

## NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 165 - 199)

ELEMENT NAME: PROCESSING CODE (2-165)		
VALIDITY EDITS		
N/A		
RELATIONAL EDITS		
RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
OVERRIDE CODE	SEE BELOW	
TYPE OF SUBMISSION	SEE BELOW	
NAS EXCEPTION REASON	SEE BELOW	
HEALTH CARE PLAN CODE	SEE BELOW	
DIAGNOSIS EDITION IDENTIFIER	SEE BELOW	
PROCEDURE TEXT IDENTIFIER	SEE BELOW	
REASON FOR ADJUSTMENT	SEE BELOW	
SPECIAL PROCESSING CODE	SEE BELOW	
SPECIAL RATE CODE	SEE BELOW	
EDITED ELEMENT RELATIONSHIP		

PROCESSING CODE IS A GROUP NAME FOR THE 9 ELEMENTS LISTED. IT HAS NO EDIT CRITERIA ITSELF. IF THE COMPONENT ELEMENTS ARE CORRECT, THIS ELEMENT IS CORRECT.



**ELEMENT NAME: OVERRIDE CODE (2-170) (CONTINUED)****AND**PATIENT DATE OF BIRTH INDICATES AGE<sup>1</sup> < 34

ONE OVERRIDE CODE MUST = 'I'.

IF ANY OCCURRENCE OF OVERRIDE CODE = 'I'

PATIENT AGE<sup>2</sup> MUST BE < 34 FOR AT LEAST ONE OCCURRENCE

PATIENT RELATIONSHIP =	T	FORMER SPOUSE
	H	
	R	
	Y	

**2-170-09R** IF FILING DATE IS LATER THAN LAST DAY OF CALENDAR YEAR FOLLOWING CALENDAR YEAR IN WHICH CARE WAS RECEIVED (BASED ON EARLIEST BEGIN DATE OF CARE) ONE OVERRIDE CODE MUST = 'F'.

**OR**

IF THE EARLIEST BEGIN DATE OF CARE ≥ 01/01/94

IF FILING DATE &gt; THE EARLIEST END DATE OF CARE PLUS ONE YEAR ONE OVERRIDE CODE MUST = 'F'

IF ANY OCCURRENCE OF OVERRIDE CODE = 'F'

FILING DATE MUST BE LATER THAN LAST DAY OF CALENDAR YEAR FOLLOWING CALENDAR YEAR IN WHICH CARE WAS RECEIVED (BASED ON EARLIEST BEGIN DATE OF CARE).

**2-170-10R** IF ANY OCCURRENCE OF  
OVERRIDE CODE =

	M	NATO
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SPONSOR STATUS MUST =

	T	FOREIGN MILITARY
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**2-170-11R** IF ANY TREATMENT DIAGNOSIS = MATERNITY AND PATIENT DATE OF BIRTH INDICATES AGE<sup>1</sup> < 12  
ONE OVERRIDE CODE MUST = 'E'.

IF ANY OCCURRENCE OF OVERRIDE CODE = 'E'

PATIENT AGE<sup>2</sup> MUST BE < 12 AND AT LEAST ONE TREATMENT DIAGNOSIS MUST = MATERNITY

**2-170-12R** IF ANY PROCEDURE **OR** DIAGNOSIS CODE IS FOR FEMALE AND PATIENT SEX IS MALE  
ONE OVERRIDE CODE MUST = 'G'.

IF ANY OCCURRENCE OF OVERRIDE CODE = 'G'

AT LEAST ONE PROCEDURE **OR** DIAGNOSIS CODE MUST BE FOR FEMALE AND PATIENT SEX MUST BE MALE.IF ANY PROCEDURE **OR** DIAGNOSIS CODE IS FOR MALE (AND **NOT** FOR CIRCUMCISION AND PRINCIPAL/SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY) AND PATIENT SEX IS FEMALE

ONE OVERRIDE CODE MUST = 'H'.

IF ANY OCCURRENCE OF OVERRIDE CODE = 'H'

AT LEAST ONE PROCEDURE **OR** DIAGNOSIS CODE MUST BE FOR MALE (AND **NOT** FOR CIRCUMCISION AND PRINCIPAL/SECONDARY TREATMENT DIAGNOSIS IS NOT FOR DELIVERY) AND PATIENT SEX MUST BE FEMALE.

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES, OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.

<sup>2</sup> IF OVERRIDE IS CODED, AGE MUST MEET EDIT CRITERIA AT SOME TIME, SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.

**ELEMENT NAME: OVERRIDE CODE (2-170) (CONTINUED)**

**2-170-13R** OVERRIDE CODE OCCURRENCES MUST BE LEFT JUSTIFIED.

**2-170-14R** IF ANY OCCURRENCE OF OVERRIDE CODE = 'S'

**THEN**

CONTRACTOR NUMBER  
MUST =

03 MANAGED CARE SUPPORT - REGION 3/4 **OR**

06 MANAGED CARE SUPPORT - REGION 6 **OR**

07 MANAGED CARE SUPPORT - CENTRAL REGION  
CENTRAL **OR**

11 MANAGED CARE SUPPORT - REGION 11 **OR**

25 MANAGED CARE SUPPORT - REGION 2/5 **OR**

26 MANAGED CARE SUPPORT - REGION 1 **OR**

53 FOUNDATION HEALTH FEDERAL SERVICES (CRI)  
**OR**

57 NEW ORLEANS COORDINATED CARE PROGRAM  
**OR**

59 AETNA GOVERNMENT HEALTH PLANS, INC. **OR**

60 MANAGED CARE SUPPORT REGION 9, 10, 12 **OR**

72 MANAGED CARE SUPPORT - FHC OPTIONS

**2-170-15R** IF ANY OCCURRENCE OF OVERRIDE CODE = 'O', AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST BE = 'M' (HEALTH CARE FINDER AND PARTICIPATING PROVIDER PROGRAM) AND CONTRACTOR NUMBER MUST = 45.

