

Billing for Certified Registered Nurse Anesthetist (CRNA)

Revised: March 5, 2024

Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Refer to additional billing requirements in the service specific section of the MHCP Provider Manual before you submit the claim for services.

Log in to MN-ITS

1. [Log in](#) to MN-ITS
2. From the left menu:
 - a. Select MN-ITS
 - b. Select Submit DDE Claims (837)
 - c. Select Professional (837P)

Submit the Claim

To submit the claim follow the instructions in the tables below for each of the following claim screens:

[Billing Provider](#)

[Subscriber](#)

[Claim Information](#)

[Coordination of Benefits \(COB\)](#)

[Services](#)

Billing Provider

The billing provider screen auto-populates with the information in the enrollment profile for the NPI/UMPI used to login to MN-ITS. If changes are needed, use the [Change of Enrollment Information](#) to notify MHCP Provider Enrollment.

Refer to the table below for instruction and information about each field on this screen.

Field Name * (X12 Loop & element)	Field Instruction
Organization (Loop: 2010AA, NM103 (last or organization) NM104 (first)	The name of the Billing Provider: This could be an Organization, business or the Name of an individual provider identified by the NPI used to login to MN-ITS.
Taxonomy (Loop: 2000A, PRV03)	This field only displays information when a Health care provider specialty location code has been added to the provider file. If multiple taxonomy codes have been added, additional information will display. Select the radio button to identify the appropriate location for this claim.
Address 1 (Loop: 2010AA, N301)	The first address line reported on the provider file
Address 2 (Loop: 2010AA, N302)	The second address line reported on the provider file
City (Loop: 2010AA, N401)	The city name for the address in address fields 1 and 2
State (Loop: 2010AA, N402)	The state name for the address in address fields 1 and 2
Zip	The zip code for the address in address fields 1 and 2

<i>(Loop: 2010AA, N403)</i>	
Telephone <i>(Loop: 2010AA, PER04)</i>	Telephone number reported on the provider file
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Cancel to cancel the claim entry • Continue to proceed to the next screen

Subscriber

Use the Subscriber screen to report the recipient who received the service(s) reported on this claim.

Refer to the table below for instruction and information about each field on this screen.

Field Name* <i>(X12 loop & element)</i>	Field Instruction
Subscriber ID <i>(Loop: 2010BA, NM109)</i>	Enter the 8-digit MHCP ID for the subscriber (recipient) indicated on the MHCP member identification card.
Birth Date <i>(Loop: 2010BA, DMG02)</i>	Enter the birth date of the subscriber (MMDDCCYY). Select the Search action button.
The following fields auto-populate based on the information entered in the Subscriber ID and Birth Date fields.	
Subscriber First Name <i>(Loop: 2010BA, NM104)</i>	The first name of the subscriber.
Middle Initial <i>(Loop: 2010BA, NM105)</i>	The middle initial of the subscriber.
Last Name <i>(Loop: 2010BA, NM103)</i>	The last name of the subscriber.
Gender <i>(Loop: 2010BA, DMG03)</i>	The gender of the subscriber. Select the Delete action button in this section to remove the subscriber information if not correct.
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Claim Information

Use the Claim Information screen(s) to report claim level information that will identify the type of claim and details about the service(s).

Refer to the table below for instruction and information about each field on this screen.

Field Name* <i>(X12 Loop & element)</i>	Field Instruction
Claim Frequency Code <i>(Loop: 2300, CLM05-3)</i>	Specifies if the claim is an original, replacement or void Default is original. If hand keying a claim to be replaced or voided, select the radio button in front of replacement or void.

