ASC X12N/006020X313

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

006020™

Health Care Claim Request for Additional Information (277)

SEPTEMBER 2014

Intellectual Property

ASC X12 has developed Standards to facilitate the transmission of electronic business messages for over 30 years. The Data Interchange Standards Association (DISA) holds the copyright on the Standards and associated publications designed to facilitate implementation of the Standards on behalf of ASC X12. Users of all ASC X12 publications should be aware of the permissible uses, as well as the limitations on such usage, as outlined here: http://store.x12.org/store/ip-use.

Table of Contents

Preface

ASC X12 standards are developed to identify the broadest data requirements for a transaction set. Type 3 Technical Reports (TR3) define explicit data requirements for a specific business purpose. Trading partners who implement according to the instructions in this TR3 can exchange data with multiple trading partners in a consistent manner.

Trading partners define their specific transport requirements separately. Neither ASC X12 standards nor TR3s define transport requirements.

1 Purpose and Business Information

1.1 Implementation Purpose and Scope

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to provide standardized data requirements and content for all users of the ASC X12 Health Care Claim Request for Additional Information (277). This implementation guide focuses on the use of the 277 by a health care payer to request additional information to support a health care claim or encounter. The use of the 277 for this specific business purpose is the reason for this separate implementation guide.

This implementation guide provides a detailed explanation of the transaction set by defining uniform data content, identifying valid code tables, and specifying values applicable for the business focus of the 277 Request for Additional Information. The intention of the developers of the 277 is represented in the guide.

This implementation guide is designed to assist those who request or who receive requests to supplement claim review using the 277 format. The entities requesting additional health care information include, but are not limited to, insurance companies, Third Party Administrators (TPAs), managed care service organizations, state and federal agencies and their contractors, plan purchasers, and any other entity that processes health care claims or manages the delivery of health care services.

Other business partners affiliated with the 277 include billing services, health care providers, consulting services, vendors of systems, software and EDI translators, and EDI network intermediaries such as Automated Clearing Houses (ACHs), Value-Added Net-works (VANs), and telecommunications services.

1.2 Version Information

This implementation guide is based on the October 2009 ASC X12 standards, referred to as Version 6, Release 2, Sub-release 0 (006020).

The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 006020**X313**.

The two-character Functional Identifier Code for the transaction set included in this implementation guide:

- ***HN Health Care Information Status Notification (277)***

The Version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted in the Functional Group Header (GS segment) that begins a functional group of these transaction sets. For more information, see the descriptions of GS01 and GS08 in Appendix C.

1.3 Implementation Limitations

1.3.1 Batch and Real-Time Usage

There are multiple methods available for sending and receiving business transactions electronically. Two common modes for EDI transactions are batch and real-time.

Batch - In a batch mode the sender does not remain connected while the receiver processes the transactions. Processing is usually completed according to a set schedule. If there is an associated business response transaction (such as a 271 Response to a 270 Request for Eligibility), the receiver creates the response transaction and stores it for future delivery or transmits the response transaction back to the sender of the original transaction. The sender of the original transmission reconnects at a later time and picks up the response transaction if the transaction was not transmitted back to the sender of the original transaction. This implementation guide does not set specific response time parameters for these activities.

Real-Time - In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender. This implementation guide does not set specific response time parameters for implementers.

This implementation guide was based on requirements for batch mode. Willing trading partners may use batch or real-time mode.

1.3.2 Other Usage Limitations

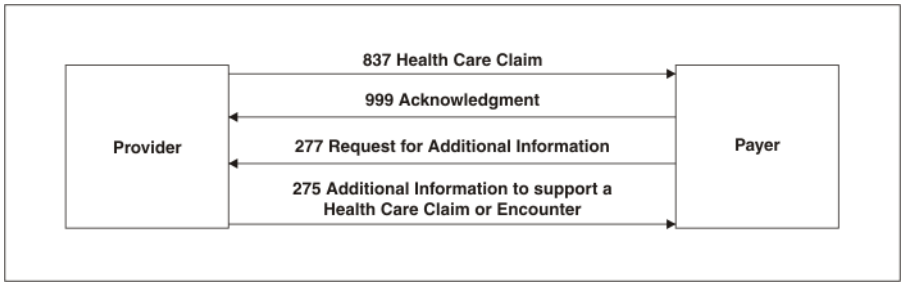
There are no other usage limitations.

1.4 Business Usage

The ASC X12 Health Care Claim Request for Additional Information (277) implementation guide addresses usage of the 277 as a **request for additional information to support a health care claim or encounter.** The 277 transaction provides the mechanism for asking questions or making requests for information about specific claims or service lines. The actual answer or additional information response is provided in the ASC X12 Additional Information to Support a Health Care Claim or Encounter (275).

The 277 has the capability to request information for multiple claims and patients. However the 275 transaction structure only allows the submitter to send one claim in each 275. A separate Transaction Set Header/Trailer (ST/SE) must be sent for each claim. The LX segment within the 275 can be repeated to respond to multiple questions on an individual claim.

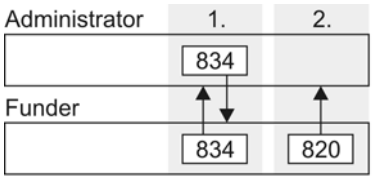
Figure 1.1 - General Claim Status Information Flow



1.4.1 Health Care Transaction Flow

Each ASC X12 implementation guide explains how to use ASC X12 transaction sets to meet a single defined business purpose. The following diagrams, current as of publication, depict the business functions supported by the ASC X12 health care implementation guide.The intent of these diagrams is to represent the possible exchanges between trading partners using these implementation guides. Trading partners include entities that administer part or all of a health plan, fund the plan and enroll members, and provide the health care services.

Enrollment



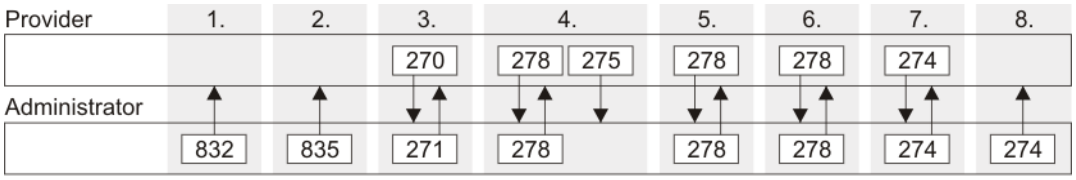
1. Enrollment

005010X220 834 Benefit Enrollment and Maintenance

2. Premium Payment

005010X218 820 Payroll Deducted and Other Group Premium Payment For Insurance Products

Pre-adjudication



1. Fee Schedule

006020X304 832 Health Care Fee Schedule

2. Capitation Roster and Payment

005010X221 835 Health Care Claim Payment/Advice

3. Eligibility

005010X279 270 Health Care Eligibility Benefit Inquiry
271 Health Care Eligibility Benefit Information Response

4. Health Care Services Review Request

006020X315 278 Health Care Services Review – Request for Review
278 Health Care Services Review – Response
006020X316 275 Additional Information to Support a Health Care Services Review

5. Health Care Services Review Inquiry

005010X215 278 Health Care Services Review Inquiry
278 Health Care Services Review Response

6. Health Care Services Review Notification

005010X216	278	Health Care Services Review Notification
	278	Health Care Services Review Acknowledgment

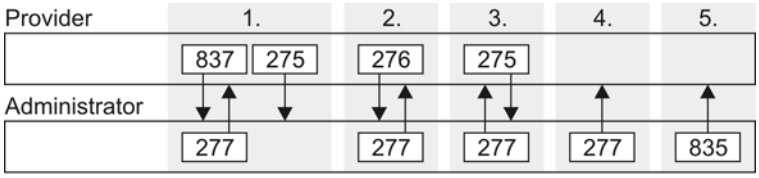
7. Provider Information

004050X253	274	Health Care Provider Information
	274	Health Care Provider Information

8. Participating Provider Roster

004050X109	274	Health Care Provider Directory

Adjudication



1. Health Care Claim and Encounter plus Additional Support Information

005010X222	837	Health Care Claim: Professional
005010X223	837	Health Care Claim: Institutional
005010X224	837	Health Care Claim: Dental
005010X225	837	Health Care Service Data Reporting
006020X314	275	Additional Information to Support a Health Care Claim or Encounter
005010X214	277	Health Care Claim Acknowledgment

2. Health Care Claim Status

005010X212	276	Health Care Claim Status Request
	277	Health Care Claim Status Response

3. Health Care Claim Additional Information

006020X313	277	Health Care Claim Request for Additional Information
006020X314	275	Additional Information to Support a Health Care Claim or Encounter

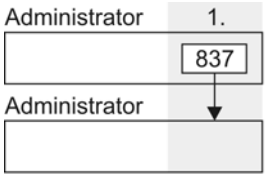
4. Health Care Claim Pending Status

005010X228	277	Health Care Claim Pending Status Information

5. Health Care Claim Payment

005010X221	835	Health Care Claim Payment/Advice

Post-adjudication



1. Coordination of Benefits

005010X222	837	Health Care Claim: Professional
005010X223	837	Health Care Claim: Institutional
005010X224	837	Health Care Claim: Dental

1.4.2 Transaction Participants

The hierarchical level structure is used to identify and relate the participants involved in the transaction. The relationships between the hierarchical levels are described by the hierarchical level code data elements, also known as HL01 and HL02. The data element, HL03, identifies the participants within the transaction. The participants described are as follows:

When HL03 = 20, the hierarchical level contains the Information Source. This entity is the decision maker in the business transaction. For this business use, this entity is the payer who is requesting additional information for the specified claims.

When HL03 = 21, the hierarchical level contains the Information Receiver. This entity is the recipient of the request for additional information from Information Source. This entity will be identified via their electronic ID. For this business use, this entity can be a provider, a provider group, a claims clearinghouse, a service bureau, etc.

When HL03 = 19, the hierarchical level contains the Provider of Service. This entity delivered the health care service. Provider of Service is generic in that this could be the entity that originally submitted the claim (Billing Provider) or may be the entity that provided or participated in some aspect of the health care (Rendering Provider).

When HL03 = PT the hierarchical level contains the Patient information. This entity is the recipient of the health care service rendered for which additional information is being requested.

The Information Receiver and the Service Provider hierarchical levels have a unique relationship. Information Receiver refers to the entity that processes the detailed information contained within the transaction set. In some cases, the Information Receiver is an entity acting on behalf of the Service Provider. When this occurs, the entity is

described when HL03 = 21, and the Provider of Service is described when HL03 = 19. In other instances, the Information Receiver is also the Service Provider. When this occurs, the same entity is described at two hierarchical levels - when HL03 = 21 and when HL03 = 19.

The coding examples are presented sequentially as found within an actual transaction set. However, for reading ease each segment begins on a new line.

The following example demonstrates the coding of the segments and data elements within the Information Source hierarchical level:

```
HL*1**20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
```

The following is a coding example of the Information Receiver hierarchical level:

```
HL*2*1*21*1~
NM1*41*2*XYZ SERVICE*****46*X67E~
```

The following is a coding example of the Service Provider hierarchical level:

```
HL*3*2*19*1~
NM1*1P*2*HOME MEDICAL*****XX*1666666666~
```

The following is a coding example of the Patient Hierarchical level:

```
HL*4*3*PT~
NM1*QC*1*MANN*JOHN****MI*345678901~
```

1.4.3 Claim and Service Information

Unlike the Transaction Participants, specific claim and service detail information is not given a hierarchical level. Claim and service information is positioned in the Patient hierarchical level. The specific claim(s) for which information is being requested is described in Loop 2200, while the service information follows the claim data in Loop 2220.

A payer may request additional information in support of a claim at the claim level, service line level, or at both locations. The STC segments at the claim and service level are used to express the specific information the payer requires from the provider to complete the adjudication process for the identified claim.

See Section 1.4.4.1 - *STC Composite and Code Use Rules* for additional information.

1.4.3.1 The Claim

When a request for additional information is made, the payer supplies the parameters that assist providers in locating the claim and data within their system. These parameters are frequently the Provider's Assigned Claim Identifier, medical record number, and dates of service which are sent in Loop 2200.

1.4.3.1.1 Claim Association of the 277 with the 275

The 277 transaction is used for requesting additional information about a specific claim. The additional information response must be able to be associated with the original request in the payer's adjudication system. The association of the request and additional information is accomplished with a trace number identified in the TRN Segment (TRN02).

The 277 Request for Additional Information, Loop 2200D TRN segment conveys the payer's claim control number. This identification number is assigned by the payer's system. This identifier is used by the payer to associate the additional information response to the appropriate claim.

When the additional information response is sent in an ASC X12 275 transaction, this number is returned in the 2000A TRN segment. The payer needs to receive this number back with the response to complete the association process.

1.4.3.1.2 Claim Level Identifiers

Within the 2200D loop, various identifiers can be sent by the payer to help providers identify the patient's claim or services within their system. These identifiers are reported in REF segments.

The following are examples of these REF segment identifiers:

REF*X1*SMITH123~	Provider's Assigned Claim Identifier
REF*EA*JS980503LAB~	Medical Record Number
REF*D9*123456789~	Claim Identification Number for Clearinghouses and other Transmission Intermediaries

1.4.3.1.3 Claim Level Dates

The DTP segment occurs twice at the 2200D level and specifies the claim service dates and the response due date.

The response due date is supplied by the Information Source (Payer) to indicate the date the requested information must be returned. Should this date pass without the requested information being supplied by the Information Receiver, the payer may decide to allow the claim to proceed through the adjudication process based upon the information already received in the claim.

1.4.3.1.4 Claim Supplemental Information

The 2210D Loop, Claim Supplemental Information, is situational and can be used for internal work flow routing by the Information Source. The payer uses the segments within this loop to identify the entity who is expecting to receive the additional information from the provider. When the additional information is returned using the 275, only the Payer Response Contact Information, PER segment, is returned in the 1000A Loop of the 275. Payers may optionally decide to provide information on other methods (non EDI) such as fax, email address, mailing address, etc. for the return of attachment data.

1.4.3.2 The Service

When the requested information is more clearly identified by specifying the claim service line, Loop 2220 is used. The service information follows the Loop 2200 claim data. Some payers' adjudication systems support service line information requests.

For service line requests for additional information, the SVC segment is used to report the actual service (procedure) data. A specific service date is also required when requesting additional information at the service line level.

1.4.4 277 Status Information (STC) Segment Usage

The STC segment is used to express the specific information the payer requires from the provider to complete the adjudication process for the identified claim. A payer may request additional information in support of a claim, at the claim level, service line level, or at both locations.

See Section 1.4.4.1 - *STC Composite and Code Use Rules* for additional information.

The STC segment contains three iterations of the C043 (Health Care Claim Status) composite within STC01, STC10 and STC11.

The Health Care Claim Status composite (C043) consists of four elements:

- The first element in the C043 composite (C043-01) is the Health Care Claim Status Category Code, Code Source 507. The Category Code indicates the type of request for additional information. While the code source includes multiple values, the only

valid codes for this business use are the Request for Additional Information Codes (R-prefix).

- The second element in the C043 composite (C043-02) is the Logical Observation Identifier Names and Codes (LOINC®), Code Source 663. The LOINC® codes contain the detail information about the actual question and modifiers. Refer to the HL7 specifications for additional information on LOINC® codes and their modifiers.

  Note: The dash "-" character displayed in a LOINC® code (e.g., 18657-7) is part of the LOINC® code. Please refer to Section B.1.1.2 - *Delimiters* for further information.

- The third element in the C043 composite (C043-03) is the Entity Identifier Code (ASC X12 data element 98). This element is not used within this implementation.

- The fourth element in the C043 composite (C043-04) is the Code List Qualifier Code (ASC X12 data element 1270). The Code List Qualifier Code is used to identify that the second element of the composite contains a LOINC® code. For the purposes of this implementation, this element must always contain the value "LOI".

The Category Codes and LOINC® codes are code lists external to the ASC X12 standards. See Appendix A, *External Code Sources*, for more information on these code sources.

A committee of healthcare industry representatives from payer, provider and vendor organizations maintains the Health Care Claim Status Category Codes, Code Source 507. The code list is updated after each ASC X12 trimester meeting. Version specific code additions or deactivations are noted on the code lists.

The Blue Cross Blue Shield Association (BCBSA) is the owner of the Health Care Claim Status Category Code list. The primary distribution source is the Washington Publishing Company web site (www.wpc-edi.com). This web site offers an online conferencing facility that allows interested parties to submit requests for new codes, changes to existing codes, or simply view comments on pending requests. Individuals who are unable to access the Internet may contact BCBSA directly.

LOINC® codes provide a standard set of universal names and codes for identifying individual laboratory and clinical results as well as other clinical information. LOINC® codes are maintained by Regenstrief Institute, Inc.

1.4.4.1 STC Composite and Code Use Rules

The following rules apply to use of the composites and codes within the STC segment:

- Each STC segment defines a single request for additional information. A maximum of three LOINC® codes can be used to define the request.
- The STC segment at the 2200D claim level is situational; it is required when requesting information at the claim level.
- The request for additional information can be asked at the claim level, service line level, or at both levels.
- Multiple requests for additional information for the same claim and/or line must be conveyed with separate STC segments.
- STC01 is required and describes the question or the requested information. For example, LOINC® code 18657-7 is requesting the Rehabilitation treatment plan, plan of treatment (narrative).
- LOINC® codes entered in STC10 and STC11 are situational and are used to provide greater specificity.
- **General versus specific:** When requesting additional information, payers are strongly encouraged to be as specific as possible in their LOINC® code assignment to avoid general requests for additional information.

  For example: 'operative report' versus 'medical records'.

