with a negative total billed amount as if a zero total billed amount was submitted.
2300	CLM05-3	Claim Frequency Code	1 2 3 4 7 8	Enter the claim frequency code as the third digit of the type of bill. Enter: • “1” to indicate that a complete claim/encounter is being submitted. • “7” to indicate that the claim/encounter is replacing a previously submitted and adjudicated claim/encounter. ForwardHealth will void the previously submitted

Loop ID	Reference	Name	Codes	Notes/Comments
				claim/encounter and completely replace it with this corrected claim/encounter. • "8" to indicate that ForwardHealth should void and recoup a previously submitted claim/encounter in its entirety. If submitting a claim/encounter with type of bill 11X, 15X, 16X, 17X, or 18X, enter one of the above values or one of the following values as appropriate: • "2" to indicate that this is the first claim/encounter in an interim billing situation. ForwardHealth will process the claim/encounter as if a "1" was submitted. • "3" to indicate that this is a continuing claim/encounter of an interim billing situation. ForwardHealth will process the claim/encounter as if a "7" was submitted. Refer to the notes above for the usage of "7". • "4" to indicate that this is the last claim/encounter in an interim billing situation. ForwardHealth will process the claim/encounter as if a "7" was submitted. Refer to the notes above for the usage of "7". If submitting a value of "3", "4", "7", or "8", include ForwardHealth's internal control number (ICN) from the previously submitted claim/encounter in the Payer Claim Control Number segment in Loop 2300. Otherwise, ForwardHealth will process the claim/encounter as if a "1" was submitted in this element. Note for Claims: Electronic claim adjustments are subject to the same requirements as paper claim adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of

Loop ID	Reference	Name	Codes	Notes/Comments
				the original claim payment is needed. Providers should submit claim reconsideration requests on paper with supporting documentation.
2300	DTP	Date-Repricer Received Date		For IRIS Encounters, enter the IRIS Funding file date.
2300	DTP01	Date/Time Qualifier	**050** (Received)	For IRIS Encounters, enter 050 (Received).
2300	DTP02	Date Time Format Qualifier	**D8** (Date Expressed)	For IRIS Encounters, enter D8 (Date Expressed) in Format CCYYMMDD.
2300	DTP03	Date Time Period		For IRIS Encounters, enter the expression of a date.
2300	PWK	Claim Supplemental Information		For Claims, include this segment to indicate supplemental information has been submitted for the claim. For Encounters, include this segment if the encounter represents a chart review.
2300	PWK01	Report Type Code		For Claims, enter the appropriate value from the implementation guide. For Encounters, enter “09” (Progress Report).
2300	PWK02	Attachment Transmission Code	**BM** (By Mail) **AA** (Available on Request at Provider Site)	For Claims, enter “BM”. For Encounters, enter “AA”.
2300	CN1	Contract Information		For Claims, do not include this segment. For Encounters, include this segment to report a “shadow price” when the service is provided by a sub-capitated provider.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CN101	Contract Type Code	05 (Capitated)	For Encounters, enter “05”.
2300	CN102	Contract Amount		For Encounters, enter the "shadow price".
2300	REF	Prior Authorization	G1 (CLTS only)	Note for Claims: ForwardHealth does not require prior authorization (PA) numbers to be submitted on the 837 transaction, except for the Children’s Long-Term Support (CLTS) Program. For LTC Encounters, submit the Service Authorization number associated with the service.
2300	REF	Payer Claim Control Number		Include this segment when the claim/ encounter represents a request to adjust or void a previously paid claim/ encounter (as indicated by a value of “3”, “4”, “7”, or “8” in CLM05-3).
2300	REF02	Payer Claim Control Number		Enter the most recent ForwardHealth ICN of the claim/encounter that this claim/encounter is adjusting or voiding.
2300	REF	Auto Accident State		ForwardHealth does not use this segment.
2300	REF	Referral Number		Include this segment when a referral is involved. This segment may be used to provide additional information when it comes to indicating another provider (such as a federally qualified health center [FQHC]) referred the member to the billing provider.
2300	REF01	Referral Number Qualifier	9F	Enter "9F" to submit a referral number.
2300	REF02	Referral Number		Enter the referral number. This element may be used to provide additional information when it comes to indicating another provider (such as an FQHC) referred the member to the billing provider.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CRC	EPSDT Referral		ForwardHealth does not use this segment.
2300	HI	Principal Diagnosis		Enter the principal diagnosis in this segment.
2300	HI01-9	Present on Admission Indicator	**N** (No) **U** (Unknown) **W** (Not Applicable) **Y** (Yes)	Enter the Present on Admission (POA) indicator as applicable. Note: Exempt providers are not required to submit a POA indicator.
2300	HI	Other Diagnosis Information		Note: ForwardHealth uses up to 24 diagnosis codes from this segment plus the principal diagnosis to process a claim/encounter.
2300	HI	Occurrence Span Information		Enter occurrence span information in this segment. To document a hospital leave of absence on an LTC claim/encounter, enter “75” as the occurrence span code with the associated dates of absence. At the service-line level, enter the corresponding revenue code “0185”.
2300	HI	Value Information		Enter value code information in this segment. For all institutional claim and encounter types, use this segment to indicate covered and noncovered days. For newborn institutional claims/encounters use this segment to indicate covered and noncovered days (Value Code = “54”).

