



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

gainwell

Delaware Medicaid Enterprise System Health Care Claim:

Professional, Institutional, Dental (837) Transaction
Standard Companion Guide

Companion to Health Care Claims ASC X12N 837
005010X222

ASC X12N 837 005010X223 ASC X12N 837 005010X224
Implementation Guides

Change History

Version #	Date	Modified By	Description
9.0	January 2026	Gainwell Technologies	CAS02 Claim Adjustment Reason Code added to Table 1, Table 2, and Table 3
8.0	April 2021	Gainwell Technologies	Global update for Gainwell Technologies
7.0	October 2020	Gainwell Technologies	8371 & 837P Added DSCYF to Loop 2010BB NM109
6.0	January 2019	EDI Department	All monetary, 9-digit references were updated to reflect acceptance of 10-digit figures
5.0	August 2018	EDI Department	8371 2320 (SBR09) Added 16 Qualifier
4.0	June 2018	EDI Department	Update for Encounter Claims 837P & 835D 2310B & 2430A (NM103) 8371 2310D & 2420C (NM103)
3.0	October 2017	EDI Department	Section 1 INTRODUCTION - REFERENCES <ul style="list-style-type: none"> Removed the sentence: Data Interchange Standards Association at www.disa.org Section 10 TRANSACTION SPECIFIC INFORMATION <ul style="list-style-type: none"> Documentation-only update to 837 Professional Loop 2300 Element REF02 Name Payer Claim Control Number or ICN <ul style="list-style-type: none"> Changed 15-digit ICN to 13-digit ICN
2.0	July 2017	EDI Department	Update to DXC Technology
1.0	December 2016	EDI Department	Initial release for DMES

Disclosure Statement

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Preface

This Companion Guide to the Health Care Claims (837s) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Delaware Medicaid Enterprise System (DMES). Transmissions based on this Companion Guide, used in tandem with the **ASC X12N 837 005010X222 and the associated errata 005010X222A1; ASC X12N 837 005010X223 and the associated errata 005010X223A1 and 005010X223A2; ASC X12N 837 005010X224 and the associated errata 005010X224A1; and 005010X224A2 Implementation Guides**, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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Introduction

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

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

The HIPAA regulations at 45 CFR 162.915 require that covered entities **not** enter into transition partner agreements that would do any of the following:

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

Scope

The Companion Guide is to be used with, and to supplement, the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the Companion Guide is to provide trading partners with a guide to communicate Delaware Medicaid Enterprise System (DMES) specific information required to exchange transactions successfully.

The Companion Guide is intended for business and technical users, within or on behalf of trading partners, and who are responsible for the testing and setup of electronic claim status request and response transactions to DMES.

Overview

This section of the Companion Guide will provide guidance for establishing a relationship with DMES for the business purpose of doing Health Care Claims (837s).

References

This section specifies additional on-line sources of helpful information related to electronic data interchange and X12 transactions.

ASC X12 at www.X12.org

ACA Section 1104 information is at the CMS website. For information on ACA Administrative Simplification information, follow this link:

<https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA>

Additional Information

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this Companion Guide. TR3s can be purchased from the ASC X12 store at <http://store.x12.org/store/>.

Getting Started

Working with Delaware DMES

The Electronic Data Interchange (EDI) Department is available to assist trading partners when questions arise.

Trading Partner Registration

Trading Partner registration is completed through the secure Delaware Medical Assistance Program (DMAP) provider portal. All required fields must be completed, and an electronic signature must be included.

Certification and Testing Overview

All covered entities who submit electronic transactions are required to certify. This includes Clearing Houses, Software Vendors, Provider Groups, and Managed Care Organizations (MCOs). If you submit your claims through one of these agencies, they will certify on your behalf. However, if you submit your own claims, you will need to certify. If you submit your claims through an MCO, you should receive information from the MCO regarding certification requirements.

Testing with the Payer

Testing is required for Health Care Claims (837s).

Connectivity with the Payer/Communications

You must register and access the secure DMAP provider portal in order to upload EDI files. To register/logon to the DMAP provider portal:

<https://medicaid.dhss.delaware.gov>

Contact Information

EDI Customer Service

Please contact the Delaware EDI Department at 800-999-3371 Option 0, Option 2 or send inquiries via email to DelawareECSTGroup@gainwelltechnologies.com.

