


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STANDARD COMPANION GUIDE
TRANSACTION INFORMATION

INSTRUCTIONS RELATED TO THE
HEALTH CARE CLAIM PAYMENT/ADVICE (835)
BASED ON ASC X12 TECHNICAL REPORTS TYPE 3 (TR3)
VERSION 005010X221A1

COMPANION GUIDE
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1 INTRODUCTION

1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires 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 primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s)
- Change the meaning or intent of the standard’s implementation specification(s)

1.3 Compliance according to ASC X12 Standard for Electronic Data Interchange Report Type 3 (TR3)

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the TR3
- Modifying any requirement contained in the TR3.

1.4 Intended Use

The Transaction Specific Information of this companion guide must be used in conjunction with an associated ASC X12 Standard for Electronic Data Interchange Report Type 3 (TR3). The Transaction Specific Information in this companion guide is not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 TR3 and is in conformance with ASC X12’s Fair Use and Copyright statements.

2 ASC X12 STANDARDS FOR ELECTRONIC DATA INTERCHANGE REPORT TYPE 3

- 005010X221A1 Health Care Claim Payment/Advice (835)

3 TRANSACTION SPECIFIC INFORMATION

3.1 835 Health Care Claim Payment/Advice Instruction Table

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
	ISA	**INTERCHANGE CONTROL HEADER**	
	ISA01	Authorization Information Qualifier	Expect 00
	ISA02	Authorization Information	Blank
	ISA03	Security Information Qualifier	Expect 00
	ISA04	Security Information	Blank
	ISA05	Interchange ID Qualifier	Expect ZZ
	ISA06	Interchange Sender ID	Expect AHCCCS866004791
	ISA07	Interchange ID Qualifier	Expect ZZ
	ISA08	Interchange Receiver ID	Expect SFTP folder name
	ISA09	Interchange Date	Expect Interchange Date in YYMMDD
	ISA10	Interchange Time	Expect Interchange Time in HHMM
	ISA11	Interchange Control Standards ID	Expect ^
	ISA12	Interchange Control Version Number	Expect 00501
	ISA13	Interchange Control Number	Expect Interchange Control Number
	ISA14	Acknowledgement Requested	Expect 0
	ISA15	Usage Indicator	Expect P for Production
	ISA16	Component Element Separator	Expect |
	GS	**FUNCTIONAL GROUP HEADER**	
	GS01	Functional Identifier Code	Expect HP
	GS02	Application Sender's Code	Expect AHCCCS866004791
	GS03	Application Receiver's Code	Expect AZ + 6 digit provider ID + 2 digit Pay to Code Example: AZ12345601
	GS03	Date	Expect GS Date in CCYYMMDD
	GS05	Time	Expect GS Time in HHMM
	GS06	Group Control Number	Expect GS Control Number
	GS07	Responsible Agency Code	Expect X
	GS08	Version/Release/Industry Id Code	Expect 005010X221A1
	ST	**TRANSACTION SET HEADER**	
	ST01	Transaction Set Identifier Code	Expect 835
	ST02	Transaction Set Control Number	Expect 0001, next ST02 will be 0002 and so on
	BPR	**FINANCIAL INFORMATION**	
	BPR01	Transaction Handling Code	Expect H when check is $0 Expect I when check greater than $0

