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Introduction
This section provides knowledge on PC Print as well as explains the benefits of using this system.

Description and Use:
The PC based ANSI ASC X12.835 translator program (PC Print) is an interactive program written for the IBM PC and compatibles. It allows the viewing and printing of the Medicare Part A Electronic Remittance Advice received by the Provider in the form of an ANSI ASC X12.835 Electronic Remittance Advice.

The primary purpose of the program is to produce a paper remittance advice containing all of the data residing within the ANSI ASC X12.835 Electronic Remittance Advice transmission. The intent of the paper remittance advice is to facilitate Accounts Receivable processing for the end user, a Provider, who does not have access to sophisticated data processing facilities. Also, to produce a paper remittance advice acceptable for subsequent payers processing when electronic links capable of ANSI ASC X12.835 transmission do not exist.
Benefits of the PC Print program:

Viewing facilities exist to display a Single Claim. Compressed font is incorporated in order to display the detail line item activity of a claim.

The All Claims display will allow the operator to view all of the claims in a 25 claim count increment, within the transmission in an abbreviated format. The All Claims display allows for left and right scrolling in order to view the entire Header and Detail of each claim displayed.

A Summary Subtotal/ Total Bill Type, Bill Summary, will display the sub-totals for each payment category, per provider fiscal year and the total remittance found within the Single Claim display, accumulated and displayed by TOB (Type of Bill).

A Payment Summary, Provider Summary, identifies the total paid to the Provider for this billing cycle/ transmission. It also indicates the total claims within the billing cycle/ transmission. Non-claim payment adjustments are displayed when applicable. These adjustments allow for Provider payments when claims are not present, for example, Periodic Interim Payments, Cost Report Settlements, etc. The adjustments also allow for various other financial transactions required between Fiscal Intermediaries and Providers.

The PC Print program allows the end user to view or print all of the above displays. These displays can be done selectively in all situations.

Technical Support

Within the Standard System Maintainer/ Fiscal Intermediary community, designated local, Fiscal Intermediary support personnel should be contacted for technical support. Updates will be distributed through established channels.

Comments

The Standard System Maintainer will receive requests for enhancements and corrections through the existing Question/ Problem process.

The PC Print environment has limitations on the size of a data file used. It has been determined that a data file with greater than approximately 80,000 segments will not appropriately process in this PC Print Software. FISS does not recommend using files greater than 80,000 segments. Further in this document segments will be covered.
**Glossary**

This section provides you a brief listing of acronyms used in the PC Print software. This is presented at the beginning of the manual to assist in understanding.

**Table of Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC</td>
<td>All Claims Report/Screen</td>
</tr>
<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
</tr>
<tr>
<td>ASC</td>
<td>Accredited Standards Committee (ASC X12)</td>
</tr>
<tr>
<td>BS</td>
<td>Bill Summary Report/Screen</td>
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<td>PAR</td>
<td>Project Assistance Request</td>
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<td>PS</td>
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<td>SC</td>
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<tr>
<td>SL</td>
<td>Segment List</td>
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<tr>
<td>TAR</td>
<td>Telephone Assistance Request (Question)</td>
</tr>
<tr>
<td>X12</td>
<td>835 ERA Data File</td>
</tr>
</tbody>
</table>
Getting Started

This section provides instructions for getting started using PC Print.

Installation Software

PC Print has been packaged using Microsoft ® Visual Studio Windows Installer. This software allows all files needed to install the application to be easily packaged and then installed on the user's machine.
GETTING STARTED

Uninstall Process:

Before loading a new version of PC Print, it is imperative that you **uninstall** the old version.

1) Click **Start**
2) Click **Control Panel**
3) Click **Add/Remove Programs**
4) Select **PCP or PC Print** (whichever is applicable)
5) Click **Add/Remove**
6) Click **Remove**.

Installation:

1) Go to the [HTTPS://WWW.ARKFISSMedicare.Com](https://WWW.ARKFISSMedicare.Com) Website
2) Login
   a) Click FISS PC Print
   b) Click Download PC Print Version 4.0
   c) Follow the Down Load Instructions

Note: If you would like to test the 5010 PC Print Version 4.0 and still utilize the 4010.A1 Version 3.6.1 in a production environment you do not need to perform the Uninstall Process.
GETTING STARTED

Running the PC Print Program

To run the program, simply double-click on the icon. The PC Print program runs over a network identically to how it runs locally. You should be careful when saving or archiving transmissions, that you choose the appropriate directory.

ERA Version Information

ERA Versions 4010.A1/5010

The 5010 Version 4.0 of PC Print allows the end user to load and view either a 4010.A1 or a 5010 835 X12 ERA data file. As in the previous PC Print version, for Inpatient claims there will be line level adjustments for non-covered and denied charges and claim level adjustments as appropriate. For outpatient claims all adjustments will be at the line level, with the exception of Outlier; it will be reported at claim level.

The 5010 version reflects the Provider Summary Report (screen and report), a new change for this screen/report is that it includes the Payer Business and Technical Contact Information.

The 5010 version also has modified the Single Claim Report (screen and report) to reflect additional service line information, the Line Item Control Number, the Service Line Description for Not Otherwise Classified and the Health Care Policy Indicator.

The other changes that were implemented for these reports as well as the Bill Summary and the All Claims reports were minimal, such as the removal of fields no longer being used.
To set up for printing, select “File” from the title bar.
Then select “Print Setup” from the pull down menu.
GETTING STARTED

Along with the printer setup in the PC Print application being set up, you will need to ensure that the Print Drivers are also set appropriately as one of the reports, Single Claim, uses two print fonts.

NOTE: If the print drivers are not configured correctly, the single claim will not print appropriately. It will print as a single line. PC Print does not print the report; it turns over the print to Windows, which communicates to a selected printer. Therefore, it is very important that the appropriate print drivers are loaded on any network printers or on the PC for any local printers. If there is still an issue printing the reports it may be due to old hardware technology being used with new software technology, thus, an upgrade of printer and/or operating system may be required.

GENERAL TEXT PRINT FILE
If the user wants to generate a print file (generate text file) there should be a generic/text print driver loaded. To create the print file, setup the dialog box by:

1) Printer Name: Generic/Text Printer
2) Paper Size: Ledger
3) Orientation: Portrait

Once the file is created, it can be downloaded to a mainframe for viewing.
Chapter 4

Menu Bar Options
This section will focus on explaining all the options on the Menu Bar that are available through PC Print and their purpose.

Accessing the Screen

Upon double clicking on the “PC Print” Icon, the system will bring you to this screen. Take notice that the “SL” button is always pre-selected. Before you can view any claim information a data file needs to be selected.
MENU OPTION “FILE”

Select the “FILE” option from the title bar.

When you select “File”, you will be offered various choices based on the particular format of PC Print you are using. In the above example, we have just opened PC Print, no data file has been selected, and thus only certain options are available.
MENU BAR OPTIONS

Edit Option

MENU OPTION “EDIT”

The “Edit” option offers a Mark for Print, Find, and Find Next. “Mark for Print” is available for use on the All Claims and Single Claims reports. The “Find Next” becomes available for use after the initial “Find” when viewing the claims.
MENU BAR OPTIONS

View Option

MENU OPTION “VIEW”

The “View” menu option allows for selection of the Tool Bar, Status Bar and the Legend (Screen Header for the All Claims format).

View also identifies the keyboard commands necessary to navigate through the various screens that make up the PC Print Application.

Also available for use is the “Next” and “Prev” options. These can be used to parse forward and backward through the different formats.
Based on changes made for the processing of a HIPAA 5010 835 X12 file, this menu option is no longer required to be used. The application is mapping this information from the 835 X12 file.

The “Admin” menu has two options.

1) The “Intermediary” option is where the user can add the Intermediary name and address so that it will be printed out on the reports and screens.

2) The “Provider” option is where the user can add the Provider(s) number, name, and address information so it will appear on the reports and screens.
INTERMEDIARY SETUP

Based on changes made for the processing of a HIPAA 5010 835 X12 file, this menu option is no longer required to be used. The application is mapping this information from the 835 X12 file.

The Intermediary Setup dialog box is selected by clicking on “Admin” then “Intermediary” and is used to set up the Intermediary data to be reflected on the screens and reports. When updating the dialog box to move from field to field, press the “TAB” key.

After entering all the requested information, click “OK” to accept.
PROVIDER SETUP

Based on changes made for the processing of a HIPAA 5010 835 X12 file, this menu option is no longer required to be used. The application is mapping this information from the 835 X12 file.

The Provider Setup dialog box is selected by clicking on “Admin” then “Provider” and is used to set up the Provider(s) data to be reflected on the screens and reports.

Dialog Box Buttons:

“Previous” - If you are a few records into this file and would like to go back and view the prior provider information click “Previous.”

“Next” - If you are in this file and would like to go to the next provider in the file click “Next.”

“Add” - If you need to add a new provider’s information to get a blank screen click “Add”, then “OK.”

