Joint Venture Hospital Laboratories

Companion Guide

ASC X12N 837I (005010X223A2)
Health Care Claim: Institutional 837

ASC X12N 837P (005010X222A1)
Health Care Claim: Professional 837

Version 1.5.3
December 2024

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Preface

This information is provided by Joint Venture Hospital Laboratories (JVHL) and is to be used as a reference in preparation of claims/encounter data submitted in conjunction with services contracted to Joint Venture Hospital Laboratories (JVHL). These instructions must be used as an adjunct to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated ANSI X12N 5010 HIPAA Professional Implementation X222A1 Guides and ANSI X12N 5010 HIPAA Institutional Implementation X223A2 Guides all of which are available from the Washington Publishing Company web site at: www.wpc-edi.com.

Disclosure Statement

The Washington Publishing Company documentation was prepared for use by all health insurance payers in the United States. The JVHL ANSI Companion Document is a supplement, but does not contradict any requirements in the ASC X12N 837 (005010X222A1 or 005010X223A2) data standards, as mandated by Health and Human Services.

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1. Introduction

1.1 Scope

This document is to be used as a companion document to the HIPAA Implementation Guide. It is designed for early implementation of the HIPAA Transactions for Professional or Institutional Claims/Encounters.

1.2 Overview

This Companion Guide will replace the previous JVHL Companion Guide for 837 Health Care Claim transactions. This Companion Guide will assist you in designing and implementing 837 Institutional and Professional Claim transactions that meet JVHL's processing standards. The JVHL Companion Guide identifies key data elements that we request be sent in the submitted transaction set. Adherence to these guidelines will enable you to more effectively submit 837 Institutional and Professional claim transactions to JVHL.

1.3 References

This document is to be used along with the X12N 5010 HIPAA Professional X222 and Institutional X223 Implementation Guides and the X222A1/X223A2 Errata. To obtain your copy of the Implementation Guide and Addenda, visit the Washington Publishing Company web site at: **www.wpc-edi.com.**

2. Getting Started

2.1 Trading Partner Registration

To request information on becoming a registered "Electronic Data Interchange (EDI) Trading Partner" with JVHL; please contact:

Rob Ramey
(248) 594-0998 x202
support@jvhl.org

Please note; that the following points are representative of the "basic requirements" to becoming an established "EDI Trading Partner" with JVHL*.

- ✓ Each trading partner is required to establish and maintain its respective EDI operation.
- ✓ EDI data exchange will not commence until both parties have demonstrated competency in conducting EDI transactions.
- ✓ JVHL will assist (where applicable) but will not provide EDI training.
- ✓ Both parties will agree to maintain trained EDI Operators and support personnel necessary to conducting EDI operations on a daily basis.
- ✓ Each party shall monitor the performance of its EDI Operations and take "Corrective Action" when deemed appropriate.

*A more detailed and comprehensive discussion of these and other topics is furnished to registrants as an integral part of the "(JVHL) Trading Partner Agreement" official document.

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3. Connectivity with the Payer/Communications

3.1 Transmission Administrative Procedures

The JVHL communication server provides secure internet access for both transmitting and receiving EDI transactions. Please contact Rob Ramey (Section 4 – Contact Information) for the account setup and software requirements.

3.2 Re-Transmission Procedure

Retransmission of 837 Health Care claims must use a new filename and ISA control number to avoid rejections for duplicate submission.

4. Contact Information

4.1 EDI Customer Service

Dave Moceri
Information Systems Support Tech
(248) 594-0998 x204
support@jvhl.org

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4.2 EDI Technical Assistance

Rob Ramey
IT Director
(248) 594-0998 x202
support@jvhl.org

5. Control Segments/Envelopes

5.1 ISA-IEA Segments

Element	Instruction
ISA05 – Interchange ID Qualifier	Report ZZ
ISA06 – Interchange Sender ID	Sender's Federal ID number
ISA07 – Interchange ID Qualifier	Report ZZ
ISA08 – Interchange Receiver ID	Report 382142103 (PLM Tax ID)
ISA15 – Usage Indicator	All providers submitting claims must first pass a format test. Enter T in this field when testing. Whenever a test file is sent, contact Rob Ramey at (248) 594-0998 x202. Once approved to send production data enter P in this field.