Loop ID	Reference	Name	Codes	Notes/Comments
2310A	NM1	Attending Provider Name		Note: The attending provider is the individual who has overall responsibility for the member's medical care and treatment reported on the claim/encounter. This can be an individual or organizational entity. Note: For personal care providers, this segment should indicate the attending personal care provider, not the attending physician. If the attending personal care provider does not have an NPI or ForwardHealth provider number, then the billing organization information should be used.
2310A	PRV	Attending Provider Specialty Information		If the attending provider's NPI is associated with multiple ForwardHealth enrollment files, use this segment to provide the taxonomy code associated with the correct enrollment file. If the billing provider's NPI is associated with only one ForwardHealth enrollment file or if the attending provider does not have an NPI, do not use this segment.
2310A	REF	Attending Provider Secondary Identification		Include this segment only when the attending provider is enrolled with ForwardHealth but is a non-healthcare (atypical) provider without an NPI, and thus an NPI was not submitted in the NM1 segment of this loop.
2310A	REF01	Reference Identification Qualifier	**G2** (Provider Commercial Number)	Enter "G2".
2310A	REF02	Attending or Provider Secondary Identifier		Enter the attending provider's eight- or nine-digit ForwardHealth provider number.
2310D		Rendering Provider Name		Include this loop only when billing for a professional service on an outpatient claim/encounter.

Loop ID	Reference	Name	Codes	Notes/Comments
2310D	REF	Rendering Provider Secondary Identification		Include this segment only when the rendering provider is enrolled with ForwardHealth but is a non-healthcare (atypical) provider without an NPI, and thus an NPI was not submitted in the NM1 segment of this loop.
2310D	REF01	Reference Identification Qualifier	**G2** (Provider Commercial Number)	Enter “G2”.
2310D	REF02	Rendering Provider Secondary Identifier		Enter the rendering provider’s eight- or nine-digit ForwardHealth provider number.
2320		Other Subscriber Information		For Claims, include this loop to identify other payers that are potentially involved in paying on this claim/ encounter. Note: For more information on other insurance indicators and Medicare status disclaimer codes, refer to Section 4.1 of this guide. For Encounters, use one iteration of this loop and required subloops to report information about how the submitter (HMO, MCO, or FEA) adjudicated the encounter. If there were other primary payers involved (such as Medicare), use one iteration of this loop and required subloops per payer to communicate the other primary payer’s adjudication information.
2320	SBR	Other Subscriber Information		
2320	SBR09	Claim Filing Indicator Code	**HM** (Health Maintenance Organization) **ZZ** (Mutually Defined)	For HMO Encounters, when using this loop to report submitter adjudication information, enter “HM” to indicate the submitter is an HMO.