**<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES, OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.**

**<sup>2</sup> IF OVERRIDE IS CODED, AGE MUST MEET EDIT CRITERIA AT SOME TIME, SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.**

**ELEMENT NAME: TYPE OF SUBMISSION (2-175)****VALIDITY EDITS****2-175-01** VALUE MUST = 'A', 'B', 'C', 'D', 'E', 'F', 'I', 'O', OR 'R'.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
HCSR INDICATOR	SEE BELOW	FILING DATE, TYPE OF NET RECORD ON PREVIOUS HCSR ON DATABASE, AMOUNT PAID BY GOVERNMENT CONTRACTOR, CONTRACT NUMBER, CONTRACT BEGIN AND END DATES, SPONSOR SOCIAL SECURITY NUMBER, BATCH/VOUCHER NUMBER
AMOUNT OF OHI/TPL	SEE BELOW	
<b>2-155-02R</b> AMOUNT PAID BY GOVERNMENT CONTRACTOR		FILING DATE
FILING DATE	SEE BELOW	
DENIAL REASON CODE	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

<b>2-175-02R</b> WHEN TYPE OF SUBMISSION IS =	I INITIAL
	R RESUBMISSION
	O ZERO PAYMENT
	D COMPLETE DENIAL
	F ADJUSTMENT NEW SUFFIX
THIS HCSR INDICATOR MUST NOT BE PRESENT ON THE DATABASE FOR THIS CONTRACT NUMBER	

**2-175-03R** WHEN TYPE OF SUBMISSION IS EQUAL TO 'F' (ADJUSTMENT NEW SUFFIX), A HCSR **EXCLUSIVE OF SUFFIX** MUST BE PRESENT ON THE DATABASE (I.E., IF THE 'NEW SUFFIX' HCSR BEING SUBMITTED IS SUFFIX = 'D', AT LEAST ONE HCSR WITH THE SAME ICN AND SUFFIX NOT EQUAL TO 'D' MUST EXIST ON THE DATABASE).

- THE FOLLOWING EDITS (2-175-04R AND 2-175-06R) ARE GENERATED WHEN PROCESSING ADJUSTMENT AND COMPLETE CANCELLATION HCSRS. THESE RECORDS ARE MATCHED AND APPLIED TO THEIR CORRESPONDING INITIAL SUBMISSION HCSR AND ANY CORRESPONDING ADJUSTMENT HCSRS DURING EDITING. THE RESULT IS EITHER A SUCCESSFUL MATCH WITH THE 'NET' (WHICH IS THEN EDITED) OR AN INCOMPATIBLE MATCH (2-175-04R), OR NO MATCH IS FOUND (2-175-06R).

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES. OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.

**ELEMENT NAME: TYPE OF SUBMISSION (2-175) (CONTINUED)**

**2-175-04R** INCOMPATIBLE MATCH FOUND.  
 MULTIPLE 'A' (ADJUSTMENTS) ARE ALLOWED FOR A HCSR. ONLY ONE 'C' (CANCELLATION) IS ALLOWED FOR AN HCSR, THERE WILL BE NO SUBSEQUENT 'A's. A CANCELLATION (C) CANNOT BE APPLIED TO A HCSR ALREADY ON THE DATABASE WITH ZERO IN (NET) AMOUNT PAID BY GOVERNMENT CONTRACTOR, **UNLESS** TYPE OF NET RECORD = 'A'.

**WHEN** TYPE OF SUBMISSION IS EQUAL TO 'B' (ADJUSTMENT TO NON-HCSR DATA) **OR** 'E' (CANCELLATION OF NON-HCSR DATA), A HCSR WITH TYPE OF NET RECORD = 'I', 'R', 'O', 'D', 'A', 'C', 'F', 'X', **OR** 'E' **MUST NOT** BE PRESENT ON THE DATABASE. (THERE **CAN** BE A HCSR WITH TYPE OF NET RECORD = 'B'.)

**2-175-06R** NO MATCH FOUND.  
**WHEN** TYPE OF SUBMISSION IS EQUAL TO 'A' (ADJUSTMENT) **OR** 'C' (CANCELLATION), THERE MUST BE A 'MATCH' OF A HCSR (WITH TYPE OF NET RECORD = 'I', 'F', 'R', **OR** 'O') ON THE DATABASE, **UNLESS** FILING DATE IS MORE THAN XX MONTHS OLD (TO BE DETERMINED BY DATABASE PURGE PARAMETER). THIS 'MATCH' CONSISTS OF HCSR INDICATOR (ICN AND HCSR SUFFIX). REFER ALSO TO 2-175-05R, WHERE SPONSOR SOCIAL SECURITY NUMBER1, AND CONTRACT NUMBER2 MAY ALSO BE INCLUDED.

NOTE: IF FILING DATE IS MORE THAN XX MONTHS OLD, A HCSR WITH TYPE OF NET RECORD = 'A', 'I', 'F', 'R', **OR** 'O' **MAY (OR MAY NOT)** EXIST ON THE DATABASE. THUS, THE MATCH IS APPLIED IF NET RECORD EXISTS.