“Delete” - If you need to delete a provider record from this file, bring the provider record to the screen and click “Delete,” then “OK.”
Based on changes made for the processing of a HIPAA 5010 835 X12 file, this menu option is no longer required to be used. The application is mapping this information from the 835 X12 file.

Example of adding a Provider to the Provider Setup File.

Click on “Add” button in the Provider Setup Dialog box. Complete the provider information. To add the next provider, click “Add” and complete the provider information. If finished, click “OK”.

NOTE: Clicking “Next” gives you new provider fields just like “Add”. When you click “OK” it stores the data as well.
MENU OPTION “HELP”

The “Help” menu option is currently NOT available for use as ‘Help’. Upon selecting ‘Help’, selecting ‘About PCP01’ will provide the version number of the PC Print in use.

Depending on which Windows Platform is being used the following instructions may vary. A Windows Platform prior to Vista will process as follows: Upon clicking “Help\ Index or Help\ Using Help” you will receive a message box stating, “Cannot find the C:\ Program Files\ FISS\ PCP01.HLP file. Do you want to try to find this file yourself?” Always click “NO.”

A second message box will come up stating “Cannot find the C:\ Program files\ FISS\ PC Print\ PCP01.HLP file. Check to see that the files exist on your disk. If it doesn’t you need to reinstall it.” Click “OK” No reinstall is required as a help file for PC Print does not exist at this time.

When performing the help as stated above, Windows Vista will provide a dialog box that presents the message “Failed to Launch Help”, then click OK.
Chapter 5

Tool Bar Options

This section will focus on explaining all the options that are available on the Tool Bar through PC Print and what they are used for.

X12 Button

Clicking on the X12 button brings up the “Open” dialog box.

Select “Data” file for viewing the data files, select one, then click the “Open” button.

Another option to select a Data file is the File name: Once a file has been viewed, it will be available to be selected from the ‘Drop Down’ Box. For Data files to show up in the ‘Drop Down’ Box, they must be named in the following format, YMMDD.X12.
Select a data file and click "Open."

If you find that the data file selected is not the correct one, click the X12 button again and make another selection as stated above.

NOTE: It automatically defaults to the data folder within PC Print.
Once the data file is opened, the PC Print application will display (on the left side of the screen) the data file segment listing the GS segment(s).

Also displayed on this screen in a deblocked segment format (one segment per line), is “each segment” of the transmitted X12.835 file.

At the bottom of the screen there is a status bar that provides information about the 835 X1 data file. It provides the total number of claims in the file and the total number of segments in the file.

If the total number of segments exceeds the file size limitation of approximately 80,000 segments and the user accesses the All Claims or Single Claims report and encounters the claim that exceeds the limitation, an error message will be received. The User will need to shut down PC Print and restart the application.
Upon clicking on any segment, the detail data elements for that segment will be displayed on the right side of the screen. This segment list is primarily a diagnostic tool.
The "SL" (Segment List) button will return the display to the segment list format from any other location in the application.

Example: If the current selection is "AC" for the All Claims screen, selection of the "SL" button would return the user to the segment list display.
The “PS” (Provider Summary) button will bring up the Payment Summary screen format.

The Provider Summary Report (screen and report) now includes the Payer Business and Technical Contact information in addition to the PLB composite data when reporting provider level adjustments.

NOTE: The up/down arrows allow for the forward and backward parsing through the file. A vertical scroll bar is available for parsing through the screen, if necessary.
The "BS" (Bill Summary) button allows access to view the Type of Bill summary records generated per provider.

NOTE: The up/down arrows allow for the forward and backward parsing through the file.

A vertical scroll bar is available for parsing through the screen, if necessary.
The “AC” (All Claims) button provides access to the “All Claims” display.

NOTE: The up/down arrow buttons allow for parsing forward and backward through the file.

The right/left and up/down scroll bars are available at the bottom and right of the screen respectively to move through the “All Claims” screen to view the data in its entirety. (See next screen to view the missing columns.)
You can view the three fields shown below by scrolling to the right.

The Scroll Bar is active for this screen.
The “SC” (Single Claim) button will display individual claims on the screen.

The Single Claim Report (screen and report) reflects the Coordination of Benefits (COB) data when there has been a COB transfer. The name and number of the Trading Partner are reflected on the report. In addition, at the service line the line item control number, health care policy indicator and the Not Otherwise Classified service line description are now reported.

**NOTE:** The screen has a split screen display. The upper portion presents the claim level data and the lower portion displays the line item detail of the claim.

Both sections of the screen have up/down and right/left movement ability in order to view all data available.

Up/down arrow buttons are available to parse through the claims forward and backward.
The **Printer** button will print the “Current Single Claim”, the “All Claims Report”, the “Current Bill Summary”, and the “Current Provider Summary”.

(Note printer options are listed in the next chapter.)

The arrow up and down buttons are available for parsing through to the next claim to be viewed/printed.
Chapter 6

Printing Options

This section will provide you with various options used to print each report.

Printing the "Single Claim" Report

1) The print button on the Tool Bar can be utilized when in the "Single Claim" format. The arrow up and down buttons are available to parse through the claims. See example A.

2) To print all of the claims in the data file in the single claim format, from the menu bar click "File", then "Print All Items." All of the claims will print in the single claim format. See example B.

3) While in the single claim and parsing through, you can select certain claims to be printed. This process is done by selecting "Edit" then "Mark For Print." See example C.

   Once you have selected "Mark For Print", a box will appear that will show you the number(s) of the claim(s) that has/ have been selected. See example D.

   Continue this process until you have selected all the claims that you wish to print. Now select "File" then "Print Marked Items" and the claims that were marked will be printed. See example E.
Printing the “All Claims” Report

1) When in the “All Claims” format, printing the entire report can be done by clicking on the “Printer” button.

2) When in the “All Claims” format and you would like to print only selected claims, but in the single claim format, first select the claims to be printed by clicking on “Edit” then “Mark For Print” for all the claims to be printed. Once the selection is complete click on the “SC” button. This brings you into the single claims format, then select “File” then “Print Marked Items.” The claims selected from the AC format will be printed in the SC format.

3) Another way to print the entire “All Claims” report is to select “File” then “Print” (or CTRL+P).

Printing the “Provider Summary” Report

1) When in the “Provider Summary” format, click on the “Printer” button on the Tool Bar and the current summary will print. To print additional summaries, parse through using the up/ down arrows and use the “Printer” button.

2) Another way to print the “Provider Summary” report(s) is to select “File” then “Print” (or CTRL-P).

Printing the “Bill Summary” Report

1) When in the “Bill Summary” format, click on the “Printer” button on the Tool Bar and the current summary will print. To print additional summaries, parse through using the up/ down arrows and use the “Printer” button.

2) Another way to print the “Bill Summary” report(s) is to select “File” then “Print” (or CTRL-P).

NOTE: It is not necessary to go to File/ Print if you are using the CTRL-P sequence.
### Print Example A

**Medicare National Standard Intermediary Remittance Advice**

- **ISSN HEALTH SYSTEM**: YHEI 08/30/2002 YASS MEDICARE SERVICES
- **843 SOUTH STREET**
- **DATE**: 10/18/2002
- **FIFTH AVENUE**
- **PITTSBURGH, PA 15245**
- **BII**: 2313321203
- **TIN**: 111

**PATIENT**: K00

**SIC**: 12345678

**SRC**: XANGA

**PCN**: 123456789

**CLIA STAT**: 1

**THRU**: 09/26/2003

**NBR**: 123456789

**TIN**: 123456789

**O1**: C00

### CHARGES:

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DESCRIPTION</th>
<th>AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>19504.10</td>
<td>Reported</td>
<td>10701.51</td>
</tr>
<tr>
<td>19504.10</td>
<td>Outlier</td>
<td>0.00</td>
</tr>
<tr>
<td>19504.10</td>
<td>Allow/Reim</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### DEDUCTIONS:

- **INSURANCE**: 0.00
- **CASH**: 0.00
- **BLOOD**: 0.00
- **INSURANCE**: 0.00
- **EQUIPMENT**: 0.00
- **MEDICAL**: 0.00
- **REIMbursement**: 0.00
- **EQUIPMENT**: 0.00
- **MEDICAL**: 0.00
- **STANDARD**: 0.00

### CHARGES:

- **INSURANCE**: 0.00
- **CASH**: 0.00
- **BLOOD**: 0.00
- **INSURANCE**: 0.00
- **EQUIPMENT**: 0.00
- **MEDICAL**: 0.00
- **STANDARD**: 0.00

### AMOUNTS:

- **INSURANCE**: 0.00
- **CASH**: 0.00
- **BLOOD**: 0.00
- **INSURANCE**: 0.00
- **EQUIPMENT**: 0.00
- **MEDICAL**: 0.00
- **STANDARD**: 0.00
# PRINTING OPTIONS

## Print Example B

![Image of PC Print for Windows software interface]