Loop ID	Reference	Name	Codes	Notes/Comments
				For LTC Encounters, when using this loop to report submitter adjudication information, enter ‘’ZZ” to indicate the submitter is an LTC MCO or FEA.
2320	CAS	Claim Level Adjustments		Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 transaction, copy the CAS segment from the 835 to this CAS segment. For Encounters, when using this loop to report submitter adjudication information, use one or more iterations of this segment to explain any differences between the provider’s claim-level billed amount and the submitter’s claim-level paid amount using Claim Adjustment Reason Codes.
2320	AMT	COB Payer Paid Amount		Use this segment for the amount paid on the claim by the payer within Loop 2320.
2320	AMT	Remaining Patient Liability		Use this segment to indicate the remaining member liability amount. For Encounters, do not include this segment when using Loop 2320 to report submitter adjudication information.
2320	AMT	COB Total Non-Covered Amount		Include this segment when the member has other insurance or Medicare, but the charges are known to be noncovered. In this case, enter the total billed amount and no other AMT segments for the other payer. Note*:* When reporting for commercial insurance, this will generate an OI Indicator of “OI-Y”. When reporting for Medicare, this will generate a Medicare Disclaimer of “8”.

Loop ID	Reference	Name	Codes	Notes/Comments
				For Encounters, do not include this segment when using Loop 2320 to report submitter adjudication information.
2320	MIA	Inpatient Adjudication Information		Include this segment when it is returned in the 835 transaction from a previous payer or if this iteration of 2320 is being used to indicate that an inpatient hospital or nursing home claim was not submitted to another payer based on the notes in the SBR segment of Loop 2320 of this guide.
2320	MOA	Outpatient Adjudication Information		Include this segment when it is returned in the 835 transaction from a previous payer or if this iteration of 2320 is being used to indicate an outpatient claim was not submitted to another payer based on the notes in the SBR segment of Loop 2320 of this guide.
2330B	NM1	Other Payer Name		
2330B	NM109	Other Payer Primary Identifier		Enter the other payer's identifier. Note: ForwardHealth will use this number in combination with Loop 2430 to calculate other insurance and Medicare payments. For Encounters, when using this loop to report submitter adjudication information, enter the submitter's ForwardHealth-assigned Payee Provider ID (for HMOs and MCOs) or ForwardHealth-assigned Waiver ID (for FEAs).
2330B	DTP	Claim Check or Remittance Date		For Encounters, when using this loop to report submitter adjudication information, use this segment to report the date the submitter paid the encounter.

Loop ID	Reference	Name	Codes	Notes/Comments
2330B	REF	Other Payer Prior Authorization Number		ForwardHealth does not use this segment.
2330B	REF	Other Payer Claim Control Number		ForwardHealth does not use this segment.
2300C		Other Payer Attending Provider		ForwardHealth does not use this loop.
2300D		Other Payer Operating Physician		ForwardHealth does not use this loop.
2330E		Other Payer Other Operating Physician		ForwardHealth does not use this loop.
2330G		Other Payer Rendering Provider		ForwardHealth does not use this loop.
2330H		Other Payer Referring Provider		ForwardHealth does not use this loop.
2330I		Other Payer Billing Provider		ForwardHealth does not use this loop.
2400	SV2	Institutional Service Line		
2400	SV201	Service Line Revenue Code		Enter the revenue code specific to the service information being reported. To document a hospital leave of absence on an LTC claim/encounter, enter revenue code “0185” to correspond to the occurrence span dates and occurrence span code of “75” reported in the claim/encounter header.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	SV203	Line Item Charge Amount		Note: ForwardHealth processes claims/encounters submitted with a negative service line billed amount as if a zero service line billed amount was submitted.
2400	DTP	Date-Service Date		
2400	DTP02	Date Time Period Format Qualifier	**D8** (Date Expressed in Format CCYYMMDD) **RD8** (Range of Dates Expressed in Format CCYYMMDD–CCYYMMDD)	Note: When “RD8” is used on outpatient claims/encounters, ForwardHealth assumes the exact same service, including the number of units, was performed on each day within the range.
2400	DTP03	Service Date		Note: ForwardHealth requires service line dates on all outpatient claims/ encounters and claims/encounters with prescription drugs billed.
2400	NTE	Third Party Organization Notes		For LTC Encounters, use this segment to provide the Support Indicator.
2400	NTE02	Description		For IRIS Encounters, submit a value of either “S” to indicate the service was self-directed or “E” to indicate the service was electronic visit verification (EVV) exempt. For MCO Encounters, submit a value of either “C” to indicate the service was MCO directed or “S” to indicate the service was self-directed.
2410		Drug Identification		Include this loop when submitting a drug-related Healthcare Common Procedure Coding System procedure code.
2410	LIN	Drug Identification		

