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Wellmark Blue Cross and Blue Shield

HIPAA Transaction Standard Companion Guide Section 2, 837 Coordination of Benefits

Refers to the X12N Implementation Guide ANSI Version
4010A1

Version Number: 3.0

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This *Companion Guide* is a work in progress. Wellmark reserves the right to make changes to this *Companion Guide* at any time without notice. Changes appear in blue text and may be accompanied by a yellow note in the margin.

February 05, 2010

1 Introduction

Wellmark places a high priority on being the easiest plan with which to do business. The transmission of electronic claims from your organization to Wellmark in a standard data format is a key component in making it easy to do business with us. This 837P Companion Guide provides information about the 1996 Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) accepted standard which is the American National Standards Institute (ANSI) Institutional Claim 837 transaction, version 4010A1.

This Companion Guide was created to be used in conjunction with the HIPAA-AS Implementation Guide, which provides comprehensive information needed to create an ANSI 837 transaction. The Companion Guide does not supersede the specifications of the Implementation Guide; rather, it is intended to clarify the areas where the Implementation Guide provides options or choices.

The HIPAA-AS Implementation Guide can be downloaded from the following Internet address:
http://www.wpc-edi.com/hipaa/HIPAA_40.asp .

When a transaction is sent to Wellmark, it first processes through Business Exchange Services (BES). BES translates the ANSI 837 transaction into a format readable by Wellmark's internal system. Section 1 of the Wellmark Companion Guide provides further information about the process of sending electronic transactions to Wellmark via BES.

The purpose of HIPAA-AS is to standardize transactions as much as possible. However, transactions may have some data elements that are treated differently by different payers. There may be instances where HIPAA requires certain data be sent, but Wellmark may not require that data to conduct business. In such cases, Wellmark may only store this data. See the Questions and Answers page for more information on the 837.

Billing the Appropriate 837 Version

There are four versions of the 837 transaction:

- 837I (Institutional)
- 837P (Professional)
- 837D (Dental)
- 837COB (Coordination of Benefits transaction). Effective 7/1/09, Wellmark began accepting 837 non- Medicare COB claims. Effective 2/5/10 Wellmark began accepting Medicare COB claims submitted by providers.

In general, practitioners bill using the 837P, facilities use the 837I, and dentists use the 837D.

Medicare COB Claims:

1. When Medicare Part A (Institutional) is the primary payer and the claim is **Inpatient**- Medicare provides payment information at the claim level. Medicare payment information is to be created at the claim level when submitting these claims to Wellmark.
2. When Medicare Part A (Institutional) is the primary payer and the claim is **Outpatient**- Medicare provides payment information at the header and line level. Medicare payment information is to be created at the header and line level when submitting these claims to Wellmark.
3. When Medicare Part B (Professional) is the primary payer, Medicare provides payment information at the header and line level. Medicare payment information is to be created at the header and line level when submitting these claims to Wellmark.

Note: When submitting Medicare COB claims to Wellmark, these claims must be placed in a separate file from other 837 formatted claims and a special Receiver ID (**88848MC**) is to be used in the **ISA08** and **GS03** elements. If Medicare COB claims are not submitted using this Receiver ID, the claims will be rejected and not allowed into Wellmark's system. When claims that are not Medicare COB are submitted using the new submitter ID, the claims will be rejected out of the Wellmark system.

Additional Information:

1. All providers, physicians, and suppliers need to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0909.pdf>) — **before** attempting to balance bill Wellmark. **Do not balance bill** until you have received written confirmation from Medicare that your patients' claims **will not** be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over. Medicare will continue to issue supplemental notifications to all participating providers, physicians, and suppliers informing them if claims targeted for crossover, as evidenced by MA18 or N89 on the MRA, do not actually result in successful crossover transmissions.

Approximately 99 percent of all claims that Medicare identifies for crossover, as cited on your Medicare Remittance Advice, **actually are crossed over** by CMS' Coordination of Benefits Contractor (COBC). The remaining percentage error out at the COBC due to HIPAA compliance issues or related data errors, resulting in the provider, physician, or supplier's receipt of a Medicare-generated special notification letter specifying the reason for the claim's failure to cross over.

2. If you have any questions, call the EC Solutions Assistance Center at 800-407-0267. You may also email the Assistance Center at ecsolutionsdsm@hp.com.

See the following exhibits/examples for Wellmark specific requirements regarding various 837 loops and segments for Medicare COB Claims.

