ACS EDI Gateway Services
Electronic Claims Acquisition Services

West Virginia Workers' Compensation
HCFA 1500
Version 3.1

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We make revisions to this document on an as-needed basis. To help you easily identify information that has changed, we provide a graphical element with the date of revision inside it. Depending on the chapter, the graphic is located in one of two areas:

Rev.01/01/01

- For text areas, graphic is placed on the left-most page margin.
- For matrix areas, graphic is placed on the right-most margin. Rev.01/01/01

In addition, the following is a list of changes with their page numbers and revision dates.

Revisions/Details	Date
Page 13, Enrollment Information • Changed web site address to "www.acs-gcro.com	11/21/01
Page 14, Claims Edits, ***Records*** • Added "HCFA" after "West Virginia Workers' Compensation"	7/03/01
Page 17, Highlights • Changed **Receiver and Payer ID** from "77026" to 77025"	7/03/01
Page 25, CCHS Requirements Matrix • Changed "**Payor Name**" to "Payer Name"	7/03/01
Page 40, CCHS Requirements Matrix • Changed **Batch Total Charges** from "9(09)" to "9(07)v99"	7/03/01
Page 41, CCHS Requirements Matrix • Changed **Receiver ID** from "77026" to 77025" and "West Virginia Medicaid" to "West Virginia Workers' Compensation"	7/03/01
Page 1, Changed www.hcfa.gov/medicare/edi/ed.htm to to http://cms.hhs.gov/providers/edi/edi3.asp	1/7/03

Chapter 1 Introduction

ACS, a leader in health care technology, provides Gateway services to providers enrolled in contracted health care plans. Our electronic claims acquisition services provide an array of tools that allow you to:

- Easily submit all of your claims to one source
- Submit claims twenty-four hours a day, seven days a week
- Receive confirmation of receipt of each file transferred
- Receive payment from health care plans on a regular basis

Health care plans that participate with ACS are referred to as "payers." Claims are accepted electronically into our data center in Tallahassee, Florida and are processed through various electronic systems to payment. As a gateway service, we provide connectivity to various healthcare plans and states where ACS is the fiscal agent.

This manual outlines the procedures necessary for the transmission of electronic claims. It targets billing services and software vendors who are developing electronic claims submission capabilities for transmission to ACS.

Chapter 4 of this manual contains important payer-specific information required by ACS. The ACS Clearinghouse System (CCHS) Requirements Matrix, which follows Chapter 4, details the records and fields required for claims processing.

Rev.01/07/03

This manual is intended to be used in conjunction with the national format specifications published by HCFA. These publications offer field-by-field breakdowns, definitions, and valid values. They can be accessed at http://cms.hhs.gov/providers/edi/edi3.asp. For UB92 claims, access the link to **UB92 Version 5.0 Flat File Format**. For HCFA 1500 claims, access the link to **HCFA National Standard Format Version 3.01**.

Chapter 2 Communications

ACS' EDI Gateway

ACS' EDI Gateway consists of an interactive, menu-driven bulletin board that allows you to upload your claim files and receive immediate confirmation of the status of your transfer. The EDI Gateway is accessed using a standard modem and supports modem speeds of up to 33,600 BPS.

Communication Protocols

ACS currently supports the following options:

- Async – XMODEM, YMODEM, ZMODEM, Kermit

Transmission Hours

Claims transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

Teleprocessing Requirements

The general specifications for communication with ACS are:

Telecommunications	Hayes-compatible 2400-33.6K BPS asynchronous modem
File Format	ASCII text data
Compression Techniques	PKZIP will compress one-to-many files in a single ZIP archive. Microsoft Compress will compress only a single file. GnuZip will compress only a single file. ARC (Archive) will compress one-to-many files in a single file. LHA or LHARC will compress one-to-many files in a single file. ACS accepts transmissions with any of the above compression techniques, as well as non-compressed files.
Data Format	8 data bit, 1 stop bit, no parity, full duplex
Transmission Protocol	ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit CRC (Cyclical Redundancy Check). XMODEM uses 128 byte blocks and a 16-bit CRC. YMODEM uses 1024 byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

Transmission Procedures

CALLING SYSTEM	HOST SYSTEM
1. Dials ACS' HOST	Answers call, negotiates a common baud rate, and sends to the caller-> **"Enter your User Name=>"**
2. Enters User Name & <CR>	Receives User Name (Logon Name) and sends to the caller-> **"Enter your User Number=>"**
3. Enters User Number & <CR>	Receives User Number (Logon User ID) and verifies if caller is an authorized user. Sends HOST selection menu followed by a user prompt-> **"Please Enter Your Selection=>"**
4. Enter Desired Selection & <CR>	**#1. Electronic Claim Submission:** Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller. **#3. Select File Transfer Protocol:** Allows submitter to change the protocol for the current submission only. The protocol may be changed to (**K**)ermit, (**X**)Modem, (**Y**)Modem, or (**Z**)Modem. Enter the first letter of the protocol that you wish to use. **#9. Exit & Disconnect:** Terminates connection.
5. Enter "1" to send file & <CR>	Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=> "Please Enter Your Selection=>"

6. Enter Desired Selection & <CR>

#1. Electronic Claim Submission: Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller.

#3. Select file Transfer Protocol: Allows submitter to change the protocol for the current transmission only.

#4. Download Confirmation: Allows submitter to download the confirmation report. See below for further explanation.

#9. Exit & Disconnect: Terminates connection.

Confirmation Reports

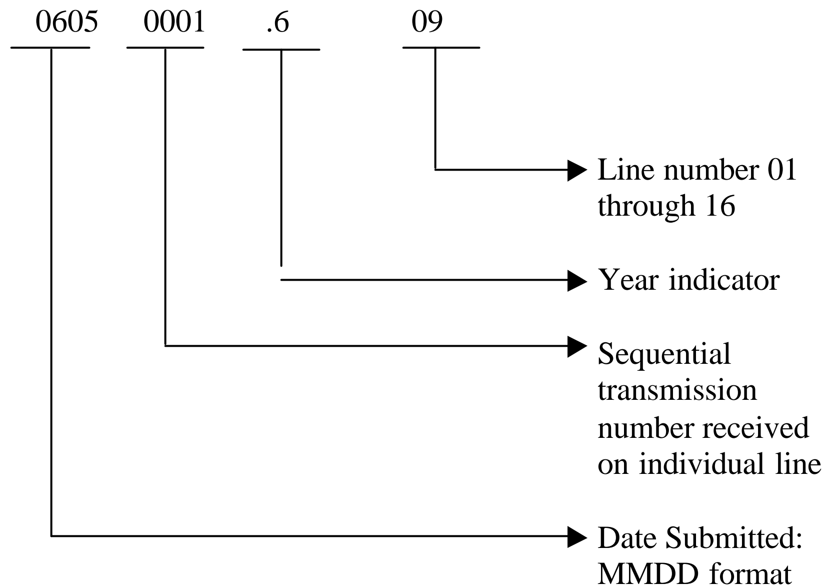
After the transmission is complete, a confirmation report describing the success or failure of the transmission is produced. The confirmation report will appear briefly on the monitor of the computer that is used to submit the data. You may download the report by selecting Option 4 (as outlined above). The file will be sent to the download directory of the communications software that is used for transmission. The file naming convention is line##.txt, with ## representing the last two digits of the file number assigned by ACS. For example, the name of the electronic confirmation report for file name 02010001.621 will be line21.txt.

