CHAPTER 6
SECTION 2

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)[4]		
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			
NO ERROR	IF EARLIEST BEGIN DATE OF CARE IS OLDER THAN 6 YEARS **THEN** DO NOT CHECK PATIENT ZIP CODE **AND** BYPASS ALL PATIENT ZIP CODE EDITS		
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		

[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.**
[4] **IF EARLIEST BEGIN DATE IS > THAN 6 YEARS ZIP CODE TABLE WILL NOT BE CHECKED.**

ELEMENT NAME: PATIENT ZIP CODE (2-100) (CONTINUED)			
	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 ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY
	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.**
[4] **IF EARLIEST BEGIN DATE IS > THAN 6 YEARS ZIP CODE TABLE WILL NOT BE CHECKED.**

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	MCS - TRICARE-TIDEWATER PRIME
		H	MCS - HOMESTEAD, ENROLLED PATIENT
		K	MCS - CALIFORNIA/HAWAII, ENROLLED PATIENT
		U	MCS - PRIME, CIVILIAN PCM
		Z	MCS - 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	MCS - TRICARE-TIDEWATER PRIME
		G	MCS - TRICARE-TIDEWATER EXTRA
		R	TRICARE EXTRA - NORTH CAROLINA
		N	NON-PRIME

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

ELEMENT NAME: ENROLLMENT STATUS (2-105) (CONTINUED)		
	S	CRI STANDARD PROGRAM
	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM
	Y	CHCBP STANDARD
	AA	CHCBP EXTRA
	T	MCS - STANDARD PROGRAM
	U	MCS - PRIME
	V	MCS - EXTRA
	Z	MCS - PRIME (WITH MTF/CLINIC PCM)
IF SOURCE OF HEALTH CARE DATA IS AN FI		
THEN ENROLLMENT STATUS MUST =	F	FI STANDARD PROGRAM
	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM
	E	MCS - TRICARE -TIDEWATER PRIME
	G	MCS - TRICARE-TIDEWATER EXTRA
	H	MCS - HOMESTEAD, ENROLLED PATIENT
	I	MCS - HOMESTEAD, NON-ENROLLED PATIENT, NETWORK PROVIDER
	J	MCS - HOMESTEAD STANDARD PROGRAM
	Y	CHCBP STANDARD
	AA	CHCBP 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**
	P	NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM **OR**
	Q	NEW ORLEANS COORDINATED CARE STANDARD PROGRAM **OR**
	Y	CHCBP STANDARD **OR**
	AA	CHCBP EXTRA
IF SOURCE OF HEALTH CARE DATA IS MANAGED CARE SUPPORT		
THEN ENROLLMENT STATUS MUST =	K	MCS - CALIFORNIA/HAWAII, ENROLLED PATIENT **OR**
	L	MCS - CALIFORNIA/HAWAII, NON- ENROLLED PATIENT, NETWORK PROVIDER **OR**
	M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM **OR**

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

ELEMENT NAME: ENROLLMENT STATUS (2-105) (CONTINUED)			
		O	NEW ORLEANS PRIME **OR**
		P	NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM **OR**
		Q	NEW ORLEANS COORDINATED CARE STANDARD PROGRAM **OR**
		T	MCS - STANDARD PROGRAM **OR**
		U	MCS - PRIME, CIVILIAN PCM **OR**
		V	MCS - EXTRA **OR**
		Y	CHCBP STANDARD **OR**
		AA	CHCBP EXTRA **OR**
		R	TRICARE EXTRA - NORTH CAROLINA **OR**
		W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		Z	MCS - PRIME, MTF/PCM **OR**
		BB	TSP **OR**
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD **OR**
		PS	TRICARE SENIOR PHARMACY **OR**
		SR	SHCP - REFERRED CARE **OR**
		SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		ST	SHCP - TRICARE ELIGIBLE **OR**
		TS	TRICARE SENIOR SUPPLEMENT **OR**
		WA	FOREIGN REMOTE ADSM **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM **OR**
		WO	FOREIGN REMOTE ADFM **OR**
		XF	FOREIGN PRIME ADFM
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
[1] **PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE**			