Exhibit 1: 837 Medicare COB Part A - Inpatient Claim: *Wellmark pays Secondary to Medicare and no other payer is present. (see also example 1)*

Loop and Segment	Values used	Wellmark Requirements
ISA08 GS03	88848MC	Wellmark requires 88848MC be submitted in the ISA08 and GS03 segments for Medicare COB claims. Failure to submit these claims with this value will result in claim rejection.
2000B SBR01	S - Wellmark paying secondary or	Use of ' S ' in this loop and segment requires loops 2320 , 2330A and 2330B
2320 SBR01	P –Used to represent the primary payer (Medicare).	Required when Wellmark is not paying primary (2000B SBR01 = S)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR09	Insurance type code MA = Medicare Part A (Institutional)	' MA ' is required in SBR09 to identify the payer as Medicare Part A. If this is not received, the claim will not process appropriately and will result in claim rejection.
2320 CAS	Claim Level Adjustments CAS01 = CO – provider responsibility CAS01 = PR – Patient responsibility	Claim level CAS segments are required on Medicare Part A-Inpatient claims. Both the patient responsibility (adjustment group code ' PR ') and/ or provider contractual obligations (adjustment group code ' CO ') are required. In addition any non-covered amounts indicated in loop 2400 SV207 must be identified here with a Group code and Claim adjustment Reason code. (835 loop 2100 CAS). Failure to submit CAS segments when the claim is not paid at 100% of billed charge will result in claim rejection.
2320 AMT	AMT01 = C4 – COB paid amount AMT01 = N1 – Medicare paid amount	The total Medicare paid amount must be provided in this loop using C4 or N1. AMT01= C4 or N1 (835 loop 2100 CLP04). Failure to submit the Medicare paid amount will result in claim rejection.
2320 AMT	AMT01 = B6 – Allowed amount or AMT01 = AAE – Approved amount	Submit when provided by Medicare
2320 AMT	AMT01 = A8 - Other Payer Total non-covered amount	Submit when provided by Medicare. This amount must also be identified by Claim adjustment Group and reason codes (2320 CAS).
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B N3 2330B N4	N3 Other Payer Address N4 Other Payer City/State/ZIP Code	Provide when known
2330B DTP	DTP01 = 573 Other payer adjudication date	Must be provided in this loop on Inpatient claims.
2430 SVD and CAS	Line adjudication information and line adjustment information	This would not be provided as payment information is given at claim level only
Balancing		Wellmark requires the total paid amount and adjustment amounts to balance with the total billed amount. Or claim will be rejected.

Example 1: Following is an Inpatient Medicare Part A COB claim: *Wellmark is secondary (Not all loops and segments are displayed. Only those loops and segments used in Wellmark COB processing are listed.)*

2000B	SBR*S*18*****BL (Wellmark's Subscriber loop)
2300	CLM*ABC123TEST*16509.26***11:A:1*Y*A*Y*Y*****Y (Balancing is PAID + PR1 + CO94 = CLM2)
2320	SBR*P*18**MEDICARE****MA (Failure to submit 'MA' in SBR09 may result in claim rejection)
2320	CAS*CO*94*12794.49 (Balancing: N1 + PR1 + CO94 = CLM2)
2320	CAS*PR*1*1068 (Balancing: N1 + PR1 + CO94 = CLM2)
2320	AMT*B6*16509.26
2320	AMT*N1*2646.77 (Balancing: N1 + PR1 + CO94 = CLM2)
2320	DMG*D8*19400913*M
2320	OI***Y***Y
2330A	NM1*IL*1*SUBSCRIBER*ONE*A***MI*#####A (Other payer Subscriber Name)
2330A	N3*1 E MAIN ST (Other payer Subscriber Address)
2330A	N4*DES MOINES*IA*50309 (Other payer Subscriber City State Zip)
2330B	NM1*PR*2*MEDICARE****PI*03001 (Medicare -Other Payer and Payer ID)
2330B	N3*900 42ND STREET SOUTH (Other Payer Address)
2330B	N4*FARGO*ND*581086724 (Other Payer Address)
2330B	DTP*573*D8*20091030 (Medicare Adjudication Date)
2400	LX*1 SV2*0117**1146*DA*1*1146 LX*2 SV2*0250**1185.96*UN*30*0 LX*3 SV2*0258**762*UN*5*0 LX*4 SV2*0270**256*UN*5*0 LX*5 SV2*0271**340*UN*2*0 LX*6 SV2*0272**7258.3*UN*15*0 LX*7 SV2*0305**127*UN*1*0 LX*8 SV2*0306**97*UN*2*0 LX*9 SV2*0307**77*UN*1*0 LX*10 SV2*0312**141*UN*1*0 LX*11 SV2*0360**3031*UN*1*0 LX*12 SV2*0370**834*UN*128*0 LX*13 SV2*0710**1254*UN*114*0