5.2 GS-GE Segments

Element	Instruction
GS02 – Application Sender's Code	Sender's Federal ID number
GS03 – Application Receiver's Code	Report 382142103. (PLM Tax ID)

5.3 ST-SE Segments

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Segment ID	Element ID	Name	Code	Notes
ST		Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	Health Care Claim
	ST02	Transaction Set Control Number	< Control #> Attributes: AN - 4/9	Identifying control number that must be unique within the transaction set functional group; assigned by the originator for a transaction set
	ST03	Implementation Convention Reference	005010X222A1 (Prof) / 005010X223A2 (Inst)	Contains same value as GS08
SE		Transaction Set Trailer		
	SE01	Number of Included Segments	<# Segments>	Number of segments included in a transaction set including ST and SE segments
	SE02	Transaction Set Control Number	< Control #> Attributes: AN - 4/9	The Transaction Set Control Number in ST02 and SE02 must be identical

6. Payer Specific Business Rules and Limitations

6.1 Delimiters and Data Content

- **Delimiters**
  a. Overview – The Implementation Guide uses the following delimiters in the examples. These characters **(*~ :^)** are widely used and must not be submitted within the data content of the 837.
  b. Data Element: The first element separator following the ISA will define what Data Element Delimiters are used throughout the entire transaction. **Recommended Data Delimiter * (Asterisk)**
  c. Repetition: The 11th element (ISA11) will define what Repetition Delimiter is used throughout the entire transaction. **Recommended Repetition Delimiter ^ (Caret)**
  d. Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **Recommended Segment Delimiter ~ (Tilde)**

- **Data Content**
  a. Mandatory – All mandatory data elements defined in the Implementation Guide must be submitted.
  b. Exception (Technical and Professional Component Charges) – For services where both a Technical and Professional component may be billed, the service should be billed to JVHL as follows:

  BILL CPT-4 CODES ON SEPARATE LINES WITH THE APPROPRIATE MODIFIERS: Example - 88305TC indicates the technical component is being submitted. 8830526 indicate the professional component is being submitted.

  IT IS IMPERATIVE THAT SPLIT BILLING OF THESE SERVICES OCCURS AND THAT THE APPROPRIATE MODIFIER IS INCLUDED ON EACH CLAIM LINE.

6.2 Coordination of Benefits (COB) Submission for 837 Claims

a. To submit COB claims, your data processing system / clearinghouse must be able to:

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- Create or forward claims in the full HIPAA standard format (837)
- Include payment information received from the primary payer's HIPAA standard electronic remittance advice (ERA).

b. COB claims require that the **837P or 837I** format is used and that insurance claims billed feature another payer as the primary with one of the following JVHL payers as the secondary payer:
   - Aetna (J1)
   - Aetna Better Health Premier Plan(M5)
   - Aetna Better Health Medicaid (**J8** - DOS >= 1/1/2017)
   - AmeriHealth Caritas VIP Care Plus (MD)
   - Bay County Health Plan (MA) – Termed 12/31/2018
   - BCBSM (KC)
   - BCN (J9)
   - BEHP (JE) – Termed 3/31/2018
   - Blue Cross Complete (KP, CC)
   - AmeriHealth Caritas VIP Care Plus (MD)
   - Cigna Healthcare (KD)
   - Community Care Assoc. (Health Choice) (JW)
   - Consumer's Mutual Insurance (KW)
   - DMC Care (JS – Only Claim With DOS Prior to 2/1/2015) – Termed 12/31/2017
   - Genesee County Health Plan (MB)
   - HAP (JG, JH)
   - HAP ASR (MR) – DOS 6/1/2021 and later
   - HAP CareSource (Midwest) (JB)
   - Health Plus (KE) – No claim level adjustments/payments allowed
   - Humana (KV)
   - McLaren Health Plan (K7)
   - Meridian Health Plan of Michigan (Health Plan of Michigan) (J2)
   - Priority Health (JZ)
   - Reliance HMO (MK)
   - Saginaw County Health Plan (MC) - Termed 12/31/2018
   - United Health Care (J5)
   - United Healthcare Community Plan (Great Lakes Health Plan) (JR)
   - VA Community Care (MS)
   - WellCare (MM)

