Field	Description	Required	Additional Explanation
1	Provider Name and Address	Yes	Enter the name and address of the provider billing the services.
2	Pay to Name and Address	Situationally Required	Enter when the remit address is different than provider address in box 1.
3a	Patient Control Number	No	Enter the patient account number.
3b	Medical Record Number	No	
4	Type of Bill	Yes	Beginning with a leading 0 enter the four-digit code that indicates the type of bill and frequency of the service billed. For example: 0117
5	Federal Tax ID Number	Yes	Enter the facility's federal tax identification number.
6	Statement Covers Period	Yes	Enter the beginning and ending dates of the billing period., in MMDDYY format.
7	Future Use	N/A	
8	Patient Name	Yes	Enter the patients name, last name, first name, and middle initial as it appears on the ID card.
9a-e	Patient Address	Yes	Enter the patient's address, if patient is homeless or address is unknown enter NKA, No Known Address, Unknown or Homeless.
10	Patient Birth Date	Yes	
11	Patient Sex	No	
12	Admission/Start of Dare Date	Situationally Required	Enter the date for the start of care in MMDDYY format. This is required for inpatient stays.
13	Admission Hour	Situationally Required	Enter the hour, in two-digit format, on which the patient was admitted for care. This is required for inpatient stays.
14	Type of Admission	Yes	Enter the numeric admission type.
15	Source/Point of Admission	Yes	Enter the source of admission code.
16	Discharge Hour	Situationally Required	Enter the hour, in two-digit format, on which the patient was discharged from care. This is required for inpatient stays.

Field	Description	Required	Additional Explanation
17	Patient Discharge Status	Yes	Enter the two-digit status of the patient upon discharge.
18-28	Condition Codes	Situationally Required	Enter the two-digit code(s) when appropriate for the billing of services.
29	Accident State	Situationally Required	Enter the state abbreviation where the accident occurred.
30	Future Use	N/A	
31-34	Occurrence Codes and Dates	Situationally Required	Enter the two-digit code, and date in MMDDYY format, when appropriate for the billing of services.
35-36	Occurrence Span Codes and Dates	Situationally Required	Enter the two-digit code, and from/through date in MMDDYY format, when appropriate for the billing of services.
37	Future Use	N/A	
38	Responsible Party Name and Address	Situationally Required	Enter the last name, first name, and middle initial, along with address, city, state, and zip of the responsible party when appropriate.
39-41	Value Codes and Amounts	Situationally Required	Enter the two-digit code along with the value, when appropriate for the billing of services.
42	Revenue Code	Yes	Enter the four-digit revenue code associated with the description billed in field 43.
43	Description/NDC Code	Situationally Required	Enter the description associated with the revenue code billed in field 42. Enter any applicable NDC codes, units, and units of measure associated with the revenue code or HCPCS for each line.
44	HCPCS/Rates/HIPPS Code	Situationally Required	Enter the appropriate HCPCS/CPT and modifier, HIPPS code or rate (as applicable).
45	Service Date	Situationally Required	Enter the date of service in MMDDYY format, this is not required for inpatient stays.
46	Service Units	Yes	Enter the number of units or days for the service line billed.
47	Total Charges	Yes	Enter the total charges.

Field	Description	Required	Additional Explanation
48	Non-Covered Charges	No	
49	Future Use	N/A	
50	Payer Identification	Yes	Enter the health plan name as it appears on the patient's insurance card. Include any other insurance the patient has coverage through.
51	Health Plan ID	Yes	
52	Release of Information	Yes	
53	Assignment of Benefits	Yes	
54	Prior Payments	No	Enter any prior payments received from other coverage towards the claim. Include EOB's or other proof of payment with the claim.
55	Estimated Amount Due	No	Enter the estimated amount due.
56	NPI	Yes	Enter the 10-digit NPI.
57	Other Provider ID	No	
58	Insured's Name	No	
59	Patients Relationship to Insured	No	
60	Insured's Unique ID	Yes	Enter the ID of the insured member.
61	Insured's Group Name	No	Enter the group name.
62	Insured's Group Number	No	Enter the group number.
63	Treatment Authorization Code	Situationally Required	Enter the prior authorization number.
64	Document Control Number	Situationally Required	Enter the original claim number when applicable.
65	Employer Name	No	Enter the name of the primary insured's employer.
66	Diagnosis and Procedure Code Qualifier	Yes	Enter the appropriate ICD indicator for the date of service. "0" indicates IDC-10 codes which are for dates of service 10/1/15 and after "9" indicates ICD-9 codes which are for dates of service prior to 10/1/15

Field	Description	Required	Additional Explanation
67	Principal Diagnosis Code	Yes	Enter the principal diagnosis related to the service. Include the present on admission indicated when appropriate
67 A-Q	Other Diagnosis Code and Present on Admission Indicator	Yes	Enter additional diagnosis codes related to the services billed as required. Include the present on admission indicator when appropriate
68	Future Use	N/A	
69	Admitting Diagnosis Code	Situationally Required	Required for inpatient services. Not required for outpatient services.
70	Patient's Reason for Visit	Situationally Required	Enter the diagnosis code the indicates the patients the reason for the visit.
71	PPS Code	Situationally Required	Enter the appropriate DRG for inpatient stays.
72	External Cause of Injury Code	Situationally Required	Enter the appropriate diagnosis code for services related to an external cause of injury, such as a motor vehicle accident, work injury, poisoning, etc.
73	Future Use	N/A	
74	Principal Procedure Code and Date	Situationally Required	Enter the ICD code related to procedures performed. Include the date of service in MMDDYY format.
75	Future Use	N/A	
76	Attending Provider Name and Identifiers	Yes	Enter the attending providers last name, first name, and NPI.
77	Operating Provider Name and Identifiers	Situationally Required	Enter the operating providers last name, first name, and NPI.
78-79	Other Provider Name and Identifiers	Situationally Required	Enter the other providers last name, first name, and NPI.
80	Remarks	Situationally Required	
81	Code-Code Fields	N/A	

Samaritan Health Plans