Loop ID	Reference	Name	Codes	Notes/Comments
2410	LIN03	National Drug Code		Enter the National Drug Code in this field when applicable.
2410	CTP	Drug Quantity		
2410	CTP04	National Drug Unit Count		Enter the numeric quantity in this field.
2410	CTP05-1	Code Qualifier	**F2** (International Unit) **GR** (Gram) **ME** (Milligram) **ML** (Milliliter) **UN** (Unit)	Enter the unit of measurement that corresponds to the value entered in the CTP04 field.
2410	REF	Prescription or Compound Drug Association Number		Enter prescription or link sequence number in this segment.
2410	REF01	Reference Identification Qualifier	**XZ** (Pharmacy Prescription Number) **VY** (Link Sequence Number)	Enter “XZ” to indicate the pharmacy prescription number or “VY” to indicate a link sequence number.
2420B		Other Operating Physician		ForwardHealth does not use this loop.
2420C		Rendering Provider Name		Include this loop when billing professional services on an outpatient claim/encounter and the service level rendering provider is different than the claim/encounter level rendering provider.
2420C	REF	Rendering Provider Secondary Identification		Include this segment only when the rendering provider is enrolled with ForwardHealth but is a non-healthcare (atypical) provider without an NPI, and thus an NPI was not submitted in the NM1 segment of this loop.

Loop ID	Reference	Name	Codes	Notes/Comments
2420C	REF01	Reference Identification Qualifier	**G2** (Provider Commercial Number)	Enter “G2”.
2420C	REF02	Rendering Provider Secondary Identifier		Enter the rendering provider’s eight- or nine-digit ForwardHealth provider number.
2420D	NM1	Referring Provider Name		Include this segment when the referring provider is different than the attending provider and the service level referring provider is different than the claim/encounter level referring provider.
2430		Line Adjudication Information		For Claims, include this loop when other payers are known to potentially be involved in paying on this claim at the service-line level. For Encounters, use one iteration of this loop to report information about how the submitter (HMO, MCO, or FEA) adjudicated the service line. If there were other primary payers involved (such as Medicare), use one iteration of this loop per payer to communicate the other primary payer’s adjudication information for the service line.
2430	SVD	Line Adjudication Information		
2430	SVD01	Other Payer Primary Identifier		Use this identifier to indicate the other payer by matching the appropriate Other Payer Primary Identifier in Loop 2330B, Element NM109. For Encounters, when using this loop to report submitter adjudication information, use the same MMIS-assigned Payee Provider ID or Waiver ID used in Loop 2330B, Element NM109.

