



Standard Companion Guide

Refers to the Implementation Guide

Based on X12 Version 005010X221A1

Health Care Claim Payment/Advice

(835)

Companion Guide Version Number: 4.0

April 2025

CHANGE LOG

<i>Version</i>	<i>Release date</i>	<i>Changes</i>
1.0	08/08/2013	Initial External Release Draft
1.2	09/17/2014	PLB segment Notes
1.3	12/15/2016	Removed REF*1W other claim related identification for Member ID reporting
2.0	1/19/2018	Reformatted entire document and updated various sections with current information, including hyperlinks and contacts.
2.1	7/31/2018	Updated phone number for EDI Support and hyperlink to EDI Transaction Support form
3.0	5/22/2024	Updated logo and PLB segment Notes, Claim Filing Indicator codes, and Payment Method Codes.
4.0	4/25/2025	Updated Hyperlinks and contact forms. Added CAQH Core to section 6.

PREFACE

This Companion Guide to the ASC X12N/005010X221A1 Health Care Claim Payment Advice (835) Implementation Guide, also known as Technical Report Type 3 (TR3) clarifies and specifies the data content when exchanging electronically with UnitedHealth care.

Transmissions based on this Companion Guide, used in tandem with the specified ASC X12/005010X221A1 835 Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N/005010X221A1 835 implementation Guide adopted for use under HIPAA. The Companion Guide is not intended to convey information that exceeds the requirements or usages of data expressed in the Implementation Guides.

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1. INTRODUCTION

This section describes how Technical Report Type 3 (TR3), also called Health Care Claim: Professional (835) ASC X12N/005010X222A1, Companion Guide, adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has something additional, over and above, the information in the Companion Guide. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the Companion Guide's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The table below specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the Companion Guides.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides:

IG Page #	Loop	Reference	Name	Codes	Length	Comments
71	1000A	NM1	Submitter Name			This type of row exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell
114	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element

114	2100C	NM108	Identification Code Qualifier	MI		This type of row exists when a note for a particular code value is required. For example, this note may say that value MI is the only valid value. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
184	2300	HI	Principal Diagnosis Code			
	2300	HI01-2	Code List Qualifier Code			This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable

1.1. SCOPE

This guide is to be used by the Trading Partner for the development of the ASC X12/005010X221A1 835 transaction for the purpose of reporting claim payment information from UnitedHealthcare.

1.2. OVERVIEW

This UnitedHealthcare Community Plan Health Care Claim Payment/Advice Companion Guide has been written to assist you in designing and implementing Claim Payment Advice transactions to meet UnitedHealthcare's processing standards. This Companion Guide must be used in conjunction with the Health Care Claim Payment/Advice (835) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange (Version 005010X221), April 2006, and the Errata (Version 005010X221A1), June 2010. The UnitedHealthcare Companion Guide identifies key data elements from the transaction set that will be provided in the transaction. The recommendations made are to enable you to more effectively complete EDI transactions with UnitedHealthcare.

Updates to this Companion Guide occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library.

REFERENCE

For more information regarding the ASC Standards for Electronic Data Interchange (X12/005010X221A1) Health Care Claim Payment/Advice (835) and to purchase copies of the Implementation Guides, contact X12.org.

1.3. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers. Please note that this is UnitedHealthcare’s approach to 837 Professional claim transactions. After careful review of the existing IG for Version 005010X222A1, we have compiled the UnitedHealthcare specific CG. We are not responsible for any changes and updates made to the IG.

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE

UnitedHealthcare exchanges transactions with clearinghouses, also referred to as Trading Partners. Most transactions go through the Optum clearinghouse, Optum360, the managed gateway for UnitedHealthcare EDI transactions.

2.2 CLEARINGHOUSE CONNECTION

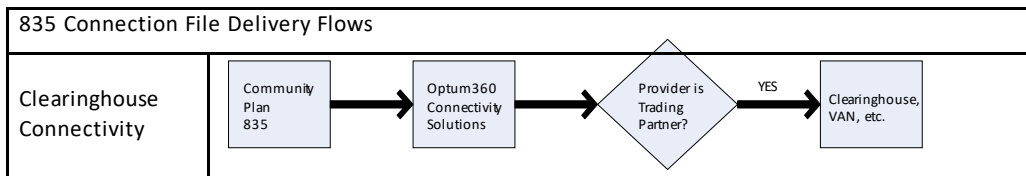
Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss their ability to support the ASC X12N/005010X221A1 Health Care Claim Payment/Advice transaction (835), as well as associated timeframes, costs, etc. This includes protocols for testing the exchange of transactions with UnitedHealthcare through your clearinghouse.

