HIPAA EDI Companion Guide
for
835 Electronic Remittance Advice

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3 (TR3)

Version 005010X221A1

Companion Guide Version: 2.0

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

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Disclosure Statement

This document is intended to be a companion guide for use in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata). The information in this document is provided for Jefferson Health Plans and its associated Trading Partners.

This document contains clarifications as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard for Electronic Transactions. This document is not intended to convey information that exceeds the requirements or usages of data expressed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata).

This document is not intended, and should not be regarded, as a substitute for the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata)

Jefferson Health Plans may make improvements and/or changes to the information contained in this document without notice.

Preface

This companion guide is intended to convey information that is within the framework of the ASC X12N Technical Report Type 3 (TR3) adopted for use under HIPAA. This companion guide to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3 and Errata) adopted under HIPAA will clarify and specify Jefferson Health Plans communication protocols, business rules and information applicable to the 835 Electronic Remittance Advice Transaction. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 (TR3), are compliant with X12 syntax, those guides, and HIPAA.

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Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

#	Version	Date	Author	Updates
1	1.0	10/11	Operations Technical Support	• Initial version of 835 5010 Companion Guide Document. This version was also posted to the Jefferson Health Plans external website,
2	2.0	11/18/13	Claims Department	• Changed the Plan name and logo. • Providers now are enrolling with ECHO to receive their ERA/EFT.
3	3.0	10/9/24	Claims Department	• Updated naming and contact information

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. The provisions for administrative simplification contained within HIPAA require the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions. These transactions primarily occur between health care providers and health insurance plans or clearinghouses. HIPAA directs the Secretary of HHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Scope

This companion guide explains the procedures and requirements necessary for Trading Partners of Jefferson Health Plans to transmit the following HIPAA standard transactions:

- 835 Electronic Remittance Advice (835)

This companion guide is intended to convey information that is within the framework of the ASC X12N Technical Report Type 3 (TR3) adopted for use under HIPAA. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 (TR3), are compliant with X12 syntax, those guides, and HIPAA.

References

Additional information on the HIPAA Final Rule for Standards for Electronic Transmissions and the endorsed Implementation Guides can be found at:

- httpp://www.cms.gov/hipaa/hipaa2 (HIPAA Administrative Simplification)
- http://www.wpc-edi.com (Washington Publishing Company)

Contact information

EDI Claims Customer Service and Technical Assistance
Electronic Data Interchange (EDI) customer service and technical assistance requests focus solely on the generation, processing, and/or transmission of a HIPAA standard transaction. EDI customer service and technical assistance requests will not focus on transaction results such as claim payment and remittance results.

Please contact Jefferson Health Plans EDI Department at EDI@jeffersonhealthplans.com for technical assistance.

Non-EDI Customer Service and Assistance
Non-EDI customer service and assistance requests focus solely on transaction results such as claim payment and remittance advice, member maintenance, or member eligibility. Non-EDI customer service and assistance requests will not focus on the generation, processing, and/or transmission of a HIPAA standard transaction.

Please contact Jefferson Health Plans Provider Services at 1-888-991-9023 for non-EDI customer service and assistance.

Getting Started

1. Communicate your plans by:
    a. Download the funding agreement

2. Formalize agreements and authorizations
    a. Review and sign the funding agreement
    b. Provide all required information and according to the funding agreement.

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835 Electronic Remittance Advice Specifications

General Notes

- An ANSI X12N 837 Health Care Claim is NOT required in order to receive ANSI X12N 835 Electronic Remittance Advice.
- Transaction files are provided via a secure FTP site.
- Transaction files are posted to an FTP site for your retrieval on a weekly basis.
- Transaction delimiters will be as follows:
  - Data Element = *
  - Segment = ~
  - Component/Sub-element = : (colon)
- Jefferson Health Plans will use all standard code sets within the 835 transaction.
- Jefferson Health Plans trading partner ID is 445562154, with a qualifier of "mutually defined" (ZZ).

