# NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 144)

| ELEMENT NAME: PATIENT ZIP CODE (2-100) | | |
|---|---|---|
| **VALIDITY EDITS** | | |
| 2-100-01 | MUST BE 9 CHARACTERS, EITHER 9 DIGITS, **OR** 5 DIGITS (NOT 5 ZEROES **OR** 5 NINES) FOLLOWED BY 4 BLANKS, **OR** 2 CHARACTERS FOLLOWED BY 7 BLANKS. MUST NOT BE ALL ZEROES **OR** ALL NINES. | |
| 2-100-02 | MUST BE VALID ZIP CODE IN THE ELECTRONIC ZIP CODE FILE, BASED ON THE EARLIEST BEGIN DATE OF CARE **OR** THE FIRST 2 CHARACTERS AGAINST OF COUNTRY CODES TABLE (SEE CHAPTER 2, ADDENDUM A) | |

| **RELATIONAL EDITS** | | |
|---|---|---|
| **RELATED TO ELEMENT** | **EDITED ELEMENT RELATIONSHIP** | **ALSO RELATES TO ELEMENT(S)** |
| NAS EXCEPTION REASON | SEE BELOW | |
| NAS NUMBER | SEE BELOW | |
| SPECIAL PROCESSING CODE | SEE BELOW | |
| ENROLLMENT STATUS | SEE BELOW | |
| PROGRAM INDICATOR | SEE BELOW | |

| **EDITED ELEMENT RELATIONSHIP** | | |
|---|---|---|
| 2-100-03R | IF NAS EXCEPTION REASON IS CODED | |
| | **THEN** PATIENT ZIP CODE MUST BE **WITHIN** AN MTF[3] CATCHMENT AREA[1] | |
| | **UNLESS** NAS EXCEPTION REASON CODE = | O LIVING-RELATED DONOR LIVER TRANSPLANT |
| | **OR** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ST[2] SPECIALIZED TREATMENT FACILITY |
| | **THEN BYPASS THIS EDIT** | |
| 2-100-04R | IF NAS NUMBER IS PRESENT | |
| | **THEN** PATIENT ZIP CODE MUST BE **WITHIN** AN MTF[3] CATCHMENT AREA[1] | |
| | **UNLESS** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ST[2] SPECIALIZED TREATMENT FACILITY **OR** |

[1] **CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.**
[2] **STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.**
[3] **MTF IS A 40 MILE CATCHMENT AREA.**

| ELEMENT NAME: | PATIENT ZIP CODE (2-100) (CONTINUED) | | |
|---|---|---|---|
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR** |
| | | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 |
| | **OR** ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| | | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD |
| | **THEN** BYPASS THIS EDIT | | |
| 2-100-05R | IF SPECIAL PROCESSING CODE | 9 | FORT DRUM COOPERATIVE MEDICAL CARE |
| | PATIENT ZIP CODE MUST BE IN THE FORT DRUM DEMONSTRATION PROJECT AREA | | |
| 2-100-06R | IF ENROLLMENT STATUS = 'A', 'B', 'C', 'K', 'L', 'M', 'N' **OR** 'S' | | |
| | **AND** NO OCCURRENCE OF OVERRIDE CODE = 'S' | | |
| | PATIENT ZIP CODE MUST BE IN CALIFORNIA **OR** HAWAII. | | |
| 2-100-07R | IF ENROLLMENT STATUS = 'H', 'I', 'J', 'O', 'P' **OR** 'Q' | | |
| | **AND** NO OCCURRENCE OF OVERRIDE CODE = 'S' | | |
| | PATIENT ZIP CODE MUST BE A VALID ZIP CODE FOR THE NEW ORLEANS COORDINATED CARE PROGRAM OR A BASE REALIGNMENT AND CLOSURE (BRAC) SITE. (SEE CHAPTER 2, ADDENDUM K) | | |
| 2-100-08R | IF PROGRAM INDICATOR = | T | DENTAL |
| | **AND** PATIENT ZIP CODE IS A VALID ZIP CODE FOR THE HOMESTEAD MANAGED CARE SUPPORT AREA (SEE CHAPTER 2, ADDENDUM K) | | |
| | CONTRACTOR NUMBER MUST = | 45 | WISCONSIN PHYSICIANS SERVICE |

[1] CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.
[2] STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
[3] MTF IS A 40 MILE CATCHMENT AREA.

| ELEMENT NAME: | ENROLLMENT STATUS (2-105) | | |
|---|---|---|---|
| **VALIDITY EDITS** | | | |
| 2-105-01 | MUST BE A VALID VALUE LISTED IN CHAPTER 2. | | |
| **RELATIONAL EDITS** | | | |
| | RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
| | OVERRIDE CODE | SEE BELOW | |
| | SOURCE OF HEALTH CARE DATA (DERIVED) | SEE BELOW | |
| | PROVIDER CONTRACT AFFILIATION CODE | SEE BELOW | |
| | SPECIAL PROCESSING CODE | SEE BELOW | |
| **EDITED ELEMENT RELATIONSHIP** | | | |
| 2-105-02R | IF ANY OCCURRENCE OF OVERRIDE CODE = | Z | ENHANCED BENEFIT |
| | ENROLLMENT STATUS MUST BE = | A | FOUNDATION HEALTH PLAN |
| | | B | PARTNERS HEALTH PLAN |
| | | C | QUEENS HEALTH CARE PLAN |
| | | N | NON-PRIME, e.g., EXTRA |
| | | O | NEW ORLEANS PRIME |
| | | P | NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM |
| | | E | MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME |
| | | H | MANAGED CARE SUPPORT - HOMESTEAD, ENROLLED PATIENT |
| | | K | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, ENROLLED PATIENT |
| | | U | MANAGED CARE SUPPORT - PRIME, CIVILIAN PCM |
| | | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM |
| 2-105-03R | IF SOURCE OF HEALTH CARE DATA (THIS IS A **DERIVED** ELEMENT) IS A CRI CONTRACTOR | | |
| | **THEN** ENROLLMENT STATUS MUST = | A | FOUNDATION HEALTH PLAN |
| | | B | PARTNERS HEALTH PLAN |
| | | C | QUEENS HEALTH CARE PLAN |
| | | E | MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME |

[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**

| ELEMENT NAME: | ENROLLMENT STATUS (2-105) (CONTINUED) | | |
|---|---|---|---|
| | | G | MANAGED CARE SUPPORT - TRICARE-TIDEWATER EXTRA |
| | | R | TRICARE EXTRA - NORTH CAROLINA |
| | | N | NON-PRIME |
| | | S | CRI STANDARD PROGRAM |
| | | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA |
| | | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | | U | MANAGED CARE SUPPORT - PRIME |
| | | V | MANAGED CARE SUPPORT - EXTRA |
| | | Z | MANAGED CARE SUPPORT - PRIME (WITH MTF/ CLINIC PCM) |
| | IF SOURCE OF HEALTH CARE DATA IS AN FI | | |
| | **THEN** ENROLLMENT STATUS MUST = | F | FI STANDARD PROGRAM |
| | | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | | E | MANAGED CARE SUPPORT - TRICARE -TIDEWATER PRIME |
| | | G | MANAGED CARE SUPPORT-TRICARE-TIDEWATER EXTRA |
| | | H | MANAGED CARE SUPPORT - HOMESTEAD, ENROLLED PATIENT |
| | | I | MANAGED CARE SUPPORT - HOMESTEAD, NON-ENROLLED PATIENT, NETWORK PROVIDER |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA **OR** |
| | | R | TRICARE EXTRA - NORTH CAROLINA |
| | IF SOURCE OF HEALTH CARE DATA IS NEW ORLEANS DEMONSTRATION | | |
| | **THEN** ENROLLMENT STATUS MUST BE = | O | NEW ORLEANS PRIME **OR** |
| **1 PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE** | | | |