c. Required payment information for commercial electronic COB claims:
   - Adjustment amounts – at both claim level and service line level
   - Adjustment reasons – contractual obligations, deductible, coinsurance, etc.
   - Primary payer paid amount – at both claim level and service line level

d. Other adjudication edits:
   - Procedures are to be bundled before billing COB to JVHL
   - Service line amounts must balance
   - Claim amounts must balance
   - All services lines must pass adjudication edits for claim to process

e. The required data (information) for JVHL COB claims should be available in the previous payer's adjudication of the claim. Please review section 9.2 of this document for transaction specific instructions on processing the data. The following topics are covered in greater detail:

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- Loop / Segment
- Data Element
- Requirements

7. Acknowledgements and/or Reports

7.1 Report Inventory

JVHL has instituted ASC X 12N compliant processes to generate interchange and implementation acknowledgements for ASC X12 files submitted by our trading partners. The acknowledgements that will be generated fall into two categories:

Interchange Acknowledgement (TA1)
Implementation Acknowledgement (999)

Receipt of the TA1 acknowledgement is not mandated by HIPAA, but will be generated for trading partners requesting this acknowledgement. It will also be generated for all trading partners as a notification of any interchange problems.

JVHL will always generate and return an Implementation Acknowledgement Transaction Set (999). The acknowledgements will be returned using the same method used for submitting EDI files to JVHL. If JVHL's SFTP site is used to submit claims data, then the acknowledgement files will be placed in the trading partner's pickup folder on our SFTP site. If JVHL's Secure Website is used to submit claims data, then the acknowledgement files will be placed in the trading partner's pickup folder on our Secure Website. Each acknowledgement file name will have an extension of '.999'.

JVHL will combine the TA1 acknowledgement segment (when it is generated) within the same ISE/IEA envelope that includes the 999 response. Below is an example of the general format that the EDI file will follow under these circumstances.

ISA
*TA1**
*GS**
(999) segments
*GE**
*IEA**

A TA1 segment will always be generated if an Interchange problem is detected. An example of an Interchange problem is if the EDI file being validated has an ISA control number that has previously been used by the submitter. If no Interchange problems are detected, then JVHL will only generate a TA1 segment if the EDI file that is being acknowledged contains a '1' in ISA014 (Acknowledgement Requested).

One advantage to requesting that a TA1 segment always be returned is that it includes the ISA control number from the original EDI file, which can be used to correlate the 999 information back to the original file. Otherwise, the file submitter needs to make sure that each GS (Functional Group Header) control number that is sent to JVHL is unique, as that is the identifying number which is used in the 999 response.

The 999 acknowledgement provides the ability for data rejections at various levels. Information in the 999 file can be rejected at the Interchange Level, the Functional Group Level, or the Transaction Set Level. It is important that the 999 acknowledgement file always be reviewed, since all claims below a rejected level will not be imported into the JVHL Claim System.

The 999 file will be the only notification provided to the trading partner. No notification will be made to the billing provider.

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Further information (re: TA1, 999) can be obtained from the Washington Publishing Company (www.wpc-edi.com).