1.4.5 277 Transaction Uses

The Health Care Information Status Notification (277) transaction set has multiple implementation conventions to meet various business needs of the health care industry. The transaction set can be used to provide healthcare claim information in the following business scenarios:

- **ASC X12 Health Care Claim Request for Additional information (277),** which is a payer's request for additional information to support a health care claim. This function is supported in this implementation guide.
- **ASC X12 Health Care Claim Status Request and Response (276/277),** where the 277 is a response to a request for claim status information. This function is not supported in this implementation guide.

- **ASC X12 Health Care Claim Acknowledgement (277),** which is a business application response to the ASC X12 837 claim/encounter transactions. This function is not supported in this implementation guide.

- **ASC X12 Health Care Claim Pending Status Information (277),** which is used as a listing of pended claims in a payer's system. This function is not supported in this implementation guide.

Figure 1.2 - *General ASC X12 Health Care Claim Information Flow* illustrates the flow of information related to several usages of the 277. The multiple uses of the 277 claim status are differentiated by values in the ST and BHT Segments of Table 1 data. Element BHT06, in addition to the ST03 and GS08 values, is used to distinguish between these varied business functions. The various 277 - BHT06 code values are:

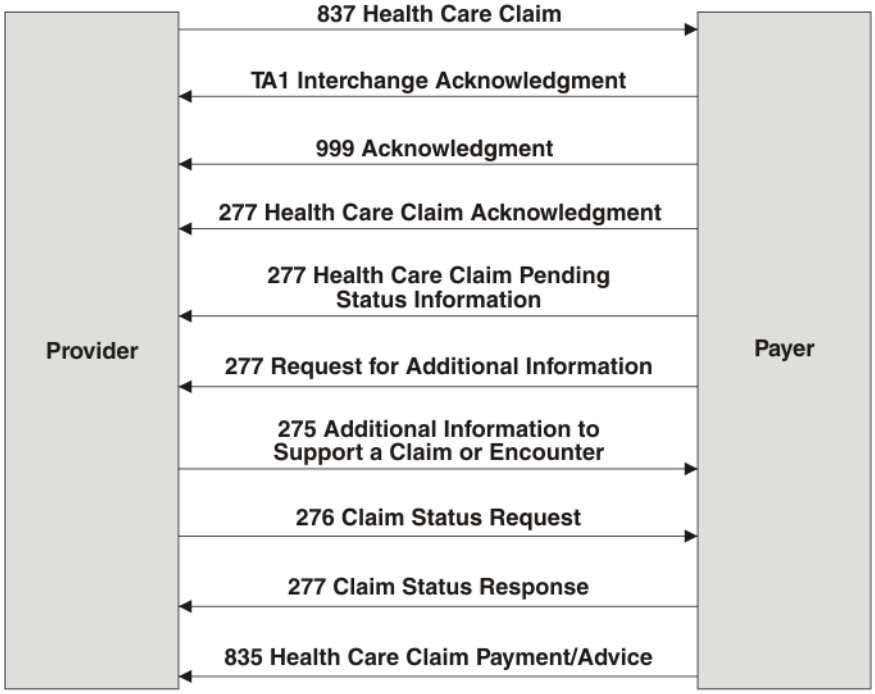
- DG - Response (Health Care Claim Status Request and Response)

- NO - Notice (Health Care Claim Pending Status Information)

- RQ - Request (Health Care Claim Request for Additional Information)

- TH - Receipt Acknowledgment Advice (Health Care Claim Acknowledgment)

Figure 1.2 - General ASC X12 Health Care Claim Information Flow



1.5 Business Terminology

No special business terms are used in this implementation guide.

1.6 Transaction Acknowledgments

The purpose of transaction acknowledgments is to report to the sender whether the transaction being acknowledged was accepted or rejected.

The ASC X12 Technical Report Type 2, *Acknowledgment Reference Model* provides guidance on several control structures and transaction set standards intended to augment EDI auditing and control systems.

1.7 Related Transactions

There are one or more transactions related to the transactions described in this implementation guide.

1.7.1 The Claim (837)

Submitting a claim using the 837 is the first step in the claim adjudication process. The data elements found on the original claim have their source from the provider's billing system. When additional supporting information is required for a claim to complete the payer's adjudication process, the payer can request the information from the provider using the 277 Request for Additional Information. Data from the original claim is returned to the provider on the 277 to facilitate locating the claim or the supporting information.

1.7.2 The Health Care Patient Information (275)

When a claim requires supporting medical documentation to complete the payer's adjudication process, the payer can electronically request the information using the 277 transaction. Data from the original claim is included on the 277 to assist the provider with locating the claim or the supporting information. The provider may return the supporting medical documentation by sending the 275 transaction, Additional Information to Support a Health Care Claim or Encounter. The provider will return the medical documentation along with various data elements from the 277 to facilitate association of the response to the request within the payer's adjudication system.

1.8 Trading Partner Agreements

Trading partner agreements are used to establish and document the relationship between trading partners. A trading partner agreement must not override the specifications in this implementation guide if a transmission is reported in GS08 to be a product of this implementation guide.

1.9 HIPAA Role in Implementation Guides

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191 - known as HIPAA) direct the Secretary of Health and Human Services to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

This implementation guide has been developed for use as an insurance industry implementation guide. At the time of publication it has not been adopted as a HIPAA standard. Should the Secretary adopt this implementation guide as a standard, the Secretary will establish compliance dates for its use by HIPAA covered entities.

1.10 Data Overview

This section introduces the structures of the 277. Familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure is recommended. For a review, see Appendix B, *Nomenclature* and Appendix C, *EDI Control Directory*.

1.10.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set: the implementation view and the standard view. The intent of the implementation view is to clarify the purpose and use of the segments by restricting the view to display only those segments used with their assigned health care names. The implementation view for the 277 is presented in Section 2.3.1, Implementation. The standard view for the 277 displays all segments available within the transaction set with their assigned ASC X12 names. This view is presented in Section 2.3.2, X12 Standard.

The transaction set is divided into two levels, or tables, Table 1 and Table 2.

Table 1

Table 1 is named the Header Level and contains the transaction control information. The ST segment identifies the start of a transaction and the specific transaction set. The

BHT identifies the transactions business purpose and the hierarchical structure used in Table 2.

Table 2

Table 2 is named the Detail Level because it contains the detail information for the business function of the transactions. This table uses the hierarchical level structure. Each hierarchical level (HL) is a series of loops, which are identified by numbers and letters. The hierarchical level that identifies the patient is Loop ID-2000D. The patient name is contained in Loop ID-2100D. Specific claim details begin with Loop ID-2200D.

The following are HL segment coding examples and the data element significance within the HL segments:

HL*120*1~**	Information Source Level
HL*2*1*21*1~	Information Receiver Level
HL*3*2*19*1~	Service Provider Level
HL*4*3*PT~	Patient Level

- HLs are sequentially numbered. The sequential number is found in HL01, which is the first data element in the HL segment.
- The second element, HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level is subordinate. The absence of a data value in HL02, indicates it is the highest hierarchical level. In this example, the Information Source is the highest parent. The Information Receiver level is subordinate to the Information Source hierarchical level numbered 1 (HL01 = 1). The Provider Service Level is subordinate to the Information Receiver hierarchical level numbered 2 (HL01 = 2), etc.
- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 = 20, the hierarchical level is the Information Source. When HL03 = PT, the hierarchical level is the Patient.
- Data element HL04 indicates whether or not child (subordinate) hierarchical levels exist. A value of "1" indicates subordinate hierarchical levels exist. A value of "0" or the absence of a data value indicates that no subordinate hierarchical levels exist.

2 Transaction Set

NOTE
See Appendix B, Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

2.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable.

This implementation guide uses a format that depicts both the generalized standard and the insurance industry-specific implementation. In this implementation guide, **IMPLEMENTATION** specifies the requirements for this implementation. **X12 STANDARD** is included as a reference only.

The transaction set presentation is comprised of two main sections with subsections within the main sections:

2.3 Transaction Set Listing

There are two sub-sections under this general title. The first sub-section concerns this implementation of a generic X12 transaction set. The second sub-section concerns the generic X12 standard itself.

IMPLEMENTATION

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail.

STANDARD

This section is included as a reference.

2.4 Segment Detail

There are three sub-sections under this general title. This section repeats once for each segment used in this implementation providing segment specific detail and X12 standard detail.

SEGMENT DETAIL

This section is included as a reference.

DIAGRAM

This section is included as a reference. It provides a pictorial view of the standard and shows which elements are used in this implementation.

ELEMENT DETAIL

This section specifies the implementation details of each data element.

These illustrations (Figures 2.1 through 2.5) are examples and are not extracted from the Section 2 detail in this implementation guide. Annotated illustrations, presented below in the same order they appear in this implementation guide, describe the format of the transaction set that follows.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

8XX Insurance Transaction Set

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	0100	ST	Transaction Set Header	R	1	
54	0200	BPR	Financial Information	R	1	
60	0400	TRN	Reassociation Key	R	1	
62	0500	CUR	Non-US Dollars Currency	S	1	
65	0600	REF	Receiver ID	S	1	
66	0600	REF	Version Number	S	1	
68	0700	DTM	Production Date	S	1	
			PAYER NAME			1
70	0800	N1	Payer Name	R	1	
72	1000	N3	Payer Address	S	1	
75	1100	N4	Payer City, State, Zip	S	1	
76	1200	REF	Additional Payer Reference Number	S	1	
78	1300	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	0800	N1	Payee Name	R	1	
81	1000	N3	Payee Address	S	1	
82	1100	N4	Payee City, State, Zip	S	1	
84	1200	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 2.1. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix B.1, ASC X12 Nomenclature* for a complete description of the standard

8XX Insurance Transaction Set

Functional Group ID: **XX**

This Draft Standard for Trial Use contains the format and establishes the data contents of the Insurance Transaction Set (8XX) within the context of the Electronic Data Interchange (EDI) environment.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BPR	Beginning Segment	M	1	
0300	NTE	Note/Special Instruction	O	>1	
0400	TRN	Trace	O	1	

Figure 2.2. Transaction Set Key — Standard

SEGMENT DETAIL

Industry assigned Segment Name → **NM1 - PATIENT NAME**

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

See X12.6 for a description of these values

Industry assigned Loop ID and Loop Name

Industry Loop Repeat

Industry Segment Repeat

Loop:	**2100B — PATIENT NAME Loop Repeat: 1**
Segment Repeat:	**1**
Usage:	**SITUATIONAL**
Situational Rule:	**Required when the patient is different from the insured. If not required by this implementation guide, do not send.**
TR3 Notes:	**1. Any necessary identification number must be provided in NM109.**
TR3 Example:	**NM1*QC*1*Shepard*Sam*A***34*452114586~**

Industry usage

Situational Rule

Industry Notes

Example

Figure 2.3. Segment Key — Implementation

DIAGRAM

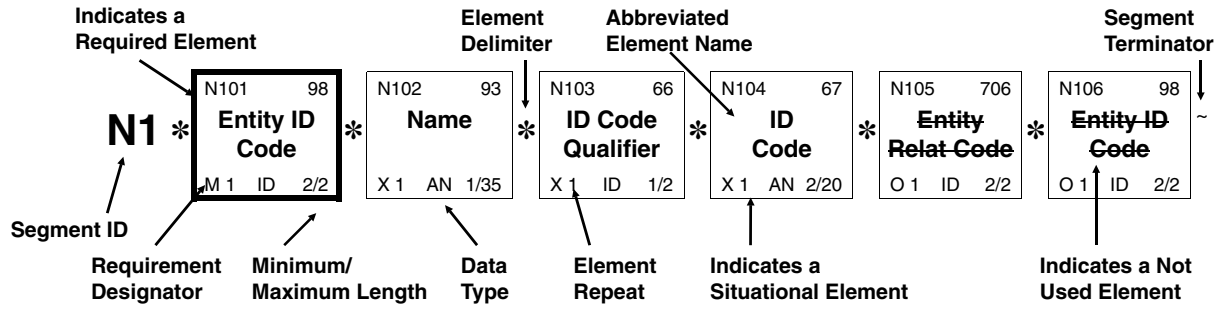


Figure 2.4. Segment Key — Diagram

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** (Element Repeat)	**M 1**
			To identify a medical procedure by its standardized codes and applicable modifiers	
			Use the Primary Payer's adjudicated Medical Procedure Code.	
REQUIRED	**SVC01-01**		**235 Product/Service ID Qualifier**	**M ID 2/2**
			Code identifying the type/source of the descriptive number used in Product/Service ID (234)	
			INDUSTRY NAME: **Product or Service ID Qualifier**	
			The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.	
			CODE / DEFINITION	
			AD — **American Dental Association Codes**	
			CODE SOURCE **135:** American Dental Association	
			HP — **Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code**	
			CODE SOURCE **716:** Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities	
REQUIRED	**SVC01-02**		**234 Product/Service ID**	**M AN 1/80**
			Identifying number for a product or service	
NOT USED	**SVC01-03**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-04**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-05**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-06**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-07**		**352 Description**	**O AN 1/80**
NOT USED	**SVC01-08**		**234 Product/Service ID**	**O AN 1/80**
NOT USED	**SVC01-09**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-10**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-11**		**1339 Procedure Modifier**	**O AN 2/2**
NOT USED	**SVC01-12**		**1339 Procedure Modifier**	**O AN 2/2**
REQUIRED	**SVC02**	**782**	**Monetary Amount**	**M 1 R 1/18**
			Monetary amount	
			SEMANTIC: SVC02 is the submitted service charge.	
			This value can not be negative.	
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O 1 R 1/18**
SITUATIONAL	**SVC04**	**234**	**Product/Service ID**	**O 1 AN 1/48**
			Identifying number for a product or service	
			SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code.	
			SITUATIONAL RULE: ***Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If not required by this implementation guide, do not send.***	
			INDUSTRY NAME: **National Uniform Billing Committee Revenue Code**	

Reference Designator

Composite Number

Industry Usage: See the following page for complete descriptions

Industry Note

Selected Code Values

See Appendix A for external code source reference

Data Element Number

X12 Semantic Note

Situational Rule

Industry Name See Appendix E for definition

Figure 2.5. Segment Key — Element Summary

2.2 Implementation Usage

2.2.1 Industry Usage

Industry Usage describes when loops, segments, and elements are to be sent when complying with this implementation guide. The three choices for Usage are required, not used, and situational. To avoid confusion, these are named differently than the X12 standard Condition Designators (mandatory, optional, and relational).

Required This loop/segment/element must always be sent.

Required segments in Situational loops only occur when the loop is used.

Required elements in Situational segments only occur when the segment is used.

Required component elements in Situational composite elements only occur when the composite element is used.

Not Used This element must never be sent.

Situational Use of this loop/segment/element varies, depending on data content and business context as described in the defining rule. The defining rule is documented in a Situational Rule attached to the item.

There are two forms of Situational Rules.

The first form is “Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender’s discretion, but cannot be required by the receiver.” The data qualified by such a situational rule cannot be required or requested by the receiver, transmission of this data is solely at the sender’s discretion.

The alternative form is “Required when <explicit condition statement>. If not required by this implementation guide, do not send.” The data qualified by such a situational rule cannot be sent except as described in the explicit condition statement.

2.2.1.1 Transaction Compliance Related to Industry Usage

A transmitted transaction complies with an implementation guide when it satisfies the requirements as defined within the implementation guide. The presence or absence of an item (loop, segment, or element) complies with the industry usage specified by this implementation guide according to the following table.

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

This table specifies how an entity is to evaluate a transmitted transaction for compliance with industry usage. It is not intended to require or imply that the receiver must reject non-compliant transactions. The receiver will handle non-compliant transactions based on its business process and any applicable regulations.

2.2.2 Loops

Loop requirements depend on the context or location of the loop within the transaction. See Appendix B for more information on loops.

- A nested loop can be used only when the associated higher level loop is used.
- The usage of a loop is the same as the usage of its beginning segment.
  - If a loop's beginning segment is Required, the loop is Required and must occur at least once unless it is nested in a loop that is not being used.
  - If a loop's beginning segment is Situational, the loop is Situational.
- Subsequent segments within a loop can be sent only when the beginning segment is used.
- Required segments in Situational loops occur only when the loop is used.

2.3 Transaction Set Listing

2.3.1 Implementation

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail. Refer to section 2.1 Presentation Examples for detailed information on the components of the Implementation section.

IMPLEMENTATION

277 Health Care Claim Request For Additional Information

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
32	0100	ST	Transaction Set Header	R	1	
33	0200	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Information Source Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			1
35	0100	HL	Information Source Level	R	1	
			LOOP ID - 2100A PAYER NAME			1
37	0500	NM1	Payer Name	R	1	
39	0800	PER	Payer Contact Information	S	1	

Table 2 - Information Receiver Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			1
43	0100	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
45	0500	NM1	Information Receiver Name	R	1	

Table 2 - Service Provider Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SERVICE PROVIDER LEVEL			>1
47	0100	HL	Service Provider Level	R	1	
			LOOP ID - 2100C SERVICE PROVIDER NAME			1
49	0500	NM1	Service Provider Name	R	1	

Table 2 - Patient Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D PATIENT LEVEL			>1
52	0100	HL	Patient Level	R	1	
			LOOP ID - 2100D PATIENT NAME			1
53	0500	NM1	Patient Name	R	1	
			LOOP ID - 2200D PAYER CLAIM CONTROL NUMBER			>1
55	0900	TRN	Payer Claim Control Number	R	1	
56	1000	STC	Claim Level Status Information	S	>1	
60	1100	REF	Provider's Assigned Claim Identifier	S	1	
61	1100	REF	Institutional Bill Type Identification	S	1	
62	1100	REF	Medical Record Identification Number	S	1	
63	1100	REF	Claim Identifier For Transmission Intermediaries	S	1	
64	1100	REF	Property & Casualty Claim Number	S	1	
65	1100	REF	Case Reference Identifier	S	1	
66	1100	REF	Attachment Request Tracking Identifier	S	1	
67	1100	REF	Prior Attachment Request Tracking Identifier	S	1	
68	1200	DTP	Service Date	S	1	
70	1200	DTP	Response Due Date	R	1	
			LOOP ID - 2210D CLAIM SUPPLEMENTAL INFORMATION			1
71	1300	PWK	Claim Supplemental Information	S	1	
73	1400	PER	Payer Response Contact Information	R	1	
77	1600	N3	Payer Response Contact Address	S	1	
78	1700	N4	Payer Response Contact City, State, ZIP Code	S	1	
			LOOP ID - 2220D SERVICE LINE INFORMATION			>1
80	1800	SVC	Service Line Information	S	1	
85	1900	STC	Service Line Status Information	R	>1	
89	2000	REF	Service Line Item Identification	S	1	
90	2100	DTP	Service Date	S	1	
91	2150	TOO	Tooth Information	S	32	
93	2700	SE	Transaction Set Trailer	R	1	

2.3.2 X12 Standard

This section is included as a reference. The implementation guide reference clarifies actual usage. Refer to section 2.1 Presentation Examples for detailed information on the components of the X12 Standard section.

