National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim Status Request and Response

276/277

ASC X12N 276/277 (004010X093)

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1 Purpose and Business Overview

1.1 Document Purpose

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 ANSI ASC X12.316 Health Care Claim Status Request (276) and the ANSI ASC X12.317 Health Care Claim Status Response (277). This implementation guide focuses on the use of the 276 to request the status of a health care claim(s) and the 277 to respond with the information regarding the specified claim(s). This implementation guide provides detailed explanations of the transaction sets by defining uniform data content, identifying valid code tables, and specifying values applicable for the business focus of the 276 Health Care Claim Status Request and the 277 Health Care Claim Status Response. The intention of the developers of the 276 and 277 is represented in the guide.

This implementation guide is designed to assist those who request the health care claim status using the 276 format, those who receive the 276 request, those who respond using the 277 format, and those who receive the 277 format.

Entities requesting health care claim status include, but are not limited to, hospitals, nursing homes, laboratories, physicians, dentists, allied professional groups, employers, and supplemental (i.e., other than primary payer) health care claims adjudication processors.

Organizations sending the 277 Health Care Claim Status Response include payers, who may be insurance companies; third party administrators; service corporations; state and federal agencies and their contractors; plan purchasers; and any other entity that processes health care claims.

Other business partners affiliated with the 276 and/or the 277 include billing services; consulting services; vendors of systems; software and EDI translators; and EDI network intermediaries such as Automated Clearing Houses (ACHs), Value-Added Networks (VANs), and telecommunications services.

1.1.1 Trading Partner Agreements

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g.,

payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values which are not valid in this Implementation Guide
- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

1.1.2 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Health Claims Status Request and Response. Should the Secretary adopt the X12N 276/277 Health Care Claim Status Request and Response transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA. If adopted under HIPAA, the X12N 276/277 Health Care Claim Status Request and Response transaction cannot be implemented except as described in this Implementation Guide.

1.1.3 Disclaimers Within The Transactions

The developers of this Implementation Guideline strongly discourage the transmission of a disclaimer as a part of the transaction. Any disclaimers necessary should be outlined in the agreement between trading partners. Under no circumstances should there be more than one disclaimer returned per individual response.

1.2 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010). This is the first ASC

X12N guide for this business function of these transaction sets. Previous documentation for these transaction sets includes tutorials based upon Version 3, Release 7, Sub-release 0 (003070) of the 276 and 277.

1.3 Business Use

The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following:

- a solicited response to a health care claim status request (276)
- a notification about health care claim(s) status, including front end acknowledgments
- a request for additional information about a health care claim(s)

The 276 is used only in conjunction with the 277 Health Care Claim Status Response. Therefore, this implementation guide addresses the paired usage of the 276 as a **request for claim status** and the 277 as a **response to that request.**

Separate implementation guides were developed to detail using the 277 Health Care Payer Unsolicited Claim Status and the 277 Health Care Claim Request for Additional Information.

It is the intent of the authors that claim status requests processed in a realtime mode will only provide a status of a claim that has been accepted by the payers' adjudication system within 90 days from the date of the inquiry.

Claim status requests that are processed in a batch mode, will return claim status information that is available on the payers' adjudication system that has not been purged.

1.3.1 Health Care Claim Status Request

The 276 is used to transmit request(s) for status of specific health care claim(s).

Authorized entities involved with processing the claim need to track the claim's current status through the adjudication process. The purpose of generating a 276 is to obtain the current status of the claim within the adjudication process. Status information can be requested at the claim and/or line level.

The 276 includes information that is necessary for the payer to identify the specific claim in question. The primary, or unique, identifying element(s) may be supplied to obtain an exact match. However, when the requester does not know the unique element(s), the claim generally is located by supplying several parameters including the provider number, patient identifier, date(s) of service, and submitted charge(s) from the original claim.

1.3.2 Health Care Claim Status Response

The payer uses the 277 Health Care Claim Status Response to transmit the current status within the adjudication process to the requester. When the 276 does not uniquely identify the claim within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester.

Examples of status locations within a payer's adjudication process, which vary from payer to payer, may include the following:

- pre-adjudication (accepted/rejected claim status)
- claim pended for development (incorrect/incomplete claim(s) within adjudication process) or suspended claim(s) requesting additional information
- finalized claims

Further defined, finalized claims may have outcomes that include the following:

- finalized rejected claim(s)
- finalized denied claim(s)
- finalized approved claim(s) pre-payment
- finalized approved claim(s) post-payment

The status locations are described briefly to convey a cohesive understanding of the use of the 277 Health Care Claim Status Response.

1.3.2.1 Pre-Adjudication System Status

Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This process is performed so that incorrectly formatted claims or those that are missing information can be returned to the provider for correction. Returned claims may not have claim numbers assigned by the payer. For additional information see the 277 Health Care Payer Unsolicited Claim Status Implementation Guide.

1.3.2.2 Claim(s) Pended for Development or Suspended for Additional Information

Payers may perform validation editing within their adjudication system and accept, but pend, erroneous claims. Generally, the payer assigns a claim number to the pended claim, notifies the provider of the reason(s) why the claim is pended, requests corrective action, and continues the adjudication process when the corrected information is received.

Similar to a pended claim, a suspended claim requires additional information to complete the adjudication process. Generally, this information is not billing information but rather supplemental information that supports or explains the rendered health care services. This information may be required according to the insurer's medical or utilization policy to monitor the provider's health care delivery patterns, or to manage and coordinate the health care delivered to the individual.

The payer uses the 277 Health Care Claim Request for Additional Information to notify the provider of claims that are pended or suspended and of the specific, additional information requested to release each claim for continued adjudication processing. This guide does not detail the actual request for additional information.

1.3.2.3 Finalized Claim(s)

Claims that complete the adjudication process are referred to as “finalized claims.” These claims are returned to the provider/submitter by way of the Health Care Claim Payment/Advice (835). The adjudication determination is concluded. Subsequent business events (e.g., an adjustment or an appeal) may occur, but the claim would be given additional identification. Claims may be finalized and rejected, denied, approved for payment, or paid.

1.3.2.4 Finalized Rejected Claim(s)

Pended claims (i.e., incorrect or incomplete claims within the payer’s adjudication system) that exceed the response time frame are finalized and rejected. Generally, the payer removes the claim(s) from his or her pended workload and retains this information in history files.

1.3.2.5 Finalized Denied Claim(s)

Claims may reach final adjudication status and not result in a claim payment. One reason is that the claim services billed on the claim are denied. Reasons why services may be denied include the following: no contract is in effect for the patient, the contract does not cover the services billed, and prior claims were paid to the maximum allowed covered benefit for the currently billed services.

1.3.2.6 Finalized Approved Claim(s) Pre-Payment

Claims may be in final adjudication status but have not yet resulted in a check (electronic or paper) being issued. Due to processing requirements within payment systems, claims may be in this status for specific time intervals. For example, some payers create checks for disbursement on a weekly basis while other payers issue checks no more frequently than fourteen days from receipt. Generally, the amount to be paid is available for claims in this status; however, it is typical that the check number is unknown.

1.3.2.7 Finalized Approved Claim(s) Post-Payment

When claims reach final adjudication status and are paid, complete information is available for inquiry. In some situations the claims approved for payment may not have a check issued. Two examples of this include penalty withholdings and recoveries from erroneously made prior payments.

A payer can expect to receive inquiries for claims that complete the adjudication process. Examples of reasons for post-payment claim status inquiries include the following: coordination of benefits, appeal of adjudication results, and adjustment billing.

1.4 Information Flow

Figure 1, General Claim Status Information Flow, illustrates the flow of information related to the 276 and all uses of the 277 Health Care Claim Status Response.

It is recognized from this overview that the provider needs to differentiate between the multiple uses of the 277 claim status. See 2.2.2.1, 276 Table 1 — Header Level, for details. For additional information, see the *277 Health Care Payer Unsolicited Claim Status Implementation Guide (X070)* and the *277 Health Care Claim Request for Additional Information Implementation Guide (X104).*

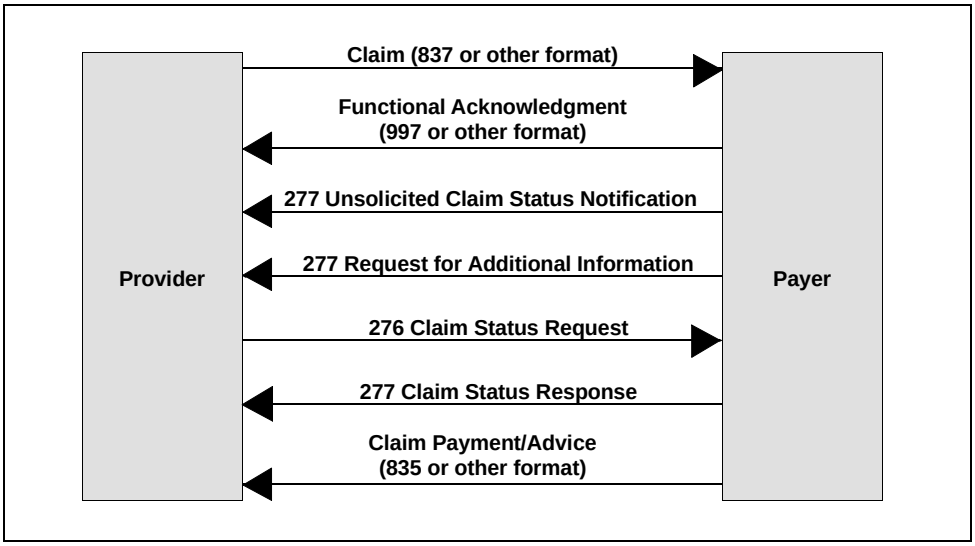


Figure 1. General Claim Status Information Flow

Figure 2, Information Flow for Claim Status Request/Response, illustrates the flow of information for the 276 Health Care Claim Status Request and the 277 Health Care Claim Status Response.

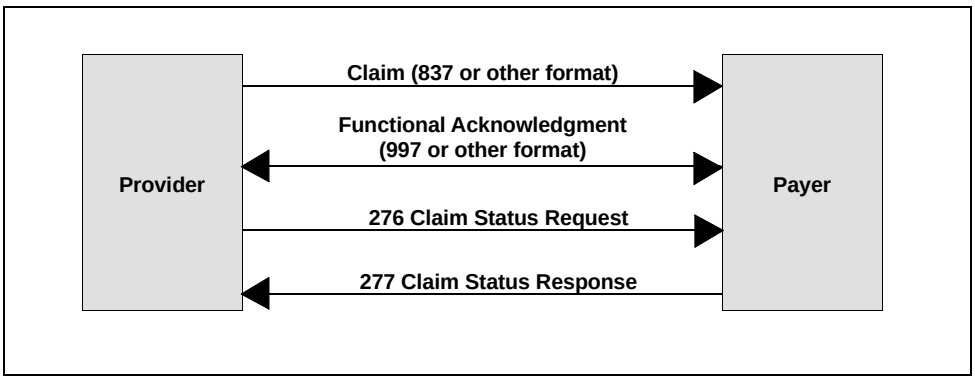


Figure 2. Claim Status Request/Response

1.5 Batch and Real Time Definitions

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time.

Batch – When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. In a batch mode, the sender sends multiple transactions to the receiver, either directly or through a switch (clearinghouse), and does not remain connected while the receiver processes the transactions. If there is an associated business response transaction (such as a 271 response to a 270 for eligibility), the receiver creates the response transaction for the sender off-line. The original sender typically reconnects at a later time (the amount of time is determined by the original receiver or switch) and picks up the response transaction. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

Important: When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see section A.1.5.1 for details).

Real Time – Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the response transaction, a 997 Functional Acknowledgment, or a TA1 segment (for details on the TA1 segment, see section A.1.5.1).

2 Data Overview

This section introduces the structure of the 276 and 277 transaction sets and describes the positioning of the business data within the structure. Familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structures is recommended. For a review, see Appendix A, ASC X12 Nomenclature, and Appendix B, EDI Control Directory.

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set: the Implementation view and the Standard view. Figure 3, 276 Transaction Set Listing, and figure 4, 277 Transaction Set Listing, show the Implementation view. This view displays only the segments and their designated health care names described in this implementation guide. 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.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
010	HL	Information Source Level	R	1	
		LOOP ID - 2100A PAYER NAME			>1
050	NM1	Payer Name	R	1	
060	N3	Payer Address	S	2	
	...				

Figure 3. 276 Transaction Set Listing

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
010	HL	Information Source Level	R	1	
		LOOP ID - 2100A PAYER NAME			>1
050	NM1	Payer Name	R	1	
060	N3	Payer Address	S	2	
	...				

Figure 4. 277 Transaction Set Listing

The standard view is presented in section 3, Transaction Set. The Standard view displays all segments available within the transaction set with their assigned ASC X12 names.

2.2 Data Use by Business Use

The 276 and 277 transaction sets are similar in structure but are not duplicates. Both transactions are presented here in parallel. Similarities are noted and differences are contrasted. The business use is presented sequentially as the tables, loops, segments, data elements, and data values are described.

Both the 276 and the 277 transaction sets are divided into two levels, or tables. Table 1 contains transaction control information. Table 2, which is presented in 2.2.3, Table 2 — Detail Information, contains the detail information for the business function of the transaction.

2.2.1 Table 1 — Transaction Control Information

Table 1 is named the Header Level, which includes the ST and BHT segments. The ST segment identifies the start of a transaction and the specific transaction set. The BHT identifies the transactions business purpose and the hierarchial structure.

Table 1 contains the same segments for both of the 276 and 277 transaction sets.

2.2.2 Claim Status Theory

The level of information potentially available for a Claim Status Response may vary drastically from Payer to Payer. In order to make this transaction usable to the Information Receiver and to give the Information Source a target to which to build, minimum theoretical guidelines must be established for the industry. Payers are free to provide a greater level of detail information, but are required to meet these basic minimums.

The primary vehicle for the claim status information in the 277 transaction is the STC segment and the three iterations of the C043 composite. Other information usage is described in the implementation detail in section 3. This section will provide implementation guidelines for the STC segment and the C043 composite.

The STC segment contains three iterations of the C043 (Health Care Claim Status) composite. These are located at STC01, STC10 and STC11. STC01 is required. STC10 and 11 are optional and are used to provide additional information in complicated situations. A complicated situation could be when multiple attachments have been requested of the Provider for a specific claim.

The first element in C043 (C043-1) is the Health Care Claim Status Category Code. For the business use of this implementation guide, all codes in the list apply except the REQUEST group of codes (R0, R1, R2, R3, R4, R5 and RQ). The Request codes apply only to the 277 transaction as a Request for Additional Information. For this implementation, the Information Source is required to be able to supply status information to discriminate between all of the applicable Status Category Codes. For instance, providing only support for code P0 (Pending: Adjudication/Details) when a claim is really in a category of P3 (Pending/Requested Information) would not meet the minimum business requirements of this transaction set.

The second element of C043 (C043-2) is the Health Care Claim Status Code. This element provides more detailed information as to the reason for the claim being in the category identified in C043-1. This element is Required for use when the composite is used. While the Information Source should endeavor to provide full information by making use of the entire code list, the minimum requirement is to support the following basic codes:

Code Description

0 Cannot provide further status electronically.
1 For more detailed information, see remittance advice.
2 More detailed information in letter.

For instance, when a claim is pended awaiting additional information to identify the medical necessity for the service, the Information Source must report a Category code of P3 and a Status code of 0. The Information Source is encouraged to support more detail by identifying a Status code of 287 (Medical necessity for service).

The third element of C043 (C043-2) is the Entity Identifier. The code in this element provides the identity of an entity referred to in the Status code in C043-2. This element would only be used when an Information Source supports more than the minimum level of information.

2.2.2.1 276 Table 1 — Header Level

See figure 5, 276 Header Level, for an example of Table 1.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BHT	Beginning of Hierarchical Transaction	R	1	

Figure 5. 276 Header Level

A coding example of Table 1 in the 276 follows. Appendix A, ASC X12 Nomenclature, gives descriptions of data element separators (e.g. *) and segment terminators (e.g. ~).

```
ST*276*0001~
BHT*0010*13~
```

The Transaction Set Header Segment (ST) identifies the transaction set by using the 276 as the data value for the transaction set identifier code data element. The ST segment also contains a unique control number (i.e., 0001 in the example). The transaction set originator (i.e., the provider in the example) assigns the unique control number.

The Beginning of Hierarchical Transaction Segment (BHT) indicates that the transaction uses a hierarchical data structure. The value of 0010 in the hierarchical structure code data element describes the order of the hierarchical levels and the business purpose of each level. This data element is described in greater detail in 2.2.2.3, Hierarchical Level Data Structure.

Using a value of 13 in the Transaction Set Purpose Code data element defines the transaction as a **request**. In contrast to the 277 transaction set, the 276 is a single purpose transaction set. Therefore, the Transaction Type Code is not necessary and is not used.

2.2.2.2 277 Table 1 — Header Level

See figure 6, 277 Header Level, for an example of Table 1.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BHT	Beginning of Hierarchical Transaction	R	1	

Figure 6. 277 Header Level

The following is a coding example of Table 1 in the 277 Health Care Claim Status Response:

```
ST*277*1111~
BHT*0010*08****DG~
```

The Transaction Set Header Segment (ST) identifies the transaction set as a 277. The transaction set originator (i.e., the payer in this example) assigns the unique control number (i.e., 1111 in the example) .

The 277 also uses a hierarchical data structure, which is indicated by using the Beginning of Hierarchical Transaction Segment (BHT). The order of the hierarchical levels and the business purpose of each level is identical to the 276; therefore, the hierarchical structure code data element uses the value 0010. This data element is defined in greater detail in 2.2.2.3, Hierarchical Level Data Structure.

The BHT segment in the 277 transaction set also identifies the transaction as a **response** by using a value 08 in the Transaction Set Purpose Code. Because the 277 transaction is multi-functional, it is important for the receiver to know which business purpose is served. Therefore, the Transaction Set Type Code data element is used. A data value of DG is used in the Transaction Set Type Code to indicate that this response is a **reply to an inquiry**.

The Functional Group Header Segment (GS) provides additional identification of the business purpose of multi-functional transaction sets. See Appendix B, EDI Control Directory, for a detailed description of the elements in the GS segment.

2.2.2.3 Hierarchical Level Data Structure

The hierarchical level structure is used to identify and relate the participants involved in the transaction. The participants identified in the 277 are generally the payer, submitter (e.g., service bureau, Automated Clearing House, provider groups), provider of service, subscriber, and dependent. A 0010 value in the BHT hierarchical structure code describes the order of appearance of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- Information Source

- Information Receiver
- Service Provider
- Subscriber
- Dependent

2.2.3 Table 2 — Detail Information

The hierarchical level structure is used in Table 2. Each hierarchical level (HL) is a series of loops. The loops are identified by numbers. The hierarchical level that identifies the participant and the relationship to other participants is Loop ID-2000. The individual or entity name is contained in Loop ID-2100. See 2.2.3.1, Transaction Participants, for detailed information.

Specific claim details begin with Loop ID-2200. It is at this point — Loop ID-2200 — that the 276 and 277 transactions begin to differ. See 2.2.3.2, Claim, and 2.2.3.3, Claim Request, for detailed information.

Figure 7, 276 Detail Level, presents the segments used in Table 2 of the 276. These segments define the participants and the specific claim(s) for which status is requested.

Table 2 - Detail, Subscriber Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000D SUBSCRIBER LEVEL			**>1**
010	**HL**	Subscriber Level	**R**	**1**	
040	**DMG**	Subscriber Demographic Information	**S**	**1**	
		LOOP ID - 2100D SUBSCRIBER NAME			**>1**
050	**NM1**	Subscriber Name	**R**	**1**	
		LOOP ID - 2200D CLAIM SUBMITTER TRACE NUMBER			**>1**
090	**TRN**	Claim Submitter Trace Number	**S**	**1**	
100	**REF**	Payer Claim Identification Number	**S**	**1**	
100	**REF**	Institutional Bill Type Identification	**S**	**1**	
100	**REF**	Medical Record Identification	**S**	**1**	
110	**AMT**	Claim Submitted Charges	**S**	**1**	
120	**DTP**	Claim Service Date	**S**	**1**	
		LOOP ID - 2210D SERVICE LINE INFORMATION			**>1**
130	**SVC**	Service Line Information	**S**	**1**	
140	**REF**	Service Line Control Number	**S**	**1**	
150	**DTP**	Service Line Date	**S**	**1**	

Table 2 - Detail, Dependent Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000E DEPENDENT LEVEL			**>1**
010	**HL**	Dependent Level	**S**	**1**	
040	**DMG**	Subscriber Demographic Information	**S**	**1**	
		LOOP ID - 2100E PATIENT NAME			**>1**
050	**NM1**	Patient Name	**R**	**1**	
	. . .				

Figure 7. 276 Detail Level

Figure 8, 277 Detail Level, presents the segments used in Table 2 of the 277. These segments define the participants and the specific status for the claim(s) identified in the 276 Health Care Claim Status Request.

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	**HL**	Hierarchical Level	**M**	**1**	
020	**SBR**	Subscriber Information	**O**	**1**	
030	**PAT**	Patient Information	**O**	**1**	
040	**DMG**	Demographic Information	**X**	**1**	
		LOOP ID - 2100			**>1**
050	**NM1**	Individual or Organizational Name	**O**	**1**	
080	**PER**	Administrative Communications Contact	**X**	**1**	
		LOOP ID - 2200			**>1**
090	**TRN**	Trace	**O**	**1**	
100	**STC**	Status Information	**M**	**>1**	
110	**REF**	Reference Identification	**O**	**3**	
120	**DTP**	Date or Time or Period	**O**	**2**	
		LOOP ID - 2210			**>1**
130	**PWK**	Paperwork	**O**	**1**	
140	**PER**	Administrative Communications Contact	**X**	**1**	
150	**N1**	Name	**O**	**1**	
		LOOP ID - 2220			**>1**
180	**SVC**	Service Information	**O**	**1**	
190	**STC**	Status Information	**M**	**>1**	
200	**REF**	Reference Identification	**O**	**1**	
210	**DTP**	Date or Time or Period	**O**	**1**	
		. . .			

Figure 8. 277 Detail Level

The hierarchical level structure presented in figure 9, Participants and Their Relationships, is the same for both the 276 Health Care Claim Status Request and the 277 Health Care Claim Status Response.

The participants described are as follows:

- **Information Source —** This entity is the decision maker in the business transaction. For this business use, this entity is the payer.

Table 2 - Detail, Information Source Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A INFORMATION SOURCE LEVEL			**>1**
010	**HL**	Information Source Level	**R**	**1**	
		LOOP ID - 2100A PAYER NAME			**>1**
050	**NM1**	Payer Name	**R**	**1**	

Figure 9. Participants and Their Relationships

- **Information Receiver—** This entity expects the response from the information source. For this business use, this entity can be a provider, a provider group, an Claims Clearinghouse, a service bureau, an agency, an employer, etc.
- **Service Provider —** This entity delivered the health care service.
- **Subscriber —** This entity is known by the insurance carrier.
- **Dependent —** This entity is entitled to health care benefits because of his or her relationship to the subscriber.

NOTE
The term “information source” does not refer to who is sending the transaction. Instead, it refers to the owner of the decision making information. In this business use, the term “information source” describes the entity that has the current status information for the specified claim(s). Therefore, the information source hierarchical level describes the payer in both the 276 request transaction and the 277 response transaction.

The relationships between the hierarchical levels are described by the hierarchical level code data element, also known as HL03. The value found in HL03 identifies the relationships within the transaction.

When HL03 = 20, the hierarchical level contains the information source.

When HL03 = 21, the hierarchical level contains the information receiver.

When HL03 = 19, the hierarchical level contains the service provider.

When HL03 = 22, the hierarchical level contains the subscriber information.

When HL03 = 23, the hierarchical level contains the dependent information.

Sample Table 2 configurations for the 276 Health Care Claim Status Request follow:

Request for claim status when the patient is the subscriber.

Information Source (20)
Information Receiver (21)
Service Provider (19)
Subscriber (22)
Requested Claim(s) Identification

The following matrix identifies the segments that may be used in the hierarchical levels for the 276 when the subscriber is the patient:

Loop ID	Seg. ID	Info. Source HL (20)	Info. Receiver HL (21)	Service Provider HL (19)	Subscriber HL (22)	Dependent HL (23)	Business Purpose
2000	HL	YES	YES	YES	YES		Describes participants and relationships
2000	DMG				YES		Subscribers Demographic Information
2100	NM1	YES	YES	YES	YES		Participant name
2200	TRN				YES		Transaction Trace Number
2200	REF				YES		Payer’s claim number
2200	REF				YES		Institutional Bill Type

Loop ID	Seg. ID	Info. Source HL (20)	Info. Receiver HL (21)	Service Provider HL (19)	Subscriber HL (22)	Dependent HL (23)	Business Purpose
2200	REF				YES		Medical Record
2200	AMT				YES		Submitted charges
2200	DTP				YES		Dates of service
2210	SVC				YES		Line item inquiry - service info
2210	REF				YES		Line item inquiry - line item number
2210	DTP				YES		Line item inquiry - line item dates of service
2220	STC				YES		Line Level Status

Sample 1: Table 2 Configurations for 276 Health Care Claim Status Request.

Request for claim status when the patient is the dependent.

Information Source (20)
Information Receiver (21)
Service Provider (19)
Subscriber (22)
Dependent (23)
Requested Claim(s) Identification

The following matrix identifies the segments that may be used in the hierarchical levels for the 276 when the dependent is the patient:

Loop ID	Seg. ID	Info. Source HL (20)	Info. Receiver HL (21)	Service Provider HL (19)	Subscriber HL (22)	Dependent HL (23)	Business Purpose
2000	HL	YES	YES	YES	YES	YES	Describes participants and relationships
2000	DMG					YES	Patients Demographic Information
2100	NM1	YES	YES	YES	YES	YES	Participant name
2100	PER	YES	NO	NO	NO	NO	Payer contract information
2200	TRN					YES	Transaction Trace Number
2200	REF					YES	Payer's claim number
2200	REF					YES	Institutional Bill Type
2200	REF					YES	Medical Record
2200	AMT					YES	Submitted charges
2200	DTP					YES	Dates of service
2210	SVC					YES	Line item inquiry - service info
2210	REF					YES	Line item inquiry - line item number
2210	DTP					YES	Line item inquiry - line item dates of service
2220	STC					YES	Line Level Status

Sample 2: Table 2 Configurations for 276 Health Care Claim Status Request.

The following are sample Table 2 configurations for the 277 Health Care Claim Status Response:

Response with claim status when the patient is the subscriber.

Information Source (20)
Information Receiver (21)
Service Provider (19)
Subscriber (22)
Claim Status Response

The following matrix identifies the segments that may be used within the hierarchical levels for the 277 Health Care Claim Status Response when the subscriber is the patient:

Loop ID	Seg. ID	Info. Source HL (20)	Info. Receiver HL (21)	Service Provider HL (19)	Subscriber HL (22)	Dependent HL (23)	Business Purpose
2000	HL	YES	YES	YES	YES		Describes participants and relationships
2000	DMG				YES		Subscribers Demographic Information
2100	NM1	YES	YES	YES	YES		Participant name
2200	TRN				YES		Transaction Trace Number
2200	STC				YES		Claim Status
2200	REF				YES		Payer's Claim Number
2200	REF				YES		Institutional Bill Type
2200	REF				YES		Medical Record
2200	DTP				YES		Dates of service
2220	SVC				YES		Line item inquiry - service info
2220	REF				YES		Line item inquiry - line item number
2220	DTP				YES		Line item inquiry - line item dates of service
2220	STC				YES		Line Level Status

Sample 3: Table 2 Configurations for 277 Health Care Claim Status Response.

Response with claim status when the patient is the dependent.

Information Source (20)
Information Receiver (21)
Service Provider (19)
Subscriber (22)
Dependent (23)
Claim Status Response

The following matrix identifies the segments that may be used within the hierarchical levels for the 277 Health Care Claim Status Response when the dependent is the patient:

Loop ID	Seg. ID	Info. Source HL (20)	Info. Receiver HL (21)	Service Provider HL (19)	Subscriber HL (22)	Dependent HL (23)	Business Purpose
2000	HL	YES	YES	YES	YES	YES	Describes participants and relationships
2000	DMG					YES	Patients Demographic Information
2100	NM1	YES	YES	YES	YES	YES	Participant name
2200	TRN					YES	Transaction Trace Number
2200	STC					YES	Claim status
2200	REF					YES	Payer's claim number
2200	REF					YES	Institutional Bill Type
2200	REF					YES	Medical Record
2200	DTP					YES	Dates of service
2220	SVC					YES	Line item inquiry - service info
2220	REF					YES	Line item inquiry - line item number
2220	DTP					YES	Line item inquiry - line item dates of service
2220	STC					YES	Line Level Status

Sample 4: Table 2 Configuration for the 277 Health Care Claim Status Response.

2.2.3.1 Transaction Participants

A detailed view of the segments and data elements used to describe the participants and their relationships is presented here. The segments and data elements are found in Loop ID-2000 and Loop ID-2100.

NOTE
The term "Information Source" does **not** refer to who is sending the transaction. Instead, it refers to the owner of the decision making information. In this business use, the term "Information Source" describes the entity that has the current status information for the specified claim(s). Therefore, the Information Source hierarchical level describes the payer in both the 276 Request transaction and the 277 Response transaction.

