

## 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](#))<sup>4</sup>

#### 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<sup>3</sup> CATCHMENT AREA<sup>1</sup>**

**UNLESS NAS EXCEPTION  
REASON CODE =**

**O LIVING-RELATED DONOR LIVER TRANSPLANT**

**OR ANY OCCURRENCE OF  
SPECIAL PROCESSING  
CODE =**

**ST<sup>2</sup> SPECIALIZED TREATMENT FACILITY**

**THEN BYPASS THIS EDIT**

**2-100-04R** IF NAS NUMBER IS PRESENT

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

<sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.

<sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.

<sup>4</sup> **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<sup>3</sup> CATCHMENT AREA<sup>1</sup>

UNLESS ANY OCCURRENCE OF  
SPECIAL PROCESSING CODE = ST<sup>2</sup> SPECIALIZED TREATMENT FACILITY<sup>Y</sup>

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

<sup>1</sup> CATCHMENT AREA DETERMINATION IS BASED ON ADMISSION DATE.

<sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.

<sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.

<sup>4</sup> 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**

<b>2-105-02R</b> IF ANY OCCURRENCE OF OVERRIDE CODE =  ENROLLMENT STATUS MUST BE =	Z	ENHANCED BENEFIT
	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	<b>MCS</b> - TRICARE-TIDEWATER PRIME
	H	<b>MCS</b> - HOMESTEAD, ENROLLED PATIENT
	K	<b>MCS</b> - CALIFORNIA/HAWAII, ENROLLED PATIENT
U	<b>MCS</b> - PRIME, CIVILIAN PCM	
Z	<b>MCS</b> - PRIME, MTF/PCM	

**2-105-03R** IF SOURCE OF HEALTH CARE DATA (THIS IS A **DERIVED** ELEMENT) IS A CRI CONTRACTOR

<b>THEN ENROLLMENT STATUS MUST =</b>	A	FOUNDATION HEALTH PLAN
	B	PARTNERS HEALTH PLAN
	C	QUEENS HEALTH CARE PLAN
	E	<b>MCS</b> - TRICARE-TIDEWATER PRIME
	G	<b>MCS</b> - TRICARE-TIDEWATER EXTRA
	R	TRICARE EXTRA - NORTH CAROLINA
	N	NON-PRIME

<sup>1</sup> 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	<b>MCS</b> - TRICARE-TIDEWATER STANDARD PROGRAM
Y	<b>CHCBP</b> STANDARD
AA	<b>CHCBP</b> EXTRA
T	<b>MCS</b> - STANDARD PROGRAM
U	<b>MCS</b> - PRIME
V	<b>MCS</b> - EXTRA
Z	<b>MCS</b> - PRIME (WITH MTF/CLINIC PCM)

IF SOURCE OF HEALTH CARE DATA IS AN FI

**THEN ENROLLMENT STATUS  
 MUST =**

F	FI STANDARD PROGRAM
D	<b>MCS</b> - TRICARE-TIDEWATER STANDARD PROGRAM
E	<b>MCS</b> - TRICARE -TIDEWATER PRIME
G	<b>MCS</b> - TRICARE-TIDEWATER EXTRA
H	<b>MCS</b> - HOMESTEAD, ENROLLED PATIENT
I	<b>MCS</b> - HOMESTEAD, NON-ENROLLED PATIENT, NETWORK PROVIDER
J	<b>MCS</b> - HOMESTEAD STANDARD PROGRAM
Y	<b>CHCBP</b> STANDARD
AA	<b>CHCBP</b> EXTRA <b>OR</b>
R	TRICARE EXTRA - NORTH CAROLINA

IF SOURCE OF HEALTH CARE DATA IS NEW ORLEANS DEMONSTRATION

**THEN ENROLLMENT STATUS  
 MUST BE =**

O	NEW ORLEANS PRIME <b>OR</b>
P	NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM <b>OR</b>
Q	NEW ORLEANS COORDINATED CARE STANDARD PROGRAM <b>OR</b>
Y	<b>CHCBP</b> STANDARD <b>OR</b>
AA	<b>CHCBP</b> EXTRA

IF SOURCE OF HEALTH CARE DATA IS MANAGED CARE SUPPORT

**THEN ENROLLMENT STATUS  
 MUST =**

K	<b>MCS</b> - CALIFORNIA/HAWAII, ENROLLED PATIENT <b>OR</b>
L	<b>MCS</b> - CALIFORNIA/HAWAII, NON- ENROLLED PATIENT, NETWORK PROVIDER <b>OR</b>
M	<b>MCS</b> - CALIFORNIA/HAWAII STANDARD PROGRAM <b>OR</b>