| ELEMENT NAME: | ENROLLMENT STATUS (2-105) (CONTINUED) | | |
|---|---|---|---|
| | | P | NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM **OR** |
| | | Q | NEW ORLEANS COORDINATED CARE STANDARD PROGRAM **OR** |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD **OR** |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA |
| | IF SOURCE OF HEALTH CARE DATA IS MANAGED CARE SUPPORT | | |
| | **THEN** ENROLLMENT STATUS MUST = | K | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, ENROLLED PATIENT **OR** |
| | | L | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, NON- ENROLLED PATIENT, NETWORK PROVIDER **OR** |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM **OR** |
| | | O | NEW ORLEANS PRIME **OR** |
| | | P | NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM **OR** |
| | | Q | NEW ORLEANS COORDINATED CARE STANDARD PROGRAM **OR** |
| | | T | MANAGED CARE SUPPORT - STANDARD PROGRAM **OR** |
| | | U | MANAGED CARE SUPPORT - PRIME, CIVILIAN PCM **OR** |
| | | V | MANAGED CARE SUPPORT - EXTRA **OR** |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD **OR** |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM EXTRA **OR** |
| | | R | TRICARE EXTRA - NORTH CAROLINA **OR** |
| | | W | ACTIVE DUTY - USA **OR** |
| | | X | ACTIVE DUTY - EUROPE **OR** |
| | | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM **OR** |
| | | BB | TRICARE SENIOR PRIME **OR** |
| | | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD **OR** |
| | | PS | TRICARE SENIOR PHARMACY **OR** |
| | | SR | SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE **OR** |

[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**

| ELEMENT NAME: | ENROLLMENT STATUS (2-105) (CONTINUED) | | |
|---|---|---|---|
| | | SN | SUPPLMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE **OR** |
| | | SO | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE **OR** |
| | | ST | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE **OR** |
| | | TS | TRICARE SENIOR SUPPLEMENT |
| 2-105-04R | IF PROVIDER CONTRACT AFFILIATION CODE = | 1 | CONTRACTED |
| | **THEN** ENROLLMENT STATUS MUST NOT = | S | CRI STANDARD PROGRAM FOUNDATION HEALTH PLAN |
| | IF PROVIDER CONTRACT AFFILIATION CODE = | 2 | NOT CONTRACTED |
| | **THEN** ENROLLMENT STATUS MUST NOT = | N | NON-PRIME |
| 2-105-05R | IF ENROLLMENT STATUS MUST BE = | A | FOUNDATION HEALTH PLAN **OR** |
| | | B | PARTNERS HEALTH PLAN **OR** |
| | | C | QUEENS HEALTH PLAN **OR** |
| | | N | NON-PRIME |
| | **THEN** PRICING CODE IN FIRST DETAIL OCCURRENCE IS '9'. | | |
| 2-105-06R | IF ENROLLMENT STATUS = | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) STANDARD **OR** |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) EXTRA |
| | **THEN** PROGRAM INDICATOR MUST NOT = | H | PROGRAM FOR PERSONS WITH DISABILITIES |
| 2-105-07R | IF ENROLLMENT STATUS = | W | TPR ACTIVE DUTY - USA **OR** |
| | | X | ACTIVE DUTY - EUROPE |
| | **THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | AD | ACTIVE DUTY **OR** |
| | | GU | ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REPORT: NOT-AT-RISK PAYMENT BY CONTRACTOR |
| 2-105-08R | IF ENROLLMENT STATUS = | BB | TRICARE SENIOR PRIME |
| | **THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | MS | TRICARE SENIOR PRIME (NETWORK) **OR** |
| | | MN | TRICARE SENIOR PRIME (NON-NETWORK) |

[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**

| ELEMENT NAME: | ENROLLMENT STATUS (2-105) (CONTINUED) | | |
|---|---|---|---|
| 2-105-09R | IF ENROLLMENT STATUS = | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM |
| | THEN ADMISSION DATE MUST BE > 10/01/1997 | | |
| 2-105-10R | IF ENROLLMENT STATUS = | 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 FOR TRICARE ELIGIBLE |
| | **THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | AN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE |
| | | AR | SUPPLEMENTAL HEALTH CARE PROGRAM - MTF-REFERRED CARE |
| | | CE | SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM |
| | | SC | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE |
| | | SE | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE |
| 2-105-11R | IF ENROLLMENT STATUS = | TS | TRICARE SENIOR SUPPLEMENT |
| | **THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | SN | TRICARE SENIOR SUPPLEMENT (NON-NETWORK) **OR** |
| | | SS | TRICARE SENIOR SUPPLEMENT (NETWORK) |
| 2-105-12R | IF ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| | **THEN** PROGRAM INDICATOR MUST = | D | DRUG |
| | **OR** ALL OCCURRENCES OF TYPE OF SERVICE SECOND BYTE MUST = | 9 | OTHER MEDICAL SERVICES & SUPPLIES **OR** |
| | | 1 | MEDICAL CARE |
| | **OR** DENIAL REASON CODE ≠ BLANK | | |
| 2-105-13R | IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| | **AND** CLAIM FORM TYPE = | I | ELECTRONIC DRUG CLAIM SUBMISSION |
| | THEN NAS NUMBER (NDC CODE) MUST NOT BE BLANK. | | |

[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**

## ELEMENT NAME:    ENROLLMENT STATUS (2-105) (CONTINUED)

|  |  |  |  |
|---|---|---|---|
| | **UNLESS** ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | 1 | MEDICAID |
| **2-105-14R** | IF ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| | **THEN** EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001 | | |
| **2-105-15R** | IF EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD |
| | **THEN** AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST = | FF | TRICARE FOR LIFE (FIRST PAYOR) **OR** |
| | | FS | TRICARE FOR LIFE (SECOND PAYOR) |
| **2-105-16R** | IF ENROLLMENT STATUS = | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD |
| | **THEN** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 | | |
| **2-105-17R** | IF ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY **OR** |
| | | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD |
| | **THEN** PATIENT'S DATE OF BIRTH MUST BE ≥ 64 YEARS AND 11 MONTHS[1] | | |

[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**

| Element Name: NAS Number (2-110) |
| --- |

| Validity Edits |
| --- |

| | |
| --- | --- |
| **2-110-01** | IF NAS NUMBER IS CODED |
| | POSITION 2 - 4 (MTF FACILITY #), MUST BE VALID (USER SUPPLIED USE MTF NUMBERS). |
| | POSITION 1 MUST BE ZERO. |
| | POSITION 5 - 8 (JULIAN DATE; FORMAT YDDD), 'Y' MUST BE 0 - 9, DDD MUST BE 001 - 366. |
| | POSITION 9 - 11 (SEQUENCE #), MUST BE NUMERIC AND NOT ZERO. |
| | **UNLESS** FIRST 4 DIGITS = '6501'<br>   **AND** PATIENT ZIP CODE IS BETWEEN 23000 - 23899 INCLUSIVE<br>      **THEN** BYPASS THIS EDIT |
| | **OR** POSITION 1-2 MUST BE '46' **OR** '47' AND POSITION 3-11 MUST BE ZEROS. |
| | IF NAS NUMBER IS NOT CODED, MUST BE BLANK-FILLED. |

| Relational Edits | | |
| --- | --- | --- |
| **Related To Element** | **Edited Element Relationship** | **Also Relates To Element(s)** |
| NAS EXCEPTION REASON | SEE BELOW | TYPE OF SERVICE, PATIENT ZIP CODE, SPONSOR BRANCH OF SERVICE, DENIAL REASON CODE, CARE BEGIN DATE, PROGRAM INDICATOR |
| TYPE OF SERVICE | SEE BELOW | |
| PATIENT ZIP CODE | SEE BELOW | CARE BEGIN DATE |

| Edited Element Relationship | | |
| --- | --- | --- |
| **NO ERROR** IF ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| **THEN** BYPASS BOTH THE VALIDITY AND RELATIONAL EDITS FOR NAS NUMBER | | |
| **NO ERROR** IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | R | MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR** |
| | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR** |
| | AN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE **OR** |
| | AR | SUPPLEMENTAL HEALTH CARE PROGRAM - REFERRED CARE **OR** |

