

Uploading an 837 Batch Claim File





ConnectCenter provides the ability to upload a file of claims created in an Electronic Medical Record system, Practice Management System, Hospital Information System or similar application. To be processed, claims files must use the ANSI 837 5010 EDI format. This document provides some guidance on how to construct a compliantly formatted file but it is not a replacement for the ANSI 837 Implementation Guideline.

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Getting Started

To submit completed 837 claim files, use the **ConnectCenter** file upload feature. This feature is found within the **Mailbox** menu.

-  If you create claim files through a third-party application such as a PMS, HIS or EMR system, work with your software vendor for any modifications needed to create properly formatted batch claim files.
-  If you are not familiar with the ANSI 837 transaction format and not able to engage your software vendor for assistance, you should use the claim data entry tool provided in ConnectCenter to create claims online. Refer to the **Keying a Claim** Quick Reference Guides for more information about online claim creation.
-  File names can contain alpha and numeric characters. You can use underscores, periods, and hyphens. Do not use spaces or any special characters other than underscores, periods, and hyphens.
-  Please do **not** submit claims on the **same day** that you create a new

ConnectCenter submitter account. An overnight configuration process must be executed before claim files can be correctly associated with your account.

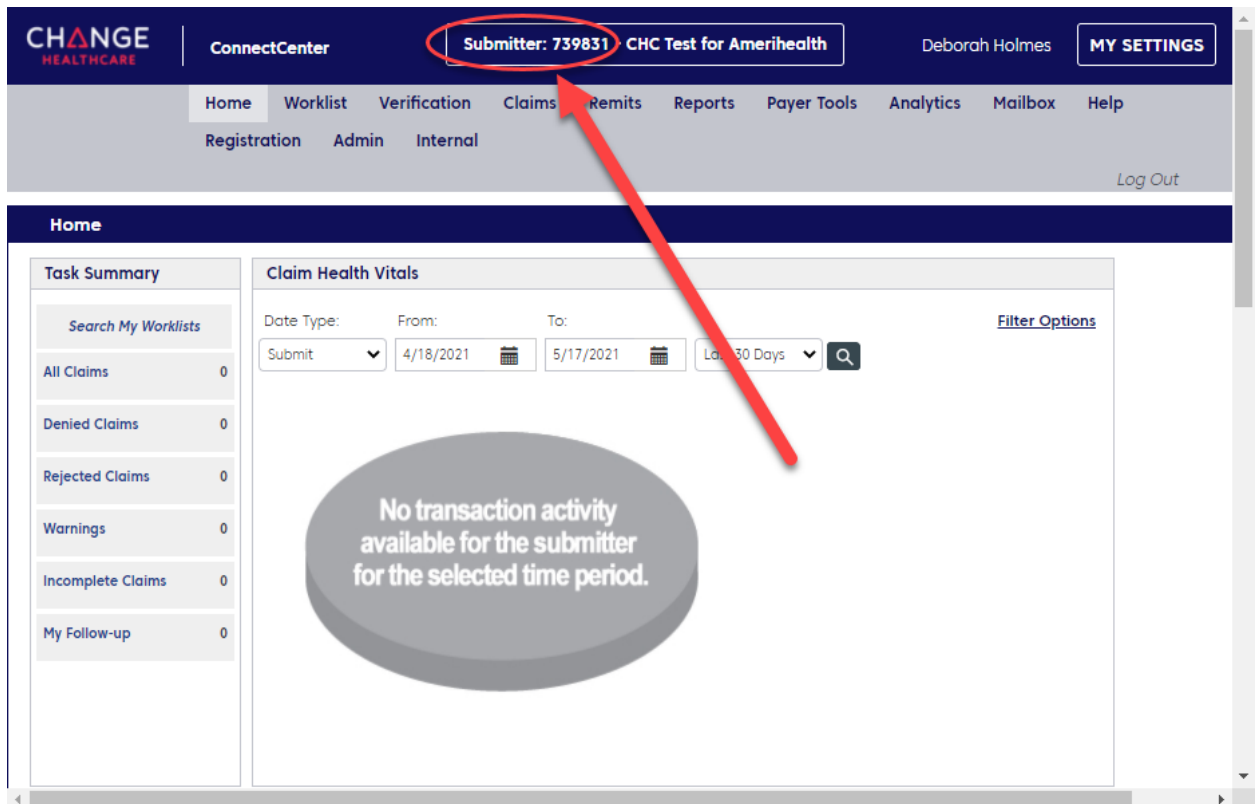
Plan Identifiers

The payer IDs (CPIDs) in the attached list should be used in the 2010BB NM1 segments to identify which plan is being billed. Please note that a different ID should be used for Institutional claims than for Professional claims. Be sure to select the **CPID** from the column appropriate to the type of claims you are creating. As additional reference information, the 5-character payer IDs that are more commonly used to identify these plans are included in this table but these **must not** be used in the 2010BB NM1.