The following is an example of a confirmation report. The first line indicates successful file transmission. The second line indicates a rejected transmission. Below the sample confirmation report is a detailed explanation of the components of a confirmation report. Please notify an EDI Business Analyst during the testing process if your communications package does not allow you to receive the confirmation report.

```
Date:  01/05/01                ACS Host System            Time:  07:02
User Name:  JANED                                         User Number:  123456789

File Number     Payer    Frmt    Type     Claims    Batches    Tot. Charges    Status    Msg.
---------------  -------  ------  ------   --------  ---------  ---------------  --------  ----------
06050001.609    77027    UB      UB92       1000          1        69500.00     PROD        001
06050001.609    77027    NSF     HCFA        100          1         2500.00     PROD        001

Messages
001 – File Received

** End of Report **
```

Field Name	**Explanation**
Date	(MM/DD/YY) date transmission received
Time	(HH:MM) time transmission received
User Name	Name that identifies the submitter to the host system

Field Name	**Explanation**
User Number	Number that allows the submitter access to the host system
File Number	(MMDDnnnn.x0n) tracking number for file receipt verification



Payer	Entity to receive the claims. Identified by a five-digit ID.
Frmt	Format. File structure of the logical files transmitted. "NSF" = National Standard Format, "UB" = Uniform Billing Format
Type	Claim type received. "HCFA" = HCFA 1500 claims, "DENT" = dental claims, "UB92" = Institutional Claims
Claims	Number of claims
Batches	Number of batches
Tot. Charges	Total charges

Field Name	Explanation
Status	Disposition of the file as determined by the host system. “Test” = file is processed as a test, “Prod” = file is processed as production, “Reject” = file is not accepted for processing and must be resubmitted, “Hold” = file is accepted but will not be processed
Msg	Message number. Reference the corresponding entry in the “Messages” area of the confirmation report for interpretation. Message numbers are assigned sequentially as files are processed. A “Msg” of 001 may not always imply the same condition. 001 is the first condition that occurred, 002 is the second condition that occurred, and so on
Messages	Explanation of the “Msg” field. Files that are not accepted have a status of “reject.” These files are not processed; they must be corrected and transmitted again by the submitter

Confirmation Messages

The following edits are applied to incoming transmissions before the confirmation report is generated. One or more of the following messages will be on the confirmation report if a condition is present.

MESSAGE	DESCRIPTION
Invalid record length, Rec. 9999	Specific to file format. Record indicated is too long or too short.
Invalid (non-text) characters, Rec. 9999	Record number indicated contains non-text characters. Sequence of control characters may be incorrect. Must have both a Carriage Return character and a Line Feed character at the end of every line. Must be a CR character (hex0D) followed by a LF character (hex 0A).
Invalid record sequence, Rec. 9999	Record ID is incorrect. Refer to the record number indicated and its preceding record.
User not approved for Payer/Format/Type	File does not match criteria of submitter's enrollment. One (or more) of these fields is incorrect (Payer ID, file format, claim type).
Number of detail recs exceeds maximum	Number of line items exceeds the maximum allowed by the payer for this claim type.
Unknown format/type	File format and claim type could not be determined. Unable to accept the file.

MESSAGE	DESCRIPTION
Payer ID not found	Payer ID on the TPL record is spaces and Receiver ID on the header record is spaces. Unable to accept the claim(s).
Editor Off	Not a true error message. For information only. File accepted with no edits performed during communications link. No file statistics are returned to the submitter.
File received	File successfully transmitted and received.
Too many logical files in physical file	Current max of 500 logical files per physical file transmission.

Testing Procedures

You must complete the testing process before you can submit electronic claims for payment. ACS' EDI Business Analysts are available to assist you through the testing process. Each test transmission is inspected thoroughly to ensure that no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real claim data. The number of test transmissions required depends on the percentage of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to your software or ACS' host system.

Before testing, contact an EDI Business Analyst at (850) 201-1171 to obtain a Vendor ID and test Logon Name and password. The Vendor ID, a five-digit alphanumeric code that must appear in the VENDOR ID field of the file header record, is used to identify the software that is being used to transmit claims.

When the testing process is complete and the software is approved, software vendors must send a client list to ACS. This list must detail the names and Submitter IDs of all clients who will use the approved software to submit electronic claims directly to ACS. All clients submitting claims for payment, including billing agents and clearinghouses, must be enrolled with ACS' EDI Support Unit. The EDI Support Unit will assign all direct submitters a Submitter ID, Logon Name, and Logon ID. Refer to Chapter 4 of this manual for the EDI Support Unit telephone number.

Testing Steps

Refer to "Transmission Procedures" in Chapter 2 for directions on using the Logon Name and Logon User ID. Each test transmission must contain ten to twenty claims. When the transmission is complete, select menu option 4 to receive a brief confirmation notice verifying receipt of the data or indicating that the transmission failed. A sample confirmation report and detailed instructions on interacting with the host menu system is located in Chapter 2 of this manual. If the transmission fails continuously, contact the EDI Business Analyst Unit.

ACS processes the data through several validation and reformatting programs. The resulting edit/error report is used to determine if problems exist with your record formats.

An EDI Business Analyst will determine if problems exist with the format and will contact you with the results of your test.

Chapter 4 Payer-Specific Data for West Virginia Worker's Compensation

EDI Support

The EDI Support Unit assists users with questions about electronic claims submission. ACS' EDI Support Unit is available to all Workers' Compensation clients and providers Monday through Friday from 8:00 a.m. to 6:00 p.m. EST. Contact the EDI Support Unit at 1-800-827-5328. The EDI Support Unit:

- Provides information on available services
- Enrolls users for claims submission
- Verifies receipt of electronic transmissions
- Provides technical assistance to users who are experiencing transmission difficulties

Enrollment Information

Clearinghouses, billing agents, and providers using self-programmed systems who will be sending electronic claims to ACS for Workers' Compensation must complete a Workers' Compensation Electronic Media Agreement. This form provides ACS the information necessary to assign a Logon Name, Logon ID, and Submitter ID, which are required to submit electronic claims. You can obtain a copy of this form by contacting the EDI Support Unit or by downloading it from our website at www.acs-gcro.com.

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Transmission Telephone Number

ACS provides availability for claims transmission 24 hours a day, 7 days a week. There are no restrictions on the number of claims or the frequency of transmissions. The claims transmission telephone number is 1-850-385-7455.

Tracking Transmission/Production Problems

Please have the following information available when calling the EDI Support Unit regarding transmission and production issues.

Submitter ID: Your Submitter ID is our key to accessing your submitter information. Please have this number available each time you contact the EDI Support Unit.