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
	BPR02	Monetary Amount	Expect Provider Payment Amount not greater than 99999999.99 or Zero.
	BPR03	Credit/Debit Flag Code	Expect C – Credit
	BPR04	Payment Method Code	Expect ACH when electronic payment is made Expect CHK when payment issued by check Expect NON when no payment is made
	BPR05	Payment Format Code	Expect CCP when payment is ACH
	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	Expect 01 when payment is ACH
	BPR07	Sender DFI Identifier	Expect Sender DFI Identifier when payment is ACH
	BPR08	Account Number Qualifier	Expect DA when payment is ACH
	BPR09	Sender Bank Account Number	Expect Sender Bank Account Number when payment is ACH
	BPR10	Payer Identifier	Expect Payer Tax ID/1866004791 when payment is ACH
	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	Expect 01 when payment is ACH
	BPR13	Receiver or Provider Bank ID Number	Expect Provider Bank ID Number when payment is ACH
	BPR14	Account Number Qualifier	Expect DA when payment is ACH
	BPR15	Receiver or Provider Account Number	Expect Provider Account Number when payment is ACH
	BPR16	Check issue or EFT Effective Date	Expect Check Issue or Payment Effective Date
	TRN	**REASSOCIATION TRACE NUMBER**	
	TRN01	Trace Type Code	Expect 1
	TRN02	Check or EFT Trace #	Expect Check Number if payment is by check Expect EFT Trace Number if payment is electronic Expect AHCCCS Invoice Number if nonpayment and AHCCCS Invoice Number exists Expect XccyymmddXXXXXXXX with X being pay entity payment date and 8 byte AHCCCS provider ID
	TRN03	Payer Identifier	Expect Payer Tax ID 1866004791

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
	TRN04	Originating Co Supplemental Code	Expect AHCCCS funding source ADOC-ADOC FFS (G) BFFS-Behavioral Health Non KidsCare FFS (B) BKFS-KidsCare Behavioral Health (C) FFSV-Acute FFS (A) FQMB-QMB (M) JDOC-Juvenile DOC (N) KFFS-KidsCare FFS (K) LFFS-LTC FFS (L) MDOC-Maricopa DOC (J) School Based Claiming FFSV – Admin (D) FFSV – (R) LFFS – Admin (E) LFFS – Admin (S)
REF	**REF**	**RECEIVER IDENTIFICATION**	
	REF01	Receiver ID Qualifier	Expect EV
	REF02	Receiver Identifier	Expect SFTP Directory Folder Name, entity that retrieves transaction
DTM	**DTM**	**PRODUCTION DATE**	
	DTM01	Date Time Qualifier	Expect 405
	DTM02	Production Date	Expect Date of Finance Cycle, CCYYMMDD
1000A	**N1**	**PAYER IDENTIFICATION**	
1000A	N101	Entity Identifier Code	Expect PR
1000A	N102	Payer Name	Expect AHCCCS
1000A	**N3**	**PAYER ADDRESS**	
1000A	N301	Payer Address Line	Expect 801 E JEFFERSON
1000A	**N4**	**PAYER CITY, STATE, ZIP**	
1000A	N401	Payer City Name	Expect PHOENIX
1000A	N402	Payer State Code	Expect AZ
1000A	N403	Payer Postal Zone or ZIP Code	Expect 85034
1000A	**PER**	**PAYER BUSINESS CONTACT INFORMATION**	
1000A	PER01	Contact Function Code	Expect CX
1000A	PER02	Payer Contact Name	Expect Claims Customer Service
1000A	PER03	Communication Number Qualifier	Expect TE
1000A	PER04	Payer Contact Communication Number	Expect 6024177670
1000A	PER05	Communication Number Qualifier	Expect TE
1000A	PER06	Payer Contact Communication Number	Expect 8005230231
1000A	**PER**	**PAYER TECHNICAL CONTACT INFORMATION**	
1000A	PER01	Contact Function Code	Expect BL

