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Schenectady, NY 12305

MVP Health Care

# Testing and Implementation Guide

*ANSI X12 276/277 Version 4010X093A1  
Health Care Claim Status Request and  
Response  
Batch Mode Only*

*Member ID begins with 8*

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**VERSION CHANGE LOG**

<b>Version 1.0 Original</b>	<b>September 24, 2003</b>
<b>Version 1.1</b> Added Request/Response Naming Conventions Added loop ID and element ID's to bullet 4&5, page 6 Added Communication Specifications	<b>October 1, 2003</b>
<b>Version 1.2</b> Added STC 10 and 11 elements to handle multiple status codes Added additional processing information to STC01-1 and 2	<b>October 13, 2003</b>
<b>Version 1.3</b> Removed Member validation to match requirements Modified Claim Search Criteria to include Proc and Rev Codes	<b>October 23, 2003</b>
<b>Version 1.4</b> Added Washington Publishing Company links for code sets	<b>November 20, 2003</b>
<b>Version 1.5</b> Removed unused segments	<b>January 15, 2004</b>
<b>Version 1.6</b> Added search criteria for member Added search criteria for provider Added search criteria for claim level status Added search criteria for claim line level status Added Service Line Information segments Loop 2210D Added Dependent Service Line Information segments Loop 2220E	<b>April 24, 2006</b>
<b>Version 2.0</b> Updated logo and cleaned up guide.	<b>April 27, 2009</b>

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## INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 276/277 Health Care Claim Status Request and Response transaction implementation guide provides the standardized data requirements to be implemented for this transaction.

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## PURPOSE

The purpose of this document is to provide the information necessary to submit Health Care Claim Status Inquiry transactions electronically to MVP Health Care. **This companion guide is to be used in conjunction with the ANSI X12N implementation guides.** The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The HIPAA implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at [www.wpc-edi.com/hipaa/](http://www.wpc-edi.com/hipaa/). Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>  
United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admsimp/>  
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>  
Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>  
National Council of Prescription Drug Programs (NCPDP) – <http://www.ncpdp.org/>  
National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>  
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

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## SPECIAL CONSIDERATIONS

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### Request Transactions Supported

This section is intended to identify the type and version of the ASC X12N Health Care Claim Status Request transaction that MVP will accept.

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|---|
| <ul style="list-style-type: none"><li>• 276 Health Care Claim Status Request – <b>ASC X12N 276 (004010X093A1)</b></li></ul> |
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### Response Transactions Supported

This section is intended to identify the response transactions supported by MVP.

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| <ul style="list-style-type: none"><li>• 277 Health Care Claim Status Response - <b>ASC X12N 277 (004010X093A1)</b></li></ul> |
| <ul style="list-style-type: none"><li>• 997 Functional Acknowledgement - <b>ASC X12N 276 (004010X093A1)</b></li></ul>        |

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### Communication Specifications

This companion guide supports the receipt of the 276, Health Care Claim Status Request and the 277 Health Care Claim Status Response for **batch mode only**. The file can be uploaded via the Internet or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 997 in batch mode to its trading partners. The file can be downloaded via the Internet or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 277, Health Care Claim Status Response, in batch mode to its trading partners. The file can be downloaded via the Internet or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

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## Use of the 276 Health Care Claim Status Inquiry

The 276 Health Care Claim Status Request is designed to provide claim status information for patient claims previously submitted to MVP. Since MVP assigns a different member ID number to subscribers and their dependents the use of the dependent loop is not required. Use the subscriber loop for both subscriber and dependents is allowable.

It is recommended trading partners be required to submit the X12 276 data with the equivalent of:

- A Patient ID in the NM1 segment of HL22 Subscriber Level Loop (2000DLoop) - NM108 should equal MI and NM109 should equal the patient's ID number
- Rendering Provider ID in the NM1 segment of HL19 Provider Level Loop (2000C Loop) - NM108 should equal SV and NM109 should equal the MVP Provider ID number

<ul style="list-style-type: none"> <li>• Table 2 – Subscriber Level Detail will contain information on the patient claim. This claim can be for the subscriber or dependent. (Loops 2100D, 2100D and 2200D).</li> </ul>
<ul style="list-style-type: none"> <li>• Table 2 – Dependent Level Detail (Loops 2000E, 2100E and 2200E) are <b>not</b> required.</li> </ul>
<ul style="list-style-type: none"> <li>• MVP processes claim level and service level requests from information receivers.</li> </ul>
<ul style="list-style-type: none"> <li>• MVP provider validation             <ol style="list-style-type: none"> <li>1. Match Rendering Provider ID in the NM1 segment of HL19 Provider Level Loop (2000C Loop) to Rendering MVP Provider ID attached to Patient MVP Claim.</li> </ol> </li> </ul>
<ul style="list-style-type: none"> <li>• MVP search criteria patient validation are:             <ol style="list-style-type: none"> <li>1. Patient Identifier (Loop 2100D – NM109) or (Loop 2100E – NM109)</li> <li>2. Patient First Name (Loop 2100D – NM104) or (Loop 2100E – NM104)</li> <li>3. Patient Date of Birth (Loop 2100D – DMG02) or (Loop 2100E – DMG02)</li> </ol> </li> </ul>
<ul style="list-style-type: none"> <li>• MVP search criteria for claim level validation are:             <ol style="list-style-type: none"> <li>1. Find Patient using search criteria above</li> <li>2. Provider Identifier (Loop 2100C – NM109)                     <ol style="list-style-type: none"> <li>3a. Claim Dates (Loop 2200D - DTP02 qualifier 232)</li> <li>3b. Total Charges (Loop 2200D - AMT02 qualifier T3)</li> </ol> </li> <li>Or</li> <li>3. Payer Claim Control Number (Loop 2200D – REF02 qualifier 1K)</li> </ol> <p><i>Note: all Searches include MVP Provider ID validation (Loop 2100C – NM109)</i></p> </li> </ul>
<ul style="list-style-type: none"> <li>• MVP search criteria for line level validation are:             <ol style="list-style-type: none"> <li>1. Find Patient using search criteria above</li> <li>2. Provider Identifier (Loop 2100C – NM109)</li> <li>3. Service Date (Loop 2210D - DTP02 qualifier 472)</li> <li>4. Service Line Procedure Code (Loop 2210D – SVC01-2) or Revenue Code (Loop 2210D – SVC04)</li> <li>5. Service Line Charge Amounts (Loop 2210D – SVC02)</li> </ol> </li> </ul>