ELEMENT NAME: ENROLLMENT STATUS (2-105) (CONTINUED)			
2-105-05R	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	CHCBP (CHCBP) STANDARD **OR**
		AA	CHCBP (CHCBP) EXTRA
	THEN PROGRAM INDICATOR MUST NOT =	H	PFPWD
2-105-07R	IF ENROLLMENT STATUS =	W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		WA	FOREIGN REMOTE ADSM
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AD	FOREIGN ADSM CLAIMS **OR**
		GU	ADSM ENROLLED IN TPR: 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)
2-105-09R	IF ENROLLMENT STATUS =	Z	MCS - PRIME, MTF/PCM
	THEN ADMISSION DATE MUST BE > 10/01/1997		
2-105-10R	IF ENROLLMENT STATUS =	SN	SHCP - NON-MTF-REFERRED CARE **OR**
		SO	SHCP - NON-TRICARE ELIGIBLE **OR**
		SR	SHCP - MTF-REFERRED CARE **OR**
		ST	SHCP FOR TRICARE ELIGIBLE
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	AN	SHCP - NON-MTF-REFERRED CARE
		AR	SHCP - MTF-REFERRED CARE
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM
		SC	SHCP - NON-TRICARE ELIGIBLE
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY

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

ELEMENT NAME: ENROLLMENT STATUS (2-105) (CONTINUED)			
2-105-11R	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.		
	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	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	FF	TFL (FIRST PAYOR) **OR**
		FS	TFL (SECOND PAYOR)
2-105-17R	IF ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY **OR**
		FE	TFL - EXTRA **OR**
		FS	TFL - STANDARD
	THEN PATIENT'S DATE OF BIRTH MUST BE ≥ 64 YEARS AND 11 MONTHS[1]		
2-105-18R	IF ENROLLMENT STATUS =	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN EARLIEST BEGIN DATE OF CARE IS ≥ 09/01/2002		

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

ELEMENT NAME: ENROLLMENT STATUS (2-105) (CONTINUED)			
	AND AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	GN	TPR ENROLLED ADFM - NON-NETWORK **OR**
		GT	TPR ENROLLED ADFM - NETWORK

[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'
	AND PATIENT ZIP CODE IS BETWEEN 23000 - 23899 INCLUSIVE
	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		

[1] **FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN 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.**
[4] **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)			
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	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		GU	ADSM ENROLLED IN TPR: NOT-AT-RISK PAYMENT BY CONTRACTOR **OR**
		MN	TRICARE SENIOR PRIME (NON-NETWORK) **OR**
		MS	TRICARE SENIOR PRIME (NETWORK) **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY **OR**
		W	MENTAL HEALTH WRAP AROUND
	THEN NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.		
NO ERROR	IF SPONSOR STATUS =	T	FOREIGN MILITARY (NATO)
	THEN NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.		
NO ERROR	IF ANY OCCURRENCE OF DENIAL REASON CODE =	9	NON-AVAILABILITY STATEMENT CANCELLED OR NOT PROVIDED **OR**
		2	INELIGIBLE CLAIMANT **OR**
		A	DEERS INELIGIBLE **OR**
		N	MULTIPLE DENIAL REASONS
NO ERROR	IF PROGRAM INDICATOR =	H	PFPWD
	THEN NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.		
NO ERROR	IF AMOUNT OF OTHER HEALTH INSURANCE PAID IS > ZERO		
	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	MCS - TRICARE-TIDEWATER PRIME **OR**

