

Electronic Claims Transactions Reports Manual

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EC Solutions

P.O. Box 9232
Mail Station 4W 274
Des Moines, IA 50306-9232
Toll Free #: 1-800-407-0267
Fax #: 1-800-691-1038
Email: ECSolutionsDSM@hp.com

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Electronic Claims Transactions Reports Manual

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Introduction

- Welcome** Welcome to the Electronic Claims Reports Manual. This manual was designed to help electronic claim submitters understand the reports from Web BBS that are associated with electronic claim submission.
- Explanation Of Contents** First, a timeline is provided that shows **when** reports will be available and the **order** in which they will be made available based on the time the claims were submitted.
- Next, is an illustration of an audit trail. A claim must be *accepted* on all reports in order to be paid. Any claim listed as an *exception* was rejected, and you must correct the error(s) and resubmit the claim.
- Finally, this manual contains report descriptions. Included is an example of each report to show its layout, and field descriptions to help identify the information it contains.
- Availability** The reports described in this document are available for download for 14 days. After 14 days, the reports are removed from Web BBS and will no longer be available.
- Call Us With Your Questions** When reviewing a report, if you determine you need help understanding its content or an error message, please feel free to contact the EC Solutions Assistance Center at 800-407-0267.

Electronic Reports Timeline

This timeline applies to the transmitted claims if the claim file itself is accepted. If not accepted, a .999 report will be generated. See Page 4 for further details.

The following tables identifies when the .999, .txn, .z16, ebr and .dpr reports will be available based on the time the claim file is submitted and for what LOB it was submitted.

Wellmark, Aware Dental and Blue Dental

When the claim file is submitted...	.999 and .txn are available...	.z16 payer is available...
<u>between 7:00 a.m. and 10:00 a.m. CST</u> Monday - Friday	2 – 6 hours after the upload	after 11:30 a.m.; if .txn received by 10:30 a.m.
<u>between 10:00 a.m. and 2:00 p.m. CST</u> Monday - Friday	2 – 6 hours after the upload	after 4:30 p.m.; if .txn received by 3:30 p.m.
<u>between 2:00 p.m. and 7:00 a.m. CST</u> Monday - Friday	2 – 6 hours after the upload	after 8:30 a.m.; if .txn received by 7:30 a.m.
after business hours and on weekends	2 – 6 hours after the upload	after 8:30 a.m. the next business day

Commercial

When the claim file is submitted...	.999 and .txn are available...	.ebr is available...	.dpr is available...
<u>before 2 p.m. CST</u> Monday – Friday	2 – 6 hours after the upload	after 5:30 p.m. the same day or up to two weeks later	One to 30 days after submission date
<u>after 2 p.m. CST</u> Monday – Friday	2 – 6 hours after the upload	after 5:30 p.m. the next business day or up to two weeks later	One to 30 days after submission date
after business hours and on weekends	2 – 6 hours after the upload	after 5:30 p.m. the next business day or up to two weeks later	One to 30 days after submission date

Claim Audit Trail

Each payer has its own edit process where claims are either accepted or rejected.

- Claims that pass all edits are the Accepted Claims. These are passed on to the next level and become the *total claims* submitted on the next report.
- Claims that fail one or more edits become the Rejected Claims. These are **not** passed on to the next level and are **not** included on other reports. Claims with errors must be corrected in your billing software and resubmitted.
- Claims routed to Web BBS produce the .txn report.
- Claims forwarded to Wellmark produce a .z16 report.
- Claims forwarded to Availity produce an .ebr report.
- Claims forwarded to payers other than Wellmark produce a .dpr report.

Wellmark, Aware Dental and Blue Dental Example:

Order	Report	Claims Submitted	Accepted Claims	Rejected Claims
1 st	.txn	100	90	10
2 nd	.z16	90	80	10

Commercial Example:

Order	Report	Claims Submitted	Accepted Claims	Rejected Claims
1 st	.txn	100	90	10
2 nd	.ebr	90	89	1

Note: The .dpr is returned by some payers and will only reflect total number of claims submitted, accepted and rejected by that particular payer. It is possible that all claims transmitted within in a batch to a payer will not appear on one .dpr report. The individual claims could appear on .dpr for different days.

