

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

**ELEMENT NAME: RECORD TYPE INDICATOR (1-001)**

VALIDITY EDITS

**1-001-01** MUST BE = '1'

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>0-25-02R</b> BATCH IDENTIFIER		
TYPE OF SUBMISSION	SEE BELOW	RECORD TYPE INDICATOR

EDITED ELEMENT RELATIONSHIP

**1-001-03R** IF RECORD TYPE INDICATOR = '1'

AND IF TYPE OF SUBMISSION =	A ADJUSTMENT
	C CANCELLATION
	B ADJUSTMENT TO NON-HCSR DATA
	E CANCELLATION OF NON-HCSR DATA

AND A MATCH IS FOUND ON THE HCSR DATABASE (BASED ON HCSR INDICATOR), THEN THE RECORD TYPE INDICATOR FOR THE HCSR ON THE DATABASE MUST BE EQUAL TO THE RECORD TYPE INDICATOR ON THE ADJUSTMENT/CANCELLATION HCSR BEING SUBMITTED. THIS IS TRUE FOR 'MATCHES' TO ALL 'NET' HCSR<sub>s</sub> ON THE DATABASE, INCLUDING FRAGMENTED RECORDS SUCH AS A TYPE OF SUBMISSION 'B' MATCHING TO A PRIOR 'B'.

**ELEMENT NAME: HEALTH CARE SERVICES RECORD INDICATOR (1-005)**

VALIDITY EDITS

GROUP ELEMENT

RELATIONAL EDITS

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>1-175-02R</b> TYPE OF SUBMISSION <b>THROUGH</b> <b>1-175-06R</b>		FILING DATE, TYPE OF RECORD ON PREVIOUS HCSR ON DATABASE, AMOUNT PAID BY GOVERNMENT CONTRACTOR

**ELEMENT NAME: FILING DATE (1-015)**

**VALIDITY EDITS**

**1-015-01** MUST BE A VALID JULIAN DATE.

**RELATIONAL EDITS**

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>1-015-02R</b>	DATE HCSR PROCESSED TO COMPLETION	≤	
<b>1-015-03R AND 1-015-04R</b>	OVERRIDE CODE	SEE BELOW	BEGIN AND END DATE OF CARE
<b>1-040-04R</b>	DATE ADJUSTMENT IDENTIFIED		TYPE OF SUBMISSION
<b>1-280-03R</b>	BEGIN DATE OF CARE		
<sup>1</sup>	END DATE OF CARE	≥	
<sup>2</sup>	ADMISSION DATE	≥	

**EDITED ELEMENT RELATIONSHIP**

**1-015-03R** IF BEGIN DATE OF CARE ≥ 01/01/94  
 IF FILING DATE > END DATE OF CARE PLUS ONE YEAR  
 ONE OVERRIDE CODE MUST = 'F'

**ELSE**

FILING DATE MUST BE LESS THAN OR EQUAL TO THE LAST DAY OF THE YEAR  
 FOLLOWING THE YEAR IN WHICH CARE WAS RECEIVED (BASED ON BEGIN DATE OF  
 CARE)

**WHEN:** NO OCCURRENCE OF OVERRIDE CODE IS CLAIM FILED AFTER DEADLINE (F).

**1-015-04R** FILING DATE MUST BE LESS THAN BEGIN DATE OF CARE PLUS SIX YEARS WHEN ANY  
 OCCURRENCE OF OVERRIDE CODE.  
 'F' (CLAIM FILED AFTER DEADLINE).

<sup>1</sup> SEE 1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE) AND 1-280-02R (BEGIN DATE OF CARE ≤  
 END DATE OF CARE).

<sup>2</sup> SEE 1-280-03R (BEGIN DATE OF CARE ≤ FILING DATE) AND/OR 1-280-02R (BEGIN DATE OF CARE ≤  
 END DATE OF CARE) AND/OR 1-235-03R (ADMISSION DATE ≤ END DATE OF CARE)

**ELEMENT NAME: FILING STATE/COUNTRY (1-016)****VALIDITY EDITS****1-016-01** MUST BE A VALID STATE/COUNTRY CODE.**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
SPECIAL PROCESSING CODE	SEE BELOW	
CONTRACTOR NUMBER <sup>1</sup>	SEE BELOW	CONTRACT NUMBER <sup>1</sup>
SPECIAL RATE CODE	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP****1-016-04R** FILING STATE MUST BE AUTHORIZED FOR THIS CONTRACTOR**AND**

CONTRACT ON THE CONTRACTOR DATABASE

**UNLESS**

THE PATIENT ZIP CODE IS IN THE BERGSTROM AIR FORCE BASE

**OR**

LUKE/WILLIAMS AIR FORCE BASE CATCHMENT AREAS.