[1] **FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.**
[2] **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2001 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.**

| ELEMENT NAME: | NAS NUMBER (2-110) (CONTINUED) | | |
|---|---|---|---|
| | | CE | SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR** |
| | | GU | ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT-AT-RISK PAYMENT BY CONTRACTOR. **OR** |
| | | MN | TRICARE SENIOR PRIME (NON-NETWORK) **OR** |
| | | MS | TRICARE SENIOR PRIME (NETWORK) **OR** |
| | | SC | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE **OR** |
| | | SE | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE **OR** |
| | | SM | SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY |
| | **OR** ENROLLMENT STATUS = | FE | TRICARE FOR LIFE - EXTRA **OR** |
| | | FS | TRICARE FOR LIFE - STANDARD |
| | **THEN** NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING. | | |
| **NO ERROR** | IF EARLIEST BEGIN DATE OF CARE ≥ 09/23/1996 | | |
| | **AND** ENROLLMENT STATUS = | E | MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME |
| | | H | MANAGED CARE SUPPORT - HOMESTEAD ENROLLED PATIENT |
| | | K | MANAGED CARE SUPPORT - CALIFORNIA/ HAWAII, TRICARE PRIME ENROLLED PATIENT |
| | | O | NEW ORLEANS PRIME |
| | | U | MANAGED CARE SUPPORT - PRIME, CIVILIAN PCM |
| | | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM |
| | **THEN** NO NAS IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING. | | |
| 2-110-02R | IF PATIENT ZIP CODE IS NOT IN A CATCHMENT AREA[1] NAS NUMBER MUST = BLANK | | |
| | **UNLESS** SPECIAL PROCESSING CODE = 'ST'. | | |
| 2-110-03R | IF NAS EXCEPTION REASON IS NOT BLANK NAS NUMBER MUST = BLANK. | | |
| 2-110-04R | IF EARLIEST BEGIN DATE OF CARE ≥ 09/23/1996 | | |
| | **AND** ENROLLMENT STATUS = | E | MANAGED CARE SUPPORT - TRICARE-TIDEWATER PRIME |
| | | O | NEW ORLEANS PRIME |

[1] **FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.**
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| ELEMENT NAME: | NAS NUMBER (2-110) (CONTINUED) | | |
|---|---|---|---|
| | | 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 NAS EXCEPTION REASON = BLANK | | |
| | **AND** TYPE OF SERVICE (FIRST BYTE) = 'I' **OR** 'M', | | |
| | **AND** PATIENT ZIP CODE IS IN A CATCHMENT AREA[1] | | |
| | NAS NUMBER MUST BE CODED | | |
| | **UNLESS** HEALTH CARE PLAN CODE = | 11 | MCS FORT BRAGG DEMO **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 **OR** |
| | SPONSOR STATUS = | T | NATO |
| | IN WHICH CASE NAS NUMBER MUST = BLANK. | | |
| 2-100-06R | IF SPECIAL PROCESSING FLAG = | I | BERGSTROM AIR FORCE BASE |
| | | J | LUKE/WILLIAMS AFB CATCHMENT AREA |
| | NAS NUMBER $\neq$ 46000000000 | | |
| 2-110-07R | IF NAS EXCEPTION REASON = BLANK | | |
| | **AND** ONE 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. | | |
| | **AND** TYPE OF SERVICE = | A C O N | FIRST BYTE |
| | **AND** PATIENT ZIP CODE IS IN A CATCHMENT AREA | | |
| | **AND** BEGIN DATE OF CARE > 11/01/1991 **AND** < 09/23/1996 | | |

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| ELEMENT NAME: | NAS Number (2-110) (Continued) | | |
|---|---|---|---|
| | NAS NUMBER MUST BE CODED | | |
| | **UNLESS** SPONSOR STATUS = | T | FOREIGN MILITARY **OR** |
| | HEALTH CARE PLAN CODE = | 11 | MCS FORT BRAGG DEMO **OR** |
| | ANY OCCURRENCE OF DENIAL REASON CODE = | 9 | NONAVAILABILITY 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 |
| | IN WHICH CASE NAS NUMBER MUST BE = BLANK | | |
| **2-110-09R** | (NATIONAL STSF) | | |
| | IF NAS EXCEPTION REASON = BLANK | | |
| | **AND** PATIENT ZIP CODE IS IN THE 48 CONTIGUOUS UNITED STATES AND THE DISTRICT OF COLUMBIA | | |
| | **AND** (PROCEDURE CODE[2] = 47133, 47135 **OR** 47136 [LIVER TRANSPLANT] **AND** BEGIN DATE OF CARE ($\geq$ 03/01/1997 **AND** $\leq$ 02/19/1998) **OR** $\geq$ 09/01/1999 | | |
| | **OR** (PROCEDURE CODE[2] = 38240 [ALLOGENEIC BONE MARROW TRANSPLANT] **AND** BEGIN DATE OF CARE $\geq$ 10/01/1997) | | |
| | **OR** (PROCEDURE CODE[2] = 50300, 50320, 50340, 50360, 50365, 50370, **OR** 50380 [KIDNEY TRANSPLANT] **AND** BEGIN DATE OF CARE $\geq$ 09/01/1999) | | |
| | **THEN** NAS NUMBER MUST BE CODED, | | |
| **2-110-11R** | NAS NUMBER MUST BE BLANK | | |
| | **WHEN** SPONSOR STATUS = | T | FOREIGN MILITARY |
| | **OR** ANY OCCURRENCE OF DENIAL REASON CODE = | 9 | NONAVAILABILITY STATEMENT NOT PROVIDED **OR** |
| | | 2 | INELIGIBLE CLAIMANT **OR** |
| | | A | DEERS **OR** |
| | | N | MULTIPLE DENIAL REASONS |
| | **OR** AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO | | |

[1]  **FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.**
[2]  **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2001 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.**

| ELEMENT NAME: | REASON FOR PAYMENT REDUCTION (2-113) |
|---|---|

### VALIDITY EDITS

**2-113-01**  MUST BE 'A', 'B', **OR** 'C'.

### RELATIONAL EDITS

| | RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|---|---|---|---|
| | ENROLLMENT STATUS | SEE BELOW | |
| | REASON FOR PAYMENT REDUCTION | SEE BELOW | |
| | NUMBER OF PAYMENT REDUCTION DAYS/SERVICES | SEE BELOW | |

### EDITED ELEMENT RELATIONSHIP

**2-113-02R**  IF AMOUNT OF PAYMENT REDUCTION IS NOT EQUAL TO ZERO AND NUMBER OF PAYMENT REDUCTION DAYS/SERVICES IS NOT EQUAL TO ZERO.
  REASON FOR PAYMENT REDUCTION MUST NOT BE BLANK.