	If the claim has been retrieved from a submit response or from the request status feature, the claim will display with the option selected.
Payer Claim Control Number <i>(Loop: 2300, REF02)</i>	Identifies the previously processed claim when the claim frequency code is replacement or void. The payer claim control field is protected until replacement or void is selected. Once selected, enter the payer claim control number to be replaced or voided. If the claim has been retrieved from a submit response or the request status feature, the claim number will auto-populate.
Place of Service <i>(Loop: 2300 CLM05-1)</i>	From the drop down menu, select the code that identifies where the service was performed. Default is 11 (office).
Patient Control Number <i>(Loop: 2300, CLM01)</i>	Enter a unique identifier to help identify this claim for this recipient. This will be reported on the remittance advice.
Assignment/ Plan Participation <i>(Loop: 2300, CLM07)</i>	Code indicating whether the provider accepts payment from MHCP. Default is Assigned. Select the correct response if different than the default.
Benefits Assignment <i>(Loop: 2300, CLM08)</i>	The determination of the policy holder or person authorized to act on their behalf, to give MHCP permission to pay the provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information <i>(Loop: 2300, CLM09)</i>	The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations. Default is Yes. Select the correct response if different than the default.
Provider Indicator <i>(Loop: 2300, CLM06)</i>	Identifies whether the provider's signature is on file, certifying services were performed by the provider. Default is Signature on File. Select the correct response if different than the default.
Diagnosis Type Code <i>(Loop: 2300, HI01-1)</i>	From the drop down menu, select whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification.
Diagnosis Code <i>(Loop: 2300, HI01-2, HI02-2, HI03-2, HI04-2)</i>	Enter the ICD or other industry accepted code(s) that best describes the condition/reason the recipient needed the service(s). Select the Add action button in this section to include the diagnosis code on the claim. Once a diagnosis code is entered it will display in the table below. Repeat the code entry to report all diagnoses for the claim. Select the Delete button next to a diagnosis code to remove it from the

	claim.
Situational Claim Information – Select the situational claim information accordion panel to report situational information when required.	
Prior Authorization Number (Loop: 2300, REF02)	When authorization is required, enter the approved authorization number.
Medical Record Number (Loop: 2300, REF02)	This field is not required for CRNA.
Claim Note (Loop: 2300, NTE02)	Use only when additional information is required. Enter a free form description to provide additional information about this claim.
Attachment Control Number (Loop: 2300, PWK06)	Use only when an attachment is required. Enter a code/number, assigned by the provider, identifying an attachment for this claim. MHCP uses only the first 30 characters when matching the attachments to the claim.
Type (Loop: 2300, PWK01)	Use only when an attachment is required. From the drop down select the code indicating the attachment type ID and the description of the attachment. Select the Add action button in this section to include the attachment information on the claim.
Contact Name (Loop: 2010CA, PER02)	This field is not required for CRNA.
Telephone Number (Loop: 2010CA, PER04)	This field is not required for CRNA.
Extension (Loop: 2010CA, PER06)	This field is not required for CRNA.
Related Causes (Loop: 2300, CLM11-1)	This field is not required for CRNA.
Date of Accident (Loop: 2300, DTP03)	This field is not required for CRNA.
Certification Condition (Loop: 2300, CRC02)	This field is not required for CRNA.
Condition Code (Loop: 2300, CRC03, CRC04, CRC05,)	This field is not required for CRNA.
Situational Ambulance Information - Select the situational claim information accordion panel to report situational information for ambulance when required.	
Certification Condition (Loop: 2300, CRC02)	This field is not required for CRNA.
Condition Code (Loop: 2300, CRC03, CRC04, CRC05, CRC06, CRC07)	This field is not required for CRNA.
Patient Weight (Loop: 2300, CR102)	This field is not required for CRNA.
Transport Distance (Loop: 2300, CR106)	This field is not required for CRNA.
Transport Reason Code	This field is not required for CRNA.

<i>(Loop: 2300 CR104)</i>	
Round Trip Purpose Description <i>(Loop: 2300, CR109)</i>	This field is not required for CRNA.
Stretcher Purpose Description <i>(Loop: 2300, CR110)</i>	This field is not required for CRNA.
Pickup Address <i>(Loop: 2310E, N301)</i>	This field is not required for CRNA.
Address {contd} <i>(Loop: 2310E, N302)</i>	This field is not required for CRNA.
City <i>(Loop: 2310E, N401)</i>	This field is not required for CRNA.
State <i>(Loop: 2310E, N402)</i>	This field is not required for CRNA.
Zip Code <i>(Loop: 2310E, N403)</i>	This field is not required for CRNA.
Dropoff Address <i>(Loop: 2310F, N301)</i>	This field is not required for CRNA.
Address {contd} <i>(Loop: 2310F, N302)</i>	This field is not required for CRNA.
City <i>(Loop: 2310F, N401)</i>	This field is not required for CRNA.
State <i>(Loop: 2310F, N402)</i>	This field is not required for CRNA.
Zip Code <i>(Loop: 2310F, N403)</i>	This field is not required for CRNA.
Other Providers (Claim Level) – Select the Other Providers accordion panel when required to report other provider information.	
Rendering Provider	
NPI/UMPI <i>(Loop: 2310B, NM109)</i>	CRNA providers are required to enter rendering provider information on all claims: <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Pay-To Provider	
NPI/UMPI <i>(Loop: 2010AB, NM109)</i>	If different than the billing provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who should be paid for the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Referring Provider	
NPI/UMPI <i>(Loop: 2310A, NM109)</i>	If different than the billing provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who referred the recipient for the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim

Supervising Provider	
Service Facility Location	
NPI/UMPI (Loop: 2310C, NM109)	CRNA providers are required to enter Service Facility Location information on all claims: <ul style="list-style-type: none"> • Enter the NPI of the location where the service was performed • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Coordination of Benefits (COB)

Use the COB screen to report other payers, private insurance (TPL) or Medicare's financial responsibility for all or a portion of the claim. If no other payers are involved with this claim, select the Continue button at the bottom of this screen to proceed to the next screen.

To report each type of other payer information at the claim/header level use the tables below:

[Third Party Liability \(TPL\)/Other insurance \(non-Medicare\)](#)

[Medicare/HMO Medicare Risk](#)

TPL/Private Insurance

Complete the following fields to report adjustment, payments and denials from the private insurance (Non-Medicare) carrier.

If reporting MB-Medicare Part B or 16-Health Maintenance Organization, HMO Medicare Risk insurance use the instructions in the [Medicare/HMO Medicare Risk](#) table below.

Field Name* (X12 Loop & Element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Enter the full name of the insurance carrier. Do not use symbols such as slashes, dashes, periods or plus signs.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter the Identifier of the insurance carrier (this is available on the eligibility response for this recipient). Do not use symbols such as slashes, dashes, periods or plus signs.
Claim Filing Indicator (Loop: 2320, SBR09)	From the drop down menu, select the code identifying the type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting TPL/private insurance.
Payer Responsibility (Loop: 2320, SBR01)	From the drop down menu, select the code identifying the insurance carrier's level of responsibility for payment of the claim.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the insurance carrier. For Medicare this would be the Medicare health insurance claim number (HICN) or the Medicare beneficiary identifier (MBI) number.

Relationship Code <i>(Loop: 2320, SBR02)</i>	From the drop down menu, select the relationship of the MHCP subscriber (recipient) to the policy holder
Claim Adjustment Group Code <i>(Loop: 2320, CAS01)</i>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>From the drop down menu, select the adjustment code identifying the general category of payment adjustment.</p> <p>Use the Washington Publishing Company link, on right, to find the HIPAA compliant code that matches the adjustment response on the other payer's EOB.</p>
Adj Reason Code <i>(Loop: 2320, CAS02, CAS05, CAS08, CAS11, CAS14, CAS17)</i>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>Enter the code identifying the reason the other payer adjusted the payment. Refer to the other payer EOB or EOMB.</p> <p>Use the Washington Publishing Company link, on right, to find the HIPAA compliant code that matches the adjustment response on the other payer's EOB.</p>
Adj Amount <i>(Loop: 2320, CAS03, CAS06, CAS09, CAS12, CAS15 CAS18)</i>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>Enter the dollar amount of the adjustment.</p>
Adj Quantity <i>(Loop: 2320, CAS04, CAS07, CAS10, CAS13, CAS16, CAS19)</i>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>Enter the number of units not paid when the units paid are different than the number of units submitted on the claim.</p> <p>Select the Add action button in this section to include the adjustment entries on the claim. Repeat the Claim Adjustment entries to report all adjustments as noted on the EOB from the TPL/private insurance.</p> <p>Select the Delete action button next to an adjustment to remove it from the claim.</p>
Payer Paid Amount <i>(Loop: 2320, AMT02)</i>	<p>This field is used only when reporting TPL/private insurance at the claim (header) level rather than at the service line.</p> <p>Enter the total dollar amount paid by their other payer.</p>
Non-Covered Charge Amount <i>(Loop: 2320, AMT02)</i>	Not used by MHCP
Benefits Assignment <i>(Loop: 2320, O103)</i>	<p>The determination of the policy holder, or person authorized to act on their behalf, to give the other payer permission to pay the provider directly.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p>

Release of Information (Loop 2320, O106)	The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations Default is Yes. Select the correct response if different than the default.
Section Action Buttons	Select: <ul style="list-style-type: none"> • Delete in this section to remove this payer from the claim level and at the line level • Save in this section to include the TPL/private insurance information on the claim
Section Action Button	Select the ADD action button in this section to enter additional payers. Repeat the COB entry process to report all payers for the claim.
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Medicare and HMO Medicare Risk

Complete the following fields to report adjustment, payments and denials from Medicare or an HMO Medicare Risk plan.