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
1000A	PER02	Payer Technical Contact Name	Expect AHCCCS SERVICE DESK
1000A	PER03	Communication Number Qualifier	Expect EM
1000A	PER04	Payer Contact Communication Number	Expect SERVICEDESK@AZAHCCCS.GOV
1000A	**PER**	**PAYER WEB SITE**	**Expect when any 2110 loop HealthCare Policy REF segment is used**
1000A	PER01	Contact Function Code	Expect IC
1000A	PER03	Communication Number Qualifier	Expect UR
1000A	PER04	Payer Contact Communication Number	Expect https://www.azahcccs.gov/shared/MedicalPolicyManual
1000B	**N1**	**PAYEE IDENTIFICATION**	
1000B	N101	Entity Identifier Code	Expect PE
1000B	N102	Information Receiver Last or Organization Name	Expect Billing Provider Name
1000B	N103	Identification Code Qualifier	Expect XX if Billing Provider has an NPI Expect FI if Billing Provider is atypical
1000B	N104	Payee Identification Code	Expect NPI if Billing Provider has an NPI Expect Federal Taxpayer's Identification Number if atypical
1000B	**N3**	**PAYEE ADDRESS**	
1000B	N301	Payee Address Line	Expect Payee's Street Address Line1
1000B	N302	Payer Address Line	Expect Payee's Street Address Line 2 if applicable
1000B	**N4**	**PAYEE CITY, STATE, ZIP CODE**	
1000B	N401	Payee City Name	Expect Payee City Name
1000B	N402	Payee State Code	Expect Payee State Code
1000B	N403	Payee Zip Code	Expect Payee Zip Code
1000B	**REF**	**PAYEE ADDITIONAL IDENTIFICATION**	
1000B	REF01	Reference Identification Qualifier	Expect TJ when payee has an NPI Expect PQ when payee does not have an NPI
1000B	REF02	Additional Payee Identifier	Expect Federal Taxpayer's Identification Number when payee has an NPI Expect 8 byte AHCCCS provider ID when payee does not have an NPI
2000	**LX**	**HEADER NUMBER**	
2000	LX01	Assigned Number	Expect 1, next LX will be 2 and so on
2100	**CLP**	**CLAIM PAYMENT INFORMATION**	
2100	CLP01	Claim Submitter's Identifier/Patient Control Number	Expect Patient Control Number, up to 20 bytes. If no patient control number received, expect 0.

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
2100	CLP02	Claim Status Code	Expect 1 when processed as primary by AHCCCS Expect 2 when processed as secondary by AHCCCS Expect 3 when processed as tertiary or more by AHCCCS Expect 4 when claim is denied for member not recognized in AHCCCS system Expect 22 when previous payment reversed
2100	CLP03	Total Claim Charge Amount	Expect - The Total Charged Amount for the claim. This amount includes Share of Cost payments by the patient and amounts paid by other carriers prior to AHCCCS.
2100	CLP04	Claim Payment Amount	Expect - The amount AHCCCS would have paid prior to any discounts or interest
2100	CLP05	Patient Responsibility Amount	Expect - The Share of Cost Amount paid by the recipient. If a Share of Cost Amount is paid by a patient, it is included in the provider's Charged Amount and shown on the claimlevel CAS Segment.
2100	CLP06	Claim Filing Indicator Code	Expect MC (Medicaid)
2100	CLP07	Payer Claim Control Number	Expect - The 15-character Claim Reference Number (CRN) assigned by AHCCCS.
2100	CLP08	Facility Type Code	For Professional and Dental Claims, CLP08 is the Place of Service. Since the adjudication system maintains Place of Service at the line rather than the claim level, CLP08 is the Place of Service from the initial line. For Institutional Claims, CLP08 consists of the first and second characters of the Type Bill Code.
2100	CLP09	Claim Frequency Code	CLP09 Claim Frequency Code values of "7"(Replacement) and "8" (Void) indicate claims that perform these functions. All other valid Claim Frequency values are for original claims.
2100	CLP11	DRG Code	Expect Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems
2100	CLP12	DRG Weight	Expect Diagnosis-related group (DRG) weight
2100	CLP13	Discharge Fraction	Expect Discharge fraction
2100	**CAS**	**CLAM ADJUSTMENT**	
2100	CAS01	Claim Adjustment Group Code	Expect: CO – Contractual Obligation OA – Other Adjustments PI – Payer Initiated Reduction PR – Patient Responsibility
2100	CAS02	Adjustment Reason Code	Expect applicable Claim Adjustment Reason Code (CARC)
2100	CAS03	Adjustment Amount	Expect - Adjustment Amount
2100	**NM1**	**PATIENT NAME**	
2100	NM101	Entity Identifier Code	Expect QC
2100	NM102	Entity Type Qualifier	Expect 1
2100	NM103	Patient Last Name	Expect Member Last Name from original claim
2100	NM104	Patient First Name	Expect Member First Name from original claim
2100	NM105	Patient Middle Name	Expect Member Middle Name from original claim