**2-175-05R** <sup>1</sup>SPONSOR SOCIAL SECURITY NUMBER IS ONLY LOOKED AT AS 'MATCH' CRITERIA IF THERE ARE DUPLICATE HCSR SUFFIXES. **IN THAT CASE**, IF A MATCH IS NOT FOUND ON SPONSOR SOCIAL SECURITY NUMBER FOR THIS HCSR INDICATOR (ICN AND HCSR SUFFIX), THEN THE HCSR CANNOT BE MATCHED AND NETTED. THE ORIGINAL SPONSOR SSAN MUST BE SUBMITTED ON ALL SUBSEQUENT ADJUSTMENTS/CANCELLATIONS.

<sup>2</sup>CONTRACT NUMBER IS ONLY LOOKED AT AS 'MATCH' CRITERIA IF THERE ARE DUPLICATE SPONSOR SOCIAL SECURITY NUMBERS FOR DUPLICATE HCSR SUFFIXES. FOR ADJUSTMENTS AND CANCELLATIONS WITH FILING DATES OUTSIDE OF THE BEGIN AND END DATES OF THE CURRENT CONTRACT, THE MATCH ON CONTRACT NUMBER IS OPTIONAL. (1-175-06R)

**2-175-07R** IF TYPE OF SUBMISSION = 0 ZERO PAYMENT  
 EITHER/BOTH AMOUNT OF OHI/TPL MUST BE > ZERO.

**2-175-09R** IF ALL DETAIL OCCURRENCES ARE DENIED (DENIAL REASON CODE NOT BLANK)

TYPE OF SUBMISSION MUST  
 BE =

C COMPLETE CANCELLATION

D COMPLETE DENIAL

B ADJUSTMENT NON-HCSR DATA

E CANCELLATION NON-HCSR DATA

F ADJUSTMENT NEW SUFFIX

A ADJUSTMENT TO PRIOR HCSR DATA

**2-175-10R** IF TYPE OF SUBMISSION = I INITIAL

R RESUBMISSION

D COMPLETE DENIAL

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES. OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.

**ELEMENT NAME: TYPE OF SUBMISSION (2-175) (CONTINUED)**

O ZERO PAYMENT

A HCSR MUST NOT BE PRESENT ON THE DATABASE WITH THIS HCSR INDICATOR, EXCLUDING THE SUFFIX (20 BYTES), FOR THIS CONTRACT NUMBER, WITH A DIFFERENT BATCH/VOUCHER NUMBER.

**2-175-11R** A HCSR SUFFIX PREVIOUSLY ASSIGNED CANNOT BE 'RE-USED' **WHEN** TYPE OF SUBMISSION = 'F' (ADJUSTMENT TO PRIOR HCSR DATA, ADDITIONAL HCSR SUFFIX) FOR THIS SAME INTERNAL CONTROL NUMBER.

NOTE: THIS EDIT RELATES TO ADMINISTRATIVE CLAIM COUNT ASSIGNMENT ONLY.

**2-175-12R** IF AMOUNT ALLOWED = '0',

**THEN**

TYPE OF SUBMISSION MUST = A ADJUSTMENT TO PRIOR HCSR DATA

B ADJUSTMENT NON HCSR DATA

C CANCELLATION

D COMPLETE DENIAL

E COMPLETE CANCELLATION OF NON-HCSR DATA

F ADJUSTMENT NEW SUFFIX

**2-175-13R** IF RESUBMISSION NUMBER = ZERO FOR THIS BATCH **OR** VOUCHER,

TYPE OF SUBMISSION MUST = A ADJUSTMENT TO PRIOR HCSR DATA

B ADJUSTMENT NON HCSR DATA

C COMPLETE CANCELLATION PRIOR HCSR DATA

D COMPLETE DENIAL

E COMPLETE CANCELLATION NON HCSR DATA

F ADJUSTMENT NEW SUFFIX

I INITIAL

O ZERO PAY WITH 100% OHI/TPL

**2-175-14R** IF RESUBMISSION NUMBER > ZERO FOR THIS BATCH **OR** VOUCHER

TYPE OF SUBMISSION MUST = A ADJUSTMENT TO PRIOR HCSR DATA

B ADJUSTMENT NON HCSR DATA

C COMPLETE CANCELLATION PRIOR HCSR DATA

D COMPLETE DENIAL

E COMPLETE CANCELLATION NON HCSR DATA

F ADJUSTMENT NEW SUFFIX

O ZERO PAY WITH 100% OHI/TPL

R RESUBMISSION OF 'T'

**2-175-15R** IF TYPE OF SUBMISSION = I INITIAL

F ADJUSTMENT NEW SUFFIX

<sup>1</sup> **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES. OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.**

**ELEMENT NAME: TYPE OF SUBMISSION (2-175) (CONTINUED)**

R RESUBMISSION

AMOUNT BILLED, AMOUNT ALLOWED, AMOUNT PAID BY OTHER HEALTH INSURANCE, AMOUNT ALLOWED BY OTHER HEALTH INSURANCE, AMOUNT OF THIRD PARTY LIABILITY, AMOUNT OF PAYMENT REDUCTION, PATIENT COINSURANCE, PATIENT COPAYMENT, AMOUNT APPLIED TOWARD DEDUCTIBLE, AMOUNT PAID BY GOVT CONTRACTOR, NUMBER OF PAYMENT REDUCTION DAYS/SERVICES, NUMBER OF SERVICES, TOTAL CHARGES BY PROCEDURE CODE, AMOUNT ALLOWED BY PROCEDURE CODE MUST BE  $\geq$  '0'.