Logon Name and Logon User ID: These allow asynchronous submitters access to the host system for claims submission. The EDI Support Unit uses this information to reference your submitted data.

File Name: When inquiring about the receipt of a transmission, please have the host system file name available. The host system file name, unique to each transmission, is found on each confirmation report. An example and explanation of the host system file name is found in Chapter 2 of this manual.

Claims Edits

Dates	All dates must be numeric, valid dates
Records	All records are 320 characters in length. Records must follow the sequence dictated by the West Virginia Workers' Compensation HCFA format.
Fields	Numeric fields must be unsigned, right-justified, zero-filled, and can only contain numeric characters (0-9). Alphanumeric fields must be left-justified, space-filled, and can contain alpha (A-Z) and numeric (0-9) characters.
Control Characters	The sequence of control characters must be correct on every record. There must be a carriage return character and a line feed character at the end of every line.
Field Requirements	The FIELD REQ column on the CCHS Requirements Matrix uses these values:

R	Required	**Record:** Must send this record **Field:** Claim can not be paid without this information.
C	Conditional	Under certain conditions, this information must be included for payment. See comments where necessary.
O	Optional	Does not affect processing.
-	Not Used	Not currently used.

Field Definition

The FIELD DEFINITION column on the CCHS Requirements Matrix uses standard COBOL methods for describing data.

X(02) = Where X denotes alphanumeric characters and 02 is the length of the data.

9(06) = Where 9 denotes numeric data and 06 is the length of the data

9(07)v99 = Where the v denotes an implied decimal. This is the method for describing amount fields. The value to the left indicates a seven-character field with no decimal. The last two characters in the field represent the cents associated with the amount. The total length of this field is nine characters with no decimal.

Sequence of Records

The following sequence of file records identifies the order of the records, the type of record, and the record name. A file must contain a file header, one or more batches, and a file trailer. Each batch within a file must consist of one or more claims.

Record Type					Record Name
AA0		File Header Record			Submitter Data
	BA0		Batch Header		Provider Data 1
	BA1		Batch Header		Provider Data 2
		CA0			Claim Header Record – Patient
				DA0	Insurance Information Record – Payer
				DA1	Insurance Information Record – Payer
				EA0	Claim Detail Record – Claim Level
				FA0	Service Line Detail Record – Root
				FD0	Service Line Detail Record – Dental
		XA0			Claim Trailer Record – Claim Totals
	YA0				Batch Trailer Record – Batch Totals
ZA0					File Trailer Record – File Totals

Highlights

The West Virginia Workers' Compensation Receiver and Payer ID is 77025. Transmissions without this value in the appropriate fields will not be processed.

- Each user is assigned a five-digit Submitter ID.
- An 11-digit Workers' Compensation original Submitter ID is required on the header record of all files. This number is assigned by Workers' Compensation.
- All dates are in the CCYYMMDD format.
- Unless indicated otherwise, use the HCFA NSF-defined values for data fields.
- Fields marked as "Required" are required for all claim types unless otherwise noted.
- Field DA0-18, Insured Identification Number, is a nine-digit SSN. No claim number is accepted in this field. Batches with claims containing alphabetical characters or more than nine digits are rejected.
- Field EA0-07, Accident/Symptom Date, is required on every claim submitted to Workers' Compensation. Batches with claims without this date are rejected.

CCHS REQUIREMENTS MATRIX

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SUBMITTER DATA **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
AA0-01.0	Record ID	X(03)	01	03	R	Must = "AA0"
AA0-02.0	Submitter ID	X(16)	04	19	R	Must equal "ZA0-02.0." The 5-digit submitter ID assigned by ACS during enrollment
AA0-03.0	Reserved	X(09)	20	28	-	
AA0-04.0	Submission Type	X(06)	29	34	-	
AA0-05.0	Submission Number	X(06)	35	40	-	
AA0-06.0	Submitter Name	X(33)	41	73	R	
AA0-07.0	Submitter Address – 1	X(30)	74	103	R	
AA0-08.0	Submitter Address – 2	X(30)	104	133	C	
AA0-09.0	Submitter City	X(20)	134	153	R	
AA0-10.0	Submitter State	X(02)	154	155	R	
AA0-11.0	Submitter Zip	X(09)	156	164	R	
AA0-12.0	Submitter Region	X(05)	165	169	-	
AA0-13.0	Submitter Contact	X(33)	170	202	R	
AA0-14.0	Submitter Phone	X(10)	203	212	R	
AA0-15.0	Creation Date	X(08)	213	220	-	
AA0-16.0	Submission Time	X(06)	221	226	-	
AA0-17.0	Receiver ID	X(16)	227	242	R	"77025" = Workers' Comp. Assigned by ACS. Must equal ZA0-04.0.
AA0-18.0	Receiver Type Code	X(01)	243	243	R	"B" = Workers' Compensation
AA0-19.0	Version Code National	9(05)	244	248	R	Must equal "00301" Invalid codes will cause file to reject.
AA0-20.0	Version Code – Local	9(05)	249	253	-	
AA0-21.0	Test / Prod Indicator	X(04)	254	257	-	
AA0-22.0	Password	X(08)	258	265	-	

CCHS REQUIREMENTS MATRIX

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SUBMITTER DATA **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
AA0-23.0	Retransmission Status	X(01)	266	266	-	
AA0-24.0	Original Submitter ID	X(16)	267	282	R	Assigned by Workers' Comp., 11 digits.
AA0-25.0	Vendor App Cat	X(01)	283	283	-	
AA0-26.0	Vendor Software Version	X(05)	284	288	C	Vendor ID assigned by ACS. (Required for software vendors only.)
AA0-27.0	Vendor Software Update	X(02)	289	290	-	
AA0-28.0	COB File Indicator	X(01)	291	291	-	
AA0-29.0	Process from Date	X(08)	292	299	-	
AA0-30.0	Process thru Date	X(08)	300	307	-	
AA0-31.0	Acknowledgment Request	X(01)	308	308	-	
AA0-32.0	Date of Receipt	X(08)	309	316	-	
AA0-33.0	Filler – National	X(04)	317	320	-	Spaces