**OR**CONTRACTOR NUMBER = 03 MANAGED CARE SUPPORT - REGION 3/4 **OR**06 MANAGED CARE SUPPORT - REGION 6 **OR**07 MANAGED CARE SUPPORT - CENTRAL REGION **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

THEN CHECKING OF THE FILING STATE AGAINST THE COMS DATABASE WILL BE  
BYPASSED.**1-016-05R** IF SPECIAL RATE CODE = 'G', 'H', 'I', 'J', 'M', 'N', 'O', **OR** 'Q' (TRICARE/CHAMPUS DRG)  
**THEN** FILING STATE/COUNTRY MUST NOT BE A FOREIGN COUNTRY EXCEPT FOR  
PUERTO RICO.NOTE: FOR A LIST OF CODES SEE [CHAPTER 2, ADDENDUM A](#) AND [ADDENDUM B](#).<sup>1</sup> **BATCH/VOUCHER HEADER INPUT RECORD AND CONTRACTOR DATABASE.**

**ELEMENT NAME: SEQUENCE NUMBER (1-020)**

**VALIDITY EDITS**

**1-020-01** MUST BE A COMBINATION OF ALPHABETIC OR NUMERIC CHARACTERS.

**NOTE: CANNOT BE SPACES OR SPECIAL CHARACTERS.**

**RELATIONAL EDITS**

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

**ELEMENT NAME: TIME (1-021)**

**VALIDITY EDITS**

**1-021-01** MUST BE NUMERIC.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)

**1-021-02R** TIME MUST BE GREATER THAN ZERO WHEN:

HCSR FILING DATE IS EQUAL TO OR GREATER THAN 2-1-95

**ELEMENT NAME: HCSR SUFFIX (1-025)**

**VALIDITY EDITS**

**1-025-01** MUST BE A NON-BLANK ALPHABETIC CHARACTER.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
HCSR SUFFIX	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

**1-025-02R** THE HCSR SUFFIX MUST NOT CHANGE UPON RESUBMISSION OF AN INITIAL HCSR THAT WAS PART OF A CLAIM BREAKDOWN (MULTIPLE SUFFIXES) UNLESS THE HCSR IN THE INITIAL SUBMISSION WAS INVALID (OTHER THAN A - Z), OR THE HCSR INDICATOR DUPLICATED A HCSR ALREADY ON THE DATABASE.

**1-025-03R** ONE HCSR SUFFIX WITHIN INTERNAL CONTROL NUMBER MUST HAVE HCSR SUFFIX = 'A' UPON INITIAL SUBMISSION TO TMA UNLESS:

TYPE OF SUBMISSION =	F (ADJUSTMENT TO PRIOR HCSR DATA, ADDITIONAL SUFFIX) OR
	G (ADDITIONAL DRG INTERIM BILLING)

**ELEMENT NAME: PROGRAM INDICATOR (1-030)****VALIDITY EDITS**

**1-030-01** PROGRAM INDICATOR MUST BE 'H' (PROGRAM FOR PERSONS WITH DISABILITIES) OR 'I' (INSTITUTIONAL)

**RELATIONAL EDITS**

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

**ELEMENT NAME: DATE HCSR PROCESSED TO COMPLETION (1-035)****VALIDITY EDITS**

**1-035-01** MUST BE A VALID GREGORIAN DATE.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>1-035-02R</b> PERIOD END DATE	≤	
<b>1-035-03R</b> PERIOD BEGIN DATE	≥	
<b>1-015-02R</b> FILING DATE		
<b>1-040-03R</b> DATE ADJUSTMENT IDENTIFIED		
<b>1-235-02R</b> ADMISSION DATE		
<b>1-280-04R</b> BEGIN DATE OF CARE		
<b>1-285-04R</b> END DATE OF CARE		

**ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED (1-040)**

**VALIDITY EDITS**

**1-040-01** MUST BE VALID GREGORIAN DATE, OR ALL ZEROES.

**RELATIONAL EDITS**

	RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>1-040-02R</b>	TYPE OF SUBMISSION	SEE BELOW	
<b>1-040-03R</b>	DATE HCSR PROCESSED TO COMPLETION	SEE BELOW	TYPE OF SUBMISSION
<b>1-040-04R</b>	FILING DATE	SEE BELOW	TYPE OF SUBMISSION
<b>1-235-05R</b>	ADMISSION DATE		TYPE OF SUBMISSION
<b>1-280-05R</b>	BEGIN DATE OF CARE		TYPE OF SUBMISSION
<b>1-285-05R</b>	END DATE OF CARE		TYPE OF SUBMISSION

**EDITED ELEMENT RELATIONSHIP**

<b>1-040-02R</b>	DATE ADJUSTMENT IDENTIFIED MUST BE ALL ZEROES <b>WHEN</b> TYPE OF SUBMISSION =	D	CONTRACTOR DENIAL
		I	INITIAL SUBMISSION
		R	RESUBMISSION OF ERROR REJECT
		O	ZERO PAYMENT
	DATE ADJUSTMENT IDENTIFIED MUST BE A VALID GREGORIAN DATE <b>WHEN</b> TYPE OF SUBMISSION =	A	ADJUSTMENT
		C	COMPLETE CANCELLATION
		B	ADJUSTMENT TO NON-HCSR DATA
		E	CANCELLATION OF NON-HCSR DATA
		F	ADJUSTMENT HCSR NEW SUFFIX
		G	ADDITIONAL DRG INTERIM BILLING
<b>1-040-03R</b>	DATE ADJUSTMENT IDENTIFIED MUST BE: ≤ DATE HCSR PROCESSED TO COMPLETION AND ≥ FILING DATE  <b>WHEN</b> TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
		C	COMPLETE CANCELLATION <b>OR</b>
		B	ADJUSTMENT TO NON-HCSR DATA <b>OR</b>
		E	CANCELLATION OF NON-HCSR DATA <b>OR</b>
		F	ADJUSTMENT HCSR NEW SUFFIX <b>OR</b>
		G	ADDITIONAL DRG INTERIM BILLING

**ELEMENT NAME: SPONSOR SOCIAL SECURITY NUMBER (1-045)****VALIDITY EDITS**

**1-045-01** MUST BE 9 NUMERIC DIGITS (IF PRESENT) OR ALL BLANKS. CANNOT BE ALL ZEROS OR ALL NINES.

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
SPONSOR STATUS	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

**1-045-02R** IF SPONSOR STATUS = 'T' (FOREIGN MILITARY), SPONSOR SOCIAL SECURITY NUMBER MUST BE ALL BLANKS OR 9 NUMERIC DIGITS.  
OTHERWISE, (FOR ANY OTHER SPONSOR STATUS) SPONSOR SOCIAL SECURITY NUMBER MUST BE 9 NUMERIC DIGITS.

**ELEMENT NAME: SPONSOR PAY GRADE (1-050)****VALIDITY EDITS**

**1-050-01** MUST BE ONE OF THE VALUES LISTED FOR THIS ELEMENT IN [CHAPTER 2](#).

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
TYPE OF SUBMISSION	SEE BELOW	
SPONSOR STATUS	SEE BELOW	
SPONSOR BRANCH OF SERVICE	SEE BELOW	
PROGRAM INDICATOR	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

<b>1-050-03R</b>	IF SPONSOR STATUS =	T	FOREIGN MILITARY
	SPONSOR PAY GRADE MUST BE =	90	UNKNOWN (INCLUDING NATO)
		41-58	GS1 - GS18
<b>1-050-04R</b>	IF SPONSOR BRANCH OF SERVICE =	E	PHS
		I	NOAA
	SPONSOR PAY GRADE MUST NOT BE =	01-09	ENLISTED
<b>1-050-05R</b>	IF PROGRAM INDICATOR =	H	PROGRAM FOR PERSONS WITH DISABILITIES
	SPONSOR PAY GRADE MUST BE =	01-09	ENLISTED
		11-15	WARRANT OFFICER

**ELEMENT NAME: SPONSOR PAY GRADE (1-050) (CONTINUED)**

20-31 OFFICER

**ELEMENT NAME: SPONSOR BRANCH OF SERVICE (1-055)**

**VALIDITY EDITS**

**01-055-01** MUST BE 'A', 'E', 'F', 'I', 'M', 'N', 'P', OR 'C' (SEE [CHAPTER 2](#))

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
PROGRAM INDICATOR	SEE BELOW	
VOUCHER BRANCH OF SERVICE <sup>1</sup>	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP**