[1] FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN 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.
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ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)			
		H	MCS - HOMESTEAD ENROLLED PATIENT **OR**
		K	MCS - CALIFORNIA/HAWAII, TRICARE PRIME ENROLLED PATIENT **OR**
		O	NEW ORLEANS PRIME **OR**
		U	MCS - PRIME, CIVILIAN PCM **OR**
		W	TPR ADSM - USA **OR**
		Y	CHCBP STANDARD **OR**
		Z	MCS - PRIME, MTF/PCM **OR**
		FE	TRICARE FOR LIFE - EXTRA **OR**
		FS	TRICARE FOR LIFE - STANDARD **OR**
		AA	CHCBP EXTRA **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN NO NAS IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.		
NO ERROR	IF EARLIEST BEGIN DATE OF CARE IS OLDER THAN 6 YEARS **THEN** DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA		
2-110-02R	IF PATIENT ZIP CODE IS NOT IN AN MTF[3] CATCHMENT AREA[1]		
	THEN NAS NUMBER MUST = BLANK		
	UNLESS SPECIAL PROCESSING CODE = 'ST'[2] SPECIALIZED TREATMENT		
2-110-03R	IF NAS EXCEPTION REASON IS NOT BLANK		
	THEN NAS NUMBER MUST = BLANK.		
2-110-04R	IF NAS EXCEPTION REASON = BLANK		
	AND TYPE OF SERVICE (FIRST BYTE) = 'I'		
	AND PATIENT ZIP CODE IS IN AN MTF[3] CATCHMENT AREA[1]		
	AND BEGIN DATE OF CARE < 12/28/2003		
	THEN NAS NUMBER MUST BE CODED		
	UNLESS HEALTH CARE PLAN CODE =	11	MCS FORT BRAGG DEMO
	OR ANY OCCURRENCE OF OVERRIDE CODE =	Q	FORMER SPOUSE WITH PRE-EXISTING CONDITION
	THEN NAS NUMBER MUST = BLANK.		
2-110-06R	IF SPECIAL PROCESSING FLAG =	I	BERGSTROM AIR FORCE BASE
		J	LUKE/WILLIAMS AFB CATCHMENT AREA

[1] FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.
[2] STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
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ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)

	NAS NUMBER ≠ 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		
	THEN NAS NUMBER MUST BE CODED		
	UNLESS HEALTH CARE PLAN CODE =	11	MCS FORT BRAGG DEMO
	OR ANY OCCURRENCE OF OVERRIDE CODE =	Q	FORMER SPOUSE WITH PRE-EXISTING CONDITION
	THEN 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][4]		
	AND BEGIN DATE OF CARE (≥ 03/01/1997 **AND** ≤02/19/1998)		
	OR (PROCEDURE CODE[2] = 38240 [ALLOGENEIC BONE MARROW TRANSPLANT][4]		
	AND BEGIN DATE OF CARE ≥ 10/01/1997 **AND** ≤12/31/2002)		
	OR (PROCEDURE CODE[2] = 50300, 50320, 50340, 50360, 50365, 50370, **OR** 50380 [KIDNEY TRANSPLANT][4]		
	AND BEGIN DATE OF CARE ≥ 09/01/1999 **AND** ≤05/31/2003)		
	THEN NAS NUMBER MUST BE CODED		
2-110-10R	• MENTAL HEALTH CHECK		
	IF NAS EXCEPTION REASON = BLANK		
	AND TYPE OF SERVICE (FIRST POSITION =	1	INPATIENT
	AND PRINCIPAL TREATMENT DIAGNOSIS = 290 THROUGH 316		
	AND PATIENT ZIP CODE IS IN AN MTF[2] CATCHMENT AREA[1]		

[1] FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.
[2] STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
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ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)

THEN NAS NUMBER MUST BE CODED

UNLESS ANY OCCURRENCE OF
OVERRIDE CODE = C GOOD FAITH PAYMENT

[1] **FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN 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.**
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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.
THEN REASON FOR PAYMENT REDUCTION MUST NOT BE BLANK
UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 'CA' (CIVIL ACTION PAYMENT)

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

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

ELEMENT NAME: AMOUNT BILLED (2-115) (CONTINUED)			
		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'		

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.		