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
2100	NM108	Identification Code Qualifier	Expect MR
2100	NM109	Patient Identifier	Expect AHCCCS Member ID
2100	**NM1**	**CORRECTED PATIENT/INSURED NAME**	**EXPECT WHEN CORRECTED MEMBER INFORMATION NEEDS TO BE REPORTED**
2100	NM101	Entity Identifier Code	Expect 74
2100	NM102	Entity Type Qualifier	Expect 1
2100	NM103	Corrected Patient or Insured Last Name	Expect when submitted Last Name is different than adjudicated Last Name
2100	NM104	Corrected Patient or Insured First Name	Expect when submitted First Name is different than adjudicated First Name
2100	NM105	Corrected Patient or Insured Middle Name	Expect when submitted Middle Name is different than adjudicated Middle Name
2100	NM108	Identifier Code Qualifier	Expect C
2100	NM109	Corrected Ins Identification Indicator	Expect when submitted Member ID is different than adjudicated Member ID
2100	**NM1**	**SERVICE PROVIDER NAME**	**EXPECT WHEN RENDERING PROVIDER IS DIFFERENT THAN PAYEE**
2100	NM101	Entity Identifier Code	Expect 82
2100	NM102	Entity Type Qualifier	Expect: 1 – if person 2 – if non-person entity
2100	NM108	Identification Code Qualifier	Expect: XX – if provider has National Provider ID (NPI) MC – for atypical provider
2100	NM109	Rendering Provider Identifier	Expect NPI if medical provider Expect 8 byte AHCCCS provider ID+Pay To Code if atypical provider
2100	**NM1**	**CORRECTED PRIORITY PAYER NAME**	**EXPECT WHEN A CLAIM IS DENIED BECAUSE THE MEMBER HAS OTHER INSURANCE BUT THE OTHER INSURANCE INFORMATION WAS NOT SUBMITTED ON THE CLAIM, OR THE MEMBER IS ENROLLED WITH AN AHCCCS CONTRACTED HEALTH PLAN. AHCCCS HAS IDENTIFIED A PRIORITY PAYER.**
2100	NM101	Entity Identifier Code	Expect PR
2100	NM102	Entity Type Qualifier	Expect 2
2100	NM103	Corrected Priority Payer Name	Expect the Corrected Priority Payer Name or AHCCCS contracted health plan name
2100	NM108	ID Code Qualifier	Expect PI
2100	NM109	Corrected Priority Payer ID	Expect the AHCCCS carrier ID for this payer or the AHCCCS contracted health plan number
2100	**NM1**	**OTHER SUBSCRIBER NAME**	**EXPECT WHEN CORRECTED PRIORITY PAYER SEGMENT IS SENT AND THE NAME OR ID OF THE OTHER SUBSCRIBER IS KNOWN.**
2100	NM101	Entity Identifier Code	Expect GB
2100	NM102	Entity Type Qualifier	Expect 1