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**Level of Detail Expected by the Health Care Claim Status Information Receiver**

The 277 Health Care Claim Status Response transactions are used to provide claim status information back to the information receiver. MVP will provide the following level of detail:

• Table 2 – Subscriber Level Detail information (if appropriate)
• Table 2 – Dependent Level Detail information (if appropriate)
• Claim Level and Service Line information (if appropriate)

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**Delimiters Supported**

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. 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, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

MVP will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

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**Limitations**

- The 276 is used only in conjunction with the 277 Health Care Claim Status Response. 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. This implementation guide should not be used for those purposes.

## Implementation of Health Care Claim Status Submission

There will be four phases of implementation.

1. Development Phase - An MVP appointed Representative will contact the client to review these procedures. MVP will set up a client specific profile to receive claim submissions, process claims, and send acknowledgments and business edit reports. In response, the client will create or modify their programs as necessary to provide MVP with the required data and to receive required data from MVP.
2. Test Phase – The client must notify MVP when they are ready to begin submitting test files. MVP and the client will set up a schedule to receive and send data across the desired media. Upon receiving the file, MVP will validate the file format and data for accuracy. MVP will run the file through the claim submission process, which will do a series of error checking. Upon completion of the claim inquiry process, a response will be created. The MVP IT Representative will test and identify all technical errors. During the testing phase, the EDI Coordinator will be responsible for the education of providers/hospitals with regard to EDI errors/failures. The Client will review and discuss any questions or problems with MVP. The goal will be to achieve a 100% HIPAA compliant claim submission prior to going live.
3. Production - Once testing has reached a 100% acceptance level and both parties have signed off, MVP will move the process into production and go live with the claim inquiry/responses EDI files will be processed at a mutually agreed upon time. Files submitted after that time will be processed on the next scheduled pick-up time.  
**Providers/hospitals may contact Provider Claims Services at 1-800-684-9286 with questions regarding individual claim errors.** All transaction error questions should be directed to the EDI Coordinators: 1-877-461-4911.
4. Post Production - MVP will closely monitor the client's claim inquiry/response for a period of two weeks.

**MVP Requirements for the ANSI X12 276 Transaction - Health Care Claim Status Request**

REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		<b>INTERCHANGE/FUNCTION HEADERS</b>		
<b>R</b>	<b>ISA</b>	<b>INTERCHANGE CONTROL HEADER</b>		
R	ISA01	AUTHORIZATION INFORMATION QUALIFIER	00	No Authorization Information Present in I02
R	ISA02	AUTHORIZATION INFORMATION		Blank
R	ISA03	SECURITY INFORMATION QUALIFIER	00	No Security Information Present in I04
R	ISA04	SECURITY INFORMATION		Blank
R	ISA05	INTERCHANGE ID QUALIFIER	30	Federal Tax ID
R	ISA06	INTERCHANGE SENDER ID		Sender Tax ID
R	ISA07	INTERCHANGE ID QUALIFIER	30	Federal Tax ID
R	ISA08	INTERCHANGE RECEIVER ID	141650868	MVP Tax ID
R	ISA09	INTERCHANGE DATE	YYMMDD	Date of interchange(YYMMDD)
R	ISA10	INTERCHANGE TIME	HHMM	Time of interchange
R	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	U.S. EDI Community of ASC X12, TDCC and UCS
R	ISA12	INTERCHANGE CONTROL VERSION NUMBER	00401	Draft Standards Approved by ASC X12 thru October 1997
R	ISA13	INTERCHANGE CONTROL NUMBER		Must match IEA02
R	ISA14	ACKNOWLEDGMENT REQUESTED	0	0 = NO
R	ISA15	TEST INDICATOR	P	P = production
R	ISA16	COMPONENT ELEMENT SEPARATOR	:	Delimiter
<b>R</b>	<b>GS</b>	<b>FUNCTIONAL GROUP HEADER</b>		
R	GS01	FUNCTIONAL IDENTIFIER CODE	HR	Health Care Claim Status Request
R	GS02	APPLICATION SENDER'S CODE		Sender's Tax ID
R	GS03	APPLICATION RECEIVER'S CODE	141650868	MVP Federal Tax ID
R	GS04	DATE		Group Creation Date (CCYYMMDD)
R	GS05	TIME		Creation Time (HHMM)
R	GS06	GROUP CONTROL NUMBER		Assigned by Sender
R	GS07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	GS08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004010X093A1	
		<b>TABLE 1 - TRANSACTION HEADER</b>		
R	ST	<b>TRANSACTION SET HEADER</b>		
R	ST01	TRANSACTION SET IDENTIFIER CODE	276	Health Care Claim Status Request
R	ST02	TRANSACTION SET CONTROL NUMBER		Must match SE02 control number
R	BHT	<b>BEGINNING OF HIERARCHICAL TRANSACTION</b>		Define the business structure of the transaction set; identify business application purpose and reference data.
R	BHT01	HIERARCHICAL STRUCTURE CODE	0010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependent
R	BHT02	TRANSACTION SET PURPOSE CODE	13	Request
R	BHT04	TRANSACTION SET CREATION DATE	CCYYMMDD	Date format - CCYYMMDD
		<b>TABLE 2 - DETAIL, INFORMATION SOURCE LEVEL</b>		
Loop 2000A	R	<b>INFORMATION SOURCE LEVEL</b>		MVP is the Information Source
R	HL	<b>INFORMATION SOURCE LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender to identify a particular data segment in the HL structure
R	HL03	HIERARCHICAL LEVEL CODE	20	Information source
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
Loop 2100A	R	<b>PAYER NAME</b>		
R	NM1	<b>PAYER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	PR	Payer
R	NM102	ENTITY TYPE QUALIFIER	2	Non person entity
R	NM103	PAYER NAME	MVP	MVP's name
R	NM108	IDENTIFICATION CODE QUALIFIER	FI	Federal Tax ID
R	NM109	PAYER IDENTIFIER	141650868	MVP's Federal Tax ID