ELEMENT NAME: AMOUNT ALLOWED (2-120) (CONTINUED)			
2-120-04R	AMOUNT ALLOWED MUST BE ZERO **WHEN** ALL DETAIL DENIAL REASON CODES CONTAIN DENIAL CODE VALUES AND		
	AND TYPE OF SUBMISSION =	I	INITIAL SUBMISSION **OR**
		R	RESUBMISSION OF ERROR REJECT **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		F	ADJUSTMENT NEW SUFFIX **OR**
		D	COMPLETE DENIAL
	ELSE TYPE OF SUBMISSION =	B	ADJUSTMENT NON-HCSR DATA **OR**
		E	CANCELLATION NON-HCSR DATA
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	COMPLETE CANCELLATION
	WITH FILING DATE OLDER THAN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE		
	THEN AMOUNT ALLOWED MUST BE ≤ZERO.		
2-120-07R	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**:		

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE (2-125) (CONTINUED)			
	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 **OR**
		B	ADJUNCTIVE DENTAL CARE PREAUTHORIZATION NOT OBTAINED **OR**
		C	PROCEDURE/SERVICES IN TRICARE REGIONS CARE NOT PRE-AUTHORIZED
	TYPE OF SUBMISSION =	A	ADJUSTMENT TO PRIOR HCSR DATA **OR**
		C	COMPLETE CANCELLATION OF PRIOR HCSR DATA **OR**
		F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF REJECT
	UNLESS SPECIAL PROCESSING CODE = 'CA' (CIVIL ACTION PAYMENT)		

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

[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)			
	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		
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	TFL (SECOND PAYOR) **OR**
		MS	TRICARE SENIOR PRIME (NETWORK) **OR**
		MN	TRICARE SENIOR PRIME (NON-NETWORK)
	THEN BYPASS ALL COINSURANCE RELATIONAL EDITING.		

[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 EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001		
	AND ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY
	THEN BYPASS ALL COINSURANCE RELATIONAL 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	MCS - HOMESTEAD STANDARD PROGRAM
		M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM
		Q	NEW ORLEANS STANDARD PROGRAM
		F	FI STANDARD PROGRAM
		D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM
		T	MCS - STANDARD PROGRAM
		Y	CHCBP 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

[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 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
		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.		

[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)			
2-140-08R	• EDITS FOR FAMILY MEMBERS OF ACTIVE DUTY SPONSORS & EXCLUDING PHARMACY CLAIM		
	PATIENT COINSURANCE MUST BE = ZERO		
	WHEN SPONSOR STATUS =	A	ACTIVE DUTY **OR**
		B	RECALLED ACTIVE DUTY **OR**
		E	MEPCOM ENLISTEE **OR**
		J	ACADEMY/OCS **OR**
		N	NATIONAL GUARD **OR**
		P	TAMP DESIGNEE **OR**
		Q	PRISON/APPELLATE **OR**
		T	FOREIGN MILITARY **OR**
		V	RESERVE
	AND PATIENT RELATIONSHIP TO SPONSOR ≠	THRY	FORMER SPOUSE
	AND PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	AND ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] =	A	AMBULATORY SURGERY COST-SHARED AS INPATIENT **OR**
		I	INPATIENT **OR**
		K	EMERGENCY ROOM ADMISSION **OR**
		M	MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT **OR**
		P	PARTIAL PSYCHIATRIC HOSPITALIZATION CARE COST-SHARED AS INPATIENT
	ENROLLMENT STATUS =	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM **OR**
		F	FI STANDARD PROGRAM **OR**
		J	MCS - HOMESTEAD STANDARD PROGRAM **OR**
		M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM **OR**

[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 **OR**
		S	CRI STANDARD PROGRAM **OR**
		T	MCS - STANDARD PROGRAM **OR**
		Y	CHCBP STANDARD
	AND NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT **OR**
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9	FORT DRUM **OR**
		6	HOME HEALTH CARE **OR**
		A	INTERNAL PARTNERSHIP **OR**
		F	ARMY CAM DEMONSTRATIONS **OR**
		G	ARMY CAM DEMONSTRATIONS **OR**
		H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA **OR**
		K	GEORGIA/FLORIDA PPO **OR**
		N	CHAMPUS SELECT **OR**
		O	CAMCHAS **OR**
		R	MEDICARE/TRICARE DUAL ENTITLEMENT **OR**
		S	RESOURCE SHARING **OR**
		*	VA MEDICAL CENTER CLAIM **OR**
		#	HOSPICE **OR**
		!	NORTHERN REGION COORDINATED CARE
	AND TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF ERROR REJECT
	THEN PATIENT COINSURANCE MUST BE = ZERO		
	ELSE TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		B	ADJUSTMENT NON-HCSR DATA **OR**
		C	CANCELLATION **OR**
		E	CANCELLATION OF NON-HCSR DATA