Web BBS ANSI Reports Overview

Batch File Evaluation

A batch of claims is transmitted to Web BBS. Web BBS evaluates the batch for formatting errors. If an entire batch errors due to formatting issues, a File Reject Report (.999) is created and the entire transmission of the batch will need to be resubmitted.

Claim Level Evaluation

When the batch format is correct, Web BBS continues to evaluate each claim within the batch. A single .TXN report is generated for each valid batch transmission.

These reports are generated per submission and are available for download according to the timetable on page 5.

.999 - File Error Report

Description	The .999 report is the claim processing report generated when Web BBS cannot process an uploaded file due to file format errors. This report lists error messages that explain what caused the rejection so you can correct the errors and retransmit the file.
All Claims Are Rejected	Due to the file format errors, all claims on the file are rejected by Web BBS and are not routed to any of the payers.
Call For Assistance	Because this report is difficult to read to the untrained eye, you may call the EC Solutions Assistance Center at 800-407-0267 for an explanation of the report.
Availability	The .999 is available for download for 14 days. After 14 days, it is removed from Web BBS and will no longer be available.
Example	The following illustration is an example of a .999 report. It is easily recognized by its short length and lack of claim detail. Fields containing the error are in bold .

Example 1

This example shows a file rejected due to an invalid payer ID.

```
ISA*00*00          *00*          *ZZ*xxxxxx          *ZZ*800000038
*020509*1445*U*00401*003695670*0*P*:
TA3*16*046667523ECMS*011*ISA*003695670*000817*1000*ZZ*800000038*ZZ*xxxxxx*RJ*0
20509*1445
IEA*0*003695670*
```

Example 2

This example shows a file rejected due to an invalid submitter ID.

```
ISA*00*00          *00*          *ZZ*88848          *ZZ*INVALID38
*020508*1038*U*00401*003695670*0*P*:
TA3*16*046667523ECMS*009*ISA*003695670*000817*1000*ZZ*INVALID38*ZZ*88848*RJ*0
20508*1038
IEA*0*003695670*
```

Example 3

This example shows a file rejected due to a duplicate file being sent to Web BBS.

```
ISA*00*          *00*          *ZZ*88848          *ZZ*0000XXXXX
*031209*1552*U*00401*000000001*0*P*>~TA1*342888000*031209*1552*R*025~IEA*0*00
0000001
```

.txn – Transaction Status Report

Description The Transaction Status Report (.txn) lists all claims accepted and/or rejected within the file transmission for all payers that are accepted by EC Solutions. In addition, this report will also list any eligibility errors for Wellmark claims (Payer ID 88848). At the top of this report is a summary which lists the total number of claims submitted, the total number of claims accepted and rejected. It also shows the total dollar amount for each of these listings. This detail report lists activity by submitter, provider, and payer.

Call For Assistance If you need assistance reading this report, you may call the EC Solutions Assistance Center at 800-407-0267 for an explanation of the report.

Availability The .txn is available for download for 14 days. After 14 days, it is removed from Web BBS and is no longer available.

