837 INSTITUTIONAL & PROFESSIONAL CLAIMS
Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Adheres to the CORE v5010 Master Companion Guide Template

July 2025 | v .9

Disclosure Statement

This document is intended for billing providers and trading partners who exchange or have an interest in exchanging electronic claims and their related transactions with CareCentrix. The information contained herein is provided solely for educational purposes and should not be treated as a legally binding document. This document is to be used in conjunction with the Accredited Standards Committee (ASC) X12 Implementation Guides to define electronic transaction requirements. It does not define any billing policies specific to CareCentrix or its health plan partners.

Preface

This Companion Guide to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the claim data content when exchanging electronically with CareCentrix. Transmissions based on this companion guide, used in conjunction with the v5010 ASC X12N 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 the HIPAA. This 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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1 INTRODUCTION

1.1 SCOPE

This guide covers the 837p and the 837i transactions sent to CareCentrix, and the acknowledgement transactions sent back in response. It does not cover any other Electronic Data Interchange (EDI) transactions. It should be used as an instructional manual for providers and clearinghouses in conjunction with the ASC X12 837 Professional and/or Institutional Implementation Guides.

1.2 OVERVIEW

This guide will replace all previous CareCentrix Companion Guides. It adheres to the CAQH Core-mandated Companion Guide template. It outlines how to submit electronic claim transactions to CareCentrix, including information on testing, envelope values, important claim elements, acknowledgements, and support procedures.

1.3 REFERENCES

The following are additional recommended resources to be utilized in conjunction with this guide.

- The Accredited Standard TR3 Implementation Guides (https://x12.org/products/technical-reports)
- Washington Publishing Health Care Documentation and References (https://x12.org/reference)
- CareCentrix Provider Manual
- Complete list of taxonomy codes (https://taxonomy.nucc.org/)
- Council for Affordable Quality Healthcare

1.4 ADDITIONAL INFORMATION

CareCentrix encourages providers to submit claims electronically for more accurate and timely processing.

2 GETTING STARTED

2.1 WORKING WITH CARECENTRIX

CLAIM SUBMISSION: Currently, CareCentrix partners with three EDI clearinghouses: Waystar, Availity and Optum (Optum/Change Healthcare), who work with a number of practice management software vendors. For a complete list of their software vendors, please contact Waystar, Availity or Optum (Optum/Change Healthcare) directly. Providers may not submit claims directly to CareCentrix. Providers must utilize one of these clearinghouses, either directly or indirectly through a third Clearinghouse that has an agreement with Waystar, Availity or Optum(Optum/Change Healthcare).

- If you wish to join the CareCentrix provider network, please visit our HomeBridge Provider Portal for details.
- If you have questions related to the use of the HomeBridge Provider Portal, please send an email to portalinfo@carecentrix.com.

REMITTANCE ADVICE RECEIPT: Providers must also complete Electronic Remittance Advice (ERA) Enrollment if they wish to receive 835's instead of paper Explanations of Payment. See the **EFT and ERA Enrollment** section on the **HomeBridge Provider Portal**

2.2 TRADING PARTNER REGISTRATION

CareCentrix currently partners with three EDI clearinghouses, Waystar, Availity and Optum/Optum/Change Healthcare for electronic claim submission. CareCentrix does not accept 837 transactions directly from providers or from any other clearinghouses. Providers must enroll with one of our clearinghouse partners to submit EDI claims to CareCentrix. To begin this process, providers should contact Waystar, Availity or Optum/Change Healthcare directly.

WAYSTAR – 1-844-692-9782 (www.waystar.com)
AVAILITY - 1-800-AVAILITY (www.AVAILITY.com)
OPTUM/OPTUM/CHANGE HEALTHCARE - 1-866-371-9066 (www.Optum/Change Healthcare.com)

2.3 CERTIFICATION AND TESTING OVERVIEW

CLAIM SUBMISSION: Once a provider has completed the CareCentrix enrollment form and received confirmation that they are approved for electronic claim submission, there is no further certification and testing required to submit claims.

REMITTANCE ADVICE RECEIPT: Once a provider has completed the enrollment forms for ERA, CareCentrix will perform internal testing and generate 835 files from the provider's three most recent paper Explanations of Payment.

3 TESTING WITH THE PAYER

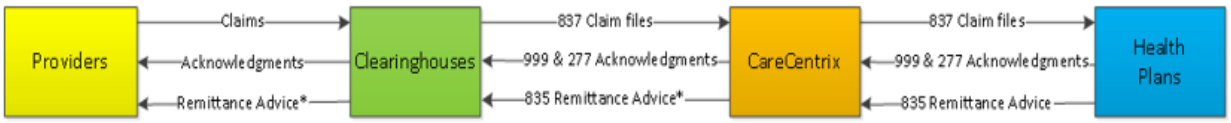
CLAIM SUBMISSION: No testing is required to submit claims, only EDI Enrollment.

REMITTANCE ADVICE RECEIPT: To test ERA enrollment, CareCentrix will create three 835 files and verify that the TIN, NPI and address match what the provider has provided. If everything is acceptable, CareCentrix will enable the provider's 835's in production.

4 PAYER CONNECTIVITY/COMMUNICATIONS

4.1 PROCESS FLOWS

Below is a high-level overview of CareCentrix claims processing.



*Exception – If a Provider is NOT enrolled to receive Electronic Remittance Advice (835 ERA's), then paper Explanation of Payments (EOP's) are mailed directly to the provider by CareCentrix in lieu of 835's.