STANDARD

277 Health Care Information Status Notification

Functional Group ID: HN

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Information Status Notification Transaction Set (277) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter, health care services review, or transactions related to the provisions of health care. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BHT	Beginning of Hierarchical Transaction	M	1	
0300	REF	Reference Information	O	10	
		LOOP ID - 1000			>1
0400	NM1	Individual or Organizational Name	O	1	
0500	N2	Additional Name Information	O	2	
0600	N3	Party Location	O	2	
0700	N4	Geographic Location	O	1	
0800	REF	Reference Information	O	2	
0900	PER	Administrative Communications Contact	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
0100	HL	Hierarchical Level	M	1	
0200	SBR	Subscriber Information	O	1	
0300	PAT	Patient Information	O	1	
0400	DMG	Demographic Information	O	1	
		LOOP ID - 2100			>1
0500	NM1	Individual or Organizational Name	O	1	
0600	N3	Party Location	O	2	
0700	N4	Geographic Location	O	1	
0800	PER	Administrative Communications Contact	O	1	
		LOOP ID - 2200			>1
0900	TRN	Trace	O	1	
1000	STC	Status Information	O	>1	
1100	REF	Reference Information	O	9	
1200	DTP	Date or Time or Period	O	2	
1210	QTY	Quantity Information	O	5	

1220	AMT	Monetary Amount Information	O	5	
		LOOP ID - 2210			>1
1300	PWK	Paperwork	O	1	
1400	PER	Administrative Communications Contact	O	1	
1500	N1	Party Identification	O	1	
1600	N3	Party Location	O	1	
1700	N4	Geographic Location	O	1	
		LOOP ID - 2220			>1
1800	SVC	Service Information	O	1	
1900	STC	Status Information	O	>1	
2000	REF	Reference Information	O	9	
2100	DTP	Date or Time or Period	O	1	
2150	TOO	Tooth Identification	O	>1	
		LOOP ID - 2225			>1
2200	PWK	Paperwork	O	1	
2300	PER	Administrative Communications Contact	O	1	
2400	N1	Party Identification	O	1	
2500	N3	Party Location	O	1	
2600	N4	Geographic Location	O	1	
2700	SE	Transaction Set Trailer	M	1	

NOTES:

2/0200 The SBR segment may only appear at the Subscriber (HL03=22) level.

2/0400 The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

2/1300 The 2210 loop may be used when there is a status notification or a request for additional information about a particular claim.

2/2200 The 2225 loop may be used when there is a status notification or a request for additional information about a particular service line.

2.4 277 - Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Refer to section 2.1 Presentation Examples for detailed information on the components of the Segment Detail section.

SEGMENT DETAIL

ST - TRANSACTION SET HEADER

X12 Segment Name: Transaction Set Header

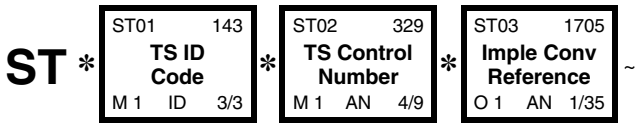
X12 Purpose: To indicate the start of a transaction set and to assign a control number

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: ST*277*0001*006020X313~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ST01	143	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set	M 1 ID 3/3
			SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).	
			CODE: 277 — DEFINITION: Health Care Information Status Notification	
REQUIRED	ST02	329	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	M 1 AN 4/9
			The Transaction Set Control Number in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there.	
REQUIRED	ST03	1705	**Implementation Convention Reference** Reference assigned to identify Implementation Convention	O 1 AN 1/35
			SEMANTIC: The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.	
			IMPLEMENTATION NAME: **Version, Release, or Industry Identifier**	
			This element must be populated with the implementation guide Version/Release/Industry Identifier Code named in Section 1.2.	
			This element contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST/SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.	

SEGMENT DETAIL

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

X12 Segment Name: Beginning of Hierarchical Transaction

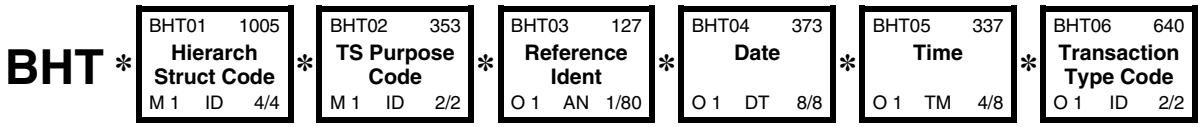
X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **BHT*0085*48*277RFI000001*20110801*1211*RQ~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set **Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL parent loop at the same hierarchical level.** CODE — DEFINITION **0085** — **Information Source, Information Receiver, Provider of Service, Patient**	**M 1 ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set CODE — DEFINITION **48** — **Suspended**	**M 1 ID 2/2**
REQUIRED	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SEMANTIC:** BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. **IMPLEMENTATION NAME: Originator Application Transaction Identifier** **Maximum length of this element is constrained by B.1.1.3.1.**	**O 1 AN 1/80**

REQUIRED	**BHT04**	**373**	**Date**	**O**	**1**	**DT**	**8/8**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

IMPLEMENTATION NAME: Transaction Set Creation Date

REQUIRED	**BHT05**	**337**	**Time**	**O**	**1**	**TM**	**4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

IMPLEMENTATION NAME: Transaction Set Creation Time

REQUIRED	**BHT06**	**640**	**Transaction Type Code**	**O**	**1**	**ID**	**2/2**

Code specifying the type of transaction

CODE	DEFINITION
RQ	**Request**

SEGMENT DETAIL

HL - INFORMATION SOURCE LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000A — INFORMATION SOURCE LEVEL Loop Repeat: 1**

Segment Repeat: **1**

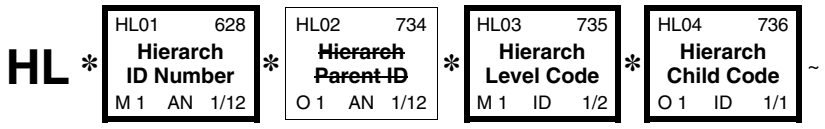
Usage: **REQUIRED**

TR3 Notes:

1. **The entity requesting this information is the payer.**

TR3 Example: **HL*1**20*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M 1 ID 1/2**

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - PAYER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

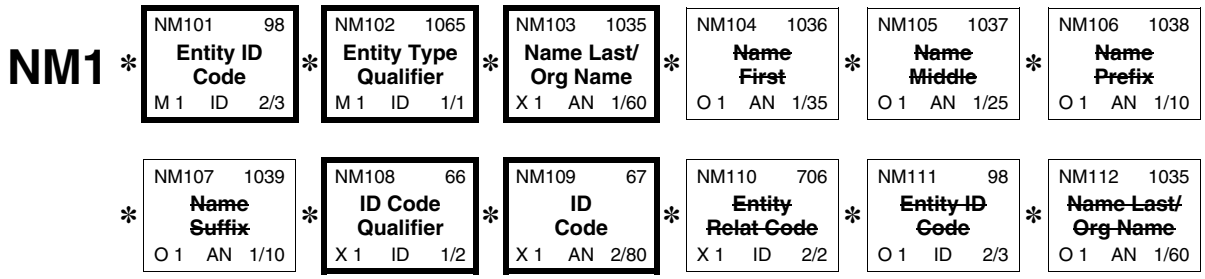
Loop: **2100A — PAYER NAME Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **NM1*PR*2*ABC INSURANCE CO*****XV*11122333~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**
			CODE / DEFINITION **PR** — **Payer**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **2** — **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Payer Name**	**X 1 AN 1/60**

NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	X 1	ID	1/2

CODE	DEFINITION
PI	**Payor Identification**
	Use when XV is not used.
XV	**Centers for Medicare and Medicaid Services PlanID**
	Use when reporting Health Plan ID (HPID) or Other Entity Identifier (OEID).
	CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID

REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **IMPLEMENTATION NAME:** **Payer Identifier**	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

PER - PAYER CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

X12 Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

Loop: **2100A — PAYER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

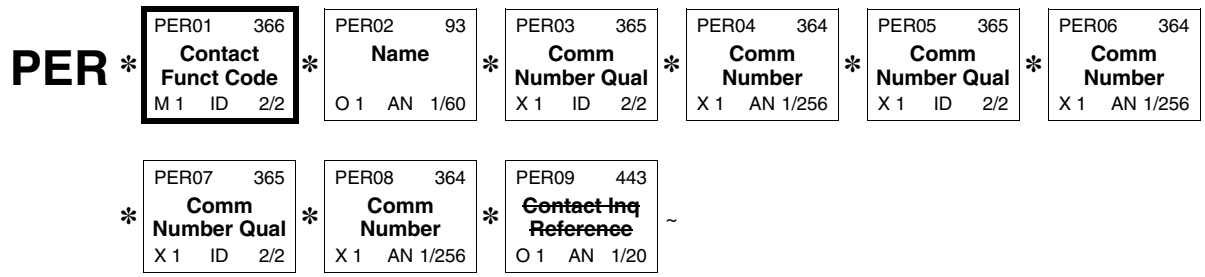
Situational Rule: **Required when the payer has contact data that may provide medical or other policy information that may apply to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.**

TR3 Notes:

1. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number must always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number. Therefore, the following telephone number (555) 555-1234 would be represented as 5555551234. Do not submit long distance access numbers, such as 1, in the telephone number. Telephone extensions, when applicable, must be submitted in the next element immediately following the telephone number. When submitting telephone extensions, only submit the numeric extension, do not include data that indicates an extension, such as "ext" or "x-".**
2. **This PER Segment provides general payer customer support information and is not returned in the 275.**

TR3 Example: **PER*IC**UR*www.anyhealthplan.com/policies.html~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**

CODE	DEFINITION
IC	**Information Contact**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**

SITUATIONAL RULE: ***Required when it is necessary to identify a contact name or department for questions or general information related to the payer's additional information requests. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

IMPLEMENTATION NAME: **Payer Contact Name**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1 ID 2/2**

SYNTAX: P0304

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

CODE	DEFINITION
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**

SITUATIONAL **PER04** **364** **Communication Number** **X 1 AN 1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0304

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

IMPLEMENTATION NAME: **Payer Contact Communication Number**

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X 1 ID 2/2**
Code identifying the type of communication number

SYNTAX: P0506

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**

SITUATIONAL **PER06** **364** **Communication Number** **X 1 AN 1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0506

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

IMPLEMENTATION NAME: **Payer Contact Communication Number**

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1**	**ID**	**2/2**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1**	**AN**	**1/256**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when the payer has a contact communication number that may provide medical or other policy information related to the additional information requests in this transaction. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

IMPLEMENTATION NAME: **Payer Contact Communication Number**

NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O 1**	**AN**	**1/20**

SEGMENT DETAIL

HL - INFORMATION RECEIVER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

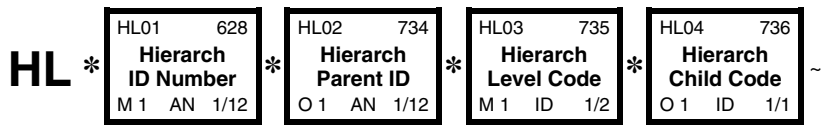
Loop: **2000B — INFORMATION RECEIVER LEVEL Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **HL*2*1*21*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **CODE** / **DEFINITION** **21** — **Information Receiver**	**M 1 ID 1/2**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - INFORMATION RECEIVER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100B — INFORMATION RECEIVER NAME Loop Repeat: 1**

Segment Repeat: **1**

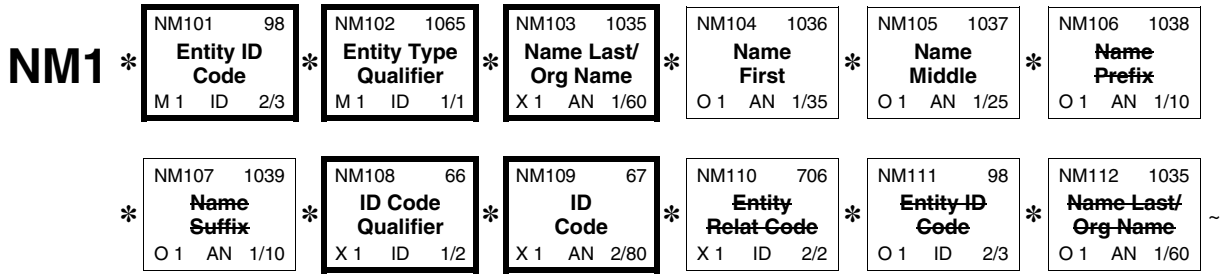
Usage: **REQUIRED**

TR3 Notes:

1. **Recipient of the request from the Information Source. For this business use, this entity can be a provider, a provider group, a clearinghouse, a service bureau, an agency, etc.**

TR3 Example: **NM1*41*2*ABC SUBMITTER*****46*999999999~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

This is the submitter of the original claim or the entity designated to receive the request for additional information.

CODE	DEFINITION
41	**Submitter**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M**	**1**	**ID**	**1/1**
			CODE / **DEFINITION** **1** — **Person** **2** — **Non-Person Entity**				
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Information Receiver Last or Organization Name**	**X**	**1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the value in NM102 = 1 and the person has a first name that is known. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Information Receiver First Name**	**O**	**1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***Required when NM102 = 1 and the person has a middle name or initial that is known. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Information Receiver Middle Name**	**O**	**1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **CODE** / **DEFINITION** **46** — **Electronic Transmitter Identification Number (ETIN)**	**X**	**1**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **IMPLEMENTATION NAME:** **Information Receiver Identification Number** **The ETIN is established through Trading Partner agreement.**	**X**	**1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

SEGMENT DETAIL

HL - SERVICE PROVIDER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

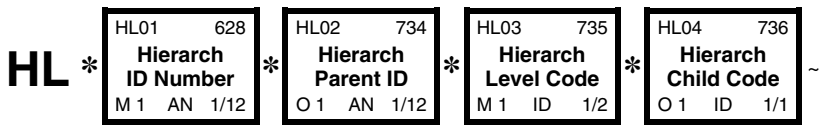
Loop: **2000C — SERVICE PROVIDER LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **HL*3*2*19*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M 1 ID 1/2**

CODE	DEFINITION
19	**Provider of Service**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - SERVICE PROVIDER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

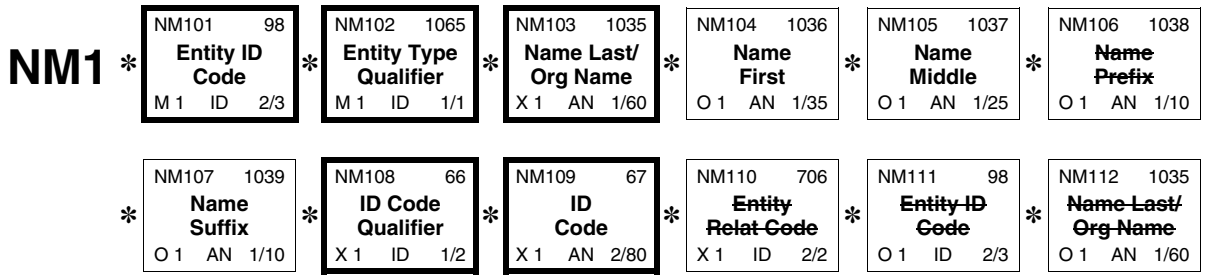
Loop: **2100C — SERVICE PROVIDER NAME Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **NM1*1P*2*HOME MEDICAL*****XX*1666666666~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

CODE	DEFINITION
1P	**Provider**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Provider Last or Organization Name**	**X 1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the value in NM102 = 1 and the person has a first name that is known. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Provider First Name**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***Required when NM102 = 1 and the person has a middle name or initial that is known. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Provider Middle Name**	**O 1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name **SITUATIONAL RULE:** ***Required when NM102 = 1 and the person has a name suffix that is known. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Provider Name Suffix**	**O 1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X 1**	**ID**	**1/2**

CODE	DEFINITION
FI	**Federal Taxpayer's Identification Number**
SV	**Service Provider Number**
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **Required for providers in the United States or its territories when the provider is eligible to receive a National Provider Identifier (NPI).** **OR** **Required for providers not in the United States or its territories when the provider has received an NPI. If not required by this implementation guide, do not send.**

CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: **Provider Identifier**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

HL - PATIENT LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

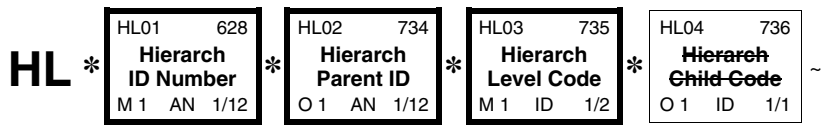
Loop: **2000D — PATIENT LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **HL*4*3*PT~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **CODE** **DEFINITION** **PT** **Patient**	**M 1 ID 1/2**
NOT USED	**HL04**	**736**	**Hierarchical Child Code**	**O 1 ID 1/1**