CCHS REQUIREMENTS MATRIX

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PROVIDER DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
BA0-01.0	RECORD ID	X(03)	01	03	R	Must equal "BA0."
BA0-02.0	EMC PROVIDER IDENTIFIER	X(15)	04	18	R	Must equal "YA0-02.0". Eleven-digit WVWC Provider ID (Tax ID plus a two-digit location code). Default location code is "00". This identifies the provider to be paid.
BA0-03.0	BATCH TYPE	X(03)	19	21	R	"200" = Dental, "100" = All Others. Must equal YA0-03.0.
BA0-04.0	BATCH NUMBER	9(04)	22	25	R	Must equal "YA0-04.0".
BA0-05.0	BATCH IDENTIFICATION	X(06)	26	31	-	
BA0-06.0	PROVIDER TAX ID	X(09)	32	40	R	Must equal "YA0-06.0".
BA0-07.0	RESERVED (BA0-07.0)	X(06)	41	46	-	Spaces
BA0-08.0	PROVIDER TAX ID TYPE	X(01)	47	47	-	
BA0-09.0	NATIONAL PROVIDER ID	X(15)	48	62	-	
BA0-10.0	PROVIDER "UPIN" - "USIN" ID	X(06)	63	68	O	
BA0-11.0	RESERVED (BA0-11.0)	X(06)	69	74	-	Spaces
BA0-12.0	PROVIDER MEDICAID NUMBER	X(15)	75	89	-	
BA0-13.0	PROVIDER CHAMPUS NUMBER	X(15)	90	104	-	
BA0-14.0	PROVIDER BLUE SHIELD NUMBER	X(15)	105	119	-	
BA0-15.0	PROVIDER COMMERCIAL NUMBER	X(15)	120	134	-	
BA0-16.0	PROVIDER OTHER NUMBER 1	X(15)	135	149	-	
BA0-17.0	PROVIDER OTHER NUMBER 2	X(15)	150	164	-	
BA0-18.0	PROVIDER ORGANIZATION NAME	X(33)	165	197	C	
BA0-19.0	PROVIDER LAST NAME	X(20)	198	217	C	Must be entered if BA0-18.0 is blank.
BA0-20.0	PROVIDER FIRST NAME	X(12)	218	229	C	Must be entered if BA0-18.0 is blank.
BA0-21.0	PROVIDER MIDDLE INITIAL	X(01)	230	230	-	

CCHS REQUIREMENTS MATRIX

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PROVIDER DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
BA0-22.0	PROVIDER SPECIALTY	X(03)	231	233	-	
BA0-23.0	SPECIALTY LICENSE NUMBER	X(15)	234	248	-	
BA0-24.0	STATE LICENSE NUMBER	X(15)	249	263	-	
BA0-25.0	DENTIST LICENSE NUMBER	X(15)	264	278	-	
BA0-26.0	ANESTHESIA LICENSE NUMBER	X(15)	279	293	-	
BA0-27.0	FILLER – NATIONAL	X(13)	294	306	-	Spaces
BA0-28.0	FILLER – LOCAL	X(14)	307	320	-	Spaces

CCHS REQUIREMENTS MATRIX

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PROVIDER DATA 2 **RECORD OPTIONAL**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
BA1-01.0	RECORD ID "BA1"	x(03)	01	03	R	Must Equal "BA1"
BA1-02.0	EMC PROV ID	x(15)	04	18	R	Eleven-digit WVWC Provider ID (Tax ID plus a two-digit location code). Default location code is "00".
BA1-03.0	BATCH TYPE	x(03)	19	21	R	"200" = Dental, "100" = All Others.
BA1-04.0	BATCH NO	x(04)	22	25	R	
BA1-05.0	BATCH ID	x(06)	26	31	-	
BA1-06.0	PROV TYPE ORG	x(03)	32	34	-	
BA1-07.0	PROV SVC ADDR1	x(30)	35	64	O	
BA1-08.0	PROV SVC ADDR2	x(30)	65	94	O	
BA1-09.0	PROV SVC CITY	x(20)	95	114	O	
BA1-10.0	PROV SVC STATE	x(02)	115	116	O	
BA1-11.0	PROV SVC ZIP	x(09)	117	125	O	
BA1-12.0	PROV SVC PHONE	x(10)	126	135	O	
BA1-13.0	PROV PAY TO ADDR1	x(30)	136	165	O	
BA1-14.0	PROV PAY TO ADDR2	x(30)	166	195	O	
BA1-15.0	PROV PAY TO CITY	x(20)	196	215	O	
BA1-16.0	PROV PAY TO STATE	x(02)	216	217	O	
BA1-17.0	PROV PAY TO ZIP	x(09)	218	226	O	
BA1-18.0	PROV PAY TO PHONE	x(10)	227	236	O	
BA1-19.0	FILLER-NATIONAL	x(84)	237	320	-	Spaces

CCHS REQUIREMENTS MATRIX

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PATIENT DATA **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
CA0-01.0	RECORD ID	X(03)	01	03	R	Must equal "CA0".
CA0-02.0	RESERVED (CA0-02.0)	X(02)	04	05	-	Spaces
CA0-03.0	PATIENT CONTROL NUMBER	X(17)	06	22	R	Must be the same value on each claim record (CA0-XA0). WVWC limited to 12 characters. Will show on remittance advice.
CA0-04.0	PATIENT LAST NAME	X(20)	23	42	R	
CA0-05.0	PATIENT FIRST NAME	X(12)	43	54	R	
CA0-06.0	PATIENT MIDDLE INITIAL	X(01)	55	55	C	
CA0-07.0	PATIENT GENERATION	X(03)	56	58	-	
CA0-08.0	PATIENT DATE OF BIRTH	X(08)	59	66	R	CCYYMMDD format. Must be less than or equal to the "SERVICE FROM DATE" (FA0-05.0).
CA0-09.0	PATIENT SEX CODE	X(01)	67	67	R	"M" = Male, "F" = Female, space = unknown
CA0-10.0	PATIENT TYPE OF RESIDENCE	X(01)	68	68	C	
CA0-11.0	PATIENT ADDRESS 1	X(30)	69	98	O	
CA0-12.0	PATIENT ADDRESS 2	X(30)	99	128	O	
CA0-13.0	PATIENT CITY	X(20)	129	148	O	
CA0-14.0	PATIENT STATE	X(02)	149	150	O	
CA0-15.0	PATIENT ZIP CODE	X(09)	151	159	O	
CA0-16.0	PATIENT TELEPHONE NUMBER	X(10)	160	169	O	
CA0-17.0	PATIENT MARITAL STATUS	X(01)	170	170	O	
CA0-18.0	PATIENT STUDENT STATUS	X(01)	171	171	O	
CA0-19.0	PATIENT EMPLOYMENT STATUS	X(01)	172	172	O	
CA0-20.0	PATIENT DEATH INDICATOR	X(01)	173	173	O	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
PATIENT DATA **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
CA0-21.0	PATIENT DATE OF DEATH	X(08)	174	181	C	
CA0-22.0	OTHER INSURANCE INDICATOR	X(01)	182	182	R	1=Yes, patient has other insurance. 2=Yes, patient has other insurance not reflected on this bill. 3=No, patient has no other insurance.
CA0-23.0	CLAIM EDITING INDICATOR	X(01)	183	183	-	
CA0-24.0	TYPE OF CLAIM INDICATOR	X(02)	184	185	R	
CA0-25.0	LEGAL REPRESENTATIVE INDICATOR	X(01)	186	186	-	
CA0-26.0	ORIGIN CODE	X(09)	187	195	-	
CA0-27.0	PAYOR CLAIM CONTROL NUMBER	X(17)	196	212	-	
CA0-28.0	PROVIDER NUMBER	X(15)	213	227	R	
CA0-29.0	CLAIM IDENTIFICATION NUMBER	X(06)	228	233	-	
CA0-30.0	FILLER - NATIONAL	X(87)	234	320	-	Spaces