8. Trading Partner Agreements

8.1 Trading Partners

Trading Partner Agreements for existing Partners are currently on file with JVHL. For new Trading Partners please contact Rob Ramey Ph: (248) 594-0998 x202, email: **support@jvhl.org**

9. Transaction Specific Information

9.1 Institutional (837I) and Professional (837P) Claims

Note: If there is a difference between the Professional and Institutional instructions, they will be preceded with 'P' for Professional and 'I' for Institutional

Institutional (837I) and Professional (837P) Claims			
Loop	**Segment/Element**	**Instruction**	**Element Name**
1000A	NM109	Report the Federal Tax Id of the submitter	Submitter Primary ID number
1000B	NM109	Report 382142103 as the receiver ID code.	ID Code
2010AA	NM108	Report XX	ID code qualifier
2010AA	NM109	Report the National Provider Identifier (NPI) of the billing provider	Billing Provider ID
2000B	SBR01	If billing JVHL as a secondary payer then see the JVHL 837 COB Companion Guide for the required segments, fields, and list of payers. When billing JVHL for a secondary payer not listed in the COB guide, send a hard copy claim to JVHL (999 Republic Drive, Ste. 300; Allen Park, MI 48101) with COB information attached.	Payer Resp. Sequence Number Code
2000B	SBR09	CI – Commercial and any HMOs	Claim Filing Indicator
2010BA	NM108	All payers – Report MI	Subscriber Id, Contract Number

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Institutional (837I) and Professional (837P) Claims (cont'd)			
Loop	**Segment/Element**	**Instruction**	**Element Name**
2010BB	NM108	Report PI	Qualifier
2010BB	NM109	JVHL provider claims use the following codes to identify payers. Note that plan participation is determined by the provider facility's membership level in JVHL. J1 – Aetna U.S. Healthcare M5 – Aetna Better Health Premier Plan MD - AmeriHealth Caritas VIP Care Plus MA – Bay County Health Plan - Termed 12/31/2018 JE – Beaumont Employee Health Plan (Termed DOS 3/31/2018) J9 – Blue Care Network* (JVHL Network) JJ – Blue Care Network* (BCN Commercial Labs) JQ – Blue Care Network* (BCN Reimbursable Labs) MJ – Blue Care Network* (Critical Access / Small Volume Labs) KP – Blue Cross Complete KC - BCBSM Medicare Plus Blue PPO KD – Cigna Healthcare (Non-HAP and CIGNA-HAP members) KD – Cigna Healthcare (CIGNA-Priority Health Dual Branded ID cards with Payer ID 62308 on the back of the card) KQ – Cigna Healthcare – (Health Partners members only) JW – Community Care Associates (Healthchoice) J8 – CoventryCares - Aetna Better Health of MI JS – DMC Care (Termed 12/31/2017) MB – Genesee County Health Plan M1 – Harbor Health Plan (Termed 12/31/2018) JG – Health Alliance Plan (Capitated Contracts) Continued on next page ->	Payer ID

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Institutional (837I) and Professional (837P) Claims (cont'd)			
Loop	**Segment/Element**	**Instruction**	**Element Name**
		JH – Health Alliance Plan (Fee for Service Contracts) MR – HAP ASR – DOS 6/1/2021 and later JB – HAP CareSource KE – Health Plus (Health Plus Agreement terms DOS 12/31/2016) KV - Humana K7- McLaren Health Plan J2 – Meridian Health Plan of MI (Health Plan of Michigan) **MN – UM Health Plan (formerly Physicians Health Plan)** JZ - Priority Health JZ – Priority Health (Priority Health-CIGNA Dual Branded ID cards with Payer ID 38217 on the back of the card) MP – Provider Network of America MK – Reliance HMO MC – Saginaw County Health Plan - Termed 12/31/2018 J5 – United Healthcare (non-Golden Rule Members) KR – United Healthcare (Golden Rule Members) JR – United Healthcare Community Plan (Great Lakes Health Plan) MS – VA Community Care MM – WellCare * For identification of Blue Care Network claims, use the payer code assigned to the provider by JVHL.	
2010BB	REF01	Report G2 – Provider Commercial Number or LU – Location number	Reference ID qualifier
2010BB	REF02	Report the JVHL assigned billing location code ** If the submitter prefers not to submit the JVHL Lab Code in 2010BB and it is determined that the lab code is necessary for proper processing (NPI is shared across multiple JVHL facilities), then the following alternative is available. ** The lab code can be sent in the 2010AA NM103 element as: **Lab Name Here --##--** **Where the ## would be replaced by the JVHL assigned lab code, with two dashes before and after the lab code. So if the Lab Name was JVHL and the lab code was VH it would be sent as:** **NM1*85*2*JVHL --VH--*****XX*1234567890~**	Provider secondary qualifier