[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 WITH FILING DATE OLDER THAN NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE		
	THEN PATIENT COINSURANCE MUST BE ≤ZERO.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
2-140-09R	• EDITS FOR STANDARD OUTPATIENT WITH NO DISCOUNT AGREEMENT EXCLUDING PHARMACY CLAIMS		
	PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE)		
	WHEN SPONSOR STATUS =	A	ACTIVE DUTY **OR**
		B	RECALLED ACTIVE DUTY **OR**
		E	MEPCOM ENLISTEE **OR**
		J	ACADEMY/OCS **OR**
		N	NATIONAL GUARD **OR**
		P	TAMP DESIGNEE **OR**
		Q	PRISON/APPELLATE **OR**
		T	FOREIGN MILITARY **OR**
		V	RESERVE
	OR PATIENT RELATIONSHIP TO SPONSOR ≠	T H R Y	FORMER SPOUSE
	AND PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	AND ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] =	O	OUTPATIENT
	AND ENROLLMENT STATUS =	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM **OR**
		F	FI STANDARD PROGRAM **OR**
		J	MCS - HOMESTEAD STANDARD PROGRAM **OR**
		M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM **OR**

[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 **OR**
		S	CRI STANDARD PROGRAM **OR**
		T	MCS - STANDARD PROGRAM **OR**
		Y	CHCBP STANDARD
	AND SPECIAL RATE CODE ≠	D	DISCOUNT RATE AGREEMENT
	AND TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF ERROR REJECT
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE		
	AND NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT **OR**
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HOME HEALTH CARE **OR**
		9	FORT DRUM **OR**
		A	INTERNAL PARTNERSHIP **OR**
		F	ARMY CAM DEMONSTRATIONS **OR**
		G	ARMY CAM DEMONSTRATIONS **OR**
		H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA **OR**
		K	GEORGIA/FLORIDA PPO **OR**
		N	CHAMPUS SELECT **OR**
		O	CAMCHAS **OR**
		R	MEDICARE/TRICARE DUAL ENTITLEMENT **OR**
		S	RESOURCE SHARING **OR**
		*	VA MEDICAL CENTER CLAIM **OR**
		#	HOSPICE **OR**

[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)			
		!	NORTHERN REGION COORDINATED CARE
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≤10/01/2001 **THEN** BYPASS THIS EDIT		
2-140-10R	• EDITS FOR RETIRED SPONSORS AND THEIR FAMILY MEMBERS, AND FAMILY MEMBERS OF DECEASED SPONSORS (**OR** FORMER SPOUSE) EXCLUDING PHARMACY CLAIMS.		
	PATIENT COINSURANCE MUST BE 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED		
	WHEN SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE
	OR PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	AND PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	AND ENROLLMENT STATUS =	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM **OR**
		F	FI STANDARD PROGRAM **OR**
		J	MCS - HOMESTEAD STANDARD PROGRAM **OR**
		M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM **OR**
		Q	NEW ORLEANS STANDARD PROGRAM **OR**
		S	CRI STANDARD PROGRAM **OR**
		T	MCS - STANDARD PROGRAM **OR**
		Y	CHCBP 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)			
	AND ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] =	I	INPATIENT **OR**
		K	EMERGENCY ROOM ADMISSION **OR**
		M	MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT **OR**
		P	PARTIAL PSYCHIATRIC HOSPITALIZATION CARE COST-SHARED AS INPATIENT
	AND SPECIAL RATE CODE =	~~b~~	NO SPECIAL RATE **OR**
		A	DRG 4% DISCOUNT **OR**
		B	DRG 3% DISCOUNT **OR**
		C	DRG 2% DISCOUNT **OR**
		E	DRG 1% DISCOUNT **OR**
		F	DRG NO DISCOUNT
	AND NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	6	HOME HEALTH CARE **OR**
		9	FORT DRUM **OR**
		A	INTERNAL PARTNERSHIP **OR**
		F	ARMY CAM DEMONSTRATIONS **OR**
		G	ARMY CAM DEMONSTRATIONS **OR**
		H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA **OR**
		K	GEORGIA/FLORIDA PPO **OR**
		N	CHAMPUS SELECT **OR**
		O	CAMCHAS **OR**
		R	MEDICARE/TRICARE DUAL ENTITLEMENT **OR**
		S	RESOURCE SHARING **OR**
		U	MEDICARE PHARMACY **OR**
		*	VA MEDICAL CENTER CLAIM **OR**
		#	HOSPICE **OR**
		!	NORTHERN REGION COORDINATED CARE
	AND TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**