**2-113-03R**  IF ENROLLMENT STATUS EQUALS 'T', 'U', 'V', 'Y', 'Z', 'AA', **OR** 'BB'
  REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', 'C', **OR** BLANK.
  **ELSE** REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', **OR** BLANK.


| ELEMENT NAME: | AMOUNT BILLED (2-115) |
|---|---|

### VALIDITY EDITS

**2-115-01**  MUST BE NUMERIC.

### RELATIONAL EDITS

| | RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|---|---|---|---|
| | TYPE OF SUBMISSION | SEE BELOW | FILING DATE |
| | PRINCIPAL TREATMENT DIAGNOSIS | SEE BELOW | TYPE OF SUBMISSION, SPECIAL PROCESSING CODE |
| | AMOUNT ALLOWED | SEE BELOW | SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE |
| | TOTAL CHARGES BY PROCEDURE CODE | SEE BELOW | |
| | PROGRAM INDICATOR | SEE BELOW | |

### EDITED ELEMENT RELATIONSHIP

**2-115-02R**  AMOUNT BILLED MUST BE > ZERO **WHEN**

| | | | |
|---|---|---|---|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION | |
| | D | COMPLETE DENIAL | |
| | R | RESUBMISSION OF ERROR REJECT | |
| | O | ZERO PAYMENT WITH 100% OHI/TPL | |

| ELEMENT NAME: | AMOUNT BILLED (2-115) (CONTINUED) | | |
|---|---|---|---|
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-115-03R | AMOUNT BILLED MUST = THE TOTAL OF ALL DETAIL TOTAL CHARGES BY PROCEDURE CODE. | | |
| 2-115-05R | AMOUNT BILLED MUST BE ≥ AMOUNT ALLOWED **WHEN** | | |
| | SPECIAL RATE CODE = | b | NO SPECIAL RATE |
| | | D | DISCOUNT RATE |
| | PRICING CODE IN FIRST DETAIL OCCURRENCE IS NOT 9 | | |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | D | COMPLETE DENIAL |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-115-06R | IF AMOUNT BILLED IS LESS THAN THE AMOUNT ALLOWED | | |
| | **THEN** NO OCCURRENCE OF TYPE OF SUBMISSION = | A | ADJUSTMENT TO HCSR DATA |
| | | B | ADJUSTMENT TO NON-HCSR DATA |
| | | C | COMPLETE CANCELATION OF HCSR DATA |
| | | E | COMPLETE CANCELLATION OF NON-HCSR DATA |
| | SPECIAL RATE CODE MUST BE = | R | AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | S | DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | **OR** PRICING CODE MUST BE = | C | AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | D | DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | E | AMBULATORY SURGERY-PAID AS BILLED |
| | | P | TRICARE CLAIMCHECK-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | Q | TRICARE CLAIMCHECK-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |

| ELEMENT NAME: | AMOUNT BILLED (2-115) (CONTINUED) |
|---|---|
| R | TRICARE CLAIMCHECK-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED |

WITH PROVIDER PARTICIPATION INDICATOR EQUAL 'Y'.

**UNLESS** TYPE OF SUBMISSION = 'A', 'C', 'B', **OR** 'E'

## ELEMENT NAME:  AMOUNT ALLOWED (2-120)

### VALIDITY EDITS

| 2-120-01 | MUST BE NUMERIC. |
|---|---|

### RELATIONAL EDITS

| | RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
|---|---|---|---|
| 2-115-05R | AMOUNT BILLED | | SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE |
| | TYPE OF SUBMISSION | SEE BELOW | AMOUNT PAID BY OHI/TPL, FILING DATE, PATIENT COINSURANCE, PATIENT COPAYMENT, AMOUNT APPLIED TOWARD DEDUCTIBLE |
| | DENIAL REASON CODE | SEE BELOW | TYPE OF SUBMISSION, FILING DATE |
| | AMOUNT ALLOWED BY PROCEDURE CODE | SEE BELOW | SPECIAL RATE CODE |

### EDITED ELEMENT RELATIONSHIP

| 2-120-02R | AMOUNT ALLOWED MUST BE ZERO **WHEN** TYPE OF SUBMISSION IS COMPLETE CONTRACTOR DENIAL (D). |
|---|---|
| 2-120-03R | AMOUNT ALLOWED MUST BE ZERO **WHEN** TYPE OF SUBMISSION IS COMPLETE CANCELLATION (C) WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE, **UNLESS** THE CANCELLED NET HCSR REPORTS AMOUNT PAID BY OHI **OR** AMOUNT OF TPL > ZERO, IN WHICH CASE AMOUNT ALLOWED MUST BE ZERO, AND (AMOUNT PAID BY OHI PLUS AMOUNT OF TPL PLUS COINSURANCE PLUS COPAYMENT) MUST BE ≥ AMOUNT ALLOWED. |
| 2-120-04R | AMOUNT ALLOWED MUST BE ZERO **WHEN** ALL DETAIL DENIAL REASON CODES CONTAIN DENIAL CODE VALUES AND |

| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
|---|---|---|
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL |
| **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

| ELEMENT NAME: | AMOUNT ALLOWED (2-120) (CONTINUED) | | |
|---|---|---|---|

| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
|---|---|---|---|
| | **ELSE** TYPE OF SUBMISSION = | B | ADJUSTMENT NON-HCSR DATA |
| | | E | CANCELLATION NON-HCSR DATA **OR** |
| | TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE OLDER THAN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | **THEN** AMOUNT ALLOWED MUST BE ≤ ZERO. | | |
| **2-120-06R** | IF AMOUNT ALLOWED IS GREATER THAN THE AMOUNT BILLED | | |
| | **THEN** NO OCCURRENCE OF TYPE OF SUBMISSION = | A | ADJUSTMENT TO HCSR DATA |
| | | B | ADJUSTMENT TO NON-HCSR DATA |
| | | C | COMPLETE CANCELLATION OF HCSR DATA |
| | | E | COMPLETE CANCELLATION OF NON-HCSR DATA |
| | SPECIAL RATE CODE MUST BE = | R | AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | S | DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | **OR** PRICING CODE MUST BE = | C | AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | D | DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | E | AMBULATORY SURGERY-PAID AS BILLED |
| | | P | TRICARE CLAIMCHECK-ADDED PROCEDURE, AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | Q | TRICARE CLAIMCHECK-ADDED PROCEDURE, DISCOUNTED AMBULATORY SURGERY-FACILITY PAYMENT RATE |
| | | R | TRICARE CLAIMCHECK-ADDED PROCEDURE, AMBULATORY SURGERY-PAID AS BILLED |
| | WITH PROVIDER PARTICIPATION INDICATOR EQUAL 'Y'. | | |
| | **UNLESS** TYPE OF SUBMISSION = 'A', 'C', 'B', **OR** 'E' | | |
| **2-120-07R** | AMOUNT ALLOWED MUST EQUAL THE TOTAL DETAIL OCCURRENCES OF AMOUNT ALLOWED BY PROCEDURE CODE (DOES NOT INCLUDE DENIED OCCURRENCES). | | |

| Element Name: | Amount Paid By Other Health Insurance (2-125) | | |
|---|---|---|---|
| **Validity Edits** | | | |
| 2-125-01 | MUST BE NUMERIC. | | |
| **Relational Edits** | | | |
| | **Related To Element** | **Edited Element Relationship** | **Also Relates To Element(s)** |
| | TYPE OF SUBMISSION | SEE BELOW | |
| | OVERRIDE CODE | SEE BELOW | |
| **Edited Element Relationship** | | | |
| 2-125-02R | AMOUNT PAID BY OTHER HEALTH INSURANCE MUST BE ≥ ZERO **WHEN** | | |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | D | COMPLETE DENIAL **OR** |
| | TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-125-03R | AMOUNT PAID BY OTHER HEALTH INSURANCE MUST EQUAL ZERO **WHEN**: | | |
| | ANY OCCURRENCE OF OVERRIDE CODE = | U | BENEFICIARY INDEMNIFICATION PAYMENT |

| Element Name: | Other Health Insurance Amount Allowed (2-127) | | |
|---|---|---|---|
| **Validity Edits** | | | |
| 2-127-01 | MUST BE NUMERIC. | | |
| **Relational Edits** | | | |
| | **Related To Element** | **Edited Element Relationship** | **Also Relates To Element(s)** |
| | NONE | | |

| ELEMENT NAME:   AMOUNT OF THIRD PARTY LIABILITY (2-130) | | |
|---|---|---|
| **VALIDITY EDITS** | | |
| 2-130-01 | MUST BE NUMERIC. | |
| **RELATIONAL EDITS** | | |
| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
| TYPE OF SUBMISSION | SEE BELOW | |
| OVERRIDE CODE | SEE BELOW | |
| **EDITED ELEMENT RELATIONSHIP** | | |