### CHARGES:
- **PAYMENT DATA:** 462-000 0.000=REIM RATE
- **1904.10=REPORTED:** 190701.81=DRG AMOUNT 0.00=MSP PRIM PAYER
- **0.00=NOV/DENIED:** 079.54=DRG/PER/CAP 0.00=PROP COMPONENT
- **0092.99=CLAIM ADJS:** 091.99=LINE ADJ ANT 0.00=EPSP AMOUNT
- **39520.10=COVERED:** 69509.10=DRG OUTLIER 0.00=PROD AMOUNT
- **DAYS/VISITS:** 0.0=CAP OUTLIER 190504.10=ALLO/REIM
- **15=COST REPT:** 0.0=CAP EXHIBIT 190504.10=ALLO/REIM
- **0=EXHIBIT:** 0.0=CAP EXHIBIT 190504.10=ALLO/REIM
- **0=NON-COVERED:** 0.0=CAP EXHIBIT 190504.10=ALLO/REIM
- **0=NON-COVERED:** 0.0=CAP EXHIBIT 190504.10=ALLO/REIM
- **0=NON-COVERED:** 0.0=CAP EXHIBIT 190504.10=ALLO/REIM
- **ADJ REASONS CODE:** CO 99 8992.59

### ADJ REASONS CODE:
- **DEC:** 0024 02/21 0025 02/21 0026 02/21 0027 02/21 0086 02/21
- **DISCHARGE:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
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- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
- **ADJUSTMENTS:** 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
PRINTING OPTIONS

Print Example C

---

This image contains a screenshot of a computer interface with a title "PRINTING OPTIONS" and a section labeled "Print Example C." The screenshot appears to be from a software program, likely related to billing or financial data, given the presence of terms like "PAID," "EXP DATE," and other financial-related abbreviations. The interface includes a table with columns for dates, amounts, and other financial details, indicating a transaction history or financial record. The numbers and data points suggest a detailed record, possibly related to payments or reimbursements.
Print Example D
PRINTING OPTIONS

Print Example E
Chapter 7

Find Options

This chapter will offer instructions on how to locate claims, both “All Claims and Single Claims”.

Find Options General

The “Find” option is available on the “All Claims” and the “Single Claim” screens. Each will be addressed separately.

The “Find” option is available on the “All Claims” and the “Single Claim” screens. Each will be addressed separately.
**FIND OPTIONS**

Single Claim Find

Bring up the single claim screen by clicking the “SC” button.

Click on **“Edit”**, then click on **“Find.”**
As you can see, in the “Find” dialog box there are options as to what data field you wish to do a find on (patient last name, medical record number, HIC number, and the patient control number).

In the “Find What” box, key in the data to search on, then click on the appropriate search field, then click “OK.”

The application will search for your selection and bring it to the screen for viewing or it will bring up the message “Search text not found.”
NOTE: In this application you have the capability to toggle between the single claim screen and the all claims screen. If you are in “Single Claim” view and click the “AC” button, when the “All Claim” screen comes up, the single claim that you were on will be highlighted in the all claim view.
In the all claims “AC” search/find, before we begin, we need to note a feature of this screen. In the status bar at the bottom of the screen it states “Displaying claims 1 through 10 of the total 10 claims.” If there are more claims, click on the “A
down” button to view the next set.
Then the status bar will reflect “Displaying claims xx through xx of the total xx claims.”

Select “Edit/Find” and input the search criteria and click “OK.” Once the claim is found it is highlighted. If you want to view the claim in the single claim format, click on the highlighted claim then click on the “SC” button and the application will take you directly to the single claim format for that particular claim.
Bring up the all claims screen by clicking the “AC” button.

Click on “Edit”, in the pull down menu click on “Find.”

If the “Find” returns more than one claim with the same search criteria, the “Find Next” will then be available.
As you can see, in the “Find” dialog box there are options as to what data field you wish to do a find on (patient last name, medical record number, HIC number, and the patient control number).

In the “Find What” box, key in the data to search on, then click on the appropriate search field, then click “OK.”

The application will search for your selection and bring it to the screen for viewing or it will bring up the message “Search text not found.”
The search found the requested patient and highlighted the claim. If you click on the highlighted claim and then the “SC” button, the application will take you to the single claim format of that claim.
This screen came up from the previous application request.

From here (SC) you can click on the “AC” button and the application will take you back to the claim in all claim format.
Chapter 8

Processing Procedures

This section will give you the directions necessary to load a new “data file” and to process claims once the data file has been successfully loaded.

Loading New Data File and PC Print Process

Each new 835 mailbox transmission received will need to be copied or transferred from the data set file into the PC Print data file before viewing and or printing in the PC Print application. The recommended data file naming convention is YYMMDDX.X12 (example: 981128A.X12, remittance advice date).

Copy or transfer from your system remittance advice mailbox an 835 X12 File and place it in a folder that can be accessed by the PC Print Application.
Upon double clicking the “PC Print” icon you will see this screen.

As you will notice, the “SL” button is selected. Before you can view any claim information a data file needs to be selected.
Clicking on the X12 button brings up the “Open” dialog box.

Select the “Data” folder for viewing the data files, then click “Open.”
Select a data file and click on "Open."

If you find that the data file selected is not the correct one, click the X12 button again and make another selection as stated above.
Once your data file is selected it will appear on the screen in the segment list format. Starting from the left, the first column will show the “GS” segments, the second column shows the segments within the “GS” and the third column reflects the data in each segment (example follows).

You will notice that in the bottom left of the screen it states the total number of claims and total number of segments in the data file.
This screen shows the data in each segment as selected. A vertical scroll bar is available for parsing through the data file.

You will notice that in the Status Bar at the bottom of the screen it states the total number of claims and total number of segments in the data file.

NOTE: The PC Print environment has limitations on the size of a data file used. It has been determined that a data file with greater than approximately 80,000 segments will not appropriately process in this PC Print Software. FISS does not recommend using files greater than 80,000 segments. Further in this document segments will be covered.
Selecting the "PS" button brings up the Provider Summary screen.

The Status Bar at the bottom of the screen displays the total number of claims.

NOTE: Provider Summary is available from the "View" menu and as a keyboard sequence CTRL-R.
Selecting the “BS” button brings up the Bill Summary screen. The Status Bar at the bottom of the screen displays the total number of claims.

NOTE: Bill Type Summary is available from the “View” menu and as a keyboard sequence CTRL-B.
Selecting the “AC” button brings up the All Claims screen.

As you will notice in the status bar at the bottom of the screen, it states which claims are being displayed, the total number of claims in the data file and which claim is currently selected/highlighted. To view a second set of claims, click on the down arrow in the tool bar.

NOTE: All Claims is available from the “View” menu and as a keyboard sequence CTRL-A.
Selecting the “SC”, Single Claim button accesses the single claim.

The Status Bar at the bottom of the screen displays the total number of claims.

NOTE: Single Claim is available from the “View” menu and as a keyboard sequence CTRL-S.
## System Layout/Mapping

This section provides the information necessary to see and understand the mapping for each report.

### All Claims Report

<table>
<thead>
<tr>
<th>Field</th>
<th>Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NUMBER/ NPI</td>
<td>Loop 1000B, N1 Payee Identification, N104 when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ</td>
</tr>
<tr>
<td>PROVIDER NAME:</td>
<td>Loop 1000B, N1 Payee Identification, N102 when N101 equals PE</td>
</tr>
<tr>
<td>FPE:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS303 Fiscal Period Date</td>
</tr>
<tr>
<td>INTERMEIDARY NAME</td>
<td>Loop 1000A, N1 Payer Identification, N102 when N101 equals PR</td>
</tr>
<tr>
<td>PAID:</td>
<td>Header, BPR Financial Information, BPR16 Check/ EFT Date</td>
</tr>
</tbody>
</table>

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**MAPPING 5010 835 TO ALL Claims REPORT Header**

<table>
<thead>
<tr>
<th>Field</th>
<th>Element</th>
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</thead>
<tbody>
<tr>
<td>patient name</td>
<td>patient cntrl number</td>
</tr>
<tr>
<td>icn number</td>
<td>hic number</td>
</tr>
<tr>
<td>claim #</td>
<td>claim status</td>
</tr>
<tr>
<td>national provider id</td>
<td>hic chg=x job=xxx</td>
</tr>
<tr>
<td>frm dt</td>
<td>cost</td>
</tr>
<tr>
<td>thr dt</td>
<td>coved</td>
</tr>
<tr>
<td>cv ln</td>
<td>ncv l</td>
</tr>
<tr>
<td>cvd chgs</td>
<td>new tech/ ect</td>
</tr>
</tbody>
</table>

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**Chapter 9**

**System Layout/Mapping**

This section provides the information necessary to see and understand the mapping for each report.
<table>
<thead>
<tr>
<th><strong>SYSTEM LAYOUT/MAPPING</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>PAGE NUMBER:</strong></td>
</tr>
<tr>
<td><strong>PATIENT NAME</strong></td>
</tr>
<tr>
<td><strong>PATIENT CNTRL NUMBER</strong></td>
</tr>
<tr>
<td><strong>FRM DT</strong></td>
</tr>
<tr>
<td><strong>COST</strong></td>
</tr>
<tr>
<td><strong>REPTD CHGS</strong></td>
</tr>
<tr>
<td><strong>DRG NBR</strong></td>
</tr>
<tr>
<td><strong>OUTLIER AMT</strong></td>
</tr>
<tr>
<td><strong>REMIB RATE</strong></td>
</tr>
<tr>
<td><strong>ALLOW/REIM</strong></td>
</tr>
<tr>
<td><strong>INTEREST</strong></td>
</tr>
<tr>
<td><strong>ICN NUMBER</strong></td>
</tr>
<tr>
<td><strong>HIC NUMBER</strong></td>
</tr>
<tr>
<td><strong>THR DT</strong></td>
</tr>
<tr>
<td><strong>COVDV</strong></td>
</tr>
<tr>
<td><strong>NCVD/DENIED</strong></td>
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</table>
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals adjustment codes 1 and 66.

