

AARP Enrollment Information

Description	Loop	Segment	Element	Data value	I/G page	comments
Billing Provider information (must be included on all claims)						
1. name and address	2010AA	NM1	NM101	85 Billing Provider	82	NM104, NM105, and NM107 only sent if NM102 is valued with 1, person
			NM102	1 Person		
			NM103	2 Non-Person Entity		
			NM104	Billing Provider Last or Organizational Name		
		NM105	Billing Provider First Name	84		
		NM107	Billing Provider Middle Name			
		N3	Billing Provider Name Suffix			
		N301	Billing Provider Address Line 1			
		N302	Billing Provider Address Line 2			
		N4	Billing Provider City Name			
N401	Billing Provider State Code	85,86				
N402	Billing Provider Postal ZIP Code					
N403	Billing Provider Postal ZIP Code					
2. taxpayer identification number	2010AA	NM1	NM108	24 Employer's Identification Number	83	If XX - <i>NPI</i> is used in NM108, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.
			NM109	34 Social Security Number		
	2010AA	REF	REF01	Billing Provider Identifier	88	
			REF02	EI Employer's Identification Number SY Social Security Number Billing Provider Additional Identifier		

Description	Loop	Segment	Element	Data value	I/G page	comments
AARP HealthCare Options Member information (must be included on all claims)						
1. Insured name and address	2010BA	N3 N4	NM101	IL Insured or Subscriber 1 Person Subscriber Last Name Subscriber First Name Subscriber Middle Name Subscriber Name Suffix MI Member Identification Number Subscriber Primary Identifier Subscriber Address Line Subscriber City Name Subscriber State Code Subscriber Postal ZIP Code	112-4 115 116,7	Only allowed value for NM102 will be 1, person. Subscriber identifier must be the member's AARP HealthCare Options ID number which is 11 digits.
			NM102			
			NM103			
			NM104			
			NM105			
			NM107			
			NM108			
			NM109			
			N301			
			N401			
2. Insured date of birth	2010BA	DMG	DMG02	Subscriber Birth Date	118	

Claim level information (must be included on all claims)						
1. Assignment of Benefits Indicator	2300	CLM	CLM08	Benefits Assignment Certification Indicator /NNo or YYes	165	
2. Diagnosis code(s)	2300	HI	HI01-1	BK Principal Diagnosis Diagnosis Code BF Diagnosis Diagnosis Code BF Diagnosis Diagnosis Code BF Diagnosis Diagnosis Code BF Diagnosis Diagnosis Code	252 253-5	Report the principal diagnosis and additional diagnosis as needed.
			HI01-2			
			HI02-1			
			HI02-2			
			HI03-1			
			HI03-2			
			HI04-1			
			HI04-2			

Service Line Information (must be included on all claims)

					I/G	
Description	Loop	Segment	Element	Data value	page	comments
Procedure Code	2400	SV1	SV01-1 SV01-2 SV01-3 SV01-4 SV01-5	HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Procedure Code Procedure code modifier 1 Procedure code modifier 2 Procedure code modifier 3	382,3	Modifiers are required when a they clarify or improve the reporting accuracy of the associated procedure code.
Charged amount	2400	SV1	SV2	Submitted charge amount	384	
Units of service indicator	2400	SV1	SV103	MJ Minutes UN Unit	385	
Units of service	2400	SV1	SV104	Service Count, units or minutes	385	
Date of Service	2400	DTP	DTP01 DTP03	472 Service Date of service	415, 6	Date of service may be a single date or a date range
Claim level information (must be included on all claims <i>where the patient is known to have Medicare</i>)						
1. Medicare claim (Health Insurance Claim) number	2330A	NM1	NM108 NM109	MI Member Identification Number Other Subscriber Primary Identifier	335	

					I/G	
Description	Loop	Segment	Element	Data value	page	comments
1. Other insurance type	2320	SBR	SBR05 SBR09	MB Medicare Part B MB Medicare Part B	304	
2. Medicare Assignment of Benefits Indicator	2300	CLM	CLM07	Medicare Assignment Code A Assigned B Assignment Accepted on Clinical Lab Services Only C Not Assigned P Patient Refuses to Assign Benefits	164	
3 Medicare document control number	2330B	REF	REF01 REF02	F8 Original Reference Number Other Payer Secondary Identifier	350, 1	
4. Medicare payment date	2330B	DTP	DTP01 DTP03	573 Date Claim Paid	348,9	This segment is required when the payer identified in this iteration of the 2330 loop has previously adjudicated the claim and Loop-ID 2430 (Line Adjudication Information) is not used.
Service Line information (must be included on all claims <i>where the patient is known to have Medicare</i>)						
Medicare approved amount	2400	AMT	AMT01 AMT02	AMT01 qualifier is AAE	462	

					I/G	
Description	Loop	Segment	Element	Data value	page	comments
Medicare Paid Amount	2430	SVD	SVD02		534	This numbering SVD01 should match NM109 in Loop ID-2330B which is identifies Medicare.
Medicare deductible	2430	CAS	CASxx	Typically reported by Medicare with group code PR and claim adjustment reason code 1, "deductible"	537	
Medicare co-insurance	2430	CAS	CASxx	Typically reported by Medicare with group code PR and claim adjustment reason code 2, "coinsurance"	537	
Medicare limiting charge	2430	CAS	CASxx	Typically reported by Medicare with group code PR, CO, or OA and claim adjustment reason code 45, "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."	537	
Medicare adjudication date	2430	DTP	DTP01 DTP03	573 Date Claim Paid	545	