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		<b>TABLE 2 - DETAIL, INFORMATION RECEIVER LEVEL</b>		
<b>Loop 2000B</b>	<b>R</b>	<b>INFORMATION RECEIVER LEVEL</b>		This entity expects response from the information source.
<b>R</b>	<b>HL</b>	<b>INFORMATION RECEIVER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender to identify a particular data segment in the HL structure
R	HL02	HIERARCHICAL PARENT ID NUMBER		HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
R	HL03	HIERARCHICAL LEVEL CODE	21	Information Receiver
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
<b>Loop 2100B</b>	<b>R</b>	<b>INFORMATION RECEIVER NAME</b>		Individual or organization requesting to receive the status information.
<b>R</b>	<b>NM1</b>	<b>RECEIVER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	41	Submitter
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1 = Person 2 = Non person entity
R	NM103	INFORMATION RECEIVER LAST OR ORGANIZATION NAME		Name of entity receiving the information
S	NM104	INFORMATION RECEIVER FIRST NAME		The first name is required when the value in NM102 is '1'
S	NM105	INFORMATION RECEIVER MIDDLE NAME		
S	NM107	INFORMATION RECEIVER NAME SUFFIX		
R	NM108	IDENTIFICATION CODE QUALIFIER	FI	Federal Tax ID
R	NM109	INFORMATION RECEIVER IDENTIFICATION NUMBER		Tax ID of entity receiving the information
		<b>TABLE 2 - DETAIL, SERVICE PROVIDER LEVEL</b>		
<b>Loop 2000C</b>	<b>R</b>	<b>SERVICE PROVIDER LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>SERVICE PROVIDER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender to identify a particular data segment in the HL structure

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	HL02	HIERARCHICAL PARENT ID NUMBER		HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
R	HL03	HIERARCHICAL LEVEL CODE	19	Provider of Service
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
<b>Loop 2100C</b>	<b>R</b>	<b>PROVIDER NAME</b>		This is the billing provider from the original submitted claim.
<b>R</b>	<b>NM1</b>	<b>PROVIDER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	1P	Provider
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1 = Person 2 = Non person entity
R	NM103	PROVIDER LAST OR ORGANIZATION NAME		
S	NM104	PROVIDER FIRST NAME		The first name is required when the value in NM102 is '1'
S	NM105	PROVIDER MIDDLE NAME		
S	NM107	PROVIDER NAME SUFFIX		
R	NM108	IDENTIFICATION CODE QUALIFIER	SV	Service Provider Number
R	NM109	PROVIDER IDENTIFIER		MVP Provider ID Number
		<b>TABLE 2 - DETAIL, SUBSCRIBER LEVEL</b>		
<b>Loop 2000D</b>	<b>R</b>	<b>SUBSCRIBER LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>SUBSCRIBER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender to identify a particular data segment in the HL structure
R	HL02	HIERARCHICAL PARENT ID NUMBER		HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
R	HL03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	HL04	HIERARCHICAL CHILD CODE	0	0=No Subordinate HL Segment in This Hierarchical Structure. Required when there are no dependent claim status requests for this subscriber.

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
<b>S</b>	<b>DMG</b>	<b>SUBSCRIBER DEMOGRAPHIC INFORMATION</b>	<b>1</b>	Required when the subscriber is the patient.
R	DMG01	DATE FORMAT QUALIFIER	D8	Date Expressed in Format CCYYMMDD
R	DMG02	SUBSCRIBER BIRTH DATE		Date of Birth
R	DMG03	SUBSCRIBER GENDER CODE		F = Female, M=Male
<b>Loop 2100D</b>	<b>R</b>	<b>SUBSCRIBER NAME</b>		
<b>R</b>	<b>NM1</b>	<b>SUBSCRIBER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	IL, QC	IL = Insured or Subscriber QC=Patient (Use this code only when the subscriber is the patient)
R	NM102	ENTITY TYPE QUALIFIER	1	1= Person
R	NM103	SUBSCRIBER LAST NAME		
R	NM104	SUBSCRIBER FIRST NAME		The first name is required when the value in NM102 is '1'
S	NM105	SUBSCRIBER MIDDLE NAME		
S	NM107	SUBSCRIBER NAME SUFFIX		
R	NM108	IDENTIFICATION CODE QUALIFIER	MI	MI=Member ID Number
R	NM109	SUBSCRIBER IDENTIFIER		MVP Member ID Number
<b>Loop 2200D</b>	<b>S</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		
<b>S</b>	<b>TRN</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		Use of this segment is required if the subscriber is the patient.
R	TRN01	TRACE TYPE CODE	1	Current Transaction Trace Numbers
R	TRN02	TRACE NUMBER		Trace number assigned by receiver. This data element corresponds to the CLM01 data element of the ASC X12N Dental, Institutional, and Professional Implementation Guides.
<b>S</b>	<b>REF</b>	<b>PAYER CLAIM IDENTIFICATION NUMBER</b>		Use this only if the subscriber is the patient. This is the payer's assigned control number. Recommend sending this segment on claim inquires when the information is known.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	1K	Payer's Claim Number