[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)			
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF ERROR REJECT
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
2-140-11R	PATIENT COINSURANCE MUST BE 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **OR** 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT BILLED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE)		
	WHEN SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE
	OR PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	AND PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	AND ENROLLMENT STATUS =	D	MCS - TRICARE-TIDEWATER STANDARD PROGRAM **OR**
		F	FI STANDARD PROGRAM **OR**
		J	MCS - HOMESTEAD STANDARD PROGRAM **OR**

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

[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 **OR**
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
2-140-12R	PATIENT COINSURANCE MUST BE 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **OR** 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT BILLED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) **WHEN**		
	SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		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	MCS - HOMESTEAD STANDARD PROGRAM
		M	MCS - CALIFORNIA/HAWAII STANDARD PROGRAM
		Q	NEW ORLEANS STANDARD PROGRAM
		F	FI STANDARD PROGRAM
		D	TRICARE BASIC STANDARD PROGRAM
		T	MCS - STANDARD PROGRAM
		Y	CHCBP STANDARD

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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¢ ROUNDING ERROR) OF AMOUNT ALLOWED **AND**		
	PATIENT COPAYMENT MUST BE ZERO		
	WHEN ENROLLMENT STATUS =	U	MCS - PRIME **OR**
		Z	MCS - PRIME (WITH MTF/CLINIC PCM) **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	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¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) EXCLUDING PHARMACY CLAIMS		
	WHEN SPONSOR STATUS =	A	ACTIVE DUTY **OR**
		B	RECALLED ACTIVE DUTY **OR**
		E	MEPCOM ENLISTEE **OR**
		J	ACADEMY/OCS **OR**

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

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9	FORT DRUM **OR**
		A	INTERNAL PARTNERSHIP **OR**
		R	MEDICARE/TRICARE DUAL ENTITLEMENT **OR**
		S	RESOURCE SHARING
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
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 =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE
	PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	ENROLLMENT STATUS =	F	FI STANDARD PROGRAM **OR**
		Q	NEW ORLEANS STANDARD PROGRAM **OR**
		S	CRI STANDARD PROGRAM **OR**
		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] =	I	INPATIENT **OR**
		K	EMERGENCY ROOM ADMISSION **OR**
		M	MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT
	ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	F	ARMY CAM DEMONSTRATIONS **OR**
		G	ARMY CAM DEMONSTRATIONS
	NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT
	NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9	FORT DRUM **OR**
		A	INTERNAL PARTNERSHIP **OR**
		R	MEDICARE/TRICARE DUAL ENTITLEMENT **OR**
		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¢ 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

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

PATIENT RELATIONSHIP TO SPONSOR =	THRY	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	CHCBP 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

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
	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
		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	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	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

[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.		
		NO OCCURRENCE OF OVERRIDE CODE =	K	CATASROPHIC LOSS
			V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
			U	BENEFICIARY INDEMNIFICATION PAYMENT
		NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9	FORT DRUM
			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