Example The following pages contain examples of .txn reports for the 837P, 837I, and 837D transactions. Each report contains similar fields and layouts. Each example contains *numbered* fields and field names in **bold**. The *numbers* are provided to easily identify each field on the following table but are not displayed on the actual report.

```

+++++
1. TRANSACTION SUMMARY BY STATUS
+++++

2. Total Txns: 2          3. Total Charges: $302.75
4. Total Reject Txn: 1    5. Total Reject Charges: $205.75
6. Total Accept Txn: 1    7. Total Accept Charges: $97.00

8. TRANSACTION STATUS REPORT          9. Page:1

10. Submitter Name - HAPPY HOSPITAL      11. Submitter ID - 800000036
12. Submission ID - A5802COZ
13. Processing Date and Time - 01/27/2011 14:44:37
14. Provider Name - DR HAPPY             15. Provider ID - 1234567890
16. Payer Name - BLUE SHIELD OF IOWA     17. Payer ID - 88848
18. TXN Format/Version - Professional Claim A1 X12 5010

-----
19.Submitter File# 20.Receipt Date 21.Create Date 22.Group CTL# 23.Transaction #
24.Member ID                               25. ECS Document#
26.Patient Last Name 27.Patient First Name 28.Patient CTL#
29.TOB/POS 30.Charge 31.From Date 32.To Date
33.Status
-----
026815000 110127 20110127 24001 000000001
ZYH987654321 576055742
JETSON GEORGE 289
111 $97.00 20110106 20110106
REJECT
34.Reject Explanation
35.Segment/Record 36.Field Name 37.Segment Count
N3 Subscriber Addr 17
Reject : Segment N3 is used. It is expected to be used only when Subscriber is
the same person as Patient (loop 2000B, SBR02 = '18'). Segment N3 is defined in
the guideline at position 0250.
38.Additional Explanation: Subscriber Address may be used only when Subscriber is
the Patient.
-----
026815000 110127 20110127 24001 000000001
XYZ123456789 555555555
BOOP BETTY CONTROL123
131 $205.75 20110130 20110130
ACCEPT

39. Total Txns: 2          40. Total Charges: $302.75
41. Total Reject Txn: 1    42. Total Reject Charges: $205.75
43. Total Accept Txn: 1    44. Total Accept Charges: $ 97.00
    
```