Exhibit 2: 837 Medicare COB Part A-Outpatient Claim: *Wellmark pays Secondary to Medicare and no other payer is present. (See also Example 2)*

Loop and Segment	Values used	Wellmark Requirements
ISA08 GS03	88848MC	Wellmark requires 88848MC be submitted in the ISA08 and GS03 segments for Medicare COB claims. Failure to submit these claims with this value will result in claim rejection.
2000B SBR01	S- Wellmark paying secondary or	Use of S in this loop and segment requires loops 2320, 2330A and 2330B
2320 SBR01	P –Used to represent the primary payer (Medicare).	Required when Wellmark is not paying primary (2000B SBR01 = S)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR09	Insurance type code MA = Medicare Part A (Institutional)	' MA ' is required in SBR09 to identify the payer as Medicare Part A. If this is not received, the claim will not process appropriately and may lead to claim rejection.
2320 CAS	Claim Level Adjustments	Claim level CAS segments are not required on Medicare Part A-Outpatient claims. These are required at the 2430 loop.
2320 AMT01	AMT01 = C4 – COB paid amount AMT01 = N1 – Medicare paid amount	The total Medicare paid amount must be provided in this loop using C4 or N1. (835 loop 2100 CLP04). Failure to submit the total Medicare paid amount will result in claim rejection. Medicare paid amount in this loop must equal the sum of line level paid amounts or claim will be rejected.
2320 AMT01	AMT01 = B6 – Allowed amount or AMT01 = AAE – Approved amount	Submit when provided by Medicare
2320 AMT01	AMT01 = A8 - Other Payer Total non-covered amount	Submit when provided by Medicare. This amount must also be identified by Claim adjustment Group and reason codes (2430 CAS).
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B N3 and N4	N3 Other Payer Address N4 Other Payer City/State/ZIP Code	Provide when known
2430 SVD	Line adjudication information SVD02 = line paid amount	This segment is required even when the paid amount is zero. Failure to report the SVD segment on all detail lines will result in claim rejection. (835 loop 2110 SVC03)
2430 CAS	Line adjustment information CAS01 = CO – provider responsibility CAS01 = PR – Patient responsibility	Both the patient responsibility (adjustment group code ' PR ') and/ or provider contractual obligation (adjustment group code ' CO ') are required. In addition any non-covered amounts indicated in loop 2400 SV207 must be identified here with a Group code and Claim adjustment Reason code. (835 loop 2110 CAS). Failure to submit CAS segments when the service is not paid by Medicare at 100% of charge will result in claim rejection.
2430 DTP	DTP01 = 573 Other payer adjudication date	Must be provided in this loop on Outpatient claims.
Balancing		Wellmark requires the line level paid amount and line level adjustment amounts to balance with the line billed amount.

	(2320 AMT01 = C4 or N1) must equal sum of all (SVD02). If the line level information does not balance, the claim will be rejected.
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Example 2: Following is an Outpatient Medicare Part A COB claim, where Wellmark is secondary (Not all loops and segments are displayed. Only those loops and segments used in Wellmark COB processing are listed)

2000B	SBR*S*18*****BL
2300	CLM*123ABCTEST*117***13:A:1*Y*A*Y*Y*****Y
2320	SBR*P*18**MEDICARE*****MA (Failure to submit 'MA' in SBR09 may result in claim rejection)
2320	AMT*B6*117
2320	AMT*N1*56.75 (Total paid amount must equal the sum of all 2430 SVD02 amounts)
2320	DMG*D8*19320807*M
2320	OI***Y***Y
2330A	NM1*IL*1*SUBSCRIBER*ONE*A***MI*#####A
2330A	N3*1 MAIN ST
2330A	N4*DES MOINES*IA*50309
2330B	NM1*PR*2*MEDICARE*****PI*03001 (Medicare -Other Payer and Payer ID)
2330B	N3*900 42ND STREET SOUTH
2330B	N4*FARGO*ND*581086724
2400	LX*1 SV2*0510*HC:99212*117*UN*1*0 (Balancing: SVD01 + CO45 + PR2= SV203) DTP*472*D8*20090908
2430	SVD*03001*56.75*HC:99212*0510*1 (Balancing: SVD01 + CO45 + PR2= SV203)
2430	CAS*CO*45*46.05 (Balancing: SVD01 + CO45 + PR2= SV203)
2430	CAS*PR*2*14.2 (Balancing: SVD01 + CO45 + PR2= SV203)
2430	DTP*573*D8*20091030 (Medicare Adjudication Date)