Data Content and Specifications

Loop	Segment / Element	Description	Element Length	Mapping Comments
Interchange		**Interchange Control Loop**		**Required**
	ISA	Interchange Control Segment		
	ISA01	Authorization Information Qualifier	2/2	"00" No Authorization Information Present
	ISA02	Authorization Information	10/10	Leave Blank
	ISA03	Security Information Qualifier	2/2	"00" No security Information Present
	ISA04	Security Information	10/10	Leave Blank
	ISA05	Interchange Sender ID Qualifier	2/2	"ZZ" Mutually Defined

	Segment / Element	Description	Element Length	Mapping Comments
	ISA06	Interchange Sender ID	15/15	"445562154 "
	ISA07	Interchange Receiver ID Qualifier	2/2	Your Receiver ID Qualifier as per Trading Partner Agreement document
	ISA08	Interchange Receiver ID	15/15	Your Receiver ID as per Trading Partner Agreement document
	ISA09	Interchange Date	6/6	Date of interchange. Date format is YYMMDD
	ISA10	Interchange Time	4/4	Time of interchange. Time format is HHMM
	ISA11	Interchange Control Standards Identifier	1/1	"^"
	ISA12	Interchange Control Version Number	5/5	"00501" ANSI Version number that covers the Interchange Control Segment.
	ISA13	Interchange Control Number	9/9	Interchange Control Number. Must = IEA02
	ISA14	Acknowledgement Requested	1/1	"0" No Acknowledgement Requested "1" Acknowledgement Requested
	ISA15	Usage Indicator	1/1	"P" Production Data "T" Test Data
	ISA16	Component element Separator	1/1	":" Delimiter used to separate Components (colon)
Functional Group		Functional Group Loop		Required
	GS	Functional Group Header		Required
	GS01	Functional Identifier Code	2/2	"HP" = Health Care Claim Payment Advice
	GS02	Application Sender Code	2/15	"445562154"
	GS03	Application Receiver ID	2/15	Receiver ID specified in your Jefferson Health Plans Agreement
	GS04	Date	8/8	Date Expressed in CCYYMMDD format
	GS05	Time	4/4	Time in HHMMSS format
	GS06	Group Control Number	1/9	Functional Group Control Number. Value must equal GE02

Loop	Segment / Element	Description	Element Length	Mapping Comments
	GS07	Responsible Agency Code	1/2	"X" Accredited Standards Committee X12
	GS08	Version/Release/Industry Identifier	1/12	"005010X221A1"
0000		Transaction Set Loop		Required will contain one or more transactions
	ST	Transaction Set Header		Required
	ST01	Transaction Set Identifier Code	3/3	"835"
	ST02	Transaction Set Control Number	4/9	Transaction Set Control Number. Must equal SE02
0000	BPR	Financial Information		Required
	BPR01	Transaction Handling Code	1/2	"I" = Remittance Information Only This is the only value being used by Jefferson Health Plans at this time.
	BPR02	Monetary Amount	1/18	Total Actual Provider Payment Amount
	BPR03	Credit/Debit Flag	1/1	"C" = Credit This is the only value being used by Jefferson Health Plans at this time.
	BPR04	PAYMENT METHOD CODE	3/3	"CHK" = Check This is the only value being used by Jefferson Health Plans at this time.
	BPR05	PAYMENT FORMAT CODE	1/10	Not used at this time
	BPR06	(DFI) ID NUMBER QUALIFIER	2/2	Not used at this time
	BPR07	(DFI) IDENTIFICATION NUMBER	3/12	Not used at this time
	BPR08	Account Number Qualifier	1/3	Not used at this time
	BPR09	Sender Bank Account Number	1/35	Not used at this time
	BPR010	ORIGINATING COMPANY IDENTIFIER	10/10	Not used at this time
	BPR11	Originating Company Supplemental Code	9/9	Not used at this time
	BPR12	DFI Identification Number Qualifier	2/2	Not used at this time
	BPR013	Receiver or Provider Bank ID Number	3/12	Not used at this time
	BPR014	ACCOUNT NUMBER QUALIFIER	1/3	Not used at this time