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
PAYOR DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
DA0-01.0	RECORD ID	X(03)	01	03	R	Must equal “DA0”.
DA0-02.0	SEQUENCE NUMBER	X(02)	04	05	R	
DA0-03.0	PATIENT CONTROL NUMBER	X(17)	06	22	R	Must equal “CA0-03.0”.
DA0-04.0	CLAIM FILING INDICATOR	X(01)	23	23	R	“P” = Payment is being requested of this payor. “I” = Information only.
DA0-05.0	SOURCE OF PAYMENT	X(01)	24	24	R	“B” = Workers’ Compensation
DA0-06.0	INSURANCE TYPE CODE	X(02)	25	26	O	
DA0-07.0	NATIONAL PAYOR IDENTIFICATION	X(09)	27	35	R	“77025”= Workers’ Compensation, assigned by ACS.
DA0-08.0	NOT USED	-	-	-		
DA0-09.0	PAYER NAME	X(33)	36	68	R	WV Worker’s Compensation
DA0-10.0	GROUP NUMBER	X(20)	69	88	O	
DA0-11.0	GROUP NAME	X(33)	89	121	O	
DA0-12.0	PPO / HMO INDICATOR	X(01)	122	122	-	
DA0-13.0	PPO IDENTIFICATION	X(15)	123	137	-	
DA0-14.0	PRIOR AUTHORIZATION NUMBER	X(15)	138	152	C	
DA0-15.0	ASSIGNMENT OF BENEFITS INDICATOR	X(01)	153	153	-	
DA0-16.0	PATIENT SIGNATURE SOURCE	X(01)	154	154	-	
DA0-17.0	PATIENT RELATIONSHIP TO INSURED	9(02)	155	156	O	
DA0-18.0	INSURED IDENTIFICATION NUMBER	X(25)	157	181	R	Patient’s SSN. Do not include dashes.
DA0-19.0	INSURED LAST NAME	X(20)	182	201	O	
DA0-20.0	INSURED FIRST NAME	X(12)	202	213	O	
DA0-21.0	INSURED MIDDLE INITIAL	X(01)	214	214	O	
DA0-22.0	INSURED GENERATION	X(03)	215	217	-	
DA0-23.0	INSURED SEX	X(01)	218	218	-	
DA0-24.0	INSURED DATE OF BIRTH	X(08)	219	226	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

PAYOR DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
DA0-25.0	INSURED EMPLOYMENT STATUS CODE	X(01)	227	227	-	
DA0-26.0	SUPPLEMENTAL INSURANCE IND	X(01)	228	228	-	
DA0-27.0	INSURANCE LOCATION IDENTIFIER	X(07)	229	235	-	
DA0-28.0	MEDICAID ID NO	X(25)	236	260	-	
DA0-29.0	SUPPLEMENTAL PATIENT IDENTIFIER	x(25)	261	285	-	
DA0-30.0	ASSIGM 4081 IND	x(01)	286	286	-	
DA0-31.0	COB ROUTING IND	x(01)	287	287	-	
DA0-32.0	FILLER-NATIONAL	x(33)	288	320	-	Spaces

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

PAYOR DATA 2 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
DA1-01.0	RECORD ID "DA1"	X(03)	01	03	R	Must equal "DA1"
DA1-02.0	SEQUENCE NO	X(02)	04	05	R	
DA1-03.0	PAT CONTROL NO	X(17)	06	22	R	
DA1-04.0	PAYOR ADDR1	X(30)	23	52	-	
DA1-05.0	PAYOR ADDR2	X(30)	53	82	-	
DA1-06.0	PAYOR CITY	X(20)	83	102	-	
DA1-07.0	PAYOR STATE	X(02)	103	104	-	
DA1-08.0	PAYOR ZIP	X(09)	105	113	-	
DA1-09.0	DISALLOWED COST CONT	9(5)v99	114	120	-	
DA1-10.0	DISALLOWED OTHER	9(5)v99	121	127	-	
DA1-11.0	ALLOWED AMOUNT	9(5)v99	128	134	-	
DA1-12.0	DEDUCTIBLE AMOUNT	9(5)v99	135	141	-	
DA1-13.0	COINSURANCE AMOUNT	9(5)v99	142	148	-	
DA1-14.0	PAYOR AMOUNT PAID	9(5)v99	149	155	R	
DA1-15.0	ZERO PAY IND	X(01)	156	156	-	
DA1-16.0	ADJUDICATION IND 1	X(02)	157	158	-	
DA1-17.0	ADJUDICATION IND 2	x(02)	159	160	-	
DA1-18.0	ADJUDICATION IND 3	x(02)	161	162	-	
DA1-19.0	CHAMPUS SPNSR BRANCH	x(01)	163	163	-	
DA1-20.0	CHAMPUS SPNSR GRADE	X(02)	164	165	-	
DA1-21.0	CHAMPUS SPNSR STATUS	X(01)	166	166	-	
DA1-22.0	INS CARD EFFECT DATE	X(08)	167	174	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

PAYOR DATA 2 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
DA1-23.0	INS CARD TERM DATE	X(08)	175	182	-	
DA1-24.0	BALANCE DUE	9(5)v99	183	189	-	
DA1-25.0	EOMB DATE1	X(08)	190	197	-	
DA1-26.0	EOMB DATE2	X(08)	198	205	-	
DA1-27.0	EOMB DATE3	X(08)	206	213	-	
DA1-28.0	EOMB DATE4	X(08)	214	221	-	
DA1-29.0	CLAIM RECEIPT DATE	X(08)	222	229	-	
DA1-30.0	AMT PAID TO BENE	9(5)v99	230	238	-	
DA1-31.0	BENEFIT CHECK/EFT TRACE NUMBER	X(15)	239	253	-	
DA1-32.0	BENEFIT CHECK DATE	X(08)	354	261	-	
DA1-33.0	AMT PAID TO PROV	9(5)v99	262	270	-	
DA1-34.0	PROV CHECK/EFT TRACE NUMBER	X(15)	271	285	-	
DA1-35.0	PROV CHECK DATE	X(08)	286	293	-	
DA1-36.0	INTEREST PAID	9(5)v99	294	302	-	
DA1-37.0	APPROVED AMT	9(5)v99	303	311	-	
DA1-38.0	CONTRACT AGREEMENT IND	X(01)	312	312	-	
DA1-39.0	FILLER NATIONAL	X(08)	313	320	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