<sup>1</sup> 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 <b>OR</b>
	P	NEW ORLEANS NOT ENROLLED, NOT STANDARD PROGRAM <b>OR</b>
	Q	NEW ORLEANS COORDINATED CARE STANDARD PROGRAM <b>OR</b>
	T	MCS - STANDARD PROGRAM <b>OR</b>
	U	MCS - PRIME, CIVILIAN PCM <b>OR</b>
	V	MCS - EXTRA <b>OR</b>
	Y	CHCBP STANDARD <b>OR</b>
	AA	CHCBP EXTRA <b>OR</b>
	R	TRICARE EXTRA - NORTH CAROLINA <b>OR</b>
	W	TPR ADSM - USA <b>OR</b>
	X	FOREIGN ADSM <b>OR</b>
	Z	MCS - PRIME, MTF/PCM <b>OR</b>
	BB	TSP <b>OR</b>
	FE	TFL - EXTRA <b>OR</b>
	FS	TFL - STANDARD <b>OR</b>
	PS	TRICARE SENIOR PHARMACY <b>OR</b>
	SR	SHCP - REFERRED CARE <b>OR</b>
	SN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	SO	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	ST	SHCP - TRICARE ELIGIBLE <b>OR</b>
	TS	TRICARE SENIOR SUPPLEMENT <b>OR</b>
	WA	FOREIGN REMOTE ADSM <b>OR</b>
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE ADSM <b>OR</b>
	WO	FOREIGN REMOTE ADFM <b>OR</b>
	XF	FOREIGN PRIME ADFM
<b>2-105-04R</b>	IF PROVIDER CONTRACT AFFILIATION CODE =	1 CONTRACTED
	<b>THEN ENROLLMENT STATUS MUST NOT =</b>	S CRI STANDARD PROGRAM FOUNDATION HEALTH PLAN
	IF PROVIDER CONTRACT AFFILIATION CODE =	2 NOT CONTRACTED
	<b>THEN ENROLLMENT STATUS MUST NOT =</b>	N NON-PRIME

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE

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

<b>2-105-05R</b>	IF ENROLLMENT STATUS MUST BE =	A FOUNDATION HEALTH PLAN <b>OR</b>
		B PARTNERS HEALTH PLAN <b>OR</b>
		C QUEENS HEALTH PLAN <b>OR</b>
		N NON-PRIME
	<b>THEN PRICING CODE IN FIRST DETAIL OCCURRENCE IS '9'.</b>	
<b>2-105-06R</b>	IF ENROLLMENT STATUS =	Y CHCBP (CHCBP) STANDARD <b>OR</b>
		AA CHCBP (CHCBP) EXTRA
	<b>THEN PROGRAM INDICATOR MUST NOT =</b>	H PFPWD
<b>2-105-07R</b>	IF ENROLLMENT STATUS =	W TPR <b>ADSM - USA OR</b>
		X <b>FOREIGN ADSM OR</b>
		<b>WA FOREIGN REMOTE ADSM</b>
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	AD <b>FOREIGN ADSM CLAIMS OR</b>
		GU ADSM ENROLLED IN TPR: NOT-AT-RISK PAYMENT BY CONTRACTOR
<b>2-105-08R</b>	IF ENROLLMENT STATUS =	BB TRICARE SENIOR PRIME
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	MS TRICARE SENIOR PRIME (NETWORK) <b>OR</b>
		MN TRICARE SENIOR PRIME (NON-NETWORK)
<b>2-105-09R</b>	IF ENROLLMENT STATUS =	Z MCS - PRIME, MTF/PCM
	<b>THEN ADMISSION DATE MUST BE &gt; 10/01/1997</b>	
<b>2-105-10R</b>	IF ENROLLMENT STATUS =	SN SHCP - NON-MTF-REFERRED CARE <b>OR</b>
		SO SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
		SR SHCP - MTF-REFERRED CARE <b>OR</b>
		ST SHCP FOR TRICARE ELIGIBLE
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	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 <b>OR</b>
		SM SHCP - EMERGENCY

<sup>1</sup> PATIENT AGE IS CALCULATED BASED ON DATE OF BIRTH AND EARLIEST BEGIN DATE OF CARE

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

<b>2-105-11R</b>	IF ENROLLMENT STATUS =	TS	TRICARE SENIOR SUPPLEMENT
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	SN	TRICARE SENIOR SUPPLEMENT (NON-NETWORK) <b>OR</b>
		SS	TRICARE SENIOR SUPPLEMENT (NETWORK)
<b>2-105-12R</b>	IF ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY
	<b>THEN PROGRAM INDICATOR MUST =</b>	D	DRUG
	<b>OR ALL OCCURRENCES OF TYPE OF SERVICE SECOND BYTE MUST =</b>	9	OTHER MEDICAL SERVICES & SUPPLIES <b>OR</b>
		1	MEDICAL CARE
	<b>OR DENIAL REASON CODE ≠ BLANK</b>		
<b>2-105-13R</b>	IF EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001		
	<b>AND ENROLLMENT STATUS =</b>	PS	TRICARE SENIOR PHARMACY
	<b>AND CLAIM FORM TYPE =</b>	I	ELECTRONIC DRUG CLAIM SUBMISSION
	<b>THEN NAS NUMBER (NDC CODE) MUST NOT BE BLANK.</b>		
	<b>UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	1	MEDICAID
<b>2-105-14R</b>	IF ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY
	<b>THEN EARLIEST BEGIN DATE OF CARE ≥ 04/01/2001</b>		
<b>2-105-15R</b>	IF EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001		
	<b>AND ENROLLMENT STATUS =</b>	FE	TFL - EXTRA <b>OR</b>
		FS	TFL - STANDARD
	<b>THEN AT LEAST ONE OCCURRENCE OF SPECIAL PROCESSING CODE MUST =</b>	FF	TFL (FIRST PAYOR) <b>OR</b>
		FS	TFL (SECOND PAYOR)
<b>2-105-17R</b>	IF ENROLLMENT STATUS =	PS	TRICARE SENIOR PHARMACY <b>OR</b>
		FE	TFL - EXTRA <b>OR</b>
		FS	TFL - STANDARD
	<b>THEN PATIENT'S DATE OF BIRTH MUST BE ≥ 64 YEARS AND 11 MONTHS<sup>1</sup></b>		
<b>2-105-18R</b>	IF ENROLLMENT STATUS =	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD SM
	<b>THEN EARLIEST BEGIN DATE OF CARE IS ≥ 09/01/2002</b>		