Loop ID	Reference	Name	Codes	Notes/Comments
2430	SVD02	Service Line Paid Amount		For Encounters, enter the amount paid to provider.
2430	CAS	Line Adjustment		For Claims, include this segment when another payer has made payment at the service line. If the other payer returned an 835 with a service line CAS, the CAS segment from the 835 should be copied to this CAS. To generate an other insurance indicator of “D”, a CAS segment for a non-Medicare payer must be used in either Loop 2320 or 2430. The value(s) of the claim adjustment reason code(s) is used to determine if the other insurance indicator is “D” or blank. ForwardHealth will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code” submitted on paper claims. For Encounters, when using this loop to report submitter adjudication information, use one or more iterations of this segment to explain any differences between the provider’s service-line billed amount and the submitter’s service-line paid amount using Claim Adjustment Reason Codes. Note: If this iteration of Loop 2430 contains information from a Medicare payer, ForwardHealth will also look for Medicare’s coinsurance, copayment, and deductible.

4 Transaction Instructions Additional Information

4.1 Business Scenarios

4.1.1 Terminology

The term subscriber will be used as a generic term throughout the companion guide. This term could refer to any one of the following depending upon the health program for which the 837I transaction is being processed:

- BadgerCare Plus
- SeniorCare
- WCDP
- Wisconsin Medicaid
- WWWP

4.1.2 Examples

ForwardHealth derives coordination of benefit information from the 837 that providers directly submitted. This companion guide has pointed out the pieces of information ForwardHealth uses to derive those values; however, the implementation guide frequently requires additional information in the segments where this information is found. Below are examples that show how the information may appear on the 837.

4.1.3 Other Insurance Indicators

In order to have an other insurance indicator assigned to a claim/encounter, at least one additional payer must be represented on the claim/encounter. The inclusion of Loop 2320 and any required subloops represent each payer. ForwardHealth can assign one of three Other Insurance codes to electronic claims/encounters based on information supplied on the claim/encounter.

There are four Other Insurance (OI) Indicators that potentially can be associated with a claim/encounter. The four codes are: “Blank”, “OI-P”, “OI-D”, and “OI-Y”.

A disclaimer code of “Blank” is present when the member does not have commercial insurance. A disclaimer code of “OI-P” is present when the member has commercial insurance coverage, the claim was submitted to the insurance carrier, and a payment was made on the claim. A disclaimer code of “OI-D” is present when the member has commercial insurance coverage and the claim was submitted to the insurance

carrier, but the claim was denied. There are various situations that could render a disclaimer code of “OI-Y”. These include the member denied coverage or will not cooperate, the provider knows the service in question is not covered by the carrier, the member’s commercial health insurance failed to respond to initial and follow-up claims, benefits are not assignable or cannot get assignment, or benefits are exhausted.

Other Insurance = OI-D

In this example, the provider billed $146.00. The other insurance carrier allowed $0.00 and paid $0.00. The reason the other insurance carrier did not pay the claim is indicated with the CAS segment copied from the 835 received from the other insurance carrier.

Loop 2320
SBR*A*18*******CI~
CAS*CO*45*146.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*999999999~

Loop 2330B
NM1*PR*2*ABC INSURANCE*****PI*001~
DTP*573*D8*20100819~

Other Insurance = OI-P

In this example, the provider billed $100.00 and applied $50.00 to deductible and $50.00 was beyond max fee.

Loop 2320
SBR*A*18*******CI~
CAS*PR*1*50.00~
CAS*CO*45*50.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1-IL*1*LAST NAME*FIRST NAME****MI*9999999999~

Loop 2330B
NM1*PR*2*ABC INSURANCE*****PI*001~
DTP*573*DE*20100819~

Other Insurance = OI-Y

In this example, the provider billed $40.00. The member has other insurance coverage, but the claim was not submitted to their insurance carrier. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from the other insurance carrier.