[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)			
		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
		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¢ 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

[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	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
		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

[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
	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
		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	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9	FORT DRUM
		6	HOME HEALTH CARE
		A	INTERNAL PARTNERSHIP
		R	MEDICARE/TRICARE DUAL ENTITLEMENT

[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)			
		S	RESOURCE SHARING
		#	HOSPICE
	NO OCCURRENCE OF PATIENT RELATIONSHIP TO SPONSOR =	THRY	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		
2-140-24R	• EDIT FOR CHAMPUS SELECT, 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
		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	CHCBP STANDARD

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

	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
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	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¢ 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

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

	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
		Y	CHCBP 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 **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT **OR**
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF ERROR REJECT
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		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¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE)		

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
	WHEN SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE
	OR PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	AND PROGRAM INDICATOR =	D	DRUG **OR**
		I	INSTITUTIONAL **OR**
		N	NON-INSTITUTIONAL **OR**
		T	DENTAL
	AND ENROLLMENT STATUS =	F	FI STANDARD PROGRAM **OR**
		Y	CHCBP STANDARD
	AND ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE[1] =	A	AMBULATORY SURGERY **OR**
		O	OUTPATIENT
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	N	CHAMPUS SELECT
	AND NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS **OR**
		U	BENEFICIARY INDEMNIFICATION PAYMENT **OR**
		V	ADFM PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	AND TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**
		R	RESUBMISSION OF ERROR REJECT

[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 **OR**
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
2-140-27R	PATIENT COINSURANCE MUST BE 15% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED		
	WHEN SPONSOR STATUS =	A	ACTIVE DUTY **OR**
		B	RECALLED ACTIVE DUTY **OR**
		E	MEPCOM ENLISTEE **OR**
		J	ACADEMY/OCS **OR**
		N	NATIONAL GUARD **OR**
		P	TAMP DESIGNEE **OR**
		Q	PRISON/APPELLATE **OR**
		T	FOREIGN MILITARY **OR**
		V	RESERVE
	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 **OR**
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE =	O	OUTPATIENT
	TYPE OF SUBMISSION =	F	ADJUSTMENT NEW SUFFIX **OR**
		G	ADDITIONAL DRG INTERIM BILLING **OR**
		I	INITIAL SUBMISSION **OR**
		O	ZERO PAYMENT WITH 100% OHI/TPL **OR**

[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
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		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 **OR**
		B	RECALLED ACTIVE DUTY **OR**
		E	MEPCOM ENLISTEE **OR**
		J	ACADEMY/OCS **OR**
		N	NATIONAL GUARD **OR**
		P	TAMP DESIGNEE **OR**
		Q	PRISON/APPELLATE **OR**
		T	FOREIGN MILITARY **OR**
		V	RESERVE
	ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	!	NORTHERN REGION COORDINATED CARE
	NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS
		V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
	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.		

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

2-140-28R	PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ 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
	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

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
		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
		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 **OR**
		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¢ ROUNDING ERROR) OF AMOUNT ALLOWED		
	WHEN SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE

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ELEMENT NAME:	PATIENT COINSURANCE (2-140) (CONTINUED)		
	OR PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	MEDICARE PHARMACY
	AND NO OCCURRENCE OF OVERRIDE CODE =	K	CATASTROPHIC LOSS
	AND PROGRAM INDICATOR =	D	DRUG
	AND TYPE OF SUBMISSION =	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 ERROR REJECT
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
2-145-29R	PATIENT COPAYMENT MUST EQUAL ZERO		
	WHEN SPONSOR STATUS =	D	100% DISABLED **OR**
		F	FORMER MEMBER **OR**
		H	MEDAL OF HONOR **OR**
		I	PERMANENTLY DISABLED **OR**
		K	DECEASED **OR**
		O	TEMPORARILY DISABLED **OR**
		R	RETIRED **OR**
		W	TITLE III RETIREE