<b>1-055-03R</b> IF VOUCHER BRANCH OF SERVICE =	01 ARMY <b>OR</b>
	02 AIR FORCE <b>OR</b>
	03 MARINE CORPS/NAVY <b>OR</b>
	21 ACTIVE DUTY ARMY (TPR) <b>OR</b>
	22 ACTIVE DUTY AIR FORCE (TPR) <b>OR</b>
	23 ACTIVE DUTY MARINE CORPS/NAVY (TPR) <b>OR</b>
	41 ARMY (COMPREHENSIVE CLINIC EVALUATION PROGRAM) <b>OR</b>
	42 AIR FORCE (COMPREHENSIVE CLINIC EVALUATION PROGRAM) <b>OR</b>
	43 MARINE CORPS/NAVY (COMPREHENSIVE CLINIC EVALUATION PROGRAM) <b>OR</b>
	71 ARMY - DIRECT PAY, SPECIAL/EMERGENT CARE & ABUSED DEPENDENT OF DISCHARGED OR DISMISSED MEMBER <b>OR</b>
	72 AIR FORCE - DIRECT PAY, SPECIAL/EMERGENT CARE & ABUSED DEPENDENT OF DISCHARGED OR DISMISSED MEMBER <b>OR</b>
	73 MARINE CORPS/NAVY - DIRECT PAY, SPECIAL/EMERGENT CARE & ABUSED DEPENDENT OF DISCHARGED OR DISMISSED MEMBER <b>OR</b>
	A1 ARMY (SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY) <b>OR</b>
	A2 AIR FORCE (SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY) <b>OR</b>
	A3 MARINE CORPS/NAVY (SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY) <b>OR</b>

<sup>1</sup> BATCH/VOUCHER HEADER



**ELEMENT NAME: SPONSOR BRANCH OF SERVICE (1-055) (CONTINUED)**

	B1	ARMY (SUPPLEMENTAL HEALTH CARE PROGRAM - MTF REFERRED) <b>OR</b>
	B2	AIR FORCE (SUPPLEMENTAL HEALTH CARE PROGRAM - MTF REFERRED) <b>OR</b>
	B3	MARINE CORPS/NAVY (SUPPLEMENTAL HEALTH CARE PROGRAM - MTF REFERRED)
	C1	ARMY - TRICARE SENIOR SUPPLEMENT <b>OR</b>
	C2	AIR FORCE - TRICARE SENIOR SUPPLEMENT <b>OR</b>
	C3	MARINE CORPS/NAVY - TRICARE SENIOR SUPPLEMENT <b>OR</b>
	D1	ARMY - PHARMACY REDESIGN PILOT PROGRAM <b>OR</b>
	D2	AIR FORCE - PHARMACY REDESIGN PILOT PROGRAM <b>OR</b>
	D3	MARINE CORPS/NAVY - PHARMACY REDESIGN PILOT PROGRAM
<b>THEN</b>		
SPONSOR BRANCH OF SERVICE =	A	ARMY <b>OR</b>
	F	AIR FORCE <b>OR</b>
	M	MARINES <b>OR</b>
	N	NAVY
<b>1-055-04R</b>		
IF VOUCHER BRANCH OF SERVICE =	05	NON-DOD - SPECIAL/EMERGENT CARE & ABUSED DEPENDENT OF DISCHARGED OR DISMISSED MEMBER <b>OR</b>
	25	ACTIVE DUTY - NON-DOD (TPR) <b>OR</b>
	45	NON-DOD (COMPREHENSIVE CLINICAL EVALUATION PROGRAM) <b>OR</b>
	A5	NON-DOD (SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY) <b>OR</b>
	B5	NON-DOD (SUPPLEMENTAL HEALTH CARE PROGRAM - MTF REFERRED) <b>OR</b>
	C5	NON-DOD - TRICARE SENIOR SUPPLEMENT <b>OR</b>
	D5	NON-DOD - PHARMACY REDESIGN PILOT PROGRAM
<b>THEN</b>		
SPONSOR BRANCH OF SERVICE =	E	PUBLIC HEALTH SERVICE <b>OR</b>
	I	NOAA <b>OR</b>
	P	COAST GUARD