<sup>1</sup> 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

<sup>1</sup> 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

- <sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.
- <sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
- <sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.
- <sup>4</sup> **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2004 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.**



**ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)**

<b>NO ERROR</b> IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	R	MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR) <b>AND</b> EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
	T	MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) <b>AND</b> EARLIEST BEGIN DATE OF CARE ≥ 10/01/2001 <b>OR</b>
	AN	SHCP - NON-MTF-REFERRED CARE <b>OR</b>
	AR	SHCP - REFERRED CARE <b>OR</b>
	CE	SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM <b>OR</b>
	GU	ADSM ENROLLED IN TPR: NOT-AT-RISK PAYMENT BY CONTRACTOR <b>OR</b>
	MN	TRICARE SENIOR PRIME (NON-NETWORK) <b>OR</b>
	MS	TRICARE SENIOR PRIME (NETWORK) <b>OR</b>
	SC	SHCP - NON-TRICARE ELIGIBLE <b>OR</b>
	SE	SHCP - TRICARE ELIGIBLE <b>OR</b>
	SM	SHCP - EMERGENCY <b>OR</b>
	W	MENTAL HEALTH WRAP AROUND

**THEN NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.**

<b>NO ERROR</b> IF SPONSOR STATUS =	T	FOREIGN MILITARY (NATO)
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**THEN NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.**

<b>NO ERROR</b> IF ANY OCCURRENCE OF DENIAL REASON CODE =	9	NON-AVAILABILITY STATEMENT CANCELLED OR NOT PROVIDED <b>OR</b>
	2	INELIGIBLE CLAIMANT <b>OR</b>
	A	DEERS INELIGIBLE <b>OR</b>
	N	MULTIPLE DENIAL REASONS

<b>NO ERROR</b> IF PROGRAM INDICATOR =	H	PPFWD
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**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.**

<b>NO ERROR</b> IF EARLIEST BEGIN DATE OF CARE ≥ 09/23/1996 AND ENROLLMENT STATUS =	E	MCS - TRICARE-TIDEWATER PRIME <b>OR</b>
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<sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE  
BEGIN DATE.

<sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT  
AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.

<sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.

<sup>4</sup> **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2004 AMERICAN  
MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS  
APPLY TO GOVERNMENT USE.**

**ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)**

H	MCS - HOMESTEAD ENROLLED PATIENT <b>OR</b>
K	MCS - CALIFORNIA/HAWAII, TRICARE PRIME ENROLLED PATIENT <b>OR</b>
O	NEW ORLEANS PRIME <b>OR</b>
U	MCS - PRIME, CIVILIAN PCM <b>OR</b>
W	TPR ADSM - USA <b>OR</b>
Y	CHCBP STANDARD <b>OR</b>
Z	MCS - PRIME, MTF/PCM <b>OR</b>
FE	TRICARE FOR LIFE - EXTRA <b>OR</b>
FS	TRICARE FOR LIFE - STANDARD <b>OR</b>
AA	CHCBP EXTRA <b>OR</b>
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<sup>3</sup> CATCHMENT AREA<sup>1</sup>

**THEN NAS NUMBER MUST = BLANK**

**UNLESS** SPECIAL PROCESSING CODE = 'ST'<sup>2</sup> 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<sup>3</sup> CATCHMENT AREA<sup>1</sup>

**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

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

<sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.

<sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.