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
2100	NM103	Other Subscriber Last Name	Expect Name if Other Subscriber Identifier is not present
2100	NM108	ID Code Qualifier	Expect MI if identifier is known
2100	NM109	Other Subscriber Identifier	Expect Other Subscriber Identifier if known
2100	**MIA**	**INPATIENT ADJUDICATION INFORMATOION**	**EXPECT WHEN REPORTING REMARK CODES FOR INPATIENT ADJUDICATION**
2100	MIA01	Covered Days or Visits Count	Expect 0
2100	MIA05	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MIA20	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MIA21	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MIA22	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MIA23	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MIA24	Claim Payment Remark CD	Expect Remittance Advice Remark Code (RARC), if applicable
2100	**MOA**	**OUTPATIENT ADJUDICATION INFORMATION**	**EXPECT WHEN REPORTING REMARK CODES FOR OUTPATIENT ADJUDICATION**
2100	MOA03	Remark Code	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MOA04	Remark Code	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MOA05	Remark Code	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MOA06	Remark Code	Expect Remittance Advice Remark Code (RARC), if applicable
2100	MOA07	Remark Code	Expect Remittance Advice Remark Code (RARC), if applicable
2100	**REF**	**OTHER CLAIM RELATED IDENTIFICATION**	**EXPECT WHEN ADDITIONAL REFERENCE IDENTIFIERS APPLY TO THIS CLAIM**
2100	REF01	Reference Identification Qualifier	Expect CE, Class of Contract (Reimbursement Methodology) Expect EA, Medical Record Identification Number (When submitted on original claim) Expect F8, Original Reference Number (Prior CRN) Expect G1, Prior Authorization (For paid claims) Expect 6P, Group Number (Other insured group number if known)
2100	REF02	Other Claim Related Identifier	Expect the 15 character Claim Reference Number (CRN) of the claim being replaced or voided when the Claim Frequency Code (CLP09) has a value of “7” (Replacement) or “8” (Void)
2100	**DTM**	**STATEMENT FROM OR TO DATE**	
2100	DTM01	Date Time Qualifier	Expect: Expect 232 for service begin date Expect 233 for service end date
2100	DTM02	Claim Date	Expect CCYYMMDD
2100	**DTM**	**COVERAGE EXPIRATION DATE**	**EXPECT WHEN CLAIM HAS BEEN DENIED FOR MEMBER NOT BEING ENROLLED FOR DATES OF SERVICE**
2100	DTM01	Date Time Qualifier	Expect 036
2100	DTM02	Date	Expect CCYYMMDD
2100	**AMT**	**CLAIM SUPPLEMENTAL INFORMATION**	

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
2100	AMT01	Amount Qualifier Code	Expect AU Coverage Amount for paid claims Expect D8 Discount Amount when prompt payment applies Expect I Interest Amount when interest payment applies Expect F5 Patient Amount Paid when share of cost applies
2100	AMT02	Claim Supplemental Information Amount	Expect Claim Supplemental Information Amount
2100	**QTY**	**CLAIM SUPPLEMENTAL INFORMATION QUANTITY**	
2100	QTY01	Quantity Qualifier	Expect CA Covered Actual for allowed units
2100	QTY02	Quantity	Expect Quantity
2110	**SVC**	**SERVICE PAYMENT INFORMATION**	
2100	SVC01	Composite Medical Procedure Identifier	
2110	SVC01-1	Product or Service ID Qualifier	Expect HC HCPCS Code if used for pricing/pay Expect NU NUBC Code, Rev Code if used for pricing/pay Expect N4 National Drug Code, if used for price/pay
2110	SVC01-2	Adjudicated Procedure Code	Expect adjudicated procedure or revenue code
2110	SVC01-3	Procedure Modifier	Expect procedure modifier, if applicable
2110	SVC01-4	Procedure Modifier	Expect procedure modifier, if applicable
2110	SVC01-5	Procedure Modifier	Expect procedure modifier, if applicable
2110	SVC01-6	Procedure Modifier	Expect procedure modifier, if applicable
2110	SVC02	Line Item Charge Amount	Expect Service Line Item Charge Amount
2110	SVC03	Line Item Provider Payment	Expect Service Line Item Provider Payment Amount
2110	SVC04	NUBC Revenue Code	Expect when a revenue code was considered during adjudication in addition to the procedure code.
2110	SVC05	Units of Service Paid Count	Expect Units of Service Paid Count
2110	SVC07	Original Units of Service Count	Expect when submitted units of service is different than the paid units of service in SVC05
2110	**DTM**	**SERVICE DATE**	
2110	**DTM01**	**Date/Time Qualifier**	Expect 150 Service Period Start Date Expect 151 Service Period End Date Expect 472 to indicate a single service date
2110	**DTM02**	**Service Date**	Expect CCYYMMDD
2110	**CAS**	**SERVICE ADJUSTMENT**	
2110	CAS01	Claim Adjustment Group Code	Expect CO,OA,PI, PR
2110	CAS02	Adjustment Reason Code	Expect applicable Claim Adjustment Reason Code (CARC)
2110	CAS03	Adjustment Amount	Expect Adjustment Amount