2-130-02R     AMOUNT OF THIRD PARTY LIABILITY MUST BE ≥ ZERO **WHEN**

| | | |
|---|---|---|
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF ERROR REJECT |
| | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | F | ADJUSTMENT NEW SUFFIX |
| | D | COMPLETE DENIAL **OR** |
| TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | C | COMPLETE CANCELLATION |

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.

2-130-03R     AMOUNT OF THIRD PARTY LIABILITY MUST EQUAL ZERO **WHEN**

| | | |
|---|---|---|
| ANY OCCURRENCE OF OVERRIDE CODE = | U | BENEFICIARY INDEMNIFICATION PAYMENT |

| ELEMENT NAME: | AMOUNT OF PAYMENT REDUCTION (2-133) | |
|---|---|---|
| **VALIDITY EDITS** | | |
| **2-133-01** | MUST BE NUMERIC. | |
| **RELATIONAL EDITS** | | |
| **RELATED TO ELEMENT** | **EDITED ELEMENT RELATIONSHIP** | **ALSO RELATES TO ELEMENT(S)** |
| REASON FOR PAYMENT REDUCTION | SEE BELOW | |
| AMOUNT OF PAYMENT REDUCTION | SEE BELOW | |
| TYPE OF SUBMISSION | SEE BELOW | |
| **EDITED ELEMENT RELATIONSHIP** | | |

**2-133-02R**     AMOUNT OF PAYMENT REDUCTION MUST BE GREATER THAN ZERO **WHEN**:

| REASON FOR PAYMENT REDUCTION = | A | MENTAL HEALTH PREAUTHORIZATION NOT OBTAINED TIMELY |
|---|---|---|
| | B | ADJUNCTIVE DENTAL CARE PREAUTHORIZATION NOT OBTAINED |
| | C | PROCEDURE/SERVICES IN TRICARE REGIONS CARE NOT PRE-AUTHORIZED |
| TYPE OF SUBMISSION = | A | ADJUSTMENT TO PRIOR HCSR DATA |
| | C | COMPLETE CANCELLATION OF PRIOR HCSR DATA |
| | I | INITIAL SUBMISSION |
| | R | RESUBMISSION OF REJECT |
| | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | F | ADJUSTMENT NEW SUFFIX |
| | G | ADDITIONAL DRG INTERIM BILLING |

| ELEMENT NAME:   PATIENT COINSURANCE (2-140) | | |
|---|---|---|
| **VALIDITY EDITS** | | |

**2-140-01**     MUST BE NUMERIC.

| **RELATIONAL EDITS** | | |
|---|---|---|
| RELATED TO ELEMENT | EDITED ELEMENT RELATIONSHIP | ALSO RELATES TO ELEMENT(S) |
| TYPE OF SUBMISSION | SEE BELOW | FILING DATE, AMOUNT ALLOWED |
| SPECIAL RATE CODE | SEE BELOW | ENROLLMENT STATUS, PROGRAM INDICATOR, TYPE OF SUBMISSION, FILING DATE, AMOUNT ALLOWED, OVERRIDE CODE, SPECIAL PROCESSING CODE |
| SPECIAL PROCESSING CODE | SEE BELOW | TYPE OF SUBMISSION, FILING DATE |
| SPONSOR STATUS | SEE BELOW | PROGRAM INDICATOR, TYPE OF SERVICE, SPECIAL RATE CODE, ENROLLMENT STATUS, TYPE OF SUBMISSION, FILING DATE, PATIENT RELATIONSHIP TO SPONSOR, AMOUNT ALLOWED, AMOUNT APPLIED TOWARD DEDUCTIBLE, OVERRIDE CODE, SPECIAL PROCESSING CODE |
| SPONSOR STATUS | SEE BELOW | PROGRAM INDICATOR, TYPE OF SERVICE, SPECIAL RATE CODE, ENROLLMENT STATUS, TYPE OF SUBMISSION, FILING DATE, PATIENT RELATIONSHIP TO SPONSOR, AMOUNT ALLOWED, AMOUNT APPLIED TOWARD DEDUCTIBLE, OVERRIDE CODE, SPECIAL PROCESSING CODE |
| SPECIAL PROCESSING CODE | SEE BELOW | SPONSOR STATUS, TYPE OF SERVICE, ENROLLMENT STATUS, TYPE OF SUBMISSION, FILING DATE |
| OVERRIDE CODE | SEE BELOW | SEE BELOW |
| **EDITED ELEMENT RELATIONSHIP** | | |

**NO ERROR**  IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001 **AND** < 10/01/2001

| **AND** PROGRAM INDICATOR = | D | DRUG |
|---|---|---|

**THEN** BYPASS THE RELATIONAL EDITS FOR PATIENT COINSURANCE

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| **NO ERROR** | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | T | MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) **AND** EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 **OR** |
| | | FS | TRICARE FOR LIFE (SECOND PAYOR) **OR** |
| | | MS | TRICARE SENIOR PRIME (NETWORK) **OR** |
| | | MN | TRICARE SENIOR PRIME (NON-NETWORK) |
| | **THEN** BYPASS ALL COINSURANCE RELATIONAL EDITING. | | |
| **NO ERROR** | IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | PS | TRICARE SENIOR PHARMACY |
| | **THEN** BYPASS ALL COINSURANCE RELATIONAL EDITING. | | |
| **NO ERROR** | IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | NE | OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM (RESERVIST CALLED TO ACTIVE DUTY UNDER EXECUTIVE ORDER 13223) |
| | **AND** ANY OCCURRENCE OF PRICING CODE = | W | PRICED OVER CMAC |
| | **THEN** BYPASS ALL COINSURANCE EDITING. | | |
| 2-140-02R | PATIENT COINSURANCE MUST BE ZERO **WHEN** | | |
| | TYPE OF SUBMISSION = | D | COMPLETE CONTRACTOR DENIAL |
| 2-140-03R | PATIENT COINSURANCE MUST BE ZERO **WHEN** | | |
| | TYPE OF SUBMISSION = | C | COMPLETE CANCELLATION WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRS STORED ON THE DATABASE |
| | **UNLESS** THE CANCELLED HCSR REPORTS AMOUNT ALLOWED > ZERO, IN WHICH CASE PATIENT COINSURANCE MUST BE ≥ ZERO. | | |
| 2-140-05R | PATIENT COINSURANCE MUST BE ≤ AMOUNT ALLOWED **WHEN** | | |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | | PATIENT COINSURANCE (2-140) (CONTINUED) | |
|---|---|---|---|
| | | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | SPECIAL RATE CODE = | D | DISCOUNT RATE AGREEMENT |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | | A | INTERNAL PARTNERSHIP |
| | | F | ARMY CAM DEMONSTRATIONS |
| | | G | ARMY CAM DEMONSTRATIONS |
| | | O | CAMCHAS |
| | | K | GEORGIA/FLORIDA PPO |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | | * | VA MEDICAL CENTER CLAIM |
| | | # | HOSPICE |
| 2-140-07R | PATIENT COINSURANCE MUST BE ZERO **WHEN**: | | |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | A | PARTNERSHIP PROGRAM (INTERNAL PROVIDERS WITH SIGNED AGREEMENTS) |
| | | S | RESOURCE SHARING |
| | | # | HOSPICE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | D | COMPLETE DENIAL |
| | TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | **ELSE** TYPE OF SUBMISSION = | B | ADJUSTMENT NON-HCSR DATA |
| | | E | CANCELLATION NON-HCSR DATA |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | COMPLETE CANCELLATION |
| | WITH FILING DATE OLDER THAN NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | **THEN** PATIENT COINSURANCE MUST BE ≤ ZERO. | | |
| 2-140-08R | • EDITS FOR FAMILY MEMBERS OF ACTIVE DUTY SPONSORS. | | |
| | PATIENT COINSURANCE MUST BE = ZERO | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PATIENT RELATIONSHIP TO SPONSOR ≠ | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