	Segment / Element	Description	Element Length	Mapping Comments
	BPR015	Receiver or Provider ACCOUNT NUMBER	1/35	Not used at this time
	BPR016	Check Issue or EFT Effective Date	8/8	Check Issuance Date in CCYYMMDD Format
	TRN	Reassociation Trace Number		Required
	TRN01	Trace Type Code	1/2	"1" = Current Transaction Trace Numbers
	TRN02	REFERENCE IDENTIFICATION	1/50	Check Number
	TRN03	ORIGINATING COMPANY IDENTIFIER	10/10	Employer Identification number, prefixed a "1"
	TRN04	Originating Company Supplemental Code	1/50	Not used at this time
	CUR	Foreign Currency Information		Segment not used at this time
0000	REF	Receiver Identification		Situational (When Receiver is different than Payee)
	REF01	Receiver Identification Number	2/3	"EV" = Receiver Identification Number
	REF02	Receiver REFERENCE IDENTIFICATION	1/50	Receiver Identification Number
	REF	Version Identification		Segment not used at this time
	DTM	Production Date		Segment not used at this time
1000A		Payer Identification Loop		Required
	N1	Payer Identification		Required
	N101	Payer Identifier Code	2/3	"PR" Payer
	N102	Payer NAME	1/60	“Jefferson Health Plans of Philadelphia”
	N103	Identification Code Qualifier	1/2	Not required at this time
	N104	Payer Identification Code	1/80	Not required at this time
	N3	Payer Address		Required
	N301	Payer Address Line	1/55	"901 Market St"
	N302	Payer Address Line	1/55	“Suite 500”
	N4	Payer City, State, Zip Code		Required
	N401	Payer City Name	2/30	"Philadelphia"

Loop	Segment / Element	Description	Element Length	Mapping Comments
	N402	Payer State Code	2/2	"PA"
	N403	Payer Postal Zone or Zip Code	3/15	"19107"
	REF	Additional Payer Identification		Segment not used at this time
	PER	Payer Contact Information		
	PER01	Contact Function Code	2/2	"CX" = Payers Claim Office
	PER02	Payer Contact Name	1/60	"Claim Department"
	PER03	Communication Number Qualifier	2/2	"TE" = Telephone
	PER04	Payer Contact Communication Number	1/256	"2159914350"
	PER	Payer Technical Contact Information		Required
	PER01	Contact Function Code	2/2	"BL"
	PER02	Payer Technical Contact Name	1/60	"EDI Support"
	PER03	Communication Number Qualifier	2/2	"TE" = Telephone
	PER04	Payer Contact Communication Number	1/256	"2159914290"
	PER05	Payer Contact Communication Number	2/2	"EM" = Electronic Mail
	PER06	Payer Technical Contact Communication	1/256	"EDI@HEALTHPART.COM"
	PER	Payer Web Site		
	PER01	Contact Function Code	2/2	"IC" = Information Contact
	PER02	Name	1/60	Not used at this time
	PER03	Communication Number Qualifier	1/256	"UR" = Uniform Resource Locator (URL)
	PER04	Communication Number	1/256	"www.healthpart.com"
1000B		Payee Identification Loop		Required
	N1	Payee Identification		Required
	N101	Payer Identifier Code	2/3	"PE" = Payee
	N102	Payee Name	1/60	Payee Name Provided

Loop	Segment / Element	Description	Element Length	Mapping Comments
	N103	Payee Identification Code Qualifier	1/2	"XX" = National Provider Identifier "FI" = Federal Taxpayers's Identification Number (when NPI not mandated)
	N104	Payee Identification Code	2/80	Corresponding Identifier
	N3	Payee Address		Situational (when needed to inform Receiver of Payee Address)
	N301	Payee Address Line	1/55	Payee Address Information provided to Jefferson Health Plans
	N302	Payee Address Line	1/55	Payee Address Information, if second line needed
	N4	Payee City, State, Zip Code		Situational (when needed to inform Receiver)
	N401	Payee City Name	1/30	Payee City Name provided
	N402	Payee State Code	2/2	Payee State Name provided
	N403	Payee Postal Zone or Zip Code	1/15	Payee Zip Code provided
	REF	Payee Additional Identification		Situational (When additional identification is needed)
	REF01	Additional Payee Identification Qualifier	2/3	"PQ" = Payee Identification
	REF02	Reference Identification Code	1/30	Jefferson Health Legacy Number
	REF01	Additional Payee Identification Qualifier	2/3	"TJ" = Federal Taxpayer Identification Number
	REF02	Reference Identification Code	1/30	Federal Taxpayer Identification Number
2000		Header Number Loop		Situational (Required when claim or service level information follows)
	LX	Header Number		Situational (required for 2000 Header Number Loop)
	LX01	Claim Sequence Number	1/6	Transaction Sequence Number
	TS3	Provider Summary Information		Segment not used at this time
	TS2	Provider supplemental Summary Information		Segment not used at this time
2100		Claim Payment Information Loop		Required
	CLP	Claim payment Information		Required
	CLP01	Patient Control Number	1/38	Claim Submitter's Identifier
	CLP02	Claim Status Code	1/2	Claim Status. See page 124 of HIPAA TR3 for valid codes
	CLP03	Total Claim Charge Amount	1/18	Total Claim Charge Amount (not reflecting any potential interest).