SEGMENT DETAIL

NM1 - PATIENT NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

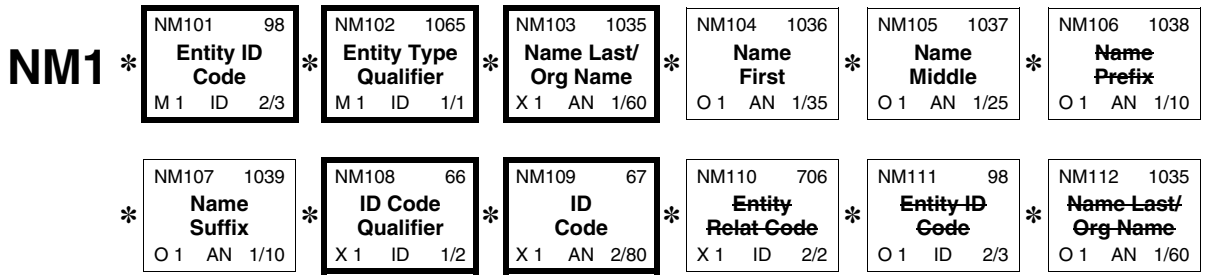
Loop: **2100D — PATIENT NAME Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **NM1*QC*1*SMITH*JOHN*Q**IV*MI*99887777~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**
			CODE / DEFINITION **QC** **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**
			CODE / DEFINITION **1** **Person**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Patient Last Name**	**X 1 AN 1/60**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**1**	**AN**	**1/35**
			SITUATIONAL RULE: ***Required when the value in NM102 = 1 and the person has a first name that is known. If not required by this implementation guide, do not send.***				
			IMPLEMENTATION NAME: **Patient First Name**				
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**1**	**AN**	**1/25**
			SITUATIONAL RULE: ***Required when NM102 = 1 and the person has a middle name or initial that is known. If not required by this implementation guide, do not send.***				
			IMPLEMENTATION NAME: **Patient Middle Name or Initial**				
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**1**	**AN**	**1/10**
			SITUATIONAL RULE: ***Required when NM102 = 1 and the person has a name suffix that is known. If not required by this implementation guide, do not send.***				
			IMPLEMENTATION NAME: **Patient Name Suffix**				
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**1**	**ID**	**1/2**

CODE	DEFINITION
II	**Standard Unique Health Identifier for each Individual in the United States**
	Required if the HIPAA Individual Patient Identifier is mandated for use. If not required, use value "MI" instead.
MI	**Member Identification Number**
	The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Use MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809	**X**	**1**	**AN**	**2/80**
			IMPLEMENTATION NAME: **Patient Primary Identifier**				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

SEGMENT DETAIL

TRN - PAYER CLAIM CONTROL NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

Loop: **2200D — PAYER CLAIM CONTROL NUMBER Loop Repeat: >1**

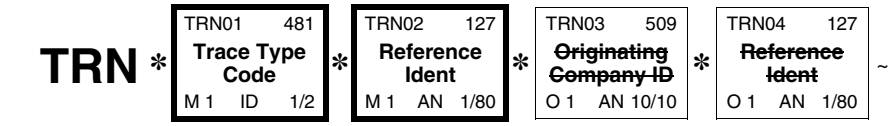
Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes: **1. This is the payer's claim control number.**

TR3 Example: **TRN*1*0612991010987~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **1** — **Current Transaction Trace Numbers**	**M 1 ID 1/2**
REQUIRED	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: TRN02 provides unique identification for the transaction. IMPLEMENTATION NAME: **Payer Claim Control Number** **This is the Control Number assigned by the payer. This number is used by the Payer to connect the request to the response. This number must be returned in the 275 response in the 2000A TRN02 data element.** **Maximum length of this element is constrained by B.1.1.3.1.**	**M 1 AN 1/80**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O 1 AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O 1 AN 1/80**

SEGMENT DETAIL

STC - CLAIM LEVEL STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **>1**

Usage: **SITUATIONAL**

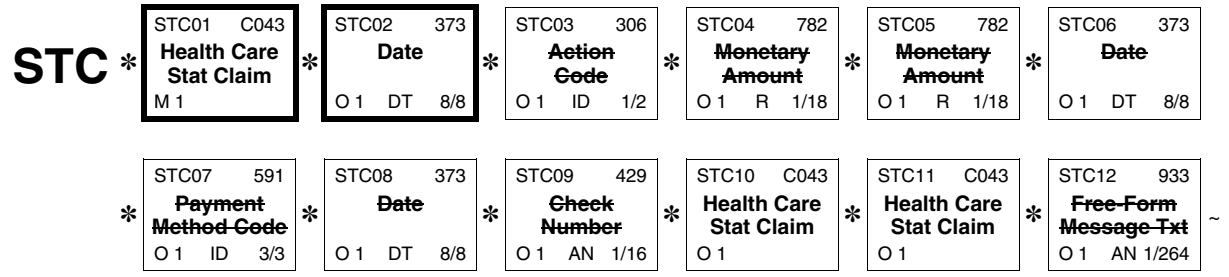
Situational Rule: **Required when requesting additional information at the claim level. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **See Section 1.4.4 - Status Information (STC) Segment Usage for specific STC segment information related to the hierarchical level, composites and code use.**
2. **The codes in this STC segment must be returned in the 275 response in the 2000A STC.**

TR3 Example: **STC*RO:18682-5::LOI*20110824~ or STC*R4:18660-1::LOI*20110824********R4:19790-6::LOI~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**M 1**
REQUIRED	**STC01-01**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02. **IMPLEMENTATION NAME: Health Care Claim Status Category Code** **Use Requests for Additional Information "R" type Category Codes only.**	**M AN 1/30**

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC01-02**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Additional Information Request Code

This is the LOINC® Code that defines the additional information being requested.

NOT USED	**STC01-03**		**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
REQUIRED	**STC01-04**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**O**	**ID**	**1/3**

SEMANTIC:
C043-04 is used to identify the Code Source referenced in C043-02.

This value indicates that STC01-02, STC10-02, STC11-02 are Logical Observation Identifier Names and Codes (LOINC®).

CODE	DEFINITION
LOI	**Logical Observation Identifier Names and Codes (LOINC) Codes** **CODE SOURCE 663:** Logical Observation Identifier Names and Codes (LOINC)

REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year		**O 1**	**DT**	**8/8**

SEMANTIC: STC02 is the effective date of the status information.

IMPLEMENTATION NAME: Status Information Effective Date

This is the date the claim was placed in this status by the Information Source's adjudication process.

NOT USED	**STC03**	**306**	**Action Code**		**O 1**	**ID**	**1/2**
NOT USED	**STC04**	**782**	**Monetary Amount**		**O 1**	**R**	**1/18**
NOT USED	**STC05**	**782**	**Monetary Amount**		**O 1**	**R**	**1/18**
NOT USED	**STC06**	**373**	**Date**		**O 1**	**DT**	**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O 1**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O 1**	**DT**	**8/8**
NOT USED	**STC09**	**429**	**Check Number**		**O 1**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O 1**		

SITUATIONAL RULE: ***Required when additional LOINC® codes are needed to provide greater specificity. If not required by this implementation guide, do not send.***

REQUIRED **STC10-01** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02.

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

Use Requests for Additional Information "R" type Category Codes only.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC10-02** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Additional Information Request Code**

This will be the LOINC® Code that further specifies the request for information.

NOT USED **STC10-03** **98** **Entity Identifier Code** **O** **ID** **2/3**

REQUIRED **STC10-04** **1270** **Code List Qualifier Code** **O** **ID** **1/3**
Code identifying a specific industry code list

SEMANTIC:
C043-04 is used to identify the Code Source referenced in C043-02.

CODE	DEFINITION
LOI	**Logical Observation Identifier Names and Codes (LOINC) Codes** CODE SOURCE **663:** Logical Observation Identifier Names and Codes (LOINC)

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O** **1**
Used to convey status of the entire claim or a specific service line

SITUATIONAL RULE: ***Required when additional LOINC® codes are needed to provide greater specificity. If not required by this implementation guide, do not send.***

REQUIRED **STC11-01** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02.

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

Use Requests for Additional Information "R" type Category Codes only.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC11-02**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Additional Information Request Code

This will be the LOINC® Code that further specifies the request for information.

NOT USED	**STC11-03**		**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
REQUIRED	**STC11-04**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**O**	**ID**	**1/3**

SEMANTIC:
C043-04 is used to identify the Code Source referenced in C043-02.

CODE	DEFINITION
LOI	**Logical Observation Identifier Names and Codes (LOINC) Codes** **CODE SOURCE 663:** Logical Observation Identifier Names and Codes (LOINC)

NOT USED	**STC12**	**933**		**Free-form Message Text**	**O**	**1**	**AN**	**1/264**

SEGMENT DETAIL

REF - PROVIDER'S ASSIGNED CLAIM IDENTIFIER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

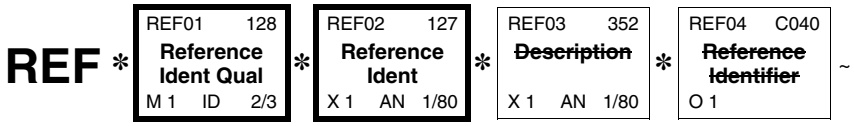
Usage: **SITUATIONAL**

Situational Rule: **Required when the Provider's Assigned Claim Identifier was submitted on the claim. If not required by this implementation guide, do not send.**

TR3 Notes: **1. This segment is the Provider's Assigned Claim Identifier submitted in the CLM01 of the 837.**

TR3 Example: **REF*X1*PT12345~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **X1** — **Provider Claim Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **IMPLEMENTATION NAME: Provider's Assigned Claim Identifier** **Maximum length of this element is constrained by B.1.1.3.1.** **The maximum number of characters to be supported for this field is '35'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - INSTITUTIONAL BILL TYPE IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

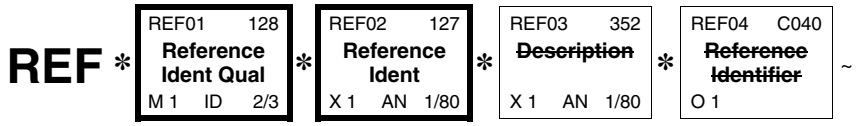
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required for Institutional claims when Institutional Type of Bill was received on the claim. If not required by this implementation guide, do not send.**

TR3 Example: **REF*BLT*111~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **BLT** **Billing Type**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **Concatenate the 837I CLM05-01 (Facility Type Code) and CLM05-03 (Claim Frequency Code) values.** **Code Source 236: Uniform Billing Claim Form Bill Type** **Code Source 235: Claim Frequency Type Code** **Maximum length of this element is constrained by B.1.1.3.1.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - MEDICAL RECORD IDENTIFICATION NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

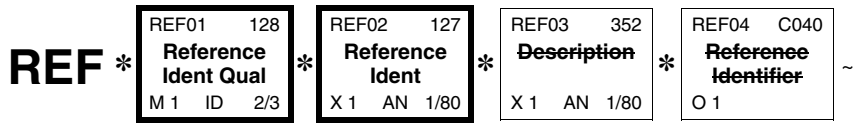
Usage: **SITUATIONAL**

Situational Rule: **Required when the Medical Record Identification Number was submitted on the original claim. If not required by this implementation guide, do not send.**

TR3 Notes: **1. The Medical Record Identification Number is reported in the 837, 2300 Loop REF02 (REF01 = EA).**

TR3 Example: **REF*EA*44444TH56~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **EA** — **Medical Record Identification Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Medical Record Identification Number** **Maximum length of this element is constrained by B.1.1.3.1.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

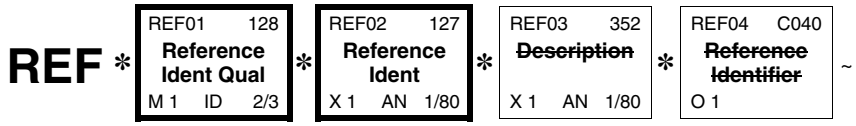
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when a transmission intermediary (clearinghouse or other) needs to attach their own unique tracking number. If not required by this implementation guide, do not send.**

TR3 Example: **REF*D9*TJ98UU321~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: **D9** DEFINITION: **Claim Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Clearinghouse Trace Number** **Maximum length of this element is constrained by B.1.1.3.1.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - PROPERTY & CASUALTY CLAIM NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

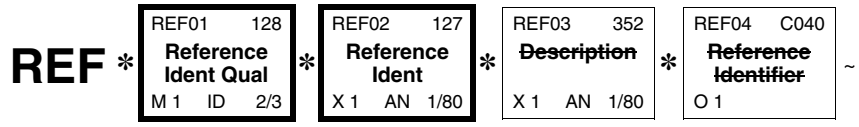
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when requesting information related to a Property & Casualty claim. If not required by this implementation guide, do not send.**

TR3 Example: **REF*Y4*4445555~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **Y4** — **Agency Claim Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Property Casualty Claim Number** **Maximum length of this element is constrained by B.1.1.3.1.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - CASE REFERENCE IDENTIFIER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

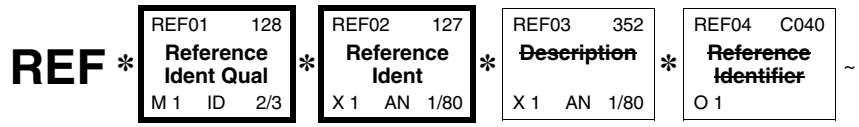
Usage: **SITUATIONAL**

Situational Rule: **Required when a case reference identifier is assigned by the payer and necessary for tracking related attachment requests. If not required by this implementation guide, do not send.**

TR3 Notes: **1. A case reference identifier may be assigned by the payer to link related attachment requests which may involve single or multiple patients and/or providers.**

TR3 Example: **REF*3H*XRAY123~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE — DEFINITION **3H — Case Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Case Reference Identifier**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - ATTACHMENT REQUEST TRACKING IDENTIFIER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

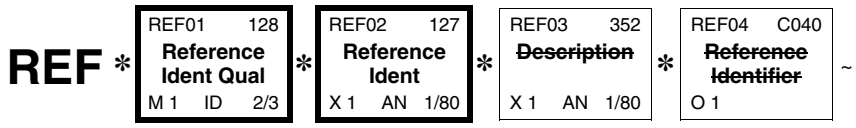
Usage: **SITUATIONAL**

Situational Rule: **Required when an attachment request tracking identifier is assigned by the payer to this attachment request and is necessary for tracking purposes. If not required by this implementation guide, do not send.**

TR3 Notes: **1. This identifier is used to track an individual attachment request for a single claim.**

TR3 Example: **REF*X9*DOC234~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **X9 — Internal Control Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Attachment Request Tracking Identifier**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - PRIOR ATTACHMENT REQUEST TRACKING IDENTIFIER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

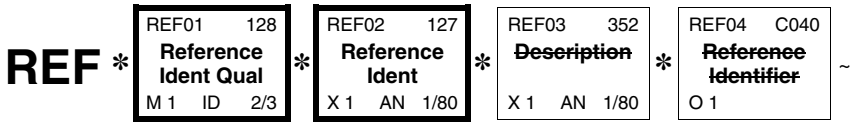
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when a previously issued attachment request tracking identifier has been terminated and replaced with the current attachment request tracking identifier (REF01=X9). If not required by this implementation guide, do not send.**

TR3 Example: **REF*Q4*DOC123~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **Q4** — **Prior Identifier Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Prior Attachment Request Tracking Identifier**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

DTP - SERVICE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

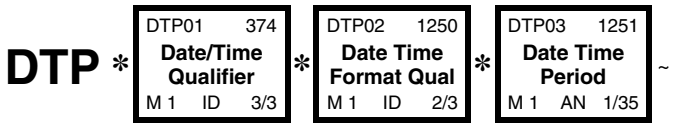
Situational Rule: **Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.**

TR3 Example: **DTP*472*D8*20110201~ OR**
DTP*472*RD8*20110201-20110205~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: Date Time Qualifier	
			CODE — DEFINITION **472 — Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M 1 ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE — DEFINITION **D8 — Date Expressed in Format CCYYMMDD** **RD8 — Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1**	**AN**	**1/35**

IMPLEMENTATION NAME: Claim Service Period

SEGMENT DETAIL

DTP - RESPONSE DUE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2200D — PAYER CLAIM CONTROL NUMBER**

Segment Repeat: **1**

Usage: **REQUIRED**

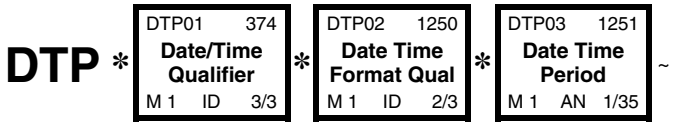
TR3 Notes:

1. **This date is supplied to indicate the date the requested information is to be returned by the Information Receiver.**

   Should this date pass without the requested information being supplied by the Information Receiver, the payer may decide to allow the claim to proceed through the adjudication process based upon the information already received.

TR3 Example: **DTP*106*D8*20110228~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: Date Time Qualifier	
			CODE **DEFINITION** **106** **Required By**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **D8** **Date Expressed in Format CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1 AN 1/35**
			IMPLEMENTATION NAME: Response Due Date	

SEGMENT DETAIL

PWK - CLAIM SUPPLEMENTAL INFORMATION

X12 Segment Name: Paperwork

X12 Purpose: To identify the type or transmission or both of paperwork or supporting information

X12 Set Notes:
1. The 2210 loop may be used when there is a status notification or a request for additional information about a particular claim.

X12 Syntax:
1. **P0506**
   If either PWK05 or PWK06 is present, then the other is required.
2. **P1011**
   If either PWK10 or PWK11 is present, then the other is required.