Field Name* (X12 Loop & Element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Enter the full name of the insurance carrier. Do not use symbols such as slashes, dashes, periods or plus signs.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter the Payer ID of the Medicare contractor or Medicare Risk (Advantage) health plan. <ul style="list-style-type: none"> • For Medicare: Refer to the CMS Provider Compliance Group Map for contractor contact information in your area • For HMO/Medicare Risk/Advantage (Coverage Type: 07): Refer to the recipient's MN-ITS Eligibility Response. The Payer ID is displayed in the Carrier ID field
Claim Filing Indicator (Loop: 2320, SBR09)	From the drop down menu, select the code identifying the type of insurance. Once the claim filing indicator is selected, additional fields will display for reporting Medicare payments.
Payer Responsibility (Loop: 2320, SBR01)	From the drop down menu, select the code identifying the insurance carrier's level of responsibility for payment of the claim.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the insurance carrier.
Relationship Code (Loop: 2320, SBR02)	From the drop down menu, select the relationship of the MHCP subscriber (recipient) to the policy holder.
Other Payers Claim Control Number (Loop: 2330B, REF02)	Enter the claim number reported on the Medicare EOMB.
Payment Remark Code (Loop: 2320, MOA03-MOA07)	Enter the remittance advice remark codes reported on the Medicare EOMB. Report only if on the Medicare EOMB. Select the Add action button in this section to include the remark code

	<p>on the claim. Repeat the remark code entries to report all remark codes as noted on the Medicare EOMB.</p> <p>Select the Delete action button next to a remark code to remove it from the claim.</p>
Payer Paid Amount (Loop: 2320, AMT02)	This field is not used when reporting Medicare or HMO Medicare risk insurance COB. This information should be reported at the service line.
Non-Covered Charge Amount (Loop: 2320, AMT02)	Not used by MHCP
Benefits Assignment (Loop: 2320, O103)	<p>The determination of the policy holder, or person authorized to act on their behalf, to give the other payer permission to pay the provider directly.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p>
Release of Information (Loop 2320, O106)	<p>The determination of whether the provider has a signed statement by the recipient on file, authorizing the release of medical data to other organizations.</p> <p>Default is Yes.</p> <p>Select the correct response if different than the default.</p>
Section Action Buttons	<p>Select:</p> <ul style="list-style-type: none"> • Delete in this section to remove this payer from the claim level and at the line level • Save in this section to include the TPL/private insurance information on the claim
Section Action Button	Select the ADD action button in this section to enter additional payers. Repeat the COB entry process to report all payers for the claim.
Screen Action Buttons	<p>Select:</p> <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Services

Use the Services screen to describe details for each service being billed. Information reported on a service line will override information reported at the header (claim) level for that line.

Refer to the table below for instruction and information about each field on this screen.

Field Name* (X12 Loop and element)	Field Instruction
Date of Service (From) (Loop: 2400, DTP03)	Enter the date the service was provided (MMDDCCYY).
Date of Service (To) (Loop: 2400, DTP03 * RD8* required in DTP02 when TO date is reported)	Enter the last date of a consecutive date range the service was provided, only when required (MMDDCCYY). Bill only for services provided within the same calendar month.
Place of Service	From the drop down menu, select the code that identifies where the