<sup>4</sup> **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2004 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.**

**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   FIRST BYTE  
  C  
  O  
  N

AND PATIENT ZIP CODE IS IN A CATCHMENT AREA

AND BEGIN DATE OF CARE &gt; 11/01/1991 AND &lt; 09/23/1996

THEN NAS NUMBER MUST BE CODED

UNLESS HEALTH CARE PLAN  
CODE =                               11   MCS FORT BRAGG DEMOOR 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<sup>2</sup> = 47133, 47135 OR 47136 [LIVER TRANSPLANT]<sup>4</sup>)

AND BEGIN DATE OF CARE (≥ 03/01/1997 AND ≤ 02/19/1998)

OR (PROCEDURE CODE<sup>2</sup> = 38240 [ALLOGENEIC BONE MARROW TRANSPLANT]<sup>4</sup>)

AND BEGIN DATE OF CARE ≥ 10/01/1997 AND ≤ 12/31/2002)

OR (PROCEDURE CODE<sup>2</sup> = 50300, 50320, 50340, 50360, 50365, 50370, OR 50380 [KIDNEY TRANSPLANT]<sup>4</sup>)

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<sup>2</sup> CATCHMENT AREA<sup>1</sup><sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.<sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.<sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.<sup>4</sup> CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2004 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED. APPLICABLE FARS/DFARS RESTRICTIONS APPLY TO GOVERNMENT USE.

**ELEMENT NAME: NAS NUMBER (2-110) (CONTINUED)**

THEN NAS NUMBER MUST BE CODED

UNLESS ANY OCCURRENCE OF  
OVERRIDE CODE = C GOOD FAITH PAYMENT

- <sup>1</sup> FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.
- <sup>2</sup> STSF IS A REGIONAL 200 MILES, 48 CONTIGUOUS STATES, OR MULTI-REGIONAL CATCHMENT AREA, DEPENDING ON TYPE OF STSF BEING PROCESSED.
- <sup>3</sup> MTF IS A 40 MILE CATCHMENT AREA.
- <sup>4</sup> **CPT CODES, DESCRIPTIONS AND OTHER DATA ONLY ARE COPYRIGHT 2004 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.  
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
<b>OR</b> TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> 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 =	<del>h</del>	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
<b>OR</b> TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		

**2-115-06R** IF AMOUNT BILLED IS LESS THAN THE AMOUNT ALLOWED

<b>THEN</b> 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

**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 HCSR<sub>s</sub> 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  $\leq$  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  $\geq$  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  $\geq$  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 <b>OR</b>
TYPE OF SUBMISSION =	A ADJUSTMENT
	C COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR<sub>s</sub> 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>OR</b>
	B	ADJUNCTIVE DENTAL CARE PREAUTHORIZATION NOT OBTAINED <b>OR</b>
	C	PROCEDURE/SERVICES IN TRICARE REGIONS CARE NOT PRE-AUTHORIZED
TYPE OF SUBMISSION =	A	ADJUSTMENT TO PRIOR HCSR DATA <b>OR</b>
	C	COMPLETE CANCELLATION OF PRIOR HCSR DATA <b>OR</b>
	F	ADJUSTMENT NEW SUFFIX <b>OR</b>
	I	INITIAL SUBMISSION <b>OR</b>
	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	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

<sup>1</sup> 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  $\geq$  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  $\geq$  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.

<sup>1</sup> 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  $\geq$  04/01/2001

AND ENROLLMENT STATUS =	PS TRICARE SENIOR PHARMACY
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**THEN** BYPASS ALL COINSURANCE RELATIONAL EDITING.**2-140-02R** PATIENT COINSURANCE MUST BE ZERO **WHEN**

TYPE OF SUBMISSION =	D COMPLETE CONTRACTOR DENIAL
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**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
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**UNLESS** THE CANCELLED HCSR REPORTS AMOUNT ALLOWED  $>$  ZERO, IN WHICH  
CASE PATIENT COINSURANCE MUST BE  $\geq$  ZERO.**2-140-05R** PATIENT COINSURANCE MUST BE  $\leq$  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
-------------------------

<b>OR</b> TYPE OF SUBMISSION =	A ADJUSTMENT
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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
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<sup>1</sup> 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
<b>2-140-07R</b>	<b>PATIENT COINSURANCE MUST BE ZERO WHEN:</b>	
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 HCSR <sub>s</sub> STORED ON THE DATABASE	B	ADJUSTMENT NON-HCSR DATA
ELSE TYPE OF SUBMISSION =	E	CANCELLATION NON-HCSR DATA
OR TYPE OF SUBMISSION =	A	ADJUSTMENT
	C	COMPLETE CANCELLATION
WITH FILING DATE OLDER THAN NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE	<b>THEN PATIENT COINSURANCE MUST BE ≤ ZERO.</b>	