Providers send claims via their clearinghouses (Waystar, Availity or Optum/Optum/Change Healthcare). A claim file is then sent from each Clearinghouse and received by the CareCentrix EDI Gateway, and validated for basic syntax and balancing. A notification is returned to the provider via their designated clearinghouse in the form of a Functional Acknowledgement (999.) The claims are then validated further by CareCentrix front-end edits and may either be accepted or rejected, which is communicated via a 277 transaction. 835 Remittance Advice transactions or paper EOP's are sent when the claim is adjudicated. CareCentrix's claim determination is based upon the health plan's adjudication outcome.

4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

CareCentrix currently partners with two EDI clearinghouses, Availity and Optum/Change Healthcare, who both work with a number of practice management software vendors and trading partners. Through Availity and Optum/Change Healthcare, Providers within the CareCentrix Provider Network are able to connect to the CareCentrix EDI Gateway.

Clearinghouse	Contact Information	Payer ID
Waystar	1-844-692-9782 www.waystar.com	11346 = CareCentrix Fallon and MGBH 11347 = CareCentrix FL Blue 11348 = CareCentrix Horizon 11349 = CareCentrix BCBSM 11350 = CareCentrix Wellcare 11345 = CareCentrix
Availity	1-800-AVAILITY www.AVAILITY.com	11346 = CareCentrix Fallon and MGBH 11347 = CareCentrix FL Blue 11348 = CareCentrix Horizon 11349 = CareCentrix BCBSM 11350 = CareCentrix Wellcare 11345 = CareCentrix
Optum/Change Healthcare	1-866-371-9066 www.ChangeHealthcare.com	11346 = CareCentrix Fallon and MGBH 11347 = CareCentrix FL Blue 11348 = CareCentrix Horizon 11349 = CareCentrix BCBSM 11350 = CareCentrix Wellcare 11345 = CareCentrix

4.3 RE-TRANSMISSION PROCEDURE

In the event that an EDI file failed in transmission when submitted to the CareCentrix EDI Gateway, trading partners are expected to retransmit the file.

4.4 COMMUNICATION PROTOCOL SPECIFICATIONS

CareCentrix supports two communication methods for file transmission, File Transfer Protocol (FTP) and Secure File Transfer Protocol (SFTP). Files are batched and processed daily.

- FTP is a standard network protocol used to transfer files between a client (trading partner) and server (CareCentrix) on a computer network. FTP is built on a client-server architecture model and uses separate control and data connections between the client and the server. Note: additional encryption will be required for any trading partners that use this method of file transmission.

- SFTP is a method of transferring files between computers over a Secure Shell (SSH) data stream and is the recommended communication method.

- FTPS is a file protocol that encrypts data where the connection is authenticated using a user id, password and SSL certificate. This adds an additional layer of security.

CareCentrix supports two ASC X12 file formats, wrapped and unwrapped. The wrapped file format uses a continuous data flow that uses delimiters to designate the end of the data string or segment. Unwrapped files are segmented with a carriage return and line feed. This creates a new segment of data per line. Both file layouts are acceptable and can be handled and processed within the CareCentrix EDI Gateway.

4.5 PASSWORDS

Trading partners connecting to one of our clearinghouse partners' system should contact their designated clearinghouse listed below for any access related issues.

Clearinghouse Connections	Contact Information
Waystar	1-844-692-9782 www.waystar.com
Availity	1-800-AVAILITY www.AVAILITY.com
Optum/Change Healthcare	1-866-371-9066 https://business.optum.com/en/

5 CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE

- For ERA enrollment issues, providers should email the ERA Enrollment team at ERAITenrollment@carecentrix.com.
- For provider claim rejections or other EDI-related questions, providers should email the EDI Support team at EDIsupport@carecentrix.com.

5.2 EDI TECHNICAL SUPPORT

- For EDI technical issues, providers should email the EDI Support team at EDIsupport@carecentrix.com.

5.3 PROVIDER SERVICE NUMBER

- Provider Network Services can be reached at 877-725-6525.

5.4 APPLICABLE WEBSITES/E-MAIL

- For additional information on the CareCentrix Provider Network, please visit the CareCentrix HomeBridge Provider Portal.
- For HomeBridge Provider Portal related issues or questions, please contact us at portalinfo@carecentrix.com.

6 CONTROL SEGMENTS/ENVELOPES

Control segments/envelopes are used to provide information about the trading partner and the type of information contained within the transmission. The control segments of the health care transactions are comprised of an Envelope (ISA-IEA); a Functional Group Header (GS/GE); and a Transaction Set (ST/SE).

6.1 ISA-IEA

The Interchange Control Header (ISA) and Interchange Control Footer (IEA) are segments or sections within an EDI X12 file indicating the beginning and ending of an interchange, also referred to as the data envelope structure. The interchange header for an X12 transaction contains sender and receiver information and is the outermost layer of the EDI data structure. The very last segment in an EDI file is the IEA segment.

The table below contains the CareCentrix-specific values for the ISA. This table does not represent all of the fields necessary in the ISA. The 837 Implementation Guide should be reviewed for complete information on the ISA.

ISA Information					
LOOP	FIELD REFERENCE	NAME	LENGTH	Codes	NOTES/COMMENTS
None	ISA08	Interchange Receiver ID	15	113454103	CareCentrix Receiver ID- Trailing spaces are needed to pad the value to 15 spaces.