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 a service bureau entity acting on behalf of the Service Provider. When this occurs, the service bureau entity is described when HL03 = 21, and the provider of service is described when HL03 = 19. In other instances, the Information Receiver also is the Service Provider. When this occurs, the same entity is described at two hierarchical levels — when HL02 = 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*****SV*987666666~
```

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

```
HL*4*3*22*1~
NM1*IL*1*MANN*JOHN****MI*345678901~
```

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

```
HL*5*4*23~
NM1*QC*1*MANN*JOSEPH****MI*345678901-02~
```

2.2.3.1.1 HL Segment

The following is a summary from the HL segment coding examples:

`HL*1**20*1~`	Extract from the Information Source level
`...`	
`HL*2*1*21*1~`	Extract from the Information Receiver level
`...`	
`HL*3*2*19*1~`	Extract from the Service Provider
`...`	
`HL*4*3*22*1~`	Extract from the Subscriber level
`...`	
`HL*5*4*23~`	Extract from the Dependent level
`...`	

Based on the preceding HL segment coding examples, the following is noted:

- HLs are sequentially numbered. The sequential number is found in HL01, which is the first data element in the HL segment.
- The second element, or HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level is subordinate. Information source is the parent. By the absence of a data value in HL02, it is known that this is the highest hierarchical level. The information receiver level is subordi-

nate to the hierarchical level numbered 1 (HL01). The provider of service level is subordinate to the hierarchical level numbered 2 (HL02), 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 = 23, the hierarchical level is the dependent.
- Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of “1" indicates subsequent hierarchical levels. A value of ”0" or the absence of a data value indicates that no hierarchical levels follow.

NOTE
Specific claim detail information is not given a hierarchical level. The specific claim(s) in question are described in Loop ID-2200 and the service information follows in Loop ID-2220. This claim(s) information is said to “float”. There is a technique for placing this information within the hierarchical levels. Claim information is positioned in the same hierarchical level that describes its owner-participant, either the Subscriber or the Dependent. That means the claim(s) information is placed at the Subscriber hierarchical level when the patient is the subscriber and placed at the Dependent hierarchical level when the patient is the dependent of the subscriber.

Optionally, Loop ID-2210 is available at the discretion of the payer. Some payers may request that the provider route the response information to a specific location.

2.2.3.1.2 NM1 Segment

Always use the NM1 segment to carry the primary identifier (see NM108 and NM109). The following is a coding example of the NM1 segment:

NM1*PR*2*ABC INSURANCE***PI*12345~**

Within the NM1,

NM101 = PR
This value indicates that the Information Source is a payer. Other values used for the identified participants in this implementation guide are submitter (41), service provider (1P), insured (IL), and patient (QC).

NM102 = 2
This value indicates that the entity is a non-person. An entity that is a person is identified with a value of 1. When the entity is a person, NM103 and NM104 contain the last and first names, respectively.

NM103 = ABC INSURANCE
This value identifies the Information Source as ABC INSURANCE. While the name is not required, the developers of this implementation guide recommend using it.

NM108 = PI
This value identifies the next data element as the assigned Payer Identification. Other values used for the participants identified in this implementation guide include the following:

- Employer’s Identification Number (24)
- Health Insurance Claim Number (HN)
- Member Identification Number (MI)

- Medicaid Recipient Identification Number (MR)
- Insured's Unique Identification Number (N)
- Service Provider Number (SV)

NM109 = 12345
This value is the actual identification code associated with NM108 (e.g., PI), that is, the payer named ABC INSURANCE in this example.

2.2.3.1.3 PER Segment

The payer uses the PER segment to specify the administrative communications contact who should receive inquiries regarding the claim status response. The PER Segment will only be used in the 277 Response.

PER*ICEM*CLMSTAT@123.COM~**

Within the PER,

PER01 = IC
This value indicates this is the Information Contact.

PER03 = EM
This value indicates the provider should email to request clarifying information from the payer regarding the claim status.

PER04 = CLMSTAT@123.COM
This is the email address the provider sends the clarification request to.

2.2.3.2 Claim

Although Loop ID-2200 contains segments in the 276 that are different from the 277 Health Care Claim Status Response, the intent of the loop is similar in both transactions. The specific claim identification parameters are found in Loop ID-2200. Because the provider and payer identify the claim using different parameters, the segments used for the request are different from the segments used for the response.

When a claim status is requested, the provider supplies parameters that help the payer locate the claim. Frequently, these parameters are the claim number, dates of service, type of bill, and insured's identification number (see NM1 for patient). See paragraph 2.2.3.3, Claim Request.

Similarly, when the claim status is returned, the payer supplies the parameters that help the provider locate the claim. Frequently, these parameters are the patient control number, medical record number, type of bill, and dates of service. See paragraph 2.2.3.5, Claim Response.

In some payers' adjudication systems, a request for claim line item status can be accommodated. Additional parameters must be specified when a specific line item status is requested. These parameters are specified in the 276 Health Care Claim Status Request Loop ID-2210 and in the 277 Health Care Claim Status Response Loop ID-2220.

The detailed description of the segments and data elements that are used to request claim status at the line level are presented in 2.2.3.4, Line Item Request.

The description of the response is presented in 2.2.3.6, Line Item Response.

2.2.3.3 Claim Request

The following is a coding example of the 276 Health Care Claim Status Request Loop ID-2200:

```
TRN*1*1722634842~
REF*EJ*SMITH123~
AMT*T3*75~
DTP*232*RD8*19960401-19960402~
```

Figure 10, The Claim Request, presents an Implementation view of Loop ID-2200.

Table 2 - Detail, Subscriber Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
	...				
		LOOP ID - 2200D CLAIM SUBMITTER TRACE NUMBER			**>1**
090	**TRN**	Claim Submitter Trace Number	**S**	**1**	
100	**REF**	Payers Claim Identification Number	**S**	**1**	
100	**REF**	Institutional Bill Type Identification	**S**	**1**	
100	**REF**	Medical Record Identification	**S**	**1**	
110	**AMT**	Claim Submitted Charges	**S**	**1**	
120	**DTP**	Claim Service Date	**S**	**2**	
	...				

Figure 10. The Claim Request

2.2.3.3.1 TRN Segment

The 276/277 transaction acts as the mechanism for requests for information, about specific claims. The actual response must be able to be reassociated with the original request. This is accomplished with a control number.

This identification number is found in TRN02.

An example follows:

```
TRN*1*1722634842~
```

TRN01 = 1
This value indicates that the number in TRN02 is a current transaction trace number.

TRN02 = 1722634842
The value shown may be the internal control number for the claim, or document control number for the specific question. In subsequent response transaction set exchanges involving this claim, the provider returns the value found in this element to the payer. The payer locates the "key" data element (i.e., the claim number in this element) for his or her data files/databases.

2.2.3.3.2 REF Segment at the Claim Level

The REF segment identifies the specific claim in question. The provider's primary identifier frequently - the patient account number - and the institutional type of bill, which is a supplemental identifier, are found in the REF segment. The medical record number, a supplemental identifier for the provider's use, also is located in the REF segment. The REF segment can be repeated a maximum of three times in this location.

The following are coding examples of the REF segment:

REF*1K*9918046987~	Patient Account number
REF*BLT*131~	Institutional type of bill
REF*EA*JS980503LAB~	Provider's medical record number

REF*1K*9918046987~

Within the REF,

REF01 = 1K
This value indicates that the next data element contains the payer's assigned claim number.

REF02 = 9918046987
The value shown is the actual claim number assigned by the payer for this claim. In subsequent transaction set exchanges involving this claim, the provider returns the value found in this element to the payer. The payer locates the "key" data element (i.e., the claim number in this element) for his or her data files/databases.

When REF01 is BLT, REF02 contains the institutional type of bill (e.g., 131).

When REF01 is EA, REF02 contains the patient's medical record number assigned by the provider.

The sequence of the appearance of 1K, BLT or EA segments is not significant, but the segments must be contiguous.

2.2.3.3.3 AMT Segment

The AMT segment indicates the total monetary amount of the billed services on the claim.

The following is a coding example of the AMT segment:

AMT*T3*75~

Within the AMT,

AMT01 = T3
This is the amount code qualifier. When it is populated with T3, the subsequent data value is known to be total submitted charges.

AMT02 = 75
This value means the claim's submitted charges were $75.

2.2.3.3.4 DTP Segment

The DTP segment specifies the claim statement period from and through dates as supplied by the claim originator.

The following is a coding example of the DTP segment:

DTP*232*RD8*19960401-19960402~

Within the DTP,

DTP01 = 232
This is the date/time qualifier element. When its value is "232", the date found in DTP03 is known to be the claim statement period start and end date as used in the implementation guide.

DTP02 = RD8
This is the date/time period format qualifier. When its value is "RD8", the format of the date in DTP03 is known to be CCYYMMDD-CCYYMMDD.

DTP03 = 19960401-19960402
The date range represented in DTP03 is the claim statement period from and through dates on the submitted claim, as defined by the prior qualifiers.

2.2.3.4 Line Item Request

The following is a coding example of Loop ID-2210, which is used when the 276 is at the service line item level:

SVC*HC:99214*75*0**1~**
REF*FJ*03~
DTP*472*RD8*19960401-19960401~

Figure 11, Service Line Item Identification (Request) presents an implementation view of Loop ID-2210D.

Table 2 - Detail, Subscriber Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
	...				
		LOOP ID - 2210D SERVICE LINE INFORMATION			**>1**
130	**SVC**	Service Line Information	**S**	**1**	
140	**REF**	Service Line Item Identification	**S**	**1**	
150	**DTP**	Service Line Date	**S**	**1**	

Figure 11. Service Line Item Identification (Request)

2.2.3.4.1 SVC Segment

A provider uses the SVC segment to identify a particular service or line item for which the status is requested. Specific service information is identified in the following example:

SVC*HC:99214*75*0**1~**

Within the SVC,

SVC01-1 = HC
This value indicates that the next data element contains an item from the Health Care Financing Administration Common Procedural Coding System (HCPCS) codes list.

SVC01-2 = 99214
This is the actual HCPCS code for the service being requested.

SVC02 = 75
This is the actual amount billed for this service, $75.00.

SVC03 = 0
This is the actual paid amount for this service. This is a mandatory data element. The paid amount is $0.00 because the claim in this example has not been paid yet.

SVC07 = 1
This value represents the original submitted units of service.

2.2.3.4.2 REF at the Service Line Level

At the service line level, the REF segment identifies the line item number of the billed service for which status is requested. Line item information is primarily for professional claims. This line item control number is the number initially assigned by the provider in the original claim.

REF*FJ*03~

Within the REF,

REF01 = FJ
When REF01 contains the value “FJ”, the line item control number is identified in REF02.

REF02 = 03
This is the actual line item number. The service line item number is three.

2.2.3.4.3 DTP Segment at the Service Line Level

At this location, the DTP segment identifies the dates of service for the specified line item.

DTP*472*RD8*19960401-19960401~

Within the DTP,

DTP01 = 472
This is the date/time qualifier element. When its value is “472", the date found in DTP03 is known to be the service date.

DTP02 = RD8
This is the date/time period format qualifier. When its value is “RD8", the format of the date in DTP03 is known to be CCYYMMDD-CCYYMMDD.

DTP03 = 19960401-19960402
The date range represented in DTP03 is the dates of service for the specified line item, as defined by the prior qualifiers.

2.2.3.5 Claim Response

The following is a coding example of the 277 Health Care Claim Status Response Loop-ID 2200:

```
TRN*2*1722634842~
STC*F2:88:QC*960930**75~
REF*1K*9612991010987W~
DTP*232*RD8*19960401-19960402~
```

When supplied by the provider, the information in the TRN, REF, or DTP segments is the same in the 277 Health Care Claim Status Response as presented in 2.2.3.3, Claim Request. The Status Information Segment (STC) reports the status, required action, and paid information of a claim or service line. This segment can be found in the 277 Health Care Claim Status Response in the two locations, as appropriate, to convey the information. The two locations are Loop ID-2200, the Claim level; and Loop ID-2220, the Detail level.

NOTE
The delimiter separating elements within a composite data element is different from the delimiter separating simple elements. In the coding examples shown below, the composite delimiter is a colon (:).
Figure 12, The Claim Response, presents an Implementation view of Loop ID-2200D.

Table 2 - Detail, Subscriber Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
	...				
		LOOP ID - 2200D CLAIM SUBMITTER TRACE NUMBER			**>1**
090	**TRN**	Claim Submitter Trace Number	**S**	**1**	
100	**STC**	Claim Level Status Information	**S**	**1**	
110	**REF**	Payer Claim Identification Number	**S**	**1**	
110	**REF**	Institutional Bil Identification Type	**S**	**1**	
110	**REF**	Medical Record Identification	**S**	**1**	
120	**DTP**	Claim Level Date	**S**	**2**	
	...				

Figure 12. The Claim Response

2.2.3.5.1 TRN Segment

The originator of the transaction needs to receive this number back in the response to the claim status request. The 277 response TRN is completed at the same level with the same trace number that was conveyed in the 276 status request.

This identification number is found in TRN02.

An example follows:

```
TRN*2*1722634842~
```

TRN01 = 2
This value indicates that the number in TRN02 is the referenced (original) trace number from the originator of the transaction.

TRN02 = 1722634842
The value shown is the transaction trace number the originator of the request can use as a key of the match the response to the original request transaction.

2.2.3.5.2 STC Segment

The STC segment is used in the claim status response at the claim level, Loop ID-2200D, and can be used at the service line level, Loop ID-2220D. In the STC segment, data elements STC01, STC10, and STC11 represent three iterations of a composite data element — Health Care Claim Status, or C043. The composite Health Care Claim Status can be used one time (STC01 only) or in conjunction with the other iterations (STC10 and/or STC11) to convey complete status information. Loop ID-2200D or Loop ID-2220D may be repeated when the three iterations of C043 are insufficient to describe the status information. If more than 3 reason codes are required to ask a single question it is necessary to submit a request to the Claim Adjustment and Status Code Committee. Request forms are available at: http://www.wpc-edi.com.

The three simple elements within the composite element are as follows:

- the Category code (STC01-1). The Category code indicates the level of processing achieved by the claim. The categories include acknowledgment (A), pending (P), finalized (F), and requests for additional information (R). From the category code list, only codes in the Supplemental, Pending, Acknowledgments and Finalized categories may be used for this business function.
- the Health Care Claim Status Message code (STC01-2). The Health Care Claim Status Message code provides more specific information about the claim or line item. Examples of status messages include “awaiting next periodic adjudication cycle” and “entity not eligible for benefits for submitted dates of service.”
- the Entity Identifier code (STC01-3). The Entity Identifier code serves to further clarify the message of the category and status message codes. It should be used only when the clarification is appropriate. Examples of entities described by this code list include the following: types of providers, services, facility types, and other health care-related entities.

The Category code and the Health Care Claim Status Message code use values specified in the Health Care Claim Status/Reason Code List. See Appendix C, External Code Sources, for instructions about how to obtain this list. The Entity Identifier code is an ASC X12 data element, and its appropriate values are specified in 3, Transaction Set.

Following is a coding example of status at the claim or service line level:

STC*F2:88:QC*1996093075~**

Within the STC,

STC01-1 = F2
This value indicates that the claim has been finalized and denied payment.

STC01-2 = 88
This message code means the “Entity not eligible for benefits for submitted dates of service.”

STC01-3 = QC
This value indicates that the entity is the patient.

STC02 = 19960930
This is the date that the claim was placed in this status by the payer's adjudication process.

STC04 = 75
This is the amount of the original submitted charges.

2.2.3.5.3 REF Segment

The REF segment can be repeated a maximum of three times in this location. The REF segment identifies the specific claim in question. The payer's primary identifier — the claim number — is supplied to the provider in the REF segment. Future communication about this claim should include the claim number. A REF segment conveys the institutional type of bill, which is a supplemental identifier for both the payer and the provider. The medical record number, a supplemental identifier for the provider's use, also is located in the REF segment.

Coding examples of the REF segment follow:

REF*1K*9621681010827~	Payer's claim number
REF*EA*JS960503LAB~	Provider's medical record number
REF*BLT*131~	Institutional type of bill

Within the REF,

REF01 = 1K
This value indicates that the next data element contains the payer's assigned claim number. "EA" identifies the medical record number; "BLT" identifies the institutional type of bill.

REF02 = 9621681010827
The value shown is the actual claim number assigned by the payer for this claim. In subsequent transaction set exchanges involving this claim, the provider returns the value found in this element to the payer. The payer uses the claim number in this element as the "key" to locate the claim in his or her data files/databases.

When REF01 is "EA", REF02 contains the medical record number assigned by the provider (e.g., JS960503LAB).

When REF01 is "BLT", REF02 contains the institutional type of bill (e.g., 131).

2.2.3.5.4 DTP Segment

The DTP segment specifies the dates of service as supplied by the claim originator.

The following is a coding example of the DTP segment:

DTP*232*RD8*19960401-19960402~

Within the DTP,

DTP01 = 232
This is the date/time qualifier element. When the value is "232", the date found in DTP03 is known to be the claim statement period from and through dates.

DTP02 = RD8
This is the date/time period format qualifier. When the value is “RD8", the format of the date in DTP03 is known to be CCYYMMDD-CCYYMMDD.

DTP03 = 19960401-19960402
The date range, represented in DTP03, is the claim statement period from and through dates on the submitted claim, as defined by the prior qualifiers.

Table 2 - Detail, Subscriber Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
	...				
		LOOP ID - 2220D SERVICE LINE INFORMATION			**>1**
180	**SVC**	Service Line Information	**S**	**1**	
190	**STC**	Service Line Status Information	**S**	**1**	
200	**REF**	Service Line Item Identification	**S**	**1**	
210	**DTP**	Service Line Date	**S**	**1**	
	...				

Figure 13. Line Item Status Response

2.2.3.6 Line Item Response

Use Loop ID-2220 when a request for claim status information is made specifying the line level, and the payer is able to accommodate claim status response at the line level.

The following is a coding example of Loop ID-2220, claim status response at the service line level:

```
SVC*HC:99214*75*0****1~
STC*R4:352:4Y~
REF*FJ*03~
DTP*472*RD8*19960401-19960401~
```

Figure 13, Line Item Status Response, presents an Implementation view of Loop ID-2220D.

2.2.3.7 SVC Segment

The SVC segment is returned by a payer. The SVC segment identifies the line item billed services. Due to payers adjudication requirements, service lines may be bundled or unbundled. In this case the service line(s) returned may not be the same as the submitted service lines.

Procedure code bundling or unbundling occurs when a payer believes that the actual services performed and reported for a claim payment can be represented by a different group of procedure codes. Grouping usually results in a lower payment from the payer. Bundling occurs when two or more reported procedures are going to be paid under only one procedure code. Unbundling occurs when one submitted procedure code is to be paid and reported back as two or more procedure codes.

The following example demonstrates the identification of specific service information:

SVC*HC:99214*75*0**1~**

Within the SVC,

SVC01-1 = HC
This value indicates that the next data element contains an item from the Health Care Financing Administration Common Procedural Coding System (HCPCS) codes list.

SVC01-2 = 99214
This is the actual HCPCS code for the service line item.

SVC02 = 75
This is the actual amount billed for this service, $75.00.

SVC03 = 0
This is the actual paid amount for this service. This is a mandatory data element. The paid amount is $0.00 because the claim in this example has not been paid yet.

SVC07 = 1
This value represents the original submitted units of service.

2.2.3.8 STC Segment

The STC segment is used in the claim status response at the line item level. In the STC segment, data elements STC01, STC10, and STC11 represent three iterations of a composite data element — Health Care Claim Status, or C043. The composite Health Care Claim Status can be used one time (STC01 only) or in conjunction with the other iterations (STC10 and/or STC11) to convey complete status information. Loop ID-2200D or Loop ID-2220D may be repeated when the three iterations of C043 are insufficient to describe the status information. If more than 3 reason codes are required to ask a single question it is necessary to submit a request to the Claim Adjustment and Status Code Committee. Request forms are available at: http://www.wpc-edi.com.

The three simple elements within the composite element are as follows:

- the Category code (STC01-1). The Category code indicates the level of processing achieved by the claim. The categories include acknowledgment (A), pending (P), finalized (F), and requests for additional information (R).
  The Category Code List is available at www.wpc-edi.com, under the Claim Adjustment and Status Code Committee selection. From the category code list, any of the code values may be used for this business function.
- the Health Care Claim Status Message code (STC01-2). The Health Care Claim Status Message code provides more specific information about the claim or line item. Examples of status messages include “awaiting next periodic adjudication cycle” and “entity not eligible for benefits for submitted dates of service.”
- the Entity Identifier code (STC01-3). The Entity Identifier code serves to further clarify the message of the category and status message codes. It should be used only when the clarification is appropriate. Examples of entities described by this code list include the following: types of providers, services, facility types, and other health care-related entities.

The Category code and the Health Care Claim Status Message code use values specified in the Health Care Claim Status/Reason Code List. See Appendix C, External Code Sources, for instructions about how to obtain this list. The Entity Identifier code is an ASC X12 data element, and its appropriate values are specified in 3, Transaction Set.

The following is a coding example of status at the claim or service line level:

STC*F2:88:QC*1996093075~**

Within the STC,

STC01-1 = F2
This value indicates that the claim has been finalized and denied payment.

STC01-2 = 88
This message code means “Entity not eligible for benefits for submitted dates of service.”

STC01-3 = QC
This value indicates that the entity is the patient.

STC02 = 19960930
This is the date that the claim was placed in this status by the payer’s adjudication process.

STC04 = 75
This is the amount of the original submitted charges.

2.2.3.8.1 REF Segment

The REF segment identifies the specific line item number of the service line. The REF segment can occur a maximum of one time in this location.

The following is a coding example of the REF segment:

REF*FJ*03~

Within the REF,

REF01 = FJ
When REF01 contains the value “FJ”, the line item control number is identified in REF02.

REF02 = 03
This is the actual line item number. The service line item number is three.

2.2.3.9 DTP Segment

At this location, the DTP segment identifies the dates of service for the specified line item.

DTP*472*RD8*19960401-19960401~

Within the DTP at the line item level,

DTP01 = 472
This is the date/time qualifier element. When the value is “472", the date found in DTP03 is known to be the service date.

DTP02 = RD8
This is the date/time period format qualifier. When the value is “RD8", the format of the date in DTP03 is known to be CCYYMMDD-CCYYMMDD.

DTP03 = 19960401-19960402
The date range represented in DTP03 is the dates of service for the specified line item, as defined by the prior qualifiers.

2.3 Interaction with Other Transaction Sets

An overview of related transaction sets and a discussion of their direct or indirect interaction with the Health Care Claim Status Request and Response (276/277) are presented here.

2.3.1 The Claim (837)

Submitting a claim, whether by using the 837 or another format, is the first step in the claim status request/response process. Certain data elements (e.g., the patient control number, type of bill, dates of service, insured identifier, service provider identifier, and claim number when available) found on the claim help locate a claim within a payer's adjudication system. When the provider initiates a claim status request, as many of these data elements as possible should be forwarded to the payer. With the exception of the claim number, the source of this information is the provider's billing system.

2.3.2 The Functional Acknowledgment (997)

The Functional Acknowledgment (997) transaction is used upon request by one of the trading partners. As shown in figure 1, General Claim Status Information Flow, the provider and the payer use the 997 in both the send and the receive modes

A 997 can be used by the following:

- the payer to acknowledge claim receipt (837)
- the provider to acknowledge receipt of an Health Care Payer Unsolicited Claim Status (277)
- the provider to acknowledge receipt of a Health Care Claim Request for Additional Information (277)
- the provider to acknowledge receipt of a Health Care Claim Payment/Advice (835)

2.3.3 The Request for Additional Information (277)

Medical and utilization reviews are performed during the adjudication process. Typically, claims that come under such review are suspended. The payer requests specific information for each claim or service suspended for medical review. This information supplements or supports the provider's request for payment of the services under review. Although the 277 Health Care Claim Request for Additional Information is used for this purpose, the 277 Health Care Claim Status Response may return similar information if the requested claim happens to be in this status location.

3 Transaction Set

3.1 Presentation Examples

NOTE
See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

The ASC X12 standards are generic. For example, multiple trading communities use the same Administrative Communications Contact (PER) segment to specify contact names and phone numbers. 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 trading community-specific implementation.

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

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

The examples in figures 14 through 19 define the presentation of the transaction set that follows.

The following pages provide illustrations, in the same order they appear in the guide, to describe the format.

The examples are drawn from the 835 Health Care Claim Payment/Advice Transaction Set, but all principles apply.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	010	ST	835 Header	R	1	
54	020	BPR	Financial Information	R	1	
60	040	TRN	Reassociation Key	R	1	
62	050	CUR	Non-US Dollars Currency	S	1	
65	060	REF	Receiver ID	S	1	
66	060	REF	Version Number	S	1	
68	070	DTM	Production Date	S	1	
			PAYER NAME			1
70	080	N1	Payer Name	R	1	
72	100	N3	Payer Address	S	1	
75	110	N4	Payer City, State, ZIP Code	S	1	
76	120	REF	Additional Payer Reference Number	S	1	
78	130	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	080	N1	Payee Name	R	1	
81	100	N3	Payee Address	S	1	
82	110	N4	Payee City, State, ZIP Code	S	1	
84	120	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 14. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See Appendix A, ASC X12 Nomenclature for a complete description of the standard

835 Health Care Claim Payment/Advice

Functional Group ID: HP

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	

Figure 15. Transaction Set Key — Standard

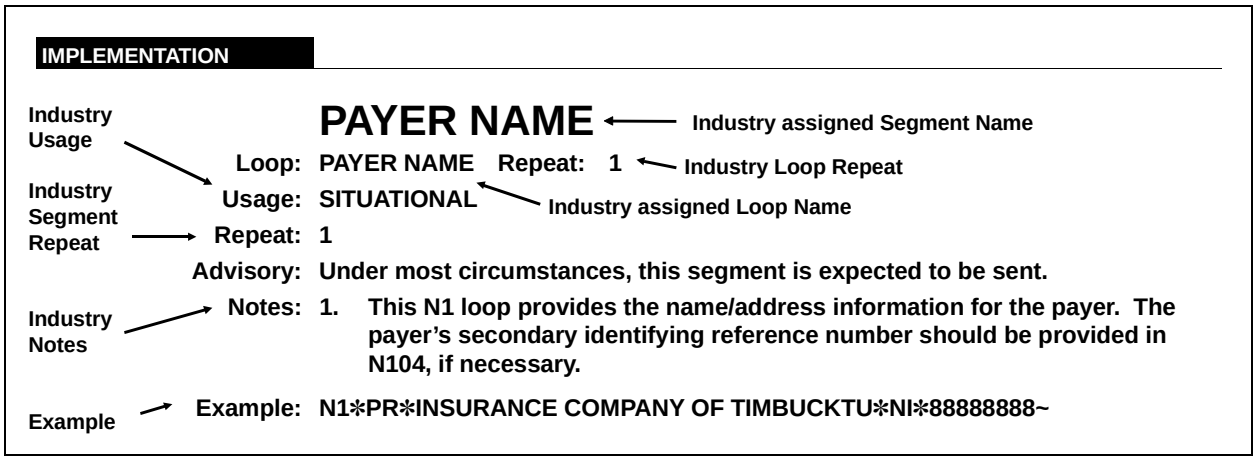


Figure 16. Segment Key — Implementation

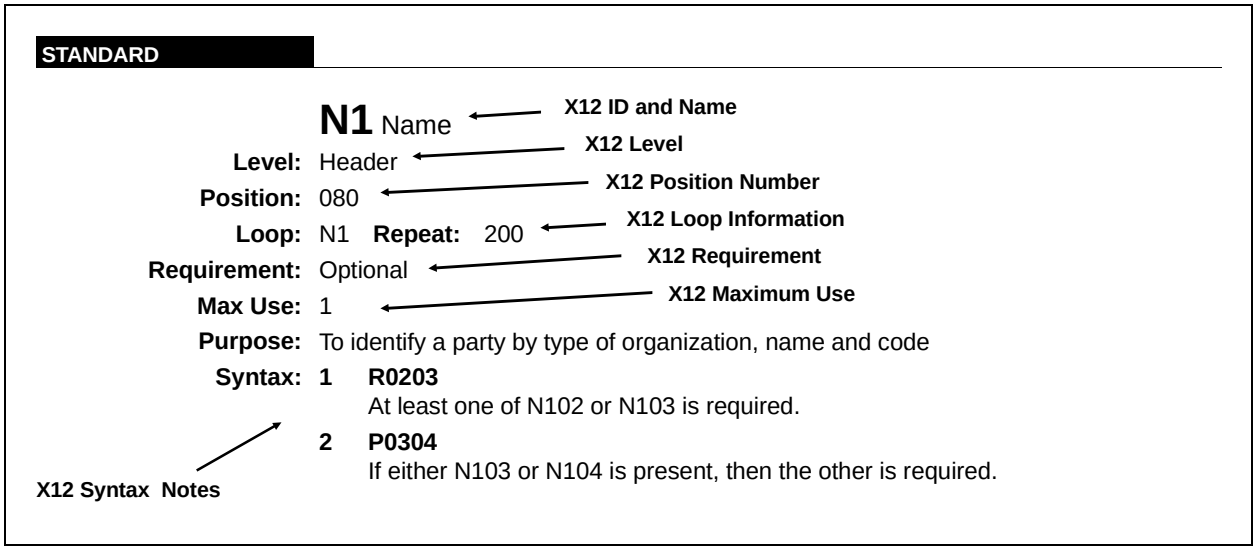


Figure 17. Segment Key — Standard

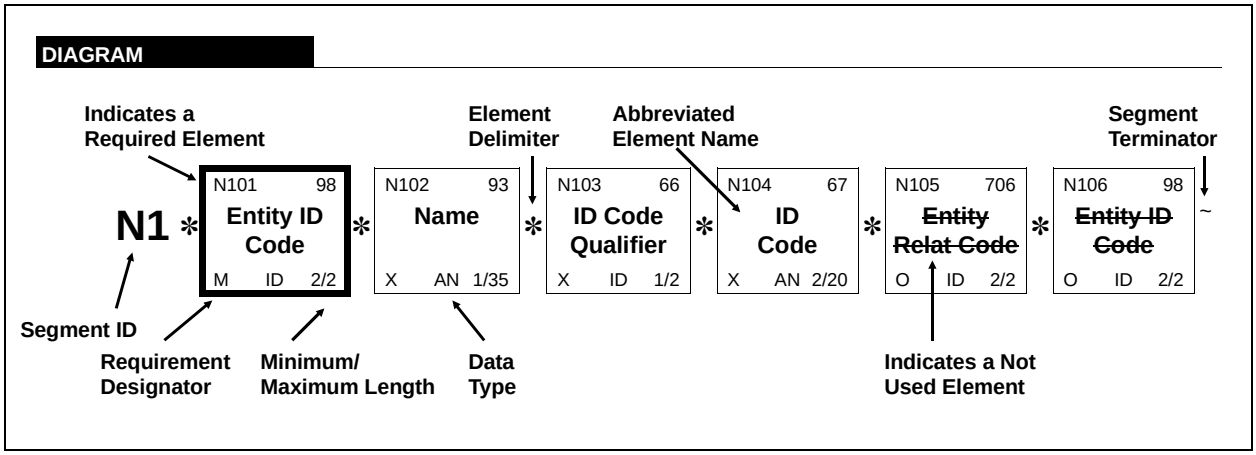
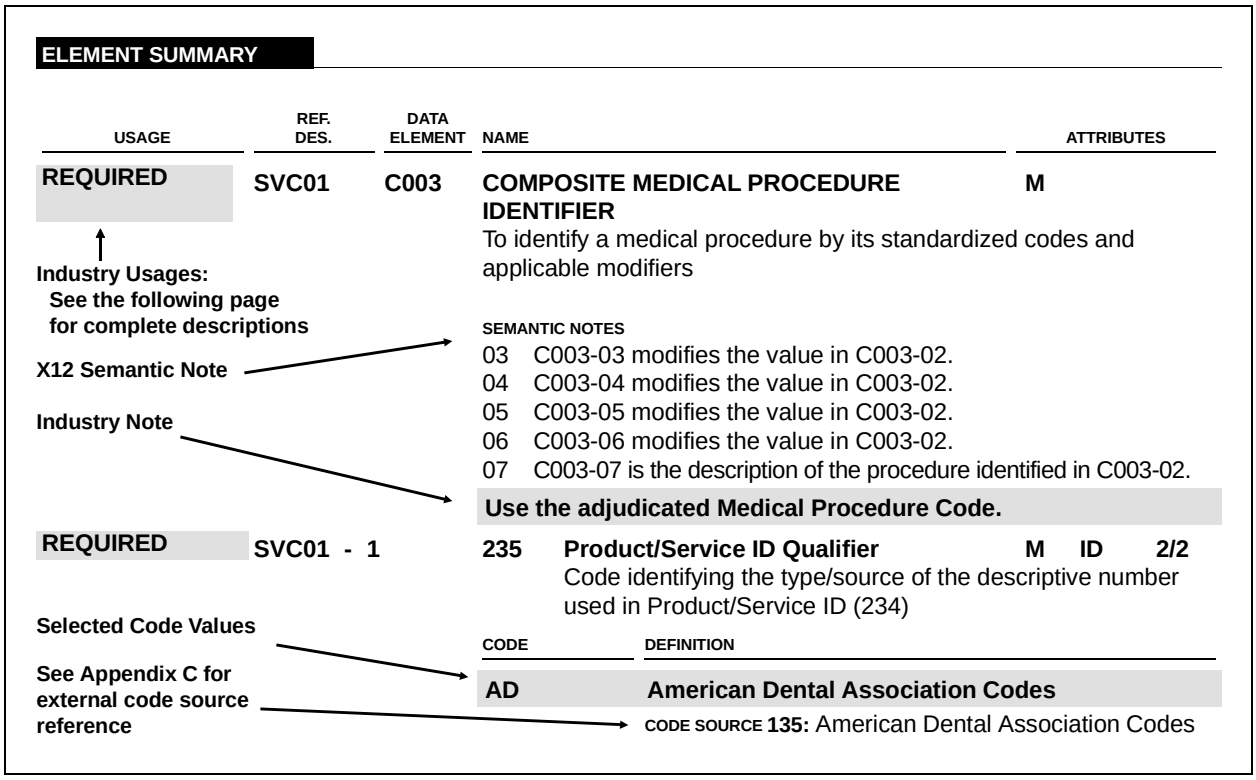


Figure 18. Segment Key — Diagram



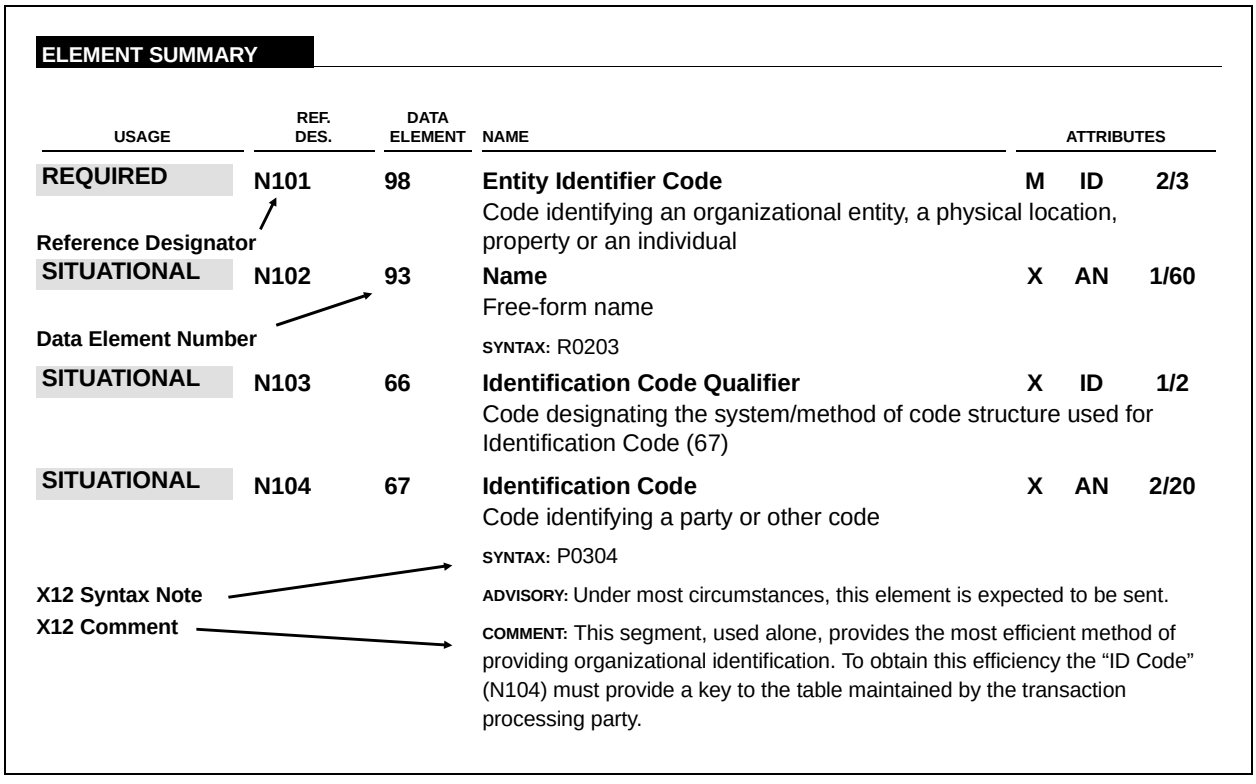


Figure 19. Segment Key — Element Summary

Industry Usages:

Required This item must be used to be compliant with this implementation guide.

Not Used This item should not be used when complying with this implementation guide.

Situational The use of this item varies, depending on data content and business context. The defining rule is generally documented in a syntax or usage note attached to the item.* The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used.

**** NOTE***
If no rule appears in the notes, the item should be sent if the data is available to the sender.

Loop Usages: Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

276 Health Care Claim Status Request

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
49	010	ST	Transaction Set Header	R	1	
50	020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
52	010	HL	Information Source Level	R	1	
			LOOP ID - 2100A PAYER NAME			>1
54	050	NM1	Payer Name	R	1	
57	080	PER	Payer Contact Information	S	1	

Table 2 - Detail, Information Receiver Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
60	010	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			>1
62	050	NM1	Information Receiver Name	R	1	

Table 2 - Detail, Service Provider Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SERVICE PROVIDER LEVEL			>1
65	010	HL	Service Provider Level	R	1	
			LOOP ID - 2100C PROVIDER NAME			>1
67	050	NM1	Provider Name	R	1	

Table 2 - Detail, Subscriber Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D SUBSCRIBER LEVEL			**>1**
70	**010**	**HL**	Subscriber Level	**R**	**1**	
72	**040**	**DMG**	Subscriber Demographic Information	**S**	**1**	
			LOOP ID - 2100D SUBSCRIBER NAME			**>1**
74	**050**	**NM1**	Subscriber Name	**R**	**1**	
			LOOP ID - 2200D CLAIM SUBMITTER TRACE NUMBER			**>1**
77	**090**	**TRN**	Claim Submitter Trace Number	**R**	**1**	
78	**100**	**REF**	Payer Claim Identification Number	**S**	**1**	
80	**100**	**REF**	Institutional Bill Type Identification	**S**	**1**	
82	**100**	**REF**	Medical Record Identification	**S**	**1**	
84	**110**	**AMT**	Claim Submitted Charges	**S**	**1**	
86	**120**	**DTP**	Claim Service Date	**S**	**1**	
			LOOP ID - 2210D SERVICE LINE INFORMATION			**>1**
88	**130**	**SVC**	Service Line Information	**S**	**1**	
91	**140**	**REF**	Service Line Item Identification	**S**	**1**	
93	**150**	**DTP**	Service Line Date	**R**	**1**	

Table 2 - Detail, Dependent Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000E DEPENDENT LEVEL			**>1**
94	**010**	**HL**	Dependent Level	**S**	**1**	
96	**040**	**DMG**	Dependent Demographic Information	**R**	**1**	
			LOOP ID - 2100E DEPENDENT NAME			**>1**
98	**050**	**NM1**	Dependent Name	**R**	**1**	
			LOOP ID - 2200E CLAIM SUBMITTER TRACE NUMBER			**>1**
101	**090**	**TRN**	Claim Submitter Trace Number	**R**	**1**	
103	**100**	**REF**	Payer Claim Identification Number	**S**	**1**	
105	**100**	**REF**	Institutional Bill Type Identification	**S**	**1**	
107	**100**	**REF**	Medical Record Identification	**S**	**1**	
109	**110**	**AMT**	Claim Submitted Charges	**S**	**1**	
111	**120**	**DTP**	Claim Service Date	**S**	**1**	
			LOOP ID - 2210E SERVICE LINE INFORMATION			**>1**
113	**130**	**SVC**	Service Line Information	**S**	**1**	
117	**140**	**REF**	Service Line Item Identification	**S**	**1**	
118	**150**	**DTP**	Service Line Date	**S**	**1**	
120	**160**	**SE**	Transaction Set Trailer	**R**	**1**	

STANDARD

276 Health Care Claim Status Request

Functional Group ID: HR

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Status Request Transaction Set (276) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a provider, recipient of health care products or services, or their authorized agent to request the status of a health care claim or encounter from a health care payer. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	
030	REF	Reference Identification	O	10	
		LOOP ID - 1000			>1
040	NM1	Individual or Organizational Name	O	1	
050	N2	Additional Name Information	O	2	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	REF	Reference Identification	O	2	
090	PER	Administrative Communications Contact	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
010	HL	Hierarchical Level	M	1	
020	SBR	Subscriber Information	O	1	
030	PAT	Patient Information	O	1	
040	DMG	Demographic Information	O	1	
		LOOP ID - 2100			>1
050	NM1	Individual or Organizational Name	O	1	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	PER	Administrative Communications Contact	O	1	
		LOOP ID - 2200			>1
090	TRN	Trace	O	1	
100	REF	Reference Identification	O	3	
110	AMT	Monetary Amount	O	1	
120	DTP	Date or Time or Period	O	2	
		LOOP ID - 2210			>1
130	SVC	Service Information	O	1	
140	REF	Reference Identification	O	1	
150	DTP	Date or Time or Period	O	1	
160	SE	Transaction Set Trailer	M	1	

NOTES:

2/020 The SBR segment may only appear at the Subscriber (HL03=22) level.

2/030 The PAT segment may only appear at the Dependent (HL03=23) level.

2/040 The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*276*0001~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

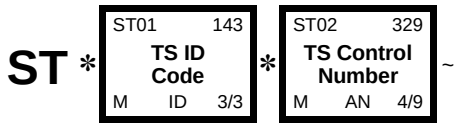
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) 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** **DEFINITION** **276** **Health Care Claim Status Request**	**M ID 3/3**
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 **The value in ST02 must be identical to SE02.**	**M AN 4/9**

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Example: **BHT*0010*13**19961220~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 020

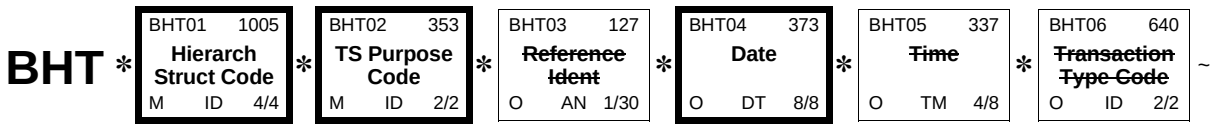
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 **CODE** / **DEFINITION** **0010** — **Information Source, Information Receiver, Provider of Service, Subscriber, Dependent**	**M ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set **CODE** / **DEFINITION** **13** — **Request**	**M ID 2/2**
NOT USED	**BHT03**	**127**	**Reference Identification**	**O AN 1/30**
REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Transaction Set Creation Date*** **SEMANTIC:** BHT04 is the date the transaction was created within the business application system.	**O DT 8/8**

NOT USED	BHT05	337	Time	O	TM	4/8
NOT USED	BHT06	640	Transaction Type Code	O	ID	2/2

IMPLEMENTATION

INFORMATION SOURCE LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

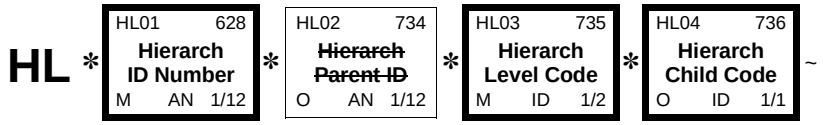
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 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 ID 1/2**

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O** **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.**

IMPLEMENTATION

PAYER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Payers with multiple locations or multiple lines of business may require that the payer name be completed.**

Example: **NM1*PR*2*ABC INSURANCE*****PI*12345~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

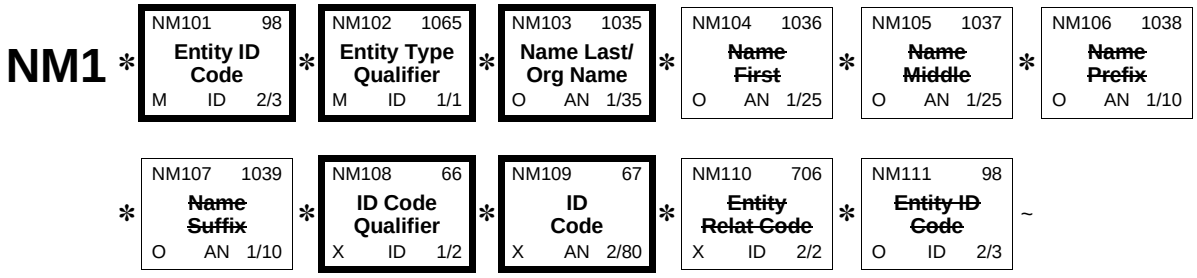
Requirement: Optional

Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Payer Name***

This data element will be required unitl the National Payer Identifier is active.

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

SYNTAX: P0809

Payer identifiers should be used with the following preferences:

(PI) Payer ID
(NI) NAIC Code
(AD) If the Payer is a Blue Cross or Blue Shield Plan, BCBSA Plan Code
(PP) If the Payer is a Pharmacy Processor, Pharmacy Processor Number
(FI) Tax ID
(21) If other codes are not available or known, use HIN or Payer Identification Number

CODE	DEFINITION
21	**Health Industry Number (HIN)**
	CODE SOURCE 121: Health Industry Identification Number
AD	**Blue Cross Blue Shield Association Plan Code**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification**
PI	**Payor Identification**
PP	**Pharmacy Processor Number**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***
	CODE SOURCE 540: Health Care Financing Administration National PlanID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** SYNTAX: P0809 **For Medicare use, this is the carrier/fiscal intermediary-assigned code.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PAYER CONTACT INFORMATION

Loop: **2100A — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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 should 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 (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

2. **By definition of standard, if PER03 is used, PER04 is required.**

3. **Required only if needed for identification of contact at the payer site when known prior to transmission of the 276 claim status request.**

Example: **PER*IC*MEDICAL REVIEW DEPARTMENT*TE*3135551234*EX*6593*FX*3135554321~**
OR
PER*ICTE*3135551234***FX*3135554321~**
OR
PER*IC****FX*3135554321~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 1

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

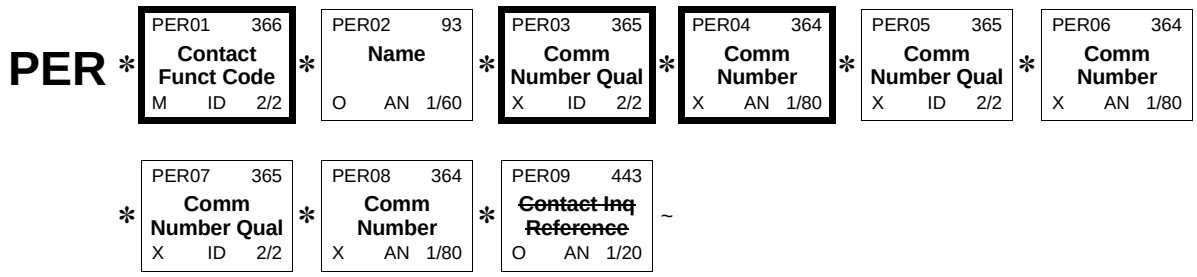
Syntax:

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Payer Contact Name*** **This element is required when a specific person or department is the contact for the response in order to clarify requests concerning aditional information requests.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Required when PER04 is used.**	**X ID 2/2**
			CODE: **ED** — DEFINITION: **Electronic Data Interchange Access Number**	
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **TE** — DEFINITION: **Telephone**	
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable *ALIAS:* ***Payer Contact Communication Number*** SYNTAX: P0304 **Use PER04 to supply International Codes, Area Code (within U.S.), Local exchanges, and telephone numbers. When an additional extension is required PER06 should be used.**	**X AN 1/80**

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Required when PER06 is used.**	**X**	**ID**	**2/2**
SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Use PER06 to supply telephone extensions only. International Codes, Area Codes (within U.S.), Exchanges, and telephone numbers should be placed in PER04.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Required when PER08 is used.**	**X**	**ID**	**2/2**
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable ALIAS: ***Payer Contact Communication Number*** SYNTAX: P0708 **Required when necessary to provide another telephone extension or fax number.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

CODE	DEFINITION
EX	**Telephone Extension**

CODE	DEFINITION
EX	**Telephone Extension**
FX	**Facsimile**

IMPLEMENTATION

INFORMATION RECEIVER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. This entity expects response from the information source.**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

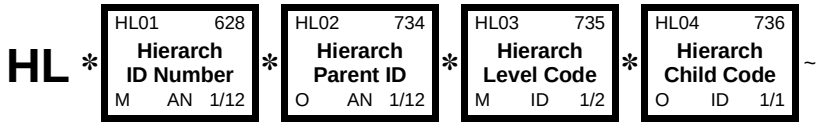
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M** **ID** **1/2**

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**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O** **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.**

IMPLEMENTATION

INFORMATION RECEIVER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. This is the individual or organization requesting to receive the status information.**

Example: **NM1*41*2*XYZ SERVICE*****46*A222222221~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

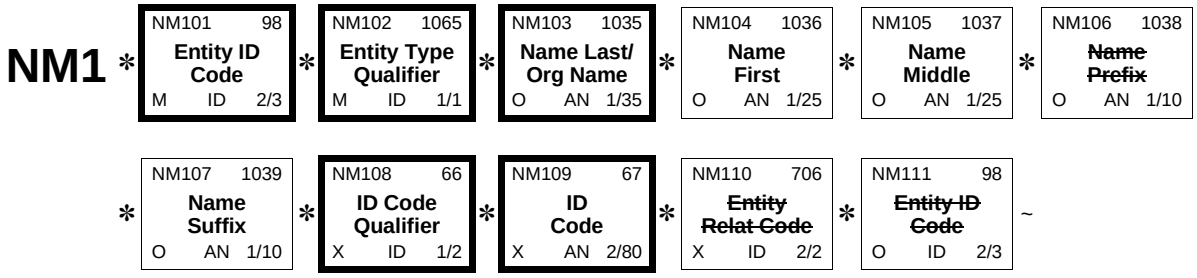
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
41	**Submitter**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

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

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Information Receiver Last or Organization Name***

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Information Receiver First Name***

The first name is required when the value in NM102 is '1' and the person has a first name.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Information Receiver Middle Name***

Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a person.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Information Receiver Name Suffix***

Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a person.

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

CODE	DEFINITION
46	**Electronic Transmitter Identification Number (ETIN)**
FI	**Federal Taxpayer's Identification Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Information Receiver Identification Number***

SYNTAX: P0809

NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

IMPLEMENTATION

SERVICE PROVIDER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

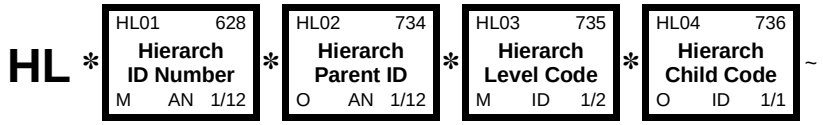
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M** **ID** **1/2**

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
19	**Provider of Service**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O** **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.**

IMPLEMENTATION

PROVIDER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. This is the billing provider from the original submitted claim.**

Example: **NM1*1P*2*HOME MEDICAL*****SV*987666666~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

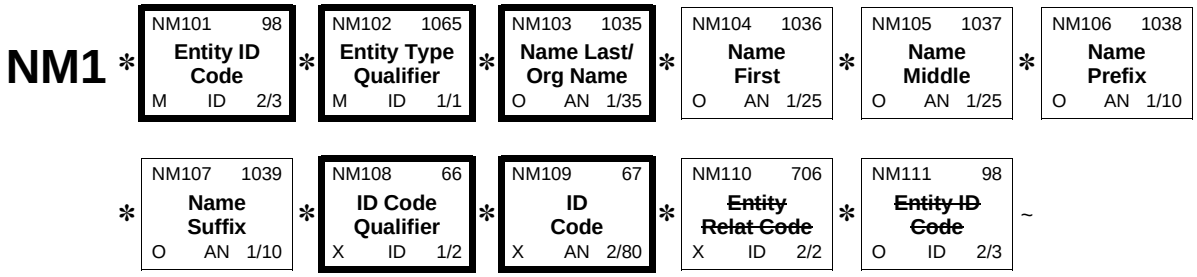
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
1P	**Provider**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

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

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Provider Last or Organization Name***

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Provider First Name***

The first name is required when the value in NM102 is '1' and the person has a first name.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Provider Middle Name***

The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.

SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Provider Name Prefix***

Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a person.

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Provider Name Suffix***

Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a person.

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

CODE	DEFINITION
FI	**Federal Taxpayer's Identification Number**
SV	**Service Provider Number** **When the provider does not have a National Provider ID and Payer has assigned a specific ID number to this provider this code is required.**

			XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***		
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Provider Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If the subscriber and the patient are the same person, do not use the next HL (HL23) for the claim information.**

Example: **HL*4*3*22*0~ or HL*4*3*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

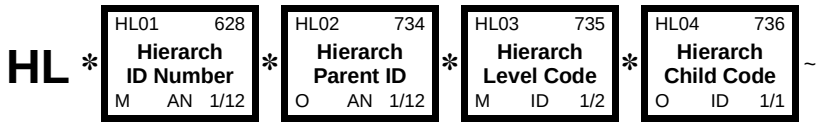
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

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
22	**Subscriber**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 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
0	**No Subordinate HL Segment in This Hierarchical Structure.** **Required when there are no dependent claim status requests for this subscriber.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.** **Required when there are dependent claims related to this subscriber.**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2000D — SUBSCRIBER LEVEL**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when the subscriber is the patient. Not used when the subscriber is not the patient.**

Example: **DMG*D8*19330706*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 040

Loop: 2000

Requirement: Optional

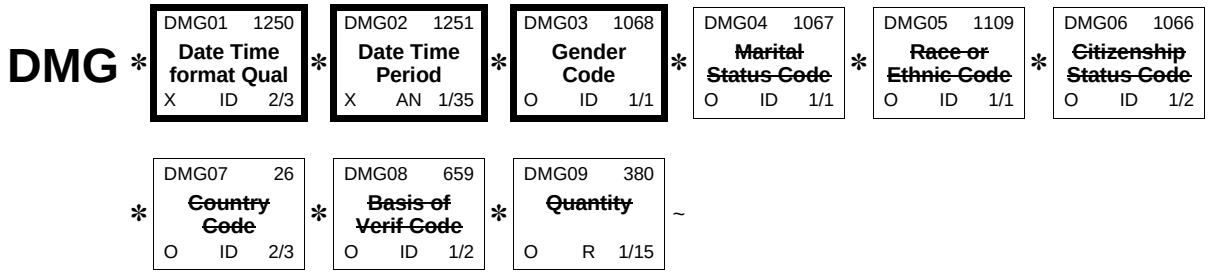
Max Use: 1

Purpose: To supply demographic information

Set Notes: **1.** The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

Syntax: **1. P0102**
If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Subscriber Birth Date*** *ALIAS:* ***Date of Birth - Subscriber*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Subscriber Gender Code*** *ALIAS:* ***Gender - Subscriber***	**O**	**ID**	**1/1**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2100D — SUBSCRIBER NAME** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*FRED****MI*123456789A~ or**
NM1*IL*1*SMITH*ROBERT**MI*9876543210~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

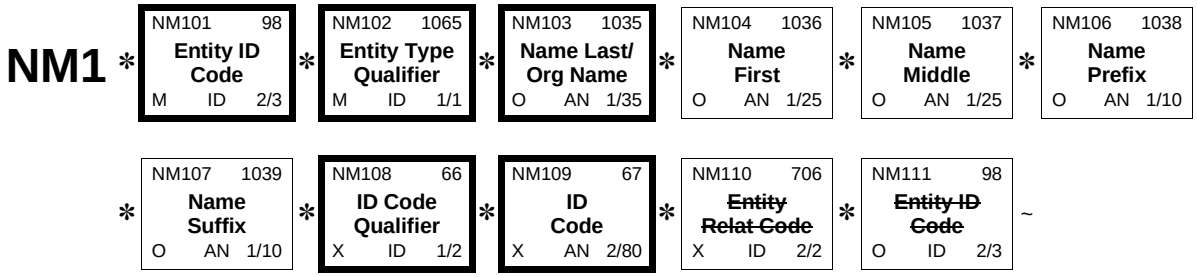
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
IL	**Insured or Subscriber**
QC	**Patient** **Use this code only when the subscriber is the patient.**

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M ID 1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity** **Use the value "2" in an employer-subscriber situation, such as Worker's Compensation. In this case, the value "IL" would appear in NM101.**

REQUIRED **NM103** **1035** **Name Last or Organization Name** **O AN 1/35**
Individual last name or organizational name

INDUSTRY: ***Subscriber Last Name***

SITUATIONAL **NM104** **1036** **Name First** **O AN 1/25**
Individual first name

INDUSTRY: ***Subscriber First Name***

The first name is required when the value in NM102 is '1' and the person has a first name.

SITUATIONAL **NM105** **1037** **Name Middle** **O AN 1/25**
Individual middle name or initial

INDUSTRY: ***Subscriber Middle Name***

The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.

SITUATIONAL **NM106** **1038** **Name Prefix** **O AN 1/10**
Prefix to individual name

INDUSTRY: ***Subscriber Name Prefix***

ADVISORY: Under most circumstances, this element is not sent.

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

SITUATIONAL **NM107** **1039** **Name Suffix** **O AN 1/10**
Suffix to individual name

INDUSTRY: ***Subscriber Name Suffix***

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

REQUIRED **NM108** **66** **Identification Code Qualifier** **X ID 1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

CODE	DEFINITION
24	**Employer's Identification Number**
MI	**Member Identification Number**

			ZZ **Mutually Defined** **The value 'ZZ' when used in this data element shall be defined as 'HIPAA Individual Identifier' once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Subscriber Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CLAIM SUBMITTER TRACE NUMBER

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use of this segment is required if the subscriber is the patient.**
2. **Use this segment to convey a unique trace or reference number from the originator of the transaction to be returned by the receiver of the transaction.**
3. **The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.**

Example: **TRN*1*1722634842~**

STANDARD

TRN Trace

Level: Detail

Position: 090

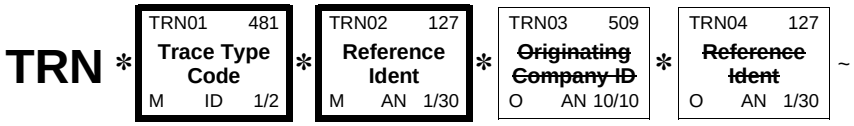
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

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 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 *INDUSTRY:* ***Trace Number*** SEMANTIC: TRN02 provides unique identification for the transaction.	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O AN 1/30**

IMPLEMENTATION

PAYER CLAIM IDENTIFICATION NUMBER

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this only if the subscriber is the patient.**
2. **This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN). This should be sent on claim inquiries when the number is known.**

Example: **REF*1K*9918046987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

Requirement: Optional

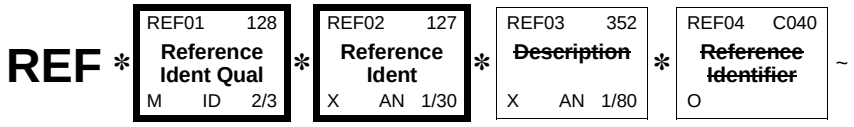
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Examples of this element include ICN, DCN, CCN.

Submit this element if the payer supplied it previously.

CODE	DEFINITION
1K	**Payor's Claim Number** **This data element corresponds to the value given in the ANSI ASC X12N 837 transaction in CLM01.**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Claim Control Number*** *ALIAS:* ***Patient Account Number*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

INSTITUTIONAL BILL TYPE IDENTIFICATION

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This segment is the institutional type of bill as submitted on the original claim, and the payer may use it as a primary lookup key.**
2. **Only use this segment if the subscriber is the patient and bill type is being sent in the inquiry request in connection with an institutional bill.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

Requirement: Optional

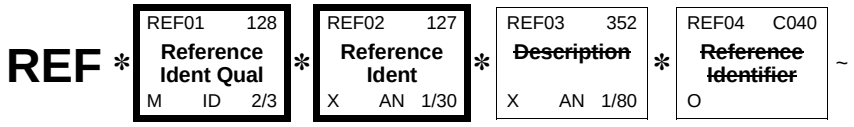
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
BLT	**Billing Type**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Bill Type Identifier*** SYNTAX: R0203 **Found on UB92 - record 40 - 4** **Found on 837 CLM-05** **Found on UB92 paper form locator 4** **Required for institutional claims inquiries.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MEDICAL RECORD IDENTIFICATION

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim.**
2. **Use this only if the subscriber is the patient.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

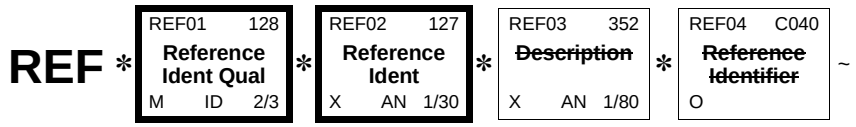
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EA** — **Medical Record Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medical Record Number*** SYNTAX: R0203 **Found on UB92 record 20 field 25** **Found on 837 CLM-05** **Found on UB92 paper form locator 23**	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

CLAIM SUBMITTED CHARGES

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when the subscriber is the patient.**
2. **Not all payer's systems retain the original submitted charges. This may be a result of bundling/unbundling situations. This amount can be used as a secondary match criteria within the payer's system if the claim has not been changed.**

Example: **AMT*T3*75~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 110

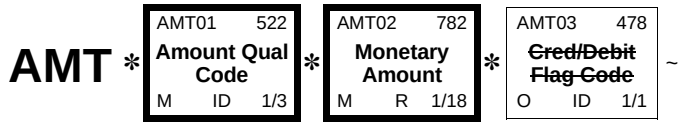
Loop: 2200

Requirement: Optional

Max Use: 1

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M ID 1/3**

CODE	DEFINITION
T3	**Total Submitted Charges** **Found on UB92 - Revenue Code 0001 and also in record 90** **Found on UB92 Paper form - Revenue Code 0001** **Found on 837 CLM02 (Professional); Revenue Code 0001 (Institutional)** **Found on NSF - XA0 Record field 12** **Found on HCFA 1500 - Block 28**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Claim Charge Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required for institutional claims. The date is the statement from and through date.**

2. **For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at Loop 2210D is required.**

Example: **DTP*232*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

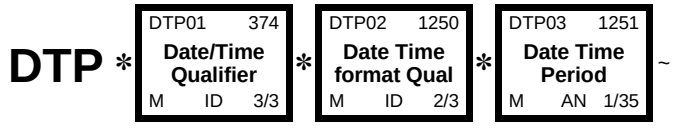
Loop: 2200

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Date Time Qualifier*** **Use this element for the dates of service submitted on the original claim.**	**M ID 3/3**

CODE	DEFINITION
232	**Claim Statement Period Start** **This includes the claim statement period end.**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
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.

If the date is a single date of service, the begin date equals the end date.

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

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

INDUSTRY: ***Claim Service Period***

IMPLEMENTATION

SERVICE LINE INFORMATION

Loop: **2210D — SERVICE LINE INFORMATION** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to request status information about a service line.**