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Institutional (837I) and Professional (837P) Claims (cont'd)			
Loop	**Segment/Element**	**Instruction**	**Element Name**
2300	CLM02	All payers – Total submitted charges must equal the sum of the line item charge/credit amounts (837P-2400/SV102 or 837I-2400/SV203).	Total Claim Charge
2300	CLM05-1	All payers – Facility Code Value JVHL will only accept professional claims with the following values: 19 – Off Campus-Outpatient Hospital (Effective DOS 1/1/2016) 22 – Outpatient Hospital 81 – Independent Laboratory JVHL will only accept Institutional claims with the following values: 13 - Outpatient Hospital 14 - Independent Laboratory 85 – Critical Access Hospital – Depending on JVHL/Payer agreement	Facility Code Value
2300	CLM05-3	All payers - Claim Frequency Type code JVHL will accept claims with any valid Place of Service indicator. All place of service indicators are treated as an 'original claim', with the exception of 7 which is treated as a corrected claim and 8 which is treated as a VOID (Void or cancel of Prior Claim- Credit).	Claim Frequency type Code
P-2300	REF01	All payers – X4 CLIA number Note: This is not required for 837I	Reference ID Qualifier
P-2300	REF02	All payers – CLIA number Note: This is not required for 837I	Reference ID
2300	REF01-F8	F8 – Original Reference Number – For Corrected and VOID claims	Reference ID Qualifier
2300	REF02-F8	Send original JVHL Claim number – For Corrected and VOID claims.	Reference ID
P-2310A I-2310A (Attending) / 2310F(Referring – If Different Than Attending)	NM109	Referring provider's NPI.	Referring Provider ID

See next page "Section 9.2" for: Coordination of Benefits (COB) Professional/Institutional Claims ->

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9.2 Coordination of Benefits (COB) Professional/Institutional Claims

Coordination of Benefits (COB) Claims			
Data Elements	**Loop/Segment**	**Requirements**	**Comments**
Other Subscriber Name	2330A/NM1	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration.	This is the "Insured's Name" from the previous payer.
Other Payer Name **Note***: Until national payer IDs are assigned, ID values can be chosen by the sender, but must match the value sent in the line level adjudication information for this payer.*	2330B/NM1	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	This is the "Insurance Plan Name or Program Name" from the previous payer.
Other Subscriber Information	2320/SBR	The 2330 loop is HIPAA required when Loop ID-2320-Other Subscriber Information is used.	This is the "Relationship Code", "Insurance Plan Name or Program Name", "Insured's Policy Group or FECA Number", "Insurance Type Code" and "Claim Filing Indicator" from the previous payer.
Adjustment codes and associated amounts	2320/CAS	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied claim level adjustments that cause the amount considered to differ from the amount originally charged.	Do not include claim level amounts. Any amounts reported should be reported at the service line level.
Payer Paid Amount	2320/AMT (AMT01=D)	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and when the primary payer has considered an amount towards this bill.	Should equal total charges minus claim and line level adjustments.
Other Insurance Coverage Information	2320/OI	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration. All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It allows for information specific only to that payer.	Information not on the CMS 1500 form. This is the "Accept Assignment", "Patient Signature" and "Release Information" and can normally be based on that already collected on the previous payers CMS 1500 form. Separate collection of this information only needed when it differs by payer.

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Coordination of Benefits (COB) Claims (cont'd)			
Data Elements	**Loop/Segment**	**Requirements**	**Comments**
Adjudication information	2430/SVD	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied line level adjustments that cause the amount considered to differ from the amount originally charged.	Information not on CMS 1500 form. This is the amount the primary payer paid for the service line and the procedure code and modifiers used to determine that payment.
Line level adjustment reason codes and associated amounts	2430/CAS	Segment is HIPAA required when submitting claim for secondary or tertiary benefits consideration and the primary payer(s) applied line level adjustments that cause the amount considered to differ from the amount originally charged.	Information not on CMS 1500 form. This shows why the other payer paid less than billed. Information most commonly required is deductible amount, coinsurance or co-pay amount, negotiated/contractual rate reduction, R&C reduction. Do not enter at claim level any amounts included at line level.