<sup>1</sup> 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 ≠**

T FORMER SPOUSE

H

R

Y

**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<sup>1</sup> =**

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**

<sup>1</sup> 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 <b>OR</b>
	S	CRI STANDARD PROGRAM <b>OR</b>
	T	MCS - STANDARD PROGRAM <b>OR</b>
	Y	CHCBP STANDARD
<b>AND NO OCCURRENCE OF OVERRIDE CODE =</b>	K	CATASTROPHIC LOSS <b>OR</b>
	U	BENEFICIARY INDEMNIFICATION PAYMENT <b>OR</b>
	V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
<b>AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	9	FORT DRUM <b>OR</b>
	6	HOME HEALTH CARE <b>OR</b>
	A	INTERNAL PARTNERSHIP <b>OR</b>
	F	ARMY CAM DEMONSTRATIONS <b>OR</b>
	G	ARMY CAM DEMONSTRATIONS <b>OR</b>
	H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA <b>OR</b>
	K	GEORGIA/FLORIDA PPO <b>OR</b>
	N	CHAMPUS SELECT <b>OR</b>
	O	CAMCHAS <b>OR</b>
	R	MEDICARE/TRICARE DUAL ENTITLEMENT <b>OR</b>
	S	RESOURCE SHARING <b>OR</b>
	*	VA MEDICAL CENTER CLAIM <b>OR</b>
	#	HOSPICE <b>OR</b>
	!	NORTHERN REGION COORDINATED CARE
<b>AND TYPE OF SUBMISSION =</b>	F	ADJUSTMENT NEW SUFFIX <b>OR</b>
	I	INITIAL SUBMISSION <b>OR</b>
	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R	RESUBMISSION OF ERROR REJECT
<b>THEN PATIENT COINSURANCE MUST BE = ZERO</b>		
<b>ELSE TYPE OF SUBMISSION =</b>	A	ADJUSTMENT <b>OR</b>
	B	ADJUSTMENT NON-HCSR DATA <b>OR</b>
	C	CANCELLATION <b>OR</b>
	E	CANCELLATION OF NON-HCSR DATA

<sup>1</sup> 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 HCSR<sub>s</sub> 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 FORMER SPOUSE

H

R

Y

**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<sup>1</sup> =**

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

<sup>1</sup> 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 <b>OR</b>
	S	CRI STANDARD PROGRAM <b>OR</b>
	T	MCS - STANDARD PROGRAM <b>OR</b>
	Y	CHCBP STANDARD
<b>AND SPECIAL RATE CODE ≠</b>	D	DISCOUNT RATE AGREEMENT
<b>AND TYPE OF SUBMISSION =</b>	F	ADJUSTMENT NEW SUFFIX <b>OR</b>
	I	INITIAL SUBMISSION <b>OR</b>
	O	ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>
	R	RESUBMISSION OF ERROR REJECT
<b>OR TYPE OF SUBMISSION =</b>	A	ADJUSTMENT <b>OR</b>
	C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
<b>AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE</b>		
<b>AND NO OCCURRENCE OF OVERRIDE CODE =</b>	K	CATASTROPHIC LOSS <b>OR</b>
	U	BENEFICIARY INDEMNIFICATION PAYMENT <b>OR</b>
	V	ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
<b>AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	6	HOME HEALTH CARE <b>OR</b>
	9	FORT DRUM <b>OR</b>
	A	INTERNAL PARTNERSHIP <b>OR</b>
	F	ARMY CAM DEMONSTRATIONS <b>OR</b>
	G	ARMY CAM DEMONSTRATIONS <b>OR</b>
	H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA <b>OR</b>
	K	GEORGIA/FLORIDA PPO <b>OR</b>
	N	CHAMPUS SELECT <b>OR</b>
	O	CAMCHAS <b>OR</b>
	R	MEDICARE/TRICARE DUAL ENTITLEMENT <b>OR</b>
	S	RESOURCE SHARING <b>OR</b>
	*	VA MEDICAL CENTER CLAIM <b>OR</b>
	#	HOSPICE <b>OR</b>

<sup>1</sup> 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 FORMER SPOUSE

H

R

Y

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

<sup>1</sup> 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)**

<b>AND ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE<sup>1</sup> =</b>	I	INPATIENT <b>OR</b>
	K	EMERGENCY ROOM ADMISSION <b>OR</b>
	M	MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT <b>OR</b>
	P	PARTIAL PSYCHIATRIC HOSPITALIZATION CARE COST-SHARED AS INPATIENT
<b>AND SPECIAL RATE CODE =</b>	<del>B</del>	NO SPECIAL RATE <b>OR</b>
	A	DRG 4% DISCOUNT <b>OR</b>
	B	DRG 3% DISCOUNT <b>OR</b>
	C	DRG 2% DISCOUNT <b>OR</b>
	E	DRG 1% DISCOUNT <b>OR</b>
	F	DRG NO DISCOUNT
<b>AND NO OCCURRENCE OF OVERRIDE CODE =</b>	K	CATASTROPHIC LOSS <b>OR</b>
	U	BENEFICIARY INDEMNIFICATION PAYMENT
<b>AND NO OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	6	HOME HEALTH CARE <b>OR</b>
	9	FORT DRUM <b>OR</b>
	A	INTERNAL PARTNERSHIP <b>OR</b>
	F	ARMY CAM DEMONSTRATIONS <b>OR</b>
	G	ARMY CAM DEMONSTRATIONS <b>OR</b>
	H	CHARLESTON NAVAL HOSPITAL CATCHMENT AREA <b>OR</b>
	K	GEORGIA/FLORIDA PPO <b>OR</b>
	N	CHAMPUS SELECT <b>OR</b>
	O	CAMCHAS <b>OR</b>
	R	MEDICARE/TRICARE DUAL ENTITLEMENT <b>OR</b>
	S	RESOURCE SHARING <b>OR</b>
	U	MEDICARE PHARMACY <b>OR</b>
	*	VA MEDICAL CENTER CLAIM <b>OR</b>
#	HOSPICE <b>OR</b>	
!	NORTHERN REGION COORDINATED CARE	
<b>AND TYPE OF SUBMISSION =</b>	F	ADJUSTMENT NEW SUFFIX <b>OR</b>
	I	INITIAL SUBMISSION <b>OR</b>