Applicable Websites

<https://medicaid.dhss.delaware.gov>

Control Segments/Envelopes

ISA-IEA

This section describes the use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

ISA01 - Value "00" is expected in this data element. ISA02 - No data is expected in this data element.

ISA03 - Value "00" is expected in this data element. ISA04 - No data is expected in this data element. ISA05 - Value "ZZ" is expected in this data element.

ISA06 - The Gainwell Technologies (Gainwell) Electronic Transaction Identification Number (ETIN) assigned to the submitter is expected in this data element. This is the same as your Trading Partner ID.

ISA07 - Value "ZZ" is expected in this data element.

ISA08 - The Gainwell ETIN "345724166" is expected in this data element. ISA12 - Value "00501" is expected in this data element.

ISA14 - Value "1" is expected in this data element if you wish to receive a TA1 response. ISA15 - Value "P" is expected for production data and value "T" is expected for test data. ISA16 - A colon (:) is expected as the component element separator.

GS-GE

This section will describe how similar transaction sets will be packaged and how DMES uses functional group control segments and numbers. It includes a description of expected application sender and receiver codes. This section also includes a description of how DMES expects functional groups to be sent and how DMES will send functional groups.

GS08 - Value "005010X222A1" for Professional, "005010X223A2" for Institutional, or "005010X224A2" for Dental is expected in this data element.

ST-SE

This section describes the use of transaction set control numbers.

ST03 - Value "005010X222A1" for Professional, "005010X223A2" for Institutional, or "005010X224A2" for Dental is expected in this data element.

Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.

Payer Specific Business Rules and Limitations

Payer specific business rule information regarding DMES can be found at this website:

<https://medicaid.dhss.delaware.gov>

Acknowledgements and/or Reports

The acknowledgement process will create the TA1 (if ISA14 has a value of '1') and the 999 acknowledgement for the inbound transactions.

Trading Partner Agreements

An Electronic Data interchange (EDI) Trading Partner is defined as any DMES customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from DMES.

Payers have EDI Trading Partner Agreements (TPAs) that accompany the standard Implementation Guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information between each party to the agreement, whether the agreement is an entity or a part of a larger agreement.

Transaction Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that DMES has additional information (over and above) the information in the IGs. The information can:

1. Limit the repeat of loops, or segments;
2. Limit the length of a simple data element;
3. Specify a sub-set of the IG's internal code listings;
4. Clarify the use of loops, segments, composite, and simple data elements; and/or
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with DMES.

In addition to the row for each segment, one or more additional rows are used to describe DMES's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

All DMES members are considered "subscribers," so they all have individual loops. See the Implementation Guide for additional information.

ETIN –This is the number that is assigned to the provider/submitter to identify their electronic transaction uniquely. This may also be referred to as the Trading Partner ID.

Naming Your Files

When uploading files, the submitter should name the files using the following format for faster processing and tracking purposes:

For FFS claims:

1. **FFS** is the acronym for Fee-for-Service.
2. **<SubmitterId>** is the trading partner ID [a/k/a submitter ID] that was assigned. This is to be used by all providers, vendors, and clearinghouses that submit batch transactions.
3. **<filename>** is assigned, preferable meaningful to receiver such as '837P fee for service'.
4. **<datetime>** is the date and time the file was submitted. The format is: yyyyymmddhhmm (year, month, day, hour, minute). This format allows the filename to be uniquely identified and helps to avoid duplicate files.
5. **<filetypeext>** is a file type extension, so that the file can be identified. Must end with ".txt".