**2-175-16R** IF TYPE OF SUBMISSION = B ADJUSTMENT TO NON-HCSR DATA **OR**

E COMPLETE CANCELLATION OF PRIOR HCSR DATA

**THEN BEGIN DATE OF CARE MUST BE < OCTOBER 1, 1994.**

**2-175-17R** IF DATE HCSR PROCESSING TO COMPLETION > 1/1/96  
AND SPONSOR BRANCH OF SERVICE = 'C' CHAMPVA

**THEN TYPE OF SUBMISSION  
MUST =**

D COMPLETE CONTRACTOR DENIAL INITIAL HCSR  
SUBMISSION

**<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND CARE DATES. OVERRIDE MUST BE CODED IF AGE MEETS EDIT CRITERIA AT ANY TIME SPANNING FROM EARLIEST BEGIN DATE OF CARE TO LATEST END DATE OF CARE.**



**ELEMENT NAME: NAS EXCEPTION REASON (2-180)****VALIDITY EDITS****2-180-01** VALUE MUST BE IN RANGE '1' - '9', 'A' - 'F', 'H', 'I', 'K' - 'O', 'Q', OR BLANK**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>2-110-03R</b> NAS NUMBER		
PATIENT ZIP CODE	SEE BELOW	SPONSOR BRANCH OF SERVICE, TYPE OF SERVICE, DENIAL REASON CODE, NAS NUMBER, BEGIN DATE OF CARE, PROGRAM INDICATOR
SPECIAL PROCESSING CODE	SEE BELOW	PATIENT ZIP CODE, TYPE OF SERVICE, BEGIN DATE OF CARE
PROGRAM INDICATOR	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

<b>NO ERROR</b> IF SPECIAL PROCESSING CODE =	AN	SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE <b>OR</b>
	AR	SUPPLEMENTAL <b>HEALTH CARE PROGRAM</b> - REFERRED CARE <b>OR</b>
	CE	SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
	GU	ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT AT RISK PAYMENT BY CONTRACTOR. <b>OR</b>
	MN	TRICARE-SENIOR PRIME (NON-NETWORK) <b>OR</b>
	MS	TRICARE-SENIOR PRIME <b>OR</b>
	SC	SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SUPPLEMENTAL HEALTH CARE PROGRAM TRICARE ELIGIBLE <b>OR</b>
	SM	SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY

**THEN** BYPASS ALL NAS EXCEPTION REASON EDITING.**2-180-02R** IF PATIENT ZIP CODE IS NOT IN A CATCHMENT AREA<sup>1</sup>  
NAS EXCEPTION REASON MUST = BLANK  
UNLESS SPECIAL PROCESSING CODE = 'ST'.**2-180-04R** IF BEGINNING DATE OF CARE ≥ 9/23/96  
AND<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.

**ELEMENT NAME: NAS EXCEPTION REASON (2-180) (CONTINUED)**

ENROLLMENT STATUS =	E	MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME
	O	NEW ORLEANS PRIME
	H	MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT
	K	MANAGED CARE SUPPORT CALIFORNIA/HAWAII, TRICARE PRIME ENROLLED PATIENT
	U	MANAGED CARE SUPPORT PRIME, CIVILIAN PCM
	Z	MANAGED CARE SUPPORT PRIME, MTF/PCM

EXIT.

IF PATIENT ZIP CODE IS IN A CATCHMENT AREA<sup>1</sup> AND NAS NUMBER IS NOT CODED AND

TYPE OF SERVICE (FIRST BYTE) =	I	INPATIENT
NAS EXCEPTION REASON MUST BE CODED		

**UNLESS**

SPECIAL PROCESSING CODE =	B	EXTERNAL PARTNERSHIP PROVIDER WITH SIGNED AGREEMENT
	C	EXTERNAL PARTNERSHIP PROVIDER WITHOUT SIGNED AGREEMENT
	S	RESOURCE SHARING

OR ANY OCCURRENCE OF DENIAL REASON CODE =	9	NON-AVAILABILITY STATEMENT NOT PROVIDED
	2	INELIGIBLE CLAIMANT
	A	DEERS
	N	MULTIPLE DENIAL REASONS

OR ANY OCCURRENCE OF OVERRIDE CODE = 'Q'  
 (FORMER SPOUSE WITH PRE-EXISTING CONDITION),

OR PROGRAM INDICATOR =	H	PROGRAM FOR PERSONS WITH DISABILITIES
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OR HEALTH CARE PLAN CODE =	11	MCS FORT BRAGG DEMO
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IN WHICH CASE NAS EXCEPTION REASON MUST BE BLANK

**2-180-05R** IF BEGINNING DATE OF CARE ≥ 9/23/96  
 AND

ENROLLMENT STATUS =	E	MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME
	O	NEW ORLEANS PRIME
	H	MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT

<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.

**ELEMENT NAME: NAS EXCEPTION REASON (2-180) (CONTINUED)**

	K	MANAGED CARE SUPPORT CALIFORNIA/HAWAII, TRICARE PRIME ENROLLED PATIENT
	U	MANAGED CARE SUPPORT PRIME, CIVILIAN PCM
	Z	MANAGED CARE SUPPORT PRIME, MTF/PCM
EXIT.		
IF ANY SPECIAL PROCESSING CODE =	3 4 6 9 E	DEMONSTRATION
<b>AND</b> TYPE OF SERVICE =	I M	FIRST BYTE
<b>AND</b> PATIENT ZIP CODE IS IN A CATCHMENT AREA <sup>1</sup>		
NAS EXCEPTION REASON MUST =	9	DEMONSTRATION
UNLESS HEALTH CARE PLAN CODE =	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE =	5 7	LIVER/HEART TRANSPLANT
<b>AND</b> TYPE OF SERVICE =	I M	FIRST BYTE
<b>AND</b> PATIENT ZIP CODE IS IN A CATCHMENT AREA <b>AND</b> BEGIN DATE OF CARE ≤ 4/1/95		
<b>THEN</b> NAS EXCEPTION REASON MUST =	8	HEART/LIVER TRANSPLANT
UNLESS HEALTH CARE PLAN CODE =	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE =	A B C	PARTNERSHIP PROGRAM, INTERNAL PROVIDERS WITH SIGNED AGREEMENTS PARTNERSHIP PROGRAM, EXTERNAL PROVIDERS WITH SIGNED AGREEMENTS PARTNERSHIP PROGRAM, EXTERNAL PROVIDERS WITHOUT SIGNED AGREEMENTS
	#	HOSPICE
	O	HOSPICE NON-AFFILIATED PROVIDER

<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.