Loop 2320
SBR*A*18*******CI~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*ABC INSURANCE*****PI*001~

4.1.4 Medicare Status Disclaimer Code

There are three Medicare Disclaimers that can potentially be associated with a claim/encounter. The three codes are “Blank”, “7”, and “8”. A disclaimer code of “Blank” is present when the member is not enrolled in Medicare, or they are enrolled in Medicare and Medicare has made a payment on the claim. A disclaimer code of “7” is present when the member is enrolled in Medicare, the claim was submitted to Medicare, and Medicare denied payment. A disclaimer code of “8” is present when Medicare was billed for the claim but deemed the services “noncovered” or when the services are known to be “noncovered” by Medicare and therefore not submitted for payment.

Medicare Disclaimers (ForwardHealth Examples)

In order to have a Medicare disclaimer code assigned to a claim/encounter, at least one Medicare payer must be represented on the claim/encounter. The inclusion of Loop 2320 and any required subloops represent each payer. ForwardHealth can assign one of two Medicare disclaimer codes to electronic claims based on information supplied on the claim.

Medicare Disclaimer = 7 Denied

In this example, the provider billed $146.00. Medicare allowed zero and paid zero. The reason Medicare did not pay the claim is indicated with the CAS segment copied from the 835 received from Medicare.

Loop 2320
SBR* A*18*******MB~
CAS*CO*45*145.00~
AMT*D*0~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*999999999~

Loop 2330B
NM1*PR*2*MEDICARE*****PI*004~
DTP*573*D8*20100819~

Medicare Disclaimer = 8

In this example, the provider billed $40.00. The member is a Medicare beneficiary, but the claim was not submitted to Medicare. Refer to the ForwardHealth Online Handbook to determine when it is appropriate to submit claims/encounters to ForwardHealth without first receiving payment from Medicare.

Loop 2320
SBR*A*18*******MB~
AMT*A8*40.00~
OI***Y***Y~

Loop 2330A
NM1*IL*1*LAST NAME*FIRST NAME****MI*99999999~

Loop 2330B
NM1*IL*2*MEDICARE*****PI*004~

4.2 Payer-Specific Business Rules and Limitations

4.2.1 Scheduled Maintenance

ForwardHealth recycles the real-time servers every night between 00:00 a.m. to 01:00 a.m. Central Time (CT). Real-time processing is not available during this period.

ForwardHealth schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CT. Real-time processing is not available during this period.

4.3 Frequently Asked Questions

None.

4.4 Other Resources

Washington Publishing Company (WPC) at www.wpc-edi.com/.

ASC X12 at www.x12.org/.

For further information about how ForwardHealth processes a HIPAA transaction, contact the ForwardHealth EDI Department at 866-416-4979.

5 Change Summary

Version 1.1 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 07/2012
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	15	DTP	Admission Date/Hour		Removed WCDP APC note.
2300	16	HI	Admitting Diagnosis		Removed WCDP note.

Version 1.2 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 09/2012
Modified by: DJC

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	Document in Entirety				Replaced “claims” or “claim” with “claims/encounters” or “claim/encounter” as applicable throughout the guide.
	10	GS03	Application Receiver’s Code	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: “WISC_TXIX” only.
	10	BHT	Beginning of Hierarchical Transaction		Added segment.
	10	BHT06	Claim Identifier	CH (Claim) RP (Encounter)	Added element. Element is used to designate encounter. Claims will use “CH”; encounter will use “RP”.
1000B	10	NM109	Receiver Primary Identifier	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: “WISC_TXIX” only.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AB	11	NM1	Pay-to-Address		Added clarification. Encounter submissions will not receive an 835.
2010BB	12	NM109	Payer Identifier	WISC_ TXIX WISC_ WWWP WISC_ WCDP	Added clarification. Encounter: "WISC_TXIX" only.
2300	15	CLM05-3	Claim Frequency Code		Added clarification. Provider letters and paper submissions/ requests will not be supported for encounter processing.
2300	15	PWK	Claim Supple-mental Information		Added clarification. Segment is used to designate a chart review encounter.
2300	15	PWK01	Report Type Code	09 (Encounter)	Added Element. Element will designate a chart review encounter.
2300	15	PWK02	Attachment Transmission Code	BM (Claim) AA (Encounter)	Indicated "BM" is for claim. Replaced "BM" with IG language "By Mail." Added code "AA" for encounter.
2300	16	PWK05	Identification Code Qualifier	AC (Claim)	Indicated "AC" is for claim.
2320	19	SBR	Other Subscriber Identification		Added segment. Encounter can use this element to identify MCO is providing amount paid to its provider.
2320	19	SBR09	Claim Filing Indicator Code	HM (Encounter)	Added segment. Encounter can use "HM" to identify MCO is providing amount paid to its provider.
2430	23	SVD	Line Adjudication Information		Added segment.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2430	23	SVD01	Other Payer Primary Identifier		Added element. Encounter can use this element to identify MCO as a payer.
2430	24	SVD02	Service Line Paid Amount		Added element. Encounter: Enter the MCO amount paid to provider.
2430	24	CAS	Line Adjustment		Added clarification. Encounter paper claims are not supported.
	28				Added Medicare Disclaimer = Blank (Medicare Allowed/Paid) example.