Examples

FFS-<SubmitterId>-<filename><datetime>.<filetypeext>

FFS-1234-837Pfeeforservice201510101308.txt

For MCO claims:

1. **MCO** is the acronym of Managed Care Organization.
2. **<SubmitterId>** is the trading partner ID [a/k/a submitter ID] that was assigned. This is to be used by all providers, vendors, and clearinghouses that submit batch transactions. MCO is assigned, preferable meaningful to a receiver such as 'encounter' followed by a unique ID. This is to be used by Managed Care Organizations submitting encounter claims.
3. **<filename>** is assigned, preferable meaningful to receiver such as '837P fee for service'.
4. **<transaction type>** is the type of transaction:
 - a. **P** – Professional
 - b. **I** – Institutional
 - c. **D** – Dental
5. **<datetime>** is the date and time the file was submitted. The format is: yyyyymmddhhmm (year, month, day, hour, minute). This format allows the filename to be uniquely identified and helps to avoid duplicate files.
6. **<datetime>** using a datetime value ccccmddhhmm allows the filename to be uniquely identified and helps to avoid duplicate files.
 - **<filetypeext>** is a file type extension, so that the file can be identified. Must end with "837.txt".

Examples

MCO_<SubmitterId>_<filename>_<transaction type>_<datetime>.<filetypeext>

MCO_XXXXXXXX_ENCOUNTER_x_201611101308.837.txt

Table 1: 837 Professional

Loop	Element	Name	Instructions
	BHT	Beginning of Hierarchical Transactions	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2000A	PRV	Billing Provider Specialty information	This segment is now required for all DMAP claims.
	PRV03	Provider Taxonomy Code	The taxonomy the provider is enrolled with DE Medicaid should be submitted
2010BA	NM1	Subscriber Name	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID Number	This is the ten-digit Delaware Medical Assistance Identification number as listed on the Delaware Medical Assistance program card
2010BB	NM1	Payer Name	
	NM109	Payer Identifier	Enter DE_TXIX DSCYF Providers Only – Enter DSCYF
	REF	Billing Provider Secondary Identification	This is the Atypical DE Provider Number
	REF01	Reference Identification Qualifier	G2 - Provider Commercial Number or Atypical Provider Number
	REF02	Atypical Provider Number	The DMAP Atypical Provider Number submitted here when an NPI is not billed in the 2010AA NM109 loop and segment
2300	CLM	Claim Information	
	CLM01	Patient Control Number	Maximum 20 Bytes, Number will be returned on 835 Transactions
	CLM02	Monetary Amount or Total Claim Charge	Maximum of 10 digits including the cents data elements
	REF	Payer Claim Control Number	
	REF02	Payer Claim Control Number or ICN	Enter the DMAP assigned 13-digit ICN when voiding/replacing a previously paid claim
	REF	Medical Record Number	
	REF02	Medical Record Number	Maximum length of 30 bytes supported
	PWK	Claim Supplemental Information	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits)

The Sequence Number needs to be unique for each Attachment Control Number assigned.

2310B	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	Encounter Claims only: The Rendering Provider's service location is determined from the NM103 field for encounter claims. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2310B	PRV	Rendering Provider Specialty Information	
	PRV03	Reference Identification	DMAP uses rendering provider taxonomy in adjudication.
2320	SBR	Other Subscriber Information	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim filing indicator code	MB - Medicare Part B- this is expected if Medicare is the primary Other payer. HM - Health Maintenance Organization- if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this "HM" value must be used. 16 - Health Maintenance Organization (HMO) Medicare Risk – This "16" value must be used for Medicare Advantage Plans. Otherwise, select the claim filing indicator that is appropriate for the Other Payer.
	CAS	Claim Level Adjustments	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	Coordination of Benefits (COB) Payer Paid Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	Coordination of Benefits (COB) Total	

Non-Covered Amount			
AMT02		Monetary Amount	Maximum of 10 digits including the cents
AMT		Remaining Patient Liability Amount	
AMT02		Monetary Amount	Maximum of 10 digits including the cents
2330B	NM1	Other Payer Name	
NM108		Identification Code Qualifier	PI - Payer Identification
NM109		Identification Code	When the claim is an encounter and this iteration of the COB loop uses the 'HM' claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number. Otherwise, the rules below are used. Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 (Insurance_carrier_crosswalk)
2400	SV1	Professional Service	
SV101		Composite Medical Procedure Identifier	
SV101-2		Procedure Code	If a drug is being billed, an appropriate J-code or other drug related HCPCS code must be used
SV102		Monetary Amount	Maximum of 10 digits including the cents data elements
PWK		Claim Supplemental Information	Required on claims with attachments
PWK06		Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2410	LIN	Drug Identification	Required when Loop 2400 procedure code is a drug-related HCPCS code
2420A	NM1	Rendering Provider Name	
NM103		Name Last or Organization Name	Encounter Claims only: If submitted at the detail, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.

