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.

Topics covered

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.

- 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 and Biller ID

Payer ID

The payer IDs (**CPIDs**) listed in this table below 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 then 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.

Biller ID

Biller ID is another value that must be included in all claim files. If you do not know your ConnectCenter Biller ID and you typically submit to only one Aetna Better Health Plan, than the Biller ID that you are most likely to be assigned will be listed in the payer table available here.

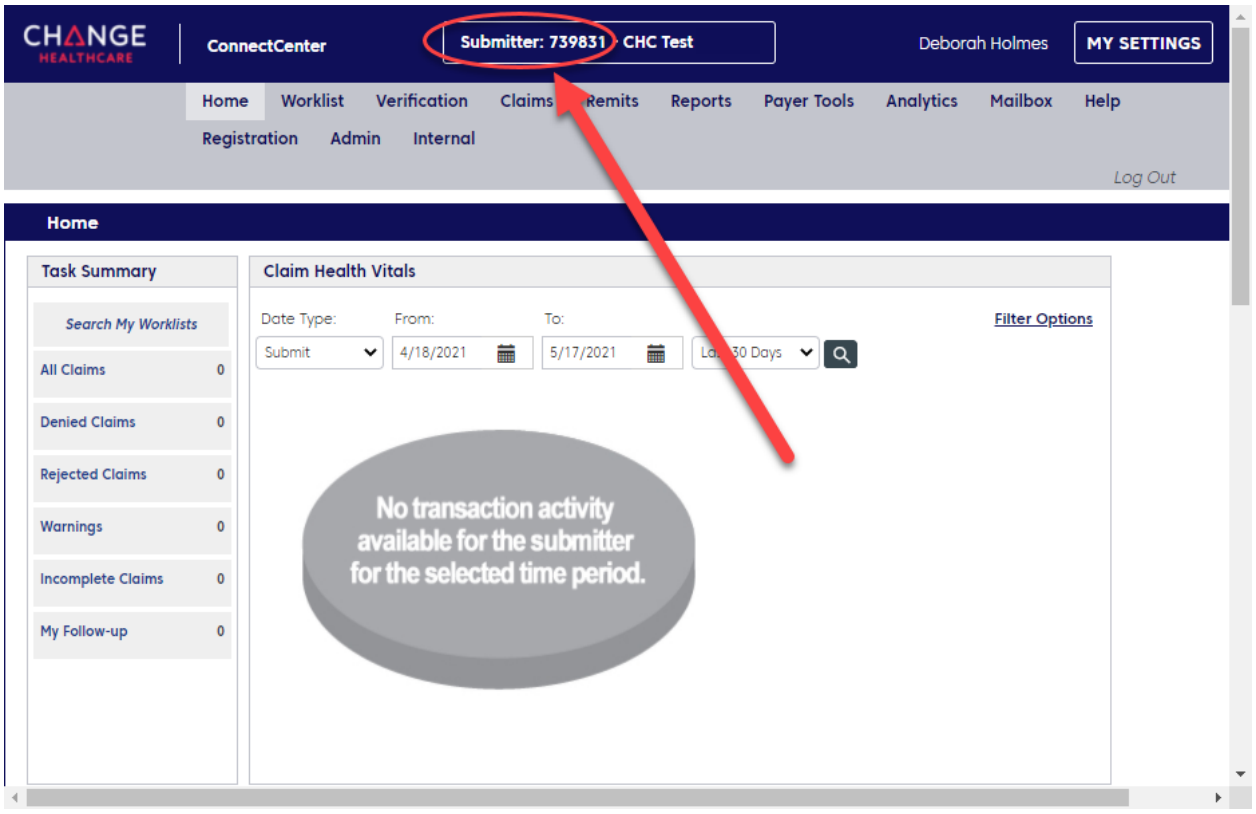
Under certain unusual circumstances, such as when a provider submits to multiple Aetna Medicaid plans, your Biller ID may not strictly correspond to the plan IDs. In that case the way to definitely determine your Biller ID is to take these steps in ConnectCenter;

- Choose "My Account" from the "Admin" menu.
- Click Organizations
- Choose "Search" to search for an organization.

In the Search Results, the value displayed as Parent Organization is the Biller ID.

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~859999859999 ~ZZ~CLAIMSCH ~171006~2004~|~00501~000000001~0~P~^_GS~HC~P999813~5500~20171006~200405~1~X~005010X223A2_

Segment Element	Description	Value	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 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
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

Segment Element	Description	Value	Max Len
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 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
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

Loop	Segment Element	Description	Value	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. • Biller ID identifies the Aetna Medicaid plan sponsoring your account. See the Plan Identifiers and Biller ID section above for additional guidance or use this list. • Submitter ID is the 6-digit number that can be found in ConnectCenter at the top, center of every screen.	Biller ID Submitter ID	12
2010BB Payer	NM108	Identification Code Qualifier *	PI	2
2010BB Payer	NM109	Payer ID should be one of the 4-digit codes explained at the beginning of this document. A table of all valid Payer IDs can be found here.	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.