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```

+++++
45. TRANSACTION SUMMARY BY PAYER
+++++

46. Total Txns  47. Rejected Txns  48. Accepted Txns  49. Accepted Charges
50. BLUE CROSS/BLUE SHIELD OF IA
      2          1          1          $97.00
+++++
51. END OF TRANSACTION STATUS REPORT
+++++

```

Report Field Descriptions for .txn

No.	Field	Description
1	TRANSACTION SUMMARY BY STATUS	Summary title of report
2	Total Txns	Total number of claims for this submitter
3	Total Charges	Total amount of charges for this submitter
4	Total Reject Txn	Total number of rejected claims for this submitter
5	Total Reject Charges	Total amount of rejected charges for this submitter
6	Total Accept Txn	Total number of accepted claims for this submitter
7	Total Accept Charges	Total amount of accepted charges for this submitter
8	TRANSACTION STATUS REPORT	Title of Report
9	Page	Page number of the report
10	Submitter Name	Name of the designated submitter
11	Submitter ID	Submitter ID number assigned by EC Solutions
12	Submission ID	Submission identification number (Batch ID)
13	Processing Date and Time	Date and time transmission was processed (mmddccyy)
14	Provider Name	Name of designated provider
15	Provider ID	Provider tax ID or NPI number
16	Payer Name	Name of designated payer
17	Payer ID	Payer identification number
18	TXN Format/Version	Claim format or version
19	Submitter File#	Number of submitter file
20	Receipt Date	Date transmission was received (yymmdd)
21	Create Date	Date the transmitted date was created (ccyymmdd)
22	Group CTL#	Number of designated provider group
23	Transaction #	Number of transaction
24	Member ID	Member identification number
25	ECS Document#	Number of document assigned by EC Solutions
26	Patient Last Name	Last name of patient
27	Patient First Name	First name of patient
28	Patient CTL#	Control number assigned to patient by provider office
29	TOB/POS	Type of Bill/Place of Service
30	Charge	Procedure charge
31	From Date	Starting date of service rendered (ccyymmdd)
32	To Date	Ending date of service rendered (ccyymmdd)
33	Status	Rejected or Accepted status
34	Reject Explanation	Heading for error information that follows
35	Segment/Record	Segment or Record where the error occurred
36	Field Name	Name of Field/Element where the error occurred

No.	Field	Description
37	Segment Count	Segment Count of Segment with error Example: 10 th segment in file (The count starts with the ISA segment as 1, GS segment as 2 and so on.)
38	Additional Explanation	More detailed information on why the error occurred
39	Total Txns	Total number of claims for this provider submitting to this payer
40	Total Charges	Total amount of charges for this provider submitting to this payer
41	Total Reject Txn	Total number of rejected claims for this provider submitting to this payer
42	Total Reject Charges	Total amount of rejected charges for this provider submitting to this payer
43	Total Accept Txn	Total number of accepted claims for this provider submitting to this payer
44	Total Accept Charges	Total amount of accepted charges for this provider submitting to this payer
45	TRANSACTION SUMMARY BY PAYER	Summary by payer
46	Total Txns	Total number of claims for each payer
47	Rejected Txns	Total number of claims rejected for each payer
48	Accepted Txns	Total number of claims accepted for each payer
49	Accepted Charges	Total amount of accepted charges for each payer
50	Payer name	Individual list of payers submitted
51	END OF TRANSACTION STATUS REPORT	End of report

.z16 - Wellmark BCBS of Iowa and South Dakota Payer Claim Confirmation Detail Report

Description The Wellmark BCBS of Iowa and South Dakota Payer Claim Confirmation Detail Report (.z16) is produced when any of the transmitted claims are Wellmark claims.

Call For Assistance If you need assistance reading this report, you may call the EC Solutions Assistance Center at 800-407-0267 for an explanation of the report.

Availability The .z16 is available for download for 14 days. After 14 days, it is removed from Web BBS and is no longer available.

Example Below is a report example with *numbered* fields and field names in **bold**. The *numbers* are provided to easily identify each field on the following table but are not displayed on the actual report.

08/01/2010 1. **WELLMARK HXAP1251 CLAIM ERROR REPORT FOR** 2. **SUB #:** 000099999

3. **PROVIDER NO:** 1234567890
4. **PROVIDER NAME:** DR. DOE

5. **BATCH**

CREATE		7. F		10. MEDICAL
DATE	6. LAST...NAME..	I	8. LOB	9. DOS
080110	FLINTSTONE	F	S	100729

 11. **PROV NPI DATA NOT RECOGNIZED BY WELLMARK** 0003

12. ***** THE ABOVE CLAIMS WERE NOT ACCEPTED FOR PROCESSING *****
12. ***** PLEASE RESUBMIT THESE CLAIMS WITH CORRECTIONS *****

END REPORT

08/01/2010 13. **WELLMARK HXAP1252 CLAIM ACCEPTANCE REPORT FOR:** 14. 000099999