<sup>1</sup> BATCH/VOUCHER HEADER

**ELEMENT NAME: SPONSOR BRANCH OF SERVICE (1-055) (CONTINUED)**

<b>1-055-05R</b>	IF VOUCHER BRANCH OF SERVICE =	10	CONTINUED HEALTH CARE BENEFIT PROGRAM <b>OR</b>
		FA	TRICARE SENIOR PRIME DOVER AFB, DOVER, DE <b>OR</b>
		FB	TRICARE SENIOR PRIME KEESLER AFB, BILOXI, MS <b>OR</b>
		FC	TRICARE SENIOR PRIME BROOKE ARMY MEDICAL CENTER, SAN ANTONIO, TX <b>OR</b>
		FD	TRICARE SENIOR PRIME WILFORD HALL MEDICAL CENTER, SAN ANTONIO, TX <b>OR</b>
		FE	TRICARE SENIOR PRIME FT. SILL, OK <b>OR</b>
		FF	TRICARE SENIOR PRIME SHEPPARD AFB, WICHITA FALLS, TX <b>OR</b>
		FG	TRICARE SENIOR PRIME FT CARSON, COLORADO SPRINGS, CO <b>OR</b>
		FH	TRICARE SENIOR PRIME AIR FORCE ACADEMY, COLORADO SPRINGS, CO <b>OR</b>
		FJ	TRICARE SENIOR PRIME NAVAL MEDICAL CENTER SAN DIEGO, SAN DIEGO, CA <b>OR</b>
		FK	TRICARE SENIOR PRIME MADIGAN ARMY MEDICAL CENTER, FORT LEWIS, WA
	<b>THEN</b>		
	SPONSOR BRANCH OF SERVICE MUST BE =	A	ARMY <b>OR</b>
		F	AIR FORCE <b>OR</b>
		M	MARINES <b>OR</b>
		N	NAVY <b>OR</b>
		E	PUBLIC HEALTH SERVICE <b>OR</b>
		I	NOAA <b>OR</b>
		P	COAST GUARD
<b>1-055-06R</b>	IF VOUCHER BRANCH OF SERVICE =	26	ARMY - NATIONAL GUARD (TPR) <b>OR</b>
		A6	ARMY - NATIONAL GUARD (SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY) <b>OR</b>
		B6	ARMY - NATIONAL GUARD (SUPPLEMENTAL HEALTH CARE PROGRAM - MTF REFERRED)

<sup>1</sup> BATCH/VOUCHER HEADER

**ELEMENT NAME: SPONSOR BRANCH OF SERVICE (1-055) (CONTINUED)****THEN**

SPONSOR BRANCH OF  
SERVICE MUST BE =       A   ARMY

AND SPONSOR STATUS =    N   NATIONAL GUARD

**<sup>1</sup> BATCH/VOUCHER HEADER****ELEMENT NAME: SPONSOR STATUS (1-065)****VALIDITY EDITS**

**1-065-01**   MUST BE ANY VALUE LISTED FOR THIS ELEMENT IN [CHAPTER 2](#).

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
TYPE OF SUBMISSION	SEE BELOW	
PATIENT RELATIONSHIP TO SPONSOR	SEE BELOW	DISCHARGE STATUS
DEERS DEPENDENT SUFFIX	SEE BELOW	DISCHARGE STATUS
PROGRAM INDICATOR	SEE BELOW	
SPONSOR BRANCH OF SERVICE	SEE BELOW	
OVERRIDE CODE	SEE BELOW	
BILL CLASSIFICATION CODE	SEE BELOW	
NAS EXCEPTION REASON	SEE BELOW	
<b>1-197-19R</b>	SPECIAL PROCESSING CODE	PATIENT RELATIONSHIP TO SPONSOR