**ELEMENT NAME: NAS EXCEPTION REASON (2-180) (CONTINUED)**

**AND**  
 TYPE OF SERVICE (FIRST BYTE) = 'T' **OR** 'M' AND PATIENT ZIP CODE IS IN A CATCHMENT AREA<sup>1</sup>

NAS EXCEPTION REASON MUST =	6	PARTNERSHIPS
	1	ENROLLMENT IN OHI WHICH IS PRIMARY COVERAGE
	2	EMERGENCY MEDICAL TREATMENT
	L	HOSPICE
UNLESS HEALTH CARE PLAN CODE =	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE =	A	PARTNERSHIP PROGRAM, INTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	B	PARTNERSHIP PROGRAM, EXTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	C	PARTNERSHIP PROGRAM, EXTERNAL PROVIDERS WITHOUT SIGNED AGREEMENTS
	O	CHARLESTON NAVAL HOSPITAL CAMCHAS MTF SERVICES
	S	RESOURCE SHARING
	#	HOSPICE
	O	HOSPICE NON-AFFILIATED PROVIDER
<b>AND</b> TYPE OF SERVICE =	A	FIRST BYTE
	C	
	O	
	N	

**AND**  
 BEGIN DATE OF CARE ≥ 11/1/91

**AND**  
 PROCEDURE CODE = (ONE OF THE APPLICABLE, I.E., CODE BASED ON DATE OF SERVICE)  
 PROCEDURE CODES LISTED IN [CHAPTER 6, ADDENDUM A, FIGURE 6-A-2A, FIGURE 6-A-2B, FIGURE 6-A-2C, AND FIGURE 6-A-2D.](#)

NAS EXCEPTION REASON MUST =	6	PARTNERSHIPS/RESOURCE SHARING
	1	ENROLLMENT IN OHI WHICH IS PRIMARY COVERAGE
	2	EMERGENCY MEDICAL TREATMENT
	I	TRICARE-TIDEWATER DRUG CLAIM
	J	TRICARE-TIDEWATER PREVENTATIVE CARE CLAIM
	L	HOSPICE

<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.

**ELEMENT NAME: NAS EXCEPTION REASON (2-180) (CONTINUED)**

	IF ANY SPECIAL PROCESSING CODE =	AD ACTIVE DUTY CLAIMS
	AND PATIENT ZIP CODE IS IN A CATCHMENT AREA	
	NAS EXCEPTION REASON MUST =	Q ACTIVE DUTY CLAIMS
	UNLESS HEALTH CARE PLAN CODE =	11 MCS - FORT BRAGG DEMO
<b>2-180-06R</b>	IF PROGRAM INDICATOR =	H PFPWD
		D DRUGS
		T DENTAL
	NAS EXCEPTION REASON CANNOT = 'A'.	
<b>2-180-07R</b>	IF PATIENT ZIP CODE IS IN A CATCHMENT AREA <sup>1</sup> AND NAS NUMBER IS NOT CODED	
	TYPE OF SERVICE =	A FIRST BYTE C O N
	<b>AND</b> BEGIN DATE OF CARE ≥ 11/1/91 AND < 9/23/96	
	<b>AND</b> PROCEDURE CODE = (ONE OF THE APPLICABLE I.E., CODE BASED ON DATE OF SERVICE) PROCEDURE CODES LISTED IN <a href="#">CHAPTER 6, ADDENDUM A, FIGURE 6-A-2A, FIGURE 6-A-2B, FIGURE 6-A-2C, AND FIGURE 6-A-2D.</a>	
	NAS EXCEPTION REASON MUST BE CODED, <b>UNLESS,</b>	
	HEALTH CARE PLAN CODE =	11 MCS - FORT BRAGG DEMO
	<b>OR</b>	
	ANY OCCURRENCE OF DENIAL REASON CODE =	9 NONAVAILABILITY STATEMENT NOT PROVIDED
		2 INELIGIBLE CLAIMANT
		A DEERS
		N MULTIPLE DENIAL REASONS
	<b>OR</b>	
	ANY OCCURRENCE OF OVERRIDE CODE =	Q FORMER SPOUSE WITH PRE-EXISTING CONDITION
	<b>OR</b>	
	PROGRAM INDICATOR =	H PROGRAM FOR PERSONS WITH DISABILITIES
	<b>OR</b>	
	SPONSOR STATUS =	T NATO
	IN WHICH CASE NAS NUMBER MUST BE = BLANK.	