Loop 2100, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals adjustment codes 23.

Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals adjustment codes 1 and 66.

Loop 2100, MOA Outpatient Adjudication Information, MOA02 Claim HCPC Payable Amount.

Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals A0.

Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals A0.

Loop 2100, CLP Claim Payment Information, CLP02 Claim Status Code.

Loop 2100, REF Other Claim Related Identification REF02 Other Claim Related Identifier when REF01 is EA.

Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 when QTY01 equals NE.

Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94, and 97.

Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94, and 97.

Loop 2100, MIA Inpatient Adjudication Information equals MIA06 Claim Disproportionate Share Amount +
MIA08 Claim PPS Capital Amount + MIA18 Claim Indirect Teaching Amount

**COIN AMT**
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 2, 3 and 122
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 2, 3 and 122

**PROF COMP**
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 89 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 89

**LNE ADJ AMT**
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94 and 97

**PER DIEM AMT**
Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when AMT01 equals DY Per Day Limit

**NATIONAL PROVIDER ID (NPI)** Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX

**HIC CHG = X**
Loop 2100, NM! Corrected Patient/Insured Name, NM109 Corrected Insured Identification Indicator when NM108 equal C Insured’s Changed Unique Identification Number

**TOB = XXX**
Loop 2100, CLP Claim Payment Information, CLP08 Facility Type Code in the first two positions of the XX and CLP09 Claim Frequency Code in the third position, last X

**CV LN**
Loop 2100, QTY Claim Supplemental Information, QTY02 Claim Supplemental Information Quantity when QTY01 equals CA Covered - Actual

**NCV L**
Not Used

**COVD CHGS**
Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when AMT01 equals AU Coverage Amount

**NEW TECH/ECT**
Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when
SYSTEM LAYOUT/MAPPING

AMT01 equals ZL New Tech Add On

ESRD AMT
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 118 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 118

CONT ADJ AMT
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45

NEW REIMB
Loop 2100, CLP Claim Payment Information, CLP04 Claim Payment Amount
Single Claim Report

PC PRINT
SINGLE CLAIM REPORT
Medicare National Standard Intermediary Remittance Advice
FISS Hospital FPE: 12/31/2008 PBSI - FISS
321 Taylor Street PAID: 03/31/2009 123 River Rd
Jax AR 77234 CLM#: 1 LR AR 72207
NPI: 1033179510 TOB: 118
TRANSFER TO (COB): MEDICAID OF FISS ID CODE:Z99999001
================================================================================
PATIENT: HAIRE H PCN: 0
HIC: 987654XXXA SVC FROM: 10/01/2008 MRN: 20906200000008FLA
CLAIM STAT: 22 THRU: 10/04/2008 ICN: 20835400000008
================================================================================
CHARGES: PAYMENT DATA: 639=DRG 0.00=REIM RATE
-3100.00=REPORTED 0.00=DRG AMOUNT 0.00=MSP PRIM PAYER
0.00=NCVD/DENIED 0.00=DRG/OPER/CAP 0.00=PROF COMPONENT
-1550.00=CLAIM ADJS 0.00=LINE ADJ AMT 0.00=ESRD AMOUNT
0.00=COVERED 0.00=OUTLIER 0.00=PROC CD AMOUNT
DAYS/VISITS: 3=COST REPT -1024.00=CASH DEDUCT
0=COVD/UTIL 0.00=BLOOD DEDUCT 0.00=INTEREST
0=NON-COVERED 0.00=COINSURANCE 0.00=CONTRACT ADJ
0=COVD VISITS 0.00=PAT REFUND 0.00=PER DIEM AMT
0=NCOV VISITS -526.00=NET REIM AMT
ADJ REASON CODES: CO 45 -1550
PR 1 -1024
REMARK CODES: MA02
<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NAME:</td>
<td>Loop 1000B, N1 Payee Identification, N102 Payee Name</td>
</tr>
<tr>
<td>FPE:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS303 Fiscal Period Date</td>
</tr>
<tr>
<td>INTERMEDIARY NAME</td>
<td>Loop 1000A, N1 Payer Identification, N102 Payer Name</td>
</tr>
<tr>
<td>PAYEE ADDRESS</td>
<td>Loop 1000B, N3 Payee Address, N301 Payee Address Line</td>
</tr>
<tr>
<td>PAID:</td>
<td>Header, BPR Financial Information, BPR16 Check/ EFT Date</td>
</tr>
<tr>
<td>INTERMEDIARY ADDRESS</td>
<td>Loop 1000A, N3 Payer Address, N301 Payer Address Line</td>
</tr>
<tr>
<td>PROVIDER CITY/ ST/ ZIP</td>
<td>Loop 1000B, N4 Payee City, State, Zip Code, N401 City, N402 State, N403 Zip Code</td>
</tr>
<tr>
<td>CLM#:</td>
<td>PC Print Assigned</td>
</tr>
<tr>
<td>INTERMEDIARY CITY/ ST/ ZIP</td>
<td>Loop 1000A, N4 Payer City, State, Zip Code, N401 City, N401 State, N403 Zip Code</td>
</tr>
<tr>
<td>NPI:</td>
<td>Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ</td>
</tr>
<tr>
<td>TOB:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP08 Facility Type Code and CLP09 Claim Frequency Code.</td>
</tr>
<tr>
<td>TRANSFER TO (COB)</td>
<td>Loop 2100, NM1 Crossover Carrier Name, NM103 Coordination of Benefits Carrier Name.</td>
</tr>
<tr>
<td>ID Code:</td>
<td>Loop 2100, NM1 Crossover Carrier Name, NM109 Coordination of Benefits Carrier Identifier when NM108 is ‘PI’ - Payor Identification.</td>
</tr>
<tr>
<td>PATIENT:</td>
<td>Loop 2100, NM1 Patient Name, NM103 Patient Last Name, NM104 Patient First Name Initial</td>
</tr>
<tr>
<td>PCN:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP01 Patient Control Number</td>
</tr>
<tr>
<td>HIC:</td>
<td>Loop 2100, NM1 Patient Name, NM109 Patient identifier when NM108 is ‘HN’- Health Insurance Claim (HIC)</td>
</tr>
</tbody>
</table>
**SYSTEM LAYOUT/MAPPING**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVC FROM:</td>
<td>Loop 2100, DTM Statement From or To Date, DTM02 when DTM01 is ‘232’ - Claim Statement Period Start.</td>
</tr>
<tr>
<td>MRN:</td>
<td>Loop 2100, REF Other Claim Related Identification, REF02 when REF01 is ‘EA’ - Medical Record Identification Number.</td>
</tr>
<tr>
<td>CLAIM STAT:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP02 Claim Status Code.</td>
</tr>
<tr>
<td>THRU:</td>
<td>Loop 2100, DTM Statement From or To Date, DTM02 when DTM01 is ‘233’ - Claim Statement Period End.</td>
</tr>
<tr>
<td>ICN:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP07 Claim Payment Control Number.</td>
</tr>
<tr>
<td><strong>Charges:</strong></td>
<td></td>
</tr>
<tr>
<td>REPORTED</td>
<td>Loop 2100, CLP Claim Payment Information, CLP03 Total Claim Charge Amount.</td>
</tr>
<tr>
<td>NCVD/DENIED</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)</td>
</tr>
<tr>
<td></td>
<td>Loop 2110, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)</td>
</tr>
<tr>
<td>CLAIM ADJS</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18</td>
</tr>
<tr>
<td>COVERED</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 when AMT01 is ‘AU’ Coverage Amount.</td>
</tr>
<tr>
<td><strong>Days/Visits:</strong></td>
<td></td>
</tr>
<tr>
<td>COST REPT</td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA15 Total Cost Report Day Count</td>
</tr>
<tr>
<td>COV/UTIL</td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA01 Total Covered Days or Visits Count</td>
</tr>
<tr>
<td>NON-COVERED</td>
<td>Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 when QTY01 equals NE</td>
</tr>
<tr>
<td>COVD VISITS</td>
<td>Loop 2100, QTY Claim Supplemental Information Quantity when QTY01 equals 'CA' - Covered - Actual.</td>
</tr>
<tr>
<td>NCOVD VISITS</td>
<td>Loop 2100, QTY Claim Supplemental Information Quantity when QTY01 equals 'NE' - Non-Covered - Estimated.</td>
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### Payment Data:

<table>
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<tbody>
<tr>
<td><strong>DRG</strong></td>
<td>Loop 2100, CLP Claim Payment Information, CLP11 Diagnosis Related Group – DRG Code.</td>
</tr>
<tr>
<td><strong>DRG AMOUNT</strong></td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA04 Claim DRG Amount.</td>
</tr>
<tr>
<td><strong>DRG/OPER/CAP</strong></td>
<td>Loop 2000, MIA Inpatient Adjudication Information, MIA06 Claim Disproportionate Share Amount, plus MIA08 Claim PPS Capital Amount, plus MIA 18 Claim Indirect Teaching Amount.</td>
</tr>
<tr>
<td><strong>LINE ADJ AMT</strong></td>
<td>Loop 2110, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount.</td>
</tr>
<tr>
<td><strong>OUTLIER</strong></td>
<td>Loop 2100, AMT Claim Supplemental Information, Amt02 when Amt01 is ‘ZM’ Add-on Outlier.</td>
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<tr>
<td><strong>CAP OUTLIER</strong></td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA17 Claim PPS Capital Outlier Amount.</td>
</tr>
<tr>
<td><strong>CASH DEDUCT</strong></td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘1’.</td>
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<tr>
<td><strong>BLOOD DEDUCT</strong></td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘66’.</td>
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<tr>
<td><strong>CO INSURANCE</strong></td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘2, 3 and 122’.</td>
</tr>
<tr>
<td><strong>PAT REFUND</strong></td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘A0’.</td>
</tr>
<tr>
<td><strong>REIM RATE</strong></td>
<td>Loop 2100, MOA Outpatient Adjudication Information, MOA01 Reimbursement Rate.</td>
</tr>
<tr>
<td>SYSTEM LAYOUT/MAPPING</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is '23'.</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MSP PRIM PAYER</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is '89'.</td>
</tr>
<tr>
<td>PROF COMPONENT</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is '118'.</td>
</tr>
<tr>
<td>ESRD AMOUNT</td>
<td>Loop 2100, MOA Outpatient Adjudication Information, MOA02 Claim HCPCS Payable Amount.</td>
</tr>
<tr>
<td>PROC CD AMOUNT</td>
<td>Loop 2110, SVC Service Payment Information, SVC03 Line Item Provider Payment Amount, this will be the sum of all revenue lines.</td>
</tr>
<tr>
<td>ALLOW/REIM</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental information Amount when AMT01 equals 'I'.</td>
</tr>
<tr>
<td>INTEREST</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental information Amount when AMT01 equals 'I'.</td>
</tr>
<tr>
<td>CONTRACT ADJ</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45</td>
</tr>
<tr>
<td>PER DIEM AMT</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental information Amount when AMT01 equals 'DY'.</td>
</tr>
<tr>
<td>NET REIM AMT</td>
<td>Loop 2100, CLP Claim Payment Information, CLP04 Claim Payment Amount.</td>
</tr>
<tr>
<td>ADJ REASON CODES:</td>
<td>Loop 2100, CAS Claim Adjustment, CAS01 Claim Adjustment Group Code.</td>
</tr>
<tr>
<td>Group Codes</td>
<td>Loop 2100, CAS Claim Adjustment, Adjustment Reason Codes CAS02, CAS05, CAS08, CAS11, CAS14, CAS17.</td>
</tr>
<tr>
<td>Adjustment Amount</td>
<td>Loop 2100, CAS Claim Adjustment, Adjustment Amount CAS03, CAS06, CAS09, CAS12, CAS15, CAS18.</td>
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SINGLE CLAIM REPORT

Service Lines

<table>
<thead>
<tr>
<th>REV</th>
<th>DATE</th>
<th>HCPCS</th>
<th>APC/HIPPS</th>
<th>MODS</th>
<th>QTY</th>
<th>CHARGES</th>
<th>ALLOW/REIM</th>
<th>GC</th>
<th>RSN</th>
<th>AMOUNT</th>
<th>REMARK CODES</th>
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</tbody>
</table>

**First Revenue Line Headings:**

**REV**
Loop 2110, SVC Service Payment Information, SVC01-2 when SVC01-1 is ‘NU’ - National Uniform Billing Committee (NUBC) Codes.

**DATE**
Loop 2110, DTM Service Date, DTM02 when DTM01 is ‘472 - Service.

**HCPCS**
Loop 2110, SVC Service Payment Information, SVC01-2 when SVC01-1 is ‘HC’ - Health Care Common Procedural Coding System (HCPCS).

**APC/ HIPPS**
Loop 2110, REF Service Identification, REF02 when REF01 is ‘APC’ - Ambulatory Payment Classification or REF01 is ‘1S’ - Ambulatory Patient Group (APG) Number.
Loop 2110, SVC Service Payment Information, SVC01-2 when SVC01-1 is ‘HP’ - Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code.
SYSTEM LAYOUT/MAPPING

MODS
Loop 2110, SVC Service Payment Information, Procedure Modifiers SVC01-3, SVC01-4, SVC01-5, SVC01-6.

QTY
Loop 2110, SVC Service Payment Information, SVC05 Units of Service Paid Count.

CHARGES
Loop 2110, SVC Service Payment Information, SVC02 Line Item Charge Amount.

ALLOW/REIM GC
Loop 2110, SVC Service Payment Information, SVC03 Line Item Provider Payment Amount.
Loop 2110, CAS Claim Adjustment, CAS01 Claim Adjustment Group Code.

RSN
Loop 2110, CAS Claim Adjustment, Adjustment Reason Codes CAS02, 05, 08, 11, 14, 17.

AMOUNT
Loop 2110, CAS Claim Adjustment, Adjustment Amount CAS03, 06, 09, 12, 15, 18.

REMARK CODES
Loop 2110, LQ Health Care Remark Codes, LQ02 when LQ01 is ‘HE’ – Claim Payment Remark Codes.

Second Revenue Line Heading:
LICN
Loop 2110, REF Line Item Control Number, REF02 when REF01 is equal 6R.

HCPI
Loop 2110, REF Healthcare Policy Identification, REF02 when REF01 is 0K.

Third Revenue Line Headings:
SVC DESC
Loop 2110, SVC Service Payment Information, when SVC06-7 is present and greater than spaces.
Bill Type Summary Report

PC PRINT
BILL SUMMARY REPORT

Medicare National Standard Intermediary Remittance Advice

LR NPI Provider: 09/30/2008 PBSI - FISS
1806 N. Cloud Street PAID: 22/0 /1090 123 River Rd
LR AR 72202 CLM#: 3 LR AR 72207
NPI: 4321999771 TOB: 11

============================================================================= SUBTOTAL/TOTAL FOR BILL TYPE =============================================================================
CHARGES:  PAYMENT DATA:  0.00=REIM RATE
6900.00=REPORTED  0.00=DRG AMOUNT  0.00=MSP PRIM PAYER
4600.00=NCVD/DENIED  0.00=DRG/OPER/CAP  0.00=PROF COMPONENT
0.00=CLAIM ADJS  0.00=LINE ADJ
0.00=COVERED  0.00=OUTLIER  0.00=PROC CD AMOUNT
DAYS/VISITS  0.00=CAP OUTLIER
12=COST REPT  0.00=CASH DEDUCT
12=COVD/UTIL  0.00=BLOOD DEDUCT  0.00=INTEREST
0=NON-COVERED  0.00=COINSURANCE  0.00=CONTRACT ADJ
0=COVD VISITS  0.00=PAT REFUND  0.00=PER DIEM AMT
0=NCOV VISITS  0.00=NET REIM AMT
### Mapping 5010 835 to Bill Summary Report

<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NAME:</td>
<td>Loop 1000B, N1 Payee Identification, N102 Payee Name when N101 equals PE</td>
</tr>
<tr>
<td>FPE:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS303 Fiscal Period Date</td>
</tr>
<tr>
<td>INTERMEDIARY NAME</td>
<td>Loop 1000A, N1 Payer Identification, N102 Payer Name when N101 equals PR</td>
</tr>
<tr>
<td>PAYEE ADDRESS</td>
<td>Loop 1000B, N3 Payee Address, N301 Payee Address Line</td>
</tr>
<tr>
<td>PAID:</td>
<td>Header, BPR Financial Information, BPR16 Check/ EFT Date</td>
</tr>
<tr>
<td>INTERMEDIARY ADDRESS</td>
<td>Loop 1000A, N3 Payer Address, N301 Payer Address Line</td>
</tr>
<tr>
<td>PROVIDER CITY/ST/ZIP</td>
<td>Loop 1000B, N4 Payee City, State, and Zip Code, N401 City, N402 State or Province Code, N403 Postal Code</td>
</tr>
<tr>
<td>CLM#:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS304 Total Claim Count</td>
</tr>
<tr>
<td>INTERMEDIARY CITY/ST/ZIP</td>
<td>Loop 1000A, N4 Payer City, State and Zip Code, N401 City, N402 State or Province Code, N403 Postal Code</td>
</tr>
<tr>
<td>NPI:</td>
<td>Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ</td>
</tr>
<tr>
<td>TOB:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS302 Facility Type Code</td>
</tr>
</tbody>
</table>

**Charges:**

- **REPORTED**: Loop 2000, TS3 Provider Summary Information, T305 Total Claim Charge Amount
- **NCVD/DENIED**: Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)  
  Loop 2110, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)
CLAIM ADJS
Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18

COVERED
5010 835 TS306 is no longer used, thus this field is no longer populated.