**EDITED ELEMENT RELATIONSHIP**

<b>1-065-03R</b>	IF PATIENT RELATIONSHIP TO SPONSOR = 'B' (SPONSOR) SPONSOR STATUS MUST NOT BE ANY VALUE LISTED UNDER ACTIVE UNLESS ENROLLMENT STATUS = 'Y', 'W', 'X', 'AA', 'SN', 'SO', 'SR', OR 'ST'	
<b>1-065-04R</b>	IF DEERS DEPENDENT SUFFIX = '20' (SPONSOR) SPONSOR STATUS MUST NOT BE ANY VALUE LISTED UNDER ACTIVE UNLESS ENROLLMENT STATUS = 'Y', 'W', 'X', 'AA', 'SN', 'SO', 'SR', OR 'ST'	
<b>1-065-05R</b>	IF PROGRAM INDICATOR = 'H' (PROGRAM FOR PERSONS WITH DISABILITIES) SPONSOR STATUS MUST BE ANY VALUE LISTED UNDER ACTIVE, OR TAMP DESIGNEE EXCEPT FOR 'T' (FOREIGN MILITARY)	
<b>1-065-07R</b>	IF ANY OCCURRENCE OF OVERRIDE CODE = 'J' (SUCCESSIVE ADMISSION) SPONSOR STATUS MUST BE ANY VALUE LISTED UNDER ACTIVE	
<b>1-065-08R</b>	IF BILL CLASSIFICATION CODE = '1' (INPATIENT) SPONSOR STATUS MUST NOT = 'T' (FOREIGN MILITARY)	
<b>1-065-09R</b>	IF PATIENT RELATIONSHIP TO SPONSOR = 'B' SPONSOR STATUS MUST NOT BE ANY VALUE LISTED UNDER DECEASED UNLESS DISCHARGE STATUS = '20' (EXPIRED)	
<b>1-065-10R</b>	IF DEERS DEPENDENT SUFFIX = '20' SPONSOR STATUS MUST NOT BE ANY VALUE LISTED UNDER DECEASED UNLESS DISCHARGE STATUS = '20' (EXPIRED)	

**ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR (1-070)**

**VALIDITY EDITS**

**1-070-01** MUST BE ONE OF THE VALUES LISTED FOR THIS ELEMENT IN [CHAPTER 2](#).

**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
TYPE OF SUBMISSION	SEE BELOW	
PATIENT DATE OF BIRTH	SEE BELOW	OVERRIDE CODE, SPONSOR BRANCH OF SERVICE
DEERS DEPENDENT SUFFIX	SEE BELOW	
<b>1-065-03R AND 1-065-09R</b> SPONSOR STATUS		DISCHARGE STATUS
PROGRAM INDICATOR	SEE BELOW	
SPONSOR BRANCH OF SERVICE	SEE BELOW	
OVERRIDE CODE	SEE BELOW	
NAS EXCEPTION REASON	SEE BELOW	
<b>1-197-19R</b> SPECIAL PROCESSING CODE	PATIENT RELATIONSHIP TO SPONSOR	

**EDITED ELEMENT RELATIONSHIP**

<b>1-070-03R</b>	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> < 17 PATIENT RELATIONSHIP MUST NOT BE = 'B' (SPONSOR)	
<b>1-070-05R</b>	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> < 12	
	PATIENT RELATIONSHIP MUST NOT BE =	S SPOUSE
		F UNREMARIED WIDOW(ER)
		G UNMARRIED WIDOW(ER)
	<b>UNLESS ONE OCCURRENCE OF OVERRIDE CODE = 'B'.</b>	
	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> < 34 PATIENT RELATIONSHIP MUST NOT BE = 'T', 'H', 'R' OR 'Y' (FORMER SPOUSE) <b>UNLESS</b> ONE OCCURRENCE OF OVERRIDE CODE = 'T'.	
<b>1-070-06R</b>	IF DEERS DEPENDENT SUFFIX = '20' (SPONSOR) PATIENT RELATIONSHIP MUST BE = 'B'	
	IF DEERS DEPENDENT SUFFIX = '01' - '19' (CHILD) PATIENT RELATIONSHIP MUST BE = 'C' (CHILD), 'V' (STEPCHILD) OR 'W' (WARD OF COURT)	
	IF DEERS DEPENDENT SUFFIX = '30' - '39' (SPOUSE) PATIENT RELATIONSHIP MUST BE = 'S', 'F', 'G', 'H', 'R', 'T' OR 'Y'.	
<b>1-070-07R</b>	IF SPONSOR STATUS = 'T' (FOREIGN MILITARY)	

<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 BEGIN DATE OF CARE TO END DATE OF CARE.

**ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR (1-070) (CONTINUED)**

	PATIENT RELATIONSHIP TO SPONSOR MUST BE =	C	CHILD
		F	UNREARRIED WIDOW(ER)
		G	UNMARRIED WIDOW(ER)
		H	UNREARRIED FORMER SPOUSE (20/20/20)
		R	UNREARRIED FORMER SPOUSE (DIVORCED AFTER 04/01/85 MTG 20/20/15)
		S	SPOUSE
		V	STEPCHILD
		Y	UNREARRIED FORMER SPOUSE (DIVORCED PRIOR 04/01/85 MTG 20/20/15)
<b>1-070-08R</b>	IF PROGRAM INDICATOR =	H	PROGRAM FOR PERSONS WITH DISABILITIES
	PATIENT RELATIONSHIP TO SPONSOR MUST BE =	C	CHILD
		F	UNREARRIED WIDOW(ER)
		G	UNMARRIED WIDOW(ER)
		S	SPOUSE
		V	STEPCHILD
<b>1-070-10R</b>	IF ANY OCCURRENCE OF OVERRIDE CODE =	J	SUCCESSIVE ADMISSION
	PATIENT RELATIONSHIP TO SPONSOR MUST BE =	C	CHILD
		F	UNREARRIED WIDOW(ER)
		G	UNMARRIED WIDOW(ER)
		S	SPOUSE
		T	UNREARRIED FORMER SPOUSE
		V	STEPCHILD
		X	OTHER
		H	UNMARRIED FORMER SPOUSE
		R	UNREARRIED FORMER SPOUSE
		Y	UNREARRIED FORMER SPOUSE
		b	SPONSOR
	UNLESS SPONSOR STATUS =	P	TAMP DESIGNEE
	<b>OR</b>		
	SPECIAL PROCESSING CODE =	SC	SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE

<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 BEGIN DATE OF CARE TO END DATE OF CARE.

**ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR (1-070) (CONTINUED)**

**1-070-13R** IF NAS EXCEPTION REASON = A ROUTINE NEWBORN CARE

PATIENT RELATIONSHIP = C CHILD

**1-070-14R** IF SPONSOR STATUS = H MEDAL OF HONOR

**THEN PATIENT  
 RELATIONSHIP TO SPONSOR  
 MUST =** **B SPONSOR OR**

**C CHILD OR**

**F UNREARRIED WIDOW(ER) OR**

**S SPOUSE OR**

**V STEPCHILD**

<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 BEGIN DATE OF CARE TO END DATE OF CARE.

**ELEMENT NAME: PATIENT NAME (1-075)**

**VALIDITY EDITS**

**1-075-01** MUST BE AT LEAST 1 CHARACTER (LEFT-JUSTIFIED) FOLLOWED BY A COMMA

**RELATIONAL EDITS**

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

**ELEMENT NAME: PATIENT SSN (1-080)**

**VALIDITY EDITS**

**1-080-01** MUST BE 9 NUMERIC DIGITS (IF PRESENT) OR ALL BLANKS. CANNOT BE ALL ZEROES OR ALL NINES

**RELATIONAL EDITS**

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

**ELEMENT NAME: PATIENT DATE OF BIRTH (1-085)****VALIDITY EDITS****1-085-01** MUST BE A VALID GREGORIAN DATE**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<b>1-085-02R</b> SYSTEM RUN DATE	MUST BE 125 OR LESS YEARS PRIOR TO RUN DATE	
<b>1-085-03R</b> BEGIN DATE OF CARE	≤	
<b>1-085-06R</b> ADMISSION DATE	≤	
<sup>1</sup> PRINCIPAL TREATMENT DIAGNOSIS	USE ICD-9-CM TAPE	
<sup>1</sup> SECONDARY TREATMENT DIAGNOSIS	USE ICD-9-CM TAPE	
NAS EXCEPTION REASON	SEE BELOW	

**EDITED ELEMENT RELATIONSHIP****1-085-07R** IF NAS EXCEPTION REASON = 'A'  
PATIENT DATE OF BIRTH MUST EQUAL ADMISSION DATE (NEWBORN)<sup>1</sup> SEE 1-315-05R, 1-320-5R, 1-325-05R, 1-330-05R, AND 1-335-05R.**ELEMENT NAME: DEERS DEPENDENT SUFFIX (1-090)****VALIDITY EDITS****1-090-01** MUST BE ONE OF THE VALUES LISTED FOR THIS ELEMENT IN [CHAPTER 2](#).**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
TYPE OF SUBMISSION	SEE BELOW	
PATIENT DATE OF BIRTH	SEE BELOW	OVERRIDE CODE, SPONSOR BRANCH OF SERVICE
PATIENT RELATIONSHIP TO SPONSOR	SEE BELOW	
<b>1-065-04R</b> SPONSOR STATUS <b>AND</b> <b>1-065-10R</b>		DISCHARGE STATUS
PROGRAM INDICATOR	SEE BELOW	
SPONSOR BRANCH OF SERVICE	SEE BELOW	

<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 BEGIN DATE OF CARE TO END DATE OF CARE.