## ELEMENT NAME:   PATIENT COINSURANCE (2-140) (CONTINUED)

| | | |
|---|---|---|
| ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT |
| | K | EMERGENCY ROOM ADMISSION |
| | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT |
| | A | AMBULATORY SURGERY COST-SHARED AS INPATIENT |
| | P | PARTIAL PSYCHIATRIC HOSPITALIZATION CARE COST-SHARED AS INPATIENT |
| ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | Q | NEW ORLEANS STANDARD PROGRAM |
| | F | FI STANDARD PROGRAM |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | 6 | HOME HEALTH CARE |
| | F | ARMY CAM DEMONSTRATIONS |
| | G | ARMY CAM DEMONSTRATIONS |
| | K | GEORGIA/FLORIDA PPO |
| | H | CHARLESTON NAVAL HOSPITAL CATCHMENT AREA |
| | O | CAMCHAS |
| | A | INTERNAL PARTNERSHIP |
| | N | CHAMPUS SELECT |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | | * | VA MEDICAL CENTER CLAIM |
| | | # | HOSPICE |
| | | ! | NORTHERN REGION COORDINATED CARE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **ELSE** TYPE OF SUBMISSION = | B | ADJUSTMENT NON-HCSR DATA |
| | | E | CANCELLATION OF NON-HCSR DATA |
| | | A | ADJUSTMENT |
| | | C | CANCELLATION |
| | WITH FILING DATE OLDER THAN NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | **THEN** PATIENT COINSURANCE MUST BE ≤ ZERO. | | |
| 2-140-09R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **WHEN** | | |
| | SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PATIENT RELATIONSHIP TO SPONSOR ≠ | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |
| | | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM |
| | | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | SPECIAL RATE CODE ≠ | D | DISCOUNT RATE AGREEMENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | | A | INTERNAL PARTNERSHIP |
| | | F | ARMY CAM DEMONSTRATIONS |
| | | G | ARMY CAM DEMONSTRATIONS |
| | | O | CAMCHAS |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

## ELEMENT NAME:    PATIENT COINSURANCE (2-140) (CONTINUED)

| | | | |
|---|---|---|---|
| | | H | CHARLESTON NAVAL HOSPITAL CATCHMENT AREA |
| | | K | GEORGIA/FLORIDA PPO |
| | | N | CHAMPUS SELECT |
| | | 6 | HOME HEALTH CARE |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | | * | VA MEDICAL CENTER CLAIM |
| | | # | HOSPICE |
| | | ! | NORTHERN REGION COORDINATED CARE |

**2-140-10R** • EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS (**OR** FORMER SPOUSE).

PATIENT COINSURANCE MUST BE 25% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED

| | | | |
|---|---|---|---|
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |

[1]  SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | F | FI STANDARD PROGRAM | |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM | |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM | |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD | |
| ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT | |
| | K | EMERGENCY ROOM ADMISSION | |
| | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT | |
| | P | PARTIAL PSYCHIATRIC HOSPITALIZATION CARE COST-SHARED AS INPATIENT | |
| SPECIAL RATE CODE = | b̸ | NO SPECIAL RATE | |
| | A | DRG 4% DISCOUNT | |
| | B | DRG 3% DISCOUNT | |
| | C | DRG 2% DISCOUNT | |
| | E | DRG 1% DISCOUNT | |
| | F | DRG NO DISCOUNT | |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS | |
| | U | BENEFICIARY INDEMNIFICATION PAYMENT | |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM | |
| | A | INTERNAL PARTNERSHIP | |
| | 6 | HOME HEALTH CARE | |
| | F | ARMY CAM DEMONSTRATIONS | |
| | G | ARMY CAM DEMONSTRATIONS | |
| | H | CHARLESTON NAVAL HOSPITAL CATCHMENT AREA | |
| | O | CAMCHAS | |
| | K | GEORGIA/FLORIDA PPO | |
| | N | CHAMPUS SELECT | |
| | R | MEDICARE/TRICARE DUAL ENTITLEMENT | |
| | S | RESOURCE SHARING | |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | U | MEDICARE PHARMACY |
| | | * | VA MEDICAL CENTER CLAIM |
| | | # | HOSPICE |
| | | ! | NORTHERN REGION COORDINATED CARE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-11R | PATIENT COINSURANCE MUST BE 25% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **WHEN** | | |
| | SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | Q | NEW ORLEANS STANDARD PROGRAM | |
| | F | FI STANDARD PROGRAM | |
| | D | MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD PROGRAM | |
| | T | MANAGED CARE SUPPORT - STANDARD PROGRAM | |
| | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD | |
| ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT | |
| | A | AMBULATORY SURGERY, COST-SHARED AS INPATIENT | |
| SPECIAL RATE CODE ≠ | D | DISCOUNT RATE AGREEMENT | |
| NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS | |
| | U | BENEFICIARY INDEMNIFICATION PAYMENT | |
| NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM | |
| | A | INTERNAL PARTNERSHIP | |
| | F | ARMY CAM DEMONSTRATIONS | |
| | G | ARMY CAM DEMONSTRATIONS | |
| | H | CHARLESTON NAVAL HOSPITAL CATCHMENT AREA | |
| | O | CAMCHAS | |
| | K | GEORGIA/FLORIDA PPO | |
| | N | CHAMPUS SELECT | |
| | 6 | HOME HEALTH CARE | |
| | S | RESOURCE SHARING | |
| | U | MEDICARE PHARMACY | |
| | * | VA MEDICAL CENTER CLAIM | |
| | # | HOSPICE | |
| | ! | NORTHERN REGION COORDINATED CARE | |
| TYPE OF SUBMISSION = | I | INITIAL SUBMISSION | |
| | R | RESUBMISSION OF ERROR REJECT | |
| | O | ZERO PAYMENT WITH 100% OHI/TPL | |
| | F | ADJUSTMENT NEW SUFFIX | |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-12R | PATIENT COINSURANCE MUST BE 25% (ALLOW 1$^\text{c}$ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **OR** 25% (ALLOW 1$^\text{c}$ ROUNDING ERROR) OF AMOUNT BILLED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **WHEN** | | |
| | SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III FUTURE RESERVE RETIREE |
| | PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | SPECIAL PROCESSING CODE = | ? | AMBULATORY SURGERY FACILITY CHARGE |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | J | MANAGED CARE SUPPORT - HOMESTEAD STANDARD PROGRAM |
| | | M | MANAGED CARE SUPPORT - CALIFORNIA/HAWAII STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |
| | | D | TRICARE BASIC STANDARD PROGRAM |
| | | T | MANAGED CARE SUPPORT - STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED) | | | |
|---|---|---|---|
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | A | AMBULATORY SURGERY, COST-SHARED AS INPATIENT |
| | SPECIAL RATE CODE = | R | AMBULATORY SURGERY FACILITY PAYMENT RATE |
| | | S | DISCOUNTED AMBULATORY SURGERY FACILITY PAYMENT RATE |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | D | DENIAL |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-14R | • EDITS FOR TRICARE PRIME - POINT OF SERVICE PROGRAM. | | |
| | PATIENT COINSURANCE MUST BE 50% (ALLOW 1$^\text{¢}$ ROUNDING ERROR) OF AMOUNT ALLOWED **AND** | | |
| | PATIENT COPAYMENT MUST BE ZERO | | |
| | **WHEN** ENROLLMENT STATUS = | U | MANAGED CARE SUPPORT - PRIME |
| | | Z | MANAGED CARE SUPPORT - PRIME (WITH MTF/ CLINIC PCM) |
| | **AND** SPECIAL PROCESSING CODE = | PO | TRICARE PRIME - POINT OF SERVICE |
| 2-140-15R | • EDIT FOR ARMY CAM DEMONSTRATIONS/TRICARE, FAMILY MEMBERS OF ACTIVE DUTY SPONSOR. | | |
| | PATIENT COINSURANCE MUST BE 15% (ALLOW 1$^\text{¢}$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PATIENT RELATIONSHIP TO SPONSOR ≠ | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | F G | ARMY CAM DEMONSTRATIONS |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | | PATIENT COINSURANCE (2-140) (CONTINUED) | |
|---|---|---|---|
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| 2-140-16R | • EDIT FOR ARMY CAM DEMONSTRATIONS, RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS (**OR** FORMER SPOUSE). | | |
| | PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT |
| | | K | EMERGENCY ROOM ADMISSION |
| | | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | F | ARMY CAM DEMONSTRATIONS |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | G | ARMY CAM DEMONSTRATIONS |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-17R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1$^{\text{c}}$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **WHEN** | | |
| | SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | ENROLLMENT STATUS = | S | CRI STANDARD PROGRAM |
| | | Q | NEW ORLEANS STANDARD PROGRAM |
| | | F | FI STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | | A | AMBULATORY SURGERY, COST-SHARED AS INPATIENT |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | F | ARMY CAM DEMONSTRATIONS |
| | | G | ARMY CAM DEMONSTRATIONS |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED >ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-18R | • EDIT FOR GEORGIA/FLORIDA PPO, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS. | | |
| | PATIENT COINSURANCE MUST BE 15% (ALLOW 1¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PATIENT RELATIONSHIP TO SPONSOR ≠ | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | K | GEORGIA/FLORIDA PPO |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > 0 |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASROPHIC LOSS |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| 2-140-19R | • EDIT FOR GEORGIA/FLORIDA PPO, RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS (**OR** FORMER SPOUSE). | | |
| | PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT |
| | | K | EMERGENCY ROOM ADMISSION |
| | | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | K | GEORGIA/FLORIDA PPO |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | A | INTERNAL PARTNERSHIP |
| | | S | RESOURCE SHARING |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-20R | PATIENT COINSURANCE MUST BE 20% (ALLOW $1^c$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | PATIENT RELATIONSHIP TO SPONSOR = | T | FORMER SPOUSE |
| | PROGRAM INDICATOR = | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | | A | AMBULATORY SURGERY, COST-SHARED AS INPATIENT |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | K | GEORGIA/FLORIDA PPO |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED) | | | |
|---|---|---|---|
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-21R | PATIENT COINSURANCE MUST EQUAL ZERO **WHEN** | | |
| | ANY OCCURRENCE OF OVERRIDE CODE = | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| 2-140-22R | • EDIT FOR AIR FORCE CAM DEMONSTRATION PRIMARY/PREVENTIVE CARE SERVICES | | |
| | PATIENT COINSURANCE MUST = ZERO | | |
| | **WHEN** SPECIAL PROCESSING CODE = | I | BERGSTROM AFB CATCHMENT AREA |
| | | J | LUKE/WILLIAMS AFB CATCHMENT AREA |
| | FIRST POSITION TYPE OF SERVICE[1] = | C | AIR FORCE CAM PRIMARY/PREVENTIVE CARE |
| 2-140-23R | • EDIT FOR CHAMPUS SELECT, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS | | |
| | PATIENT COINSURANCE MUST = ZERO | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT |
| | | K | EMERGENCY ROOM ADMISSION |
| | | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT |
| | | A | AMBULATORY SURGERY, COST-SHARED AS INPATIENT |
| | | P | OUTPATIENT PARTIAL PSYCHIATRIC HOSPITALIZATION COST-SHARED AS INPATIENT |
| | | N | OUTPATIENT COST-SHARED AS INPATIENT |
| | ENROLLMENT STATUS = | F | FI STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | N | CHAMPUS SELECT |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | 9 | FORT DRUM |
| | | 6 | HOME HEALTH CARE |
| | | A | INTERNAL PARTNERSHIP |
| | | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | S | RESOURCE SHARING |
| | | # | HOSPICE |
| | NO OCCURRENCE OF PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |

[1]  SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE | | |
| 2-140-24R | • EDIT FOR CHAMPUS SELECT, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS | | |
| | PATIENT COINSURANCE MUST BE 15% (ALLOW 1$^c$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | ENROLLMENT STATUS = | F | FI STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | N | CHAMPUS SELECT |
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | R | MEDICARE/TRICARE DUAL ENTITLEMENT |
| | | 6 | HOME HEALTH CARE |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED) | | | |
|---|---|---|---|
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | NO OCCURRENCE OF PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-25R | • EDITS FOR CHAMPUS SELECT, RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS. | | |
| | PATIENT COINSURANCE MUST BE 15% (ALLOW 1$^c$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** NO OCCURRENCE OF PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | F | FI STANDARD PROGRAM |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | I | INPATIENT |
| | | K | EMERGENCY ROOM ADMISSION |
| | | M | MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT |
| | | P | OUTPATIENT PARTIAL PSYCHIATRIC HOSPITALIZATION |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | N | CHAMPUS SELECT |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-26R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1$^c$ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANENTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | PROGRAM INDICATOR = | I | INSTITUTIONAL |
| | | N | NON-INSTITUTIONAL |
| | | D | DRUG PRIOR TO 10/01/2001 |
| | | T | DENTAL |
| | ENROLLMENT STATUS = | F | FI STANDARD PROGRAM |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM STANDARD |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] = | O | OUTPATIENT |
| | | A | AMBULATORY SURGERY |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | N | CHAMPUS SELECT |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | U | BENEFICIARY INDEMNIFICATION PAYMENT |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-27R | PATIENT COINSURANCE MUST BE 15% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | PATIENT RELATIONSHIP TO SPONSOR ≠ | T H R Y | FORMER SPOUSE |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ! | NORTHERN REGION COORDINATED CARE |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE = | O | OUTPATIENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-145-27R | PATIENT COPAYMENT MUST EQUAL ZERO | | |
| | **WHEN** SPONSOR STATUS = | A | ACTIVE DUTY |
| | | P | TAMP DESIGNEE |
| | | B | RECALLED ACTIVE DUTY |
| | | E | MEPCOM ENLISTEE |
| | | J | ACADEMY/OCS |
| | | N | NATIONAL GUARD |
| | | Q | PRISON/APPELLATE |