Loop	Segment / Element	Description	Element Length	Mapping Comments
	CLP04	Total Claim Payment Amount	1/18	Claim Payment Amount
	CLP05	Patient Responsibility Amount	1/18	Patient Responsibility Amount
	CLP06	Claim Filing Indicator Code	1/2	"HM" = Health Maintenance Organization
	CLP07	Payer Claim Control Number	1/50	Payer Claim Control Number
	CLP08	Facility Type Code	1/2	from original claim
	CLP09	Claim Frequency Code	1/1	from original claim
	CLP10	Patient Status Code	---	***Not used for HIPAA***
	CLP11	Diagnosis Related Group (DRG) Code	1/4	Code Source 229. Institutional claims only.
	CLP12	DRG Weight	1/15	Diagnosis Related Group (DRG) weight
	CLP13	PERCENT - Discharge Fraction	1/10	Not used at this time
	CAS	Claim Adjustment		Situational (to report claim level adjustments affecting amount paid)
	CAS01	Claim Adjustment Group Code	1/2	Jefferson Health Plans Supports the following Adjustment Group Codes: "CO" Contractual Obligations "OA" Other Adjustments "PI" Payor Initiated Reductions "PR" Patient Responsibility
	CAS02	Adjustment Reason Code	1/5	Code Source 139: Claim Adjustment Reason Code
	CAS03	Adjustment Amount	1/18	Claim Level Adjustment Amount
	CAS04	QUANTITY	1/15	Provided only when unit quantity is being adjusted
	CAS05 – CAS19	(Repeat of reason code, amount, and quantity sequence five times)		Not used at this time, only one adjustment is reported on a give CAS segment, and each adjustment is on a separate CAS segment.
	NM1	Patient Name		Required
	NM101	Patient Identifier Code	2/3	"QC" = Patient
	NM102	Entity Type Qualifier	1/1	"1" = Person
	NM103	Patient Last Name	1/60	

Loop	Segment / Element	Description	Element Length	Mapping Comments
	NM104	Patient First Name	1/35	
	NM105	Patient Middle Initial	1/25	
	NM106	Name Prefix		*** Element not used for HIPAA ***
	NM!07	Patient Name Suffix	1/10	Not used at this time
	NM108	Identification Code Qualifier	1/2	"MI" = Member Identification Number (other values reserved for future use)
	NM109	Patient Member Number	2/80	Corresponding Patient Identifier
	NM1	Insured Name		Segment not used at this time
	NM1	Corrected Patient/Insured Name		Segment not used at this time
	NM1	Service Provider Name		Situational (Required when different than Payee
	NM101	Entity Identifier Code	2/3	"82" Rendering Provider
	NM102	Entity Type Qualifier	1/1	"1" = Person "2" = Entity
	NM103	Rendering Provider Last or Organization Name	1/60	Not used at this time
	NM104	Rendering Provider First Name	1/35	Not used at this time
	NM105	Rendering Provider Middle Name	1/25	Not used at this time
	NM106	Name Prefix		*** Element not used for HIPAA ***
	NM107	Rendering Provider Name Suffix	1/10	Not used at this time
	NM108	Rendering Provider Identification Code Qualifier	1/2	"XX" = National Provider Identifier
	NM109	Rendering Provider Identifier	2/80	National Provider Identifier Number Provided
	NM1	Crossover Carrier Name		Segment not used at this time
	NM1	Corrected Priority Payer Name		Segment not used at this time
	MIA	Inpatient Adjudication Information		Segment not used at this time
	MOA	Outpatient Adjudication Information		Segment not used at this time
	REF	Other Claim Related Identification		Segment not used at this time