**ELEMENT NAME: DEERS DEPENDENT SUFFIX (1-090) (CONTINUED)**

**EDITED ELEMENT RELATIONSHIP**

<b>1-090-03R</b>	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> < 17 DEERS DEPENDENT SUFFIX MUST NOT BE = '20' (SPONSOR)
<b>1-090-05R</b>	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> < 12 DEERS DEPENDENT SUFFIX MUST NOT BE = '30' - '39' (SPOUSE) <b>UNLESS ONE OCCURRENCE OF OVERRIDE CODE = 'B'.</b>
<b>1-090-06R</b>	DEERS DEPENDENT SUFFIX MUST = '20' (SPONSOR) IF PATIENT RELATIONSHIP = 'B'
	DEERS DEPENDENT SUFFIX MUST BE =
	01-19 CHILDREN
	60-69 OTHER ELIGIBLE FAMILY MEMBERS
	70-75 UNKNOWN
	IF PATIENT RELATIONSHIP = 'C' (CHILD) 'V' (STEPCHILD), <b>OR</b> 'W' (WARD OF COURT)
	DEERS DEPENDENT SUFFIX MUST = '30' - '39' (SPOUSE) IF PATIENT RELATIONSHIP = 'S', 'F', <b>OR</b> 'G' <b>UNLESS TYPE OF SUBMISSION = 'D' (COMPLETE CONTRACTOR DENIAL)</b> THEN DEERS DEPENDENT SUFFIX CAN = '70' - '75' (UNKNOWN).
	DEERS DEPENDENT SUFFIX MUST BE =
	30-39 SPOUSE
	60-69 OTHER ELIGIBLE FAMILY MEMBER
	IF PATIENT RELATIONSHIP = 'T', 'H', 'R' <b>OR</b> 'Y' (FORMER SPOUSE).
<b>1-090-07R</b>	IF SPONSOR STATUS = T FOREIGN MILITARY
	DEERS DEPENDENT SUFFIX MUST BE =
	01-19 CHILDREN
	30-39 SPOUSE
<b>1-090-08R</b>	IF PROGRAM INDICATOR = H PROGRAM FOR PERSONS WITH DISABILITIES
	DEERS DEPENDENT SUFFIX MUST BE =
	01-19 CHILDREN
	30-39 SPOUSE
<b>1-090-10R</b>	IF PATIENT DATE OF BIRTH INDICATES AGE <sup>1</sup> > 2 YEARS DEERS DEPENDENT SUFFIX MUST NOT = '70' - '74' (UNKNOWN) <b>UNLESS TYPE OF SUBMISSION = 'D' (COMPLETE CONTRACTOR DENIAL).</b>

<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 BEGIN DATE OF CARE TO END DATE OF CARE.



**ELEMENT NAME: PATIENT SEX (1-095)****VALIDITY EDITS****1-095-01** MUST BE 'M' OR 'F'**RELATIONAL EDITS**

RELATED TO ELEMENT	EDITED ELEMENT RELATIONSHIP	ALSO RELATES TO ELEMENT(S)
<sup>1</sup> ADMISSION DIAGNOSIS		
<b>1-315-04R</b>	PRINCIPAL TREATMENT DIAGNOSIS	
<b>1-320-04R, 1-325-04R, 1-330-04R, AND 1-335-04R</b>	SECONDARY TREATMENT DIAGNOSIS	
<b>1-340-06R</b>	PRINCIPAL OP/NSP CODE	OVERRIDE CODE
<b>1-345-06R AND 1-350-06R</b>	SECONDARY OP/NSP CODE	OVERRIDE CODE
<b>1-365-06R</b>	REVENUE CODE	

<sup>1</sup> EDIT NOT PERFORMED (ADMISSION DIAGNOSIS), USE ICD-9-CM TAPE FOR TREATMENT DIAGNOSIS AND OP/NSP ONLY.