2430	SVD	Line Adjudication Information	If there is an Other Payer payment at the claim level in 2320, detail payments are required in this 2430 loop
	SVD02	Monetary Amount or Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	Line Adjustment	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	CAS02	Claim Adjustment Reason Code	For MCO Encounter claims, for each denied detail, send the CARC of 256.
	AMT	Remaining Patient Liability	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents

Table 2: 837 Institutional

Loop	Element	Name	Instructions
	BHT	Beginning of Hierarchical Transactions	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2000A	PRV	Billing Provider Specialty Information	This is required for all DMAP claims
	PRV03	Provider Taxonomy Code	The taxonomy the provider is enrolled with DE Medicaid should be submitted
2010BA	NM1	Subscriber Name	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID	Ten-digit Delaware Medical Assistance Identification Number as listed on the Delaware Medical Assistance program card
2010BB	NM1	Payer Name	
	NM109	Payer Identifier	Enter DE_TXIX DSCYF Providers Only – Enter DSCYF
	REF	Billing Provider Secondary Identification	Atypical DE Provider Number
	REF01	Reference Identification Qualifier	G2 - Provider Commercial Number or Atypical Provider Number
	REF02	Atypical Provider Number	
2300	CLM	Claim Information-Header	
	CLM01	Patient Control Number	Maximum of 20 bytes Number will be returned on 835 transaction
	CLM02	Monetary Amount or Total Claim Charge Amount	Maximum of 10 digits including the cents data elements
	REF	Medical Record Number	
	REF02	Medical Record Number	Maximum of 30 bytes supported
	PWK	Claim Supplemental Information	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2310A	PRV	Attending Provider Specialty Information	
	PRV03	Provider Taxonomy	DMES uses attending provider taxonomy in

		Code	adjudication
2310D	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	Encounter Claims only: The Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2320	SBR	Other Subscriber Information	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim Filing Indicator Code	<p>MA - Medicare Part A – this is expected if Medicare Part A is the primary Other Payer</p> <p>MB - Medicare Part B – this is excepted if Medicare Part B is the primary Other Payer</p> <p>HM – Health Maintenance Organization – if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this 'HM' value must be used.</p> <p>16 - Health Maintenance Organization (HMO) Medicare Risk – This will be used for Medicare Advantage Plans</p> <p>Otherwise, select, the claim filing indicator that is appropriate for the Other Payer</p>
CAS		Claim Level Adjustments	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
AMT		Coordination of Benefits (COB) Payer Paid Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
AMT		Remaining Patient Liability Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
AMT		Coordination of Benefits (COB) Total	

Non-Covered Amount		
AMT02	Monetary Amount	Maximum of 10 digits including the cents
2330B	NM1	Other Payer Name
NM108	Identification Code Qualifier	PI - Payer Identification
NM109	Identification Code	<p>When the claim is an encounter and this iteration of the COB loop uses the 'HM' claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number, otherwise, the rules below are used</p> <p>Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 Insurance carrier crosswalk</p>

2400	SV2	Institutional Service Line	
	SV201	Service Line Revenue Code	
	SV203	Line Item Charge Amount	Maximum of 10 digits including the cents data elements
	PWK	Claim Supplemental Information	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2410	LIN	Drug Identification	<i>(Note: Required when Loop 2400 procedure code is a drug-related HCPCS code.)</i>
2420C	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	Encounter Claims only: If submitted at the detail, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2430	SVD	Line Adjudication Information	If there is an Other Payer payment at the claim level in 2320, and the claim is not an inpatient, inpatient crossover, or nursing home claim, detail payments are required in this 2430 loop
	SVD02	Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	Line Adjustment	On claim submissions where an Other Payer is primary and has approved the claim and the claim is not an inpatient, inpatient crossover, or nursing home claim, the paid amount, paid date, and claim adjustment reasons /amounts are required at this level
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	CAS02	Claim Adjustment Reason Code	For MCO Encounter claims, for each denied detail, send the CARC of 256.