Exhibit 3: 837 Medicare COB Professional Claim: *Wellmark pays Secondary to Medicare and no other payer is present. (See also Example 3)*

Loop and Segment	Values used	Wellmark Requirements
ISA08 GS03	88848MC	Wellmark requires 88848MC be submitted in the ISA08 and GS03 segments for Medicare COB claims. Failure to submit these claims with this value will result in claim rejection.
2000B SBR01	S - Wellmark paying secondary or	Use of 'S' in this loop and segment requires loops 2320 , 2330A and 2330B
2320 SBR01	P –Used to represent the primary payer (Medicare).	Required when Wellmark is not paying primary (2000B SBR01 = S)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR09	Insurance type code MB = Medicare Part B (Institutional)	' MB ' is required in SBR09 to identify the payer as Medicare Part B. If this is not received, the claim will be rejected.
2320 CAS	Claim Level Adjustments	Claim level CAS segments are not required on Medicare Part B claims. These are required at the 2430 loop.
2320 AMT01	AMT01 = D – COB Payer paid amount	The total Medicare paid amount must be provided in this loop using AMT01 = D. (835 loop 2100 CLP04). Failure to submit the Medicare total paid amount will result in claim rejection.
2320 AMT01	AMT01 = B6 – Allowed amount or AMT01 = AAE – Approved amount	This amount must be equal to the sum of all line level 2400 AMT*AAE amounts. The allowed amount is required by Wellmark or the claim will be rejected.
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B N3 and N4	N3 Other Payer Address N4 Other Payer City/State/ZIP Code	Provide when known
2400 AMT	Line allowed amount AMT01 = AAE	The total sum of all 2400 AMT*AAE must equal the total allowed amount in 2320 AMT*B6.
2430 SVD	Line adjudication information SVD02 = line paid amount	This segment is required even when the paid amount is zero. Failure to report the SVD segment will result in claim rejection. The sum of all SVD02 segments must equal 2320 Paid amount. (835 loop 2110 SVC03)
2430 CAS	Line adjustment information CAS01 = CO – provider responsibility CAS01 = PR – Patient responsibility	Both the patient responsibility (adjustment group code ' PR ') and/ or provider contractual obligation (adjustment group code ' CO ') are required. Failure to report when service line paid amount (SVD02) is not equal to 100% of billed amount will result in claim rejection. (835 loop 2110 CAS)
2430 DTP	DTP01 = 573 Other payer adjudication date	Must be provided in this loop on Professional claims.
Balancing		Wellmark requires the line level paid amount and line level adjustment amounts to balance with the line billed amount. (SVD02 + CAS=SV102) Total Paid (2320 AMT01 = D) must equal sum of all line level paid amounts (SVD02).

Example 3: Following is a Medicare Part B COB claim, where Wellmark is secondary (Not all loops and segments are displayed. Only those loops and segments used in Wellmark COB processing are listed.)

2000B	SBR*S*18*****ZZ
2300	CLM*030698-00*306.86***21::1*Y*A*Y*Y*B
2320	SBR*P*18*503244131A**MB***MB
2320	AMT*D*245.49 (This amount must be equal to the sum of all loop 2400 SVD02 amounts)
2320	AMT*B6*306.86 (This amount must be equal to the sum of all loop 2400 allowed amounts)
2320	DMG*D8*19301113*F
2320	OI***Y*B**Y
2330A	NM1*IL*1*SUBSCRIBER*ONE*A***MI*#####A
2330A	N3*1 W MAIN ST
2330A	N4*DES MOINES*1A*50309
2330B	NM1*PR*2*NORIDIAN MIDWEST****PI*03302
2400	LX*1 SV1*HC:36620*47.83*UN*1*21**1 DTP*472*D8*20090615 AMT*AEE*47.83 (The sum of all 2400 AMT*AEE amounts must be equal to loop 2320 AMT*B6 amount)
2430	SVD*03302*38.26*HC:36620**1 (Balancing: SVD02 + PR2=SV102)
2430	CAS*PR*2*9.57 (CAS required on every service line where the billed amount is not paid at 100%)
2430	DTP*573*D8*20091028
2400	LX*2 SV1*HC:01402:QK*186.61*UN*11.9*21**1 DTP*472*D8*20090615 AMT*AEE*186.61 (The sum of all 2400 AMT*AEE amounts must be equal to loop 2320 AMT*B6 amount)
2430	SVD*03302*149.29*HC:01402:QK**11.9 (Balancing: SVD02 + PR2=SV102)
2430	CAS*PR*2*37.32 (CAS required on every service line where the billed amount is not paid at 100%)
2430	DTP*573*D8*20091028
2400	LX*3 SV1*HC:64448:59*72.42*UN*1*21**3 DTP*472*D8*20090615 AMT*AEE*72.42 (The sum of all 2400 AMT*AEE amounts must be equal to loop 2320 AMT*B6 amount)
2430	SVD*03302*57.94*HC:64448:59**1 (Balancing: SVD02 + PR2=SV102)
2430	CAS*PR*2*14.48 (CAS required on every service line where the billed amount is not paid at 100%)
2430	DTP*573*D8*20091028