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

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

<sup>1</sup> 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)**

<b>OR TYPE OF SUBMISSION =</b>	A ADJUSTMENT <b>OR</b>
	C CANCELLATION WITH AMOUNT ALLOWED > ZERO
<b>AND FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.</b>	
UNLESS PROGRAM INDICATOR = 'D' (DRUG) <b>AND EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 THEN BYPASS THIS EDIT</b>	
<b>2-140-12R</b>	PATIENT COINSURANCE MUST BE 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT ALLOWED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) <b>OR</b> 25% (ALLOW 1¢ ROUNDING ERROR) OF AMOUNT BILLED (MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) <b>WHEN</b>
<b>SPONSOR STATUS =</b>	D 100% DISABLED <b>OR</b>
	F FORMER MEMBER <b>OR</b>
	H MEDAL OF HONOR <b>OR</b>
	I PERMANENTLY DISABLED <b>OR</b>
	K DECEASED <b>OR</b>
	O TEMPORARILY DISABLED <b>OR</b>
	R RETIRED <b>OR</b>
	W TITLE III FUTURE RESERVE RETIREE
<b>PATIENT RELATIONSHIP TO SPONSOR =</b>	T FORMER SPOUSE H R Y
<b>PROGRAM INDICATOR =</b>	I INSTITUTIONAL
<b>SPECIAL PROCESSING CODE =</b>	? AMBULATORY SURGERY FACILITY CHARGE
<b>ENROLLMENT STATUS =</b>	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

<sup>1</sup> 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 <sup>1</sup> =	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 HCSR <sub>s</sub> STORED ON THE DATABASE.		
<b>2-140-14R</b>	• EDITS FOR TRICARE PRIME - POINT OF SERVICE PROGRAM.	
PATIENT COINSURANCE MUST BE 50% (ALLOW 1 <sup>c</sup> ROUNDING ERROR) OF AMOUNT ALLOWED AND		
PATIENT COPAYMENT MUST BE ZERO		
WHEN ENROLLMENT STATUS =	U	MCS - PRIME OR
	Z	MCS - PRIME (WITH MTF/CLINIC PGM) OR
	WF	TPR FOR ENROLLED ADFM RESIDING WITH A TPR ELIGIBLE AD <sub>SM</sub>
AND SPECIAL PROCESSING CODE =	PO	TRICARE PRIME - POINT OF SERVICE
<b>2-140-15R</b>	• EDIT FOR ARMY CAM DEMONSTRATIONS/TRICARE, FAMILY MEMBERS OF ACTIVE DUTY SPONSOR.	
PATIENT COINSURANCE MUST BE 15% (ALLOW 1 <sup>c</sup> 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

<sup>1</sup> 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)**

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

<sup>1</sup> 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	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		
<b>2-140-16R</b>	•	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	FORMER SPOUSE
	H	
	R	
	Y	
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

<sup>1</sup> 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 <sup>1</sup> =	I INPATIENT <b>OR</b>
	K EMERGENCY ROOM ADMISSION <b>OR</b>
	M MATERNITY OUTPATIENT, COST-SHARED AS INPATIENT
ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	F ARMY CAM DEMONSTRATIONS <b>OR</b>
	G ARMY CAM DEMONSTRATIONS
NO OCCURRENCE OF OVERRIDE CODE =	K CATASTROPHIC LOSS <b>OR</b>
	U BENEFICIARY INDEMNIFICATION PAYMENT
NO OCCURRENCE OF SPECIAL PROCESSING CODE =	9 FORT DRUM <b>OR</b>
	A INTERNAL PARTNERSHIP <b>OR</b>
	R MEDICARE/TRICARE DUAL ENTITLEMENT <b>OR</b>
	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
<b>OR</b> 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.	
<b>2-140-17R</b>	PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE) <b>WHEN</b>
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

<sup>1</sup> 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)**

PATIENT RELATIONSHIP TO SPONSOR =	T	FORMER SPOUSE
	H	
	R	
	Y	
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 <sup>1</sup> =	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

<sup>1</sup> 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.