Table 3: 837 Dental

Loop	Element	Name	Instructions
	BHT	Beginning of Hierarchical Transactions	
	BHT06	Transaction Type Code	CH - Providers billing fee-for-service RP - MCO submitting encounters
2010BA	NM1	Subscriber Name	
	NM108	Identification Code Qualifier	MI - Member Identification Number
	NM109	Subscriber Client ID Number	This is the ten-digit Delaware Medical Assistance Identification number as listed on the Delaware Medical Assistance Program card
2010BB	NM1	Payer Name	
	NM109	Payer Identifier	Enter DE_TXIX
2300	CLM	Claim Information	
	CLM01	Patient Control Number	Maximum 20 Bytes, Number will be returned on 835 Transactions
	CLM02	Monetary Amount or Total Claim Charge	Maximum of 10 digits including the cents data elements
	PWK	Claim Supplemental Information	Required on claims with attachments
	PWK06	Attachment Control Number	The formula for the Attachment Control Number is Provider NPI (or Atypical ID Number) plus Member ID plus From Date of Service plus Sequence Number (4 numeric digits) The Sequence Number needs to be unique for each Attachment Control Number assigned
2310A	PRV	Referring Provider Specialty Information	<i>(Required if referring provider is sent on claim)</i>
	PRV03	Provider Taxonomy Code	DMES uses referring provider taxonomy in adjudication
2310B	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	Encounter Claims only: The Rendering Provider's service location is determined from the NM103 field for encounter claims. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2310B	PRV	Rendering Provider Specialty Information	
	PRV03	Provider Taxonomy Code	DMES uses rendering provider taxonomy in adjudication

2320	SBR	Other Subscriber Information	For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information will be included in this loop
	SBR09	Claim filing indicator code	<p>MB - Medicare Part B- this is expected if Medicare is the primary Other payer</p> <p>HM - Health Maintenance Organization- if the claim is an encounter claim being submitted by a Managed Care Organization (MCO) and the Other Payer data reflects the MCO payment information, this "HM" value must be used</p> <p>Otherwise, select the claim filing indicator that is appropriate for the Other Payer</p>
	CAS	Line Adjustment	
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Monetary Amount	Maximum of 10 digits including the cents
	AMT	Coordination of Benefits (COB) Payer Paid Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	Remaining Patient Liability Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
	AMT	Coordination of Benefits (COB) Total Non-Covered Amount	
	AMT02	Monetary Amount	Maximum of 10 digits including the cents
2330B	NM1	Other Payer Name	
	NM108	Identification Code Qualifier	PI - Payer Identification
	NM109	Identification Code	<p>When the claim is an encounter and this iteration of the COB loop uses the 'HM' claim filing indicator to identify the MCO, this data element will contain the DMAP Atypical Provider number, otherwise, the rules below are used</p> <p>Value expected in data element is the National Electronic Insurance Code (NEIC) These codes can be found at: http://www.emdeon.com/payerlists or https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=34 Insurance carrier crosswalk</p>

2400	SV3	Dental Service	
	SV302	Line item charge amount	Maximum of 10 digits including the cents data elements
2420A	NM1	Rendering Provider Name	
	NM103	Name Last or Organization Name	Encounter Claims only: If submitted at the claim level, the Rendering Provider's service location is determined from the NM103 field. The MCO will place the Medicaid ID (MCD ID) of the Rendering provider in the NM103 element then followed by a space, and then rest of the name that will fit in the data element. If the name is too big, the name is truncated.
2430	SVD	Line Adjudication Information	If there is an Other Payer payment at the claim level in 2320, detail payments are required in this 2430 loop
	SVD02	Service Line Paid Amount	Maximum of 10 digits including the cents data elements
	CAS	Line Adjustment	
	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Monetary Amount	Maximum of 10 digits including the cents
	CAS02	Claim Adjustment Reason Code	For MCO Encounter claims, for each denied detail, send the CARC of 256.