(N)

HEALTHPARTNERS (A)
8170 33RD AVE S
PO Box 1289
Minneapolis, MN 554401289
CONTACT: (B)
(952) 967-6633 or 1-866-429-1474
PAYER ID: (C)
SUPPLEMENTAL ID: (BANK) (D)

PAYEE: PROVIDER ORG NAME (E)
ADDRESS 1
ADDRESS 2
CITY, MN 12345-1234
PAYEE TAX ID: (F) 123456789
PAYEE NPI: (G) 1234567890
PAYEE ID (H) V12345678900001

PROD DATE: (I)01312009
CHECK/EFT DT (J)02012009
CHECK/EFT : (K)123456789
PAYMENT: (L)12345678.90
PAYMENT METHOD: (M)(ACH,CHK,NON)

PAT CTRL#: (1)XXXXXX CLM #: (2)xxxxxxxx CLM STATUS: (3)1 PAID PRIMARY CLM DT (6)01012009-01012009 CLM CHG: (4) 200.00
PATIENT: (5)DOEABCDEFGH, JOHN S **CLM PAYMENT (7)** 190.00
PATIENT ID: (8)123456789 GRP: (9)12345 CLM FILING IND: (10) BILLING PROVIDER: (29) **PAT RESP:** (11) 0.00 PRV LIAB **(12)** **0.00**
REND PROV ID: (13)1234567890 CLM RECEIVED DT: (14) FACILITY TYPE:(15) FREQ: (16) OTHER LIAB (17) 0.00 MNTAX (18) 0.00
MED REC #: (19)1234567890 DRG: (20) DRG WGHT: (21) COV EXP DT: (22) WITHHOLD (23) 0.00 COVERED: **(24)** **200.00**
CORRECTED PATIENT: (25) CORRECTED PATIENT ID: (26)
CORRECTED PRIORITY PAYER(27) OTHER SUBSCRIBER: (28)
CROSSOVER CARRIER: (30) ID: (31)
PMI (32) 123456789 CONTRACT: (33)PLEASE SUBMIT CLAIM TO CIGNA

REMARK CODES: (34)

CLM ADJ AMT(GRP CD/CLM ADJ RSN CD): (35.1(35.2/35.3))

LINE CTRL # (a)	DOS (b)	REV (c)	ADJUDICATED PROD/SVC/MOD (d)	SUBMITTED PROD/SVC/MOD (e)	CHARGE/ ALLOWED (f) (n)	# (g)	APC (h)	ADJ AMT (GRP CD/CLM ADJ RSN CD) (i.1(i.2/i.3))	REMARK CODE(S) (j)	REND PROV ID (k)	PAYMENT (l) (m)
001	01012009-01012009		C	A	100.00 200.00	001		-100.00(OA/94) 10.00(PR/1)	N19 C0213	1234567899	190.00
002	01012009-01012009		C	B	100.00 0.00	001		100.00(CO/97)			0.00

PROVIDER ADJUSTMENT(S):

PROV ADJ CD: (o)	PROV ADJ ID: (p)	PROV ADJ AMT: (q)
CS	12849081-81852719	S12345678.90

TOTAL PAYMENT AMT (r)S12345678
TOTAL MNTAX (s)
TOTAL WITHHOLD (t)

(u)
EXPLANATION OF CODE(S):

GRP CD	GROUP CODE DESCRIPTION	ADJ RSN	ADJUSTMENT REASON DESCRIPTION	REMARK CD	REMARK CODE DESCRIPTION
(CO)	provider liability	(125)	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	[C0213]	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

(v)
Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense.
OR
FOR REMITTANCE KEY INFORMATION GO TO: www.healthpartners.com/provider