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	REF02	PAYER CLAIM CONTROL NUMBER		MVP Claim Number
S	REF	INSTITUTIONAL BILL TYPE IDENTIFICATION		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.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	BLT	Billing Type
R	REF02	BILL TYPE IDENTIFIER		Required for institutional claims inquiries. Found on UB92 - record 40 - 4 Found on 8371 in CLM-05 Found on UB92 paper form locator 4
S	REF	MEDICAL RECORD IDENTIFICATION		This is the Medical Record number submitted on the original claim. Use this only if the subscriber is the patient.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical Record Identification Number
R	REF02	MEDICAL RECORD NUMBER		Found on UB92 record 20 field 25 Found on 8371,P, D in Medical Record Segment - REF02 Found on UB92 paper form locator 23
S	AMT	CLAIM SUBMITTED CHARGES		Required when the subscriber is the patient.
R	AMT01	AMOUNT QUALIFIER CODE	T3	Total Submitted Charges
R	AMT02	TOTAL CLAIM CHARGE AMOUNT		
S	DTP	CLAIM SERVICE DATE		The date is the statement from and through date. Required for institutional claims.
R	DTP01	DATE TIME QUALIFIER	232	Claims Statement Period Start - includes the claim statement period end.
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
R	DTP03	CLAIM SERVICE PERIOD		CCYYMMDD - CCYYMMDD

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
Loop 2210D	<b>S</b>	<b>SERVICE LINE INFORMATION</b>		
	<b>SVC</b>	<b>SERVICE INFORMATION</b>		
R	SVC01-1	PRODUCT/SERVICE ID QUALIFIER		AD=American Dental Assoc Codes CI= Common Language Equipment Identifier HC= HCPCS codes ID=ICD-9cm Procedure Codes IC=Home Infusion Code N1 = NDC in 4-4-2 format N2 = NDC in 5-3-2 format N3 = NDC in 5-4-1 format N4 = NDC in 5-4-2 format ND = National Drug Code NH = National Health Related item code NU = NUBC UB92 (revenue) codes RB = NUBC UB82 Codes
R	SVC01-2	PROCEDURE MODIFIER		Procedure Code or If value in SVC01-1 is "NU" then Revenue code
S	SVC01-3	PROCEDURE MODIFIER		Procedure modifier
S	SVC01-4	PROCEDURE MODIFIER		Procedure modifier
S	SVC01-5	PROCEDURE MODIFIER		Procedure modifier
S	SVC01-6	PROCEDURE MODIFIER		Procedure modifier
NOT USED	SVC01-7	DESCRIPTION		Description
R	SVC02	MONETARY AMOUNT		Line Item Charge Amount
NOT USED	SVC03	MONETARY AMOUNT		NOT USED
S	SVC04	PRODUCT/SERVICE ID		If value in SVC01-1 is "NU" then Revenue code
NOT USED	SVC05	QUANTITY		NOT USED
NOT USED	SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		NOT USED
S	SVC07	QUANTITY		Original Units of Service Count
	<b>REF</b>	<b>SERVICE LINE ITEM IDENTIFICATION</b>		
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	FJ	Line Item Control Number
R	REF01	REFERENCE IDENTIFICATION		Line Number
	<b>DTP</b>	<b>SERVICE LINE DATE</b>		
R	DTP01	DATE/TIME QUALIFIER	472	Service
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	DTP03	DATE TIME PERIOD		Begin Date – End Date

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		<b>TABLE 2 - DETAIL, DEPENDENT LEVEL</b>		
<b>Loop 2000E</b>	<b>R</b>	<b>DEPENDENT LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>DEPENDENT LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender to identify a particular data segment in the HL structure
R	HL02	HIERARCHICAL PARENT ID NUMBER		HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
R	HL03	HIERARCHICAL LEVEL CODE	23	Dependent
R	HL04	HIERARCHICAL CHILD CODE	0	0=No Subordinate HL Segment in This Hierarchical Structure. Required when there are no dependent claim status requests for this subscriber.
<b>S</b>	<b>DMG</b>	<b>DEPENDENT DEMOGRAPHIC INFORMATION</b>		Required when the subscriber is not the patient.
R	DMG01	DATE FORMAT QUALIFIER	D8	Date Expressed in Format CCYYMMDD
R	DMG02	SUBSCRIBER BIRTH DATE		Date of Birth
R	DMG03	SUBSCRIBER GENDER CODE	F, M	F = Female, M=Male
<b>Loop 2100E</b>	<b>R</b>	<b>DEPENDENT NAME</b>		
<b>R</b>	<b>NM1</b>	<b>DEPENDENT NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	QC	QC=Patient
R	NM102	ENTITY TYPE QUALIFIER	1	1= Person
R	NM103	DEPENDENT LAST NAME		Dependent Last Name
R	NM104	DEPENDENT FIRST NAME		Dependent First Name
S	NM105	DEPENDENT MIDDLE NAME		Dependent Middle Name
S	NM107	DEPENDENT NAME SUFFIX		Dependent Suffix
R	NM108	IDENTIFICATION CODE QUALIFIER	MI	MI=Member ID Number
R	NM109	DEPENDENT IDENTIFIER		MVP Member ID Number