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
2110	**REF**	**SERVICE IDENTIFICATION**	
2110	REF01	Reference ID Qualifier	Expect E9 for attachment code from inbound attachment Expect G1 for prior authorization (For paid service line)
2110	REF02	Provider ID	Expect Service Identifier Provider Identifier
2110	**REF**	**LINE ITEM CONTROL NUMBER**	
2110	REF01	Reference identification Qualifier	Expect 6R
2110	REF02	Line Item Control Number	Expect line item control number from original claim
2110	**REF**	**HEALTHCARE POLICY IDENTIFICATION**	**EXPECT WHEN A 2110 CARC WITH THE NOTE: REFER TO 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT IS USED**
2110	REF01	Reference Identification Qualifier	Expect 0K
2110	REF02	Healthcare Policy Identification	Expect Medical Policy Manual, Chapter 100
2110	**AMT**	**SERVICE SUPPLEMENTAL AMOUNT**	
2110	AMT01	Amount Qualifier Code	Expect B6
2110	AMT02	Service Supplemental Amount	Expect Allowed Amount
2110	**LQ**	**HEALTHCARE REMARK CODES**	**EXPECT WHEN REMARK CODES (RARCS) APPLY**
2110	LQ01	Code List Qualifier Code	Expect HE
2110	LQ02	Remark Code	Expect RARC or N356
PLB	**PLB**	**PROVIDER LEVEL ADJUSTMENT**	**EXPECT WHEN A PROVIDER ADJUSTMENT HAS OCCURRED.**
PLB	PLB01	Provider Identifier	Expect provider NPI for medical provider Expect AHCCCS legacy ID for non-medical provider
PLB	PLB02	Fiscal Period Date	Expect CCYYMMDD
PLB	PLB03	Adjustment Identifier	
PLB	PLB03-1	Adjustment Reason Code	Expect CS Adjustment when an aged offset or returned check to provider occurs. Expect FB Forward Balance when a balance is moved forward to a future payment advice Expect L6 Interest when interest has been paid Expect 90 Early Payment Allowance when a prompt pay discount applies
PLB	PLB03-2	Provider Adjustment Identifier	Expect AHCCCS Invoice Number if one exists Invoice numbers for aged offsets will contain an AO in them and Invoice numbers for returned checks to provider with an RC in them. If no Invoice Number exists, expect XccyymmddXXXXXXXX, with X being the funding source (for example, A=acute care), ccyymmdd payment date, and 8 byte provider ID. When FB is used, this PLB03-2 must match the TRN02.
PLB	PLB04	Provider Adjustment Amount	Expect Provider Adjustment Amount

LOOP ID	SEGMENT/ ELEMENT ID	DESCRIPTION	AHCCCS 835 USAGE/EXPECTED VALUE
NA	**SE**	**TRANSACTION SET TRAILER**	
NA	SE01	Transaction Segment Count	Expect Transaction Segment Count
NA	SE02	Transaction Set Control Number	Expect Transaction Set Control Number
NA	**GE**	**FUNCTIONAL GROUP TRAILER**	
NA	GE01	Number of Transaction Sets Included	Expect Transaction Sets Included
NA	GE02	Group Control Number	Expect Group Control Number This number must match the control number in GS06
NA	**IEA**	**INTERCHANGE CONTROL TRAILER**	
NA	IEA01	Number of Included Functional Groups	Expect Functional Groups Included The number of functional groups of transactions in the interchange
NA	IEA02	Interchange Control Number	Expect IEA Control Number A control number identical to the header-level Interchange Control Number in ISA13

4 CHANGE SUMMARY

Ver #	Location & Section	Revision	Revision Date
1.0		Final	October 2012
2.0	Cover Page	Updated to reflect the AHCCCS Template	November 2017
2.0	Section 3 Instructions Table	Removed Section 3 Instructions Table and replaced as Section 3 Transaction Specific Information	November 2017
2.0	Section 4 TI Additional Information	Removed Section 4 Additional Information due to missing table	November 2017
3.0	Cover Page/Template	Updated using new template	March 2022
3.0	3.1 835 Health Care Claim Payment/Advice Instruction Table	Added segments/elements	March 2022