Element	Field name	label	Usage	835 element
A	Payer Name and Address,	none	HealthPartners name, address	N102 where N101 = PR N3, N4
B	Payer contact	CONTACT	HealthPartners name of business contact area and contact phone numbers for local and long distance.	PER where PER01= CX
C	Payer ID	PAYER ID	1 followed by TIN	BPR10 TRN03
'D'	Supplemental ID	SUPPLEMENTAL ID	Field contains the BANK ID associated to the payment. BANK can be used to identify product line and to reconcile multiple remits to the same vendor.	TRN04
E	Payee Name and Address	PAYEE	Defines the entity to which payment is directed. .	N102 where N101 = PE N3, N4
F	Payee Tax ID	PAYEE TAX ID	Federal Tax ID or SSN assigned to payee.	N104 where N103 = FI or REF02 where REF01 = TJ
G	Payee NPI	PAYEE NPI	NPI associated to payee	N104 where N103=XX
H	PAYEE ID	PAYEE ID	Payer assigned ID -- Payee ID assigned by HealthPartners. This provides additional identification information critical to vendor balance that is not accommodated by the NPI. A single NPI may have multiple HPFIN's associated to it..	REF02 where REF01 = PQ
I	Production End Cycle Date	PROD DATE	The last date HealthPartners adjudicated claims appearing on this remittance advice.	DTM02 where DTM01 = 405
J	Check/EFT Date	CHECK/EFT DT	This is the check issue date or in the case of a non payment remittance this is the date the remittance was generated. Required on the top of each page of a multipage remittance.	BPR16

Element	Field name	label	Usage	835 element
K	Check/EFT trace Number	CHECK/EFT	This is a trace number which is used to re-associate payments and remittances, must be a unique number for this business purpose between the payer and the payee. This is the check number, EFT payment ID or in the case of a non-payment remittance it is a unique ID assigned to the remit.	TRN02
L	Payment Amount	PAYMENT	This is the total amount of payment that corresponds to the remittance advice. The total payment amount for this remit cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the remit cannot be issued for less than zero dollars	BPR02
M	Payment method	PAYMENT METHOD	Defines the way payment is transmitted: Check, EFT or no-payment. Values: CHK, ACH, NON	BRP04
N	Page number		Remittance page number	Na
1	Patient Control Number	PAT CTRL #	This is the first 20 bytes of the provider assigned identifier submitted on the claim (CLM01). If a identifier was not submitted the value is defaulted to‘0’. This data element is the primary key for posting the remittance information into the provider’s database.	CLP01
2	Payer Claim Control number	CLM #	This is the identifier assigned by HealthPartners that identifies the claim submission. For 5010 format this value will be the same on the original, void and the replacement.	CLP07

Element	Field name	label	Usage	835 element
3	Claim status	CLM STATUS	Claim status code and narrative definition. • Usage of Denied status changed for 5010-it is only used if the patient is not recognized and the claim is not forwarded to another payer. • Status 23 – not our claim, forwarded to additional payer(s) requires usage of crossover carrier • Status 1-3 processed as primary, secondary or tertiary are used regardless of whether any part of the claim was paid.	CLP02
4	Claim Charge Amount	CLM CHG	This is the total submitted charges for the claim. This amount can be positive, zero or negative.	CLP03
5	Patient Name	PATIENT	If claim was submitted in the 5010 837 format then this is the submitted patient name else this is the name that identifies the patient on the claim. Format is last, first middle initial. Field will be in bold. .	NM103,04,05,07 where NM101 = QC
6	Statement From and To Date	CLAIM DT	This is the service date range that applies to the entire claim.	DTM02 where DTM01 = 232 and 233
7	Claim Payment Amount	CLM PAYMENT	This is the total amount paid on this claim by HealthPartners. This amount can be positive, negative or zero.	CLP04
8	Patient Identifier	PATIENT ID	If claim was submitted in the 5010 837 format then this is the submitted patient ID. Else this is the identifier assigned by HealthPartners that identifies the patient. Field will be in bold.	NM109 where NM101=QC
9	Group or Policy Number	GRP	This is the HealthPartners group number associated to the patient's coverage.	REF02 where REF01 = 1L
10	Claim filing indicator	CLM FILING IND	Coded value, used to identify different product lines within a payer.	CLP06