15. **PROVIDER NO:** 1234567890
16. **PROVIDER NAME:** DR. DOE
17. **BATCH CREATE DATE:** 080110

18. LAST NAME	19. F I	20. L B	21. FROM DATE	22. TO DATE	23. MEDICAL REC #	24. REFERENCE NUMBER	25. CLAIM AMOUNT
MOUSE	M	S	072910	072910	123456789AA	050022009692	\$805.00
DUCK	D	S	072810	072810	10014250BBB	050022009655	\$102.00
BOOP	B	S	072910	072910	10014417ABC	050022009657	\$110.00
COYOTE	W	S	073010	073010	10019826AAA	050022009689	\$515.00

26. ***** THE ABOVE CLAIMS WERE ACCEPTED FOR PROCESSING *****

END REPORT

08/01/2010 27. **WELLMARK HXAP1254 SUMMARY REPORT FOR SUBMITTER:** 28. 000099999

29. **BATCH**

CREATE DATE	30. PROVIDER ID	31. PROVIDER NAME	32. L-O-B	33. CLM TOT	34. WITH ERR	35. NO ERR	36. TOTAL CHARGES
080110	1234567890	DR. DOE	BS	0005	0001	0004	\$ 1532.00
				37. 0005	0001	0004	\$ 1532.00

END REPORT

Rejected Claims - If any claims in the transmitted file were rejected, the error section is present.

No.	Field	Description
1	Section title	WELLMARK HXAP1251 CLAIM ERROR REPORT FOR SUB #
2	Submitter Number	Submitter identification number assigned by EC Solutions
3	PROVIDER NO	Provider identification number or NPI
4	PROVIDER NAME	Name of the rendering provider
5	BATCH CREATE DATE	Date the batch was created (mmddyy)
6	LAST NAME	Last name of the patient
7	FIRST INIT	First initial of the patient
8	L-O-B	Line of business
9	DATE OF SERV	Beginning date of service for the claim (yymmdd)
10	MEDICAL REC #	Record number assigned by the provider's office
11	Error information (not labeled)	Error message and code that explains why the claim was rejected Example: PROV NPI DATA NOT RECOGNIZED BY WELLMARK 0003
12	Section trailer	THE ABOVE CLAIMS WERE NOT ACCEPTED FOR PROCESSING PLEASE RESUBMIT THESE CLAIMS WITH CORRECTIONS

Accepted Claims – If any claims in the transmitted file were accepted, the accepted claims section of the report is present.

No.	Field	Description
13	Section title	WELLMARK HXAP1252 CLAIM ACCEPTANCE REPORT FOR (submitter number)
14	Submitter Number	Submitter identification number assigned by EC Solutions
15	PROVIDER NO	Rendering provider identification number or NPI *See Appendix A
16	PROVIDER NAME	Name of the rendering provider
17	BATCH CREATE DATE	Date the batch was created (mmddyy)
18	LAST NAME	Last name of the patient
19	FI	First initial of the patient
20	L-O-B	Line of business
21	FROM DATE	Beginning date of service for the claim (mmddyy)
22	TO DATE	Ending date of service for the claim (mmddyy)
23	MEDICAL REC #	Record number assigned by the provider's office
24	REFERENCE NUMBER	Payer's assigned claim reference number
25	CLAIM AMOUNT	Amount billed for services
26	Section trailer	THE ABOVE CLAIMS WERE ACCEPTED FOR PROCESSING

Summary for Submitter – The last section of the report provides a summary of the claims for the identified submitter and provider.

No.	Field	Description
27	Section title	WELLMARK HXAP1254 SUMMARY REPORT FOR SUBMITTER
28	Submitter number	Submitter identification number assigned by EC Solutions
29	BATCH CREATE DATE	Date the batch was created (mmddyy)
30	PROVIDER ID	Provider identification number or NPI *See Appendix A
31	PROVIDER NAME	Name of rendering provider
32	L-O-B	Line of business
33	CLM TOT	Total number of claims in the batch for this provider
34	WITH ERR	Number of claims in the batch with errors
35	NO ERR	Number of claims in the batch without errors
36	TOTAL CHARGES	Total dollar amount for claims submitted without errors
37	Grand totals (not labeled)	The report provides the following grand totals for <u>all</u> providers: Claim Total, Total Claims With Errors, Total Claims Without Errors, Total Accepted Charges

.ebr - Availity Electronic Batch Report

Description The Availity Electronic Batch Report (.ebr) is a new report. It is produced for commercial claims that were transmitted to Availity and then routed to commercial payers. The .ebr contains transaction-level information indicating whether the specified payer accepted or rejected each transaction based on its own HIPAA compliance and payer-specific edits. The .ebr includes any pre-adjudication responses.

NOTE: This report must be printed in landscape format.

Call For Assistance If you need assistance reading this report, you may call the EC Solutions Assistance Center at 800-407-0267 for an explanation of the report.

Availability The .ebr is available for download for 14 days. After 14 days, it is removed from Web BBS and is no longer available.

Example Below is a report example with *numbered* fields and field names in **bold**. The *numbers* are provided to easily identify each field on the following table but are not displayed on the actual report. Field numbers 1-31 will be repeated for each payer involved.

1. Availity Electronic Batch Report