6.2 GS-GE

The GS and GE Control segments indicate the beginning and ending of a Functional Group. PLEASE NOTE: **CareCentrix only accepts a single functional group within a transaction file.**

The table below contains the CareCentrix-specific values for the GS. This table does not represent all of the fields necessary in the GS. The 837 Implementation Guide should be reviewed for complete information on the GS.

GS Information					
LOOP	FIELD REFERENCE	NAME	LENGTH	Codes	NOTES/COMMENTS
None	GS03	Application Receiver's Code	15	113454103	CareCentrix Application Receiver's Code
None	GS08	Version/Release/Industry Identifier Code	12	00510X222A1 00510X223A2	CareCentrix expects 5010 compliant transactions.

6.3 ST-SE

The ST and SE Control segments indicate the beginning and the ending of each individual transaction set, and provide the count of the transmitted segments including the beginning (ST) and ending (SE) segments. PLEASE NOTE: **CareCentrix only accepts one claim per transaction set.**

The table below contains the CareCentrix-specific values for the GS. This table does not represent all of the fields necessary in the GS. The 837 Implementation Guide should be reviewed for complete information on the GS.

ST Information					
LOOP	FIELD REFERENCE	NAME	LENGTH	Codes	NOTES/COMMENTS
None	ST03	Implementation Convention Reference	12	00510X222A1 00510X223A2	

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Secondary Claims	Wellcare	All secondary claims for plans listed to the left must be submitted directly to the health plan. CareCentrix does not accept any secondary claims for these plans.
Secondary Claims where Medicare is primary (CareCentrix client health plan is NOT the primary "Payer" billed)	All Health Plans	CareCentrix does not accept secondary claims where Medicare is primary. If you submit a secondary claim to CareCentrix where Medicare is primary, your claim will be rejected. Bill the health plan directly for this type of claim.
	All Other Health Plans	CareCentrix does not accept secondary claims where Medicare is primary. If you submit a secondary claim to CareCentrix where Medicare is primary, your claim will be rejected. Bill the health plan directly for this type of claim.
Secondary Claims where a Non-Medicare plan is primary (CareCentrix client health plan is NOT the primary "Payer" billed)	Fallon, Mass General Brigham Health plan, Neighborhood Health Plan	For the plans listed to the left only, secondary claims that are Non-Medicare primary are required to be submitted on paper. Please ensure to send a copy of the primary EOP along with your paper claim to the following address: CareCentrix – Claims PO BOX 30722-3722 Tampa, FL 33630 Or if using Federal Express, UPS or Certified Mail CareCentrix – Claims 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618

	Horizon, FL Blue, Walmart, Blue Cross Blue Shield of Michigan	Secondary claims that are non-Medicare primary may be submitted electronically with the primary claim information in the appropriate COB loops and segments.

SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Corrected/Replacement Claims (A correction or change to a previously submitted claim)	Fallon, Neighborhood Health Plan, Mass General Brighams Health Plan	Corrected claims must be submitted on paper with 'CORRECTED' written across the top of the claim without obstructing any claim elements. Please ensure to include the original CareCentrix claim number (box 22 of CMS1500 or box 64 of UB-04). These claims should be submitted to: CareCentrix – Claims PO BOX 30722-3722 Tampa, FL 33630 Or if using Federal Express, UPS or Certified Mail: CareCentrix – Claims 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
	Horizon, FL Blue, Walmart, Blue Cross Blue Shield of Michigan	Corrected claims must be submitted electronically via an 837 frequency 7, "Void & Replace" transaction. Please note that the Subscriber ID cannot be corrected using the claim frequency 7 transaction. To submit a claim correction, a frequency 7 code should be sent to CareCentrix along with the original claim ID (Payer Claim Control Number) Loop 2300 REF*6R Segment, Field REF02, within the 837 transaction. Any claims submitted electronically with a claim frequency type code 7 when the status of the previous transaction is not equal to "Finalized by CareCentrix" will be rejected.
Voided Claims (A complete withdrawal of a previously submitted claim)	Fallon, Neighborhood Health Plan, Mass General Brigham Health Plan	Providers can submit a claim recoupment request in writing to the following address. (Note: Electronic and

		paper (CMS 1500/UB-04) void claim requests are not accepted). CareCentrix - Recoupment P.O. Box 30719-3719 Tampa, FL 33630 If using Federal Express, UPS or Certified Mail: CareCentrix - Recoupment 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
	Horizon, FL Blue, Walmart, Wellcare, Blue Cross Blue Shield of Michigan	Claims requested to be voided should be billed using the industry standard claim frequency type code of '8'. To submit a void claim request, a frequency 8 code should be sent to CareCentrix along with the original claim ID (Payer Claim Control Number) in Loop 2300 REF*6R Segment, Field REF02, within the 837 transaction.
SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Claim Reconsiderations	Fallon, Neighborhood Health Plan, Mass General Brigham Health Plan	Providers can request a reconsideration of a claim determination in writing by submitting a Claim Reconsideration Form to: CareCentrix – Reconsiderations PO BOX 30720-3720 Tampa, FL 33630 If using Federal Express, UPS or Certified Mail: CareCentrix – Claims 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
	Horizon, FL Blue, Walmart, Blue Cross Blue Shield of Michigan, Wellcare	Providers can request a reconsideration of a claim determination online via the HomeBridge Provider Portal or in writing by submitting a Claim Reconsideration Form to: CareCentrix – Reconsiderations PO BOX 30720-3720 Tampa, FL 33630 If using Federal Express, UPS or Certified Mail: CareCentrix – Reconsiderations 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618

SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Claim Appeals	Fallon, Neighborhood Health Plan, Mass General Brigham Health Plan	Providers can request a claim appeal in writing by submitting a Claim Appeal Form to: CareCentrix – Appeals PO BOX 30721-3721 Tampa, FL 33630 If using Federal Express, UPS or Certified Mail: CareCentrix – Appeals 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
	Horizon, FL Blue, Walmart, Wellcare, Blue Cross Blue Shield of Michigan	Providers can request a claim appeal online via the HomeBridge Provider Portal or in writing by submitting a Claim Appeal Form to: CareCentrix – Appeals PO BOX 30721-3721 Tampa, FL 33630 If using Federal Express, UPS or Certified Mail: CareCentrix – Appeals 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618

SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Acknowledgement Files	Fallon, Neighborhood Health Plan, Mass General Brigham Health Plan	Providers will receive a 999 electronic response acknowledging receipt of the 837 file. Please note that individual claims can also be rejected within the 999 particularly for the use of invalid ICD codes, dates of service or taxonomy codes. In addition, providers will receive acknowledgement of the claim via a 277CA acceptance or rejection. If the claim is accepted by CareCentrix, the Provider will receive a 277CA response of A2:20. **Claim Status Message:** **A2:** Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system. **20:** Accepted for processing.
	Horizon, FL Blue, Walmart, Wellcare, Blue Cross Blue Shield of Michigan	Providers will receive a 999 electronic response acknowledging receipt of the 837 file. Please note that individual claims can also be rejected within the 999 particularly for the use of invalid ICD codes, dates of service or taxonomy codes. In addition, providers will receive acknowledgement of the claim via a 277CA acceptance or rejection. If the claim is accepted by CareCentrix, the Provider will receive a 277CA response of A1:20. **Claim Status Message:** **A1:** Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. **20:** Accepted for processing. This is the CareCentrix notification to the Provider that the claim has been accepted for processing, but a rejection can still be sent once the health plan receives the claim for adjudication. Providers will receive a second 277CA to indicate that the claim has been either accepted or rejected by the health plan.

SCENARIOS	HEALTH PLANS	HEALTH PLAN SPECIFIC INFORMATION
Submitting a Miscellaneous HCPCS Code	All Health Plans	Descriptions are required on miscellaneous HCPCS codes for validation against the authorization. Descriptions must match the comment/memo on the authorization. Providers must submit the miscellaneous code description, as provided upon authorization, in the SV101-7 (837P) or SV202-7 (837I) elements. DO NOT preface the description with 'CCX' or any other characters.
Same Day Visits	All Health Plans	Providers must submit all services performed on the same date of service for a given patient on a single claim. If the provider needs to bill another visit/service for a date of service already billed, a corrected claim must be submitted (See instructions for corrected claims above).
Date Span	All Health Plans	Do not bill a date span across calendar years i.e., a claim with services dated in December of 2017 and services dated January of 2018.
SNIP Edits	All Health Plans	CareCentrix will apply SNIP 1-6 editing and custom rule editing to ensure clean claims are accepted by CareCentrix. See CareCentrix Provider Manual for a list of clean claim data elements.

8 ACKNOWLEDGEMENTS

CareCentrix will always create ASC X12 transactional acknowledgements in the form of a TA1, 999 and 277CA. Note: The trading partner may choose to opt out from receiving the TA1.

8.1 TA1 TECHNICAL ACKNOWLEDGEMENTS

The X12 TA1 technical acknowledgment reports the status of the processing of an interchange header and trailer by the transaction receiver. When the ISA and IEA of the X12 file are valid, a positive TA1 acknowledgement can be sent if requested by the trading partner, but by default, the TA1 will only be generated on failures. If the ISA and IEA are not valid, a TA1 acknowledgement with an error code is sent. The expectation is that the trading partner corrects and retransmits a file associated with a TA1 rejection. To determine rejection reason, you will need to obtain the Consolidated and Original Implementation Guide from X12.org. The guide explains each element and segment contained in the TA1 in greater details.

```
Rejected Acknowledgement

ISA*00* *00* *ZZ*123456789*XX*987654321*170118*0930*^*00501*277000239*0*T:
TA1*987654321*170118*1520*R*024
IEA*0*277000236
                              |
                              |
                              |
                              └► R=Rejected

Accepted Acknowledgement

ISA*00* *00* *ZZ*123456789*XX*987654321*170118*0930*^*00501*277000239*0*T:
TA1*987654321*170118*1525*A*000
IEA*0*277000236
                              |
                              |
                              |
                              └► A=Accepted
```

8.2 999 FUNCTIONAL ACKNOWLEDGEMENTS

The X12 999 notifies the submitter that the functional group was received by the intended receiver. It may include information about the syntactical validity of the functional group and ASC X12 implementation guide compliance. The 999 will also report out if an individual claim has been accepted or rejected for EDI syntax or balancing. The expectation is that the trading partner communicates to the Provider any claims rejected on the 999. To determine the rejection reason, you will need to obtain the Consolidated Implementation Guide from X12.org. The guide explains each element and segment contained in the 999 in greater details.

```
Accepted Acknowledgement

ISA*00* *00* *ZZ*123456789*ZZ*987654321*170118*1530*^*00501*000054321*0*P*:
GS*FA*RCVRID*SNDRID*20170118*100518*1*X*005010X231A1
ST*999*0001*005010X231
AK1*HC*100000001*005010X222
AK2*837*87654321*005010X222
IK5*A ◄──────────── A=Accepted
AK9*A*1*1*1
SE*6*0001
GE*1*1
IEA*1*000004308
```

```
Rejected Acknowledgement

ISA*00* *00* *ZZ*123456789*ZZ*987654321*170118*1530*^*00501*000012345*0*P*:
GS*FA*RCVRID*SNDRID*20101208*093425*1*X*005010X231A1
ST*999*0001*005010X231
AK1*HC*100000001*005010X222
AK2*837*87654321*005010X222
IK3*DTP*33*2400*8
IK4*3*1251*7*20090711
IK3*DTP*37*2400*8
IK4*3*1251*7*20090711
IK5*R*5 ◄———————— R=Rejected
AK9*R*1*1*0
SE*10*0001
GE*1*1
IEA*1*000004287
```