Loop	Segment / Element	Description	Element Length	Mapping Comments
	REF	Rendering Provider Identification		Segment not used at this time
	DTM	Statement From or To Date		Segment not used at this time
	DTM	Coverage Expiration Date		Situational (Required due to expiration of coverage)
	DTM01	Date Time Qualifier	3/3	“036” = Expiration
	DTM02	Expiration Date	8/8	
	DTM	Claim Received Date		Situational
	DTM01	Date Time Qualifier	3/3	“050” = Received
		Received Date	8/8	
	PER	Claim Contact Information		Not used at this time
	AMT	Claim Supplemental Information		Situational (Informational only, not used for balancing)
DTM02	AMT01	Amount Qualifier Code	1/3	Allowed Values: "D8" = Discount Amount "I" = Interest "T" Tax
	AMT02	Claim Supplemental Information Amount	1/18	Corresponding Amont
	QTY	Claim Supplemental Information Quantity		Segment not used at this time
2110		Service Payment Information		Situational
	SVC	Service Payment Information		Situational (Expected to be sent under most circumstances)
	SVC01-1	Service Type Code	2/2	See HIPAA 835 Technical Report Type 3, pg. 187-188 for supported codes
	SVC01-2	Service Code	1/48	Procedure Code
	SVC01-3	PROCEDURE MODIFIER 1	2/2	Payer will be reporting up to 4 procedure Modifiers
	SVC01-4	PROCEDURE MODIFIER 2	2/2	
	SVC01-5	PROCEDURE MODIFIER 3	2/2	
	SVC01-6	PROCEDURE MODIFIER 4	2/2	
	SVC01-7	Procedure Code Description	1/80	Sub-element not used at this time

Loop	Segment / Element	Description	Element Length	Mapping Comments
	SVC02	Monetary Amount	1/18	Submitted Line Item Service Charge Amount
	SVC03	Monetary Amount	1/18	Line Item Provider Payment Amount
	SVC04	NUBC Revenue Code	1/48	Not used at this time
	SVC05	Units of Service Paid Count	1/15	If not present, the value is assumed to be 1
	SVC06-1	PRODUCT/SERVICE ID QUALIFIER	2/2	Provided if procedure code in SVC01 is different from procedure code submitted; see pg. 191 of the HIPAA Technical Report Type 3
	SVC06-2	Procedure Code	1/48	Provided if procedure code in SVC01 is different from procedure code submitted
	SVC06-3	Procedure Modifier 1	2/2	Sub-Element not used at this time
	SVC06-4	Procedure Modifier 2	2/2	Sub-Element not used at this time
	SVC06-5	Procedure Modifier 3	2/2	Sub-Element not used at this time
	SVC06-6	Procedure Modifier 4	2/2	Sub-Element not used at this time
	SVC06-7	Procedure Code Description	1/80	Sub-Element not used at this time
	SVC07	Original Units of Service Count	1/15	Only provided when paid unit is different from submitted units
	DTM	Service Start Date		Situational (if claim date is absent or different from Service Line date)
	DTM01	Date Time Qualifier	3/3	"150" = Service Period Start Date
	DTM02	Service Date	8/8	Service Start Date in CCYYMMDD Format
	DTM	Service End Date		Situational (if claim date is absent or different from Service Line date)
	DTM01	Date Time Qualifier	3/3	"151" = Service Period End Date
	DTM02	Service End Date	8/8	Service End Date in CCYYMMDD Format
	DTM	Service Date		Situational (if claim date is absent or different from Service Line date)
	DTM01	Date Time Qualifier	3/3	"472" = Service Date
	DTM02	Service Date	8/8	Service Date in CCYYMMDD Format to indicate a single day service
	CAS	Service Adjustment		Situational (to account for difference in amount paid for this service)