**Days/ Visits:**

**COST REPT**
Loop 2000, TS2 Provider Supplemental Summary Information, TS212 Total Cost Report Day Count

**COV/ UTIL**
Loop 2000, TS2 Provider Supplemental Summary Information, TS213 Total Covered Day Count

**NON-COVERED**
Loop 2000, TS2 Provider Supplemental Summary Information, TS214 Total Non Covered Day Count

**COVD VISITS**
Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 Claim Supplemental Information Quantity when QTY01 equals VS. This is the sum of all claims in the LX loop.

**NCOVD VISITS**
Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 Claim Supplemental Information Quantity when QTY01 equals NE. This is the sum of all claims in the LX loop.

**Payment Data:**

**DRG Amount**
Loop 2000, TS2 Provider Supplemental Summary Information, TS201 Total DRG Amount

**DRG/ OPER/ CAP**
Loop 2000, TS2 Provider Supplemental Summary Information, TS202 Total Federal Specific Amount plus TS203 Total Hospital Specific Amount plus TS204 Total Disproportionate Share Amount plus TS206 Total Indirect medical Education Amount.

**OUTLIER**
Loop 2000, TS2 Provider Supplemental Summary Information, TS208 Total Day Outlier Amount plus TS209 Total Cost Outlier Amount.

**CAP OUTLIER**
Loop 2100, MIA Inpatient Adjudication Information, MIA17 Claim PPS Capital Outlier Amount. This is the sum of all claims in the LX Loop.

**CASH DEDUCT**
5010 835 TS319 is no longer used, thus this field is no longer populated.

**BLOOD DEDUCT**
5010 835 TS314 is no longer used, thus this field is no longer populated.

**CO INSURANCE**
5010 835 TS316 is no longer used, thus this field is no longer populated.
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAT REFUND</td>
<td>Loop 2000, TS3 Provider Summary Information, TS322 Total Patient Reimbursement Amount.</td>
</tr>
<tr>
<td>REIM RATE</td>
<td>Loop 2100, MOA Outpatient Adjudication Information, MOA01 Reimbursement Rate.</td>
</tr>
<tr>
<td>MSP PRIM PAYER</td>
<td>Loop 2000, TS3 Provider Summary Information, TS313 Total MSP Payer Amount.</td>
</tr>
<tr>
<td>PROF COMPONENT</td>
<td>Loop 2000, TS3 Provider Summary Information, TS320 Total Professional Component Amount.</td>
</tr>
<tr>
<td>LINE ADJ</td>
<td>Loop 2110, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount.</td>
</tr>
<tr>
<td>PROC CD AMOUNT</td>
<td>Loop 2000, TS3 Provider Summary Information, TS318 Total HCPCS Payable Amount.</td>
</tr>
<tr>
<td>INTEREST</td>
<td>5010 835 TS310 is no longer used, thus this field is no longer populated.</td>
</tr>
<tr>
<td>CONTRACT ADJ</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45</td>
</tr>
<tr>
<td>PER DIEM AMT</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when AMT01 equals ‘DY’. This will be the sum of all claims in the LX Loop.</td>
</tr>
<tr>
<td>NET REIM AMT</td>
<td>5010 835 TS309 is no longer used, thus this field is no longer populated.</td>
</tr>
</tbody>
</table>
Provider Payment Summary Report

Medicare National Standard Remittance Advice
Provider Summary Hospital
789 River Rd. 123 River Rd
LR FL 32206 LR AR 72207
NPI: 1821186313
CHECK / EFT NUMBER: 0000459988
================================================================================

PAYMENT SUMMARY
PAYMENT TOTAL: 2421.43 BILLING CYCLE: 12/03/2009
TOTAL CLAIMS: 4 TOTAL PIP CLAIMS: 0

FINANCIAL ADJUSTMENTS
L3/SW: 1000.00 L6/IN: -105.13 AP/AW: 150.00

Payer Business Contact Information
Telephone:
Telephone Extension:
Facsimile:
Electronic Mail:

Payer Technical Contact Information
Telephone:
Facsimile:
Electronic Mail:
Uniform Resource Locator (URL):
Payer Web Site Uniform Resource Locator (URL):
**SYSTEM LAYOUT/MAPPING**

**MAPPING 5010 835 TO BILL SUMMARY REPORT – Header**

**Report Field**  
**Loop Segment Data Element**

**PROVIDER NAME:** Loop 1000B, N1 Payee Identification, N102 Payee Name when N101 equals PE

**INTERMEDIARY NAME** Loop 1000A, N1 Payer Identification, N102 Payer Name when N101 equals PR

**PAYEE ADDRESS** Loop 1000B, N3 Payee Address, N301 Payee Address Line

**INTERMEDIARY ADDRESS** Loop 1000A, N3 Payer Address, N301 Payer Address Line

**PROVIDER CITY/ST/ZIP** Loop 1000B, N4 Payee City, State, and Zip Code, N401 City, N402 State or Province Code, N403 Postal Code

**INTERMEDIARY CITY/ST/ZIP** Loop 1000A, N4 Payer City, State and Zip Code, N401 City, N402 State or Province Code, N403 Postal Code

**NPI:** Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ

**CHECK/EFT NUMBER:** Header TRN Re-association Trace Number, TRN02 Check or EFT Trace Number

**MAPPING 5010 835 TO PAYMENT SECTION PAYEE – Payment Summary**

**Report Field**  
**Loop Segment Data Element**

**PAYMENT TOTAL:** Header, BPR Financial Information, BPR02 Total Actual Provider Payment Amount

**BILLING CYCLE:** Header, BPR Financial Information, BPR16 Check/ EFT Effective Date

**TOTAL CLAIMS:** Loop 2000, TS3 Provider Summary Information, TS304 Total Claim Count

**TOTAL PIP CLAIMS:** Loop 2000, TS3 Provider Summary Information, TS323 Total PIP Claim Count
### MAPPING 5010 835 TO FINANCIAL ADJUSTMENTS SECTION - PAYEE SUMMARY REPORT

<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADJUSTMENT REASON CODE</td>
<td>Summary, PLB Provider Adjustment, Adjustment Reason Code PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1</td>
</tr>
<tr>
<td>PROVIDER ADJUSTMENT IDENTIFIER</td>
<td>Summary, PLB Provider Adjustment, Provider Adjustment Identifier PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2</td>
</tr>
<tr>
<td>PROVIDER ADJUSTMENT AMOUNT</td>
<td>Summary, PLB Provider Adjustment, Provider Adjustment Amount PLB04, PLB06, PLB08, PLB010, PLB12, PLB14</td>
</tr>
</tbody>
</table>

### MAPPING 5010 835 TO CONTACT SECTION - PAYEE SUMMARY REPORT

<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAYER BUSINESS CONTACT INFORMATION</td>
<td>Report Section Header</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>Loop 1000A, PER Payer Business Contact Information, PER04 when PER03 is TE or PER06 when PER05 is TE.</td>
</tr>
<tr>
<td>TELEPHONE EXTENSION:</td>
<td>Loop 1000A, PER Payer Business Contact Information, PER06 when PER05 is EX or PER08 when PER07 is EX.</td>
</tr>
<tr>
<td>FACSIMILE:</td>
<td>Loop 1000A, PER Payer Business Contact Information, PER04 when PER03 is FX or PER06 when PER05 is FX.</td>
</tr>
<tr>
<td>ELECTRONIC MAIL:</td>
<td>Loop 1000A, PER Payer Business Contact Information, PER04 when PER03 is EM or PER06 when PER05 is EM.</td>
</tr>
<tr>
<td>PAYER TECHNICAL CONTACT INFORMATION</td>
<td>Report Section Header</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>Loop 1000A, PER Payer Technical Contact Information, PER04 when PER03 is TE or PER06 when PER05 is TE.</td>
</tr>
<tr>
<td>FACSIMILE:</td>
<td>Loop 1000A, PER Payer Technical Contact Information, PER06 when PER05 is FX or PER08 when PER07 is FX.</td>
</tr>
</tbody>
</table>
ELECTRONIC MAIL:
Loop 1000A, PER Payer Business Contact Information, PER04 when PER03 is EM or PER06 when PER05 is EM.

UNIFORM RESOURCE LOCATOR (URL):
Loop 1000A, PER Payer Technical Contact Information, PER04 when PER03 is UR or PER06 when PER05 is UR.