```

-----
2. Date Received:          2010-12-13          3. Time Received:          17.21.33.417
4. Availity Batch ID:      2010121317102100      5. File Control Number:    000310861
-----
6. Payer:                  HUMANA
7. Received Claims:        2                    8. Charges:                102.00
9. Accepted Claims:        1                    10. Charges:               66.00
11. Rejected Claims:       1                    12. Charges:               66.00
-----
13. Patient Name:          MOUSE, MICKEY
14. From Date:             20100910            15. To Date:                20100910
16. Patient Control Number: 1970                17. Charge:                66.00
18. Provider Billing ID:    222222222           19. Clearinghouse Trace #:  800000031
20. Payer Claim #:         NA                    21. Availity Trace #:       323399504
-----
22. Message Initiator:     HUMANA                23. Message Type: NA      24. Message Code: TA1
25. Message:               Your claim has been successfully submitted to HUMANA.
26. Loop:                  NA
27. Segment ID:           NA      28. Element #:           NA
-----
Patient Name:          MOUSE, MINNIE
From Date:             20100910            To Date:                20100910
Patient Control Number: 1970                Charge:                66.00
Provider Billing ID:    222222222           Clearinghouse Trace #:  800000031
Payer Claim #:         NA                    Availity Trace #:       14545754
-----
29. Error Initiator:       HUMANA                Message Type: NA      30. Error Code: C
31. Error Message:        Claim Level Error - Duplicate Claim
Loop:                  NA                    Segment ID:           NA                    Element #:           NA

```

Report Header – The report header provides the report title.

No.	Field	Description
1	Report title	Availity Electronic Batch Report

Availity Batch – This is the processing information from Availity.

No.	Field	Description
2	Date Received	Date the file was received by Availity (ccyy-mm-dd)
3	Time Received	Time the file was received by Availity (hh.mm.ss)
4	Availity Batch ID	Number assigned by Availity to a transmitted batch of claims
5	File Control Number	Number assigned to a transmitted batch of claims

Summary Information - Payer name and the number and dollar amount of the rejected and accepted claims on the report.

No.	Field	Description
6	Payer	Name of the designated payer
7	Received Claims	Total number of claims rejected/accepted by Availity
8	Charges	Total dollar amount of the rejected/accepted claims
9	Accepted Claims	Total number of claims accepted by Availity
10	Charges	Total dollar amount of the accepted claims
11	Rejected Claims	Total number of claims rejected by Availity
12	Charges	Total dollar amount of the rejected claims

Claim Information – Detailed information regarding the claims that were rejected and/or accepted by Availity.

No.	Field	Description
13	Patient Name	Patient's last name, first name, and middle initial
14	From Date	From date of service on the claim
15	To Date	To date of service on the claim
16	Patient Control Number	Medical record number assigned by the billing provider
17	Charge	Dollar amount of the claim
18	Provider Billing ID	Billing providers identification number
19	Clearinghouse Trace #	Submitter number issued by EC Solutions
20	Payer Claim #	Not used at this time
21	Availity Trace #	Trace number assigned by Availity
22	Message Initiator	Payer Name
23	Message Type	Not used at this time
24	Message Code	Message code returned from Availity
25	Message	Message returned by Availity
26	Loop	If an 837 error, the loop where error occurred
27	Segment ID	If an 837 error, the segment of the loop where error occurred
28	Element #	If an 837 error, the element within the segment where error occurred
29	Error Initiator	Payer Name
30	Error Code	Error Code returned from Availity
31	Error Message	Error message that explains why the claim was rejected

.dpr – Availity Delayed Payer Report

Description The Availity Delayed Payer Report (.dpr) is produced if the payer produces an electronic claims report and sends it back to Availity. This report replaced the .z16 - Payer Claim Confirmation Detail Report. These responses include transaction receipt acknowledgement, transaction rejection messages and warning messages, as well as adjudication responses returned by the destination payer. The .dpr may be received up to 30 days after the transaction submission to Availity.

NOTE: This report must be printed in landscape format.

Call For Assistance If you need assistance reading this report, you may call the EC Solutions Assistance Center at 800-407-0267 for an explanation of the report.

Availability The .dpr is available for download for 14 days. After 14 days, it is removed from Web BBS and is no longer available.

Example Below is a report example with *numbered* fields and field names in **bold**. The *numbers* are provided to easily identify each field on the following table but are not displayed on the actual report. Field numbers 1-28 will be repeated for each payer involved.

1. Availity Delayed Payer Report

