Uploading an 837 Batch Claim File

ConnectCenter provides the ability to upload a file of claims created in an EMR, 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 about online claim creation.
- File names can contain alpha and numeric characters. You can use underscores, periods, and hyphens. Do not use spaces or special characters.

Plan Identifiers

The payer IDs 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 payer ID from the column appropriate to the type of claims you are creating.

Payer ID for Professional Claims	Payer ID for Institutional Claims	Payer Name
7190	8629	Aetna Assure Premier Plus (HMO D-SNP)
7838	1015	Aetna Better Health of California
7265	8678	Aetna Better Health of Florida
6140	4623	Aetna Better Health of Illinois MMAI
8861	5013	Aetna Better Health of Illinois
8111	1084	Aetna Better Health of Kansas

7410	9626	Aetna Better Health of Kentucky
7183	8621	Aetna Better Health of Louisiana
7758	7554	Aetna Better Health of Maryland
7220	8637	Aetna Better Health of Michigan
7190	8629	Aetna Better Health of New Jersey
6832	7612	Aetna Better Health of New York
6876	7652	Aetna Better Health of Ohio
5823	3617	Aetna Better Health of Pennsylvania
7220	8637	Aetna Better Health Premier Plan
2142	2933	Aetna Better Health of Texas
7737	9686	Aetna Better Health of Virginia
7737	9686	Aetna Better Health of Virginia (HMO D-SNP)
1147	1577	Aetna Better Health of West Virginia
3433	1015	Mercy Care Plan

Transaction Header

This section provides guidance regarding specific values required or expected in the header of a claim file.

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 Length
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 Length
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 your Mailbox ID without the leading alpha character. To look up this value, check your welcome letter or log into ConnectCenter and access the Mailbox functionality.	Mailbox 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 Submitter ID and Biller ID. • Submitter ID is 6 digit number that can be found in ConnectCenter at the top, center of every screen • Biller ID identifies the Aetna Medicaid plan sponsoring your account. If you do not know this ID, one way to find it is to take these steps in Connect Center: Choose "My Account" from the "Admin" menu. Click Organizations and then choose "Search" to search for an organization. In the Search Results, the value displayed as Parent Organization is the Biller ID.	Submitter ID	80
2010BB Payer	NM108	Identification Code Qualifier	PI	2
2010BB Payer	NM109	Payer ID should be one of the 4 digit codes identified at the beginning of this document	Payer ID	4