[Payer List](#)

Submitter ID

Your Submitter ID is needed in several places within the claim headers. Your submitter ID is the 6-digit account identifier issued to you when your account is created. When you are logged into ConnectCenter, your submitter ID is always displayed at the top of the screen.



Transaction Header

This section provides guidance regarding specific values required or expected in the header of a claim file. Where noted with an asterisk (*), the values shown in the table below are expected to be **exactly** as given. Fields not noted with an asterisk are placeholders for appropriate values matching the syntax and description provided.

Example Transaction Header:

```
ISA~00~      ~01~CYCTRANS ~ZZ~859999      ~ZZ~CLAIMSCH
~171006~2004~|~00501~000000001~0~P~^_GS~HC~P999813~5500~20171006~200405~1
~X~005010X223A2_
```

Segment	Description	Value / Syntax	Max Len
ISA 01	Authorization Information Qualifier *	00	2
ISA 02	Not Used, pass 10 spaces *		10
ISA 03	Security Information Qualifier *	01	2
ISA 04	Security Information, left justified with two trailing spaces *	CYCTRANS	10
ISA 05	Interchange ID Qualifier *	ZZ	2
ISA 06	Interchange Sender ID, use the ConnectCenter Submitter ID, left justified with trailing spaces	Submitter ID	15
ISA 07	Interchange ID Qualifier *	ZZ	2
ISA 08	Interchange Receiver ID, left justified with seven trailing spaces *	CLAIMSCH	15
ISA 09	Interchange Date, date file was sent	YYMMDD	6

Segment			
Element	Description	Value / Syntax	Max Len
ISA 10	Interchange Time, time file was sent	HHMM	4
ISA 11	Repetition Separator, Delimiter used to separate repeated occurrences. Recommended: Use a pipe []		1
ISA 12	Interchange Control Version Number *	00501	5
ISA 13	Interchange Control Number, pad with leading zeros; Must be a positive unsigned number identical to IEA 02.		9
ISA 14	Acknowledgement Request Code 0 = No acknowledgement requested 1= Interchange acknowledgement requested	0 or 1	1
ISA 15	Usage Indicator P = Product Claims; T = Test Claims	P or T	1
ISA 16	Component Element Separator Delimiter used to separate repeated occurrences. Recommended: tilde [~], underscore [_], or carrot [^]. Do not use a character that is sent as part of the claim data or is used by the payer as a delimiter.		1
GS 01	Functional Identifier Code *	HC	2
GS 02	Application Sender's Code Use Submitter ID.	Submitter ID	15
GS 03	Application Receiver's Code *	ECGCLAIMS	15
GS 04	Date, date file was created	CCYYMMDD	8
GS 05	Time, time file was created H = hours M = minutes S = seconds D or DD = decimal seconds in tenths (D) or hundredths (DD)	HHMM or HHMMSS or HHMMSSD or HHMMSSDD	8


Segment			
Element	Description	Value / Syntax	Max Len
GS 06	Group Control Number, assigned by the sender		9
GS 07	Responsible Agency Code *	X	2
GS 08	Version / Release 005010X222A1 = Professional Claims 005010X223A2 = Institutional Claims	005010X222A1 or 005010X223A2	

Additional Identifiers

Segment				
Loop	Element	Description	Value / Syntax	Max Len
1000A Submitter	NM108	Identification Code Qualifier *	46	2
1000A Submitter	NM109	Submitter Identification Code should be constructed by combining the ConnectCenter Biller ID (first) and Submitter ID (second) to create a 12-digit code. <ul style="list-style-type: none"> • Biller ID should be 214629 • Submitter ID is the 6-digit number that can be found in ConnectCenter at the top, center of every screen 	214629 Submitter ID	80
2010BB Payer	NM108	Identification Code Qualifier *	PI	2
2010BB Payer	NM109	Payer ID must be one of the 4 digit CPID codes identified on this list: Payer List	Payer ID	4

Acknowledgement and Claim Reports

Claims files typically complete the first phase of processing within 10-15 minutes which means that within 15 minutes newly uploaded claims should be visible in the Claim Health Vitals, Work List and Claim Search views. In addition, a claim acknowledgement report will be delivered to your mailbox with information regarding any claims or batches that could not be successfully processed.

-  If you do not see claims or reports within 15 minutes of uploading your files, there may be a problem with your file configuration. Please contact support if this happens.

Batch reports can provide additional insight about the status of files uploaded. These reports are typically returned with one minute of file upload. To access these reports chose Mailbox from the main menu. Change the "Directory" field to "All" to access reports. If you have a lot of reports, use additional filters such as date to shorten the list of reports returned.

The reports returned in this fashion can be challenging to understand. The most important thing to look for is the file status, which will be given in the first few lines of the report. Look for "***** TRANSFER OF FILE " followed by the name of your file. Immediately after the file name the report should say either "SUCCESSFUL" or "FAILED." If your file has a FAILED status please contact either your vendor or Change Healthcare customer support for help correcting the problem.