Element	Field name	label	Usage	835 element
11	Patient Responsibility Amount	PAT RESP	This is the total patient responsibility amount for this claim. Amounts correspond to adjustments with grouping code of PR..	CLP05
12	Provider liability	PRV LIAB	Total provider liability amount applied to the claim other than the MNTAX or withhold amounts. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals CO (excluding adjustment reason codes 137 and 104). .	na
13	Rendering provider identifier	REND PROV ID	This is the payer assigned ID number or the National Provider Identifier of the provider who performed the service. Required if the rendering provider identifier is different than the payee ID. Element should contain the NPI or the payer assigned ID number for atypical providers. Field contains either NPI or UMPI.	NM109 where NM108=XX Or NM109 where NM108 = PC
14	Claim received date	CLM RECEIVED DT	Date claim was received by HPI	DTM02 where DTM01=050
15	Facility type	FACILITY TYPE	For the 5010 remit format this element is populated on all claim types. Required when the information was received on the original claim. Professional and dental default to POS from first line	CLP08
16	Claim Frequency	FREQ	Submitted claim frequency. For 5010 remit format this element is used on all transaction types and is required if submitted on the original claim.	CLP09
17	Other liability	OTHER LIAB	Total other liability amount applied to the claim. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals OA	na

Element	Field name	label	Usage	835 element
18	MNTAX	MNTAX	Total MNTax payment amount applied to the claim. The sum of all claim and line level adjustments associated to adjustment reason codes 137. For this field, the MNTAX payment amount is not reflected as a negative, unless it is a voided claim. If no mntax amount then the value will equal zero	AMT02 where AMT01=T
19	Medical Record Number	MED REC #	This is the provider assigned medical record number that was submitted on the claim.	REF02 where REF01 = EA
20	Diagnosis Related Group Code	DRG	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP11
21	Diagnosis Related Group Weight	DRG WGHT	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP12
22	Coverage expiration date	COV EXP DT	If claim is denied because of the expiration of coverage, this is the date coverage expired.	DTM02 where DTM01=036
23	Withhold	WITHHOLD	Total withhold amount adjusted from the claim. Sum of claim and line level amounts associated to adjustment reason 104 If no withhold amount then the value will equal zero.	na
'24	Covered amount	COVERED	This is the amount of charges considered as eligible for coverage This is the sum of the original submitted provider charges that are considered for payment under the benefit provisions of the health plan. This excludes charges considered not covered (i.e. per day television or telephone charges) but includes reductions to payments of covered services (i.e reductions for amounts over fee schedule and patient deductibles**).**	AMT*AU

Element	Field name	label	Usage	835 element
25	CORRECTED PATIENT NAME	CORRECTED PATIENT	If claim was submitted in the 5010 837 format and the patient info does not match HealthPartners eligibility then this field contains the values that are different. Only the elements that are different are populated not necessarily the full name	NM1*74
26	Corrected patient ID	CORRECTED PATIENT ID	If the claim was submitted in the 5010 837 format and the patient ID does not match HealthPartners eligibility then this field contains the value from HPI eligibility.	NM109
27	Corrected Priority Payer	CORRECTED PRIORITY PAYER	This is the name of the payer that has priority over HealthPartners in making payment. For 5010 remit format, this element is only populated when HealthPartners has identified a payer primary to the HPI coverage and the COB loop was not submitted on claim.	NM103 where NM101 = PR
28	Other subscriber name	OTHER SUBSCRIBER	Populated for 5010 when a priority payer has been identified.	NM103 NM104 Where NM101=GB
29	BILLING PROVIDER:	BILLING PROVIDER:	Subsidiary provider ID, used when payment is made to other than the billing entity. For the 5010 remit format this element is populated when the submitted billing NPI is different than the payee NPI.	TS301
30	Crossover carrier name	CROSSOVER CARRIER	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23).	NM103 where NM101=TT
31	Crossover carrier ID	ID	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23). .	NM109 where NM101=TT
32	Patients Medicaid Identifier	PMI	MEDICAL ASSITANCE NUMBER	REF 02 where REF01=1W

Element	Field name	label	Usage	835 element
33	Contract Code	Contract	The contract that was used between the payer and the provider to determine payment. Populate with CIGNA misdirect message when claim should have been submitted under the CIGNA contract or the PMAP program code	REF01 where REF02=CE
34	Remark codes	REMARK CODES	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone or are not associated to a dollar adjustment. Claim can contain up to five claim level remark codes . For Non MN providers field may contain an internal remit remark code. .	MIA/MOA
35.1	Claim adjustment amount	CLM ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per claim. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts must equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS

Element	Field name	label	Usage	835 element
35.2	Claim Adjustment group code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. OA Other adjustments- avoid using OA except for business situations defined in HIPAA guide. PI Payor Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS
35.3	Claim adjustment reason code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount.	CAS
a)	Line Item control number	LINE CTRL #	Line item identifier submitted by the provider to identify the line or if control number is not submitted than the claim line number	REF02 where REF01 = 6R
b)	Dates of Service	DOS	This is the date range of services for each line. Format is MMDDCCYY-MMDDCCYY.	DTM02
c)	Revenue Code	REV	Element applies to institutional claims only. This is the revenue code submitted on the claim line.	SVC04 or SVC01-2
d)	Adjudicated Product/Service Code/Modifiers	ADJUDICATED PROD/SVC/MOD	This is the adjudicated procedure code and modifiers. Values can be HCPC, or ADA codes.	SVC01
e)	Submitted Product/Service Code/Modifiers	SUBMITTED PROD/SVC/MOD	If the code used for adjudication is different than the submitted value, than the submitted value is contained in this element.	SVC06

Element	Field name	label	Usage	835 element
f)	Line Item Charge or Billed Amount	CHARGE	This is the line item charge/billed amount that was submitted on the line.	SVC02
g)	Units	#	This is the number of paid units of service.	SVC05
h)	APC	APC	Element applies to institutional only. A value is present if adjudication considered the APC.	REF02 where REF01 = APC
i.1	Claim Adjustment Amount	ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per line. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts should equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS
i.2	Claim Adjustment Grouping Code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. OA Other adjustments- avoid using OA except for business situations defined in HIPAA guide. PI Payor Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS

Element	Field name	label	Usage	835 element
i.3	Claim Adjustment Reason Code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount. Narrative values of codes are available at www.wpc-edi.com	CAS
j)	Remittance Advice Remark Code	REMARK CODE	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone. If claim line has multiple adjustment reasons the remark code is not in relationship to the adjustment reason across from it but to the line. This is the same relationship as the 835 electronic transaction. If the facility is outside of MN, we will also supply some legacy codes. These legacy remarks primarily define our National Network utilization.	LQ
k)	Payment Amount	PAYMENT	This is the payment amount corresponding to the adjudicated service line. The line item billed amount minus the line item adjustment amounts must equal the line item payment amount.	SVC03
l)	Rendering provider ID	REND PROV ID	This is the NPI or atypical ID of the rendering provider if the value is different than the claim level.	REF
m)	Submitted procedure code description	No label	If a description was received on the original service for a not otherwise classified procedure and the adjudicated procedure is different than the submitted value.	SVC06-7
n)	Allowed amount		Allowed amount is the amount the payer deems payable prior to considering patient responsibility	AMT02 where AMT01=B6
o)	Provider adjustment reason Code	PROV ADJ CD	This is the reason for the provider adjustments that are not specific to a particular claim or service. Multiple adjustments may apply to the payment. .	PLB0

Element	Field name	label	Usage	835 element
p)	Provider Adjustment Identifier	PROV ADJ ID	For 5010 remit format the ID will vary by reason code: Adjustment codes are used as defined in the HIPAA guide.	PLB
q)	Provider Adjustment Amount	PROV ADJ AMT	This is the monetary amount of the adjustment. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	PLB
r)	Total payment	TOTAL PAYMENT AMT		NA
s)	Total mntax amount	TOTAL MNTAX	Total MNTAX payment amount applied to the check for all claims on the remittance.	NAa
t)	Total withhold amount	TOTAL WITHHOLD	Total withhold amount adjusted from check for all claims on the remittance. .	NA
u)	Explanation of code(s)	EXPLANATION OF CODE(S)	Narrative description of grouping codes, adjustment codes and remark codes contained in remit.	NA
v)			Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense. FOR REMITTANCE KEY INFORMATION GO TO: www.healthpartners.com/provider	