Loop: **2210D — CLAIM SUPPLEMENTAL INFORMATION Loop Repeat: 1**

Segment Repeat: **1**

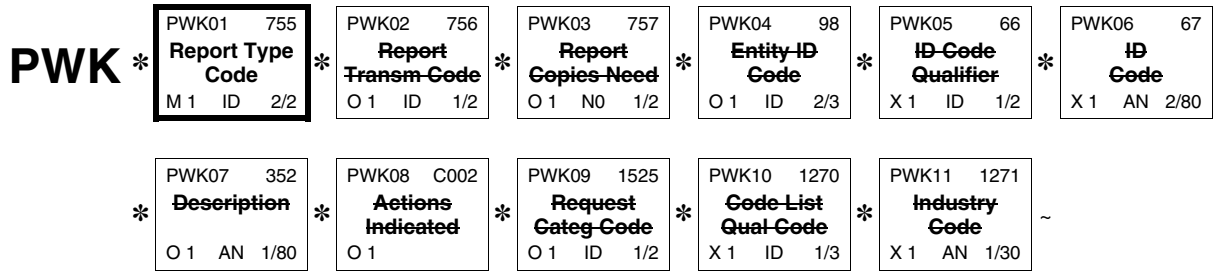
Usage: **SITUATIONAL**

Situational Rule: **Required when the payer must have the requested information returned to a specific contact person, number or location. If not required by this implementation guide, do not send.**

TR3 Notes:
1. **The PWK segment is syntactically required in order to use the Payer Response Contact data in the 2210D Loop.**

TR3 Example: **PWK*OZ~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PWK01**	**755**	**Report Type Code** Code indicating the title or contents of a document, report or supporting item	**M 1 ID 2/2**
			IMPLEMENTATION NAME: **Report Transmission Code**	
			CODE / DEFINITION **OZ** **Support Data for Claim**	
NOT USED	**PWK02**	**756**	**Report Transmission Code**	**O 1 ID 1/2**
NOT USED	**PWK03**	**757**	**Report Copies Needed**	**O 1 N0 1/2**

NOT USED	PWK04	98	Entity Identifier Code	O	1	ID	2/3
NOT USED	PWK05	66	Identification Code Qualifier	X	1	ID	1/2
NOT USED	PWK06	67	Identification Code	X	1	AN	2/80
NOT USED	PWK07	352	Description	O	1	AN	1/80
NOT USED	PWK08	C002	ACTIONS INDICATED	O	1		
NOT USED	PWK09	1525	Request Category Code	O	1	ID	1/2
NOT USED	PWK10	1270	Code List Qualifier Code	X	1	ID	1/3
NOT USED	PWK11	1271	Industry Code	X	1	AN	1/30

SEGMENT DETAIL

PER - PAYER RESPONSE CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

X12 Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

Loop: **2210D — CLAIM SUPPLEMENTAL INFORMATION**

Segment Repeat: **1**

Usage: **REQUIRED**

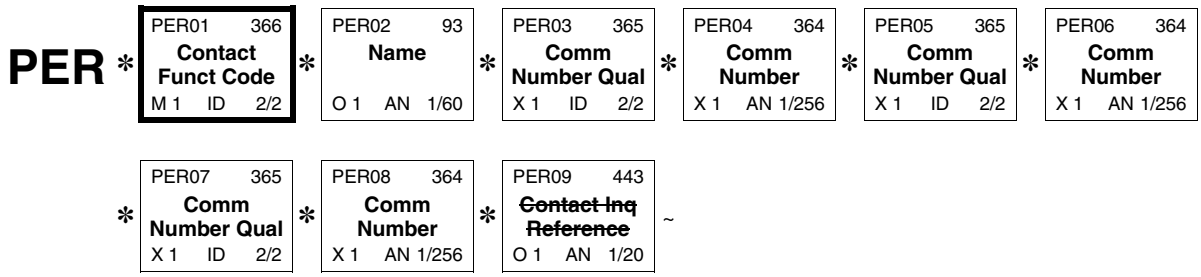
TR3 Notes:

1. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number must always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number. Therefore, the following telephone number (555) 555-1234 would be represented as 5555551234. Do not submit long distance access numbers, such as 1, in the telephone number. Telephone extensions, when applicable, must be submitted in the next element immediately following the telephone number. When submitting telephone extensions, only submit the numeric extension, do not include data that indicates an extension, such as "ext" or "x-".**
2. **The data in this PER is used by the payer for routing the requested information within their system. This data must be returned by the provider. In the 275 Transaction, this data is returned in the 1000A loop PER Segment, Payer Response Contact Information.**

TR3 Example:

PER*RE*MEDICAL REVIEW DEPARTMENT*ED*MRD123*FX*3135554321~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**
			CODE: **RE** DEFINITION: **Receiving Contact**	
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**
			SITUATIONAL RULE: ***Required when it is necessary to identify a contact name or department for questions or general information related to the payer's additional information requests. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***	
			IMPLEMENTATION NAME: **Payer Contact Name**	
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1 ID 2/2**
			SYNTAX: P0304	
			SITUATIONAL RULE: ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.***	
			The presence of the communications qualifiers does not imply the method for which data must be returned.	
			CODE: **ED** DEFINITION: **Electronic Data Interchange Access Number**	
			CODE: **EM** DEFINITION: **Electronic Mail**	
			CODE: **FX** DEFINITION: **Facsimile**	
			CODE: **TE** DEFINITION: **Telephone**	
SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1 AN 1/256**
			SYNTAX: P0304	
			SITUATIONAL RULE: ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Payer Contact Communication Number**	

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X 1** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

SITUATIONAL RULE: ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.***

The presence of the communications qualifiers does not imply the method for which data must be returned.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL **PER06** **364** **Communication Number** **X 1** **AN** **1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0506

SITUATIONAL RULE: ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Payer Contact Communication Number**

SITUATIONAL **PER07** **365** **Communication Number Qualifier** **X 1** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0708

SITUATIONAL RULE: ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.***

The presence of the communications qualifiers does not imply the method for which data must be returned.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable **SYNTAX:** P0708 **SITUATIONAL RULE:** ***Required when the payer needs to identify a specific communication number associated with the return and routing of data in the 275 transaction or to identify other communication methods for returning the data. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Payer Contact Communication Number**	**X 1**	**AN**	**1/256**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O 1**	**AN**	**1/20**

SEGMENT DETAIL

N3 - PAYER RESPONSE CONTACT ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2210D — CLAIM SUPPLEMENTAL INFORMATION**

Segment Repeat: **1**

Usage: **SITUATIONAL**

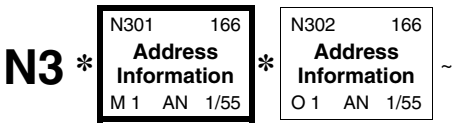
Situational Rule: **Required when the payer needs to identify a specific mailing location for the return of attachment data in the event the 275 transaction will not be used. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.**

TR3 Notes:

1. **This data is not returned in the 275 transaction.**

TR3 Example: **N3*123 MAIN STREET~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			IMPLEMENTATION NAME: **Response Contact Address Line**	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when a second address line is needed. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Response Contact Additional Address Line**	

SEGMENT DETAIL

N4 - PAYER RESPONSE CONTACT CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2210D — CLAIM SUPPLEMENTAL INFORMATION**

Segment Repeat: **1**

Usage: **SITUATIONAL**

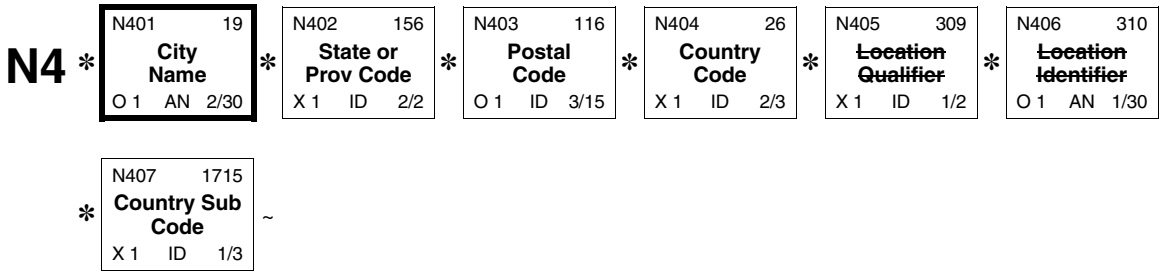
Situational Rule: **Required when the payer needs to identify a specific mailing location for the return of attachment data in the event the 275 transaction will not be used. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.**

TR3 Notes:

1. **This data is not returned in the 275 transaction.**

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **IMPLEMENTATION NAME:** **Response Contact City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Response Contact State Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Response Contact Postal Zone or ZIP Code**

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Response Contact Country Code**

CODE SOURCE 5: Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

NOT USED	**N405**	**309**	**Location Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1**	**AN**	**1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Response Contact Country Subdivision Code**

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

SVC - SERVICE LINE INFORMATION

X12 Segment Name: Service Information

X12 Purpose: To supply payment and control information to a provider for a particular service

Loop: **2220D — SERVICE LINE INFORMATION Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

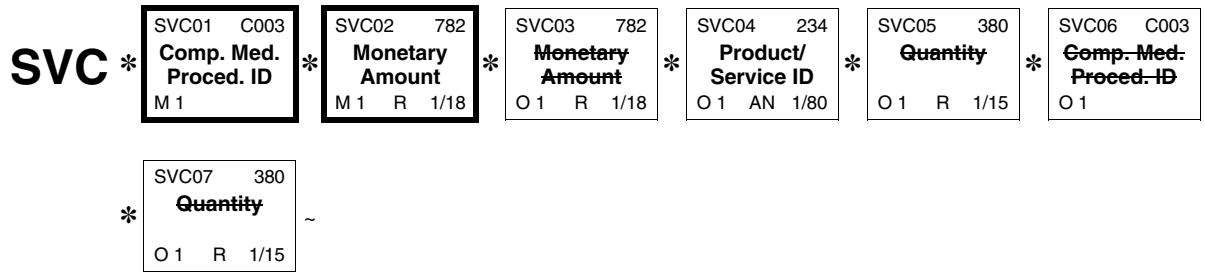
Situational Rule: **Required when the request for additional information is about a service line. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **For Institutional claims, when both an NUBC revenue code and a HCPCS or HIPPS code are reported, the HCPCS or HIPPS code is reported in SVC01-02 and the revenue code is reported in SVC04. When only a revenue code is used, it is reported in SVC01-02.**

TR3 Example: **SVC*NU:0710*15.61~ OR**
SVC*HC:99213*35~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**M 1**
REQUIRED	**SVC01-01**		**235 Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) **SEMANTIC:** C003-01 qualifies C003-02 and C003-08. C003-10 modifies the value in C003-02 and C003-08. C003-11 modifies the value in C003-02 and C003-08. C003-12 modifies the value in C003-02 and C003-08. **IMPLEMENTATION NAME: Product or Service ID Qualifier**	**M ID 2/2**

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association
ER	**Jurisdiction Specific Procedure and Supply Codes** **This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:** **If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA,** **OR** **The Secretary grants an exception to use the code set as a pilot project as allowed under the law,** **OR** **For claims which are not covered under HIPAA.** **CODE SOURCE 576:** Workers Compensation Specific Procedure and Supply Codes
HC	**Healthcare Common Procedure Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC. HCPCS consists of codes from multiple sources including AMA's CPT codes and ADA's CDT codes.** **CODE SOURCE 130:** Healthcare Common Procedure Coding System
HP	**Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code** **CODE SOURCE 716:** Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities
N4	**National Drug Code in 5-4-2 Format** **CODE SOURCE 240:** National Drug Code by Format
NU	**National Uniform Billing Committee (NUBC) UB92 Codes** **This code is the NUBC Revenue Code.** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes

		WK	**Advanced Billing Concepts (ABC) Codes**				
			At the time of this writing, this code set has been approved by the Secretary of HHS as a pilot project allowed under HIPAA law. **The qualifier may only be used in transactions covered under HIPAA:** **By parties registered in the pilot project and their trading partners,** **OR** **If a new rule names the Complementary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA,** **OR** **For claims which are not covered under HIPAA.**				
			CODE SOURCE **843:** Advanced Billing Concepts (ABC) Codes				
REQUIRED	**SVC01-02**	**234**	**Product/Service ID** Identifying number for a product or service SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs. IMPLEMENTATION NAME: **Service Identification Code** **If the value in SVC01-01 is "NU", then this element is an NUBC Revenue Code. If the Revenue Code is present in SVC01-02, then SVC04 is not used.**	**M**	**AN**	**1/80**	
SITUATIONAL	**SVC01-03**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-03 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**	
SITUATIONAL	**SVC01-04**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-04 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**	
SITUATIONAL	**SVC01-05**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-05 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**	

SITUATIONAL	**SVC01-06**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-06 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
NOT USED	**SVC01-07**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**SVC01-08**	**234**	**Product/Service ID**	**O**	**AN**	**1/80**
SITUATIONAL	**SVC01-09**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-09 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01-10**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-10 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01-11**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-11 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01-12**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-12 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required when modifiers have been applied to the procedure code reported in SVC01-02. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** SVC02 is the submitted service charge. **IMPLEMENTATION NAME:** **Line Item Charge Amount**	**M 1**	**R**	**1/18**
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O 1**	**R**	**1/18**

SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code. SITUATIONAL RULE: ***Required on institutional claims to report a NUBC revenue code when a HCPCS or HIPPS code is reported in the SVC01-02. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Revenue Code**	**O**	**1**	**AN**	**1/80**
NOT USED	**SVC05**	**380**	**Quantity**	**O**	**1**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**	**1**		
NOT USED	**SVC07**	**380**	**Quantity**	**O**	**1**	**R**	**1/15**

SEGMENT DETAIL

STC - SERVICE LINE STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2220D — SERVICE LINE INFORMATION**

Segment Repeat: **>1**

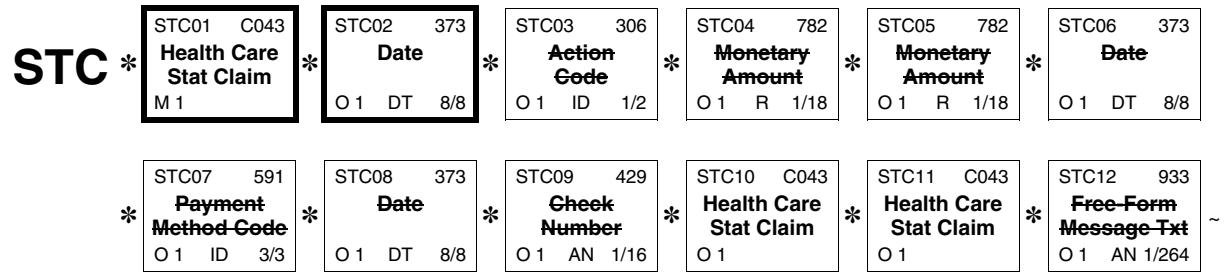
Usage: **REQUIRED**

TR3 Notes:

1. **See Section 1.4.4 - Status Information (STC) Segment Usage for specific STC segment information related to the hierarchical level, composites and code use.**
2. **The codes in this STC segment must be returned in the 275 response in the 2000A STC.**

TR3 Example: **STC*R3:18682-5::LOI*20110501~ or**
STC*R3:18660-1::LOI*20110501******R4:18790-6::LOI~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**M 1**
REQUIRED	**STC01-01**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M AN 1/30**

SEMANTIC:
C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02.

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

Use Requests for Additional Information "R" type Category Codes only.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC01-02**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04. **IMPLEMENTATION NAME: Additional Information Request Code** **This is the LOINC® Code that defines the additional information being requested.**	**M**	**AN**	**1/30**
NOT USED	**STC01-03**		**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
REQUIRED	**STC01-04**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SEMANTIC:** C043-04 is used to identify the Code Source referenced in C043-02. **CODE** / **DEFINITION** **LOI** — **Logical Observation Identifier Names and Codes (LOINC) Codes** **CODE SOURCE 663:** Logical Observation Identifier Names and Codes (LOINC)	**O**	**ID**	**1/3**
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** STC02 is the effective date of the status information. **IMPLEMENTATION NAME: Status Information Effective Date** **This is the date the claim was placed in this status by the Information Source's adjudication process.**	**O 1**	**DT**	**8/8**
NOT USED	**STC03**	**306**	**Action Code**	**O 1**	**ID**	**1/2**
NOT USED	**STC04**	**782**	**Monetary Amount**	**O 1**	**R**	**1/18**
NOT USED	**STC05**	**782**	**Monetary Amount**	**O 1**	**R**	**1/18**
NOT USED	**STC06**	**373**	**Date**	**O 1**	**DT**	**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**	**O 1**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**	**O 1**	**DT**	**8/8**
NOT USED	**STC09**	**429**	**Check Number**	**O 1**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SITUATIONAL RULE:** ***Required when additional LOINC® codes are needed to provide greater specificity. If not required by this implementation guide, do not send.***	**O 1**		
REQUIRED	**STC10-01**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02. **IMPLEMENTATION NAME: Health Care Claim Status Category Code** **Use Requests for Additional Information "R" type Category Codes only.**	**M**	**AN**	**1/30**

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC10-02**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Additional Information Request Code

This will be the LOINC® Code that further specifies the request for information.

NOT USED	**STC10-03**		**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
REQUIRED	**STC10-04**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**O**	**ID**	**1/3**

SEMANTIC:
C043-04 is used to identify the Code Source referenced in C043-02.

CODE	DEFINITION
LOI	**Logical Observation Identifier Names and Codes (LOINC) Codes** **CODE SOURCE 663:** Logical Observation Identifier Names and Codes (LOINC)

SITUATIONAL	**STC11**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O**		**1**

SITUATIONAL RULE: ***Required when additional LOINC® codes are needed to provide greater specificity. If not required by this implementation guide, do not send.***

REQUIRED	**STC11-01**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
C043-01 (Claim Status Category Codes, Code Source 507) is used to specify the logical groupings of codes used in C043-02.