8.3 277 CLAIM ACKNOWLEDGEMENTS

The X12 277 transaction will contain an acceptance or rejection acknowledgement for each claim that passed SNIP edits 1 and 2. The 277 will not be sent back for claims previously rejected on the 999. The 277 acknowledgement will be returned to the clearinghouse that submitted the 837 claims to CareCentrix. To obtain more information on a rejection, visit the CareCentrix HomeBridge Provider Portal or review the CareCentrix Rejection Guide. For additional information on the 277 claim status category and claim status codes, please visit the Washington Publishing Company website. For industry guidelines for the 277 transaction, you will need to obtain the Consolidated Implementation Guide from X12.org.

```
ISA*00* *00* *ZZ*123456789*ZZ*987654321*170118*0915*^*00501*000002754*0*T*:
GS*HN*RCVRID*SNDRID*20101119*081645*1*X*005010X214
ST*277*0001*005010X214
BHT*0085*08*000028*20101119*0816*TH
HL*1**20*1
NM1*PR*2*BC - SEND TO NORTH POLE*****46*00320
TRN*1*20101119081644
DTP*050*D8*20101119
DTP*009*D8*20101119
HL*2*1*21*1
NM1*41*2*5010 TESTING*****46*NDXXXXX
TRN*2*000028
STC*A1:20*20101119*WQ*892.75
QTY*90*3
AMT*YU*892.75
HL*3*2*19*1
NM1*85*2*5010 INC*****XX*0123456789
TRN*1*0
STC*A1:20**WQ*116
QTY*QA*1
AMT*YU*116
HL*4*3*PT
NM1*QC*1*MOUSE*MICKEY*N***MI*R99999999
TRN*2*5010 - 6
STC*A1:20*20101119*WQ*116
REF*1K*5010 - 6
DTP*472*RD8*20100730-20100730
HL*5*2*19*1
SE**0001
GE**1
IEA**000002754
```

A1: Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication. **20:** Accepted for processing.

9 TRADING PARTNER AGREEMENTS

An EDI trading partner is defined as any CareCentrix provider, billing service, employer group, clearinghouse, health plan, vendor, or financial institution that transmits to or receives electronic data from CareCentrix. CareCentrix has documented agreements with our contracted Clearinghouses, Availity and Optum/Change Healthcare, but does not require other trading partner agreements.

10 TRANSACTIONAL SPECIFIC INFORMATION

This section provides guidance for CareCentrix proper billing requirements. It does not include the enveloping, header and detail loops, or hierarchical level segments. It is not intended to replace the official 837 Implementation Guides, but rather to articulate the main data elements that CareCentrix requires when receiving either a professional or institutional claim.

10.1 PROFESSIONAL VERSION - 005010X222A1

PROFESSIONAL VERSION - 005010X222A1					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
BILLING PROVIDER DATA					
2000A		Billing Provider Specialty		R	
2000A	PRV03	Billing Provider Taxonomy Code	50	R	Some health plans require the taxonomy code; CareCentrix recommends always billing with the taxonomy code.
2010AA		Billing Provider Name		R	
2010AA	NM109	Billing Provider National Provider ID	80	R	Ensure you are billing with an NPI on file with CareCentrix that is credentialed for the member's specific health plan and provider's specific location.
2010AA	N301	Billing Provider Street Address	55	R	Billing provider street address is required. The use of a PO Box is highly discouraged.
2010AA	REF02	Billing Provider Tax ID Number (TIN)	9	R	9 digits, no separators. Claim will be rejected if TIN is not billed.
SUBSCRIBER/PATIENT DATA					
2000B		Subscriber Information		R	The SBR Segment for Subscriber is REQUIRED.
2000B	SBR03	Group Number or Policy Number	50	S	Required when the member's insurance card contains a group number. Otherwise, do not send.
2000B	SBR04	Group Name	60	S	Required when the group number is NOT available. For expedited claim processing, providers are encouraged to submit the patient's health plan name in this field. For example: • "Fallon and MGBH" • "Horizon" • "FL Blue"
2010BA		Subscriber Name		R	The NM1 Segment for Subscriber is REQUIRED.