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
Loop 2200E	S	CLAIM SUBMITTER TRACE NUMBER		
S	TRN	CLAIM SUBMITTER TRACE NUMBER		Use of this segment is required if the patient is other than subscriber.
R	TRN01	TRACE TYPE CODE	1	Current Transaction Trace Numbers
R	TRN02	TRACE NUMBER		Trace number assigned by receiver. This data element corresponds to the CLM01 data element of the ASC X12N Dental, Institutional, and Professional Implementation Guides.
S	REF	PAYER CLAIM IDENTIFICATION NUMBER		This is the payer's assigned control number. Recommend sending this segment on claim inquires when the information is known.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	1K	Payer's Claim Number
R	REF02	PAYER CLAIM CONTROL NUMBER		MVP Claim Number
S	REF	INSTITUTIONAL BILL TYPE IDENTIFICATION		Bill type is being sent in the inquiry request in connection with an institutional bill.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	BLT	Billing Type
R	REF02	BILL TYPE IDENTIFIER		Required for institutional claims inquiries. Found on UB92 - record 40 - 4 Found on 8371 in CLM-05 Found on UB92 paper form locator 4
S	REF	MEDICAL RECORD IDENTIFICATION		This is the Medical Record number submitted on the original claim.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical Record Identification Number
R	REF02	MEDICAL RECORD NUMBER		Found on UB92 record 20 field 25 Found on 8371,P, D in Medical Record Segment - REF02 Found on UB92 paper form locator 23

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
<b>S</b>	<b>AMT</b>	<b>CLAIM SUBMITTED CHARGES</b>		<b>Required when the subscriber is the patient.</b>
R	AMT01	AMOUNT QUALIFIER CODE	T3	Total Submitted Charges
R	AMT02	TOTAL CLAIM CHARGE AMOUNT		Total Claim Charge Amount
<b>S</b>	<b>DTP</b>	<b>CLAIM SERVICE DATE</b>		The date is the statement from and through date. Required for institutional claims.
R	DTP01	DATE TIME QUALIFIER	232	Claims Statement Period Start - includes the claim statement period end.
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
R	DTP03	CLAIM SERVICE PERIOD		CCYYMMDD - CCYYMMDD
<b>Loop 2210E</b>	<b>S</b>	<b>SERVICE LINE INFORMATION</b>		
	<b>SVC</b>	<b>SERVICE INFORMATION</b>		
R	SVC01-1	PRODUCT/SERVICE ID QUALIFIER		AD=American Dental Assoc Codes CI= Common Language Equipment Identifier HC= HCPCS codes ID=ICD-9cm Procedure Codes IC=Home Infusion Code N1 = NDC in 4-4-2 format N2 = NDC in 5-3-2 format N3 = NDC in 5-4-1 format N4 = NDC in 5-4-2 format ND = National Drug Code NH = National Health Related item code NU = NUBC UB92 (revenue) codes RB = NUBC UB82 Codes
R	SVC01-2	PROCEDURE MODIFIER		Procedure Code or If value in SVC01-1 is "NU" then Revenue code
S	SVC01-3	PROCEDURE MODIFIER		Procedure modifier
S	SVC01-4	PROCEDURE MODIFIER		Procedure modifier
S	SVC01-5	PROCEDURE MODIFIER		Procedure modifier

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
S	SVC01-6	PROCEDURE MODIFIER		Procedure modifier
NOT USED	SVC01-7	DESCRIPTION		NOT USED
R	SVC02	MONETARY AMOUNT		Line Item Charge Amount
NOT USED	SVC03	MONETARY AMOUNT		NOT USED
S	SVC04	PRODUCT/SERVICE ID		If value in SVC01-1 is "NU" then Revenue code
NOT USED	SVC05	QUANTITY		NOT USED
NOT USED	SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		NOT USED
S	SVC07	QUANTITY		Original Units of Service Count
	<b>REF</b>	<b>SERVICE LINE ITEM IDENTIFICATION</b>		
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	FJ	Line Item Control Number
R	REF01	REFERENCE IDENTIFICATION		Line Number
	<b>DTP</b>	<b>SERVICE LINE DATE</b>		
R	DTP01	DATE/TIME QUALIFIER	472	Service
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	DTP03	DATE TIME PERIOD		Begin Date – End Date
		<b>TRANSACTION TRAILER</b>		
R	<b>SE</b>	<b>TRANSACTION SET TRAILER</b>		
R	SE01	TRANSACTION SEGMENT COUNT		Map generated
	SE02	TRANSACTION SET CONTROL NUMBER		Same as ST02
		<b>FUNCTIONAL/INTERCHANGE TRAILERS</b>		
R	<b>GE</b>	<b>FUNCTIONAL GROUP TRAILER</b>		
R	GE01	NUMBER OF TRANSACTION SETS INCLUDED		Map Generated
R	GE02	GROUP CONTROL NUMBER		Same as GS06
R	<b>IEA</b>	<b>INTERCHANGE CONTROL TRAILER</b>		
R	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Map Generated
R	IEA02	INTERCHANGE CONTROL NUMBER		Same as ISA13