To receive Electronic Funds Transfer, you should enroll in [Optum Pay](#) online. If questions, contact EDI Support by:

- Using our [EDI Transaction Support Form](#)
- Sending an email to ac_edi_ops@uhc.com
- Calling 800-210-8315

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOW



3.2. RE-TRANSMISSION PROCEDURE

Trading Partners can request re-transmission of the entire 835 file by contacting EDI Support using our [EDI Transaction Support Form](#), sending an email to ac_edi_ops@uhc.com or calling 800-842-1109. The 835 files will be routed through the Trading Partner's regular connectivity path. Please note the re-transmission is the entire 835 file, not a specified 835 contained within a file.

Physicians and health care professionals that do not have a direct connection with UnitedHealthcare will need to contact the entity they are receiving the 835 files from to discuss how to receive a re-transmission.

4. CONTACT INFORMATION

4.1. EDI SUPPORT

Most questions can be answered by referring to the [EDI section](#) of our resource library on UHCprovider.com. View the [EDI 835: Electronic Remittance Advice \(ERA\)](#) page for information specific to 835 health claim payment transactions. Enroll in [Electronic Payments and Statements](#) to receive your 835 files.

For assistance with understanding your 835 please contact EDI Support by using our [EDI Transaction Support Form](#), sending an email to ac_edi_ops@uhc.com or calling 800-210-8315.

If you have questions related to submitting transactions through a clearinghouse, please contact your clearinghouse or software vendor directly.

5. CONTROL SEGMENTS/ENVELOPES

5.1. ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. UnitedHealthcare uses the following delimiters on your 835 files:

UnitedHealthcare uses the following delimiters on your 835 files:

1. Data Element: The first element separator following the ISA will define what Data Element Delimiter is used throughout the entire transaction. The Data Element Delimiter is an asterisk (*).
2. Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. The Segment Delimiter is a tilde (~).
3. Component-Element: Element ISA16 will define what Component-Element Delimiter is used throughout the entire transaction. The Component-Element Delimiter is a colon (:).

5.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope.

5.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE).

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1. CAQH CORE OPERATING RULES

UnitedHealthcare is certified and in conformance with the CAQH CORE Operating Rules for the Payment and Remittance category. \

6.2. 835 ENROLLMENTS

The 835 transaction enrollment registration will be done at the Federal Tax Identification Number level. Registrations for 835 at levels lower than the Federal Tax Identification Number do not currently exist.

7. ACKNOWLEDGEMENTS AND OR REPORTS

Currently UnitedHealthcare does not provide acknowledgments or reporting on the 835 transactions.

7.1. REPORT INVENTORY

835 reporting inventory is not available currently.

8. TRADING PARTNER AGREEMENTS

8.1. TRADING PARTNERS

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data directly from UnitedHealthcare.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner

Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

The agreement is related to the electronic exchange of information. The agreement is an entity or a part of a larger agreement, between each party to the agreement.

The Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

Since your clearinghouse is considered the EDI Trading Partner, you are covered under a larger agreement and there is no need to execute an EDI Trading Partner Agreement with UnitedHealthcare Community Plan.

9. TRANSACTION SPECIFIC INFORMATION

UnitedHealthcare has put together the following grid to assist you in designing and programming the information we would provide in 835 transactions. This Companion Guide is meant to illustrate the data provided by UnitedHealthcare for successful posting of Health Care Claim Payment/Advice transactions. The table contains a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IG. That information can:

1. **Limit the repeat of loops or segments**
2. **Limit the length of a simple data element**
3. **Specify a subset of the IG internal code listings**
4. **Clarify the use of loops, segments, composite and simple data elements**
5. **Provide any other information tied directly to a loop, segment and composite or simple data element pertinent to trading electronically with UnitedHealthcare**

All segments, data elements, and codes supported in the ASC X12N/005010X221A1 835 Implementation Guide are acceptable; however, all data may not be used in the processing of this transaction by UnitedHealthcare for an 835 transaction.

The following table describes UnitedHealthcare Services Company of the River Valley, Inc. (UnitedHealthcare) selections within the context of the HIPAA Implementation Guides and Addenda.

LEGEND: Shaded rows represent “segments” in the X12N Implementation Guide.

NON-SHADED rows represent “data elements” in the X12N Implementation Guide.