PROFESSIONAL VERSION - 005010X222A1					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
2010BA	NM109	Subscriber ID	80	R	• Claim will be rejected if subscriber ID is not billed. • Subscriber ID should be different from Group or Policy Number. • Subscriber ID should match the ID on the CareCentrix Service Authorization Form (SAF). • Do not include a person code on the end of the Subscriber ID.
2010BB		Payer		R	This is the destination payer.
010BB	NM109	Payer ID	9	R	11346= CareCentrix Fallon and MGBH 11347= CareCentrix FL Blue 11348= CareCentrix Horizon 11349 = CareCentrix BCBSM 11350 = CareCentrix Wellcare 11345 = CareCentrix
PATIENT DATA - SENT ONLY WHEN PATIENT IS NOT THE SUBSCRIBER (OTHERWISE PATIENT DATA IS CONTAINED IN SUBSCRIBER SEGMENTS)					
2010CA		Patient Demographics		S	2010CA Loop elements are required ONLY when patient is different than subscriber. They should NOT be sent when patient and subscriber is the same person.
CLAIM DATA					
2300		Claim Header		R	Used to specify basic data about the claim.
2300	CLM01	Patient Control Number	38	R	This is the claim number in the Provider's practice management system (or patient account number.) It is strongly recommended that this is unique for each claim.
2300	CLM02	Total Claim Charge Amount	18	R	This amount must balance to the sum of all detail line charge amounts reported in SV1 segments for a claim.
2300	CLM05-3	Claim Frequency Type Code	1	R	Acceptable Values: 1 for original claim 7 for corrected claim 8 for complete void of claim. Refer to section 6 for payer specific business rules and limitations.
2300	DTP03	Onset of Current Illness or Injury Date	35	R	This date should always be different from the date of service.
2300	DTP03	Initial Treatment Date	35	R	This date should be sent for home health claims to indicate start of care.
2300	REF02	Payer Claim Control Number	50	S	This is the CareCentrix Original Claim ID. Required on void (8) or replace (7) frequency types. Do not send for original claims.
2300	HI01-2	Principal Diagnosis Code	30	R	Do not send decimals. V codes will not be accepted as the Primary Diagnosis.

PROFESSIONAL VERSION - 005010X222A1					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
2300	HI01-2 thru HI12-2	Other Diagnosis Code	30	S	Do not send decimals. Provider should include all DX codes as applicable to substantiate medical necessity for services rendered.
REFERRING PROVIDER AND OTHER PROVIDERS					
2310A		Referring Provider		S	Required when the claim involves a referral.
2310A	NM109	Referring Provider National Provider ID	80	R	Ensure you are billing with a valid NPI.
2310B		Rendering Provider		S	The Rendering Provider Information is only required when the rendering provider is DIFFERENT than the billing provider.
2310C		Service Facility		S	The Service Facility Location information is only required when the rendering provider location is DIFFERENT than the billing provider location. It must include the name, address and NPI of the rendering provider location.
OTHER INSURANCE AND COB DATA					
2320	SBR	Other Subscriber Information		S	Other Subscriber Information is only required when there are other Payers involved in this claim – Loop 2320 should be sent once for each additional Payer. Refer to section 6 for payer specific business rules and limitations for secondary claims. See the ASC X12 Implementation Guide for specifications for the Data Elements in this Segment.
2320	CAS	Claim Level Adjustments		S	This segment is required when CareCentrix is not primary, the claim has been adjudicated by the Payer in this iteration of this loop, and the Payer has made claim level adjustments. See the ASC X12 Implementation Guide for specifications for the Data Elements in this Segment.
2320	AMT	COB Payer Paid Amount		S	This segment is required when CareCentrix is not primary, and the claim has been adjudicated by the Payer in this iteration of this loop. See the ASC X12 Implementation Guide for specifications for the Data Elements in this Segment.
CLAIM DETAIL LINE DATA					
2400		Claim Detail Line		R	Used to specify basic data about the claim service line.
2400	SV101-2	Claim Detail Line Procedure Code	48	R	HCPCS codes must be billed in whole units of 1 or greater. Units greater than 1 must be rounded up or down to the nearest whole number. NDC quantities may be submitted in fractional units with up to 2 decimal points.

PROFESSIONAL VERSION - 005010X222A1					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
2400	SV101-3	Claim Detail Line Procedure Modifier	2	S	Bill modifiers according to your provider contract to avoid claim rejection
2400	SV101-7	Procedure Description	80	S	Always populate for miscellaneous procedure codes. This description should match the description detailed on your Service Authorization Form (SAF).
2400	SV105	Place of Service Code	2	S	This field should represent where the service took place. If a service is an O & P or DME, this should reflect where the patient took possession of the equipment or supplies.
2400	REF02	Prior Authorization	50	S	Please follow your contract guidelines for obtaining service authorization. If you have been provided an authorization number (labeled Auth ID) on the CareCentrix Service Authorization Form (SAF), then the Authorization Number **is required** to be sent in this field. • Do not send multiple authorization numbers in this field. • Do not send a CareCentrix intake number in this field. • Do not send a subscriber ID in this field. • Do not send free form text or comments in this field.
2410		Drug Identification		S	National Drug Code information is required when the service is a drug.
2430E		Ordering Provider		R	Required when the service or supply was ordered by a provider who is different from the Rendering Provider for this service line.
2430E	PER	Ordering Provider Contact Information		S	Ordering Provider Contact Information is required when segment CR3 (Durable Medical Equipment Certification) is used.