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
	OR PATIENT RELATIONSHIP TO SPONSOR =	T H R Y	FORMER SPOUSE
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	U	MEDICARE PHARMACY
	AND PROGRAM INDICATOR =	D	DRUG
	AND TYPE OF SUBMISSION =	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 ERROR REJECT
	OR TYPE OF SUBMISSION =	A	ADJUSTMENT **OR**
		C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
	AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.		
	UNLESS PROGRAM INDICATOR = 'D' (DRUG) **AND** EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 **THEN** BYPASS THIS EDIT		
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
	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**

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
		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	FOREIGN ADSM CLAIMS **OR**
		AN	SHCP - NON-MTF-REFERRED CARE **OR**
		AR	SHCP - REFERRED CARE **OR**
		CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM **OR**
		GU	ADSM ENROLLED IN TPR NOT-AT-RISK PAYMENT BY CONTRACTOR **OR**
		SC	SHCP - NON-TRICARE ELIGIBLE **OR**
		SE	SHCP - TRICARE ELIGIBLE **OR**
		SM	SHCP - EMERGENCY
2-140-32R	• AS OF 04/01/2001 - NO COST-SHARES ARE REQUIREMENT FOR ACTIVE DUTY FAMILY MEMBERS **EXCEPT** FOR PHARMACY & PFPWD CLAIMS. (THIS EDIT IS CHECKED FIRST PRIOR TO CHECKING ANY PATIENT COINSURANCE EDITS. IF THE BENEFICIARY IS PRIME AND THIS IS NOT A DRUG CLAIM, THEN THE ONLY PATIENT COINSURANCE EDITING REQUIRED IS TO MAKE SURE THAT THE PATIENT COINSURANCE IS ZERO).		
	IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001		
	AND ENROLLMENT STATUS =	U	MCS - PRIME, CIVILIAN PCM **OR**
		W	TPR ADSM - USA **OR**
		X	FOREIGN ADSM **OR**
		Z	MCS - PRIME, MTF/PCM **OR**
		WA	FOREIGN REMOTE ADSM **OR**
		WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM **OR**
		WO	FOREIGN REMOTE ADFM **OR**
		XF	FOREIGN PRIME ADFM
	AND SPONSOR STATUS =	A	ACTIVE DUTY **OR**
		B	RECALLED TO ACTIVE DUTY **OR**
		N	NATIONAL GUARD **OR**
		V	RESERVE
	AND PATIENT RELATIONSHIP TO SPONSOR =	~~b~~	SPONSOR **OR**

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)				
			C	CHILD **OR**
			S	SPOUSE **OR**
			V	STEPCHILD **OR**
			W	WARD
		AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	PO	POINT OF SERVICE
		AND NO PROGRAM INDICATOR CAN =	D	DRUG **OR**
			H	PROGRAM FOR PERSONS WITH DISABILITIES
		THEN PATIENT COINSURANCE MUST ≤ ZERO		
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	MCS - EXTRA **OR**
			U	MCS - PRIME **OR**
			Z	MCS - PRIME (WITH MTF/CLINIC PCM) **OR**
			AA	CHCBP EXTRA **OR**
			WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM
		AND PROGRAM INCIATOR =	D	DRUG
		AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =	PO	TRICARE PRIME - POINT OF SERVICE
		THEN PATIENT COINSURANCE MUST = ZERO		
1-140-35R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =		GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
		THEN EARLIEST BEGIN DATE OF CARE IS ≥ 10/30/2000 **AND** < 09/01/2002		
		AND SPONSOR STATUS MUST =	A	ACTIVE DUTY **OR**
			B	RECALLED ACTIVE DUTY **OR**
			N	NATIONAL GUARD **OR**
			V	RESERVE
		AND PATIENT RELATIONSHIP TO SPONSOR MUST =	C	CHILD **OR**
			S	SPOUSE **OR**

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ELEMENT NAME: PATIENT COINSURANCE (2-140) (CONTINUED)			
		V	STEP CHILD **OR**
		W	WARD
	AND NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PO	POINT OF SERVICE
	AND NO PROGRAM INDICATOR CAN =	H	PFPWD
	AND PATIENT COINSURANCE MUST = ZERO		

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