[1]  **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | V | RESERVE |
| | | T | FOREIGN MILITARY |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ! | NORTHERN REGION COORDINATED CARE |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | | V | ACTIVE DUTY FAMILY MEMBER SERVICES PROVIDED IN TRICARE EUROPE |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE = | O | OUTPATIENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-28R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANANTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ! | NORTHERN REGION COORDINATED CARE |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | NO OCCURRENCE OF SPECIAL PROCESSING CODE = | ? | AMBULATORY SURGERY |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE = | O | OUTPATIENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-145-28R | PATIENT COPAYMENT MUST EQUAL ZERO | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANANTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R | FORMER SPOUSE |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | ! | NORTHERN REGION COORDINATED CARE |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE = | O | OUTPATIENT |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-29R | PATIENT COINSURANCE MUST BE 20% (ALLOW 1$^c$ ROUNDING ERROR) OF AMOUNT ALLOWED | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANANTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | U | MEDICARE PHARMACY |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |
| | PROGRAM INDICATOR = | D | DRUG PRIOR TO 10/01/2001 |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-145-29R | PATIENT COPAYMENT MUST EQUAL ZERO | | |
| | **WHEN** SPONSOR STATUS = | F | FORMER MEMBER |
| | | I | PERMANANTLY DISABLED |
| | | O | TEMPORARILY DISABLED |
| | | R | RETIRED |
| | | H | MEDAL OF HONOR |
| | | K | DECEASED |
| | | D | 100% DISABLED |
| | | W | TITLE III RETIREE |
| | **OR** PATIENT RELATIONSHIP TO SPONSOR = | T H R Y | FORMER SPOUSE |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | U | MEDICARE PHARMACY |
| | PROGRAM INDICATOR = | D | DRUG PRIOR TO 10/01/2001 |
| | TYPE OF SUBMISSION = | I | INITIAL SUBMISSION |
| | | R | RESUBMISSION OF ERROR REJECT |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL |
| | | F | ADJUSTMENT NEW SUFFIX |
| | | G | ADDITIONAL DRG INTERIM BILLING |
| | **OR** TYPE OF SUBMISSION = | A | ADJUSTMENT |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO |
| | WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE. | | |
| 2-140-30R | AMOUNT OF COINSURANCE MUST BE EQUAL TO ZERO **AND** | | |
| 2-145-30R | AMOUNT OF COPAYMENT MUST BE GREATER THAN ZERO **WHEN** | | |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | * | VA MEDICAL CENTER CLAIM |
| | PROGRAM INDICATOR = | D | DRUGS |
| | NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPHIC LOSS |

[1] SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | TYPE OF SUBMISSION = | A | ADJUSTMENT **OR** |
| | | C | CANCELLATION WITH AMOUNT ALLOWED > ZERO **OR** |
| | | F | ADJUSTMENT NEW SUFFIX **OR** |
| | | G | ADDITIONAL DRG INTERIM BILLING **OR** |
| | | I | INITIAL SUBMISSION **OR** |
| | | O | ZERO PAYMENT WITH 100% OHI/TPL **OR** |
| | | R | RESUBMISSION OF REJECT |
| **2-140-31R** | AMOUNT OF COINSURANCE MUST BE EQUAL TO ZERO **WHEN** | | |
| | SPONSOR STATUS = ANY VALUE LISTED UNDER ACTIVE DUTY | | |
| | ANY OCCURRENCE OF SPECIAL PROCESSING CODE = | AD | ACTIVE DUTY **OR** |
| | | AN | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-MTF-REFERRED CARE **OR** |
| | | AR | SUPPLMENTAL HEALTH CARE PROGRAM - REFERRED CARE **OR** |
| | | CE | SUPPLEMENTAL HEALTH CARE PROGRAM - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR** |
| | | GU | ACTIVE DUTY SERVICE MEMBER ENROLLED IN TRICARE PRIME REMOTE: NOT-AT-RISK PAYMENT BY CONTRACTOR **OR** |
| | | SC | SUPPLEMENTAL HEALTH CARE PROGRAM - NON-TRICARE ELIGIBLE **OR** |
| | | SE | SUPPLEMENTAL HEALTH CARE PROGRAM - TRICARE ELIGIBLE **OR** |
| | | SM | SUPPLEMENTAL HEALTH CARE PROGRAM - EMERGENCY |
| **2-140-32R** | • NO COST-SHARES REQUIREMENT FOR ACTIVE DUTY FAMILY MEMBERS **EXCEPT** FOR PHARMACY CLAIMS | | |
| | IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | U | MANAGED CARE SUPPORT - PRIME, CIVILIAN PCM **OR** |
| | | W | TPR ACTIVE DUTY CLAIMS, USA **OR** |
| | | X | ACTIVE DUTY CLAIMS, EUROPE **OR** |
| | | Z | MANAGED CARE SUPPORT - PRIME, MTF/PCM |
| | **AND** SPONSOR STATUS = | A | ACTIVE DUTY |

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**

| ELEMENT NAME: | PATIENT COINSURANCE (2-140) (CONTINUED) | | |
|---|---|---|---|
| | **AND** PATIENT RELATIONSHIP TO SPONSOR = | b̸ | SPONSOR **OR** |
| | | C | CHILD **OR** |
| | | S | SPOUSE **OR** |
| | | V | STEPCHILD **OR** |
| | | W | WARD |
| | **AND** NO OCCURRENCE OF SPECIAL PROCESSING CODE = | PO | POINT OF SERVICE |
| | **THEN** PATIENT COINSURANCE MUST = ZERO | | |
| | **UNLESS** PROGRAM INDICATOR = | D | DRUG |
| | **THEN** BYPASS THIS EDIT | | |
| 2-140-33R | • EDIT FOR PHARMACY CLAIMS WHERE BENEFICIARY IS PRIME/EXTRA - NETWORK PHARMACY - NOT POINT OF SERVICE | | |
| | IF EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | V | MANAGED CARE SUPPORT - EXTRA **OR** |
| | | U | MANAGED CARE SUPPORT - PRIME **OR** |
| | | Z | MANAGED CARE SUPPORT - PRIME (WITH MTF/ CLINIC PCM) **OR** |
| | | AA | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) EXTRA |
| | **AND** PROGRAM INCIATOR = | D | DRUG |
| | **AND** NO OCCURRENCE OF SPECIAL PROCESSING CODE = | PO | TRICARE PRIME - POINT OF SERVICE |
| | **THEN** PATIENT COINSURANCE MUST = ZERO | | |
| 2-140-34R | • EDIT FOR PHARMACY CLAIMS WHERE BENEFICIARY IS STANDARD | | |
| | IF EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 | | |
| | **AND** ENROLLMENT STATUS = | T | MANAGED CARE SUPPORT - STANDARD **OR** |
| | | Y | CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) STANDARD |
| | **AND** PROGRAM INDICATOR = | D | DRUG |
| | **AND** NO OCCURRENCE OF OVERRIDE CODE = | K | CATASTROPIC LOSS PROTECTION LIMIT REACHED |
| | **THEN** PATIENT COPAYMENT MUST ≥ $9.00 | | |

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**ELEMENT NAME:    PATIENT COINSURANCE (2-140) (CONTINUED)**

**OR** PATIENT COINSURANCE MUST = 20% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED WHICH EVER IS GREATER

[1] **SEE TYPE OF SERVICE EDIT 2-325-02R FIRST POSITION OF TYPE OF SERVICE MUST BE CONSISTENT FOR ALL DETAIL OCCURRENCES. COST-SHARE EDITING CANNOT BE DONE IF THAT EDIT FAILS!**