10.2 INSTITUTIONAL VERSION - 005010X223A2

INSTITUTIONAL VERSION – 005010X223A2					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
BILLING PROVIDER DATA					
2000A		Billing Provider Specialty		R	
2000A	PRV03	Billing Provider Taxonomy Code	50	R	Some health plans require the taxonomy code; CCX recommends always billing with the taxonomy code in the required data element field and format.
2010AA		Billing Provider Info		R	
2010AA	NM109	Billing Provider National Provider ID	80	R	Ensure you are billing with an NPI on file that is credentialed for the member's specific health plan and providers specific location.
2010AA	N301	Billing Provider Street Address	55	R	Billing provider street address is required. The use of a PO Box is highly discouraged.
2010AA	REF02	Billing Provider Tax ID Number (TIN)	9	R	9 digits, no separators. Claim will be rejected if tax ID is not billed.
SUBSCRIBER/PATIENT DATA					
2000B	SBR			R	The SBR Segment for Subscriber is REQUIRED.
2000B	SBR03	Group Number	50	S	Required when insurance card has a group number. Otherwise do not send.
2000B	SBR04	Group Name	60	S	Required when the group number is NOT available. For expedited claim processing, providers are encouraged to submit the patient's health plan name in this field. For example: • "Fallon and MGBH" • "Horizon" • "FL Blue"
2010BA	NM1	Subscriber Name		R	The NM1 Segment for Subscriber is REQUIRED.
2010BA	NM109	Subscriber ID	80	R	Claim will be rejected if subscriber ID is not billed. Subscriber ID should also be different from Group or Policy Number.
2010BA	DMG			S	DMG Segment for Subscriber should only be sent when the patient is the subscriber.
2010BA	DMG02	Subscriber Date of Birth (when Subscriber is the Patient)	8	R	In CCYYMMDD format. Claim will be rejected if date of birth is not billed.
2010BB		Payer		R	This is the destination payer.
2010BB	NM109	Payer ID	9	R	11346 = CareCentrix Fallon and MGBH 11347 = CareCentrix FL Blue 11348 = CareCentrix Horizon 11349 = CareCentrix BCBSM

INSTITUTIONAL VERSION – 005010X223A2					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
					11350 = CareCentrix Wellcare 11345 = CareCentrix
PATIENT DATA - SENT ONLY WHEN PATIENT IS NOT THE SUBSCRIBER (OTHERWISE PATIENT DATA IS CONTAINED IN SUBSCRIBER SEGMENTS)					
2010CA		Patient Demographics		S	2010CA Loop elements are required ONLY when patient is different than subscriber. They should NOT be sent when patient and subscriber is the same person.
CLAIM DATA					
2300		Claim Header		R	Used to specify basic data about the claim.
2300	CLM01	Patient Control Number	38	R	This is the claim number in the Provider's practice management system (or patient account number.) It is strongly recommended that this is unique for each claim.
2300	CLM02	Total Claim Charge Amount	18	R	This amount must balance to the sum of all detail line charge amounts reported in SV2 segments for this claim.
2300	CLM05-3	Claim Frequency Type Code	1	R	Use 1, 2,3, 9 for original claim. 7 for corrected claim and 8 for complete void of claim. Please see section 6 for payer specific business rules and limitations.
2300	REF02	Payer Claim Control Number	50	S	This is the CareCentrix Original Claim ID. Required on void (8) or replace (7) frequency types. Do not send for original claims.
2300	REF02	Prior Authorization	50	S	Treatment Authorization Codes (TAC) required on all home health claims submitted for Medicare Advantage Members.
2300	HI01-2	Principle Diagnosis Code	30	R	Do not send decimals. V Codes will not be accepted as the Primary Diagnosis. Include all DX codes as applicable to substantiate medical necessity for services rendered.
2300	HI01-2	Admitting Diagnosis Code	30	S	Do not send decimals. Admitting diagnosis is required when the facility type equals '12' (Hospital Inpatient/Medicare Part B ONLY).
ATTENDING PROVIDER AND OTHER PROVIDERS					
2310A		Attending Provider		S	The Attending Provider Information is required. This is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.
2310A	NM109	Attending Provider National Provider ID	80	R	Ensure you are billing with the Attending's first, last name, and NPI within your claim. Ensure you

INSTITUTIONAL VERSION – 005010X223A2					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
					are billing with an NPI on file that is credentialed for the member's specific health plan.
2310B		Operating Provider		S	Required when a surgical procedure code is listed on the claim. The operating physician has primary responsibility for performing the surgical procedure.
2310D		Rendering Provider		S	Required when the Rendering Provider is different from the Attending Provider.
2310E		Service Facility		S	The Service Facility Location information is only required when the rendering provider location is DIFFERENT than the billing provider location. It must include the name, address and NPI of the rendering provider location.
OTHER INSURANCE AND COB DATA					
2320	SBR	Other Subscriber Information		S	Other Subscriber Information is only required when there are other Payers involved in this claim – Loop 2320 should be sent once for each additional Payer. Please see section 6 for payer specific business rules and limitations for secondary claims. See the ANSI Standard Implementation Guide for specifications for the Data Elements in this Segment.
2320	CAS	Claim Level Adjustments		S	This segment is required when CareCentrix is not primary, the claim has been adjudicated already by the Payer in this iteration of this loop, and the Payer has made claim level adjustments. See the ANSI Standard Implementation Guide for specifications for the Data Elements in this Segment.
2320	AMT	COB Payer Paid Amount		S	This segment is required when CareCentrix is not primary, and the claim has been adjudicated already by the Payer in this iteration of this loop. See the ANSI Standard Implementation Guide for specifications for the Data Elements in this Segment.
CLAIM DETAIL LINE DATA					
2400		Claim Detail Line		R	Used to specify basic data about the claim service line.
2400	SV201	Revenue Code			When the procedure code is a HIPPS line, this field should contain revenue code 0023.
2400	SV202-1	Product or Service ID Qualifier	2	R	When the procedure code is a HIPPS line, this field should contain the qualifier of 'HP' instead of 'HC'.