<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185)**

**VALIDITY EDITS**

**2-185-01** MUST BE A VALID CODE AS DEFINED IN [CHAPTER 2](#) OR BLANK FILLED.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
ENROLLMENT STATUS	SEE BELOW	TYPE OF SUBMISSION

**EDITED ELEMENT RELATIONSHIP**

<b>2-185-03R</b> IF ENROLLMENT STATUS =	A	CRI - FOUNDATION HEALTH PLAN	
	B	CRI - PARTNERS HEALTH PLAN	
	C	CRI - QUEENS HEALTH PLAN	
	N	CRI - NOT ENROLLED, NOT STANDARD (EXTRA)	
HEALTH CARE PLAN CODE MUST BE =	01	CRI - PARTNERS HEALTH PLAN	
	02	CRI - PARTNERS HEALTH PLAN	
	03	CRI - QUEENS HEALTH PLAN	
UNLESS TYPE OF SUBMISSION =	D	DENIAL	
	C	CANCELLATION	
	E	CANCELLATION OF NON-HCSR DATA	
<b>2-185-04R</b> IF ENROLLMENT STATUS =	F	FI STANDARD PROGRAM	
	D	MANAGED CARE SUPPORT - TRICARE, STANDARD PROGRAM	
	M	MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM	
HEALTH CARE PLAN CODE MUST BE BLANK	Y	CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD	
	D	DENIAL	
	C	CANCELLATION	
UNLESS TYPE OF SUBMISSION =	E	CANCELLATION OF NON-HCSR DATA	
	<b>2-185-05R</b> IF ENROLLMENT STATUS =	O	NEW ORLEANS PRIME
		P	NEW ORLEANS NOT ENROLLED < NOT STANDARD PROGRAM
HEALTH CARE PLAN CODE MUST BE '10'	D	DENIAL	
	C	CANCELLATION	
	E	CANCELLATION OF NON-HCSR DATA	
<b>2-185-06R</b> IF ENROLLMENT STATUS =	H	MANAGED CARE SUPPORT - HOMESTEAD, STANDARD PROGRAM	

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

	I	MANAGED CARE SUPPORT - HOMESTEAD, ENROLLED PATIENT
	J	MANAGED CARE SUPPORT - HOMESTEAD, NON-ENROLLED PATIENT, NETWORK PROVIDER
HEALTH CARE PLAN CODE MUST BE '05'		
UNLESS TYPE OF SUBMISSION =	D	DENIAL
	C	CANCELLATION
	E	CANCELLATION OF NON-HCSR DATA
<b>2-185-07R</b>	IF CONTRACTOR FHC OPTIONS (MENTAL HEALTH)	
<b>THEN</b>		
HEALTH CARE PLAN CODE MUST BE '06' (MANAGED CARE SUPPORT - HOMESTEAD)		
<b>UNLESS</b>		
ENROLLMENT STATUS =	Y	CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD
	AA	CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA
<b>THEN HEALTH CARE PLAN CODE MUST BE BLANK</b>		
<b>2-185-08R</b>	IF HEALTH CARE PLAN CODE = '06' (MANAGED CARE SUPPORT - HOMESTEAD)	
<b>UNLESS</b>		
ENROLLMENT STATUS =	D	MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM
	E	MANAGED CARE SUPPORT - TRICARE-TIDEWATER EXTRA
	G	MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME
	R	TRICARE EXTRA - NORTH CAROLINA
	T	MANAGED CARE SUPPORT - STANDARD PROGRAM
	U	MANAGED CARE SUPPORT - PRIME
	V	MANAGED CARE SUPPORT - EXTRA
	W	TPR ACTIVE DUTY - USA
<b>2-185-09R</b>	IF CONTRACTOR WASHINGTON/OREGON	
<b>THEN</b>		
HEALTH CARE PLAN CODE MUST BE '07' (MANAGED CARE SUPPORT - WASHINGTON-OREGON)		
<b>UNLESS</b>		
ENROLLMENT STATUS =	Y	CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD
	AA	CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA
<b>THEN HEALTH CARE PLAN CODE MUST BE BLANK</b>		
<b>2-185-10R</b>	IF HEALTH CARE PLAN CODE = '07' (MANAGED CARE SUPPORT - <b>REGION 11</b> [WASHINGTON/OREGON])	

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

<b>THEN</b>	
ENROLLMENT STATUS MUST =	R TRICARE EXTRA - NORTH CAROLINA <b>OR</b>
	T MANAGED CARE SUPPORT - STANDARD TRICARE PROGRAM <b>OR</b>
	U MANAGED CARE SUPPORT - PRIME WITH CONTRACTOR NETWORK PCM) <b>OR</b>
	V MANAGED CARE SUPPORT - EXTRA <b>OR</b>
	W TPR ACTIVE DUTY - USA <b>OR</b>
	Z MANAGED CARE SUPPORT - PRIME (WITH MTF/CLINIC PCM) <b>OR</b>
	BB TRICARE SENIOR PRIME <b>OR</b>
	SN SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE <b>OR</b>
	SO SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE <b>OR</b>
	SR SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-REFERRED CARE <b>OR</b>
	ST SUPPLEMENTAL HEALTH CARE PROGRAM FOR TRICARE ELIGIBLE

**2-185-11R IF CONTRACTOR FHC OPTIONS (FORT BRAGG DEMO)**

<b>THEN</b>	
HEALTH CARE PLAN CODE MUST BE '11' (MANAGED CARE SUPPORT - FORT BRAGG, NC)	
<b>UNLESS</b>	
ENROLLMENT STATUS =	Y CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD <b>OR</b>
	AA CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA

**THEN HEALTH CARE PLAN CODE MUST BE BLANK**

**2-185-12R IF HEALTH CARE PLAN CODE = '11' 9 (FORT BRAGG DEMO)**

<b>THEN</b>	
ENROLLMENT STATUS MUST =	R TRICARE EXTRA - NORTH CAROLINA <b>OR</b>
	T MANAGED CARE SUPPORT - STANDARD PROGRAM <b>OR</b>
	U MANAGED CARE SUPPORT - PRIME <b>OR</b>
	V MANAGED CARE SUPPORT - EXTRA <b>OR</b>
	W TPR ACTIVE DUTY - USA <b>OR</b>
	Z' MANAGED CARE SUPPORT - PRIME (WITH NTF/CLINIC PCM)