CLAIM DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
EA0-01.0	RECORD ID “EA0”	X(03)	01	03	R	Must Equal “EA0”.
EA0-02.0	RESERVED (EA0-02.0)	X(02)	04	05	-	
EA0-03.0	PAT CONTROL NUMBER	X(17)	06	22	R	Must Equal “CA0-03.0”
EA0-04.0	EMPL RELATED IND	X(01)	23	23	R	“Y” = Yes, “N” = No
EA0-05.0	ACCIDENT IND	X(01)	24	24	R	A = Auto Accident
EA0-06.0	SYMPTOM IND	X(01)	25	25	-	
EA0-07.0	ACCIDENT/SYMPTOM DATE	X(08)	26	33	R	Date of Inquiry, CCYYMMDD
EA0-08.0	EXT CAUSE OF ACCIDENT	X(05)	34	38	C	
EA0-09.0	RESPONSIBILITY IND	X(01)	39	39	-	
EA0-10.0	ACCIDENT STATE	X(02)	40	41	-	
EA0-11.0	ACCIDENT HOUR	X(02)	42	43	-	
EA0-12.0	RELEASE OF INFO IND	X(01)	44	44	-	
EA0-13.0	RELEASE OF INFO DATE	X(08)	45	52	-	
EA0-14.0	SAME-SIMILAR SYMP IND	X(01)	53	53	-	
EA0-15.0	DISABILITY TYPE	X(01)	54	54	-	
EA0-16.0	SAME/SIMILAR SYMP DT	X(08)	55	62	-	
EA0-17.0	DISABILITY TYPE	X(01)	63	63	-	
EA0-18.0	DISABILITY FROM DATE	X(08)	64	71	-	
EA0-19.0	DISABILITY TO DATE	X(08)	72	79	-	
EA0-20.0	REFER PROV NPI	X(15)	80	94	C	Eleven-digit WVWC Provider ID (Tax ID plus a two-digit location code). Default location code is “00”.) This identifies the provider who referred the patient.
EA0-21.0	REFER PROV UPIN	X(15)	95	109	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
CLAIM DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
EA0-22.0	REFER PROV TAX TYPE	X(01)	110	110	-	
EA0-23.0	REFER PROV TAX ID	X(09)	111	119	-	
EA0-24.0	REFER PROV LAST	X(20)	120	139	-	
EA0-25.0	REFER PROV FIRST	X(12)	140	151	-	
EA0-26.0	REFER PROV MIDDLE INITIAL	X(01)	152	152	O	
EA0-27.0	REFER PROV STATE	X(02)	153	154	O	
EA0-28.0	ADMISSION DATE 1	X(08)	155	162	C	
EA0-29.0	DISCHARGE DATE 1	X(08)	163	170	C	
EA0-30.0	LAB IND	X(01)	171	171	-	
EA0-31.0	LAB CHARGES	9(5)v99	172	178	-	
EA0-32.0	DIAGNOSIS CODE – 1	X(05)	179	183	C	Do not include decimal
EA0-33.0	DIAGNOSIS CODE – 2	X(05)	184	188	O	Do not include decimal
EA0-34.0	DIAGNOSIS CODE – 3	X(05)	189	193	O	Do not include decimal
EA0-35.0	DIAGNOSIS CODE – 4	X(05)	194	198	O	Do not include decimal
EA0-36.0	PROV ASSIGN IND	X(01)	199	199	-	
EA0-37.0	PROV SIGNATURE IND	X(01)	200	200	R	
EA0-38.0	PROV SIGNATURE DATE	X(08)	201	208	O	
EA0-39.0	FACILITY/LAB NAME	X(33)	209	241	O	
EA0-40.0	DOCUMENTATION IND	X(01)	242	242	-	
EA0-41.0	TYPE OF DOCUMENTATION	X(01)	243	243	-	
EA0-42.0	FUNCTNL STATUS CODE	X(02)	244	245	-	
EA0-43.0	SPECIAL PROGRAM IND	X(02)	246	247	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
CLAIM DATA 1 **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
EA0-44.0	CHAMPUS NONAVAIL IND	X(01)	248	248	-	
EA0-45.0	SUPV PROV IND	X(01)	249	249	-	
EA0-46.0	SUB/RESUBMISSION CODE	X(02)	250	251	-	
EA0-47.0	RESUB REFERENCE NO	X(15)	252	266	-	
EA0-48.0	DATE LAST SEEN	X(08)	267	274	-	
EA0-49.0	DATE DOCUMENT SENT	X(08)	275	282	-	
EA0-50.0	HOMEBOUND IND	X(01)	283	283	-	
EA0-51.0	BLOOD UNITS PAID	X(03)	284	286	-	
EA0-52.0	BLOOD UNITS REMAINING	X(03)	287	289	-	
EA0-53.0	CPO PROV NUMBER	X(06)	290	295	-	
EA0-54.0	IDE NUMBER	X(15)	296	310	-	
EA0-55.0	FILLER-NATIONAL	X(10)	311	320	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

ROOT SEGMENT **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FA0-01.0	RECORD ID "FA0"	X(03)	01	03	R	Must Equal "FA0".
FA0-02.0	SEQUENCE NO	X(02)	04	05	R	Line Item number must be in sequential order.
FA0-03.0	PAT CONTROL NO	X(17)	06	22	R	Must Equal CA0-03.0
FA0-04.0	LINE ITEM CONTROL NO	X(17)	23	39	C	
FA0-05.0	SVC FROM DATE	X(08)	40	47	R	CCYYMMDD
FA0-06.0	SVC TO DATE	X(08)	48	55	R	CCYYMMDD
FA0-07.0	PLACE OF SVC	X(02)	56	57	R	
FA0-08.0	TYPE OF SVC CODE	X(02)	58	59	-	
FA0-09.0	HCPCS PROCEDURE CODE	X(05)	60	64	R	
FA0-10.0	HCPCS MODIFIER 1	X(02)	65	66	C	
FA0-11.0	HCPCS MODIFIER 2	X(02)	67	68	C	
FA0-12.0	HCPCS MODIFIER 3	X(02)	69	70	-	
FA0-13.0	LINE CHARGES	9(07)	71	77	R	Must be greater than 0.
FA0-14.0	DIAG CODE POINTER 1	X(01)	78	78	O	
FA0-15.0	DIAG CODE POINTER 2	X(01)	79	79	O	
FA0-16.0	DIAG CODE POINTER 3	X(01)	80	80	O	
FA0-17.0	DIAG CODE POINTER 4	X(01)	81	81	O	
FA0-18.0	UNITS OF SVC	9(04)	82	85	R	Format 9(3)v9. Default = 0010, which indicates one unit.
FA0-19.0	ANESTHESIA/OXYGEN MIN	9(04)	86	89	-	
FA0-20.0	EMERGENCY IND	X(01)	90	90	-	
FA0-21.0	COB IND	X(01)	91	91	-	
FA0-22.0	HPSA IND	X(01)	92	92	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
ROOT SEGMENT **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FA0-23.0	RENDERING PROV NPI	X(15)	93	107	R	Eleven-digit WVWC Provider ID (Tax ID plus a two-digit location code.) Default location code is “00”. This identifies the provider who rendered the service.
FA0-24.0	REFERRING PROV NPI	X(15)	108	122	-	
FA0-25.0	REFERRING PROV STATE	X(02)	123	124	-	
FA0-26.0	PUR SVC IND	X(01)	125	125	-	
FA0-27.0	DISALLOWED COST CONT	9(5)v99	126	132	-	
FA0-28.0	DISALLOWED OTHER	9(5)v99	133	139	-	
FA0-29.0	REVIEW BY CODE IND	X(01)	140	140	-	
FA0-30.0	MULTI PROCEDURE IND	X(01)	141	141	-	
FA0-31.0	MAMMOGRAPHY CERT NO	X(10)	142	151	-	
FA0-32.0	CLASS FINDINGS	X(09)	152	160	-	
FA0-33.0	PODIATRY SVC COND	X(03)	161	163	-	
FA0-34.0	CLIA ID NO	X(15)	164	178	-	
FA0-35.0	PRIMARY PAID AMOUNT	9(5)v99	179	185	-	
FA0-36.0	HCPCS MODIFIER 4	X(02)	186	187	-	
FA0-37.0	PROVIDER SPECIALTY	X(03)	188	190	-	
FA0-38.0	PODIATRY THERAPY IND	X(01)	191	191	-	
FA0-39.0	PODIATRY THERAPY TYPE	X(01)	192	192	-	
FA0-40.0	HOSPICE EMPLOYED PROV IND	X(01)	193	193	-	
FA0-41.0	HGB/HCT DATE	9(08)	194	201	-	
FA0-42.0	HGB RESULT	9(03)	202	204	-	
FA0-43.0	HCT RESULT	9(02)	205	206	-	
FA0-44.0	PATIENT WEIGHT	9(03)	207	209	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