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APPENDICES

1. Frequently Asked Questions

a. Is JVHL requiring all JVHL data be submitted in the ANSI ASC X12N 837 (ANSI 837) format?
- Yes. Effective 1-1-12, all electronic claim/encounter data sent to JVHL must be provided in ANSI 5010 ASC X12 837 formats.

b. Are there any charges for submitting data in the ANSI 837 format?
- **JVHL member facilities incur no direct JVHL fees associated with processing JVHL encounter data submitted in the ANSI 837 format. If a provider chooses to use a clearinghouse that charges JVHL for claim submissions, JVHL will bill the provider for whatever charges the clearinghouse requires JVHL to pay.**

c. Does JVHL require physician National Provider Number on every claim?
- Yes. Every claim must have the Referring Provider (physician) NPI populated in loop 2310A/2310F(I) segment NM108 **as well as** the Billing Provider NPI populated in loop 2010AA segment NM108.

d. Can "credit" transactions be submitted in the ANSI 837 format?
- Yes. Use CLM05-3 (Claim Frequency type code) with a value of 8 – VOID to void a previously sent claim and report the original JVHL Claim number in the REF-F8 (Original Reference Number) segment in the 2300 loop.

e. What are the data delivery methods in place?
- Data can be exchanged with JVHL using the following methods:
  - Electronic Data Interchange (EDI)

    Provides secure file transfers over the Internet at plmweb.jvhl.org. This HIPAA compliant service allows for submission and retrieval of all encounter data processing files as well as HEDIS information. To establish an account, send a request for an EDI Authorization Request Form and Business Associate Agreement to Rob Ramey at support@jvhl.org. These documents are also available at www.jvhl.org. An account is required to access the 'member' section of the website.

    The website supports use of browser-driven or a scripted file transfer protocol (sFTP). A copy of the documentation for the scripted protocol, SFTP-SSH Users Guide, may be requested from support@jvhl.org.

f. Can "corrected" transactions be submitted in the ANSI 837 format?
- **Yes. Use CLM05-3 (Claim Frequency type code) with a value of 7 and report the original JVHL Claim number in the REF-F8 (Original Reference Number) segment in the 2300 loop.**

2. Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

Date	Version	Description
01/01/2012	1.0	
04/12/2012	1.1	i. Reformat in accordance with CORE v5010 Master Companion Guide ii. The following subjects have been included with this version: • Trading Partner Registration • Connectivity with the Payer/Communications • Control Segment/Envelopes (ST-SE segments) • Trading Partner Agreements • Coordination of Benefits (COB) Claim Processing
04/17/2012	1.1.1	i. Added UHC Golden Rule contract code (KR).