Loop	Segment / Element	Description	Element Length	Mapping Comments
	CAS01	Claim Adjustment Group Code	1/2	Jefferson Health Plans uses the following Adjustment Group Codes: "CO" Contractual Obligations "OA" Other Adjustments "PI" Payor Initiated Reductions "PR" Patient Responsibility
	CAS02	Adjustment Reason Code	1/5	Code Source 139: Claim Adjustment Reason Code
	CAS03	Adjustment Amount	1/18	Service Level Adjustment Amount; negative number increases amount, positive decreases
	CAS04	Adjustment Quantity	1/15	Provided only when unit quantity is being adjusted; negative number increases amount, positive decreases
	CAS05-CAS19	(Repeat of reason code, amount, and quantity sequence five times)		Not used at this time
	REF	Service Identification		Situational (provider reference numbers specific to this service)
	REF01	Reference Identification Qualifier	2/3	Refer to HIPAA Technical Report Type 3 pg. 204 for supported code values.
	REF02	Provider Identifier	1/50	Provider Identifier
	REF	Line Item Control Number		Situational
	REF01	Reference Identification Qualifier	2/3	"6R" = Provider Control Number
	REF02	Reference Identification	1/50	Line Item Control Number
	REF	Rendering Provider Information		Situational (to identify provider specific to this service)
	REF01	Reference Identification Number	2/3	"HPI" = National Provider Identifier "TJ" = Federal Taxpayers Identification Number (other supported values as needed)
	REF02	Rendering Provider Federal ID	1/50	Corresponding identifier
	AMT	Service Supplemental Amount		Situation (Informational only, not used for balancing)
	AMT01	Amount Qualifier Code	1/3	Refer to HIPAA Technical Report Type 3 pg. 211-212 for supported codes

Loop	Segment / Element	Description	Element Length	Mapping Comments
	AMT02	Service Line Allowed Amount	1/18	Corresponding Amount (Service Line Allowed Amount)
	QTY	Service Supplemental Quantity		Segment not used at this time
	LQ	Health Care Remark Code		Situational (Informational remarks only)
	LQ01	Service Line Remittance Remark Code 1	1/3	"HE" Claim Payment Remark Codes
	LQ02	Service Line Remittance Remark Code 2	1/30	Remark Code
0000		Transaction Set Loop (Summary)		Required
	PLB	Provider Adjustment		Situational (for adjustments not specific to a claim or service)
	PLB01	Provider Identifier	1/50	
	PLB02	Fiscal Period Date	8/8	Last day of provider's fiscal year in CCYYMMDD format; if not known, December 31 of current year.
	PLB03-1	PROVIDER ADJUSTMENT REASON CODE	2/2	Refer to HIPAA Technical Report Type pg. 219-222 for supported Code Values
	PLB03-2	Provider Adjustment Identifier	1/50	Sub-Element not used
	PLB04	Provider Adjustment Amount	1/18	
	PLB05 – PLB14	(Repeat of adjustment identifier and amount sequence five more times)		Not used at this time, only one adjustment is reported on a PLB segment
	SE	Transaction Set Trailer		Required
	SE01	Number Of Included Segments	1/10	Transaction Segment Count
	SE02	Transaction Set Control Number	4/9	Transaction Set Control Number
Functional Group		Functional Group Loop (End)		Required
	GE	Functional Group Trailer		Required
	GE01	Number of Transaction Sets Included	1/6	Number of Transactions Sets included in the Functional Group
	GE02	Group Control Number	1/9	Functional Group control number must equal the value in GS06

Loop	Segment / Element	Description	Element Length	Mapping Comments
Interchange		Interchange Control Loop (End)		Required
	IEA	Interchange Control Trailer		Required
	IEA01	Number of Included Functional Groups	1/5	A count of the number of Functional Groups (GS-GE) in the interchange
	IEA02	Interchange Control Number	9/9	A control number that must equal the value in ISA 13

*** If the National Provider Identification Number is not included on the claim then a default of all 8's will be generated in this field**