IMPLEMENTATION NAME: Health Care Claim Status Category Code

Use Requests for Additional Information "R" type Category Codes only.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC11-02**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a service line. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Additional Information Request Code

This will be the LOINC® Code that further specifies the request for information.

NOT USED	**STC11-03**		**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

REQUIRED	**STC11-04**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SEMANTIC:** C043-04 is used to identify the Code Source referenced in C043-02.	**O**	**ID**	**1/3**
				CODE **DEFINITION** **LOI** **Logical Observation Identifier Names and Codes (LOINC) Codes** **CODE SOURCE 663:** Logical Observation Identifier Names and Codes (LOINC)			
NOT USED	**STC12**	**933**	**Free-form Message Text**		**O 1**	**AN**	**1/264**

SEGMENT DETAIL

REF - SERVICE LINE ITEM IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2220D — SERVICE LINE INFORMATION**

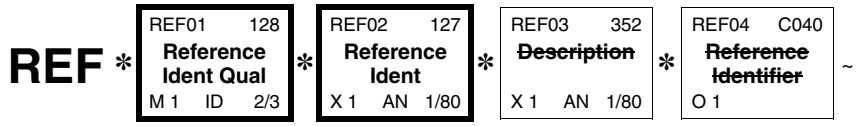
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when a Service Line Item Control Number was submitted on the claim. If not required by this implementation guide, do not send.**

TR3 Example: **REF*6R*54321~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **6R** **Provider Control Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Line Item Control Number** **Maximum length of this element is constrained by B.1.1.3.1.**	**X 1 AN 1/80**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

DTP - SERVICE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2220D — SERVICE LINE INFORMATION**

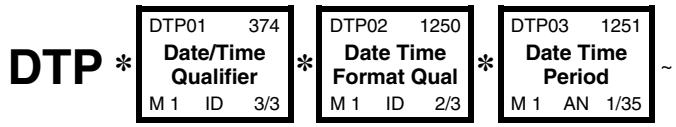
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.**

TR3 Example: **DTP*472*D8*20110201~ OR**
DTP*472*RD8*20110201-20110205~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: **Date Time Qualifier**	
			CODE / DEFINITION **472** — **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD** **RD8** — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1 AN 1/35**
			IMPLEMENTATION NAME: **Service Line Date**	

SEGMENT DETAIL

TOO - TOOTH INFORMATION

X12 Segment Name: Tooth Identification

X12 Purpose: To identify a tooth by number and, if applicable, one or more tooth surfaces

X12 Syntax: **1. P0102**
If either TOO01 or TOO02 is present, then the other is required.

Loop: **2220D — SERVICE LINE INFORMATION**

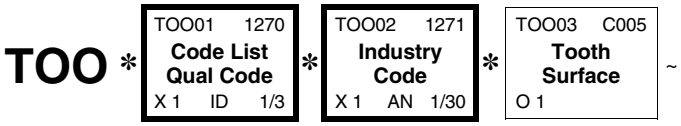
Segment Repeat: **32**

Usage: **SITUATIONAL**

Situational Rule: **Required when tooth information is needed to further define the service. If not required by this implementation guide, do not send.**

TR3 Example: **TOO*JP*12*L:O~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TOO01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102	**X 1 ID 1/3**
			CODE / **DEFINITION** **JO** — **International Standard Designation System for Teeth and Areas of the Oral Cavity** **Required when reporting areas of the oral cavity; do not use to report individual teeth.** **CODE SOURCE 135:** American Dental Association **JP** — **Universal National Tooth Designation System** **Required when reporting individual teeth; do not use when reporting areas of the oral cavity.** **CODE SOURCE 135:** American Dental Association	
REQUIRED	**TOO02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SYNTAX:** P0102 **IMPLEMENTATION NAME:** **Tooth Code**	**X 1 AN 1/30**

SITUATIONAL	**TOO03**	**C005**	**TOOTH SURFACE** To identify one or more tooth surface codes		**O**	**1**	
			SITUATIONAL RULE: ***Required when the procedure code requires tooth surface codes. If not required by this implementation guide, do not send.***				
REQUIRED	**TOO03-01**		**1369**	**Tooth Surface Code** Code identifying the area of the tooth that was treated	**M**	**ID**	**1/2**
			CODE	**DEFINITION**			
			B	**Buccal**			
			D	**Distal**			
			F	**Facial**			
			I	**Incisal**			
			L	**Lingual**			
			M	**Mesial**			
			O	**Occlusal**			
SITUATIONAL	**TOO03-02**		**1369**	**Tooth Surface Code** Code identifying the area of the tooth that was treated	**O**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required when it is necessary to report an additional tooth surface. If not required by this implementation guide, do not send.***				
			Additional tooth surface codes can be carried in TOO03-02 through TOO03-05. The code values are the same as in TOO03-01.				
SITUATIONAL	**TOO03-03**		**1369**	**Tooth Surface Code** Code identifying the area of the tooth that was treated	**O**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required when it is necessary to report an additional tooth surface. If not required by this implementation guide, do not send.***				
SITUATIONAL	**TOO03-04**		**1369**	**Tooth Surface Code** Code identifying the area of the tooth that was treated	**O**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required when it is necessary to report an additional tooth surface. If not required by this implementation guide, do not send.***				
SITUATIONAL	**TOO03-05**		**1369**	**Tooth Surface Code** Code identifying the area of the tooth that was treated	**O**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required when it is necessary to report an additional tooth surface. If not required by this implementation guide, do not send.***				

SEGMENT DETAIL

SE - TRANSACTION SET TRAILER

X12 Segment Name: Transaction Set Trailer

X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

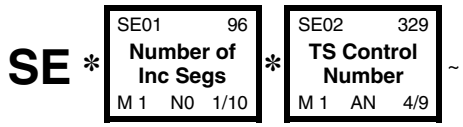
X12 Comments: **1.** SE is the last segment of each transaction set.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **SE*24*0001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments IMPLEMENTATION NAME: **Transaction Segment Count**	**M 1 N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical.**	**M 1 AN 4/9**

3 Examples

Overview

The 277 Health Care Claim Request for Additional Information has been written to be able to send questions concerning claims requiring attachment information.

The 275 Additional Information to Support a Health Care Claim or Encounter has been written to be able to send answers to standard attachments electronically.

The following scenarios reference the Rehabilitative Services (Psychiatric Rehabilitation discipline) Additional Information Specification documents. These attachment examples are being used to show how to code the 277 Request.

3.1 Scenario One - Electronic request, response is returned on paper/fax:

Scenario one depicts the utilization of the 277 and a response that is faxed to the payer in a Medicare Part A institutional environment. One claim has been electronically transmitted to the Medicare Part A fiscal intermediary through the use of XYZ Services, a third party billing service (clearinghouse). In this scenario, the claim has been accepted into the claims adjudication system and requires additional information. The Psychiatric Rehabilitation attachment is needed and is being requested so the claim can continue processing through the adjudication process.

A 277 transaction is sent to the provider for the purpose of requesting additional information. The provider responds to the request by faxing the necessary paper documentation to the payer. In this scenario, the provider does not generate a 275 transaction.

Medicare Part A Fiscal Intermediary, ABC Insurance Company, has a National Payer Identification (PlanID) of 12345. The payer received one ASC X12N 837 Institutional claim from XYZ Services with submitter number A222222221, on behalf of St. Holy Hills Hospital whose national provider number is 1666666666.

The hospital has submitted a claim for outpatient services with a service date of August 12, 2011, for Jack J. Jackson. Mr. Jackson's Medicare Health Insurance Claim Number is 987654320. The hospital assigned a Provider's Assigned Claim Identifier of JACKSON123 and a medical record number of STHHL12345.

ABC Insurance Company assigned a payer internal control number of 1822634840. On August 24, 2011, a 277 request for the psychiatric rehabilitation documentation was generated with a response due date of September 23, 2011.The 277 specifies the Payer wants the information returned to the Medical Review Department and provides a fax number 777-111-4321 and the address of 123 Main Street, Anywhere, CA 11111, in the event the requested information will not be returned via the 275. The psychiatric rehabilitation attachment is being requested to support all services on the claim; therefore, the request is being generated at the claim level.

277 Request for Additional Information Transmission

```
ST*277*1001*006020X313~
BHT*0085*48*277RFI000001*20110824*1211*RQ~
HL*1**20*1~
NM1*PR*2*ABC INSURANCE COMPANY*****XV*12345~
HL*2*1*21*1~
NM1*41*2*XYZ SERVICES*****46*A222222221~
HL*3*2*19*1~
NM1*1P*2*ST HOLY HILLS HOSPITAL*****XX*1666666666~
HL*4*3*PT~
NM1*QC*1*JACKSON*JACK*J***MI*987654320~
TRN*1*1822634840~
STC*R4:18594-2::LOI*20110824~
REF*BLT*111~
REF*X1*JACKSON123~
REF*EA*STHHL12345~
DTP*472*D8*20110812~
DTP*106*D8*20110923~
PWK*OZ~
PER*RE*MEDICAL REVIEW DEPARTMENT*FX*7771114321~
N3*123 MAIN STREET~
N4*ANYWHERE*CA*11111~
SE*22*1001~
```

3.2 Scenario Two - Electronic Request, question at line level:

Scenario two depicts the utilization of the 277 in a Medicare Part A institutional environment. Two claims have been electronically transmitted to the Medicare Part A fiscal intermediary through the use of XYZ Services, a third party billing service

(clearinghouse). In this scenario, both claims have been accepted into the claims adjudication system and require additional information in order to continue processing. A 277 transaction is sent to the provider for the purpose of requesting additional information. The provider responds to the request giving the necessary information in a 275 transaction not shown here.

Medicare Part A Fiscal Intermediary, ABC Insurance Company, has a National Payer Identification (PlanID) of 12345. The payer received two ASC X12N 837 Institutional claims from XYZ Services with submitter number A222222221, on behalf of St. Holy Hills Hospital whose provider number is 1666666666.

The hospital has submitted a claim for outpatient services with a service date of August 12, 2011, for Jack J. Jackson. Mr. Jackson's Medicare Health Insurance Claim Number is 987654320. The hospital assigned a Provider's Assigned Claim Identifier of JACKSON123 and a medical record number of STHHL12345.

ABC Insurance Company assigned a payer internal control number of 1822634840. On August 24, 2011, a 277 request for the psychiatric rehabilitation document was generated with a response due date of September 23, 2011.

The second claim for Peter M. Jones was submitted for inpatient services with service dates of August 7 to August 12, 2011. Mr Jones' Medicare Health Insurance Claim Number is 123456789A. The hospital assigned a Provider's Assigned Claim Identifier of JONES123 and a medical record number of STHHL12378.

ABC Insurance Company assigned a payer internal control number of 1822634845. On August 24, 2011, a 277 request for the psychiatric rehabilitation document was generated with a response due date of September 23, 2011. The psychiatric rehabilitation attachment is being requested to support a single service line detail; therefore, the request is being generated at the service line level.

277 Request for Additional Information Transmission

```
ST*277*1001*006020X313~
BHT*0085*48*277RFI000001*20110824*1211*RQ~
HL*1**20*1~
NM1*PR*2*ABC INSURANCE COMPANY*****XV*12345~
HL*2*1*21*1~
NM1*41*2*XYZ SERVICES*****46*A222222221~
HL*3*2*19*1~
NM1*1P*2*ST HOLY HILLS HOSPITAL*****XX*1666666666~
HL*4*3*PT~
```

```
NM1*QC*1*JACKSON*JACK*J***MI*987654320~
TRN*1*1822634840~
STC*R4:18594-2::LOI*20110824~
REF*BLT*111~
REF*X1*JACKSON123~
REF*EA*STHHL12345~
DTP*472*D8*20110812~
DTP*106*D8*20110923~
HL*5*3*PT~
NM1*QC*1*JONES*PETER*M***MI*123456789A~
TRN*1*1822634845~
REF*BLT*111~
REF*X1*JONES123~
REF*EA*STHHL12378~
DTP*106*D8*20110923~
SVC*NU:0360*2021.75~
STC*R4:18594-2::LOI*20110824~
REF*6R*0011~
DTP*472*RD8*20110807-20110812~
SE*29*1001~
```

3.3 Scenario Three - Electronic Request, questions at claim and line level:

Scenario three depicts the utilization of the 277 and a response (not shown here) that is faxed to the payer in a Medicare Part A institutional environment. One claim has been electronically transmitted to the Medicare Part A fiscal intermediary through the use of XYZ Services, a third party billing service (clearinghouse). In this scenario, the claim has been accepted into the claims adjudication system and requires additional information. A claim level request for psychiatric rehab treatment plan and a service line level request for the psychiatric treatment plan, date attending doctor signed are being conveyed via the 277.

A 277 transaction is sent to the provider for the purpose of requesting additional information. The provider responds to the request by faxing the necessary paper documentation to the payer. In this scenario, the provider does not generate a 275 transaction.

Medicare Part A Fiscal Intermediary, ABC Insurance Company, has a National Payer Identification (PlanID) of 12345. The payer received one ASC X12N 837 Institutional claim from XYZ Services with submitter number A222222221, on behalf of St. Holy Hills Hospital whose national provider number is 1666666666.

The hospital has submitted a claim for outpatient services with a service date of August 12, 2011, for Joe J. Jackson. Mr. Jackson's Medicare Health Insurance Claim Number is 997654320. The hospital assigned a Provider's Assigned Claim Identifier of JACKSON321 and a medical record number of STHHL12346.

ABC Insurance Company assigned a payer internal control number of 1122634840. On August 24, 2011, a 277 request for the psychiatric rehabilitation documentation was generated with a response due date of September 23, 2011. The 277 specifies the Payer contact information of the Medical Review Department at ABC Insurance Company, with a phone number of 555-555-5555 and a fax number of 999-999-9999.

277 Request for Additional Information Transmission

```
ST*277*1001*006020X313~
BHT*0085*48*277RFI000001*20110824*1211*RQ~
HL*1**20*1~
NM1*PR*2*ABC INSURANCE COMPANY*****XV*12345~
PER*IC*MEDICAL REVIEW DEPARTMENT*FX*7771114321*TE*5555555555~
HL*2*1*21*1~
NM1*41*2*XYZ SERVICES*****46*A222222221~
HL*3*2*19*1~
NM1*1P*2*ST HOLY HILLS HOSPITAL*****XX*1666666666~
HL*4*3*PT~
NM1*QC*1*JACKSON*JOE*J***MI*997654320~
TRN*1*1122634840~
STC*R4:18626-2::LOI*20110824~
REF*X1*JACKSON321~
REF*EA*STHHL12346~
REF*BLT*111~
DTP*472*D8*20110812~
DTP*106*D8*20110923~
SVC*NU:0360*2021.75~
STC*R4:18647-8::LOI*20110824~
REF*6R*0011~
DTP*472*RD8*20110807-20110812~
SE*23*1001~
```

A External Code Sources

A.1 External Code Sources

Appendix A is a listing of all external code sources referenced in this implementation guide.

- Where an external code source is referenced, the implementer is required to use only the codes from that list.
- Codes must be reported as listed in the code source (e.g. with leading zeroes).
- Implementers must follow the instructions for code use that are supplied by the code set owner.

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES
26, 100, 1715, 66/38, 235/CH, 955/SP

SOURCE
Codes for Representation of Names of Countries, ISO 3166-(Latest Release)

Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM
American National Standards Institute
25 West 43rd Street, 4th Floor
New York, NY 10036

ABSTRACT
Part 1 (Country codes) of the ISO 3166 international standard establishes codes that represent the current names of countries, dependencies, and other areas of special geopolitical interest, on the basis of lists of country names obtained from the United Nations. Part 2 (Country subdivision codes) establishes a code that represents the names of the principal administrative divisions, or similar areas, of the countries, etc. included in Part 1. Part 3 (Codes for formerly used names of countries) establishes a code that represents non-current country names, i.e., the country names deleted from ISO 3166 since its first publication in 1974. Most currencies are those of the geopolitical

entities that are listed in ISO 3166 Part 1, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166 Part 1, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166 Part 1. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166 Part 1.

22 States and Provinces

SIMPLE DATA ELEMENT/CODE REFERENCES
156, 66/SJ, 235/A5, 771/009

SOURCE
U.S. Postal Service or

Canada Post or
Bureau of Transportation Statistics

AVAILABLE FROM
The U.S. state codes may be obtained from:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013
www.usps.gov
The Canadian province codes may be obtained from:
http://www.canadapost.ca
The Mexican state codes may be obtained from:
www.bts.gov/ntda/tbscd/mex-states.html

ABSTRACT
Provides names, abbreviations, and two character codes for the states, provinces and sub-country divisions as defined by the appropriate government agency of the United States, Canada, and Mexico.

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES
116, 66/16, 309/PQ, 309/PR, 309/PS, 771/010

SOURCE
National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM
U.S Postal Service
Washington, DC 20260
New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT
The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes. The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

121 Health Industry Number

SIMPLE DATA ELEMENT/CODE REFERENCES
66/21, 128/HI, 1270/HI, I05/20

SOURCE
Health Industry Number Database

AVAILABLE FROM
Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT
The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospitals other provider organizations, and manufacturers and distributors.

130 Healthcare Common Procedure Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES
235/HC, 1270/BO, 1270/BP

SOURCE
Healthcare Common Procedure Coding System

AVAILABLE FROM
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT
HCPCS is Centers for Medicare & Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
235/NU, 235/RB, 1270/BE, 1270/BG, 1270/BH, 1270/BI, 1270/NUB

SOURCE
National Uniform Billing Data Element Specifications

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
One North Franklin

Chicago, IL 60606

ABSTRACT
Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.