**2-140-18R** • EDIT FOR GEORGIA/FLORIDA PPO, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS.

PATIENT COINSURANCE MUST BE 15% (ALLOW 1<sup>¢</sup> 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	FORMER SPOUSE
	H	
	R	
	Y	
PROGRAM INDICATOR =	I	INSTITUTIONAL
	N	NON-INSTITUTIONAL
	D	DRUG
	T	DENTAL
ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE <sup>1</sup> =	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

<sup>1</sup> 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 FORMER SPOUSE

H

R

Y

**PROGRAM INDICATOR =**

I INSTITUTIONAL

N NON-INSTITUTIONAL

D DRUG

T DENTAL

**ANY OCCURRENCE OF FIRST  
POSITION OF TYPE OF  
SERVICE<sup>1</sup> =**

I INPATIENT

K EMERGENCY ROOM ADMISSION

**<sup>1</sup> 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.		
<b>2-140-20R</b>	<b>PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE)</b>	
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 <sup>1</sup> =	O	OUTPATIENT

<sup>1</sup> 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 HCSR <sub>s</sub> STORED ON THE DATABASE.		
<b>2-140-21R</b>	<b>PATIENT COINSURANCE MUST EQUAL ZERO WHEN</b>	
ANY OCCURRENCE OF OVERRIDE CODE =	U	BENEFICIARY INDEMNIFICATION PAYMENT
<b>2-140-22R</b>	<ul style="list-style-type: none"> <li>EDIT FOR AIR FORCE CAM DEMONSTRATION PRIMARY/PREVENTIVE CARE SERVICES</li> </ul>	
PATIENT COINSURANCE MUST = ZERO		
WHEN SPECIAL PROCESSING CODE =	I	BERGSTROM AFB CATCHMENT AREA
	J	LUKE/WILLIAMS AFB CATCHMENT AREA
FIRST POSITION TYPE OF SERVICE <sup>1</sup> =	C	AIR FORCE CAM PRIMARY/PREVENTIVE CARE
<b>2-140-23R</b>	<ul style="list-style-type: none"> <li>EDIT FOR CHAMPUS SELECT, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS</li> </ul>	
PATIENT COINSURANCE MUST = ZERO		
WHEN SPONSOR STATUS =	A	ACTIVE DUTY
	P	TAMP DESIGNEE
	B	RECALLED ACTIVE DUTY

<sup>1</sup> 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 <sup>1</sup> =	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

<sup>1</sup> 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 =	T	FORMER SPOUSE
	H	
	R	
	Y	
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 HCSR <sub>s</sub> STORED ON THE DATABASE		
<b>2-140-24R</b>	• EDIT FOR CHAMPUS SELECT, FAMILY MEMBERS OF ACTIVE DUTY SPONSORS	
PATIENT COINSURANCE MUST BE 15% (ALLOW 1 <sup>c</sup> 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 <sup>1</sup> =	O	OUTPATIENT
ENROLLMENT STATUS =	F	FI STANDARD PROGRAM
	Y	CHCBP STANDARD

<sup>1</sup> 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 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	FORMER SPOUSE
	H	
	R	
	Y	
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 HCSR <sub>s</sub> STORED ON THE DATABASE.		
<b>2-140-25R</b>	• 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

<sup>1</sup> 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)**

<b>OR</b> NO OCCURRENCE OF PATIENT RELATIONSHIP TO SPONSOR =	T FORMER SPOUSE H R Y
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 <sup>1</sup> =	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 <b>OR</b> U BENEFICIARY INDEMNIFICATION PAYMENT <b>OR</b> V <b>ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA &amp; CANADA INCLUDING THE CARIBBEAN BASIN</b>
TYPE OF SUBMISSION =	F ADJUSTMENT NEW SUFFIX <b>OR</b> I INITIAL SUBMISSION <b>OR</b> O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b> R RESUBMISSION OF ERROR REJECT
<b>OR</b> TYPE OF SUBMISSION =	A ADJUSTMENT <b>OR</b> C CANCELLATION WITH AMOUNT ALLOWED > ZERO
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.	

**2-140-26R** PATIENT COINSURANCE MUST BE 20% (ALLOW 1¢ ROUNDING ERROR) OF (AMOUNT ALLOWED MINUS AMOUNT APPLIED TOWARD DEDUCTIBLE)

<sup>1</sup> 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)**

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

<sup>1</sup> 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)**

<b>OR TYPE OF SUBMISSION =</b>	A ADJUSTMENT <b>OR</b>
	C CANCELLATION WITH AMOUNT ALLOWED > ZERO
<b>AND WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.</b>	
UNLESS PROGRAM INDICATOR = 'D' (DRUG) <b>AND EARLIEST BEGIN DATE OF CARE IS ≥ 10/01/2001 THEN BYPASS THIS EDIT</b>	
<b>2-140-27R</b>	PATIENT COINSURANCE MUST BE 15% (ALLOW 1 <sup>¢</sup> ROUNDING ERROR) OF AMOUNT ALLOWED
<b>WHEN SPONSOR STATUS =</b>	A ACTIVE DUTY <b>OR</b>
	B RECALLED ACTIVE DUTY <b>OR</b>
	E MEPCOM ENLISTEE <b>OR</b>
	J ACADEMY/OCS <b>OR</b>
	N NATIONAL GUARD <b>OR</b>
	P TAMP DESIGNEE <b>OR</b>
	Q PRISON/APPELLATE <b>OR</b>
	T FOREIGN MILITARY <b>OR</b>
	V RESERVE
<b>PATIENT RELATIONSHIP TO SPONSOR ≠</b>	T FORMER SPOUSE H R Y
<b>ANY OCCURRENCE OF SPECIAL PROCESSING CODE =</b>	! NORTHERN REGION COORDINATED CARE
<b>NO OCCURRENCE OF OVERRIDE CODE =</b>	K CATASTROPHIC LOSS <b>OR</b>
	V ADFM SERVICES PROVIDED IN TRICARE EUROPE, PACIFIC OR LATIN AMERICA & CANADA INCLUDING THE CARIBBEAN BASIN
<b>ANY OCCURRENCE OF FIRST POSITION OF TYPE OF SERVICE =</b>	O OUTPATIENT
<b>TYPE OF SUBMISSION =</b>	F ADJUSTMENT NEW SUFFIX <b>OR</b>
	G ADDITIONAL DRG INTERIM BILLING <b>OR</b>
	I INITIAL SUBMISSION <b>OR</b>
	O ZERO PAYMENT WITH 100% OHI/TPL <b>OR</b>