IG Page #	Loop	Reference	Name	Codes	Length	Comments
69		BPR	Financial Information			
70-71		BPR01	Transaction Handling Code	C, I		UHC will use C (Payment Accompanies Remit) or I (remittance Info Only).
71		BPR03	Credit/Debit Flag Code	C		UHC will use C (Credit).
72		BPR04	Payment Method Code	ACH, CHK, NON,		UHC will use ACH (Automated Clearinghouse), CHK (Check), BOP, or NON (Non Payment Data).
72		BPR05	Payment Format Code	CTX		UHC will use CCP (Corporate Trade Exchange)
112	2000	TS3	Provider Summary Information			
113	2000	TS301	Reference Identification			The Provider tax ID plus a two- character identification number assigned by UHC under which the claims was adjudicated.
123	2100	CLP	Claim Payment Information			Claim Payment Information
124	2100	CLP02	Claim Status Code	1, 2, 19, 22		UHC will use the following values for the claim status codes: 1- Processed as Primary, 2- Processed as Secondary, 19-Processed as Primary, forwarded to additional payers, 22- Reversal of Previous Payment
126-127	2100	CLP06	Claim Filing Indicator Code	HM, MC 12, or 13		UHC will return the appropriate qualifier that aligns with the insurance plan adjudicated
140	2100	NM1	Patient Name			
142	2100	NM108	Identification Code Qualifier	MI		Member Identification Qualifier
142	2100	NM109	Identification Code Qualifier			Member Identification code as submitted on the inbound claim
146	2100	NM1	Service Provider Name			
148	2100	NM108	Identification Code Qualifier	XX		UHC will use XX (National Provider Identifier)

149	2100	NM109	Identification Code	UHC Unique Provider ID		The provider tax ID plus a two-character identification number assigned by UHC under which the claim was adjudicated.
182	2100	AMT				Claim Supplemental Information
182-183	2100	AMT01	Amount Qualifier Code	AU		UHC will use AU (Coverage Amt) to report the total net allowed amount for the claim
186	2110	SVC	Service Payment Information			UHC will report service lines for professional, dental, and outpatient institutional services. Service line detail for inpatient institutional claims is not provided.
206	2110	REF	Line Item Control Number			
206	2110	REF01	Reference Identification Qualifier	6R		UHC will return the Patient Control Number from the inbound 837 2400 loop REF02 if supplied
211	2110	AMT	Service Supplemental Amount			
211-212	2110	AMT01	Amount Qualifier Code	B6		UHC will report B6 (Allowed - Actual Amount) to indicate total net amount allowed for service lines.
217		PLB	Provider Adjustment			
219-222		PLB03-1	Adjustment Reason Code	FB, L3, L6 and WO		UHC will use: FB qualifier for the Forward Balance (negative amount) that will be recovered from a provider's future remits This includes Patient Acct number, Claim number, and remit number. L3 qualifier for Penalty Sanctions, L6 qualifier to illustrate interest owed along with the claim number, WO qualifier for the overpayment recovery.

10. APPENDECIES

10.1. IMPLEMENTATION CHECKLIST

1. Contact your Clearinghouse to enroll in ERA.
2. Enroll in [Optum Pay](#) with UnitedHealthcare/Optum to enroll in ACH/EFT.

10.2. FREQUENTLY ASKED QUESTIONS

1. **Does this Companion Guide apply to all UnitedHealthcare Payers?** No. This Companion Guide will apply to UnitedHealthcare Community and State plans.
2. **Why are the claim adjustment reason codes different than the adjustment codes on the EOB?**

The adjustment codes reported in the 835 transaction are from the National

Claim Adjustment Reason Code list. In most instances the UnitedHealthcare proprietary adjustment codes are reported on the EOB.

3. If a claim is submitted to UnitedHealthcare on paper and not in an 837 will the claim payment data be reported in the 835?

Yes, the source of claim submission does not impact the 835 reporting.

4. If a claim is closed for additional information will the closed claim be reported?

No. UnitedHealthcare only reports claims that are paid or denied in the 835.

5. Does enrollment to receive the 835 transaction impact the payment cycle?

No, the generation of the 835 transaction will mirror the current payment cycle for the physician or health care professional.

10.3. UNITEDHEALTHCARE COMMUNITY PLAN PAYER IDs

For a complete listing of claims and electronic remittance advice (ERA) Payer IDs for UnitedHealthcare Community Plan payers, refer to our [Claims payer list](#) and [ERA payer List](#), both posted online at UHCprovider.com/EDI.