```

-----
2. Date Received:          2010-12-06          3. Creation Time:          NA
4. Availity Batch ID:      0013988-2010120417251700_2  5. File Control Number:  000309510
-----
6. Patient Account Number: OP 138331          7. Total Charges:          130.20
8. Patient Name:           DUCK, DONALD          9. Process Date:           2010-12-04
10. From Date:            2010-07-24          11. Status:                ACK
12. Billing Provider Name: KISSEMEE HEALTH CENT  13. Billing Provider ID:  3333333333
14. Billing Provider NPI:  NA          15. Submitter Name:       KISSEMEE HEALTHT
16. Payer Name:           JOHN DEERE HEALTH CARE  17. Payer Claim Number:   NA
18. Payer ID:            95378          19. Payer Seq Number:     2
20. Availity Batch ID:      0013988-2010120417251700  21. Trace ID:             800000051
22. Claim Sequence #:      0
23. Message Type:         A          24. Message Code:
25. Message Loop:
27. Message Element:
28. Message Text:         CARRIER ACKNOWLEDGES RECEIPT OF CLAIM, NO FURTHER UPDATES TO FOLLOW [ ]
-----

```

Availity Delayed Payer Report

```

-----
Date Received:          2010-12-06          Creation Time:          NA
Availity Batch ID:      0013988-2010120417251700_2  File Control Number:  000309510
-----
Patient Account Number: OP 138331          Total Charges:          100.00
Patient Name:           DUCK, DAISY          Process Date:           2010-12-04
From Date:              2010-07-24          Status:                REJ
Billing Provider Name:  KISSEMEE HEALTH CENT  Billing Provider ID:    3333333333
Billing Provider NPI:  NA          Submitter Name:        KISSEMEE HEALTH
Payer Name:             JOHN DEERE HEALTH CARE  Payer Claim Number:   NA
Payer ID:               95378          Payer Seq Number:     2
Availity Batch ID:      0013988-2010120417251700  Trace ID:              800000051
Claim Sequence #:       0
-----

```

(continued on next page)

23. **Message Type:** R Message Code:
 Message Loop: Message Segment:
 Message Element:

28. **Message Text:** SOCIAL SECURITY/EMPLOYEE NUMBER NOT FOUND ON CARRIER FILES []

Report Header – The report header provides the report title and payer name.

No.	Field	Description
1	Report title	Availity Delayed Payer Report

Batch Information – This is processing information from Availity and the payer receiving the claims.

No.	Field	Description
2	Date Received	Date the file was received by the payer (ccyy-mm-dd)
3	Creation Time	Time the file was received by the payer (hh.mm.ss)
4	Availity Batch ID	Number assigned by Availity to a transmitted batch of claims
5	File Control Number	Unique number pulled from the ISA13

Claim Information – Detailed information regarding the claims that were rejected and/or accepted by the payer.

No.	Field	Description
6	Patient Account Number	Medical record number assigned by the billing provider
7	Total Charges	Dollar amount of the claim
8	Patient Name	Patient's last name, first name, and middle initial
9	Process Date	Date the file was processed by the payer (ccyy-mm-dd)
10	From Date	From date of service on claim (ccyy-mm-dd)
11	Status	Status received from Availity
12	Billing Provider Name	Billing provider's name
13	Billing Provider ID	Unique provider ID assigned to the provider by the payer
14	Billing Provider NPI	NPI number assigned to the billing provider
15	Submitter Name	Name of submitter
16	Payer Name	Name of the designated payer
17	Payer Claim Number	Claim number assigned by the payer
18	Payer ID	Identification number of the payer
19	Payer Seq Number	Assigned by Availity
20	Availity Batch ID	Number assigned by Availity to a transmitted batch of claims
21	Trace ID	Submitter number issued by EC Solutions
22	Claim Sequence #	Assigned by Availity
23	Message Type	A=Accepted, R=Rejected, NA=No status returned
24	Message Code	Message code returned from the payer
25	Message Loop	If an 837 error, the loop where error occurred
26	Message Segment	If an 837 error, the segment of the loop where error occurred
27	Message Element	If an 837 error, the element within the segment where error occurred
28	Message Text	Message returned by the payer