<sup>1</sup> 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
<b>OR TYPE OF SUBMISSION =</b>	A	ADJUSTMENT <b>OR</b>
	C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		
<b>2-145-27R</b>	<b>PATIENT COPAYMENT MUST EQUAL ZERO</b>	
<b>WHEN SPONSOR STATUS =</b>	A	ACTIVE DUTY <b>OR</b>
	B	RECALLED ACTIVE DUTY <b>OR</b>
	E	MEPCOM ENLISTEE <b>OR</b>
	J	ACADEMY/OCS <b>OR</b>
	N	NATIONAL GUARD <b>OR</b>
	P	TAMP DESIGNEE <b>OR</b>
	Q	PRISON/APPELLATE <b>OR</b>
	T	FOREIGN MILITARY <b>OR</b>
	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
<b>OR TYPE OF SUBMISSION =</b>	A	ADJUSTMENT
	C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		

<sup>1</sup> 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)**

**2-140-28R** PATIENT COINSURANCE MUST BE 20% (ALLOW 1<sup>e</sup> ROUNDING ERROR) OF AMOUNT ALLOWED

<b>WHEN SPONSOR STATUS =</b>	F	FORMER MEMBER
	I	PERMANANTLY DISABLED
	O	TEMPORARILY DISABLED
	R	RETIRED
	H	MEDAL OF HONOR
	K	DECEASED
	D	100% DISABLED
	W	TITLE III RETIREE
<b>OR PATIENT RELATIONSHIP TO SPONSOR =</b>	T	FORMER SPOUSE
	H	
	R	
	Y	
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
<b>OR TYPE OF SUBMISSION =</b>	A	ADJUSTMENT
	C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		

**2-145-28R** PATIENT COPAYMENT MUST EQUAL ZERO

<b>WHEN SPONSOR STATUS =</b>	F	FORMER MEMBER
	I	PERMANANTLY DISABLED

**<sup>1</sup> 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	TEMPORARILY DISABLED
	R	RETIRED
	H	MEDAL OF HONOR
	K	DECEASED
	D	100% DISABLED
	W	TITLE III RETIREE
<b>OR</b> 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
<b>OR</b> TYPE OF SUBMISSION =	A	ADJUSTMENT <b>OR</b>
	C	CANCELLATION WITH AMOUNT ALLOWED > ZERO
WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSR <sub>s</sub> STORED ON THE DATABASE.		
<b>2-140-29R</b>	PATIENT COINSURANCE MUST BE 20% (ALLOW 1 <sup>¢</sup> ROUNDING ERROR) OF AMOUNT ALLOWED	
<b>WHEN</b> SPONSOR STATUS =	D	100% DISABLED <b>OR</b>
	F	FORMER MEMBER <b>OR</b>
	H	MEDAL OF HONOR <b>OR</b>
	I	PERMANENTLY DISABLED <b>OR</b>
	K	DECEASED <b>OR</b>
	O	TEMPORARILY DISABLED <b>OR</b>
	R	RETIRED <b>OR</b>
	W	TITLE III RETIREE

<sup>1</sup> 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 FORMER SPOUSE H R Y
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	
<b>2-145-29R</b>	<b>PATIENT COPAYMENT MUST EQUAL ZERO</b>
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

<sup>1</sup> 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
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		
<b>2-140-30R</b>	AMOUNT OF COINSURANCE MUST BE EQUAL TO ZERO AND	
<b>2-145-30R</b>	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

<sup>1</sup> 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 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 =

h SPONSOR OR

<sup>1</sup> 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)**

	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
<b>THEN PATIENT COINSURANCE MUST ≤ ZERO</b>		
<b>2-140-33R</b>	• 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
<b>THEN PATIENT COINSURANCE MUST = ZERO</b>		
<b>1-140-35R</b>	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	
	GF	TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
<b>THEN EARLIEST BEGIN DATE OF CARE IS ≥ 10/30/2000 AND &lt; 09/01/2002</b>		
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

<sup>1</sup> 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!

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

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V STEP CHILD OR

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W WARD

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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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<sup>1</sup> 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!