2. **This segment is required if loop is used by ASC X12 syntax because it is the first segment in Loop ID -2210 (Service Line Information).**
3. **For Medicare Institutional claims, SVC01 would be the Health Care Financing Administration (HCFA), Common Procedural Coding System (HCPCS) Code (See Code Source 130) and SVC04 would be the Revenue Code (see Code Source 132).**

Example: **SVC*HC:99214*75*****1~**
or
SVC*NU:71X*50***1~**

STANDARD

SVC Service Information

Level: Detail

Position: 130

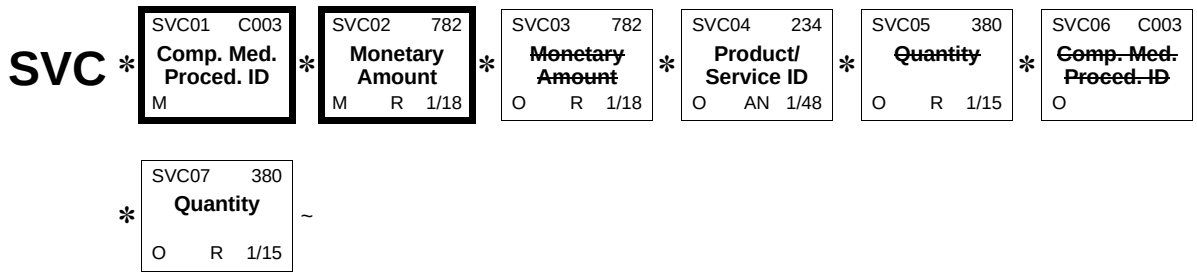
Loop: 2210 **Repeat:** >1

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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**

REQUIRED **SVC01 - 1** **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: ***Product or Service ID Qualifier***

SVC01 will contain the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted procedure code.

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, the CPT codes are reported under the code HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code
NH	**National Health Related Item Code**
NU	**National Uniform Billing Committee (NUBC) UB92 Codes** **This code is the NUBC Revenue Code.**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes
RB	**National Uniform Billing Committee (NUBC) UB82 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED	**SVC01 - 2**	**234**	**Product/Service ID** Identifying number for a product or service	**M**	**AN**	**1/48**
			INDUSTRY: ***Service Identification Code***			
			If the value in SVC01-1 is "NU", then this element is an NUBC Revenue Code. If a value is present here, then SVC04 is not used.			
SITUATIONAL	**SVC01 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Required if submitted on the original claim service line.			
NOT USED	**SVC01 - 7**	**352**	**Description**	**O**	**AN**	**1/80**
REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Line Item Charge Amount***			
			SEMANTIC: SVC02 is the submitted service charge.			
			This amount is the original submitted charge.			
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**
			INDUSTRY: ***Revenue Code***			
			SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code.			
			This is the NUBC Revenue Code. When SVC-101 equals "NU", then the NUBC Revenue Code belongs in SVC01-2.			
NOT USED	**SVC05**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**
			INDUSTRY: ***Original Units of Service Count***			
			SEMANTIC: SVC07 is the original submitted units of service.			
			These are the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1.			

IMPLEMENTATION

SERVICE LINE ITEM IDENTIFICATION

Loop: **2210D — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment if the subscriber is the patient.**
2. **Required when available from the original claim. When the Information Receiver is the Provider, this is required when the number was assigned by the provider on the original claim.**
3. **Will be used primarily for professional claim service line inquiry, and bill type is being sent in the inquiry request in connection with institutional bill.**

Example: **REF*FJ*6042201~**

STANDARD

REF Reference Identification

Level: Detail

Position: 140

Loop: 2210

Requirement: Optional

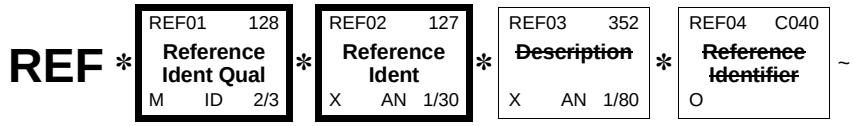
Max Use: 1

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
FJ	**Line Item Control Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203 **May or may not help the payer in the identification of the claim.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE LINE DATE

Loop: **2210D — SERVICE LINE INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. When the 2210D loop is used this segment must be present.**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 150

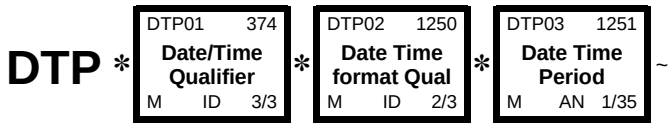
Loop: 2210

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Date Time Qualifier***	**M ID 3/3**
			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** **RD8** — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If the date is a single date of service, the begin date equals the end date.**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Service Line Date***	**M AN 1/35**

IMPLEMENTATION

DEPENDENT LEVEL

Loop: **2000E — DEPENDENT LEVEL** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

2. **Required when the patient is not the same entity as subscriber.**

Example: **HL*5*4*23~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

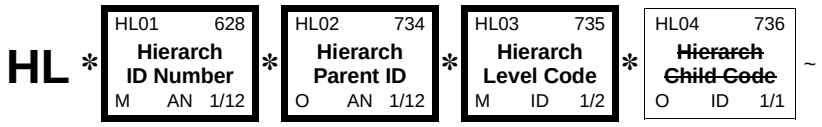
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure	**M**	**ID**	**1/2**

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
23	**Dependent**

NOT USED	**HL04**	**736**	**Hierarchical Child Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

DEPENDENT DEMOGRAPHIC INFORMATION

Loop: **2000E — DEPENDENT LEVEL**

Usage: **REQUIRED**

Repeat: **1**

Example: **DMG*D8*19330706*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 040

Loop: 2000

Requirement: Optional

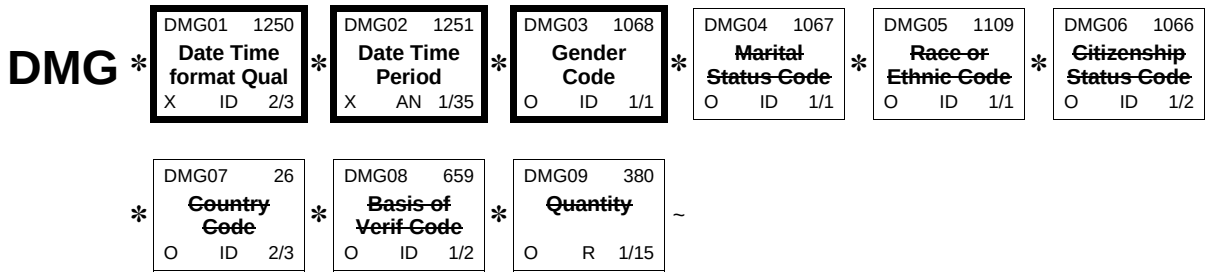
Max Use: 1

Purpose: To supply demographic information

Set Notes:
1. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

Syntax:
1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Patient Birth Date*** *ALIAS:* ***Date of Birth - Patient*** **SYNTAX:** P0102 **SEMANTIC:** DMG02 is the date of birth.	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Patient Gender Code*** *ALIAS:* ***Gender - Patient***	**O**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

IMPLEMENTATION

DEPENDENT NAME

Loop: **2100E — DEPENDENT NAME** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*JOSEPH*L****MI*12345678902~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

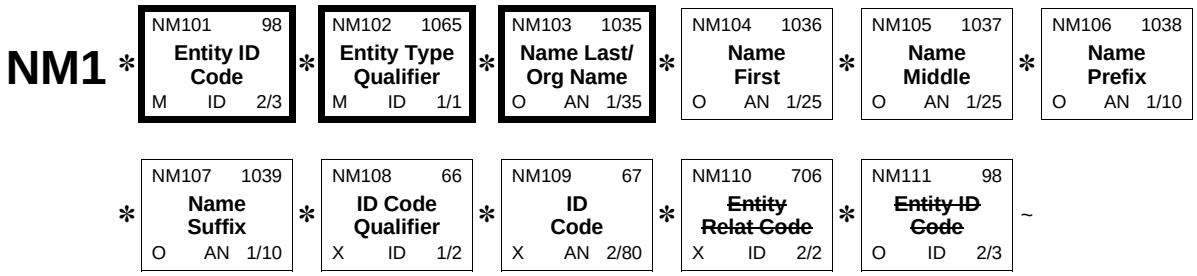
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**
			CODE: **QC** — DEFINITION: **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M ID 1/1**
			CODE: **1** — DEFINITION: **Person**	

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Patient Last Name***	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Patient First Name*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Patient Middle Name*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name *INDUSTRY:* ***Patient Name Prefix*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Patient Name Suffix*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **Required if NM109 is used.**	**X**	**ID**	**1/2**

CODE	DEFINITION
MI	**Member Identification Number**
ZZ	**Mutually Defined** **The value 'ZZ' when used in this data element shall be defined as 'HIPAA Individual Identifier' once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Patient Primary Identifier*** SYNTAX: P0809 **At this level, NM108 and NM109 are required if the dependent is assigned a unique identification number that is separate from the subscriber number in HL04 (HL22).**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CLAIM SUBMITTER TRACE NUMBER

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use of this segment is required if the patient is someone other than the subscriber.**
2. **Use this segment to convey a unique trace or reference number from the originator of the transaction to be returned by the receiver of the transaction.**
3. **The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.**

Example: **TRN*1*1722634842~**

STANDARD

TRN Trace

Level: Detail

Position: 090

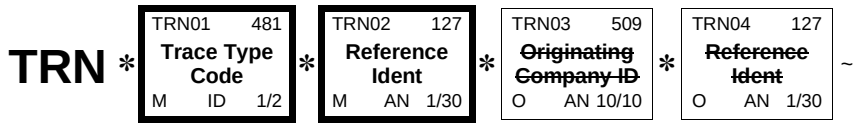
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

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 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 *INDUSTRY:* ***Trace Number*** SEMANTIC: TRN02 provides unique identification for the transaction.	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**

NOT USED	TRN04	127	Reference Identification	O	AN	1/30

IMPLEMENTATION

PAYER CLAIM IDENTIFICATION NUMBER

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this only if the subscriber is the patient.**
2. **This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN). This should be sent on claim inquiries when the number is known.**

Example: **REF*1K*9918046987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

Requirement: Optional

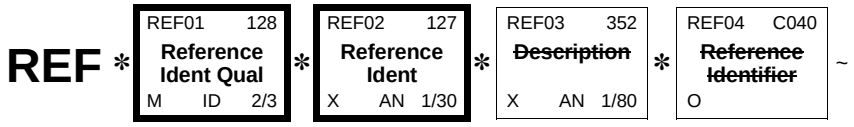
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			Examples of this element include ICN, DCN, and CCN.	
			CODE **DEFINITION** **1K** **Payor's Claim Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Claim Control Number*** **SYNTAX:** R0203	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

INSTITUTIONAL BILL TYPE IDENTIFICATION

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is the institutional type of bill as submitted on the original claim, and the payer may use it as a lookup key.**
2. **Use this segment only if the dependent is the patient and bill type is being sent in the inquiry request in connection with an institutional bill.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

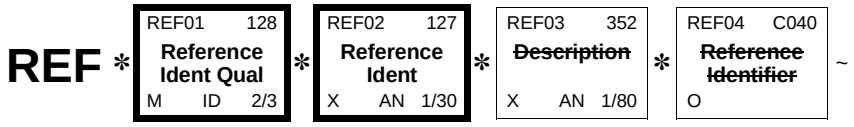
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
BLT	**Billing Type**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Bill Type Identifier*** SYNTAX: R0203 **Found on UB92 - record 40 - 4** **Found on 837 CLM-05** **Found on UB92 paper form locator 4** **Required for institutional claims inquiries.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MEDICAL RECORD IDENTIFICATION

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim.**
2. **Use this segment if the patient is someone other than the subscriber.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 100

Loop: 2200

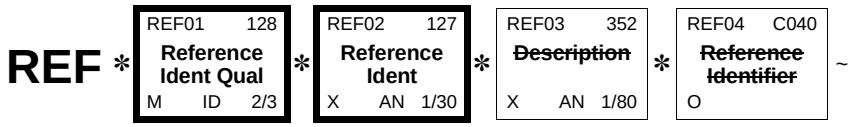
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EA — Medical Record Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medical Record Number*** SYNTAX: R0203 **Found on UB92 record 20 field 25** **Found on 837 CLM-05** **Found on UB92 paper form locator 23**	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

CLAIM SUBMITTED CHARGES

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment if the service line SVC segment, loop 2210E is not used.**

2. **Not all payers' systems retain the original submitted charges. This may be a result of "bundling/unbundling" situations. This amount can be used as secondary match criteria within the payer's system if the claim has not been changed.**

Example: **AMT*T3*75~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 110

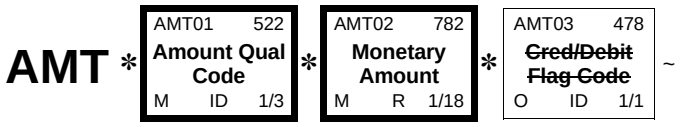
Loop: 2200

Requirement: Optional

Max Use: 1

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M ID 1/3**

CODE	DEFINITION
T3	**Total Submitted Charges**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Total Claim Charge Amount***			
			Found on UB92 - Revenue Code 0001 and also in record 90 **Found on UB92 Paper form - Revenue Code 0001** **Found on 837 CLM02 (Professional); Revenue Code 0001 (Institutional)** **Found on NSF - XA0 Record field 12** **Found on HCFA 1500 - Block 28**			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required for institutional claims. The date is the statement from and through date.**
2. **For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at 2210E is required.**
3. **For additional information on the date range use, refer to Section 2.2.3.9 in the front section of this guide.**

Example: **DTP*232*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

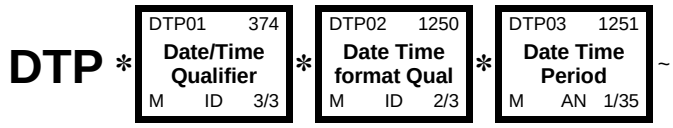
Loop: 2200

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Date Time Qualifier*** **Use this element for the date of service submitted on the original claim.**	**M ID 3/3**

CODE	DEFINITION
232	**Claim Statement Period Start**

REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M**	**ID**	**2/3**

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If the date is a single date of service, the begin date equals the end date.**

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

INDUSTRY: ***Claim Service Period***

IMPLEMENTATION

SERVICE LINE INFORMATION

Loop: **2210E — SERVICE LINE INFORMATION Repeat: >1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to request status information about a service line.**
2. **This segment is required if loop is used by ASC X12 syntax because it is the first segment in Loop ID 2210 (Service Line Information).**
3. **For Medicare Institutional claims, SVC01 would be the Health Care Financing Administration (HCFA), Common Procedural Coding System (HCPCS) Code (See Code Source 130) and SVC04 would be the Revenue Code (see Code Source 132).**

Example: **SVC*HC:99214*75*****1~**
or
SVC*NU:71X*50***1~**

STANDARD

SVC Service Information

Level: Detail

Position: 130

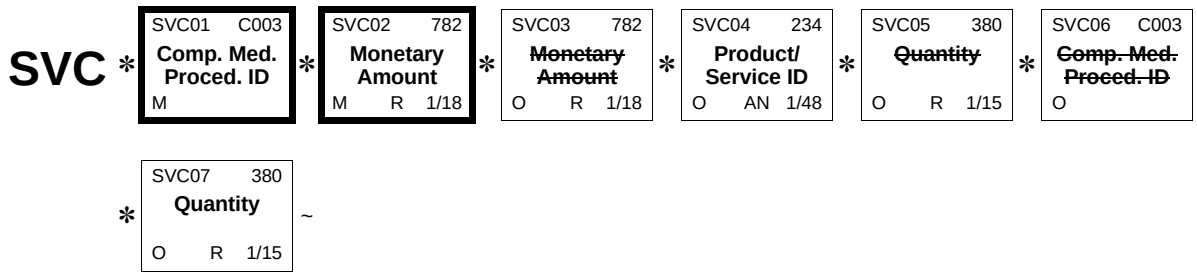
Loop: 2210 **Repeat:** >1

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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**
			SVC01 will contain the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted procedure code.	
REQUIRED	**SVC01 - 1**		**235 Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M ID 2/2**

INDUSTRY: ***Product or Service ID Qualifier***

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE 135: American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, the CPT codes are reported under the code HC.**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE 240: National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE 240: National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE 240: National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE 240: National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE 134: National Drug Code
NH	**National Health Related Item Code**

				NU	**National Uniform Billing Committee (NUBC) UB92 Codes** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes			
				RB	**National Uniform Billing Committee (NUBC) UB82 Codes** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**SVC01 - 2**		**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Service Identification Code*** **If the value in SVC01-1 is "NU", then this is an NUBC Revenue Code. If a value is present here, then SVC04 is not used.**	**M**	**AN**	**1/48**
SITUATIONAL	**SVC01 - 3**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 4**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 5**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 6**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
NOT USED	**SVC01 - 7**		**352**	**Description**	**O**	**AN**	**1/80**
REQUIRED	**SVC02**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Charge Amount*** **SEMANTIC:** SVC02 is the submitted service charge. **This amount is the original submitted charge.**	**M**	**R**	**1/18**
NOT USED	**SVC03**	**782**		**Monetary Amount**	**O**	**R**	**1/18**
SITUATIONAL	**SVC04**	**234**		**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Revenue Code*** **SEMANTIC:** SVC04 is the National Uniform Billing Committee Revenue Code. **This is the NUBC Revenue Code. When SVC-101 equals "NU", then the NUBC Revenue Code belongs in SVC01-2.**	**O**	**AN**	**1/48**
NOT USED	**SVC05**	**380**		**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**		**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		

SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Original Units of Service Count***

SEMANTIC: SVC07 is the original submitted units of service.

These are the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1.

IMPLEMENTATION

SERVICE LINE ITEM IDENTIFICATION

Loop: **2210E — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when available from the original claim. When the Information Receiver is the Provider, this is required when the number was assigned by the provider on the original claim.**

Example: **REF*FJ*6042201~**

STANDARD

REF Reference Identification

Level: Detail

Position: 140

Loop: 2210

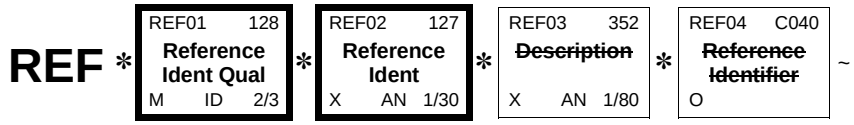
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **FJ — Line Item Control Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SERVICE LINE DATE

Loop: **2210E — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **When the 2210E loop is used this segment must be present.**
2. **For institutional claims, this is the statement period.**
3. **Will be required if SVC segment is used.**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 150

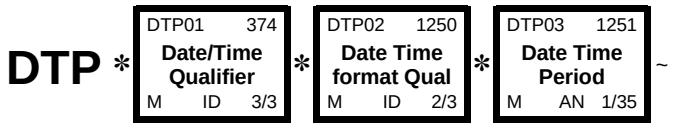
Loop: 2210

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **472** — **Service**	**M ID 3/3**
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 **RD8** — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If the date is a single date of service, the begin date equals the end date.**	**M ID 2/3**

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

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*34*0001~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 160

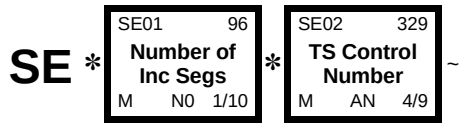
Loop: ____

Requirement: Mandatory

Max Use: 1

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)

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Transaction Segment Count***	**M 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 **Data value in SE02 must be identical to ST02.**	**M AN 4/9**

IMPLEMENTATION

277 Health Care Claim Status Notification

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
125	010	ST	Transaction Set Header	R	1	
126	020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
128	010	HL	Information Source Level	R	1	
			LOOP ID - 2100A PAYER NAME			>1
130	050	NM1	Payer Name	R	1	
133	080	PER	Payer Contact Information	S	1	

Table 2 - Detail, Information Receiver Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
136	010	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			>1
138	050	NM1	Information Receiver Name	R	1	

Table 2 - Detail, Service Provider Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SERVICE PROVIDER LEVEL			>1
141	010	HL	Service Provider Level	R	1	
			LOOP ID - 2100C PROVIDER NAME			>1
143	050	NM1	Provider Name	R	1	

Table 2 - Detail, Subscriber Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D SUBSCRIBER LEVEL			**>1**
146	**010**	**HL**	Subscriber Level	**R**	**1**	
148	**040**	**DMG**	Subscriber Demographic Information	**R**	**1**	
			LOOP ID - 2100D SUBSCRIBER NAME			**>1**
150	**050**	**NM1**	Subscriber Name	**R**	**1**	
			LOOP ID - 2200D CLAIM SUBMITTER TRACE NUMBER			**>1**
153	**090**	**TRN**	Claim Submitter Trace Number	**R**	**1**	
154	**100**	**STC**	Claim Level Status Information	**R**	**1**	
165	**110**	**REF**	Payer Claim Identification Number	**S**	**1**	
167	**110**	**REF**	Institutional Bill Type Identification	**S**	**1**	
169	**110**	**REF**	Medical Record Identification	**S**	**1**	
171	**120**	**DTP**	Claim Service Date	**S**	**1**	
			LOOP ID - 2220D SERVICE LINE INFORMATION			**>1**
173	**180**	**SVC**	Service Line Information	**S**	**1**	
177	**190**	**STC**	Service Line Status Information	**S**	**1**	
187	**200**	**REF**	Service Line Item Identification	**S**	**1**	
188	**210**	**DTP**	Service Line Date	**S**	**1**	

Table 2 - Detail, Dependent Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000E DEPENDENT LEVEL			**>1**
190	**010**	**HL**	Dependent Level	**S**	**1**	
192	**040**	**DMG**	Dependent Demographic Information	**R**	**1**	
			LOOP ID - 2100E DEPENDENT NAME			**>1**
194	**050**	**NM1**	Dependent Name	**R**	**1**	
			LOOP ID - 2200E CLAIM SUBMITTER TRACE NUMBER			**>1**
197	**090**	**TRN**	Claim Submitter Trace Number	**R**	**1**	
199	**100**	**STC**	Claim Level Status Information	**R**	**1**	
210	**110**	**REF**	Payer Claim Identification Number	**R**	**1**	
212	**110**	**REF**	Institutional Bill Type Identification	**S**	**1**	
214	**110**	**REF**	Medical Record Identification	**S**	**1**	
216	**120**	**DTP**	Claim Service Date	**S**	**1**	
			LOOP ID - 2220E SERVICE LINE INFORMATION			**>1**
218	**180**	**SVC**	Service Line Information	**S**	**1**	
221	**190**	**STC**	Service Line Status Information	**S**	**1**	
231	**200**	**REF**	Service Line Item Identification	**S**	**1**	
232	**210**	**DTP**	Service Line Date	**S**	**1**	
234	**270**	**SE**	Transaction Set Trailer	**R**	**1**	

STANDARD

277 Health Care Claim Status Notification

Functional Group ID: HN

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim 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. 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
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	
030	REF	Reference Identification	O	10	
		LOOP ID - 1000			>1
040	NM1	Individual or Organizational Name	O	1	
050	N2	Additional Name Information	O	2	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	REF	Reference Identification	O	2	
090	PER	Administrative Communications Contact	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
010	HL	Hierarchical Level	M	1	
020	SBR	Subscriber Information	O	1	
030	PAT	Patient Information	O	1	
040	DMG	Demographic Information	O	1	
		LOOP ID - 2100			>1
050	NM1	Individual or Organizational Name	O	1	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	PER	Administrative Communications Contact	O	1	
		LOOP ID - 2200			>1
090	TRN	Trace	O	1	
100	STC	Status Information	M	>1	
110	REF	Reference Identification	O	3	
120	DTP	Date or Time or Period	O	2	
		LOOP ID - 2210			>1
130	PWK	Paperwork	O	1	
140	PER	Administrative Communications Contact	O	1	
150	N1	Name	O	1	

160	N3	Address Information	O	1	
170	N4	Geographic Location	O	1	
		LOOP ID - 2220			>1
180	SVC	Service Information	O	1	
190	STC	Status Information	M	>1	
200	REF	Reference Identification	O	1	
210	DTP	Date or Time or Period	O	1	
		LOOP ID - 2225			>1
220	PWK	Paperwork	O	1	
230	PER	Administrative Communications Contact	O	1	
240	N1	Name	O	1	
250	N3	Address Information	O	1	
260	N4	Geographic Location	O	1	
270	SE	Transaction Set Trailer	M	1	

NOTES:

2/020 The SBR segment may only appear at the Subscriber (HL03=22) level.

2/040 The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

2/130 The 2210 loop may be used when there is a status notification or a request for additional information about a particular claim.

2/220 The 2225 loop may be used when there is a status notification or a request for additional information about a particular service line.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*277*0001~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

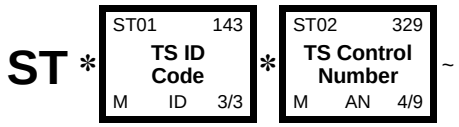
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) 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** **DEFINITION** **277** **Health Care Claim Status Notification**	**M ID 3/3**
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 **Data value in ST02 must be identical to SE02.**	**M AN 4/9**

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Example: **BHT*0010*08*277X069*961120**DG~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 020

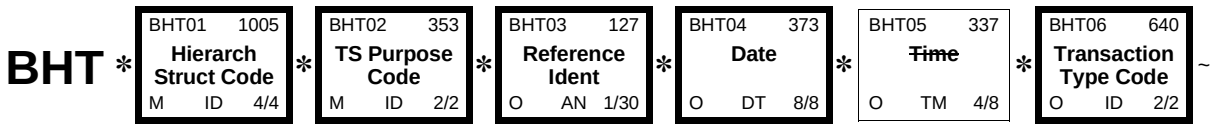
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 CODE / DEFINITION **0010** — **Information Source, Information Receiver, Provider of Service, Subscriber, Dependent**	**M ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set CODE / DEFINITION **08** — **Status**	**M 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 *INDUSTRY:* ***Originator Application Transaction Identifier*** **SEMANTIC:** BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.	**O AN 1/30**

REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**
			INDUSTRY:* *Transaction Set Creation Date **SEMANTIC:** BHT04 is the date the transaction was created within the business application system.			
NOT USED	**BHT05**	**337**	**Time**	**O**	**TM**	**4/8**
REQUIRED	**BHT06**	**640**	**Transaction Type Code** Code specifying the type of transaction	**O**	**ID**	**2/2**

CODE	DEFINITION
DG	**Response**

IMPLEMENTATION

INFORMATION SOURCE LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

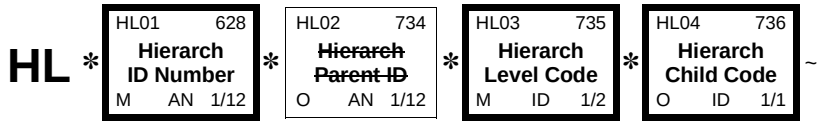
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 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 ID 1/2**

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O** **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.**

IMPLEMENTATION

PAYER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Payers with multiple locations or lines of business may require.**

Example: **NM1*PR*2*ABC INSURANCE*****PI*12345~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

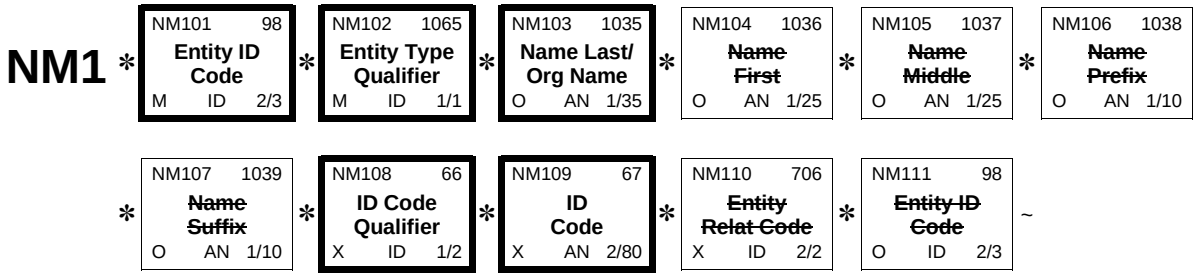
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Payer Name***

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

SYNTAX: P0809

Payer identifiers should be used with the following preferences:

(PI) Payer ID
(NI) NAIC Code
(AD) If the Payer is a Blue Cross or Blue Shield Plan, BCBSA Plan Code
(PP) If the Payer is a Pharmacy Processor, Pharmacy Processor Number
(FI) Tax ID
(21) If other codes are not available or known, use HIN or Payer Identification Number

CODE	DEFINITION
21	**Health Industry Number (HIN)**
	CODE SOURCE 121: Health Industry Identification Number
AD	**Blue Cross Blue Shield Association Plan Code**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification**
PI	**Payor Identification**
PP	**Pharmacy Processor Number**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***
	CODE SOURCE 540: Health Care Financing Administration National PlanID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PAYER CONTACT INFORMATION

Loop: **2100A — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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 should 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 (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

2. **By definition of the standard, if PER03 is used, PER04 is required.**

3. **Required only if needed for identification of contact at the payer site.**

Example: **PER*IC*MEDICAL REVIEW DEPARTMENT*TE*3135551234*EX*6593*FX*3135554321~**
OR
PER*ICTE*3135551234***FX*3135554321~**
OR
PER*IC***FX*3135554321~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 1

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

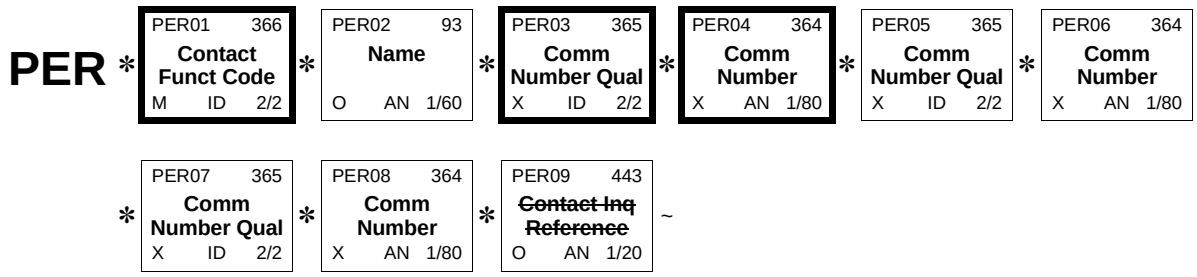
Syntax:

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O AN 1/60**
			INDUSTRY: ***Payer Contact Name***	
			This element is required when a specific person or department is the contact for the response in order to clarify requests concerning aditional information requests.	
			Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X ID 2/2**
			SYNTAX: P0304	
			Required when PER04 is used.	
			CODE: **ED** — DEFINITION: **Electronic Data Interchange Access Number**	
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **TE** — DEFINITION: **Telephone**	
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X AN 1/80**
			SYNTAX: P0304	
			Use PER04 to supply International Codes, Area Code (within U.S.), Local exchanges, and telephone numbers. When an additional extension is required PER06 should be used.	
			Used if needed to transmit communication number.	

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Required when PER06 is used.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EX	**Telephone Extension**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Use PER06 to supply telephone extensions only. International Codes, Area Codes (within U.S.), Exchanges, and telephone numbers should be placed in PER04.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Required when PER08 is used.**	**X**	**ID**	**2/2**

CODE	DEFINITION
EX	**Telephone Extension**
FX	**Facsimile**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **Required when necessary to provide another telephone extension or fax number.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

INFORMATION RECEIVER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Information Receiver**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

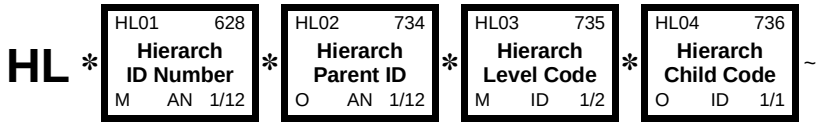
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**
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**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 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.**

IMPLEMENTATION

INFORMATION RECEIVER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **This is the individual or organization requesting to receive the status information.**

Example: **NM1*41*2*XYZ SERVICE*****46*A222222221~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

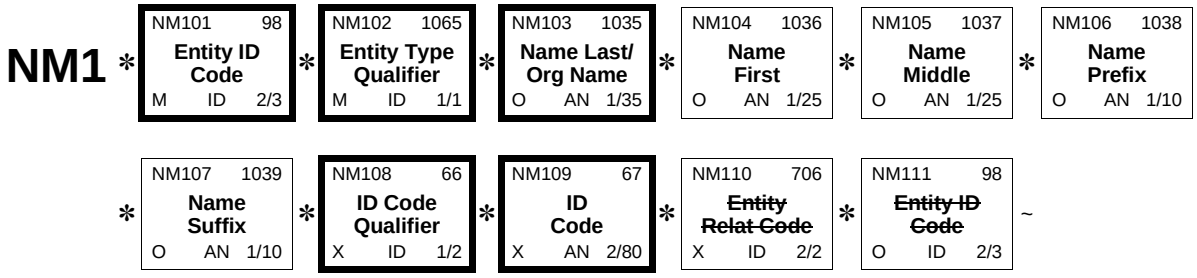
Requirement: Optional

Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
41	**Submitter**

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M** **ID** **1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

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

REQUIRED **NM103** **1035** **Name Last or Organization Name** **O** **AN** **1/35**
Individual last name or organizational name

INDUSTRY: ***Information Receiver Last or Organization Name***

SITUATIONAL **NM104** **1036** **Name First** **O** **AN** **1/25**
Individual first name

INDUSTRY: ***Information Receiver First Name***

The first name is required when the value in NM102 is '1' and the person has a first name.

SITUATIONAL **NM105** **1037** **Name Middle** **O** **AN** **1/25**
Individual middle name or initial

INDUSTRY: ***Information Receiver Middle Name***

The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.

SITUATIONAL **NM106** **1038** **Name Prefix** **O** **AN** **1/10**
Prefix to individual name

INDUSTRY: ***Information Receiver Name Prefix***

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

SITUATIONAL **NM107** **1039** **Name Suffix** **O** **AN** **1/10**
Suffix to individual name

INDUSTRY: ***Information Receiver Name Suffix***

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

REQUIRED **NM108** **66** **Identification Code Qualifier** **X** **ID** **1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

CODE	DEFINITION
46	**Electronic Transmitter Identification Number (ETIN)**
FI	**Federal Taxpayer's Identification Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Information Receiver Identification Number*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SERVICE PROVIDER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

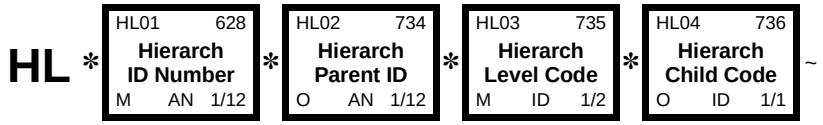
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M** **ID** **1/2**

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
19	**Provider of Service**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O** **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.**

IMPLEMENTATION

PROVIDER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*1P*2*HOME MEDICAL*****SV*987666666~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

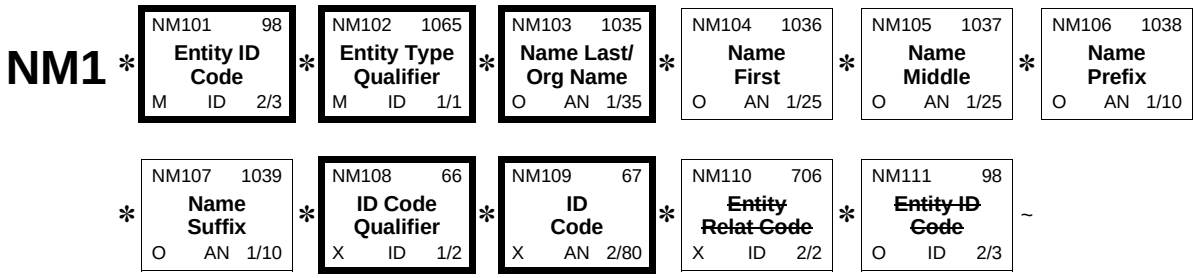
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**
			CODE: **1P** — DEFINITION: **Provider**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M ID 1/1**
			CODE: **1** — DEFINITION: **Person**	

			2	**Non-Person Entity**			
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Provider Last or Organization Name***		**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Provider First Name*** **The first name is required when the value in NM102 is '1' and the person has a first name.**		**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Provider Middle Name*** **The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.**		**O**	**AN**	**1/25**
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name *INDUSTRY:* ***Provider Name Prefix*** **Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a person.**		**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Provider Name Suffix*** **Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a person.**		**O**	**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**	**ID**	**1/2**

CODE	DEFINITION
FI	**Federal Taxpayer's Identification Number**
SV	**Service Provider Number** **When the provider does not have a National Provider ID and Payer has assigned a specific ID number to this provider this code is required.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Provider Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If the subscriber and the patient are the same person, do not use the next HL (HL23) for claim information.**

Example: **HL*4*3*22*0~ or HL*4*3*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

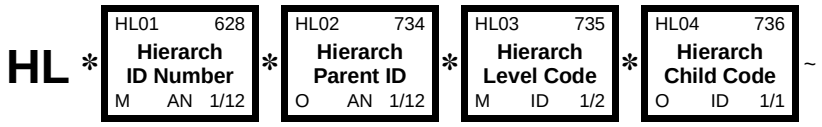
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

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
22	**Subscriber**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 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
0	**No Subordinate HL Segment in This Hierarchical Structure.** **Required when there are no dependent claim status requests for this subscriber.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.** **Required when there are dependent claims related to this subscriber.**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2000D — SUBSCRIBER LEVEL**

Usage: **REQUIRED**

Repeat: **1**

Example: **DMG*D8*19330706*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 040

Loop: 2000

Requirement: Optional

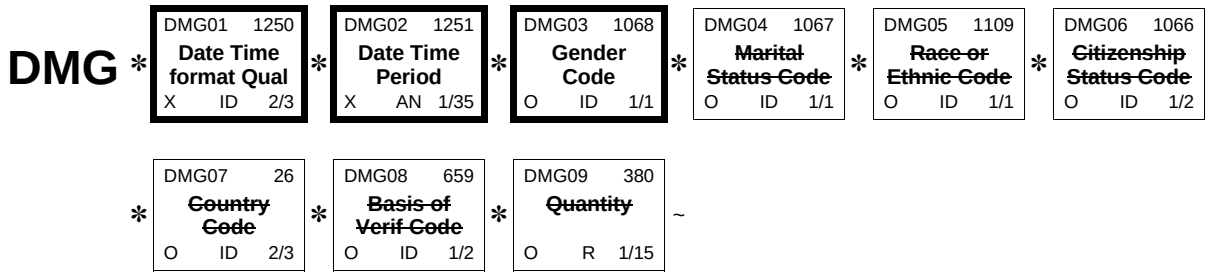
Max Use: 1

Purpose: To supply demographic information

Set Notes:
1. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

Syntax:
1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Subscriber Birth Date*** *ALIAS:* ***Date of Birth - Subscriber*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Subscriber Gender Code*** *ALIAS:* ***Gender - Subscriber***	**O**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2100D — SUBSCRIBER NAME** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*FRED****MI*123456789A~ or**
NM1*IL*1*SMITH*ROBERT**MI*9876543210~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

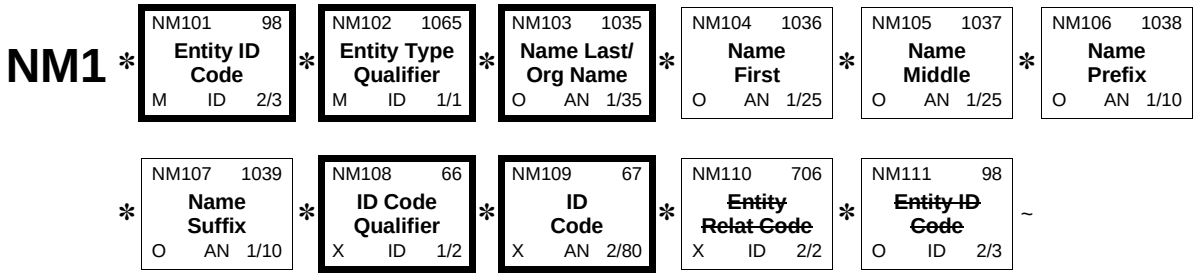
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**

CODE	DEFINITION
IL	**Insured or Subscriber**
QC	**Patient** **Use this only when the subscriber is the patient.**

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M** **ID** **1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity** **Use the value "2" in an employer-subscriber situation, such as Worker's Compensation. In this case, the value "IL" would appear in NM101.**

REQUIRED **NM103** **1035** **Name Last or Organization Name** **O** **AN** **1/35**
Individual last name or organizational name

INDUSTRY: ***Subscriber Last Name***

SITUATIONAL **NM104** **1036** **Name First** **O** **AN** **1/25**
Individual first name

INDUSTRY: ***Subscriber First Name***

The first name is required when the value in NM102 is '1' and the person has a first name.

SITUATIONAL **NM105** **1037** **Name Middle** **O** **AN** **1/25**
Individual middle name or initial

INDUSTRY: ***Subscriber Middle Name***

ADVISORY: Under most circumstances, this element is expected to be sent.

The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.

SITUATIONAL **NM106** **1038** **Name Prefix** **O** **AN** **1/10**
Prefix to individual name

INDUSTRY: ***Subscriber Name Prefix***

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

SITUATIONAL **NM107** **1039** **Name Suffix** **O** **AN** **1/10**
Suffix to individual name

INDUSTRY: ***Subscriber Name Suffix***

Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.

REQUIRED **NM108** **66** **Identification Code Qualifier** **X** **ID** **1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

CODE	DEFINITION
24	**Employer's Identification Number**
MI	**Member Identification Number**

			ZZ **Mutually Defined** **The value 'ZZ' when used in this data element shall be defined as 'HIPAA Individual Identifier' once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Subscriber Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CLAIM SUBMITTER TRACE NUMBER

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use of this segment is required if the subscriber is the patient.**
2. **This trace number is the trace or reference number from the originator of the transaction that was provided at the corresponding level within the 276 (Health Care Claim Status Request) transaction.**
3. **The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.**

Example: **TRN*2*172263482~**

STANDARD

TRN Trace

Level: Detail

Position: 090

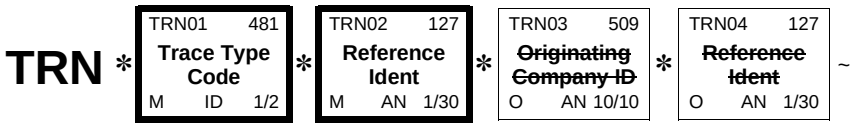
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **2 — Referenced Transaction Trace Numbers**	**M 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 *INDUSTRY:* ***Trace Number*** SEMANTIC: TRN02 provides unique identification for the transaction.	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O AN 1/30**

IMPLEMENTATION

CLAIM LEVEL STATUS INFORMATION

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. This is required if the subscriber is the patient.**

2. Claim Status information in response to solicited inquiry.

Example: **STC*A1:21*19960501**50*0~ or**
STC*FI:65*1996051150*40*19960515*CHK*19960510*50321~**

STANDARD

STC Status Information

Level: Detail

Position: 100

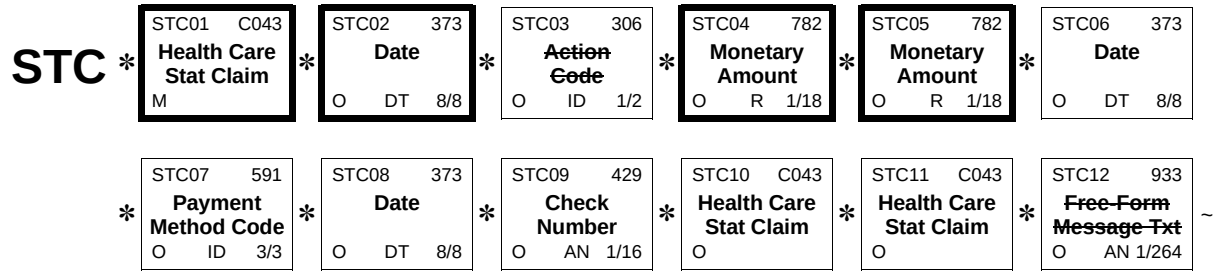
Loop: 2200

Requirement: Mandatory

Max Use: >1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** **M** Used to convey status of the entire claim or a specific service line	
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list *INDUSTRY:* ***Health Care Claim Status Category Code*** **This is the Category code. Use code source 507.**	
REQUIRED	**STC01 - 2**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list	

INDUSTRY: ***Health Care Claim Status Code***

This is the Status code. Use code source 508.

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

STC01-3 further modifies the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.

CODE	DEFINITION
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership
2P	Public Health Service Facility

2Q	Veterans Administration Facility
2S	Public Health Service Indian Service Facility
2Z	Hospital Unit of an Institution (prison hospital, college infirmary, etc.)
30	Service Supplier
36	Employer
3A	Hospital Unit Within an Institution for the Mentally Retarded
3C	Tuberculosis and Other Respiratory Diseases Facility
3D	Obstetrics and Gynecology Facility
3E	Eye, Ear, Nose and Throat Facility
3F	Rehabilitation Facility
3G	Orthopedic Facility
3H	Chronic Disease Facility
3I	Other Specialty Facility
3J	Children's General Facility
3K	Children's Hospital Unit of an Institution
3L	Children's Psychiatric Facility
3M	Children's Tuberculosis and Other Respiratory Diseases Facility
3N	Children's Eye, Ear, Nose and Throat Facility
3O	Children's Rehabilitiaion Facility
3P	Children's Orthopedic Facility
3Q	Children's Chronic Disease Facility
3R	Children's Other Specialty Facility
3S	Institution for Mental Retardation
3T	Alcoholism and Other Chemical Dependency Facility
3U	General Inpatient Care for AIDS/ARC Facility
3V	AIDS/ARC Unit
3W	Specialized Outpatient Program for AIDS/ARC
3X	Alcohol/Drug Abuse or Dependency Inpatient Unit
3Y	Alcohol/Drug Abuse or Dependency Outpatient Services

3Z	Arthritis Treatment Center
40	Receiver
43	Claimant Authorized Representative
44	Data Processing Service Bureau
4A	Birthing Room/LDRP Room
4B	Burn Care Unit
4C	Cardiac Catherization Laboratory
4D	Open-Heart Surgery Facility
4E	Cardiac Intensive Care Unit
4F	Angioplasty Facility
4G	Chronic Obstructive Pulmonary Disease Service Facility
4H	Emergency Department
4I	Trauma Center (Certified)
4J	Extracorporeal Shock-Wave Lithotripter (ESWL) Unit
4L	Genetic Counseling/Screening Services
4M	Adult Day Care Program Facility
4N	Alzheimer's Diagnostic/Assessment Services
4O	Comprehensive Geriatric Assessment Facility
4P	Emergency Response (Geriatric) Unit
4Q	Geriatric Acute Care Unit
4R	Geriatric Clinics
4S	Respite Care Facility
4U	Patient Education Unit
4V	Community Health Promotion Facility
4W	Worksite Health Promotion Facility
4X	Hemodialysis Facility
4Y	Home Health Services
4Z	Hospice
5A	Medical Surgical or Other Intensive Care Unit
5B	Hisopathology Laboratory
5C	Blood Bank

5D	Neonatal Intensive Care Unit
5E	Obstetrics Unit
5F	Occupational Health Services
5G	Organized Outpatient Services
5H	Pediatric Acute Inpatient Unit
5I	Psychiatric Child/Adolescent Services
5J	Psychiatric Consultation-Liaison Services
5K	Psychiatric Education Services
5L	Psychiatric Emergency Services
5M	Psychiatric Geriatric Services
5N	Psychiatric Inpatient Unit
5O	Psychiatric Outpatient Services
5P	Psychiatric Partial Hospitalization Program
5Q	Megavoltage Radiation Therapy Unit
5R	Radioactive Implants Unit
5S	Theraputic Radioisotope Facility
5T	X-Ray Radiation Therapy Unit
5U	CT Scanner Unit
5V	Diagnostic Radioisotope Facility
5W	Magnetic Resonance Imaging (MRI) Facility
5X	Ultrasound Unit
5Y	Rehabilitation Inpatient Unit
5Z	Rehabilitation Outpatient Services
61	Performed At
6A	Reproductive Health Services
6B	Skilled Nursing or Other Long-Term Care Unit
6C	Single Photon Emission Computerized Tomography (SPECT) Unit
6D	Organized Social Work Service Facility
6E	Outpatient Social Work Services
6F	Emergency Department Social Work Services
6G	Sports Medicine Clinic/Services

6H	Hospital Auxiliary Unit
6I	Patient Representative Services
6J	Volunteer Services Department
6K	Outpatient Surgery Services
6L	Organ/Tissue Transplant Unit
6M	Orthopedic Surgery Facility
6N	Occupational Therapy Services
6O	Physical Therapy Services
6P	Recreational Therapy Services
6Q	Respiratory Therapy Services
6R	Speech Therapy Services
6S	Women's Health Center/Services
6U	Cardiac Rehabilitation Program Facility
6V	Non-Invasive Cardiac Assessment Services
6W	Emergency Medical Technician
6X	Disciplinary Contact
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
77	Service Location
7C	Place of Occurrence
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
95	Research Institute
CK	Pharmacist
CZ	Admitting Surgeon
D2	Commercial Insurer

DD	Assistant Surgeon
DJ	Consulting Physician
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E1	Person or Other Entity Legally Responsible for a Child
E2	Person or Other Entity With Whom a Child Resides
E7	Previous Employer
E9	Participating Laboratory
FA	Facility
FD	Physical Address
FE	Mail Address
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GD	Guardian
GI	Paramedic
GJ	Paramedical Company
GK	Previous Insured
GM	Spouse Insured
GY	Treatment Facility
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IJ	Injection Point
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
LR	Legal Representative
MR	Medical Insurance Carrier

OB	Ordered By
OD	Doctor of Optometry
OX	Oxygen Therapy Facility
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PT	Party to Receive Test Report
PV	Party performing certification
PW	Pick Up Address
QA	Pharmacy
QB	Purchase Service Provider
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QO	Doctor of Osteopathy
QS	Podiatrist
QV	Group Practice
QY	Medical Doctor
RC	Receiving Location
RW	Rural Health Clinic
S4	Skilled Nursing Facility
SJ	Service Provider
SU	Supplier/Manufacturer

			T4 **Transfer Point** **Used to identify the geographic location where a patient is transferred or deverted.**			
			TQ **Third Party Reviewing Organization (TPO)**			
			TT **Transfer To**			
			TU **Third Party Repricing Organization (TPO)**			
			UH **Nursing Home**			
			X3 **Utilization Management Organization**			
			X4 **Spouse**			
			X5 **Durable Medical Equipment Supplier**			
			ZZ **Mutually Defined**			
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Status Information Effective Date*** **SEMANTIC:** STC02 is the effective date of the status information. **Use this date for the effective date of status.**	**O**	**DT**	**8/8**
NOT USED	**STC03**	**306**	**Action Code**	**O**	**ID**	**1/2**
REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Claim Charge Amount*** **SEMANTIC:** STC04 is the amount of original submitted charges. **Use this element for the amount of submitted charges. Some HMO encounters supply zero as the amount of original charges.**	**O**	**R**	**1/18**
REQUIRED	**STC05**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Payment Amount*** **SEMANTIC:** STC05 is the amount paid. **Use this element for the claim paid amount. This amount must be zero if the adjudication process is not complete. Claim total charge will quite often change from the submitted claim total charge based on claims processing instructions, ie: splitting of claims. Most payers do not store the "original submitted charge."**	**O**	**R**	**1/18**
SITUATIONAL	**STC06**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Adjudication or Payment Date*** **SEMANTIC:** STC06 is the paid date. **Use this element for the date of denial or payment. Use this date if the payment determination is complete.**	**O**	**DT**	**8/8**

SITUATIONAL **STC07** **591** **Payment Method Code** **O** **ID** **3/3**
Code identifying the method for the movement of payment instructions

Will be used when claim has a dollar payment to the provider of service.

CODE	DEFINITION
ACH	**Automated Clearing House (ACH)** **Use this code to move money electronically through the Automated Clearing House (ACH). When this code is used, information in BPR05 through BPR15 also must be included.**
BOP	**Financial Institution Option** **Use this code to indicate that the third party processor will choose the method of payment based on end point requests or capabilities.**
CHK	**Check** **Use this code to indicate that a check was issued for payment.**
FWT	**Federal Reserve Funds/Wire Transfer - Nonrepetitive** **Use this code to indicate that the funds were sent through the wire system.**
NON	**Non-Payment Data** **Use this code to indicate that this is information only and no dollars are to be moved.**

SITUATIONAL **STC08** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Check Issue or EFT Effective Date***

SEMANTIC: STC08 is the check issue date.

Use this element for the check issue date or for the date that EFT funds were released to the Automated Clearing House.

SITUATIONAL **STC09** **429** **Check Number** **O** **AN** **1/16**
Check identification number

INDUSTRY: ***Check or EFT Trace Number***

Required with a Finalized and PAID claim when the entire claim was paid using a single check or EFT. Not used with Pending or Rejected claims. If the payment is EFT (electronic file transfer), this number is the trace number.

SITUATIONAL **STC10** **C043** **HEALTH CARE CLAIM STATUS** **O**
Used to convey status of the entire claim or a specific service line

Use this element if a second claim status is needed.

REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: Health Care Claim Status Category Code			
				This is the Category code. Use code source 507.			
				Required if STC10 is used.			
REQUIRED	**STC10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: Health Care Claim Status Code			
				This is the Status code. Use code source 508.			
				Required if STC10 is used.			
SITUATIONAL	**STC10 - 3**		**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
				STC10-3 further modifies the status code in STC10-2. See code value list in STC01-3.			
SITUATIONAL	**STC11**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O**		
				Use this element if a third claim status is needed.			
REQUIRED	**STC11 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: Health Care Claim Status Category Code			
				This is the Category code. Use code source 507.			
				Required if STC11 is used.			
REQUIRED	**STC11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: Health Care Claim Status Code			
				This is the Status code. Use code source 508.			
				Required if STC11 is used.			
SITUATIONAL	**STC11 - 3**		**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
				STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.			
NOT USED	**STC12**	**933**	**Free-Form Message Text**		**O**	**AN**	**1/264**

IMPLEMENTATION

PAYER CLAIM IDENTIFICATION NUMBER

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this only if the subscriber is the patient.**
2. **This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN). This should be sent on claim inquiries when the number is known.**

Example: **REF*1K*9918046987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

Requirement: Optional

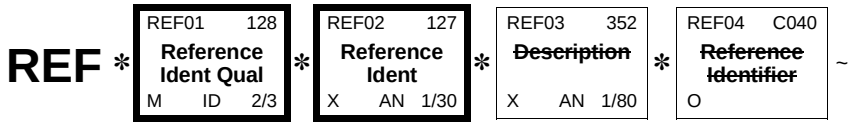
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Examples of this element include: ICN, DCN and CCN.

CODE	DEFINITION
1K	**Payor's Claim Number** **This data element corresponds to the value given in the ANSI ASC X12 837 transaction in CLM01.**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Claim Control Number*** *ALIAS:* ***Patient Account Number*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

INSTITUTIONAL BILL TYPE IDENTIFICATION

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the institutional type of bill from the original submitted claim, and it is returned when it is available.**
2. **Use when subscriber is the patient.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

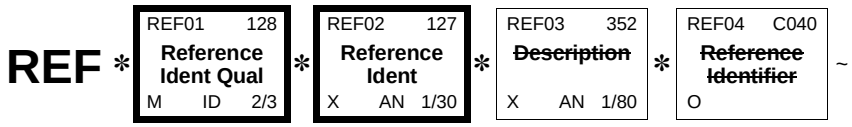
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
BLT	**Billing Type**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Bill Type Identifier*** SYNTAX: R0203 **Found on UB92 - record 40 - 4** **Found on 837 CLM-05** **Found on UB92 paper form locator 4** **Required institutional claim inquiries.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MEDICAL RECORD IDENTIFICATION

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the Medical Record number submitted on the original claim and should be returned when available from the the submitted claim.**
2. **Use this only when the subscriber is the patient.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

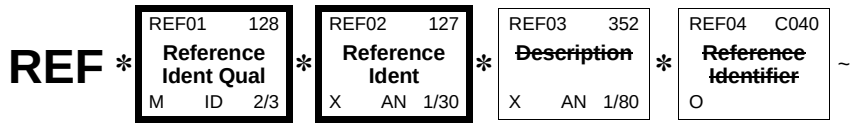
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EA** — **Medical Record Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medical Record Number*** SYNTAX: R0203 **Found on UB92 record 20 field 25** **Found on 837 REF-02** **Found on UB92 paper form locator 23**	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200D — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment for the institutional claim statement period.**
2. **Use this segment if the subscriber is the patient.**
3. **For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at 2220D is required.**

Example: **DTP*232*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

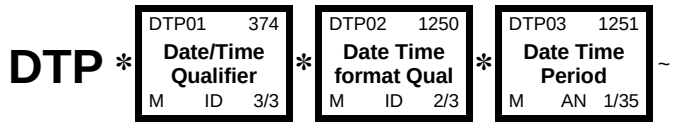
Loop: 2200

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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**	**ID**	**3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
232	**Claim Statement Period Start**

REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M**	**ID**	**2/3**

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If there is a single date of service, the begin date equals the end date.**

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

INDUSTRY: ***Claim Service Period***

IMPLEMENTATION

SERVICE LINE INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to report information about a service line.**
2. **This segment is required by ASC X12 syntax if this loop is used, because it is the first segment in the Service Line Information Loop.**
3. **For Medicare Institutional claims, SVC01 would be the Health Care Financing Administration (HCFA), Common Procedural Coding System (HCPCS) Code (See Code Source 130) and SVC04 would be the Revenue Code (see Code Source 132).**

Example: **SVC*HC:99214*75*50****1~ SVC*NU:71X*50*0****1~**

STANDARD

SVC Service Information

Level: Detail

Position: 180

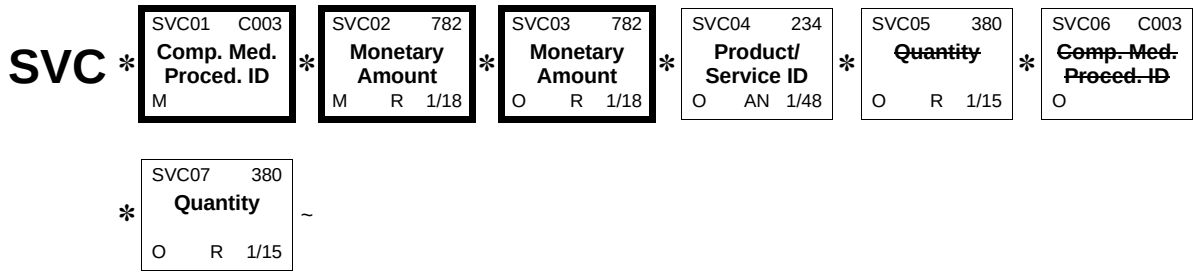
Loop: 2220 **Repeat:** >1

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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**
			SVC01-2 contains the procedure code. This code may be different than the original submitted procedure code based on claim processing instructions such as; global services or combining services (sometimes referred to as bundling or unbundling). Payers often do not store the original submitted procedure code when bundling or unbundling occurs and the procedure code gets changed during the adjudication process.	
REQUIRED	**SVC01 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because CPT codes of the American Medical Association are also level 1 HCPCS codes, the CPT codes are reported under the code HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code

			NH	**National Health Related Item Code**			
			NU	**National Uniform Billing Committee (NUBC) UB92 Codes** CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
			RB	**National Uniform Billing Committee (NUBC) UB82 Codes** CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**SVC01 - 2**		**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Service Identification Code*** **If the value in SVC01-1 is "NU", then this is an NUBC Revenue Code. If it is present here, then SVC04 is not used.**	**M**	**AN**	**1/48**
SITUATIONAL	**SVC01 - 3**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 4**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 5**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 6**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required if submitted on the original claim service line.**	**O**	**AN**	**2/2**
NOT USED	**SVC01 - 7**		**352**	**Description**	**O**	**AN**	**1/80**
REQUIRED	**SVC02**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Charge Amount*** SEMANTIC: SVC02 is the submitted service charge. **This amount is the original submitted charge.**	**M**	**R**	**1/18**

REQUIRED	**SVC03**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Line Item Provider Payment Amount***

SEMANTIC: SVC03 is the amount paid this service.

This amount is the amount paid. If the adjudication process is not complete, this is zero-filled.

This is the line item total on the current claim status. Line item charges will quite often change from the submitted charge based on claims processing instructions, ie: global services, combining services. Most payers do not store the "original submitted charge."

SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**

INDUSTRY: ***Revenue Code***

SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code.

This is the NUBC Revenue Code.When SVC01-1 equals "NU" the NUBC Revenue Code belongs in SVC01-2.

NOT USED	**SVC05**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Original Units of Service Count***

SEMANTIC: SVC07 is the original submitted units of service.

This quantity is the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1.

IMPLEMENTATION

SERVICE LINE STATUS INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment if the subscriber is the patient.**
2. **This segment is used when an information source system has the capability to provide line item information.**

Example: **STC*A3:110*19960501***65~ or STC*FI:65*19960501*******A3:400~**

STANDARD

STC Status Information

Level: Detail

Position: 190

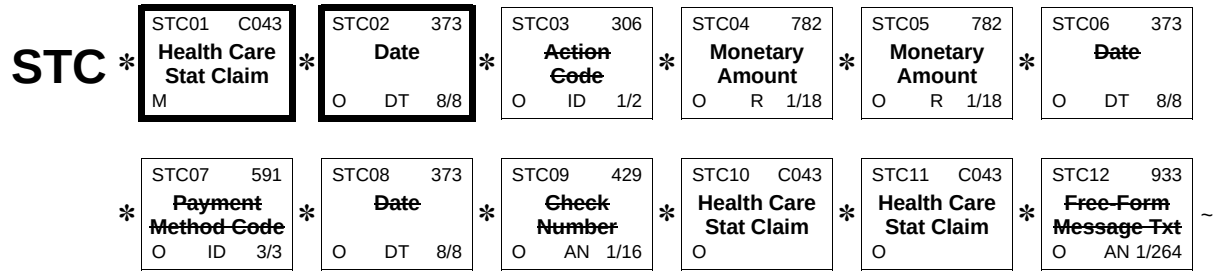
Loop: 2220

Requirement: Mandatory

Max Use: >1

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

DIAGRAM



ELEMENT SUMMARY

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**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Health Care Claim Status Category Code*** **This is the Category code. Use code source 507.**	**M AN 1/30**

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Health Care Claim Status Code***

This is the Status code. Use code source 508.

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

STC01-3 further modifies the value in STC01-2.

CODE	DEFINITION
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership
2P	Public Health Service Facility

2Q	Veterans Administration Facility
2S	Public Health Service Indian Service Facility
2Z	Hospital Unit of an Institution (prison hospital, college infirmary, etc.)
30	Service Supplier
36	Employer
3A	Hospital Unit Within an Institution for the Mentally Retarded
3C	Tuberculosis and Other Respiratory Diseases Facility
3D	Obstetrics and Gynecology Facility
3E	Eye, Ear, Nose and Throat Facility
3F	Rehabilitation Facility
3G	Orthopedic Facility
3H	Chronic Disease Facility
3I	Other Specialty Facility
3J	Children's General Facility
3K	Children's Hospital Unit of an Institution
3L	Children's Psychiatric Facility
3M	Children's Tuberculosis and Other Respiratory Diseases Facility
3N	Children's Eye, Ear, Nose and Throat Facility
3O	Children's Rehabilitiaion Facility
3P	Children's Orthopedic Facility
3Q	Children's Chronic Disease Facility
3R	Children's Other Specialty Facility
3S	Institution for Mental Retardation
3T	Alcoholism and Other Chemical Dependency Facility
3U	General Inpatient Care for AIDS/ARC Facility
3V	AIDS/ARC Unit
3W	Specialized Outpatient Program for AIDS/ARC
3X	Alcohol/Drug Abuse or Dependency Inpatient Unit
3Y	Alcohol/Drug Abuse or Dependency Outpatient Services

3Z	Arthritis Treatment Center
40	Receiver
43	Claimant Authorized Representative
44	Data Processing Service Bureau
4A	Birthing Room/LDRP Room
4B	Burn Care Unit
4C	Cardiac Catherization Laboratory
4D	Open-Heart Surgery Facility
4E	Cardiac Intensive Care Unit
4F	Angioplasty Facility
4G	Chronic Obstructive Pulmonary Disease Service Facility
4H	Emergency Department
4I	Trauma Center (Certified)
4J	Extracorporeal Shock-Wave Lithotripter (ESWL) Unit
4L	Genetic Counseling/Screening Services
4M	Adult Day Care Program Facility
4N	Alzheimer's Diagnostic/Assessment Services
4O	Comprehensive Geriatric Assessment Facility
4P	Emergency Response (Geriatric) Unit
4Q	Geriatric Acute Care Unit
4R	Geriatric Clinics
4S	Respite Care Facility
4U	Patient Education Unit
4V	Community Health Promotion Facility
4W	Worksite Health Promotion Facility
4X	Hemodialysis Facility
4Y	Home Health Services
4Z	Hospice
5A	Medical Surgical or Other Intensive Care Unit
5B	Hisopathology Laboratory
5C	Blood Bank

5D	Neonatal Intensive Care Unit
5E	Obstetrics Unit
5F	Occupational Health Services
5G	Organized Outpatient Services
5H	Pediatric Acute Inpatient Unit
5I	Psychiatric Child/Adolescent Services
5J	Psychiatric Consultation-Liaison Services
5K	Psychiatric Education Services
5L	Psychiatric Emergency Services
5M	Psychiatric Geriatric Services
5N	Psychiatric Inpatient Unit
5O	Psychiatric Outpatient Services
5P	Psychiatric Partial Hospitalization Program
5Q	Megavoltage Radiation Therapy Unit
5R	Radioactive Implants Unit
5S	Theraputic Radioisotope Facility
5T	X-Ray Radiation Therapy Unit
5U	CT Scanner Unit
5V	Diagnostic Radioisotope Facility
5W	Magnetic Resonance Imaging (MRI) Facility
5X	Ultrasound Unit
5Y	Rehabilitation Inpatient Unit
5Z	Rehabilitation Outpatient Services
61	Performed At
6A	Reproductive Health Services
6B	Skilled Nursing or Other Long-Term Care Unit
6C	Single Photon Emission Computerized Tomography (SPECT) Unit
6D	Organized Social Work Service Facility
6E	Outpatient Social Work Services
6F	Emergency Department Social Work Services
6G	Sports Medicine Clinic/Services

6H	Hospital Auxiliary Unit
6I	Patient Representative Services
6J	Volunteer Services Department
6K	Outpatient Surgery Services
6L	Organ/Tissue Transplant Unit
6M	Orthopedic Surgery Facility
6N	Occupational Therapy Services
6O	Physical Therapy Services
6P	Recreational Therapy Services
6Q	Respiratory Therapy Services
6R	Speech Therapy Services
6S	Women's Health Center/Services
6U	Cardiac Rehabilitation Program Facility
6V	Non-Invasive Cardiac Assessment Services
6W	Emergency Medical Technician
6X	Disciplinary Contact
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
77	Service Location
7C	Place of Occurrence
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
95	Research Institute
CK	Pharmacist
CZ	Admitting Surgeon
D2	Commercial Insurer

DD	Assistant Surgeon
DJ	Consulting Physician
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E1	Person or Other Entity Legally Responsible for a Child
E2	Person or Other Entity With Whom a Child Resides
E7	Previous Employer
E9	Participating Laboratory
FA	Facility
FD	Physical Address
FE	Mail Address
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GD	Guardian
GI	Paramedic
GK	Previous Insured
GM	Spouse Insured
GY	Treatment Facility
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IJ	Injection Point
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
LR	Legal Representative
MR	Medical Insurance Carrier
OB	Ordered By

OD	Doctor of Optometry
OX	Oxygen Therapy Facility
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PT	Party to Receive Test Report
PV	Party performing certification
PW	Pick Up Address
QA	Pharmacy
QB	Purchase Service Provider
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QO	Doctor of Osteopathy
QS	Podiatrist
QV	Group Practice
QY	Medical Doctor
RC	Receiving Location
RW	Rural Health Clinic
S4	Skilled Nursing Facility
SJ	Service Provider
SU	Supplier/Manufacturer

			T4	**Transfer Point** **Used to identify the geographic location where a patient is transferred or deverted.**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TT	**Transfer To**			
			TU	**Third Party Repricing Organization (TPO)**			
			UH	**Nursing Home**			
			X3	**Utilization Management Organization**			
			X4	**Spouse**			
			X5	**Durable Medical Equipment Supplier**			
			ZZ	**Mutually Defined**			
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Status Information Effective Date*** **SEMANTIC:** STC02 is the effective date of the status information. **Use this date for the effective date of status.**		**O**	**DT**	**8/8**
NOT USED	**STC03**	**306**	**Action Code**		**O**	**ID**	**1/2**
SITUATIONAL	**STC04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Charge Amount*** **SEMANTIC:** STC04 is the amount of original submitted charges. **This is the submitted line charge amount.**		**O**	**R**	**1/18**
SITUATIONAL	**STC05**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Provider Payment Amount*** **SEMANTIC:** STC05 is the amount paid. **Use this element for the line item paid amount.**		**O**	**R**	**1/18**
NOT USED	**STC06**	**373**	**Date**		**O**	**DT**	**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O**	**DT**	**8/8**
NOT USED	**STC09**	**429**	**Check Number**		**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **Use this element if a second claim status is needed.**		**O**		
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Health Care Claim Status Category Code*** **This is the Category code. Use code source 507.** **Required if STC10 is used.**	**M**	**AN**	**1/30**

REQUIRED	**STC10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: Health Care Claim Status Code			
			This is the Status code. Use code source 508.			
			Required if STC10 is used.			
SITUATIONAL	**STC10 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC10-3 further modifies the status code in STC10-2. See code value list in STC01-3.			
SITUATIONAL	**STC11 C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O**		
			Use this element if a third claim status is needed.			
REQUIRED	**STC11 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: Health Care Claim Status Category Code			
			Required if STC11 is used.			
			This is the Category Code. Use code source 507.			
REQUIRED	**STC11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: Health Care Claim Status Code			
			Required if STC11 is used.			
			This is the Status Code. Use code source 508.			
SITUATIONAL	**STC11 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.			
NOT USED	**STC12 933**	**Free-Form Message Text**		**O**	**AN**	**1/264**

IMPLEMENTATION

SERVICE LINE ITEM IDENTIFICATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when available from the original claim. When the Information Receiver is the Provider, this is required when the number was assigned by the provider on the original claim.**

Example: **REF*FJ*96042201~**

STANDARD

REF Reference Identification

Level: Detail

Position: 200

Loop: 2220

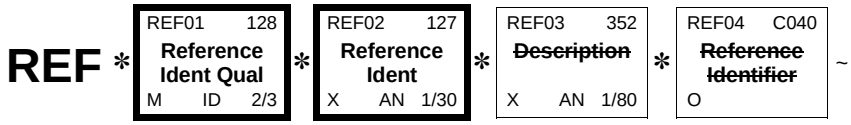
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **FJ — Line Item Control Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SERVICE LINE DATE

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This is the date of service from the original submitted claim for a specific line item.**
2. **Whenever the 2220D loop is used this segment must be present, unless reported in the claim level, Loop 2200D (Claim Service Dates).**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 210

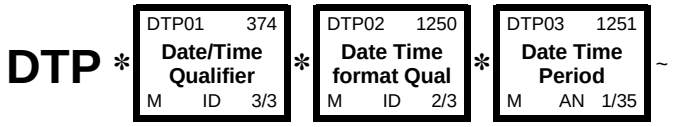
Loop: 2220

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 ID 3/3**
			INDUSTRY: ***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 ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION**	
			RD8 — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If there is a single date of service, the begin date equals the end date.**	

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

IMPLEMENTATION

DEPENDENT LEVEL

Loop: **2000E — DEPENDENT LEVEL** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

2. **Required when patient is not the same person as the subscriber.**

Example: **HL*5*4*23~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

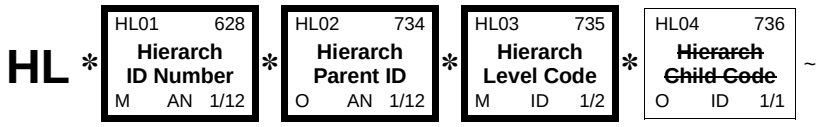
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 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 AN 1/12**

REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure	**M**	**ID**	**1/2**

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
23	**Dependent**

NOT USED	**HL04**	**736**	**Hierarchical Child Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

DEPENDENT DEMOGRAPHIC INFORMATION

Loop: **2000E — DEPENDENT LEVEL**

Usage: **REQUIRED**

Repeat: **1**

Example: **DMG*D8*19330706*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 040

Loop: 2000

Requirement: Optional

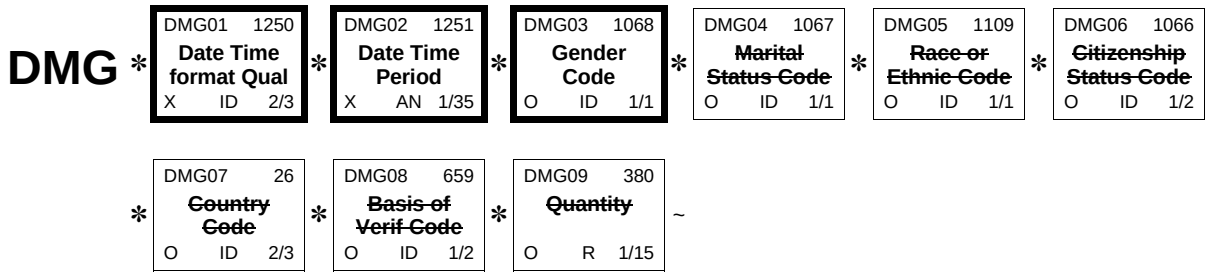
Max Use: 1

Purpose: To supply demographic information

Set Notes:
1. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

Syntax:
1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Patient Birth Date*** *ALIAS:* ***Date of Birth - Patient*** **SYNTAX:** P0102 **SEMANTIC:** DMG02 is the date of birth.	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Patient Gender Code*** *ALIAS:* ***Gender - Patient***	**O**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

IMPLEMENTATION

DEPENDENT NAME

Loop: **2100E — DEPENDENT NAME** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*JOSEPH****MI*01234567802~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

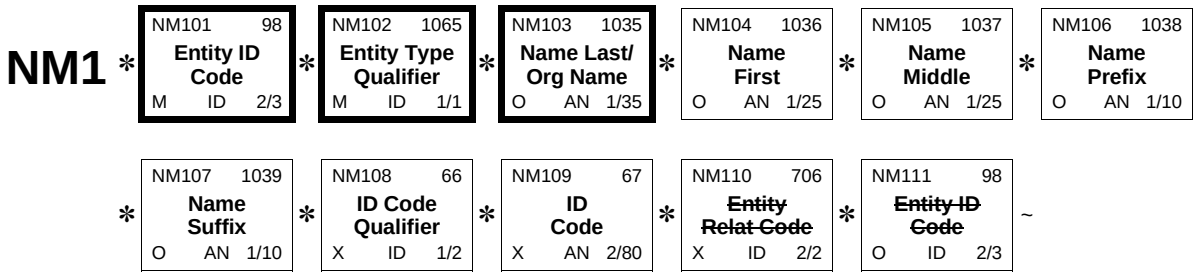
Max Use: 1