135 American Dental Association

SIMPLE DATA ELEMENT/CODE REFERENCES
1361, 235/AD, 1270/JO, 1270/JP, 1270/TQ, 1270/AAY

SOURCE
Current Dental Terminology (CDT) Manual

AVAILABLE FROM
Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT
The CDT manual contains the American Dental Association's codes for dental procedures and nomenclature and is the accepted set of numeric codes and descriptive terms for reporting dental treatments and descriptors.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1325

SOURCE
National Uniform Billing Data Element Specifications Type of Bill Last Position

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT
A variety of codes explaining the frequency of different Types of Bills (for example, Replacement Claims).

236 Uniform Billing Claim Form Bill Type

SIMPLE DATA ELEMENT/CODE REFERENCES
1332/A

SOURCE
National Uniform Billing Data Element Specifications Facility Type Code

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT
A variety of codes describing the type of medical facility.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES
235/N1, 235/N2, 235/N3, 235/N4, 235/N5, 235/N6, 1270/NDC

SOURCE
Drug Establishment Registration and Listing Instruction Booklet

AVAILABLE FROM
Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

ABSTRACT
Publication includes manufacturing and labeling information as well as drug packaging sizes.

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1271

SOURCE
Health Care Claim Status Category Code

AVAILABLE FROM
Blue Cross and Blue Shield Association Health Information Technology Department 225 N Michigan Avenue Chicago, IL 60601-7680

ABSTRACT
Code used to organize the Health Care Claim Status Codes into logical groupings

537 Centers for Medicare & Medicaid Services National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XX, 128/HPI

SOURCE
National Provider System

AVAILABLE FROM
Centers for Medicare & Medicaid Services
Office of Financial Management
Division of Provider/Supplier Enrollment
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare & Medicaid Services is developing the National Provider Identifier (NPI), which has been proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Centers for Medicare and Medicaid Services PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XV, 128/ABY

SOURCE
PlanID Database

AVAILABLE FROM
Centers for Medicare and Medicaid Services
Center of Beneficiary Services, Membership Operations Group
Division of Benefit Coordination
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare and Medicaid Services has joined with other payers to develop a unique national payer identification number. The Centers for Medicare and Medicaid Services is the authorizing agent for enumerating payers through the services of a PlanID Registrar. It may also be used by other payers on a voluntary basis.

576 Workers Compensation Specific Procedure and Supply Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
235/ER

SOURCE
IAIABC Jurisdiction Medical Bill Report Implementation Guide

AVAILABLE FROM
IAIABC EDI Implementation Manager
International Association of Industrial Accident Boards and Commissions
8643 Hauses - Suite 200
87th Parkway
Shawnee Mission, KS 66215

ABSTRACT

The IAIABC Jurisdiction Medical Bill Report Implementation Guide describes the requirements for submitting and the data contained within a jurisdiction medical report. The Implementation Guide includes: Reporting scenarios, data definitions, trading partner requirements tables, reference to industry codes, and IAIABC maintained code lists.

663 Logical Observation Identifier Names and Codes (LOINC)

SIMPLE DATA ELEMENT/CODE REFERENCES

128/LOI, 235/LB, 1270/LOI

SOURCE

Logical Observation Identifier Names and Codes (LOINC)

AVAILABLE FROM

Reginstriff Institute
Indiana University School of Medicine
1001 West 10th Street
5th Floor RHC
Indianapolis, IN 46202

ABSTRACT

List of descriptive terms and identifying codes for reporting precise test methods in medicine.

716 Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HP

SOURCE

Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

AVAILABLE FROM

Division of Institutional Claims Processing
Centers for Medicare and Medicaid Services

C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare and Medicaid services develops and publishes the HIPPS codes to establish a coding system for claims submission and claims payment under prospective payment systems. These codes represent the case mix classification groups that are used to determine payment rates under prospective payment systems. Case mix classification groups include, but may not be limited to , resource utilization groups (RUGs) for skilled nursing facilities, home health resource groups (HHRGs) for home health agencies, and case mix groups (CMGs) for inpatient rehabilitation facilities.

843 Advanced Billing Concepts (ABC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
235/WK, 1270/CAH

SOURCE
The CAM and Nursing Coding Manual

AVAILABLE FROM
Alternative Link
6121 Indian School Road NE
Suite 131
Albuquerque, NM 87110

ABSTRACT
The manual contains the Advanced Billing Concepts (ABC) codes, descriptive terms and identifiers for reporting complementary or alternative medicine, nursing, and other integrative health care procedures.

881 Version / Release / Industry Identifier Code

SIMPLE DATA ELEMENT/CODE REFERENCES
480

SOURCE
Data Interchange Standards Association

AVAILABLE FROM
Data Interchange Standards Association
7600 Leesburg Pike, Suite 430
Falls Church, VA 22043

ABSTRACT
Code indicating the version, release, sub-release, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and sub-release, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed.

932 Universal Postal Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
116

SOURCE
Universal Postal Union website

AVAILABLE FROM
International Bureau of the Universal Postal Union
POST*CODE
Case postale 13
3000 BERNE 15 Switzerland

ABSTRACT
The postcode is the fundamental, essential element of an address. A unique, universal identifier, it unambiguously identifies the addressee's locality and assists in the transmission and sorting of mail items. At present, 105 UPU member countries use postcodes as part of their addressing systems.

B Nomenclature

B.1 ASC X12 Nomenclature

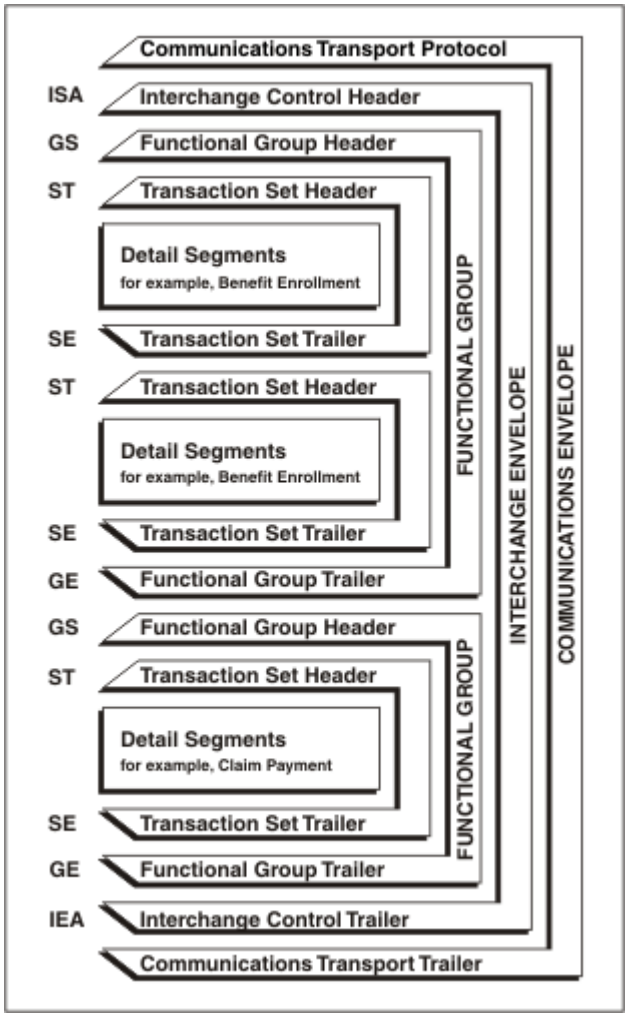
B.1.1 Interchange and Application Control Structures

Appendix B is provided as a reference to the X12 syntax, usage, and related information. It is not a full statement of Interchange and Control Structure rules. The full X12 Interchange and Control Structures and other rules (X12.5, X12.6, X12.59, X12 dictionaries, other X12 standards and official documents) apply unless specifically modified in the detailed instructions of this implementation guide (see Section B.1.1.4 - *Decimal* for an example of such a modification).

B.1.1.1 Interchange Control Structure

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer.
Figure B.1 - *Transmission Control Schematic*, illustrates this interchange control.

Figure B.1 - Transmission Control Schematic



B.1.1.2 Delimiters

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in Table B.1 - *Delimiters*, in all examples of EDI transmissions.

Table B.1 - Delimiters

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue.

B.1.1.3 Data Element Lengths

Data element minimum and maximum lengths are set by the ASC X12 standard. This implementation guide may further restrict minimum and maximum lengths within the bounds set by the standard. Such restrictions may occur implicitly by virtue of the allowed qualifier for the data element, or they may be stated explicitly in a note attached to the element or in the general limitations below.

B.1.1.3.1 Maximum Length of Data Element 127 Reference Identification

The current ASC X12 standard allows a maximum length greater than 50 characters for data element 127. For implementations governed by this implementation guide, unless another value is specified in an attached note, the maximum length of each occurrence of this data element is constrained to 50 characters.

B.1.1.3.2 Maximum Length of Data Element 782 Monetary Amount

For implementations governed by the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note that the decimal point and leading sign, if sent, are not part of the character count.

EXAMPLE

For implementations governed by HIPAA:

- The following transmitted value represents the largest positive dollar amount that can be sent: 99999999.99
- The following transmitted value is the longest string of characters that can be sent representing whole dollars. 99999999
- The following transmitted value is the longest string of characters that can be sent representing negative dollars and cents. -99999999.99
- The following transmitted value is the longest string of characters that can be sent representing negative whole dollars. -99999999

B.1.1.4 Decimal

While the ASC X12 standard supports usage of exponential notation, this guide prohibits that usage.

B.2 Object Descriptors

Object Descriptors (OD) provide a method to uniquely identify specific locations within an implementation guide. There is an OD assigned at every level of the X12N implementation:

1. Transaction Set
2. Loop
3. Segment
4. Composite Data Element
5. Component Data Element
6. Simple Data Element

ODs at the first four levels are coded using X12 identifiers separated by underbars:

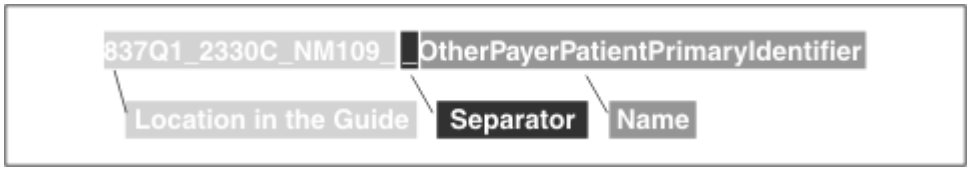
Entity	Example
1. Transaction Set Identifier plus a unique 2 character value	837Q1
2. Above plus under bar plus Loop Identifier as assigned within an implementation guide	837Q1_2330C
3. Above plus under bar plus Segment Identifier	837Q1_2330C_NM1

Entity	Example
4. Above plus Reference Designator plus under bar plus Composite Identifier	837Q1_2400_SV101_C003

The fifth and sixth levels add a name derived from the "Industry Term" defined in the X12N Data Dictionary. The name is derived by removing the spaces.

Entity	Example
5. Number 4 above plus composite sequence plus under bar plus name	837Q1_2400_SV101_C00302_ProcedureCode
6. Number 3 above plus Reference Designator plus two under bars plus name	837Q1_2330C_NM109__OtherPayerPatientPrimaryIdentifier

Said in another way, ODs contain a coded component specifying a location in an implementation guide, a separator, and a name portion. For example:



Since ODs are unique across all X12N implementation guides, they can be used for a variety of purposes. For example, as a cross reference to older data transmission systems, like the National Standard Format for health care claims, or to form XML tags for newer data transmission systems.

C EDI Control Directory

C.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **IEA**
  Interchange Control Trailer Segment

SEGMENT DETAIL

ISA - INTERCHANGE CONTROL HEADER

X12 Segment Name: Interchange Control Header

X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Usage: **REQUIRED**

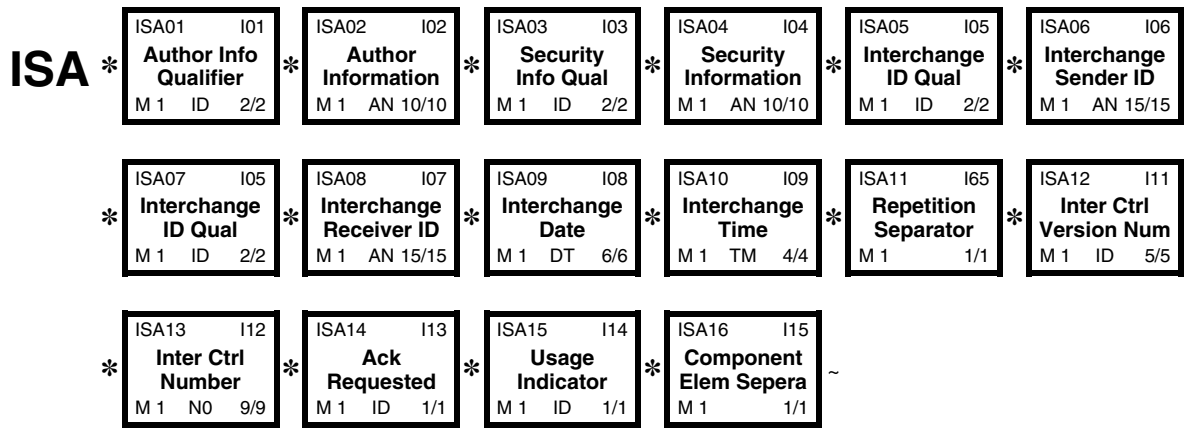
TR3 Notes:

1. **All positions within each of the data elements must be filled.**
2. **For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.**
3. **The first element separator defines the element separator to be used through the entire interchange.**
4. **The ISA segment terminator defines the segment terminator used throughout the entire interchange.**
5. **Spaces in the example interchanges are represented by "." for clarity.**

TR3 Example:

```
ISA*00*..........*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*
RECEIVERS.ID...*030101*1253*^*00602*000000905*1*T*:~
```

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code identifying the type of information in the Authorization Information	**M 1 ID 2/2**

CODE	DEFINITION
00	**No Authorization Information Present (No Meaningful Information in I02)**
03	**Additional Data Identification**

REQUIRED **ISA02** **I02** **Authorization Information** **M 1 AN 10/10**
Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M 1 ID 2/2**
Code identifying the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M 1 AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M 1 ID 2/2**
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M 1 AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M 1 ID 2/2**
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number

			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**			
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**			
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**			
			30	**U.S. Federal Tax Identification Number**			
			33	**National Association of Insurance Commissioners Company Code (NAIC)**			
			ZZ	**Mutually Defined**			
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them		**M 1**	**AN**	**15/15**
REQUIRED	**ISA09**	**I08**	**Interchange Date** Date of the interchange		**M 1**	**DT**	**6/6**
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time** Time of the interchange		**M 1**	**TM**	**4/4**
			The time format is HHMM.				
REQUIRED	**ISA11**	**I65**	**Repetition Separator** Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator		**M 1**		**1/1**
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number** Code specifying the version number of the interchange control segments		**M 1**	**ID**	**5/5**
			CODE	**DEFINITION**			
			00602	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2009**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender		**M 1**	**N0**	**9/9**
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				
			Must be a positive unsigned number and must be identical to the value in IEA02.				

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M 1 ID 1/1**
Code indicating sender's request for an interchange acknowledgment

The Interchange Acknowledgment Segment (TA1) reports the status of the processing of an interchange header and trailer by the addressed receiver. TA1 fields 1, 2, and 3 are used to identify the original interchange whose status is being reported. The ASC X12 Technical Report Type 2, *X12 Acknowledgment Reference Model* provides guidance on several control structures, including the TA1 segment, and transaction set standards intended to augment EDI auditing and control systems.

CODE	DEFINITION
0	**No Interchange Acknowledgment Requested**
1	**Interchange Acknowledgment Requested (TA1)**

REQUIRED **ISA15** **I14** **Interchange Usage Indicator** **M 1 ID 1/1**
Code indicating whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M 1 1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

SEGMENT DETAIL

GS - FUNCTIONAL GROUP HEADER

X12 Segment Name: Functional Group Header

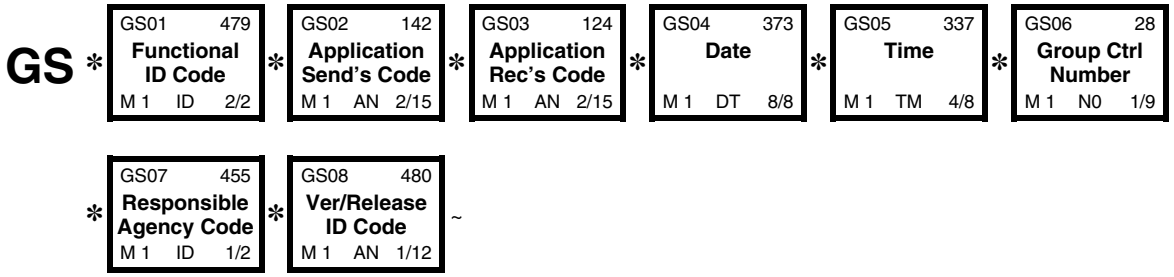
X12 Purpose: To indicate the beginning of a functional group and to provide control information

X12 Comments: **1.** A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Usage: **REQUIRED**

TR3 Example: **GS*XX*SENDER CODE*RECEIVER CODE*19991231*0802*1*X*006020X313~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **This is the 2-character Functional Identifier Code assigned to each transaction set by X12. The specific code for a transaction set defined by this implementation guide is presented in Section 1.2, Version and Release.**	**M 1 ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M 1 AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M 1 AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M 1 DT 8/8**

REQUIRED **GS05** **337** **Time** **M 1 TM 4/8**
Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: GS05 is the group time.

Use this time for the creation time. The recommended format is HHMM.

REQUIRED **GS06** **28** **Group Control Number** **M 1 N0 1/9**
Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.