<i>(Loop: 2400, SV105)</i>	service was performed, only when different than what was reported on the Claim Information screen.
Procedure Code <i>(Loop: 2400, SV101-2)</i>	Enter the CPT or HCPCS code identifying the service.
Procedure Code Modifier(s) <i>(Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)</i>	Enter the modifier that clarifies or further identifies the service indicated in the procedure code field.
Diagnosis Pointer <i>(Loop: 2400, SV107-1, SV107-2, SV107-3, SV107-4)</i>	From the drop down menu, select the diagnosis code(s), in the order of importance, that best describes the need for this service.
Line Item Charge <i>(Loop: 2400, SV102)</i>	Enter your usual and customary charge for this service. If other payers were involved with the determination of this claim/service line item, enter the charge that was submitted on the claim to the other payer.
Service Unit Count <i>(Loop: 2400, SV104)</i>	Enter the number of units for the service.
Other Payer – Select the Other Payer accordion panel when reporting other payer (Medicare and/or TPL) payments or denials at the service (line) level.	
Other Payer Primary Identifier <i>(Loop: 2430, SVD01)</i>	From the drop down menu, select the identifier of the TPL/private insurance carrier, HMO Medicare Risk or the NPI of the Medicare contractor.
Service Line Paid Amount <i>(Loop: 2430, SVD02)</i>	Enter the total dollar amount the other payer paid for this service line.
Adjudication - Payment Date <i>(Loop: 2430, DTP03)</i>	Enter the date of payment or denial determination by the Medicare payer for this service line. This field is not required for TPL/private insurance reporting.
Paid Unit Count <i>(Loop: 2430, SVD05)</i>	Enter the number of units identified as being paid from the other payer's EOB/EOMB for this service line.
Claim Adjustment Group Code <i>(Loop: 2430, CAS01)</i>	From the drop down menu, select the adjustment code identifying the general category of payment adjustment for this service line. Use the Washington Publishing Company link, on right, to find the HIPAA compliant code that matches the adjustment response on the other payer's EOB.
Adjustment Reason Code <i>(Loop: 2430, CAS02)</i>	Enter the code identifying the reason the other payer adjusted the payment for this service line. Use the Washington Publishing Company link, on right, to find the HIPAA compliant code that matches the adjustment response on the other payer's EOB.
Adjustment Amount <i>(Loop: 2430, CAS03)</i>	Enter the dollar amount of the specific adjustment for this service line.
Adjustment Quantity <i>(Loop: 2430, CAS04)</i>	Enter the number of units not paid when the units paid are different than the number of units submitted for this service line. Select the Add action button in this section to include the adjustment entries on the service line. Repeat the Other Payer COB Line Adjustment Entries to report all adjustments for this service line as noted on the EOB/EOMB.

	Select the Delete action button next to an adjustment to remove it from the service line.
Section Action Buttons (below the display of adjustments)	Select: <ul style="list-style-type: none"> • Save in this section to save the COB information for the payer to this service line • Delete in this section to remove the COB information for the payer from this service line
Section Action Buttons	Once saved, the COB Line Payments/Adjustments screen will appear with the following information: <ul style="list-style-type: none"> • Other Payer Primary identifier • Line Paid Amount • Total Adjustment for the service line Select: <ul style="list-style-type: none"> • Edit, next to a payer, to change the adjustment entries for the payer (the totals on this screen should equal the charge you sent to the primary payer) • Add, below the display of payers, to report another payer to this service line. Repeat the same steps to add additional payer information for this service line
Situational Services – Select the Situational Services accordion panel to report additional information about the service line.	
Prior Authorization (Loop: 2400, REF02)	Enter the approved authorization number for the service line, when different than the authorization number reported on the Claim Information screen.
Certification Condition Indicator (Loop: 2400, SV111)	Not used by MHCP
Ambulance Patient Count (Loop: 2400, QTY02)	This field is not required for CRNA
Line Note (Loop: 2400, NTE02)	Enter a free form description to provide additional information about this service line, when required.
Qualifier (Loop: 2400, K301)	This field is not required for CRNA
Value (Loop: 2400, K301)	This field is not required for CRNA
Description (Loop: 2400, SV101-7)	This field is not required for CRNA
NDC (Loop: 2410, LIN03)	This field is not required for CRNA
NDC Count (Loop: 2410, CPT04)	This field is not required for CRNA
CODE Qualifier (Loop: 2410, CTP05-1)	This field is not required for CRNA
Situational Ambulance Information - Select the Situational Ambulance Services accordion panel to report ambulance services information on the service line, if different than what was reported at the claim level.	
Certification Condition (Loop: 2400, CRC02)	This field is not required for CRNA