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

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.

DIAGRAM



ELEMENT SUMMARY

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 ID 2/3**
			CODE: **QC** — DEFINITION: **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	**M ID 1/1**
			CODE: **1** — DEFINITION: **Person**	

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Patient Last Name***	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Patient First Name*** **Always return this information when it is supplied on a claim.** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Patient Middle Name*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name *INDUSTRY:* ***Patient Name Prefix*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Patient Name Suffix*** **Required if additional name information is needed to identify the patient.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
MI	**Member Identification Number**
ZZ	**Mutually Defined** **The value 'ZZ' when used in this data element shall be defined as 'HIPAA Individual Identifier' once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Patient Primary Identifier*** SYNTAX: P0809 **At this level, NM108 and NM109 are required if the dependent is assigned a unique identification number that is separate from the subscriber number in HL4 (HL22).**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

CLAIM SUBMITTER TRACE NUMBER

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use of this segment is required if the patient is someone other than the subscriber.**
2. **Use this segment to convey a unique trace or reference number from the originator of the transaction to be returned by the receiver of the transaction.**
3. **The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.**

Example: **TRN*2*1722634842~**

STANDARD

TRN Trace

Level: Detail

Position: 090

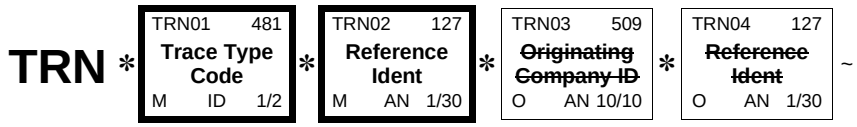
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced **CODE** / **DEFINITION** **2** — **Referenced Transaction Trace Numbers**	**M 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 *INDUSTRY:* ***Trace Number*** SEMANTIC: TRN02 provides unique identification for the transaction.	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**

NOT USED	TRN04	127	Reference Identification	O	AN	1/30

IMPLEMENTATION

CLAIM LEVEL STATUS INFORMATION

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this segment to request additional information about a claim or a service line.**
2. **Use this if the patient is someone other than the subscriber.**

Example: **STC*FI:65*19960511**50*40*19960510*CHK*19960510*50321~**

STANDARD

STC Status Information

Level: Detail

Position: 100

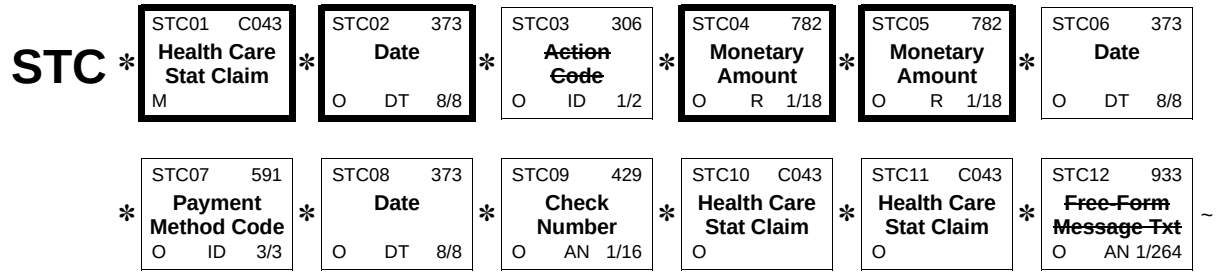
Loop: 2200

Requirement: Mandatory

Max Use: >1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** **M** Used to convey status of the entire claim or a specific service line	
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list *INDUSTRY:* ***Health Care Claim Status Category Code*** **This is the Category code. Use code source 507.**	

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Health Care Claim Status Code***

This is the Status code. Use code source 508.

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

STC01-3 further modifies the status code in STC01-2.

CODE	DEFINITION
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2D	Miscellaneous Health Care Facility
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership

2P	Public Health Service Facility
2Q	Veterans Administration Facility
2S	Public Health Service Indian Service Facility
2Z	Hospital Unit of an Institution (prison hospital, college infirmary, etc.)
30	Service Supplier
36	Employer
3A	Hospital Unit Within an Institution for the Mentally Retarded
3C	Tuberculosis and Other Respiratory Diseases Facility
3D	Obstetrics and Gynecology Facility
3E	Eye, Ear, Nose and Throat Facility
3F	Rehabilitation Facility
3G	Orthopedic Facility
3H	Chronic Disease Facility
3I	Other Specialty Facility
3J	Children's General Facility
3K	Children's Hospital Unit of an Institution
3L	Children's Psychiatric Facility
3M	Children's Tuberculosis and Other Respiratory Diseases Facility
3N	Children's Eye, Ear, Nose and Throat Facility
3O	Children's Rehabilitiaion Facility
3P	Children's Orthopedic Facility
3Q	Children's Chronic Disease Facility
3R	Children's Other Specialty Facility
3S	Institution for Mental Retardation
3T	Alcoholism and Other Chemical Dependency Facility
3U	General Inpatient Care for AIDS/ARC Facility
3V	AIDS/ARC Unit
3W	Specialized Outpatient Program for AIDS/ARC
3X	Alcohol/Drug Abuse or Dependency Inpatient Unit

3Y	Alcohol/Drug Abuse or Dependency Outpatient Services
3Z	Arthritis Treatment Center
40	Receiver
43	Claimant Authorized Representative
44	Data Processing Service Bureau
4A	Birthing Room/LDRP Room
4B	Burn Care Unit
4C	Cardiac Catherization Laboratory
4D	Open-Heart Surgery Facility
4E	Cardiac Intensive Care Unit
4F	Angioplasty Facility
4G	Chronic Obstructive Pulmonary Disease Service Facility
4H	Emergency Department
4I	Trauma Center (Certified)
4J	Extracorporeal Shock-Wave Lithotripter (ESWL) Unit
4L	Genetic Counseling/Screening Services
4M	Adult Day Care Program Facility
4N	Alzheimer's Diagnostic/Assessment Services
4O	Comprehensive Geriatric Assessment Facility
4P	Emergency Response (Geriatric) Unit
4Q	Geriatric Acute Care Unit
4R	Geriatric Clinics
4S	Respite Care Facility
4U	Patient Education Unit
4V	Community Health Promotion Facility
4W	Worksite Health Promotion Facility
4X	Hemodialysis Facility
4Y	Home Health Services
4Z	Hospice
5A	Medical Surgical or Other Intensive Care Unit
5B	Hisopathology Laboratory

5C	Blood Bank
5D	Neonatal Intensive Care Unit
5E	Obstetrics Unit
5F	Occupational Health Services
5G	Organized Outpatient Services
5H	Pediatric Acute Inpatient Unit
5I	Psychiatric Child/Adolescent Services
5J	Psychiatric Consultation-Liaison Services
5K	Psychiatric Education Services
5L	Psychiatric Emergency Services
5M	Psychiatric Geriatric Services
5N	Psychiatric Inpatient Unit
5O	Psychiatric Outpatient Services
5P	Psychiatric Partial Hospitalization Program
5Q	Megavoltage Radiation Therapy Unit
5R	Radioactive Implants Unit
5S	Theraputic Radioisotope Facility
5T	X-Ray Radiation Therapy Unit
5U	CT Scanner Unit
5V	Diagnostic Radioisotope Facility
5W	Magnetic Resonance Imaging (MRI) Facility
5X	Ultrasound Unit
5Y	Rehabilitation Inpatient Unit
5Z	Rehabilitation Outpatient Services
61	Performed At
6A	Reproductive Health Services
6B	Skilled Nursing or Other Long-Term Care Unit
6C	Single Photon Emission Computerized Tomography (SPECT) Unit
6D	Organized Social Work Service Facility
6E	Outpatient Social Work Services
6F	Emergency Department Social Work Services

6G	Sports Medicine Clinic/Services
6H	Hospital Auxiliary Unit
6I	Patient Representative Services
6J	Volunteer Services Department
6K	Outpatient Surgery Services
6L	Organ/Tissue Transplant Unit
6M	Orthopedic Surgery Facility
6N	Occupational Therapy Services
6O	Physical Therapy Services
6P	Recreational Therapy Services
6Q	Respiratory Therapy Services
6R	Speech Therapy Services
6S	Women's Health Center/Services
6U	Cardiac Rehabilitation Program Facility
6V	Non-Invasive Cardiac Assessment Services
6W	Emergency Medical Technician
6X	Disciplinary Contact
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
77	Service Location
7C	Place of Occurrence
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
95	Research Institute
CK	Pharmacist
CZ	Admitting Surgeon

D2	Commercial Insurer
DD	Assistant Surgeon
DJ	Consulting Physician
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E1	Person or Other Entity Legally Responsible for a Child
E2	Person or Other Entity With Whom a Child Resides
E7	Previous Employer
E9	Participating Laboratory
FA	Facility
FD	Physical Address
FE	Mail Address
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GD	Guardian
GI	Paramedic
GJ	Paramedical Company
GK	Previous Insured
GM	Spouse Insured
GY	Treatment Facility
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IJ	Injection Point
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
LR	Legal Representative

MR	Medical Insurance Carrier
OB	Ordered By
OD	Doctor of Optometry
OX	Oxygen Therapy Facility
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PT	Party to Receive Test Report
PV	Party performing certification
PW	Pick Up Address
QA	Pharmacy
QB	Purchase Service Provider
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QO	Doctor of Osteopathy
QS	Podiatrist
QV	Group Practice
QY	Medical Doctor
RC	Receiving Location
RW	Rural Health Clinic
S4	Skilled Nursing Facility
SJ	Service Provider

			SU	**Supplier/Manufacturer**			
			T4	**Transfer Point** **Used to identify the geographic location where a patient is transferred or deverted.**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TT	**Transfer To**			
			TU	**Third Party Repricing Organization (TPO)**			
			UH	**Nursing Home**			
			X3	**Utilization Management Organization**			
			X4	**Spouse**			
			X5	**Durable Medical Equipment Supplier**			
			ZZ	**Mutually Defined**			
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Status Information Effective Date*** **SEMANTIC:** STC02 is the effective date of the status information. **Use this date for the effective date of status.**		**O**	**DT**	**8/8**
NOT USED	**STC03**	**306**	**Action Code**		**O**	**ID**	**1/2**
REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Claim Charge Amount*** **SEMANTIC:** STC04 is the amount of original submitted charges. **Use this element for the amount of submitted charges. Some HMO encounters supply zero as the amount of original charges.**		**O**	**R**	**1/18**
REQUIRED	**STC05**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Payment Amount*** **SEMANTIC:** STC05 is the amount paid. **Use this element for the claim paid amount. This amount must be zero if the adjudication process is not complete.**		**O**	**R**	**1/18**
SITUATIONAL	**STC06**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Adjudication or Payment Date*** **SEMANTIC:** STC06 is the paid date. **Use this element for the date of denial or payment. Use this date if the payment determination is complete.**		**O**	**DT**	**8/8**

SITUATIONAL	**STC07**	**591**	**Payment Method Code** Code identifying the method for the movement of payment instructions	**O**	**ID**	**3/3**

Will be used when claim has a dollar payment to the provider of service.

CODE	DEFINITION
ACH	**Automated Clearing House (ACH)** **Use this code to move money electronically through the Automated Clearing House (ACH). When this code is used, information in BPR05 through BPR15 also must be included.**
BOP	**Financial Institution Option** **Use this code to indicate that the third party processor will choose the method of payment based on end point requests or capabilities.**
CHK	**Check** **Use this code to indicate that a check was issued for payment.**
FWT	**Federal Reserve Funds/Wire Transfer - Nonrepetitive** **Use this code to indicate that the funds were sent through the wire system.**
NON	**Non-Payment Data** **Use this code to indicate that this is information only and no dollars are to be moved.**

SITUATIONAL	**STC08**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Check Issue or EFT Effective Date***

SEMANTIC: STC08 is the check issue date.

SITUATIONAL	**STC09**	**429**	**Check Number** Check identification number	**O**	**AN**	**1/16**

INDUSTRY: ***Check or EFT Trace Number***

Required with a Finalized and PAID claim when the entire claim was paid using a single check or EFT. Not used with Pending or Rejected claims.

SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**O**		

Use this element if a second claim status is needed.

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

INDUSTRY: ***Health Care Claim Status Category Code***

This is the Category code. Use code source 507.

Required if STC10 is used.

REQUIRED	**STC10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Code***			
			This is the Status code. Use code source 508.			
			Required if STC10 is used.			
SITUATIONAL	**STC10 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC10-3 further modifies the status code in STC10-2. See code value list in STC01-3.			
SITUATIONAL	**STC11** **C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O**		
			Use this element if a third claim status is needed.			
REQUIRED	**STC11 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Category Code***			
			This is the Category code. Use code source 507.			
			Required if STC11 is used.			
REQUIRED	**STC11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Code***			
			This is the Status code. Use code source 508.			
			Required if STC11 is used.			
SITUATIONAL	**STC11 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.			
NOT USED	**STC12** **933**	**Free-Form Message Text**		**O**	**AN**	**1/264**

IMPLEMENTATION

PAYER CLAIM IDENTIFICATION NUMBER

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this only if the subscriber is the patient.**
2. **This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN).**

Example: **REF*1K*9918046987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

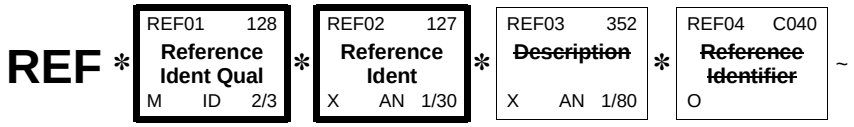
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			Examples of this element include: ICN, DCN and CCN.	
			CODE / DEFINITION	
			1K — Payor's Claim Number	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Claim Control Number*** SYNTAX: R0203	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

INSTITUTIONAL BILL TYPE IDENTIFICATION

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the institutional type of bill from the original submitted claim, and it is returned when it is available.**
2. **This is used if the dependent is the patient.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

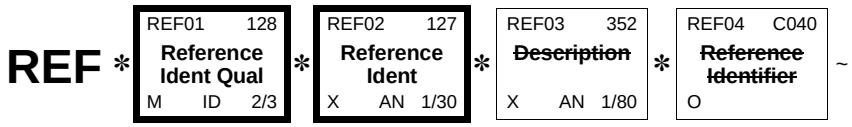
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
BLT	**Billing Type**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Bill Type Identifier*** SYNTAX: R0203 **Found on UB92 - record 40 - 4** **Found on 837 CLM-05** **Found on UB92 paper form locator 4** **Required institutional claim inquiries.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MEDICAL RECORD IDENTIFICATION

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is the Medical Record number submitted on the original claim and should be returned when available from the the submitted claim.**
2. **Use this if the patient is someone other than the subscriber.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

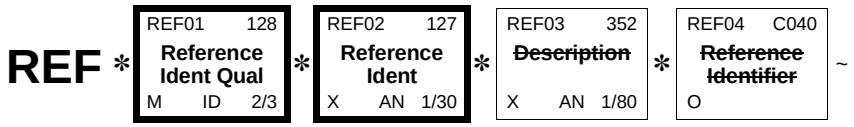
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
EA	**Medical Record Identification Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medical Record Number*** SYNTAX: R0203 **Found on UB92 record 20 field 25** **Found on 837 REF-02** **Found on UB92 paper form locator 23** **Found on REF02, Loop ID 2210, segment REF01, qualifier EA.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200E — CLAIM SUBMITTER TRACE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment for the institutional claim statement period.**
2. **This is used if the dependent is the patient.**
3. **For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at 2220D is required.**

Example: **DTP*232*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

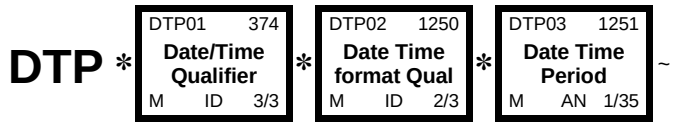
Loop: 2200

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Date Time Qualifier*** **This data element also includes the Claim Statement Period End Date.**	**M ID 3/3**

CODE	DEFINITION
232	**Claim Statement Period Start**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
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
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If there is a single date of service, the begin date equals the end date.**

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

INDUSTRY: ***Claim Service Period***

IMPLEMENTATION

SERVICE LINE INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to report information about a service line.**
2. **This segment is required by ASC X12 syntax if this loop is used, because it is the first segment in the Service Line Information Loop.**

Example: **SVC*HC:99214*75*50****1~ SVC*NU:71X*50*0****1~**

STANDARD

SVC Service Information

Level: Detail

Position: 180

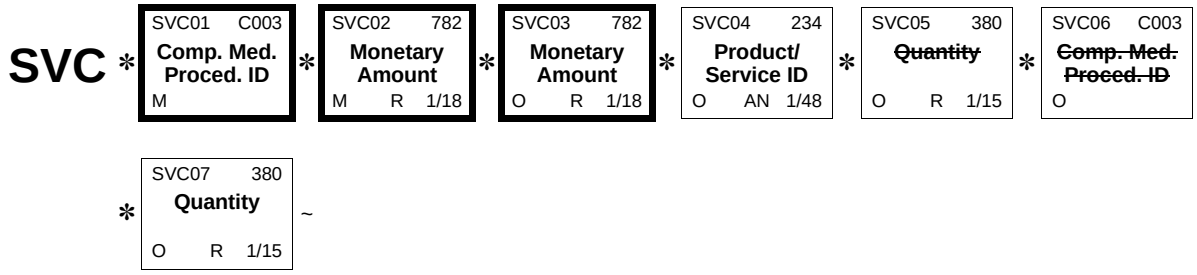
Loop: 2220 **Repeat:** >1

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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**
			SVC01-2 contains the procedure code. This code may be different than the original submitted procedure code based on claim processing instructions such as; global services or combining services (sometimes referred to as bundling or unbundling). Payers often do not store the original submitted procedure code when bundling or unbundling occurs and the procedure code gets changed during the adjudication process.	

REQUIRED **SVC01 - 1** **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: ***Product or Service ID Qualifier***

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because CPT codes of the American Medical Association are also level 1 HCPCS codes, the CPT codes are reported under the code HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code
NH	**National Health Related Item Code**
NU	**National Uniform Billing Committee (NUBC) UB92 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes
RB	**National Uniform Billing Committee (NUBC) UB82 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED **SVC01 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

INDUSTRY: ***Service Identification Code***

If the value in SVC01-1 is "NU", then this is an NUBC Revenue Code. If it is present here, then SVC04 is not used.

SITUATIONAL	**SVC01 - 3**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
				Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 4**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
				Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 5**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
				Required if submitted on the original claim service line.			
SITUATIONAL	**SVC01 - 6**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
				Required if submitted on the original claim service line.			
NOT USED	**SVC01 - 7**		**352**	**Description**	**O**	**AN**	**1/80**
REQUIRED	**SVC02**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Charge Amount*** **SEMANTIC:** SVC02 is the submitted service charge. **This amount is the original submitted charge.**	**M**	**R**	**1/18**
REQUIRED	**SVC03**	**782**		**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Provider Payment Amount*** **SEMANTIC:** SVC03 is the amount paid this service. **This is the service line paid amount. If the adjudication process is not complete, this is zero-filled.**	**O**	**R**	**1/18**
SITUATIONAL	**SVC04**	**234**		**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Revenue Code*** **SEMANTIC:** SVC04 is the National Uniform Billing Committee Revenue Code. **This is the NUBC Revenue Code.When SVC01-1 equals "NU" the NUBC Revenue Code belongs in SVC01-2.**	**O**	**AN**	**1/48**
NOT USED	**SVC05**	**380**		**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**		**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
SITUATIONAL	**SVC07**	**380**		**Quantity** Numeric value of quantity *INDUSTRY:* ***Original Units of Service Count*** **SEMANTIC:** SVC07 is the original submitted units of service. **This quantity is the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1.**	**O**	**R**	**1/15**

IMPLEMENTATION

SERVICE LINE STATUS INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is for the service status information.**
2. **This segment is used when an information source system has the capability to provide line item information.**

Example: **STC*A3:110*19960501**65~ or STC*FI:65*19960501*******A3:400~**

STANDARD

STC Status Information

Level: Detail

Position: 190

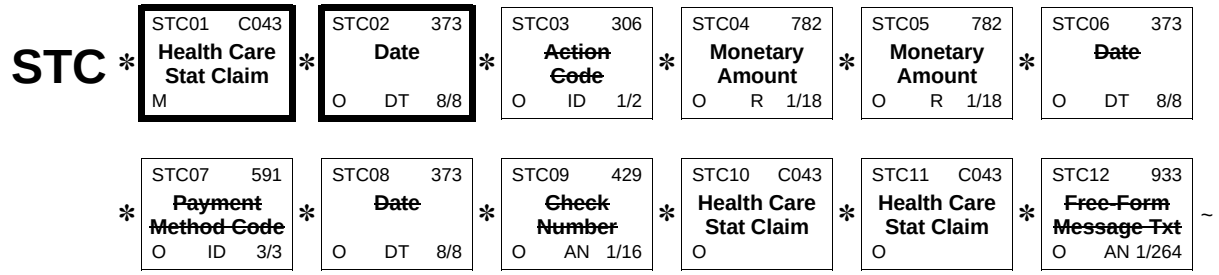
Loop: 2220

Requirement: Mandatory

Max Use: >1

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

DIAGRAM



ELEMENT SUMMARY

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**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Health Care Claim Status Category Code*** **This is the Category code. Use code source 507.**	**M AN 1/30**

REQUIRED **STC01 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Health Care Claim Status Code***

This is the Status code. Use code source 508.

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O** **ID** **2/3**
Code identifying an organizational entity, a physical location, property or an individual

STC01-3 further modifies the value in STC01-2.

CODE	DEFINITION
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2D	Miscellaneous Health Care Facility
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership

2P	Public Health Service Facility
2Q	Veterans Administration Facility
2S	Public Health Service Indian Service Facility
2Z	Hospital Unit of an Institution (prison hospital, college infirmary, etc.)
30	Service Supplier
36	Employer
3A	Hospital Unit Within an Institution for the Mentally Retarded
3C	Tuberculosis and Other Respiratory Diseases Facility
3D	Obstetrics and Gynecology Facility
3E	Eye, Ear, Nose and Throat Facility
3F	Rehabilitation Facility
3G	Orthopedic Facility
3H	Chronic Disease Facility
3I	Other Specialty Facility
3J	Children's General Facility
3K	Children's Hospital Unit of an Institution
3L	Children's Psychiatric Facility
3M	Children's Tuberculosis and Other Respiratory Diseases Facility
3N	Children's Eye, Ear, Nose and Throat Facility
3O	Children's Rehabilitiaion Facility
3P	Children's Orthopedic Facility
3Q	Children's Chronic Disease Facility
3R	Children's Other Specialty Facility
3S	Institution for Mental Retardation
3T	Alcoholism and Other Chemical Dependency Facility
3U	General Inpatient Care for AIDS/ARC Facility
3V	AIDS/ARC Unit
3W	Specialized Outpatient Program for AIDS/ARC
3X	Alcohol/Drug Abuse or Dependency Inpatient Unit

3Y	Alcohol/Drug Abuse or Dependency Outpatient Services
3Z	Arthritis Treatment Center
40	Receiver
43	Claimant Authorized Representative
44	Data Processing Service Bureau
4A	Birthing Room/LDRP Room
4B	Burn Care Unit
4C	Cardiac Catherization Laboratory
4D	Open-Heart Surgery Facility
4E	Cardiac Intensive Care Unit
4F	Angioplasty Facility
4G	Chronic Obstructive Pulmonary Disease Service Facility
4H	Emergency Department
4I	Trauma Center (Certified)
4J	Extracorporeal Shock-Wave Lithotripter (ESWL) Unit
4L	Genetic Counseling/Screening Services
4M	Adult Day Care Program Facility
4N	Alzheimer's Diagnostic/Assessment Services
4O	Comprehensive Geriatric Assessment Facility
4P	Emergency Response (Geriatric) Unit
4Q	Geriatric Acute Care Unit
4R	Geriatric Clinics
4S	Respite Care Facility
4U	Patient Education Unit
4V	Community Health Promotion Facility
4W	Worksite Health Promotion Facility
4X	Hemodialysis Facility
4Y	Home Health Services
4Z	Hospice
5A	Medical Surgical or Other Intensive Care Unit
5B	Hisopathology Laboratory

5C	Blood Bank
5D	Neonatal Intensive Care Unit
5E	Obstetrics Unit
5F	Occupational Health Services
5G	Organized Outpatient Services
5H	Pediatric Acute Inpatient Unit
5I	Psychiatric Child/Adolescent Services
5J	Psychiatric Consultation-Liaison Services
5K	Psychiatric Education Services
5L	Psychiatric Emergency Services
5M	Psychiatric Geriatric Services
5N	Psychiatric Inpatient Unit
5O	Psychiatric Outpatient Services
5P	Psychiatric Partial Hospitalization Program
5Q	Megavoltage Radiation Therapy Unit
5R	Radioactive Implants Unit
5S	Theraputic Radioisotope Facility
5T	X-Ray Radiation Therapy Unit
5U	CT Scanner Unit
5V	Diagnostic Radioisotope Facility
5W	Magnetic Resonance Imaging (MRI) Facility
5X	Ultrasound Unit
5Y	Rehabilitation Inpatient Unit
5Z	Rehabilitation Outpatient Services
61	Performed At
6A	Reproductive Health Services
6B	Skilled Nursing or Other Long-Term Care Unit
6C	Single Photon Emission Computerized Tomography (SPECT) Unit
6D	Organized Social Work Service Facility
6E	Outpatient Social Work Services
6F	Emergency Department Social Work Services

6G	Sports Medicine Clinic/Services
6H	Hospital Auxiliary Unit
6I	Patient Representative Services
6J	Volunteer Services Department
6K	Outpatient Surgery Services
6L	Organ/Tissue Transplant Unit
6M	Orthopedic Surgery Facility
6N	Occupational Therapy Services
6O	Physical Therapy Services
6P	Recreational Therapy Services
6Q	Respiratory Therapy Services
6R	Speech Therapy Services
6S	Women's Health Center/Services
6U	Cardiac Rehabilitation Program Facility
6V	Non-Invasive Cardiac Assessment Services
6W	Emergency Medical Technician
6X	Disciplinary Contact
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
77	Service Location
7C	Place of Occurrence
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
95	Research Institute
CK	Pharmacist
CZ	Admitting Surgeon

D2	Commercial Insurer
DD	Assistant Surgeon
DJ	Consulting Physician
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E1	Person or Other Entity Legally Responsible for a Child
E2	Person or Other Entity With Whom a Child Resides
E7	Previous Employer
E9	Participating Laboratory
FA	Facility
FD	Physical Address
FE	Mail Address
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GD	Guardian
GI	Paramedic
GJ	Paramedical Company
GK	Previous Insured
GM	Spouse Insured
GY	Treatment Facility
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IJ	Injection Point
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
LR	Legal Representative

MR	Medical Insurance Carrier
OB	Ordered By
OD	Doctor of Optometry
OX	Oxygen Therapy Facility
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PT	Party to Receive Test Report
PV	Party performing certification
PW	Pick Up Address
QA	Pharmacy
QB	Purchase Service Provider
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QO	Doctor of Osteopathy
QS	Podiatrist
QV	Group Practice
QY	Medical Doctor
RC	Receiving Location
RW	Rural Health Clinic
S4	Skilled Nursing Facility
SJ	Service Provider

			SU **Supplier/Manufacturer**			
			T4 **Transfer Point** **Used to identify the geographic location where a patient is transferred or deverted.**			
			TQ **Third Party Reviewing Organization (TPO)**			
			TT **Transfer To**			
			TU **Third Party Repricing Organization (TPO)**			
			UH **Nursing Home**			
			X3 **Utilization Management Organization**			
			X4 **Spouse**			
			X5 **Durable Medical Equipment Supplier**			
			ZZ **Mutually Defined**			
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Status Information Effective Date*** **SEMANTIC:** STC02 is the effective date of the status information. **Use this date for the effective date of status.**	**O**	**DT**	**8/8**
NOT USED	**STC03**	**306**	**Action Code**	**O**	**ID**	**1/2**
SITUATIONAL	**STC04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Charge Amount*** **SEMANTIC:** STC04 is the amount of original submitted charges. **This is the submitted line charge amount.**	**O**	**R**	**1/18**
SITUATIONAL	**STC05**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Line Item Provider Payment Amount*** **SEMANTIC:** STC05 is the amount paid. **Use this element for the line item paid amount.**	**O**	**R**	**1/18**
NOT USED	**STC06**	**373**	**Date**	**O**	**DT**	**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**	**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**	**O**	**DT**	**8/8**
NOT USED	**STC09**	**429**	**Check Number**	**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **Use this element if a second claim status is needed.**	**O**		

REQUIRED	**STC10 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Category Code***			
			This is the Category code. Use code source 507.			
			Required if STC10 is used.			
REQUIRED	**STC10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Code***			
			This is the Status code. Use code source 508.			
			Required if STC10 is used.			
SITUATIONAL	**STC10 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC10-3 further modifies the status code in STC10-2. See code value list in STC01-3.			
SITUATIONAL	**STC11** **C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line		**O**		
			Use this element if a third claim status is needed.			
REQUIRED	**STC11 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Category Code***			
			This is the Category code. Use code source 507.			
			Required if STC11 is used.			
REQUIRED	**STC11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Health Care Claim Status Code***			
			This is the Status code. Use code source 508.			
			Required if STC11 is used.			
SITUATIONAL	**STC11 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
			STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.			
NOT USED	**STC12** **933**	**Free-Form Message Text**		**O**	**AN**	**1/264**

IMPLEMENTATION

SERVICE LINE ITEM IDENTIFICATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when available from the original claim. When the Information Receiver is the Provider, this is required when the number was assigned by the provider on the original claim.**

Example: **REF*FJ*03~**

STANDARD

REF Reference Identification

Level: Detail

Position: 200

Loop: 2220

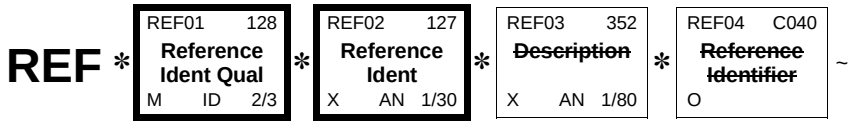
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **FJ — Line Item Control Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SERVICE LINE DATE

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This is the date of service from the original submitted claim for a specific line item.**

2. **Whenever the 2220E loop is used this segment must be present, unless reported in the Claim Level, Loop 2200E (Claim Service Date).**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 210

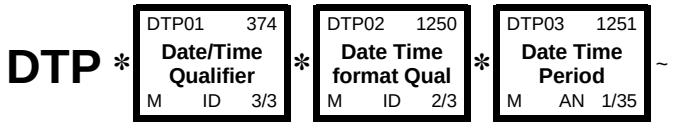
Loop: 2220

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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 ID 3/3**
			INDUSTRY: ***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 ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION**	
			RD8 — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **If there is a single date of service, the begin date equals the end date.**	

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

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*34*0001~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 270

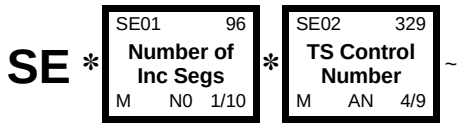
Loop: ____

Requirement: Mandatory

Max Use: 1

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)

DIAGRAM



ELEMENT SUMMARY

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 *INDUSTRY:* ***Transaction Segment Count***	**M 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 **Data value in SE02 must be identical to ST02.**	**M AN 4/9**

4 EDI Transmission Examples for Different Business Uses

4.1 Business Scenario 1 — 276

ABC Insurance is both the Medicare Part A Fiscal Intermediary and the PPO. ABC Insurance is located at 1 Smith Street, Suite 100, Tampa, FL 33131 and has a payer identification of 12345. ABC Insurance receives all EDI transmissions from XYZ Service on behalf of Home Hospital with provider numbers of 987666 for Medicare Part A and 124567890 for the PPO.

Home Hospital uses XYZ Service (electronic transmitter identification number X67E), an electronic Automated Clearing House, to help prepare and submit its electronic claims to payers. XYZ Service is located at 123 Main Street, Suite 204, Jacksonville, FL 32225.

ABC Insurance received a 276 transmission requesting the status of three claims.

The first claim submitted is on behalf of Fred Smith. Mr. Smith is a Medicare enrollee with a health insurance claim number of 123456789A.

Home Hospital requested the status of a claim for inpatient services (bill type 111) for services August 31, 1996 through September 6, 1996 in the amount of $8,513.88.

Home Hospital assigned a claim submitter trace number of 1625032606 to Mr. Smith's claim.

The second claim submitted is on behalf of Mary Jones. Mrs. Jones is a Medicare enrollee with a health insurance claim number of 234567890A. Home Hospital's claim submitter trace number is 1622241518.

Home Hospital requested the status of a claim for services from July 31, 1996 through August 9, 1996 in the amount of $7,599.00. To assist in the identification of the claim, Home Hospital included the dates of service.

The third claim submitted is on behalf of Joseph Mann who is covered as a dependent under John Mann. Joseph Mann is covered under the PPO plan, and his member identification is 345678901-02. John Mann is the insured, or subscriber, and his member identification is 345678901. Home Hospital's claim submitter trace number is 16270853402.

Home Hospital requested the status of a claim for outpatient services (bill type 131) for services from May 1, 1996 through May 30, 1996 in the amount of $4,899.50.

ABC Insurance assigned a payer claim identification number of 961681010827 to Mr. Mann's claim. This control number was returned to the provider on the 277 Front End Acknowledgment.

4.1.1 Transmission

The following is the 276 transmission sent requesting the status of the claims described in 4.1, Business Scenario 1:

```
ST*276*0001~
BHT*0010*13**19961115~
HL*1*20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
HL*2*1*21*1~
NM1*41*2*XYZ  SERVICE*****46*X67E~
HL*3*2*19*1~
NM1*1P*2*HOME HOSPITAL*****SV*987666~
HL*4*3*22*0~
DMG*D8*19201210*M~
NM1*QC*1*SMITH*FRED****MI*123456789A~
TRN*1*1625032606~
REF*BLT*111~
AMT*T3*8513.88~
DTP*232*RD8*19960831-19960906~
HL*5*3*22*0~
DMG*D8*19201115*F~
NM1*QC*1*JONES*MARY****MI*234567890A~
TRN*1*1622241518~
AMT*T3*7599~
DTP*232*RD8*19960731-19960809~
HL*6*2*19*1~
NM1*1P*2*HOME HOSPITAL*****SV*124567890~
HL*7*6*22*1~
DMG*D8*19451101*M~
NM1*IL*1*MANN*JOHN****MI*345678901~
HL*8*7*23~
DMG*D8*19651101*M~
NM1*QC*1*MANN*JOSEPH****MI*345678901-02~
TRN*1*16270853402~
REF*1K*961681010827~
REF*BLT*131~
AMT*T3*4899.5~
SE*34*0001~
```

4.2 Business Scenario 2 — 277

ABC Insurance is both the Medicare Part A Fiscal Intermediary and the PPO. ABC Insurance is located at 1 Smith Street, Suite 100, Tampa, FL 33131 and has a payer identification of 12345. ABC Insurance receives all EDI transmissions from XYZ Service on behalf of Home Hospital with provider numbers of 987666 for Medicare Part A and 124567890 for the PPO.

Home Hospital uses XYZ Service (electronic transmitter identification number of X67E), an electronic Automated Clearing House, to help prepare and submit its electronic claims to payers. XYZ Service is located at 123 Main Street, Suite 204, Jacksonville, FL 32225.

ABC Insurance received a 276 transmission requesting the status of three claims.

The first claim submitted is on behalf of Fred Smith. Mr. Smith is a Medicare enrollee with a health insurance claim number of 123456789A.

Home Hospital requested the status of a claim for inpatient services (bill type 111) for services August 31, 1996 through September 6, 1996 in the amount of $8,513.88.

ABC Insurance assigned a payer internal control number, (claim identification number), of 96347006051 to Mr. Smith's claim. The claim was "suspended" waiting on the response for additional information. The request for additional information was sent to the Home Hospital by way of an earlier 277 Request for Additional Information.

The second claim submitted is on behalf of Mary Jones. Mrs. Jones is a Medicare enrollee with a health insurance claim number of 234567890A.

Home Hospital requested the status of a claim for services from July 31, 1996 through August 9, 1996 in the amount of $7,599.00.

ABC Insurance assigned a payer internal control number, (claim identification number), of 9629675341 to Mrs. Jones claim. The claim completed processing and will be paid when the payment floor is met.

The third claim submitted is on behalf of Joseph Mann who is covered as a dependent under John Mann. Joseph Mann is covered under the PPO plan and his member identification is 345678901-02. John Mann is the insured or subscriber and his member identification is 345678901.

Home Hospital requested the status of a claim for outpatient services (bill type 131) for services from May 01, 1996 through May 30, 1996 in the amount of $4,899.50.

ABC Insurance assigned a payer internal control number of 961681010827 to Mr. Mann's claim. The claim was denied because the dependent was not eligible for benefits at the time of service.

The following is the response file that ABC Insurance sent back in response to the 276 transmission:

4.2.1 Transmission