PAYER WEBSITE UNIFORM RESOURCE LOCATOR (URL):
Loop 1000A, PER Payer Web Site, PER04 when PER03 is UR.
## Home Health / Hospice All Claims Report

<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER/ NPI</td>
<td>Loop 1000B, N1 Payee Identification, N104 when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ</td>
</tr>
<tr>
<td>PROVIDER NAME:</td>
<td>Loop 1000B, N1 Payee Identification, N102 when N101 equal PE</td>
</tr>
<tr>
<td>FPE:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS303 Fiscal Period Date</td>
</tr>
<tr>
<td>INTERMEDIARY NAME</td>
<td>Loop 1000A, N1 Payer Identification, N102 when N101 equals PR</td>
</tr>
<tr>
<td>PAID:</td>
<td>Header, BPR Financial Information, BPR16 Check/ EFT Date</td>
</tr>
<tr>
<td>PAGE NUMBER:</td>
<td>PC Print sets the page</td>
</tr>
</tbody>
</table>

<p>| PATIENT NAME | Loop 2100, NM1 Patient Name, NM103 Last Name and NM104 First Name Initial |
| PATIENT CNTRL NUMBER | Loop 2100, CLP Claim Payment Information, CLP01 Claim Submitter’s Identifier |
| FRM DT | Loop 2100, DTM Statement From or To Date, DTM02 Claim Date when DTM01 equals 232 |
| COST | Loop 2100, MIA Inpatient Adjudication Information, MIA15 Cost Report Day Count |
| REPTD CHGS | Loop 2100, CLP Claim Payment Information, CLP03 Total Claim Charge Amount |
| SN DAYS | Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 55X, this field value |</p>
<table>
<thead>
<tr>
<th>FIELD</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS DAYS</td>
<td>Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 56X, this field value is equal to SVC05</td>
</tr>
<tr>
<td>REIMB RATE</td>
<td>Loop 2100, MOA Outpatient Adjudication Information, MOA01 Reimbursement Rate</td>
</tr>
<tr>
<td>ALLOW/REIM</td>
<td>Loop 2110, SVC Service Payment Information, SVC03 Line Item Provider Payment Amount, this will be the sum of all revenue lines.</td>
</tr>
<tr>
<td>INTEREST</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when AMT01 equals I Interest</td>
</tr>
<tr>
<td>ICN NUMBER</td>
<td>Loop 2100, CLP Claim Payment Information, CLP07 Payer Claim Control Number</td>
</tr>
<tr>
<td>HIC NUMBER</td>
<td>Loop 2100, NM1 Patient Name, NM109 Patient Identifier when NM108 equals HN</td>
</tr>
<tr>
<td>THR DT</td>
<td>Loop 2100, DTM Statement From or To Date, DTM02 Claim Date when DTM01 equals 233</td>
</tr>
<tr>
<td>COVDV</td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA01 Covered Days or Visits Count</td>
</tr>
<tr>
<td>NCVD/DENIED</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when adjustment code in CAS02, 05, 08, 11, 14, 17 equals any adjustment code except 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals any adjustment code except 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122</td>
</tr>
<tr>
<td>PT DAYS</td>
<td>Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 42X, 58X, 59X or 997, this field value is equal to SVC05</td>
</tr>
<tr>
<td>NA DAYS</td>
<td>Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 57X, this field value is equal to SVC05</td>
</tr>
<tr>
<td>MSP PRI PAY</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 23 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 23</td>
</tr>
<tr>
<td><strong>SYSTEM LAYOUT/MAPPING</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>PROC CD AMT</td>
<td>Loop 2100, MOA Outpatient Adjudication Information, MOA02 Claim HCPC Payable Amount</td>
</tr>
<tr>
<td>PAT REFUND</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals A0 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals A0</td>
</tr>
<tr>
<td>CLAIM #</td>
<td>PC Print Assigned</td>
</tr>
<tr>
<td>CLAIM STATUS</td>
<td>Loop 2100, CLP Claim Payment Information, CLP02 Claim Status Code</td>
</tr>
<tr>
<td>MEDICAL REC NUMBER</td>
<td>Loop 2100, REF Other Claim Related Identification REF02 Other Claim Related Identifier when REF01 is EA</td>
</tr>
<tr>
<td>NCVDV</td>
<td>Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 when QTY01 equals NE</td>
</tr>
<tr>
<td>CLAIM ADJ</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94 and 97 Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94 and 97</td>
</tr>
<tr>
<td>ST DAYS</td>
<td>Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 44X, this field value is equal to SVC05</td>
</tr>
<tr>
<td>COINS AMT</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 2, 3 and 122 Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 2, 3 and 122</td>
</tr>
<tr>
<td>PROF COMP</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 89 and Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 89</td>
</tr>
<tr>
<td>LINE ADJ AMT</td>
<td>Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45, 94 and 97</td>
</tr>
</tbody>
</table>
**DEDUCTIBLES**

Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when adjustment code in CAS02, 05, 08, 11, 14, 17 equals 1 and or 66 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals adjustment codes 1 and 66

**NATIONAL PROVIDER ID**

Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX

**HIC CHG = X**

Loop 2100, NM! Corrected Patient/Insured Name, NM109 Corrected Insured Identification Indicator when NM108 equal C Insured’s Changed Unique Identification Number

**TOB = XXX**

Loop 2100, CLP Claim Payment Information, CLP08 Facility Type Code in the first two positions of the XX and CLP09 Claim Frequency Code in the third position, last X

**CV LN**

Loop 2100, QTY Claim Supplemental Information, QTY02 Claim Supplemental Information Quantity when QTY01 equals CA Covered – Actual

**NCV L**

Not Used

**COVD CHGS**

Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental Information Amount when AMT01 equals AU Coverage Amount

**OT DAYS**

Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 43X, this field value is equal to SVC05

**ESRD AMT**

Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 118 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 118

**CONT ADJ AMT**

Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in CAS02, 05, 08, 11, 14, 17 equals 45

**NET REIMB**

Loop 2100, CLP Claim Payment Information, CLP04 Claim Payment Amount
Home Health / Hospice Single Claim Report

Medicare National Standard Intermediary Remittance Advice

FISS Hospital
321 Taylor Street
Jax AR 77234

FISS Hospital
321 Taylor Street
Jax AR 77234

PAID: 03/31/2009 123 River Rd

Jax AR 77234
CLM#: 1

NPI: 1033179510
TOB: 118

TRANSFER TO (COB): MEDICAID OF FISS
ID CODE: Z99999001

PATIENT: HAIRE H
HIC: 987654XXXA
SVC FROM: 10/01/2008
MRN: 20906200000000FLA

CLAIM STAT: 22
THRU: 10/04/2008
ICN: 20835400000008

CHARGES:
0.00=REPORTED
0.00=NCVD/DENIED
0.00=CLAIM ADJS
0.00=LINE ADJ AMT
0.00=COVERED

DAYS/VISITS:
3=COST REPT
0=COVD/UTIL
0=NON-COVERED
0=COVD VISITS
0=NCOV VISITS

ADJ REASON CODES: CO 45 -1550
PR 1 -1024

REMARK CODES: MA02
### MAPPING 5010 835 TO SINGLE CLAIM REPORT

<table>
<thead>
<tr>
<th>Report Field</th>
<th>Loop Segment Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NAME:</td>
<td>Loop 1000B, N1 Payee Identification, N102 Payee Name</td>
</tr>
<tr>
<td>FPE:</td>
<td>Loop 2000, TS3 Provider Summary Information, TS303 Fiscal Period Date</td>
</tr>
<tr>
<td>INTERMEDIARY NAME</td>
<td>Loop 1000A, N1 Payer Identification, N102 Payer Name</td>
</tr>
<tr>
<td>PAYEE ADDRESS</td>
<td>Loop 1000B, N3 Payee Address, N301 Payee Address Line</td>
</tr>
<tr>
<td>PAID:</td>
<td>Header, BPR Financial Information, BPR16 Check/ EFT Date</td>
</tr>
<tr>
<td>INTERMEDIARY ADDRESS</td>
<td>Loop 1000A, N3 Payer Address, N301 Payer Address Line</td>
</tr>
<tr>
<td>PROVIDER CITY/ ST/ ZIP</td>
<td>Loop 1000B, N4 Payee City, State, Zip Code, N401 City, N402 State, N403 Zip Code</td>
</tr>
<tr>
<td>CLM#:</td>
<td>PC Print Assigned</td>
</tr>
<tr>
<td>INTERMEDIARY CITY/ ST/ ZIP</td>
<td>Loop 1000A, N4 Payer City, State, Zip Code, N401 City, N402 State, N403 Zip Code</td>
</tr>
<tr>
<td>NPI:</td>
<td>Loop 1000B, N1 Payee Identification, N104 Payee Identification Code when N103 equals XX, else Loop 1000B, REF Payee Additional Identification, REF02 when REF01 equals PQ</td>
</tr>
<tr>
<td>TOB:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP08 Facility Type Code and CLP09 Claim Frequency Code.</td>
</tr>
<tr>
<td>TRANSFER TO (COB)</td>
<td>Loop 2100, NM1 Crossover Carrier Name, NM103 Coordination of Benefits Carrier Name.</td>
</tr>
<tr>
<td>ID CODE:</td>
<td>Loop 2100, NM1 Crossover Carrier Name, NM109 Coordination of Benefits Carrier Identifier when NM108 is ‘PI’ – Payor Identification.</td>
</tr>
<tr>
<td>PATIENT:</td>
<td>Loop 2100, NM1 Patient Name, NM103 Patient Last Name, NM104 Patient First Name and NM105 Patient Middle Name or Initial.</td>
</tr>
<tr>
<td>PCN:</td>
<td>Loop 2100, CLP Claim Payment Information, CLP01 Patient Control Number</td>
</tr>
</tbody>
</table>
### SYSTEM LAYOUT/MAPPING