ROOT SEGMENT **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FA0-45.0	EPO DOSAGE	9(03)	210	212	-	
FA0-46.0	SERUM CREATINE DATE	X(08)	213	220	-	
FA0-47.0	CREATINE RESULT	9(03)	221	223	-	
FA0-48.0	OBLIGATED ACCEPT AMT	9(5)v99	224	230	-	
FA0-49.0	DRUG DISCOUNT AMT	9(5)v99	231	237	-	
FA0-50.0	TYPE OF UNITS IND	X(01)	238	238	-	
FA0-51.0	APPROVED AMT	9(5)v99	239	245	-	
FA0-52.0	PAID AMT	9(5)v99	246	252	-	
FA0-53.0	BENE LIABILITY AMT	9(5)v99	253	259	-	
FA0-54.0	BALANCE BILL LIMIT CHARGE	9(5)v99	260	266	-	
FA0-55.0	LIMIT CHARGE PRCNT	9(5)v99	267	273	-	
FA0-56.0	PERFORM PROV PHONE	X(10)	274	283	-	
FA0-57.0	PERFORM PROV TAX TYPE	X(01)	284	284	-	
FA0-58.0	PERFORM PROV TAX ID	X(09)	285	293	-	
FA0-59.0	PERFORM PROV ASSIGN IND	X(01)	294	294	-	
FA0-60.0	PRETRANSPLANT INDICATOR	X(01)	295	295	-	
FA0-61.0	ICD-10-PCS	X(07)	296	302	-	
FA0-62.0	UNIVERSAL PRODUCT CODE	X(14)	303	316	-	
FA0-63.0	DIAG CODE POINTER5	X(01)	317	317	-	
FA0-64.0	DIAG CODE POINTER6	X(01)	318	318	-	
FA0-65.0	DIAG CODE POINTER7	X(01)	319	319	-	
FA0-66.0	DIAG CODE POINTER8	X(01)	320	320	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

DENTAL SEGMENT **RECORD CONDITIONAL**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FD0-01.0	RECORD ID "FD0"	X(03)	01	03	R	For Dental Claims Only. Must be "FD0".
FD0-02.0	SEQUENCE NO	X(02)	04	05	R	Corresponds to related FA0 record.
FD0-03.0	PAT CONTROL NO	X(17)	06	22	R	
FD0-04.0	LINE ITEM CONTROL NO	X(17)	23	39	-	
FD0-05.0	TOOTH CODE NUMBER 1	X(02)	40	41	O	Enter the tooth number (permanent teeth) or tooth letter (deciduous teeth) when an applicable procedure code is billed.
FD0-06.0	TOOTH SURFACE(S)	X(05)	42	46	C	Enter the standard ADA designation of the tooth surface(s) when an applicable procedure code is billed.
FD0-07.0	TOOTH CODE NUMBER 2	X(02)	47	48	-	
FD0-08.0	TOOTH SURFACE(S)	X(05)	49	53	-	
FD0-09.0	TOOTH CODE NUMBER 3	X(02)	54	55	-	
FD0-10.0	TOOTH SURFACE(S) 3	X(05)	56	60	-	
FD0-11.0	TOOTH CODE NUMBER 4	X(02)	61	62	-	
FD0-12.0	TOOTH SURFACE(S) 4	X(05)	63	67	-	
FD0-13.0	INITIAL PLACE IND	X(01)	68	68	-	
FD0-14.0	PRIOR PLACE DATE	X(08)	69	76	-	
FD0-15.0	IMPRESS/PRESCRIPT DT	X(08)	77	84	-	
FD0-16.0	REPLACEMENT REASON	X(01)	85	85	-	
FD0-17.0	ORTHO TREAT IND	X(01)	86	86	-	
FD0-18.0	TREATMENT LENGTH	X(02)	87	88	-	
FD0-19.0	DATE APPL INSERTED	X(08)	89	96	-	
FD0-20.0	DATE APPL REMOVED	X(08)	97	104	-	
FD0-21.0	RESERVED (FD0-25.0)	X(10)	105	114	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
DENTAL SEGMENT **RECORD CONDITIONAL**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FD0-22.0	DATE APPL REPLACED	X(08)	115	122	-	
FD0-23.0	MOS TREAT REMAINING	X(02)	123	124	-	
FD0-24.0	DT 1ST VISIT CUR SER	X(08)	125	132	-	
FD0-25.0	RESERVED (FD0-21.0)	X(10)	133	142	-	
FD0-26.0	PRE DETERMINATION ID	X(20)	143	162	-	
FD0-27.0	RESERVED (FD-27.0)	X(10)	163	172	-	
FD0-28.0	MISSING PRIMARY TEETH	X(20)	173	192	-	
FD0-29.0	MISSING PERM TOOTH	X(02)	193	194	-	
FD0-30.0	MISSING PERM TOOTH	X(02)	195	196	-	
FD0-31.0	MISSING PERM TOOTH	X(02)	197	198	-	
FD0-32.0	MISSING PERM TOOTH	X(02)	199	200	-	
FD0-33.0	MISSING PERM TOOTH	X(02)	201	202	-	
FD0-34.0	MISSING PERM TOOTH	X(02)	203	204	-	
FD0-35.0	MISSING PERM TOOTH	X(02)	205	206	-	
FD0-36.0	MISSING PERM TOOTH	X(02)	207	208	-	
FD0-37.0	MISSING PERM TOOTH	X(02)	209	210	-	
FD0-38.0	MISSING PERM TOOTH	X(02)	211	212	-	
FD0-39.0	MISSING PERM TOOTH	X(02)	213	214	-	
FD0-40.0	MISSING PERM TOOTH	X(02)	215	216	-	
FD0-41.0	MISSING PERM TOOTH	X(02)	217	218	-	
FD0-42.0	MISSING PERM TOOTH	X(02)	219	220	-	
FD0-43.0	MISSING PERM TOOTH	X(02)	221	222	-	