Version 1.3 Revision Log

Companion Document: Health Care Claim: Institutional (837I)
Approved: 10/2013
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310A	17	NM1	Attending Provider Name		
2310A	18	NM101	Entity Identifier Code	71	When code 71 is used, the term physician covers any type of provider filling this role.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310A	18	NM103	Attending Provider Last Name		The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on the claim/encounter. This can be an individual or organizational entity. For example, personal care providers: This data element should indicate the attending personal care provider, not the attending physician. If the attending personal care provider does not have an NPI or ForwardHealth provider number, then the billing organization information should be used.
2310F	19		Referring Provider Name		*Note:* This loop is required if billing a professional service on an outpatient claim/encounter, otherwise do not send.
2310F	19	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider. Information in Loop ID-2310 applies to the entire claim/encounter unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310F	19	NM101	Entity Identifier Code	DN	Enter “DN” to submit the referring provider’s name and NPI.
2310F	19	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2310F	20	NM103	Referring Provider Last Name		Enter the referring provider’s last name.
2310F	20	NM104	Referring Provider First Name		Enter the referring provider’s first name.
2310F	20	NM108	Identification Code Qualifier	XX	Enter “XX” to indicate that the next field will contain the referring provider’s NPI.
2310F	20	NM109	Referring Provider Identifier		Enter the referring provider’s NPI.
2420D	24	NM1	Referring Provider Name		Required on an outpatient claim/encounter when the referring provider is different than the attending provider and the service level referring provider is different than the claim/encounter level referring provider.
2420D	24	NM101	Entity Identifier Code	DN	Enter “DN” to submit the referring provider’s name and NPI.
2420D	24	NM102	Entity Type Qualifier	1	The referring provider must be a person.
2420D	24	NM103	Referring Provider Last Name		Enter the referring provider’s last name.
2420D	24	NM104	Referring Provider First Name		Enter the referring provider’s first name.
2420D	24	NM108	Identification Code Qualifier	XX	Enter “XX” to indicate that the next field will contain the referring provider’s NPI.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2420D	24	1109	Referring Provider Identifier		Enter the referring provider's NPI.

Version 1.4 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 04/2015
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	14	CN1	Contract Information		The DHS requires BadgerCare Plus/SSI HMOs to report a "shadow price" on the HMO Encounter 837 transaction when the service is provided by a sub-capitated provider.
2300	14	CN101	Contract Type Code	05 (Capitated)	Encounter: Enter the value "5" to indicate a capitated amount to follow. This element is required on encounters when the service is provided by a sub-capitated provider.
2300	14	CN102	Contract Amount		Enter the "shadow price".

Version 1.5 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 07/2016
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	18	HI	Value Information		Enter value code information in this segment. *Note:* Use this segment to indicate covered and noncovered days for all

					institutional claim and encounter types. *Note:* Use this segment to indicate birthweight in grams for newborn institutional claims and encounters (Value Code = 54).