**MVP Requirements for the ANSI X12 277 Transaction - Health Care Claim Status Notification**

REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		<b>INTERCHANGE/FUNCTION HEADERS</b>		
R	<b>ISA</b>	<b>INTERCHANGE CONTROL HEADER</b>		
R	ISA01	AUTHORIZATION INFORMATION QUALIFIER	00	No Authorization Information Present in I02
R	ISA02	AUTHORIZATION INFORMATION		Blank
R	ISA03	SECURITY INFORMATION QUALIFIER	00	No Security Information Present in I04
R	ISA04	SECURITY INFORMATION		Blank
R	ISA05	INTERCHANGE ID QUALIFIER	30	Federal Tax ID
R	ISA06	INTERCHANGE SENDER ID	141650868	MVP Tax ID
R	ISA07	INTERCHANGE ID QUALIFIER	30	Federal Tax ID
R	ISA08	INTERCHANGE RECEIVER ID		Trading Partner Tax ID
R	ISA09	INTERCHANGE DATE	YYMMDD	Date of interchange
R	ISA10	INTERCHANGE TIME	HHMM	Time of interchange
R	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	U.S. EDI Community of ASC X12, TDCC and UCS
R	ISA12	INTERCHANGE CONTROL VERSION NUMBER	00401	Draft Standards Approved by ASC X12 thru October 1997
R	ISA13	INTERCHANGE CONTROL NUMBER	Assigned by MVP	Must match IEA02
R	ISA14	ACKNOWLEDGMENT REQUESTED	0	0 = NO
R	ISA15	TEST INDICATOR	P	P = production
R	ISA16	COMPONENT ELEMENT SEPARATOR	:	Delimiter
R	<b>GS</b>	<b>FUNCTIONAL GROUP HEADER</b>		
R	GS01	FUNCTIONAL IDENTIFIER CODE	HN	Health Care Claim Status Notification
R	GS02	APPLICATION SENDER'S CODE	141650868	MVP Federal Tax ID
R	GS03	APPLICATION RECEIVER'S CODE		Trading Partner Tax ID
R	GS04	DATE		Group Creation Date (CCYYMMDD)
R	GS05	TIME		Creation Time (HHMM)

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
	GS06	GROUP CONTROL NUMBER		Assigned by MVP
R	GS07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12
R	GS08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004010X093A1	Version Number
		<b>TABLE 1 - TRANSACTION HEADER</b>		
R	ST	<b>TRANSACTION SET HEADER</b>		
R	ST01	TRANSACTION SET IDENTIFIER CODE	277	Health Care Claim Status Notification
R	ST02	TRANSACTION SET CONTROL NUMBER		Must match SE02 control number
R	BHT	<b>BEGINNING OF HIERARCHICAL TRANSACTION</b>		Define the business structure of the transaction set; identify business application purpose and reference data.
R	BHT01	HIERARCHICAL STRUCTURE CODE	0010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependent
R	BHT02	TRANSACTION SET PURPOSE CODE	08	Status
R	BHT03	SUBMITTER TRANSACTION ID		Trace number submitted on the 276
R	BHT04	TRANSACTION SET CREATION DATE		System Date (CCYYMMDD)
R	BHT06	TRANSACTION TYPE CODE	DG	Response
		<b>TABLE 2 - DETAIL, INFORMATION SOURCE LEVEL</b>		
Loop 2000A	R	<b>INFORMATION SOURCE LEVEL</b>		MVP is the Information Source
R	HL	<b>INFORMATION SOURCE LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		HL Counter
R	HL03	HIERARCHICAL LEVEL CODE	20	Information source
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
Loop 2100A	R	<b>PAYER NAME</b>		
R	NM1	<b>PAYER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	PR	Payer
R	NM102	ENTITY TYPE QUALIFIER	2	Non person entity

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	NM103	PAYER NAME	MVP	MVP's name
R	NM108	IDENTIFICATION CODE QUALIFIER	FI	Federal Tax ID
R	NM109	PAYER IDENTIFIER	141650868	MVP's Federal Tax ID
<b>S</b>	<b>PER</b>	<b>PAYER CONTACT INFORMATION</b>		
R	PER01	CONTACT FUNCTION CODE	IC	Information Contact
S	PER02	PAYER CONTACT NAME	Provider Claim Service	MVP department to contact with questions
R	PER03	COMMUNICATION NUMBER QUALIFIER	TE	TE=Telephone
R	PER04	PAYER CONTACT COMMUNICATION NUMBER	1-800-684-9286	Contact Phone Number
		<b>TABLE 2 - DETAIL, INFORMATION RECEIVER LEVEL</b>		
<b>Loop 2000B</b>	<b>R</b>	<b>INFORMATION RECEIVER LEVEL</b>		Entity receiving response from MVP
<b>R</b>	<b>HL</b>	<b>INFORMATION RECEIVER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		HL Counter
R	HL02	HIERARCHICAL PARENT ID NUMBER		Parent ID Number
R	HL03	HIERARCHICAL LEVEL CODE	21	Information Receiver
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
<b>Loop 2100B</b>	<b>R</b>	<b>INFORMATION RECEIVER NAME</b>		Individual or organization requesting to receive the status information.
<b>R</b>	<b>NM1</b>	<b>PAYER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	41	Submitter
R	NM102	ENTITY TYPE QUALIFIER	1,2	1 = Person 2 = Non person entity
R	NM103	INFORMATION RECEIVER LAST OR ORGANIZATION NAME		
S	NM104	INFORMATION RECEIVER FIRST NAME		The first name is required when the value in NM102 is '1'
S	NM105	INFORMATION RECEIVER MIDDLE NAME		
S	NM107	INFORMATION RECEIVER NAME SUFFIX		
R	NM108	IDENTIFICATION CODE QUALIFIER	FI	Federal Tax ID
R	NM109	INFORMATION RECEIVER IDENTIFICATION NUMBER		Receiver Tax ID Number