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIC</td>
<td>Loop 2100, NM1 Patient Name, NM109 Patient identifier when NM108 is ‘HN’ Health Insurance Claim (HIC) Number.</td>
</tr>
<tr>
<td>SVC FROM</td>
<td>Loop 2100, DTM Statement From or To Date, DTM02 when DTM01 is ‘232’ Claim Statement Period Start.</td>
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<tr>
<td>MRN</td>
<td>Loop 2100, REF Other Claim Related Identification, REF02 when REF01 is ‘EA’ Medical Record Identification Number.</td>
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<tr>
<td>CLAIM STAT</td>
<td>Loop 2100, CLP Claim Payment Information, CLP02 Claim Status Code.</td>
</tr>
<tr>
<td>THRU</td>
<td>Loop 2100, DTM Statement From or To Date, DTM02 when DTM01 is ‘233’ Claim Statement Period End.</td>
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<tr>
<td>ICN</td>
<td>Loop 2100, CLP Claim Payment Information, CLP07 Claim Payment Control Number.</td>
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### Charges:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>REPORTED</td>
<td>Loop 2100, CLP Claim Payment Information, CLP03 Total Claim Charge Amount.</td>
</tr>
<tr>
<td>NCVD/DENIED</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)</td>
</tr>
<tr>
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<td>Loop 2110, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18 when CAS02, 05, 08, 11, 14, 17 does not equal 1, 2, 3, 23, 45, 66, 70, 89, 94, 97, 118, 122)</td>
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<tr>
<td>CLAIM ADJS</td>
<td>Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15, 18</td>
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<tr>
<td>LINE ADJ AMT</td>
<td>Loop 2110, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount.</td>
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<tr>
<td>COVERED</td>
<td>Loop 2100, AMT Claim Supplemental Information, AMT02 when AMT01 is ‘AU’ Coverage Amount.</td>
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### Days/Visits:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>COST REPT</td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA15 Total Cost Report Day Count</td>
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<tr>
<td>COV/UTIL</td>
<td>Loop 2100, MIA Inpatient Adjudication Information, MIA01 Total Covered Days or Visits Count</td>
</tr>
<tr>
<td>NON-COVERED</td>
<td>Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 when QTY01 equals NE</td>
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</tbody>
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COVD VISITS
Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 Claim Supplemental Information Quantity when QTY01 equals 'CA' - Covered - Actual.

NCOVD VISITS
Loop 2100, QTY Claim Supplemental Information Quantity, QTY02 Claim Supplemental Information Quantity when QTY01 equals 'NE' - Non-Covered - Estimated.

REIM RATE
Loop 2100, MOA Outpatient Adjudication Information, MOA01 Reimbursement Rate.

HHA SN AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 55X, this field value is equal to SVC05

HHA PT AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 42X, this field value is equal to SVC05

HHA ST AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 44X, this field value is equal to SVC05

HHA OT AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 43X, 978 this field value is equal to SVC05

HHA MS AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 56X, this field value is equal to SVC05

HHA NA AMT
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 57X, this field value is equal to SVC05

HSP ROUT CARE
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 651, this field value is equal to SVC05

HSP CONT CARE
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 652, this field value is equal to SVC05

HSP GENERAL
Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 656, this field value is equal to SVC05
HSP RESPITE  Loop 2110, SVC Service Payment Information, when SVC01-1 equals NU and SVC01-2 equals 655, this field value is equal to SVC05

HSP PHYS SVC  Loop 2110, SVC Service Payment Information, when SVC01-1 equals HC and SVC01-2 equals 657, this field value is equal to SVC05

HSP OTH  Loop 2110, SVC Service Payment Information, when SVC01-1 equals HC and SVC01-2 equals 659, this field value is equal to SVC05

COINSURANCE  Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘2, 3 and 122’.

MSP PRIM PAYER  Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘23’.

CASH DEDUCT  Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘1’.

PAT REFUND  Loop 2100, CAS Claim Adjustment, CAS03 Adjustment Amount, CAS06 Adjustment Amount, CAS09 Adjustment Amount, CAS12 Adjustment Amount, CAS15 Adjustment Amount, CAS18 Adjustment Amount when CAS02 is ‘A0’.

PROC CD AMOUNT  Loop 2100, MOA Outpatient Adjudication Information, MOA02 Claim HCPCS Payable Amount.

ALLOW/REIM  Loop 2110, SVC Service Payment Information, SVC03 Line Item Provider Payment Amount, this will be the sum of all revenue lines.

INTEREST  Loop 2100, AMT Claim Supplemental Information, AMT02 Claim Supplemental information Amount when AMT01 equals ‘I’.

CONTRACT ADJ  Loop 2100, CAS Claim Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in
SYSTEM LAYOUT/MAPPING

CAS02, 05, 08, 11, 14, 17 equals 45 and
Loop 2110, CAS Service Adjustment, CAS03, 06, 09, 12, 15 and 18 Adjustment Amount when Adjustment Code in
CAS02, 05, 08, 11, 14, 17 equals 45

NET REIM AMT
Loop 2100, CLP Claim Payment Information, CLP04 Claim Payment Amount.

ADJ REASON CODES:

Group Codes
Loop 2100, CAS Claim Adjustment, CAS01 Claim Adjustment Group Code.

Adjustment Reason Codes
Loop 2100, CAS Claim Adjustment, Adjustment Reason Codes CAS02, CAS05, CAS08, CAS11, CAS14, CAS17.

Adjustment Amount
Loop 2100, CAS Claim Adjustment, Adjustment Amount CAS03, CAS06, CAS09, CAS12, CAS15, CAS18.

REMARK CODES
Loop 2100, MIA Inpatient Adjudication Information, Claim Payment Remark Codes MIA05, MIA20, MIA21, MIA22, MIA23.
Loop 2100, MOA Outpatient Adjudication Information, Claim Payment Remark Code MOA03, MOA04, MOA05, MOA06, MOA07

SINGLE CLAIM REPORT
Service Lines

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<th>REV</th>
<th>DATE</th>
<th>HCPCS</th>
<th>APC/HIPPS</th>
<th>MODS</th>
<th>QTY</th>
<th>CHARGES</th>
<th>ALLOW/REIM</th>
<th>GC</th>
<th>RSN</th>
<th>AMOUNT</th>
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</table>

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First Revenue Line Headings:

- **Rev**: Loop 2110, SVC Service Payment Information, SVC01-2 when SVC01-1 is ‘NU’ - National Uniform Billing Committee (NUBC) Codes.
- **Date**: Loop 2110, DTM Service Date, DTM02 when DTM01 is ‘472’ - Service.
- **HCPCS**: Loop 2110, SVC Service Payment Information, SVC01-2 when SVC01-1 is ‘HC’ - Health Care Common Procedural Coding System (HCPCS).
- **APC/HIPPS**: Loop 2110, REF Service Identification, REF02 when REF01 is ‘APC’ - Ambulatory Payment Classification or REF01 is ‘1S’ - Ambulatory Patient Group (APG) Number.
- **MODS**: Loop 2110, SVC Service Payment Information, Procedure Modifiers SVC01-3, SVC01-4, SVC01-5, SVC01-6.
- **QTY**: Loop 2110, SVC Service Payment Information, SVC05 Units of Service Paid Count.
- **Charges**: Loop 2110, SVC Service Payment Information, SVC02 Line Item Charge Amount.
- **Allow/Reim**: Loop 2110, SVC Service Payment Information, SVC03 Line Item Provider Payment Amount.
- **GC**: Loop 2110, CAS Claim Adjustment, CAS01 Claim Adjustment Group Code.
- **RSN**: Loop 2110, CAS Claim Adjustment, Adjustment Reason Codes CAS02, 05, 08, 11, 14, 17.
- **Amount**: Loop 2110, CAS Claim Adjustment, Adjustment Amount CAS03, 06, 09, 12, 15, 18.
- **Remark Codes**: Loop 2110, LQ Health Care Remark Codes, LQ02 when LQ01 is ‘HE’ - Claim Payment Remark Codes.

Second Revenue Line Heading:

- **LICN**: Loop 2110, REF Line Item Control Number, REF02 when REF01 is equal 6R.
- **HCPI**: Loop 2110, REF Healthcare Policy Identification, REF02 when REF01 is 0K.

Third Revenue Line Headings:
| SVC Desc | Loop 2110, SVC Service Payment Information, when SVC06-7 is present and greater than spaces. |
THE END!