Version 1.6 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 10/2024
Modified by: AS

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	14	REF	Referral Number		Include this segment when a referral is involved. This segment may be used to provide additional information when it comes to indicating another provider (such as a federally qualified health center [FQHC]) referred the member to the billing provider.
2300	15	REF01	Referral Number Qualifier	9F	Enter "9F" to submit a referral number.
2300	15	REF02	Referral Number		Enter the referral number. This element may be used to provide additional information when it comes to indicating another provider (such as an FQHC) referred the member to the billing provider.

Version 2.0 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 03/2025
Modified by: JR/SK

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	16	REF	Prior Authorization		Note for Claims: ForwardHealth does not require prior authorization (PA) numbers to be submitted on the 837 transaction. For LTC Encounters, submit the Service Authorization number associated with the service.
2320	19	SBR	Other Subscriber Information		This segment is used when other payers are known to potentially be involved in paying on this claim. Submitters use this segment on an encounter to identify the submitting entity as a payer. This would be in addition to any other payer information that may have been on the encounter prior to the submitter's adjudication.
2320	19	SBR09	Claim Filing Indicator Code	**HM** (HMO Encounter) **ZZ** (LTC Encounter)	Encounter: Enter "HM" to identify an MCO is providing amount paid to its provider. LTC Encounter: Enter "ZZ" to identify a LTC submitter is providing amount paid to its provider.
2400	23	NTE02	Note	TPO	Support indicator. "S" for "Self-Directed" "C" for "MCO-Directed" "E" for "EVV exempt"

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2430	25	SVD	Line Adjudication Information		This segment is used when other payers are known to potentially be involved in paying on this claim at the detail line. Submitters can use this segment on an encounter to identify the detail amount paid to their provider.
2430	26	SVD02	Service Line Paid Amount		Encounter: Enter the amount paid to provider.

If the guidance in the Notes/ Comments column is preceded by:	Then that guidance only applies to:
For Claims,	• Providers
For Encounters,	• BadgerCare Plus/SSI HMOs • Long-term care (LTC) managed care organizations (MCOs) • IRIS (Include, Respect, I Self-Direct) fiscal employer agents (FEAs)
For HMO Encounters,	• BadgerCare Plus/SSI HMOs
For LTC Encounters,	• LTC MCOs • IRIS FEAs
For MCO Encounters,	• LTC MCOs
For IRIS Encounters,	• IRIS FEAs

- Moved definitions of code values from the Notes/Comments column to the Codes column throughout Section 3.
- Edited text throughout to reflect active voice in place of passive voice to increase clarity of ForwardHealth instructions.
- Changed “ForwardHealth interChange” to “ForwardHealth” throughout.
- Removed instructions that restated instructions published in the national Implementation Guide and similarly extraneous information.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	15	DTP	Date-Repricer Received Date		For IRIS Encounters, enter the IRIS Funding file date.
2300	15	DTP01	Date/Time Qualifier	050 (Received)	For IRIS Encounters, enter 050 (Received).
2300	15	DTP02	Date Time Format Qualifier	D8	For IRIS Encounters, enter D8 (Date Expressed) in Format CCYYMMDD.
2300	15	DTP03	Date Time Period		For IRIS Encounters, enter the expression of a date.

Version 2.0 Revision Log

Companion Document: 837 Health Care Claim/Encounter: Institutional (837I)
Approved: 04/2025
Modified by: CB

Loop ID	Page Revised	Reference	Name	Codes	Notes/Comments
2300	16	REF	Prior Authorization	G1 (CLTS only)	Note for Claims: ForwardHealth does not require prior authorization (PA) numbers to be submitted on the 837 transaction, except for the Children's Long-Term Support (CLTS) Program. For LTC Encounters, submit the Service Authorization number associated with the service.