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
		<b>TABLE 2 - DETAIL, SERVICE PROVIDER LEVEL</b>		
<b>Loop 2000C</b>	<b>R</b>	<b>SERVICE PROVIDER LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>SERVICE PROVIDER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		HL Counter
R	HL02	HIERARCHICAL PARENT ID NUMBER		
R	HL03	HIERARCHICAL LEVEL CODE	19	Provider of Service
R	HL04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segments in this hierarchical structure
<b>Loop 2100C</b>	<b>R</b>	<b>PROVIDER NAME</b>		This is the billing provider from the original submitted claim.
<b>R</b>	<b>NM1</b>	<b>PROVIDER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	1P	Provider
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1 = Person 2 = Non person entity
R	NM103	PROVIDER LAST OR ORGANZATION NAME		Provider Name
S	NM104	PROVIDER FIRST NAME		The first name is required when the value in NM102 is '1'
S	NM105	PROVIDER MIDDLE NAME		Provider Middle Name
S	NM107	PROVIDER NAME SUFFIX		Provider Suffix
R	NM108	IDENTIFICATION CODE QUALIFIER	SV	Service Provider Number
R	NM109	PROVIDER IDENTIFIER		MVP Provider ID Number
		<b>TABLE 2 - DETAIL, SUBSCRIBER LEVEL</b>		
<b>Loop 2000D</b>	<b>R</b>	<b>SUBSCRIBER LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>SUBSCRIBER LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		HL Counter
R	HL02	HIERARCHICAL PARENT ID NUMBER		Provider HL01
R	HL03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	HL04	HIERARCHICAL CHILD CODE	0	Return child code from the 276 Request transaction
<b>S</b>	<b>DMG</b>	<b>SUBSCRIBER DEMOGRAPHIC INFORMATION</b>		
R	DMG01	DATE FORMAT QUALIFIER	D8	Date Expressed in Format CCYYMMDD

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	DMG02	SUBSCRIBER BIRTH DATE		Subscriber date of birth
R	DMG03	SUBSCRIBER GENDER CODE		F=Female, M=Male, U=Unknown
<b>Loop 2100D</b>	<b>R</b>	<b>SUBSCRIBER NAME</b>		
<b>R</b>	<b>NM1</b>	<b>SUBSCRIBER NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	IL, QC	IL = Insured or Subscriber QC=Patient (Use this code only when the subscriber is the patient)
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1 = Person 2 = Non person entity
R	NM103	SUBSCRIBER LAST NAME		Subscriber Last Name
S	NM104	SUBSCRIBER FIRST NAME		Subscriber First Name
S	NM105	SUBSCRIBER MIDDLE NAME		Subscriber Middle Name
S	NM107	SUBSCRIBER NAME SUFFIX		Subscriber Suffix
R	NM108	IDENTIFICATION CODE QUALIFIER	MI	MI=Member ID Number
R	NM109	SUBSCRIBER PRIMARY IDENTIFIER		MVP Member ID Number
<b>Loop 2200D</b>	<b>S</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		
<b>S</b>	<b>TRN</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		Use of this segment is required if the subscriber is the patient.
R	TRN01	TRACE TYPE CODE	2	Referenced Transaction Trace Numbers
R	TRN02	TRACE NUMBER		Lookup corresponding Trace
<b>R</b>	<b>STC</b>	<b>CLAIM LEVEL STATUS INFORMATON</b>		Use of this segment is required if the subscriber is the patient.
R	STC01	HEALTH CARE CLAIM STATUS		
R	STC01-1	HEALTH CARE CLAIM STATUS CATEGORY		This is the Category code. Use code source 507 located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> . Level of processing achieved by the claim.
R	STC01-2	HEALTH CARE CLAIM STATUS CODE		This is the Category code. Use code source 508 located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> .
R	STC02	STATUS INFORMATION EFFECTIVE DATE		Date
NOT USED	STC03	ACTION CODE		NOT USED
R	STC04	TOTAL CLAIM CHARGE AMOUNT		Submitted claim charges

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	STC05	CLAIM PAYMENT AMOUNT		Pay amount
S	STC06	CLAIM ADJUDICATION DATE OR PAYMENT DATE		Claim Adjudication or Payment date
S	STC07	PAYMENT METHOD CODE	CHK	Check
S	STC08	CHECK ISSUE OR EFT EFFECTIVE DATE		Check Date
S	STC09	CHECK OR EFT TRACE NUMBER		Check Number
<b>S</b>	<b>REF</b>	<b>PAYER CLAIM IDENTIFICATION NUMBER</b>		Use this only if the subscriber is the patient. This is the payer's assigned control number.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	1K	Payer's Claim Number
R	REF02	PAYER CLAIM CONTROL NUMBER		MVP's Payer Claim Number
<b>S</b>	<b>REF</b>	<b>INSTITUTIONAL BILL TYPE IDENTIFICATION</b>		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.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	BLT	Billing Type
R	REF02	BILL TYPE IDENTIFIER		Required institutional claim inquiries.
<b>S</b>	<b>REF</b>	<b>MEDICAL RECORD IDENTIFICATION</b>		This is the Medical Record number submitted on the original claim. Use this only if the subscriber is the patient.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical Record Identification Number
R	REF02	MEDICAL RECORD NUMBER		
<b>S</b>	<b>DTP</b>	<b>CLAIM SERVICE DATE</b>		The date is the statement from and through date. Required for institutional claims.