```
ST*277*0001~
BHT*0010*08*277X093*19961120**DG~
HL*1*20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
HL*2*1*21*1~
NM1*41*2*XYZ  SERVICE*****46*X67E~
HL*3*2*19*1~
NM1*1P*2*HOME HOSPITAL*****SV*987666~
HL*4*3*22*0~
DMG*D8*19201210*M~
NM1*QC*1*SMITH*FRED****MI*123456789A~
TRN*2*1625032606~
STC*P3:60*19960930**8513.88*0~
REF*1K*96347006051~
REF*BLT*111~
DTP*232*RD8*19960831-19960906~
HL*5*3*22*0~
DMG*D8*19201115*F~
NM1*QC*1*JONES*MARY****MI*234567890A~
TRN*2*1622241518~
STC*F0:3*19960930**7599*7599~
REF*1K*9629675341~
REF*BLT*111~
DTP*232*RD8*19960731-19960809~
HL*6*2*19*1~
NM1*1P*2*HOME HOSPITAL*****SV*124567890~
HL*7*6*22*1~
DMG*D8*19451101*M~
NM1*IL*1*MANN*JOHN****MI*345678901~
HL*8*7*23~
DMG*D8*19651101*M~
NM1*QC*1*MANN*JOSEPH****MI*345678901-02~
TRN*1*16270853402~
STC*F2:88:QC*19960930**4899.5*0~
REF*1K*961681010827~
REF*BLT*131~
DTP*232*RD8*19960501-19960530~
SE*38*0001~
```

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

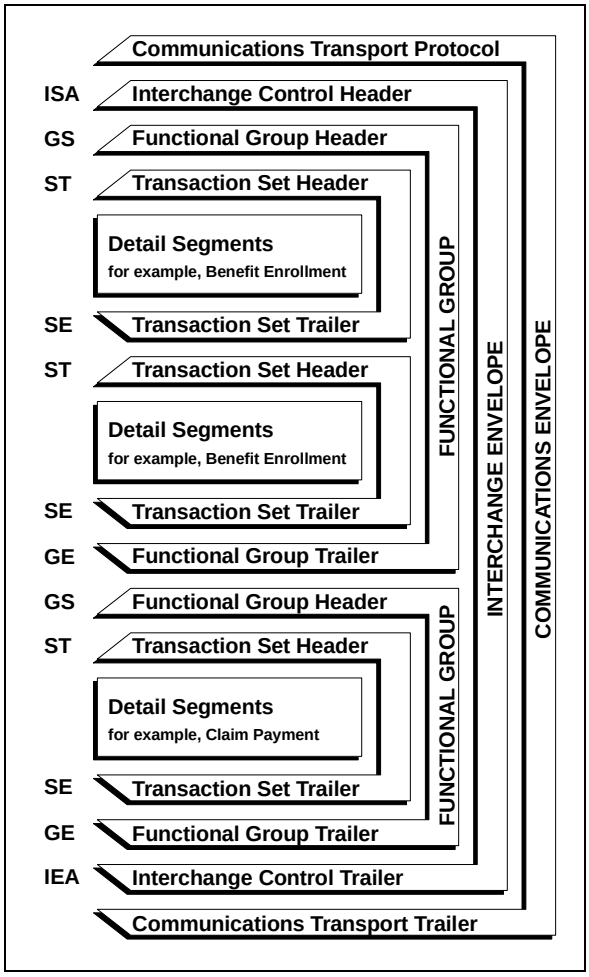


Figure A1. Transmission Control Schematic

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 A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

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 matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

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 can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a "yes" condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

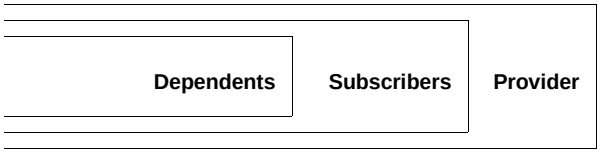
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08, Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

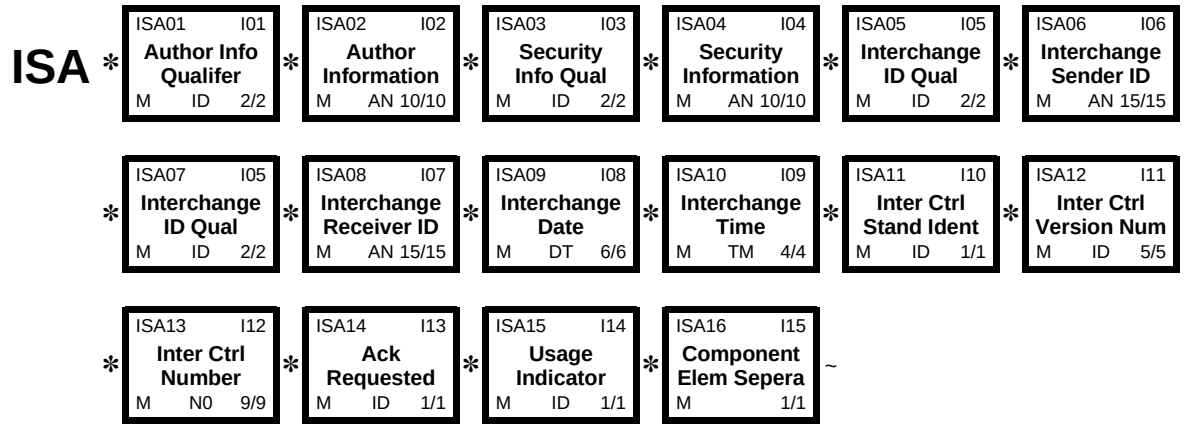
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** 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)	**M AN 10/10**

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

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M 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 ID 2/2**
Qualifier to designate 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 Identification 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 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 ID 2/2**
Qualifier to designate 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 Identification 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**		**M**	**AN**	**15/15**
			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				
REQUIRED	**ISA09**	**I08**	**Interchange Date**		**M**	**DT**	**6/6**
			Date of the interchange				
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time**		**M**	**TM**	**4/4**
			Time of the interchange				
			The time format is HHMM.				
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier**		**M**	**ID**	**1/1**
			Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer				
			CODE	DEFINITION			
			U	**U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**		**M**	**ID**	**5/5**
			This version number covers the interchange control segments				
			CODE	DEFINITION			
			00401	**Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number**		**M**	**N0**	**9/9**
			A control number assigned by the interchange sender				
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M** **ID** **1/1**
Code sent by the sender to request an interchange acknowledgment (TA1)

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED **ISA15** **I14** **Usage Indicator** **M** **ID** **1/1**
Code to indicate 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**
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

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

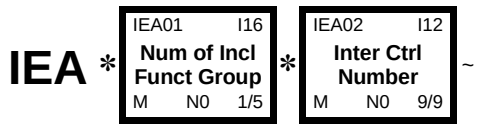
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

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

DIAGRAM



ELEMENT SUMMARY

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**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

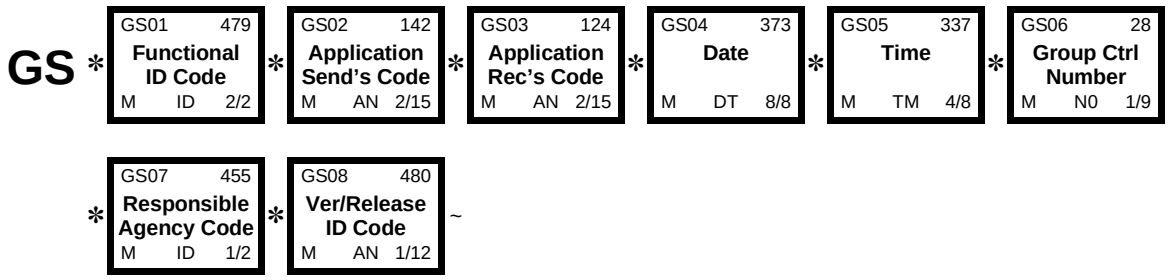
Example: **GS*HN*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X093~**

STANDARD

GS Functional Group Header

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets	**M ID 2/2**
			CODE / DEFINITION	
			HN **Health Care Claim Status Notification (277)**	
			HR **Health Care Claim Status Request (276)**	
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners	**M AN 2/15**
			Use this code to identify the unit sending the information.	
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners	**M AN 2/15**
			Use this code to identify the unit receiving the information.	
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date.	**M DT 8/8**
			Use this date for the functional group creation date.	

REQUIRED	**GS05**	**337**	**Time**	**M**	**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**	**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.

REQUIRED	**GS07**	**455**	**Responsible Agency Code**	**M**	**ID**	**1/2**

Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED	**GS08**	**480**	**Version / Release / Industry Identifier Code**	**M**	**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	DEFINITION
004010X093	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

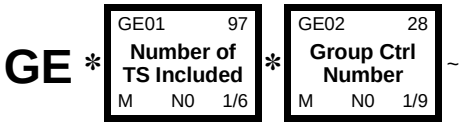
Example: **GE*1*1~**

STANDARD

GE Functional Group Trailer

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

DIAGRAM



ELEMENT SUMMARY

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**	**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**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in the Appendix.**

Example: **TA1*000000905*940101*0100*A*001~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.			
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.			
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)			
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			This is the time of the original interchange being acknowledged. (HHMM)			

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

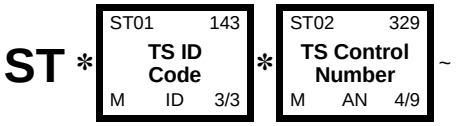
Requirement: Mandatory

Max Use: 1

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

Set Notes:
1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ST01	143	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) 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: 997 — DEFINITION: Functional Acknowledgment	M ID 3/3
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 **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.** **Use the corresponding value in SE02 for this transaction set.**	M AN 4/9

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HN*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

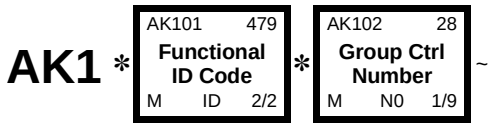
Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK101**	**479**	**Functional Identifier Code** **M ID 2/2** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	
			CODE **DEFINITION** **HN** **Health Care Claim Status Notification (277)** **HR** **Health Care Claim Status Request (276)**	
REQUIRED	**AK102**	**28**	**Group Control Number** **M N0 1/9** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER Repeat: 999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*276*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

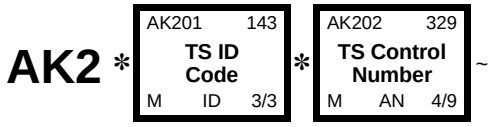
Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes: **1.** AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.	**M ID 3/3**
			CODE / **DEFINITION** **276** — **Health Care Claim Status Request** **277** — **Health Care Claim Status Notification**	
REQUIRED	**AK202**	**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 **SEMANTIC:** AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M AN 4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

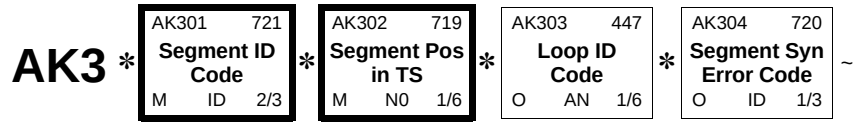
Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) **CODE SOURCE 77:** X12 Directories **This is the two or three characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes: **1. Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

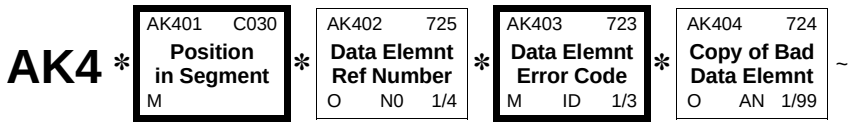
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error	**O N0 1/2**
			Used when an error occurs in a composite data element and the composite data element position can be determined.	

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**
Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE 77: X12 Directories

The Data Element Reference Number for this data element is 725. All reference numbers are found with the segment descriptions in this guide.

REQUIRED **AK403** **723** **Data Element Syntax Error Code** **M** **ID** **1/3**
Code indicating the error found after syntax edits of a data element

CODE	DEFINITION
1	Mandatory data element missing
2	Conditional required data element missing.
3	Too many data elements.
4	Data element too short.
5	Data element too long.
6	Invalid character in data element.
7	Invalid code value.
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated

SITUATIONAL **AK404** **724** **Copy of Bad Data Element** **O** **AN** **1/99**
This is a copy of the data element in error

SEMANTIC: In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

Used to provide copy of erroneous data to the original submitter, but this is not used if the error reported in an invalid character.

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

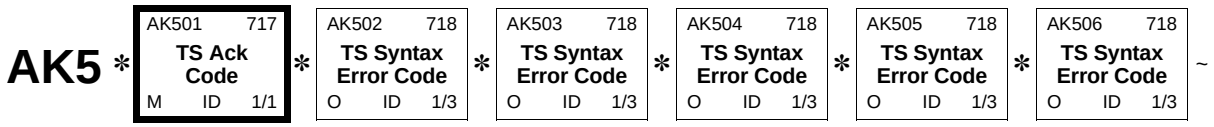
Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted But Errors Were Noted**
M	**Rejected, Message Authentication Code (MAC) Failed**
R	**Rejected** **ADVISED**
W	**Rejected, Assurance Failed Validity Tests**
X	**Rejected, Content After Decryption Could Not Be Analyzed**

SITUATIONAL **AK502** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

This code is required if an error exists.

CODE	DEFINITION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment

SITUATIONAL **AK503** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

Use the same codes indicated in AK502.

SITUATIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9*A*1*1*1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

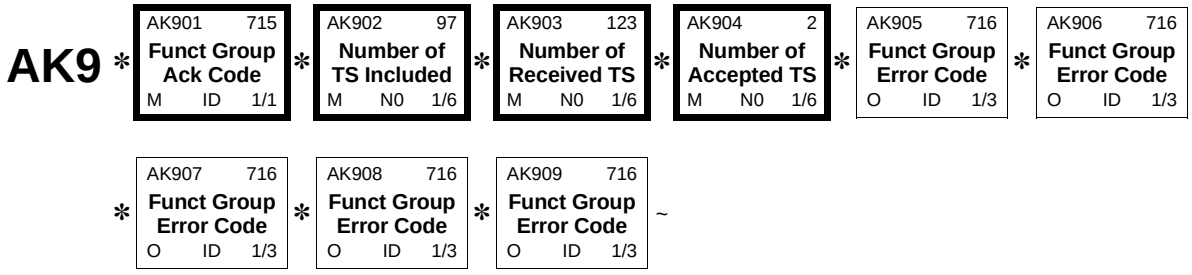
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

			P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**			
			R	**Rejected** **ADVISED**			
			W	**Rejected, Assurance Failed Validity Tests**			
			X	**Rejected, Content After Decryption Could Not Be Analyzed**			
REQUIRED	**AK902**	**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**	**N0**	**1/6**	
			This is the value in the original GE01.				
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0**	**1/6**	
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0**	**1/6**	
SITUATIONAL	**AK905**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			This code is required if an error exists.				

CODE	DEFINITION
1	**Functional Group Not Supported**
2	**Functional Group Version Not Supported**
3	**Functional Group Trailer Missing**
4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**
5	**Number of Included Transaction Sets Does Not Match Actual Count**
6	**Group Control Number Violates Syntax**
10	**Authentication Key Name Unknown**
11	**Encryption Key Name Unknown**
12	**Requested Service (Authentication or Encryption) Not Available**
13	**Unknown Security Recipient**
14	**Unknown Security Originator**
15	**Syntax Error in Decrypted Text**
16	**Security Not Supported**
17	**Incorrect Message Length (Encryption Only)**
18	**Message Authentication Code Failed**

			23	**S3E Security End Segment Missing for S3S Security Start Segment**			
			24	**S3S Security Start Segment Missing for S3E End Segment**			
			25	**S4E Security End Segment Missing for S4S Security Start Segment**			
			26	**S4S Security Start Segment Missing for S4E Security End Segment**			
SITUATIONAL	**AK906**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK907**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK908**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK909**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

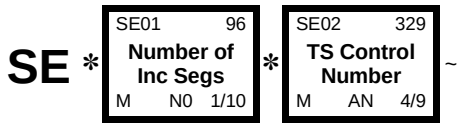
Loop: ____

Requirement: Mandatory

Max Use: 1

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)

DIAGRAM



ELEMENT SUMMARY

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	**M 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	**M AN 4/9**
			The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	

C External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

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
11 West 42nd Street, 13th Floor
New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, 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, 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. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

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.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

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 and other provider organizations - the customers of health industry manufacturers and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27

7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/RB, 235/NU, 1270/BE, 1270/BG, 1270/BH, 1270/BI

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

134 National Drug Code

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ND, 1270/NDC

SOURCE

Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM

First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT

The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/AD, 1270/JO, 1270/JP

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

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

ABSTRACT

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

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

www.wpc-edi.com
Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116

ABSTRACT

Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES

235/N1, 235/N2, 235/N3, 235/N4, 1270/NDC, 235/N5, 235/N6

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.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Category Code

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com

ABSTRACT

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

508 Health Care Claim Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Code

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com

ABSTRACT

Code identifying the status of an entire claim or service line

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

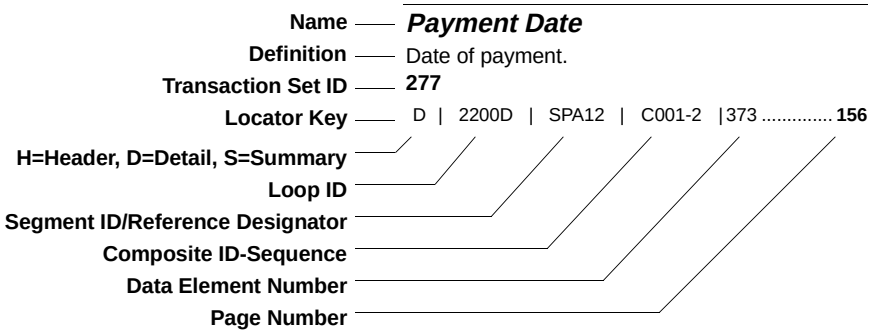
The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

D Change Summary

This is the first ASC X12N implementation guide for the 276/277. In future guides, this section will contain a summary of all changes since the previous guide.

E Data Element Name Index

This appendix contains an alphabetic listing of data elements used in this implementation guide. Consult the Data Element Dictionary for the complete list. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Adjudication or Payment Date

Date of payment or denial determination by previous payer.

277

D | 2200D | STC06 | - | 373 ..... **162**
D | 2200E | STC06 | - | 373 ..... **207**

Amount Qualifier Code

Code to qualify amount.

276

D | 2200D | AMT01 | - | 522 ..... **84**
D | 2200E | AMT01 | - | 522 ..... **109**

Bill Type Identifier

A code indicating the specific type of bill or claim.

276

D | 2200D | REF02 | - | 127 ..... **81**
D | 2200E | REF02 | - | 127 ..... **106**

277

D | 2200D | REF02 | - | 127 ..... **168**
D | 2200E | REF02 | - | 127 ..... **213**

Check Issue or EFT Effective Date

Date the check was issued or the electronic funds transfer (EFT) effective date.

277

D | 2200D | STC08 | - | 373 ..... **163**
D | 2200E | STC08 | - | 373 ..... **208**

Check or EFT Trace Number

Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship.

277

D | 2200D | STC09 | - | 429 ..... **163**
D | 2200E | STC09 | - | 429 ..... **208**

Claim Payment Amount

Net provider reimbursement amount for this claim (includes all payment to the provider).

277

D | 2200D | STC05 | - | 782 ..... **162**
D | 2200E | STC05 | - | 782 ..... **207**

Claim Service Period

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

276

D | 2200D | DTP03 | - | 1251 ..... **87**
D | 2200E | DTP03 | - | 1251 ..... **112**

277

D | 2200D | DTP03 | - | 1251 ..... **172**
D | 2200E | DTP03 | - | 1251 ..... **217**

Communication Number

Complete communications number including country or area code when applicable

276

D | 2100A | PER04 | - | 364 ..... **58**
D | 2100A | PER06 | - | 364 ..... **59**
D | 2100A | PER08 | - | 364 ..... **59**

277

D | 2100A | PER04 | - | 364 ..... **134**

D	2100A	PER06	-	364		**135**
D	2100A	PER08	-	364		**135**

Communication Number Qualifier

Code identifying the type of communication number

276

D	2100A	PER03	-	365		**58**
D	2100A	PER05	-	365		**59**
D	2100A	PER07	-	365		**59**

277

D	2100A	PER03	-	365		**134**
D	2100A	PER05	-	365		**135**
D	2100A	PER07	-	365		**135**

Contact Function Code

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

276

D	2100A	PER01	-	366		**58**

277

D	2100A	PER01	-	366		**134**

Date Time Period Format Qualifier

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

276

D	2000D	DMG01	-	1250		**72**
D	2200D	DTP02	-	1250		**87**
D	2210D	DTP02	-	1250		**93**
D	2000E	DMG01	-	1250		**96**
D	2200E	DTP02	-	1250		**112**
D	2210E	DTP02	-	1250		**118**

277

D	2000D	DMG01	-	1250		**148**
D	2200D	DTP02	-	1250		**172**
D	2220D	DTP02	-	1250		**188**
D	2000E	DMG01	-	1250		**192**
D	2200E	DTP02	-	1250		**217**
D	2220E	DTP02	-	1250		**232**

Date Time Qualifier

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

276

D	2200D	DTP01	-	374		**86**
D	2210D	DTP01	-	374		**93**
D	2200E	DTP01	-	374		**111**
D	2210E	DTP01	-	374		**118**

277

D	2200D	DTP01	-	374		**171**
D	2220D	DTP01	-	374		**188**
D	2200E	DTP01	-	374		**216**
D	2220E	DTP01	-	374		**232**

Entity Identifier Code

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

276

D	2100A	NM101	-	98		**54**
D	2100B	NM101	-	98		**62**
D	2100C	NM101	-	98		**67**
D	2100D	NM101	-	98		**74**
D	2100E	NM101	-	98		**98**

277

D	2100A	NM101	-	98		**130**
D	2100B	NM101	-	98		**138**
D	2100C	NM101	-	98		**143**
D	2100D	NM101	-	98		**150**
D	2200D	STC01	C043-3	98		**155**
D	2200D	STC10	C043-3	98		**164**
D	2200D	STC11	C043-3	98		**164**
D	2220D	STC01	C043-3	98		**178**
D	2220D	STC10	C043-3	98		**186**
D	2220D	STC11	C043-3	98		**186**
D	2100E	NM101	-	98		**194**
D	2200E	STC01	C043-3	98		**200**
D	2200E	STC10	C043-3	98		**209**
D	2200E	STC11	C043-3	98		**209**
D	2220E	STC01	C043-3	98		**222**
D	2220E	STC10	C043-3	98		**230**
D	2220E	STC11	C043-3	98		**230**

Entity Type Qualifier

Code qualifying the type of entity

276

D	2100A	NM102	-	1065		**55**
D	2100B	NM102	-	1065		**63**
D	2100C	NM102	-	1065		**68**
D	2100D	NM102	-	1065		**75**
D	2100E	NM102	-	1065		**98**

277

D	2100A	NM102	-	1065		**131**
D	2100B	NM102	-	1065		**139**
D	2100C	NM102	-	1065		**143**
D	2100D	NM102	-	1065		**151**
D	2100E	NM102	-	1065		**194**

Health Care Claim Status Category Code

Code indicating the category of the associated claim status code.

277

D	2200D	STC01	C043-1	1271		**154**
D	2200D	STC10	C043-1	1271		**164**
D	2200D	STC11	C043-1	1271		**164**
D	2220D	STC01	C043-1	1271		**177**
D	2220D	STC10	C043-1	1271		**185**
D	2220D	STC11	C043-1	1271		**186**
D	2200E	STC01	C043-1	1271		**199**
D	2200E	STC10	C043-1	1271		**208**
D	2200E	STC11	C043-1	1271		**209**
D	2220E	STC01	C043-1	1271		**221**
D	2220E	STC10	C043-1	1271		**230**
D	2220E	STC11	C043-1	1271		**230**

Health Care Claim Status Code

Code conveying the status of a health care claim.

277

D	2200D	STC01	C043-2	1271	**154**
D	2200D	STC10	C043-2	1271	**164**
D	2200D	STC11	C043-2	1271	**164**
D	2220D	STC01	C043-2	1271	**178**
D	2220D	STC10	C043-2	1271	**186**
D	2220D	STC11	C043-2	1271	**186**
D	2200E	STC01	C043-2	1271	**200**
D	2200E	STC10	C043-2	1271	**209**
D	2200E	STC11	C043-2	1271	**209**
D	2220E	STC01	C043-2	1271	**222**
D	2220E	STC10	C043-2	1271	**230**
D	2220E	STC11	C043-2	1271	**230**

Hierarchical Child Code

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

276

D	2000A	HL04	-	736	**53**
D	2000B	HL04	-	736	**61**
D	2000C	HL04	-	736	**66**
D	2000D	HL04	-	736	**71**

277

D	2000A	HL04	-	736	**129**
D	2000B	HL04	-	736	**137**
D	2000C	HL04	-	736	**142**
D	2000D	HL04	-	736	**147**

Hierarchical ID Number

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

276

D	2000A	HL01	-	628	**52**
D	2000B	HL01	-	628	**60**
D	2000C	HL01	-	628	**65**
D	2000D	HL01	-	628	**70**
D	2000E	HL01	-	628	**94**

277

D	2000A	HL01	-	628	**128**
D	2000B	HL01	-	628	**136**
D	2000C	HL01	-	628	**141**
D	2000D	HL01	-	628	**146**
D	2000E	HL01	-	628	**190**

Hierarchical Level Code

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

276

D	2000A	HL03	-	735	**52**
D	2000B	HL03	-	735	**61**
D	2000C	HL03	-	735	**66**
D	2000D	HL03	-	735	**71**
D	2000E	HL03	-	735	**95**

277

D	2000A	HL03	-	735	**128**
D	2000B	HL03	-	735	**137**
D	2000C	HL03	-	735	**142**
D	2000D	HL03	-	735	**147**
D	2000E	HL03	-	735	**191**

Hierarchical Parent ID Number

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

276

D	2000B	HL02	-	734	**60**
D	2000C	HL02	-	734	**65**
D	2000D	HL02	-	734	**70**
D	2000E	HL02	-	734	**94**

277

D	2000B	HL02	-	734	**136**
D	2000C	HL02	-	734	**141**
D	2000D	HL02	-	734	**146**
D	2000E	HL02	-	734	**190**

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

276

H		BHT01	-	1005	**50**

277

H		BHT01	-	1005	**126**

Identification Code Qualifier

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

276

D	2100A	NM108	-	66	**55**
D	2100B	NM108	-	66	**63**
D	2100C	NM108	-	66	**68**
D	2100D	NM108	-	66	**75**
D	2100E	NM108	-	66	**99**

277

D	2100A	NM108	-	66	**131**
D	2100B	NM108	-	66	**139**
D	2100C	NM108	-	66	**144**
D	2100D	NM108	-	66	**151**
D	2100E	NM108	-	66	**195**

Information Receiver First Name

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

276

D	2100B	NM104	-	1036	**63**

277

D	2100B	NM104	-	1036	**139**

Information Receiver Identification Number

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

276

D	2100B	NM109	-	67	**63**

277

D	2100B	NM109	-	67	**140**

Information Receiver Last or Organization Name

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

276

D	2100B	NM103		-	1035	**63**

277

D	2100B	NM103		-	1035	**139**

Information Receiver Middle Name

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

276

D	2100B	NM105		-	1037	**63**

277

D	2100B	NM105		-	1037	**139**

Information Receiver Name Prefix

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

277

D	2100B	NM106		-	1038	**139**

Information Receiver Name Suffix

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

276

D	2100B	NM107		-	1039	**63**

277

D	2100B	NM107		-	1039	**139**

Line Item Charge Amount

Charges related to this service.

276

D	2210D	SVC02		-	782	**90**
D	2210E	SVC02		-	782	**115**

277

D	2220D	SVC02		-	782	**175**
D	2220D	STC04		-	782	**185**
D	2220E	SVC02		-	782	**220**
D	2220E	STC04		-	782	**229**

Line Item Control Number

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

276

D	2210D	REF02		-	127	**92**
D	2210E	REF02		-	127	**117**

277

D	2220D	REF02		-	127	**187**
D	2220E	REF02		-	127	**231**

Line Item Provider Payment Amount

The actual amount paid to the provider for this service line.

277

D	2220D	SVC03		-	782	**176**
D	2220D	STC05		-	782	**185**
D	2220E	SVC03		-	782	**220**
D	2220E	STC05		-	782	**229**

Line Item Service Date

The date of service for the indicated service or claim line item.

276

D	2210E	DTP03		-	1251	**119**

277

D	2220D	DTP03		-	1251	**189**
D	2220E	DTP03		-	1251	**233**

Medical Record Number

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

276

D	2200D	REF02		-	127	**82**
D	2200E	REF02		-	127	**107**

277

D	2200D	REF02		-	127	**169**
D	2200E	REF02		-	127	**215**

Original Units of Service Count

Original units of service that were submitted by the provider (in days or units).

276

D	2210D	SVC07		-	380	**90**
D	2210E	SVC07		-	380	**116**

277

D	2220D	SVC07		-	380	**176**
D	2220E	SVC07		-	380	**220**

Originator Application Transaction Identifier

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

277

H		BHT03		-	127	**126**

Patient Birth Date

Date of birth of the patient.

276

D	2000E	DMG02		-	1251	**97**

277

D	2000E	DMG02		-	1251	**193**

Patient First Name

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

276

D	2100E	NM104	-	1036	.....	**99**

277

D	2100E	NM104	-	1036	.....	**195**

Patient Gender Code

A code indicating the sex of the patient.

276

D	2000E	DMG03	-	1068	.....	**97**

277

D	2000E	DMG03	-	1068	.....	**193**

Patient Last Name

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

276

D	2100E	NM103	-	1035	.....	**99**

277

D	2100E	NM103	-	1035	.....	**195**

Patient Middle Name

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

276

D	2100E	NM105	-	1037	.....	**99**

277

D	2100E	NM105	-	1037	.....	**195**

Patient Name Prefix

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

276

D	2100E	NM106	-	1038	.....	**99**

277

D	2100E	NM106	-	1038	.....	**195**

Patient Name Suffix

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

276

D	2100E	NM107	-	1039	.....	**99**

277

D	2100E	NM107	-	1039	.....	**195**

Patient Primary Identifier

Identifier assigned by the payer to identify the patient

276

D	2100E	NM109	-	67	.....	**100**

277

D	2100E	NM109	-	67	.....	**196**

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).

276

D	2200D	REF02	-	127	.....	**79**
D	2200E	REF02	-	127	.....	**103**

277

D	2200D	REF02	-	127	.....	**166**
D	2200E	REF02	-	127	.....	**210**

Payer Contact Name

Name identifying the payer organization's contact person.

276

D	2100A	PER02	-	93	.....	**58**

277

D	2100A	PER02	-	93	.....	**134**

Payer Identifier

Number identifying the payer organization.

276

D	2100A	NM109	-	67	.....	**56**

277

D	2100A	NM109	-	67	.....	**132**

Payer Name

Name identifying the payer organization.

276

D	2100A	NM103	-	1035	.....	**55**

277

D	2100A	NM103	-	1035	.....	**131**

Payment Method Code

Code identifying the method for the movement of payment instructions.

277

D	2200D	STC07	-	591	.....	**163**
D	2200E	STC07	-	591	.....	**208**

Procedure Modifier

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

276

D	2210D	SVC01	C003-3	1339	.....	**90**
D	2210D	SVC01	C003-4	1339	.....	**90**
D	2210D	SVC01	C003-5	1339	.....	**90**
D	2210D	SVC01	C003-6	1339	.....	**90**
D	2210E	SVC01	C003-3	1339	.....	**115**
D	2210E	SVC01	C003-4	1339	.....	**115**
D	2210E	SVC01	C003-5	1339	.....	**115**
D	2210E	SVC01	C003-6	1339	.....	**115**

277

D	2220D	SVC01	C003-3	1339	.....	**175**
D	2220D	SVC01	C003-4	1339	.....	**175**
D	2220D	SVC01	C003-5	1339	.....	**175**
D	2220D	SVC01	C003-6	1339	.....	**175**

D | 2220E | SVC01 | C003-3 | 1339 ..... **220**
D | 2220E | SVC01 | C003-4 | 1339 ..... **220**
D | 2220E | SVC01 | C003-5 | 1339 ..... **220**
D | 2220E | SVC01 | C003-6 | 1339 ..... **220**

Product or Service ID Qualifier

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

276
D | 2210D | SVC01 | C003-1 | 235 ..... **89**
D | 2210E | SVC01 | C003-1 | 235 ..... **114**

277
D | 2220D | SVC01 | C003-1 | 235 ..... **174**
D | 2220E | SVC01 | C003-1 | 235 ..... **219**

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.

276
D | 2100C | NM104 | - | 1036 ..... **68**

277
D | 2100C | NM104 | - | 1036 ..... **144**

Provider Identifier

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

276
D | 2100C | NM109 | - | 67 ..... **69**

277
D | 2100C | NM109 | - | 67 ..... **145**

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.

276
D | 2100C | NM103 | - | 1035 ..... **68**

277
D | 2100C | NM103 | - | 1035 ..... **144**

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.

276
D | 2100C | NM105 | - | 1037 ..... **68**

277
D | 2100C | NM105 | - | 1037 ..... **144**

Provider Name Prefix

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

276
D | 2100C | NM106 | - | 1038 ..... **68**

277
D | 2100C | NM106 | - | 1038 ..... **144**

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.

276
D | 2100C | NM107 | - | 1039 ..... **68**

277
D | 2100C | NM107 | - | 1039 ..... **144**

Reference Identification Qualifier

Code qualifying the reference identification

276
D | 2200D | REF01 | - | 128 ..... **78**
D | 2200D | REF01 | - | 128 ..... **80**
D | 2200D | REF01 | - | 128 ..... **82**
D | 2210D | REF01 | - | 128 ..... **91**
D | 2200E | REF01 | - | 128 ..... **103**
D | 2200E | REF01 | - | 128 ..... **105**
D | 2200E | REF01 | - | 128 ..... **107**
D | 2210E | REF01 | - | 128 ..... **117**

277
D | 2200D | REF01 | - | 128 ..... **165**
D | 2200D | REF01 | - | 128 ..... **167**
D | 2200D | REF01 | - | 128 ..... **169**
D | 2220D | REF01 | - | 128 ..... **187**
D | 2200E | REF01 | - | 128 ..... **210**
D | 2200E | REF01 | - | 128 ..... **212**
D | 2200E | REF01 | - | 128 ..... **214**
D | 2220E | REF01 | - | 128 ..... **231**

Revenue Code

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

276
D | 2210D | SVC04 | - | 234 ..... **90**
D | 2210E | SVC04 | - | 234 ..... **115**

277
D | 2220D | SVC04 | - | 234 ..... **176**
D | 2220E | SVC04 | - | 234 ..... **220**

Service Identification Code

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

276
D | 2210D | SVC01 | C003-2 | 234 ..... **90**
D | 2210E | SVC01 | C003-2 | 234 ..... **115**

277
D | 2220D | SVC01 | C003-2 | 234 ..... **175**

Service Line Date

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

276

Status Information Effective Date

The date that the status information provided is effective.

277

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

276

277

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

276

277

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

276

277

Subscriber Identifier

Insured's or subscriber's unique identification number assigned by a payer.

276

277

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

276

277

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

276

277

Subscriber Name Prefix

The name prefix of the subscriber to the indicated coverage or policy.

276

277

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

276

277

Total Claim Charge Amount

The sum of all charges included within this claim.

276

277

Trace Number

Identification number used by originator of the transaction.

276

277

Trace Type Code

Code identifying the type of reassociation which needs to be performed.

276

277

Transaction Segment Count

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

276

D		SE01	-	96	.....	**120**

277

D		SE01	-	96	.....	**234**

Transaction Set Control Number

The unique identification number within a transaction set.

276

H		ST02	-	329	.....	**49**
D		SE02	-	329	.....	**120**

277

H		ST02	-	329	.....	**125**
D		SE02	-	329	.....	**234**

Transaction Set Creation Date

Identifies the date the submitter created the transaction

276

H		BHT04	-	373	.....	**50**

277

H		BHT04	-	373	.....	**127**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

276

H		ST01	-	143	.....	**49**

277

H		ST01	-	143	.....	**125**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

276

H		BHT02	-	353	.....	**50**

277

H		BHT02	-	353	.....	**126**

Transaction Type Code

Code specifying the type of transaction.

277

H		BHT06	-	640	.....	**127**