HCFA 1500 **VER 301**
DENTAL SEGMENT **RECORD CONDITIONAL**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
FD0-44.0	MISSING PERM TOOTH	X(02)	223	224	-	
FD0-45.0	MISSING PERM TOOTH	X(02)	225	226	-	
FD0-46.0	MISSING PERM TOOTH	X(02)	227	228	-	
FD0-47.0	MISSING PERM TOOTH	X(02)	229	230	-	
FD0-48.0	MISSING PERM TOOTH	X(02)	231	232	-	
FD0-49.0	MISSING PERM TOOTH	X(02)	233	234	-	
FD0-50.0	MISSING PERM TOOTH	X(02)	235	236	-	
FD0-51.0	MISSING PERM TOOTH	X(02)	237	238	-	
FD0-52.0	MISSING PERM TOOTH	X(02)	239	240	-	
FD0-53.0	MISSING PERM TOOTH	X(02)	241	242	-	
FD0-54.0	MISSING PERM TOOTH	X(02)	243	244	-	
FD0-55.0	MISSING PERM TOOTH	X(02)	245	246	-	
FD0-56.0	MISSING PERM TOOTH	X(02)	247	248	-	
FD0-57.0	MISSING PERM TOOTH	X(02)	249	250	-	
FD0-58.0	MISSING PERM TOOTH	X(02)	251	252	-	
FD0-59.0	MISSING PERM TOOTH	X(02)	253	254	-	
FD0-60.0	MISSING PERM TOOTH	X(02)	255	256	-	
FD0-61.0	MISSING PERM TOOTH	X(02)	257	258	-	
FD0-62.0	QUADRANT	X(02)	259	260	-	
FD0-63.0	TOOTH POCKET MEASURE	X(02)	261	262	-	
FD0-64.0	FILLER-NATIONAL	X(58)	263	320	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 | **VER 301**
CLAIM TOTALS | **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
XA0-01.0	RECORD ID “XA0”	X(03)	01	03	R	Must equal “XA0”.
XA0-02.0	RESERVED (XA0-02.0)	X(02)	04	05	R	
XA0-03.0	PAT CONTROL NO	X(17)	06	22	R	Must equal “CA0-03.0”
XA0-04.0	RECORD CXX COUNT	9(02)	23	24	R	
XA0-05.0	RECORD DXX COUNT	9(02)	25	26	R	
XA0-06.0	RECORD EXX COUNT	9(02)	27	28	R	
XA0-07.0	RECORD FXX COUNT	9(02)	29	30	R	
XA0-08.0	RECORD GXX COUNT	9(02)	31	32	R	
XA0-09.0	RECORD HXX COUNT	9(02)	33	34	R	
XA0-10.0	CLAIM RECORD COUNT	9(03)	35	37	R	
XA0-11.0	RESERVED (XA0-11.0)	X(40)	38	77	R	
XA0-12.0	TOTAL CLAIM CHARGES	9(5)v99	78	84	R	
XA0-13.0	TOTAL DISAL COST CONT CHGS	9(5)v99	85	91	R	
XA0-14.0	TOTAL DISAL OTHER CHARGES	9(5)v99	92	98	R	
XA0-15.0	TOTAL ALLOWED AMOUNT	9(5)v99	99	105	R	
XA0-16.0	TOTAL DEDUCTIBLE AMOUNT	9(5)v99	106	112	-	
XA0-17.0	TOTAL COINSURANCE AMOUNT	9(5)v99	113	119	-	
XA0-18.0	TOTAL PAYOR AMOUNT PAID	9(5)v99	120	126	C	Total amount paid by third-party payers. Do not enter recipient co-pay or previous Medicaid or Medicare payments in this field.
XA0-19.0	PAT AMOUNT PAID	9(5)v99	127	133	O	
XA0-20.0	TOTAL PURCHASE SVC CHARGES	9(5)v99	134	140	-	
XA0-21.0	PROV DISCOUNT INFORMATION	X(16)	141	156	C	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

CLAIM TOTALS **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
XA0-22.0	REMARKS	X(103)	157	259	O	
XA0-23.0	FILLER-NATIONAL	X(61)	260	320	-	Spaces.

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**
BATCH TOTALS **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
YA0-01.0	RECORD ID "YA0"	X(03)	01	03	R	Must equal "YA0"
YA0-02.0	EMC PROV ID	X(15)	04	18	R	Must equal BA0-02.0
YA0-03.0	BATCH TYPE	X(03)	19	21	R	"200" = Dental, "100" = All Others.
YA0-04.0	BATCH NO	9(04)	22	25	R	Must equal BA0-04.0
YA0-05.0	BATCH ID	X(06)	26	31	R	
YA0-06.0	PROV TAX ID	X(09)	32	40	R	Must equal BA0-06.0
YA0-07.0	RESERVED (YA0-07.0)	X(06)	41	46	-	
YA0-08.0	BATCH SVC LINE COUNT	9(07)	47	53	R	
YA0-09.0	BATCH RECORD COUNT	9(07)	54	60	R	
YA0-10.0	BATCH CLAIM COUNT	9(07)v99	61	67	R	
YA0-11.0	BATCH TOTAL CHARGES	9(07)v99	68	76	R	
YA0-12.0	FILLER NATIONAL	X(244)	77	320	-	

CCHS REQUIREMENTS MATRIX

HCFA 1500 **VER 301**

FILE TOTALS **RECORD REQUIRED**

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	POSITION TO	FIELD REQ	COMMENTS
ZA0-01.0	RECORD ID “ZA0”	X(03)	01	03	R	Must equal “ZA0”.
ZA0-02.0	SUB ID	X(16)	04	19	R	Assigned by ACS during enrollment (five digits). Left-Justify and space-fill. Must equal AA0-02.
ZA0-03.0	RESERVED (ZA0-03.0)	X(09)	20	28	-	
ZA0-04.0	RECEIVER ID	X(16)	29	44	R	“77025”=West Virginia Workers’ Compensation. Assigned by ACS.
ZA0-05.0	FILE SVC LINE COUNT	9(07)	45	51	R	
ZA0-06.0	FILE RECORD COUNT	9(07)	52	58	R	
ZA0-07.0	FILE CLAIM COUNT	9(07)	59	65	R	
ZA0-08.0	BATCH COUNT	9(04)	66	69	R	
ZA0-09.0	FILE TOTAL CHARGES	9(09)v99	70	80	R	
ZA0-10.0	FILE TOTAL PAID AMT	9(09)v99	81	91	-	
ZA0-11.0	FILE TOTAL ALLOWED AMT	9(09)v99	92	102	-	
ZA0-12.0	FILLER NATIONAL	X(218)	103	320	-	