INSTITUTIONAL VERSION – 005010X223A2					
LOOP	FIELD REFERENCE	NAME	LENGTH	REQUIRED/ SITUATIONAL	NOTES/COMMENTS
2400	SV202-2	Procedure Code	48	R	A HIPPS code is required on all home health claims submitted for Medicare Advantage Members. At least one other HCPCS code should be billed on a separate service line.
2400	SV202-3	Claim Detail Line Procedure Modifier	2	S	Bill modifiers according to your provider contract or your claim will be rejected.
2400	SV202-7	Procedure Description	80	S	Always send for miscellaneous procedure codes. This description should match the description detailed on your Service Authorization Form (SAF).
2410				S	Drug Identification is required when National Drug Codes are submitted.

APPENDICES

A. Implementation Checklist

For more information on an Implementation checklist, please contact one of our clearinghouse partners at the following:

WAYSTAR - 1-844-692-9782 (www.waystar.com)
AVAILITY - 1-800-AVAILITY (www.AVAILITY.com)
OPTUM/CHANGE HEALTHCARE - 1-866-371-9066 (https://business.optum.com/en/)

B. Business Scenarios

Please refer to Section 7 for Business Scenarios.

C. Transmission Examples

For more information on transmission examples, please contact one of our clearinghouse partners:

WAYSTAR - 1-844-692-9782 (www.waystar.com)
AVAILITY - 1-800-AVAILITY (www.AVAILITY.com)
OPTUM/CHANGE HEALTHCARE - 1-866-371-9066 (https://business.optum.com/en/)

D. Frequently Asked Questions (FAQs)

How do I join the CareCentrix Provider Network?

For more information on joining the CareCentrix Provider Network, please visit the CareCentrix HomeBridge Provider Portal.

Why do I need to bill with an NPI?

The National Provider Identifier (NPI) is required wherever you identify as a Provider or Provider Organization in any standard electronic claim transaction. The NPI must be valid and must be registered with CareCentrix.

Why is my claim rejecting for an NPI?

- Ensure that you are billing with the Referring Provider's first and last name, and NPI within your claim.
- Ensure that you are billing with an NPI on file that is credentialed for the member's specific health plan.
-Ensure that you are billing per your authorization on file for the services billed.

What is a Taxonomy code, and is it required?

Taxonomy codes are administrative code sets that identify the Provider type and area of specialization for health care Providers. Each taxonomy code is a unique ten alphanumeric code that enables Providers to identify their specialty. Taxonomy codes are assigned at both the individual and organizational Provider levels.

Taxonomy codes have three distinct levels:

- Level I is a provider type
- Level II is Classification
- Level III is the area of specialization.

A complete list of taxonomy codes can be found on the National Uniform Claim Committee website.

Why is my claim rejecting for missing/invalid Taxonomy code?

Ensure to bill with the taxonomy code that CareCentrix has on file for your Provider location. If the Provider is billing with a taxonomy that does not match the Provider's location and credentialed services, the claim may reject for this reason.

Does CareCentrix have scheduled downtime for maintenance?

CareCentrix does not anticipate any scheduled maintenance that will delay delivery of production EDI files. However, in cases where unexpected technical issues occur, messages will be delivered to your clearinghouse as well as displayed on the CareCentrix HomeBridge Provider Portal.

Are there any reports available?

Please check with your clearinghouse for the availability of any reports.

Why did my claim reject for A3:122:QC when I don't think it should have?

Provider should complete the following validation:

- Name and Date of Birth matches the authorization
- Patient is active with health plan for date of service billed
- Validate that the services and patient information match what is provided on the Service Authorization Form
- Ensure that Medical Management Level (MMI) has not changed since the authorization issue date

What is the status of my claim that was submitted via EDI?

For claim status updates, please check the HomeBridge Provider Portal for the status of your claim. Should you have any questions regarding the status of your claim, please contact the Network Services department.

Why is my claim rejecting for no rate on file?

The HCPC and Modifier billed on the claim must be a credentialed service for the Provider as well as for the member's health plan.

When I'm locked out of my account on HomeBridge Provider Portal, how do I get my account unlocked?

Send an email to portalinfo@carecentrix.com to request a password reset.

I'm not sure why my claim was rejected and need further information.

Please send a secure (encrypted) email to edisupport@carecentrix.com and include the following information regarding the claim that you require assistance with:.

- Patient Name
- Date of Birth
- Subscriber ID Number
- Date of Service
- Claim Total Dollar Amount
- Tax ID Number
- Clearinghouse/EDI Gateway Utilized
- Date Claim Accepted by Payer
- Date of Submission (Paper Claims Only)

Why is my claim rejecting for invalid frequency code?

Frequency 7 (void and replace) claims can only be submitted if the original claim has been finalized and the Provider received an 835 for that claim. Also, when submitting a frequency 7, ensure to include the payer claim control number found in loop 2100, segment CLP07 of your 835 for your corrected claim.

E. Document Version Control Summary

Date	Reviewer Name	Version	Change Summary
06/30/2014	Jay Morgan	0.0	Initial Draft
07/03/2014	Jay Morgan	0.1	Changed to CAQH Template
07/14/2014	Elizabeth Gilchrist	0.2	Updated Section 10
07/15/2014	Elizabeth Gilchrist	0.3	Added Professional
10/09/2014	Jay Morgan	0.4	Added Format Types and Rebranding
4/23/2018	Natasha Bernard/ Elizabeth Gilchrist	0.5	Rewrite and Rebranding
5/16/2018	Kimberly Walters	.6	EDRC Approval Edits
8/30/2018	Kimberly Walters	.7	Modify Workflow Page 6
10/18/2019	Natasha Bernard	.8	Content Update
06/15/2025	Lisa Bouabid	.9	Update information