**2-185-13R IF CONTRACTOR (REGION 06) TEXAS/OKLAHOMA/LOUISIANA/ARKANSAS**

HEALTH CARE PLAN CODE MUST BE '09' (MANAGED CARE SUPPORT - REGION 6)



**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)****THEN**

ENROLLMENT STATUS = Y CONTINUED HEALTH CARE BENEFIT PROGRAM  
STANDARD **OR**

AA CONTINUED HEALTH CARE BENEFIT PROGRAM  
EXTRA

**THEN HEALTH CARE PLAN CODE MUST BE BLANK**

**2-185-14R** IF HEALTH CARE PLAN CODE = '09' (MANAGED CARE SUPPORT - REGION 6)

**THEN**

ENROLLMENT STATUS  
MUST = R TRICARE EXTRA - NORTH CAROLINA **OR**

T MANAGED CARE SUPPORT - STANDARD TRICARE  
PROGRAM **OR**

U MANAGED CARE SUPPORT - PRIME WITH  
CONTRACTOR NETWORK PCM) **OR**

V MANAGED CARE SUPPORT - EXTRA **OR**

W TPR ACTIVE DUTY - USA **OR**

BB TRICARE SENIOR PRIME **OR**

SN SUPPLEMENTAL HEALTH CARE PROGRAM - NON-  
MTF-REFERRED CARE **OR**

SO SUPPLEMENTAL HEALTH CARE PROGRAM - NON-  
TRICARE ELIGIBLE **OR**

SR SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-  
REFERRED CARE **OR**

ST SUPPLEMENTAL HEALTH CARE PROGRAM -  
TRICARE ELIGIBLE

**2-185-15R** IF CONTRACTOR (REGION 09, 10, 12) CALIFORNIA/HAWAII

**THEN**

HEALTH CARE PLAN CODE MUST BE '08' (MANAGED CARE SUPPORT - REGION 9, 10, 12)

**UNLESS**

ENROLLMENT STATUS = Y CONTINUED HEALTH CARE BENEFIT PROGRAM  
STANDARD **OR**

AA CONTINUED HEALTH CARE BENEFIT PROGRAM  
EXTRA

**THEN HEALTH CARE PLAN CODE MUST BE BLANK**

**2-185-16R** IF HEALTH CARE PLAN CODE = '08' (MANAGED CARE SUPPORT - REGIONS 9, 10, 12)

**THEN**

ENROLLMENT STATUS  
MUST = R TRICARE EXTRA - NORTH CAROLINA **OR**

T MANAGED CARE SUPPORT - STANDARD TRICARE  
PROGRAM **OR**

U MANAGED CARE SUPPORT - PRIME WITH  
CONTRACTOR NETWORK PCM **OR**

V MANAGED CARE SUPPORT - EXTRA **OR**

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

	W	TPR ACTIVE DUTY - USA	<b>OR</b>
	Z	MANAGED CARE SUPPORT - PRIME (WITH MTF/ CLINIC PCM)	<b>OR</b>
	BB	TRICARE SENIOR PRIME	<b>OR</b>
	SN	SUPPLEMENTAL HEALTH CARE PROGRAM - NON- MTF-REFERRED CARE	<b>OR</b>
	SO	SUPPLEMENTAL HEALTH CARE PROGRAM - NON- TRICARE ELIGIBLE	<b>OR</b>
	SR	SUPPLEMENTAL HEALTH CARE PROGRAM - MTF- REFERRED CARE	<b>OR</b>
	ST	SUPPLEMENTAL HEALTH CARE PROGRAM FOR TRICARE ELIGIBLE	
<b>2-185-17R</b>	IF CONTRACTOR (REGION 03, 04) HUMANA		
	<b>THEN</b> HEALTH CARE PLAN CODE MUST BE '13', '14', '15', '16'		
	<b>UNLESS</b> ENROLLMENT STATUS =		
	Y	CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD	<b>OR</b>
	AA	CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA	
	<b>THEN</b> HEALTH CARE PLAN CODE MUST BE BLANK		
<b>2-185-18R</b>	IF HEALTH CARE PLAN CODE = '13', '14', '15', '16' (MANAGED CARE SUPPORT - REGIONS 3/ 4, EUROPE, PACIFIC, AND SOUTHCOM)		
	<b>THEN</b> ENROLLMENT STATUS MUST =		
	R	TRICARE EXTRA - NORTH CAROLINA	<b>OR</b>
	T	MANAGED CARE SUPPORT - STANDARD TRICARE PROGRAM	<b>OR</b>
	U	MANAGED CARE SUPPORT - PRIME WITH CONTRACTOR NETWORK PCM	<b>OR</b>
	V	MANAGED CARE SUPPORT - EXTRA	<b>OR</b>
	W	TPR ACTIVE DUTY - USA	<b>OR</b>
	X	ACTIVE DUTY - EUROPE	<b>OR</b>
	Z	MANAGED CARE SUPPORT - PRIME (WITH MTF/ CLINIC PCM)	<b>OR</b>
	BB	TRICARE SENIOR PRIME	<b>OR</b>
	SN	SUPPLEMENTAL HEALTH CARE PROGRAM - NON- MTF-REFERRED CARE	<b>OR</b>
	SO	SUPPLEMENTAL HEALTH CARE PROGRAM - NON- TRICARE ELIGIBLE	<b>OR</b>
	SR	SUPPLEMENTAL HEALTH CARE PROGRAM - MTF- REFERRED CARE	<b>OR</b>