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06/11/2012	1.1.2	i. Updated guide to include information on 999 responses, which are replacing 997 responses. ii. Updated payer names for GLHP (United Healthcare Community Plan), Omnicare (CoventryCares of Michigan), Health Plan of Michigan (Meridian Health Plan of MI).
8/23/2013	1.1.3	iii. Added information for Humana claims.
11/20/2013	1.1.4	i. Added information for Consumers Mutual Insurance claims.
6/17/2014	1.1.5	i. Modified COB information to reflect that secondary claims can be submitted electronically in the 837I format
9/2014	1.1.6	i. Added information for Harbor Health Plan ii. Updated name of Coventry Cares to Aetna Better Health of MI iii. Removed references to Molina payer code JV as it has been retired iv. Added entry for CIGNA HAP-Members Only claims
9/23/2014	1.1.7	Removed Harbor Health from list of plans that accept electronic COB claims.
9/25/2014	1.1.8	Changed name of Midwest to HAP Midwest
10/31/2014	1.1.9	Added HAP as a payer that accepts electronic COB claims.
3/27/2015	1.2.0	Updated information about DMC Care COB claims
3/30/2015	1.2.1	Removed McLaren HP as an eCOB capable payer
5/13/2015	1.2.2	Added information for Aetna Better Health Premier Plan
10/16/2015	1.2.3	Added HAP Midwest to list of eCOB payers
11/5/2015	1.2.4	Update contact information. Added POS 19 as a valid place of service on Professional claims for claims with a DOS of 1/1/2016 and later.
2/9/2016	1.2.5	Updated contact information Removed United Physicians Health Association (JN) as it is a termed product as of DOS 12/31/2014
4/14/2016	1.2.6	Updated guide in relation to CIGNA-HAP Members. HAP and CIGNA made a change and now require that all CIGNA-HAP Members be billed directly to CIGNA where previously they were billed to HAP. CIGNA-HAP members should now be submitted to JVHL with the KD payer code along with other CIGNA claims.
5/12/2016	1.2.7	Added Blue Cross Complete (KP) as its own entry.
11/30/2016	1.2.8	Added information on the term date of the Health Plus agreement.
12/22/2016	1.2.9	Added information on the term date for Consumer's Mutual
4/20/2017	1.3.0	Updated Logo Updated COB allowed payer list (added Blue Cross Complete, McLaren and Aetna Better Health Medicaid)
6/28/2017	1.3.1	Added information that demonstrates corrected claims can be billed electronically and also updated VOID claim documentation to reflect where the JVHL claim number should be sent. Added information on submitting AmeriHealth Caritas VIP Care Plus (MD) claims.
7/13/2017	1.3.2	Added information for Bay, Genesee, and Saginaw County Health Plans (MA, MB, MC)
10/4/2017	1.3.3	Added AmeriHealth Caritas VIP Care Plus to the eCOB eligible payer list.

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1/14/2018	1.3.4	Updated JVHL logo. Added information about DMC Care Terming 12/31/2017.
4/10/2018	1.3.5	Added information about BEHP Terming 3/31/2018.
11/12/2018	1.3.6	Added information about Bay and Saginaw Health Plans in regards to them terming on 12/31/2018.
3/4/2019	1.3.7	Added information about Harbor Terming 12/31/2018
4/18/2019	1.3.8	Changed name of HAP Midwest to HAP Empowered
5/22/2019	1.3.9	Added information for new BCN Critical Access / Small Volume Payer Code - MJ
1/28/2020	1.4.0	Added a new Payer – Reliance HMO to the companion guide.
4/1/2020	1.4.1	Added a new Payer – WellCare to the companion guide.
7/13/2020	1.4.2	Update the Aetna Better Health COB line to include the Payer Code (J8)
8/20/2020	1.4.3	Added a new Payer – Physicians Health Plan (MN) to the companion guide
9/30/2020	1.4.4	Updated that Molina termed DOS 9/30/2020
11/19/2020	1.4.5	Added new Payer – Provider Network of America to the companion guide (MP) Updated the alternative method to send the lab code (in the NM1*85 name) to make the example more straightforward.
12/1/2020	1.4.6	Added new information for Priority Health-CIGNA Dual branded ID cards and when to use CIGNA (KD) vs Priority Health (JZ)
1/8/2021	1.4.7	Removed Molina from document as they have been termed for over 90 days.
11/18/2021	1.4.8	Added information on billing HAP ASR claims, which should use code MR
11/30/2022	1.4.9	Added Facility Type Code of 85 (Critical Access Hospital) to list of valid codes for ANSI 837I file.
12/5/2022	1.5.0	Added information on billing VA Community Care claims, which should use code MS
12/14/2022	1.5.1	Deleted a duplicated header row in the Payer Codes table.
1/8/2024	1.5.2	Updated name of HAP Empowered to HAP CareSource Updated name of CIGNA to Cigna Healthcare
12/3/2024	1.5.3	Updated name of Physicians Health Plan to UM Health Plan Updated FAQ section on fees for claim submissions

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