Non-Medicare COB Claims:

1. When the other payer provides payment information at the claim level only, this payment information is to be provided at the claim level (loop 2320). There is no need to create information for the service line detail.
2. When the other payer provides payment information at the service line level only, this payment information is to be provided at the line level (loop 2430). In addition to the service line payment information, submit the other payer total paid amount at the claim level in loop 2320. (AMT*C4 or AMT*D)
3. When the other payer provides payment information at both the claim level and service line level, the payment information is to be provided at the claim level (loop 2320) as well as service line level (loop 2430).

Additional Information:

1. Non Medicare COB claims may be submitted with your general population of claims using Receiver ID **88848** (ISA08 and GS03). Submission of Medicare COB claims using this receiver ID will result in claim rejection.
2. When Wellmark is the primary payer, do not include any other payer **payment information** (loop 2320 AMT*C4, AMT*D or loop 2320 CAS values) on the claim. Submitting other payer information, even if it is a zero dollar amount, on a Wellmark primary claim will cause delays in claim processing.
3. If you have any questions, call the EC Solutions Assistance Center at 800-407-0267. You may also email the Assistance Center at ecsolutionsdsm@eds.com.

See the following exhibits for Wellmark specific requirements regarding various 837 loops and segments for non-Medicare COB claims.

Exhibit 4: 837 COB Institutional or Professional claim: *Where other payer (not Medicare), payment information, is provided at the claim level only.*

Loop and Segment	Values used	Wellmark Requirements
ISA08 GS03	88848	The Wellmark receiver ID is submitted in the ISA08 and GS03 segments. This ID is used for COB claims and non-COB claims sent to Wellmark in the 837I and 837P format.
2000B SBR01	S- Wellmark paying secondary or T- Wellmark paying tertiary	Use of 'S' or 'T' in this loop and segment requires loops 2320, 2330A and 2330B
2320 SBR01	P –Used when only one 'other payer exists'. S- Used when more than one 'other payer' exists and payment information is provided for both. T- Used when Wellmark is Secondary and another payer pays Tertiary. Or when there are three 'other payers' processing prior to Wellmark.	Required by Wellmark when Wellmark is not paying primary (2000B SBR01 = S or T)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR05	Other Insurance type code.	IG requires on Professional claims Not used on Institutional claims.
2320 SBR09	Insurance type code	Wellmark requires this data be submitted so the other payer type can be determined.
2320 CAS	Claim Level Adjustments CAS01= CO -Provider Contractual Obligation CAS01= PR -Patient responsibility	This would be required when the payer is not paying at 100% of billed amount. (835 transaction loop 2100 CAS)
2320 AMT01	Other Payer paid amount AMT01=C4 (Institutional) AMT01=D (Professional)	Wellmark requires this data even if the paid amount is zero. AMT01= D or C4 (835 loop 2100 CLP04)
2320 AMT01	AMT01 = B6 – Allowed amount	Provide when known.
2320 AMT01	Other Payer Total non-covered amount AMT01=A8 (Institutional only)	Provide when known.
2320 AMT01	Patient Responsibility AMT01=F2 (professional only)	Provide when known (835 loop 2100 CLP05)
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B PER	Other Payer contact name	Provide when known
2330B DTP	Other payer adjudication date	Required at claim level when payment information is given at claim level.
2430 SVD and CAS	Line adjudication information and line adjustment information	This would not be provided when payment information was given at claim level only. No need to create
Balancing		Wellmark requires the total paid amount (AMT01=D or C4) and adjustment amounts (CAS amounts) to balance with the total billed amount (CLM02).