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

		ST SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE
<b>2-185-19R</b>	IF CONTRACTOR (CENTRAL REGION) TRIWEST HEALTH CARE PLAN CODE MUST BE = '12'	
	<b>UNLESS:</b> ENROLLMENT STATUS MUST =	Y CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD <b>OR</b>
		AA CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA
	<b>THEN HEALTH CARE PLAN CODE MUST BE BLANK.</b>	
<b>2-185-20R</b>	IF HEALTH CARE PLAN CODE = '12' (MANAGED CARE CENTRAL REGION (REGION 7/8))	
	<b>THEN</b> ENROLLMENT STATUS =	R TRICARE EXTRA - NORTH CAROLINA <b>OR</b>
		T MANAGED CARE SUPPORT - STANDARD TRICARE PROGRAM <b>OR</b>
		U MANAGED CARE SUPPORT - PRIME WITH CONTRACTOR NETWORK PCM <b>OR</b>
		V MANAGED CARE SUPPORT - EXTRA <b>OR</b>
		W TPR ACTIVE DUTY - USA <b>OR</b>
		Z MANAGED CARE SUPPORT - PRIME (WITH MTF/CLINIC PCM) <b>OR</b>
		BB TRICARE SENIOR PRIME <b>OR</b>
		SN SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE <b>OR</b>
		SO SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE <b>OR</b>
		SR SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-REFERRED CARE <b>OR</b>
		ST SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE
<b>2-185-21R</b>	IF CONTRACTOR (REGION 2/5) THEN HEALTH CARE PLAN CODE MUST BE = '17'	
	<b>UNLESS</b> ENROLLMENT STATUS MUST =	Y CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD <b>OR</b>
		AA CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA
	<b>THEN HEALTH CARE PLAN CODE MUST BE BLANK.</b>	
<b>2-185-22R</b>	IF HEALTH CARE PLAN CODE = '17' (MANAGED CARE SUPPORT - REGION 2/5)	
	<b>THEN</b> ENROLLMENT STATUS MUST =	R TRICARE EXTRA - NORTH CAROLINA <b>OR</b>

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

	T	MANAGED CARE SUPPORT - STANDARD TRICARE PROGRAM <b>OR</b>
	U	MANAGED CARE SUPPORT - PRIME WITH CONTRACTOR NETWORK PCM <b>OR</b>
	V	MANAGED CARE SUPPORT - EXTRA <b>OR</b>
	W	TPR ACTIVE DUTY - USA <b>OR</b>
	Z	MANAGED CARE SUPPORT - PRIME (WITH MTF/CLINIC PCM) <b>OR</b>
	SN	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - NON-MTF-REFERRED CARE <b>OR</b>
	SO	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - NON-TRICARE ELIGIBLE <b>OR</b>
	SR	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - MTF-REFERRED CARE <b>OR</b>
	ST	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - TRICARE ELIGIBLE
<b>2-185-23R</b>	IF CONTRACTOR (REGION 1) THEN HEALTH CARE PLAN CODE MUST BE = '18'	
	<b>UNLESS</b>	
	ENROLLMENT STATUS	
	MUST =	
	Y	CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD <b>OR</b>
	AA	CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA
	<b>THEN HEALTH CARE PLAN CODE MUST BE BLANK.</b>	
<b>2-185-24R</b>	IF HEALTH CARE PLAN CODE = '18' (MANAGED CARE SUPPORT - REGION 1)	
	<b>THEN</b>	
	ENROLLMENT STATUS	
	MUST =	
	R	TRICARE EXTRA - NORTH CAROLINA <b>OR</b>
	T	MANAGED CARE SUPPORT - STANDARD TRICARE PROGRAM <b>OR</b>
	U	MANAGED CARE SUPPORT - PRIME WITH CONTRACTOR NETWORK PCM <b>OR</b>
	V	MANAGED CARE SUPPORT - EXTRA <b>OR</b>
	W	TPR ACTIVE DUTY - USA <b>OR</b>
	Z	MANAGED CARE SUPPORT - PRIME (WITH MTF/CLINIC PCM) <b>OR</b>
	BB	TRICARE-SENIOR PRIME <b>OR</b>
	SN	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - NON-MTF-REFERRED CARE <b>OR</b>
	SO	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - NON-TRICARE ELIGIBLE <b>OR</b>
	SR	SUPPLEMENTAL HEALTH CARE PROGRAM <b>M</b> - MTF-REFERRED CARE <b>OR</b>

**ELEMENT NAME: HEALTH CARE PLAN CODE IDENTIFIER (2-185) (CONTINUED)**

ST SUPPLEMENTAL HEALTH CARE PROGRAM -  
TRICARE ELIGIBLE

**ELEMENT NAME: DIAGNOSIS EDITION IDENTIFIER (2-190)**

**VALIDITY EDITS**

**2-190-01** MUST BE A VALID CODE; CURRENTLY, ONLY '9' IS VALID

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
NONE		

**ELEMENT NAME: PROCEDURE TEXT IDENTIFIER (2-195)**

**VALIDITY EDITS**

**2-198-01** VALUE MUST BE '4' OR '8'.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROGRAM INDICATOR	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

**2-195-02R** IF PROGRAM INDICATOR = T DENTAL

PROCEDURE TEXT IDENTIFIER MUST = '8'.

IF PROGRAM INDICATOR ≠ T DENTAL

PROCEDURE TEXT IDENTIFIER MUST = '4'.