REQUIRED **GS07** **455** **Responsible Agency Code** **M 1 ID 1/2**
Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M 1 AN 1/12**
Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE SOURCE 881: Version / Release / Industry Identifier Code

This is the unique Version/Release/Industry Identifier Code assigned to an implementation by X12N. The specific code for a transaction set defined by this implementation guide is presented in Section 1.2, Version and Release.

CODE	DEFINITION
006020X313	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2009**

SEGMENT DETAIL

GE - FUNCTIONAL GROUP TRAILER

X12 Segment Name: Functional Group Trailer

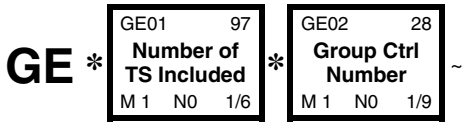
X12 Purpose: To indicate the end of a functional group and to provide control information

X12 Comments:
1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Usage: **REQUIRED**

TR3 Example: **GE*1*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M 1 N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M 1 N0 1/9**

SEGMENT DETAIL

IEA - INTERCHANGE CONTROL TRAILER

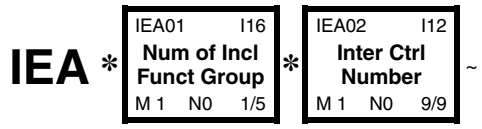
X12 Segment Name: Interchange Control Trailer

X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Usage: **REQUIRED**

TR3 Example: **IEA*1*000000905~**

DIAGRAM



ELEMENT DETAIL

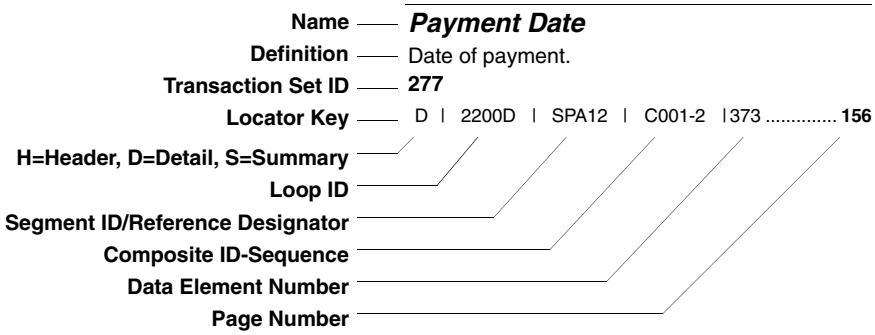
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M 1**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M 1**	**N0**	**9/9**

D Change Summary

This Implementation Guide (006020X313) defines the X12 requirements for the Health Care Claim Request For Additional Information. It is based on version/release/subrelease 006020 of the ASC X12 standards.

E Industry Names

This section contains an alphabetic listing of industry-specific names and definitions attributed to X12 generic data elements and used in this implementation guide. Data element names in normal type are generic ASC X12 names. Italic type indicates an industry defined name. Consult the appropriate X12N Data Element Dictionary, available for purchase at the ASC X12 online store, for a complete list of all X12N Industry Names.



Additional Information Request Code

Code identifying the additional information requested.

277 - Health Care Claim Request For Additional Information

D | 2200D | STC01 | C043-02 | 1271 ..... **57**
D | 2200D | STC10 | C043-02 | 1271 ..... **58**
D | 2200D | STC11 | C043-02 | 1271 ..... **59**
D | 2220D | STC01 | C043-02 | 1271 ..... **86**
D | 2220D | STC10 | C043-02 | 1271 ..... **87**
D | 2220D | STC11 | C043-02 | 1271 ..... **87**

Attachment Request Tracking Identifier

A unique reference identifier assigned by the payer to track an attachment request.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF02 | - | 127 ..... **66**

Case Reference Identifier

A unique reference identifier assigned by the payer to link related attachment requests.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF02 | - | 127 ..... **65**

Claim Service Period

The beginning and end dates for the service period covered by a claim.

277 - Health Care Claim Request For Additional Information

D | 2200D | DTP03 | - | 1251 ..... **69**

Clearinghouse Trace Number

Unique tracking number for the transaction assigned by a clearinghouse.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF02 | - | 127 ..... **63**

Code List Qualifier Code

Code identifying a specific industry code list.

277 - Health Care Claim Request For Additional Information

D | 2200D | STC01 | C043-04 | 1270 ..... **57**
D | 2200D | STC10 | C043-04 | 1270 ..... **58**
D | 2200D | STC11 | C043-04 | 1270 ..... **59**
D | 2220D | STC01 | C043-04 | 1270 ..... **86**
D | 2220D | STC10 | C043-04 | 1270 ..... **87**
D | 2220D | STC11 | C043-04 | 1270 ..... **88**
D | 2220D | TOO01 | - | 1270 ..... **91**

Communication Number Qualifier

Code identifying the type of communication number.

277 - Health Care Claim Request For Additional Information

D | 2100A | PER03 | - | 365 ..... **40**

D	2100A	PER05	-	365		**41**
D	2100A	PER07	-	365		**42**
D	2210D	PER03	-	365		**74**
D	2210D	PER05	-	365		**75**
D	2210D	PER07	-	365		**75**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

277 - Health Care Claim Request For Additional Information

D	2100A	PER01	-	366		**40**
D	2210D	PER01	-	366		**74**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format.

277 - Health Care Claim Request For Additional Information

D	2200D	DTP02	-	1250		**68**
D	2200D	DTP02	-	1250		**70**
D	2220D	DTP02	-	1250		**90**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

277 - Health Care Claim Request For Additional Information

D	2200D	DTP01	-	374		**68**
D	2200D	DTP01	-	374		**70**
D	2220D	DTP01	-	374		**90**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual.

277 - Health Care Claim Request For Additional Information

D	2100A	NM101	-	98		**37**
D	2100B	NM101	-	98		**45**
D	2100C	NM101	-	98		**49**
D	2100D	NM101	-	98		**53**

Entity Type Qualifier

Code qualifying the type of entity.

277 - Health Care Claim Request For Additional Information

D	2100A	NM102	-	1065		**37**
D	2100B	NM102	-	1065		**46**
D	2100C	NM102	-	1065		**49**
D	2100D	NM102	-	1065		**53**

Health Care Claim Status Category Code

Code indicating the category of the associated claim status code.

277 - Health Care Claim Request For Additional Information

D	2200D	STC01	C043-01	1271		**56**
D	2200D	STC10	C043-01	1271		**58**
D	2200D	STC11	C043-01	1271		**58**
D	2220D	STC01	C043-01	1271		**85**
D	2220D	STC10	C043-01	1271		**86**
D	2220D	STC11	C043-01	1271		**87**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

277 - Health Care Claim Request For Additional Information

D	2000A	HL04	-	736		**36**
D	2000B	HL04	-	736		**44**
D	2000C	HL04	-	736		**48**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

277 - Health Care Claim Request For Additional Information

D	2000A	HL01	-	628		**35**
D	2000B	HL01	-	628		**43**
D	2000C	HL01	-	628		**47**
D	2000D	HL01	-	628		**52**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

277 - Health Care Claim Request For Additional Information

D	2000A	HL03	-	735		**35**
D	2000B	HL03	-	735		**43**
D	2000C	HL03	-	735		**47**
D	2000D	HL03	-	735		**52**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

277 - Health Care Claim Request For Additional Information

D	2000B	HL02	-	734		**43**
D	2000C	HL02	-	734		**47**
D	2000D	HL02	-	734		**52**

Hierarchical Structure Code

Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

277 - Health Care Claim Request For Additional Information

H		BHT01	-	1005		**33**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67).

277 - Health Care Claim Request For Additional Information

D	2100A	NM108	-	66		**38**

D | 2100B | NM108 | - | 66 ..... **46**
D | 2100C | NM108 | - | 66 ..... **50**
D | 2100D | NM108 | - | 66 ..... **54**

Information Receiver First Name

The first name of the individual or organization who expects to receive information in response to a query.

277 - Health Care Claim Request For Additional Information
D | 2100B | NM104 | - | 1036 ..... **46**

Information Receiver Identification Number

The identification number of the individual or organization who expects to receive information in response to a query.

277 - Health Care Claim Request For Additional Information
D | 2100B | NM109 | - | 67 ..... **46**

Information Receiver Last or Organization Name

The name of the organization or last name of the individual that expects to receive information or is receiving information.

277 - Health Care Claim Request For Additional Information
D | 2100B | NM103 | - | 1035 ..... **46**

Information Receiver Middle Name

The middle name of the individual or organization who expects to receive information in response to a query.

277 - Health Care Claim Request For Additional Information
D | 2100B | NM105 | - | 1037 ..... **46**

Line Item Charge Amount

Charges related to this service.

277 - Health Care Claim Request For Additional Information
D | 2220D | SVC02 | - | 782 ..... **83**

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

277 - Health Care Claim Request For Additional Information
D | 2220D | REF02 | - | 127 ..... **89**

Medical Record Identification Number

A unique number assigned to patient by the provider to assist in retrieval of medical records.

277 - Health Care Claim Request For Additional Information
D | 2200D | REF02 | - | 127 ..... **62**

Originator Application Transaction Identifier

An identification number that identifies a transaction within the originator's applications system.

277 - Health Care Claim Request For Additional Information
H | | BHT03 | - | 127 ..... **33**

Patient First Name

The first name of the individual to whom the services were provided.

277 - Health Care Claim Request For Additional Information
D | 2100D | NM104 | - | 1036 ..... **54**

Patient Last Name

The last name of the individual to whom the services were provided.

277 - Health Care Claim Request For Additional Information
D | 2100D | NM103 | - | 1035 ..... **53**

Patient Middle Name or Initial

The middle name or initial of the individual to whom the services were provided.

277 - Health Care Claim Request For Additional Information
D | 2100D | NM105 | - | 1037 ..... **54**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

277 - Health Care Claim Request For Additional Information
D | 2100D | NM107 | - | 1039 ..... **54**

Patient Primary Identifier

Identifier assigned by the payer to identify the patient

277 - Health Care Claim Request For Additional Information
D | 2100D | NM109 | - | 67 ..... **54**

Payer Claim Control Number

A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN).

277 - Health Care Claim Request For Additional Information

D	2200D	TRN02	-	127		**55**

Payer Contact Communication Number

Complete payer contact communications number, including country or area code when applicable.

277 - Health Care Claim Request For Additional Information

D	2100A	PER04	-	364		**41**
D	2100A	PER06	-	364		**41**
D	2100A	PER08	-	364		**42**
D	2210D	PER04	-	364		**74**
D	2210D	PER06	-	364		**75**
D	2210D	PER08	-	364		**76**

Payer Contact Name

Name identifying the payer organization's contact person.

277 - Health Care Claim Request For Additional Information

D	2100A	PER02	-	93		**40**
D	2210D	PER02	-	93		**74**

Payer Identifier

Number identifying the payer organization.

277 - Health Care Claim Request For Additional Information

D	2100A	NM109	-	67		**38**

Payer Name

Name identifying the payer organization.

277 - Health Care Claim Request For Additional Information

D	2100A	NM103	-	1035		**37**

Prior Attachment Request Tracking Identifier

A unique reference identifier previously assigned by the payer to track an attachment request.

277 - Health Care Claim Request For Additional Information

D	2200D	REF02	-	127		**67**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

277 - Health Care Claim Request For Additional Information

D	2220D	SVC01	C003-03	1339		**82**
D	2220D	SVC01	C003-04	1339		**82**
D	2220D	SVC01	C003-05	1339		**82**
D	2220D	SVC01	C003-06	1339		**83**
D	2220D	SVC01	C003-09	1339		**83**
D	2220D	SVC01	C003-10	1339		**83**
D	2220D	SVC01	C003-11	1339		**83**
D	2220D	SVC01	C003-12	1339		**83**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

277 - Health Care Claim Request For Additional Information

D	2220D	SVC01	C003-01	235		**81**

Property Casualty Claim Number

Identification number for property casualty claim associated with the services identified on the bill.

277 - Health Care Claim Request For Additional Information

D	2200D	REF02	-	127		**64**

Provider First Name

The first name of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

277 - Health Care Claim Request For Additional Information

D	2100C	NM104	-	1036		**50**

Provider Identifier

Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider.

277 - Health Care Claim Request For Additional Information

D	2100C	NM109	-	67		**51**

Provider Last or Organization Name

The last name of the provider of care or name of the provider organization submitting a transaction or related to the information provided in or request by the transaction.

277 - Health Care Claim Request For Additional Information

D	2100C	NM103	-	1035		**50**

Provider Middle Name

The middle name of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

277 - Health Care Claim Request For Additional Information

D | 2100C | NM105 | - | 1037 ..... **50**

Provider Name Suffix

The name suffix of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

277 - Health Care Claim Request For Additional Information

D | 2100C | NM107 | - | 1039 ..... **50**

Provider's Assigned Claim Identifier

The identifier generated by the provider for the purposes of reassociation to their claim accounts receivable.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF02 | - | 127 ..... **60**

Reference Identification

The identification value assigned by the sender for this particular transaction.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF02 | - | 127 ..... **61**

Reference Identification Qualifier

Code qualifying the reference identification.

277 - Health Care Claim Request For Additional Information

D | 2200D | REF01 | - | 128 ..... **60**
D | 2200D | REF01 | - | 128 ..... **61**
D | 2200D | REF01 | - | 128 ..... **62**
D | 2200D | REF01 | - | 128 ..... **63**
D | 2200D | REF01 | - | 128 ..... **64**
D | 2200D | REF01 | - | 128 ..... **65**
D | 2200D | REF01 | - | 128 ..... **66**
D | 2200D | REF01 | - | 128 ..... **67**
D | 2220D | REF01 | - | 128 ..... **89**

Report Transmission Code

Code defining timing, transmission method or format by which reports are to be sent.

277 - Health Care Claim Request For Additional Information

D | 2210D | PWK01 | - | 755 ..... **71**

Response Contact Additional Address Line

The additional address line of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N302 | - | 166 ..... **77**

Response Contact Address Line

The address line of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N301 | - | 166 ..... **77**

Response Contact City Name

The city name of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N401 | - | 19 ..... **78**

Response Contact Country Code

Code identifying the country in the address of the entity that is the designated recipient of requested additional information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N404 | - | 26 ..... **79**

Response Contact Country Subdivision Code

The Country Subdivision Code of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N407 | - | 1715 ..... **79**

Response Contact Postal Zone or ZIP Code

The Postal Zone or ZIP Code of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N403 | - | 116..... **79**

Response Contact State Code

The state of the person or organization designated to receive the requested information.

277 - Health Care Claim Request For Additional Information

D | 2210D | N402 | - | 156 ..... **79**

Response Due Date

Date by which the requester must receive the information or other response that is requested.

277 - Health Care Claim Request For Additional Information

D	2200D	DTP03	-	1251	**70**

Revenue Code

A code that identifies a specific accommodation, ancillary service or billing calculation.

277 - Health Care Claim Request For Additional Information

D	2220D	SVC04	-	234	**84**

Service Identification Code

A code from a recognized coding scheme identified by a qualifier that describes the service rendered.

277 - Health Care Claim Request For Additional Information

D	2220D	SVC01	C003-02	234	**82**

Service Line Date

Date of service of the identified service line on the claim.

277 - Health Care Claim Request For Additional Information

D	2220D	DTP03	-	1251	**90**

Status Information Effective Date

The date that the status information provided is effective.

277 - Health Care Claim Request For Additional Information

D	2200D	STC02	-	373	**57**
D	2220D	STC02	-	373	**86**

Tooth Code

An indication of the tooth on which services were performed or will be performed.

277 - Health Care Claim Request For Additional Information

D	2220D	TOO02	-	1271	**91**

Tooth Surface Code

The surface(s) of the tooth on which services were performed or will be performed.

277 - Health Care Claim Request For Additional Information

D	2220D	TOO03	C005-01	1369	**92**
D	2220D	TOO03	C005-02	1369	**92**
D	2220D	TOO03	C005-03	1369	**92**
D	2220D	TOO03	C005-04	1369	**92**
D	2220D	TOO03	C005-05	1369	**92**

Trace Type Code

Code identifying the type of re-association which needs to be performed.

277 - Health Care Claim Request For Additional Information

D	2200D	TRN01	-	481	**55**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

277 - Health Care Claim Request For Additional Information

D		SE01	-	96	**93**

Transaction Set Control Number

The unique identification number within a transaction set.

277 - Health Care Claim Request For Additional Information

H		ST02	-	329	**32**
D		SE02	-	329	**93**

Transaction Set Creation Date

Identifies the date the submitter created the transaction.

277 - Health Care Claim Request For Additional Information

H		BHT04	-	373	**34**

Transaction Set Creation Time

Time file is created for transmission.

277 - Health Care Claim Request For Additional Information

H		BHT05	-	337	**34**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

277 - Health Care Claim Request For Additional Information

H		ST01	-	143	**32**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

277 - Health Care Claim Request For Additional Information

H		BHT02	-	353	**33**

Transaction Type Code

Code specifying the type of transaction.

277 - Health Care Claim Request For Additional Information

H		BHT06	-	640	**34**

Version, Release, or Industry Identifier

Code indicating the version, release, sub-release and industry identification of the EDI standard being used.

277 - Health Care Claim Request For Additional Information

H | | ST03 | - | 1705 ..... **32**

F ASC X12 Code List/External Value Domain Harmonization

F.1 Administrative Gender

Source code list

X12 DE 1068 - Gender Code
owned by ASC X12
Element Attributes: 1/1 ID

Target code list

SNOMED
owned by International Health Terminology Standard Development Organisation (IHTSDO)

X12 DE 1068 - Gender Code	SNOMED
F - Female	1086007 Female structure (body structure)
M - Male	10052007 Male structure (body structure)
U - Unknown	37791004 Indeterminate sex (body structure)