Exhibit 5: 837 COB Institutional or Professional claim: *Where other payer (not Medicare) payment information is provided at the line level only.*

Loop and Segment	Values used	Wellmark Requirements
2000B SBR01	S- Wellmark paying secondary or T- Wellmark paying tertiary	Use of S or T in this loop and segment requires loops 2320, 2330A and 2330B
2320 SBR01	P –Used when only one other payer exists. and S- Used when more than one other payer exists and payment information is provided. T- Used if Wellmark is Secondary and another payer pays Tertiary.	Required by Wellmark when Wellmark is not paying primary (2000B SBR01 = S or T)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR05	Other Insurance type code.	IG requires
2320 SBR09	Insurance type code	Wellmark prefers to receive this data
2320 CAS	Claim Level Adjustments	Would not be submitted not provided at claim level
2320 AMT01=C4 (institutional) 2320 AMT01=D (Professional)	Other Payer paid amount	Wellmark would like the total paid amount; however provider may leave this off when other payer does not provide this at the claim level. Or provider may calculate from detail line paid amounts
2320 AMT01=B6	Other payer approved amount	Do not submit if not provided at claim level
2320 AMT01=A8 (Institutional)	Other Payer Total non-covered amount	Do not submit if not provided at claim level
2320 AMT01=F2 (professional)	Patient Responsibility	Do not submit if not provided at claim level
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B PER	Other Payer contact name	Provide if known
2330B DTP	Other payer adjudication date	Provide when given.
2430 SVD01	Line adjudication Payer ID.	IG Requires. The payer ID in 2430 SVD01 must match the payer ID in 2330B NM109.
2430 SVD02	Service line paid amount	IG requires
2430 CAS	Line Adjustments	IG requires when service line is not paid at 100% of charge
Balancing		Wellmark requires the paid amount and adjustment amounts to balance with the line charge amount

Exhibit 6: 837 COB Institutional or Professional claim: *Where the other payer (not Medicare) payment information is provided at both the claim level and line level.*

Loop and Segment	Values used	Wellmark Requirements
2000B SBR01	S- Wellmark paying secondary or T- Wellmark paying tertiary	Use of S or T in this loop and segment requires loops 2320, 2330A and 2330B
2320 SBR01	P –Used when only one other payer exists. and S- Used when more than one other payer exists and payment information is provided. T- Used if Wellmark is Secondary and another payer pays Tertiary.	Required by Wellmark when Wellmark is not paying primary (2000B SBR01 = S or T)
2320 SBR02	Patient relationship to Other Insured.	IG requires
2320 SBR03	Other insured group or policy number	Provide when known
2320 SBR04	Other insured group name.	Provide when known
2320 SBR05	Other Insurance type code.	IG requires
2320 SBR09	Insurance type code	Wellmark prefers to receive this data
2320 CAS	Claim Level Adjustments	Submit when the other payer has provided this information at a claim level. (835 transaction loop 2100 CAS)
2320 AMT01=C4 (institutional) 2320 AMT01=D (professional)	Other Payer paid amount	Wellmark prefers to receive the total paid amount using AMT01= D (835 loop 2100 CLP04)
2320 AMT01=B6	Other payer allowed amount	Provide when known
2320 AMT01=A8 (Institutional)	Other Payer Total non-covered amount	Provide when known
2320 AMT01=F2 (professional)	Patient Responsibility	Provide when known (835 loop 2100 CLP05)
2320 DMG	Subscriber demographic information.	IG requires when 2330A NM102 = 1 (person) per IG
2320 OI	Other insurance coverage information	IG requires when 2320 SBR used
2330A NM1	Other subscriber name	IG requires when 2320 SBR used
2330A N3	Other subscriber address	Provide when known
2330A N4	Other subscriber city/state/zip	Provide when known
2330B NM1	Other Payer Name	IG requires when 2320 SBR used
2330B PER	Other Payer contact name	Provide when known
2330B DTP	Other payer adjudication date	Provide when given.
2430 SVD01	Line adjudication Payer ID.	IG Requires. The payer ID in 2430 SVD01 must match the payer ID in 2330B NM109.
2430 SVD02	Service line paid amount	IG requires
2430 CAS	Line Adjustments	IG requires when service line is not paid at 100% of charge
Balancing		Wellmark requires the total paid amount and adjustment amounts to balance with the total billed amount