Condition Code (Loop: 2400, CRC03, CRC04, CRC05, CRC06, CRC07)	This field is not required for CRNA
Patient Weight (Loop 2400, CR102)	This field is not required for CRNA
Transport Distance (Loop 2400, CR106)	This field is not required for CRNA
Transport Reason Code (Loop 2400, CR104)	This field is not required for CRNA
Round Trip Purpose Description (Loop: 2400, CR109)	This field is not required for CRNA
Stretcher Purpose Description (Loop: 2400, CR110)	This field is not required for CRNA
Pickup Address (Loop 2420G, N301)	This field is not required for CRNA
Address (contd) (Loop: 2420G, N302)	This field is not required for CRNA
City (Loop: 2420G, N401)	This field is not required for CRNA
State (Loop: 2420G, N402)	This field is not required for CRNA
Zip Code (Loop: 2420G, N403)	This field is not required for CRNA
Dropoff Address (Loop: 2420H, N301)	This field is not required for CRNA
Address (contd) (Loop: 2420H, N302)	This field is not required for CRNA
City (Loop: 2420H, N401)	This field is not required for CRNA
State (Loop: 2420H, N402)	This field is not required for CRNA
Zip Code (Loop: 2420H, N403)	This field is not required for CRNA
Other Providers – Select the Other Providers accordion panel when required to report other provider information on the service line, if different than what was reported at the claim level.	
Rendering Provider	
NPI/UMPI (Loop: 2420A, NM109)	CRNA providers are required to enter rendering provider information on all service lines: <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Referring Provider	
NPI/UMPI (Loop: 2420F, NM109)	If different than the provider reported on the claim information screen: <ul style="list-style-type: none"> • Enter the NPI of the provider who referred the recipient for this service • Select the Add action button in this section to add the other provider information

	<ul style="list-style-type: none"> • Select the radio button to add the other provider to the claim
Service Facility Location	
NPI/UMPI <i>(Loop: 2420C, NM109)</i>	CRNA providers are required to enter service facility location information on all service lines: <ul style="list-style-type: none"> • Enter the NPI of the location where the service was performed • Select the Add action button in this section to add the location information • Select the radio button to add the location to the claim
Ordering Provider	
NPI/UMPI <i>(Loop: 2420E, NM109)</i>	If reporting an ordering/prescribing provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who wrote the order/prescription for the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Supervising Provider	
NPI/UMPI <i>(Loop: 2420D, NM109)</i>	If reporting a supervising provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who is doing the supervising service • Select the Add action button in this section to add the supervising provider information • Select the radio button to add the supervising provider to the claim
Section Action Buttons	Select: <ul style="list-style-type: none"> • Save/View Line(s) to save the service line and view a summary table, displaying information for each line on the claim • Copy to save and copy the information to a duplicate service line. The information populated in the new service line is identical to what was entered on the copied line. Edit the information in each section of the new service line, as needed • Delete to remove the service line from the claim
Section Action Buttons	Once saved, a summary table will display the following information for each line on the claim: <ul style="list-style-type: none"> • Line number • From and to date • Procedure code • Modifier • Charge • Place of service Select: <ul style="list-style-type: none"> • Edit, next to a line, to change the information for that service line • Add to create a new service line that is blank. Repeat the service line entry steps to add all lines to the claim
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Validate to determine if the claim has met the HIPAA-compliant and certain basic requirements at both the claim and line level information. Use the Washington Publishing Company (WPC) health care codes to identify the claim status category and claim status codes displayed on the validate response

	<ul style="list-style-type: none">• Submit to identify if the claim will be paid, denied or suspended for review at the claim level and the line level of the claim. Use the Washington Publishing Company (WPC) health care codes lists to identify the claim status category and claim status codes displayed on the claim response
--	--

Copy, Replace or Void (take back) the Claim

After submitting the claim and receiving a claim response, an option to Copy, Replace, or Void the claim is available.

Use each of these features to do the following:

Copy - To correct an error of a denied claim or to copy information from other similar claims previously submitted

Replace - If the claim paid, but paid incorrectly or a line item was denied. The user may access the claim, correct the information and resubmit. The original paid amount will be taken back and replaced with the correct information on the replacement claim

Void (take back) - If the claim was submitted in error. This reverses the claim and takes the payment back

Review the [Copy, Replace, Void \(take back\), or Reverse a Claim](#) User Guide for step-by-step instructions when completing these transactions.