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	DTP01	DATE TIME QUALIFIER	232	Claims Statement Period Start - includes the claim statement period end.
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
R	DTP03	CLAIM SERVICE PERIOD		CCYYMMDD - CCYYMMDD
<b>Loop 2220D</b>	<b>S</b>	<b>SERVICE LINE INFORMATION</b>		
<b>S</b>	<b>SVC</b>	<b>SERVICE LINE INFORMATION</b>		
R	SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		SVC01-2 will contain the procedure code of the adjudicated claim.
R	SVC01-01	PRODUCT OR SERVICE ID QUALIFIER		Refer to 277 IG for full list of codes.
R	SVC01-02	SERVICE IDENTIFICATION CODE		Procedure Code = Service ID Qualifier is not equal to NU (National Uniform Billing Committee) UB92 Institutional Revenue Code= Service ID Qualifier = NU (National Uniform Billing Committee)
S	SVC01-03	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-04	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-05	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-06	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
R	SVC02	LINE ITEM CHARGE AMOUNT		This amount is the original submitted charge.
R	SVC03	LINE ITEM PROVIDER PAYMENT AMOUNT		
S	SVC04	REVENUE CODE		If Service ID Qualifier is not equal to NU (National Uniform Billing Committee) UB92
S	SVC07	ORIGINAL UNITS OF SERVICE COUNT		
<b>S</b>	<b>STC</b>	<b>SERVICE LINE STATUS INFORMATON</b>		
R	STC01	HEALTH CARE CLAIM STATUS		
R	STC01-1	HEALTH CARE CLAIM STATUS CATEGORY		This is the Category code. Use <b>Code Source 507</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> . Level of processing achieved by the claim.
R	STC01-2	HEALTH CARE CLAIM STATUS CODE		This is the Category code. <b>Code Source 508</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> .

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	STC02	STATUS INFORMATION EFFECTIVE DATE		Date
NOT USED	STC03	ACTION CODE		NOT USED
R	STC04	TOTAL CLAIM CHARGE AMOUNT		Submitted claim charges
R	STC05	CLAIM PAYMENT AMOUNT		Pay amount
NOT USED	STC06	CLAIM ADJUDICATION DATE OR PAYMENT DATE		NOT USED
NOT USED	STC07	PAYMENT METHOD CODE		NOT USED
NOT USED	STC08	CHECK ISSUE OR EFT EFFECTIVE DATE		NOT USED
NOT USED	STC09	CHECK OR EFT TRACE NUMBER		NOT USED
S	STC10	HEALTH CARE CLAIM STATUS		NOT USED
R	STC10-1	HEALTH CARE CLAIM STATUS CATEGORY CODE		NOT USED
R	STC10-2	HEALTH CARE CLAIM STATUS CODE		NOT USED
S	STC11	HEALTH CARE CLAIM STATUS		NOT USED
R	STC11-1	HEALTH CARE CLAIM STATUS CATEGORY CODE		NOT USED
R	STC11-2	HEALTH CARE CLAIM STATUS CODE		NOT USED
<b>S</b>	<b>REF</b>	<b>SERVICE LINE ITEM IDENTIFICATION</b>		Required when available from the original claim.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	FJ	Line item control number
R	REF02	LINE ITEM CONTROL NUMBER		Line item control
<b>S</b>	<b>DTP</b>	<b>SERVICE LINE DATE</b>		
R	DTP01	DATE TIME QUALIFIER	472	Service
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
R	DTP03	SERVICE LINE DATE		Service Date(CCYYMMDD-CCYYMMDD)
		<b>TABLE 2 - DETAIL, DEPENDENT LEVEL</b>		
<b>Loop 2000D</b>	<b>R</b>	<b>DEPENDENT LEVEL</b>		
<b>R</b>	<b>HL</b>	<b>DEPENDENT LEVEL</b>		
R	HL01	HIERARCHICAL ID NUMBER		HL Counter

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	HL02	HIERARCHICAL PARENT ID NUMBER		Provider HL01
R	HL03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	HL04	HIERARCHICAL CHILD CODE	0	Return child code from the 276 Request transaction
<b>S</b>	<b>DMG</b>	<b>DEPENDENT DEMOGRAPHIC INFORMATION</b>		
R	DMG01	DATE FORMAT QUALIFIER	D8	Date Expressed in Format CCYYMMDD
R	DMG02	DEPENDENT BIRTH DATE		Dependent date of birth
R	DMG03	DEPENDENT GENDER CODE		F=Female, M=Male, U=Unknown
<b>Loop 2100D</b>	<b>R</b>	<b>DEPENDENT NAME</b>		
<b>R</b>	<b>NM1</b>	<b>DEPENDENT NAME</b>		
R	NM101	ENTITY IDENTIFIER CODE	QC	QC=Patient
R	NM102	ENTITY TYPE QUALIFIER	1, 2	1 = Person 2 = Non person entity
R	NM103	DEPENDENT LAST NAME		Dependent Last Name
S	NM104	DEPENDENT FIRST NAME		Dependent First Name
S	NM105	DEPENDENT MIDDLE NAME		Dependent Middle Name
S	NM107	DEPENDENT NAME SUFFIX		Dependent Suffix
R	NM108	IDENTIFICATION CODE QUALIFIER	MI, ZZ	MI=Member ID Number, ZZ=Mutually Defined (HIC Number when approved)
R	NM109	DEPENDENT PRIMARY IDENTIFIER		MVP Member ID Number
<b>Loop 2200D</b>	<b>S</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		
<b>S</b>	<b>TRN</b>	<b>CLAIM SUBMITTER TRACE NUMBER</b>		Use of this segment is required if the subscriber is the patient.
R	TRN01	TRACE TYPE CODE	2	Referenced Transaction Trace Numbers
R	TRN02	TRACE NUMBER		Lookup corresponding Trace
<b>R</b>	<b>STC</b>	<b>CLAIM LEVEL STATUS INFORMATON</b>		
R	STC01	HEALTH CARE CLAIM STATUS		

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	STC01-1	HEALTH CARE CLAIM STATUS CATEGORY		This is the Category code. Use <b>Code Source 507</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> . Level of processing achieved by the claim.
R	STC01-2	HEALTH CARE CLAIM STATUS CODE		This is the Category code. Use <b>Code Source 508</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> .
R	STC02	STATUS INFORMATION EFFECTIVE DATE		Date
NOT USED	STC03	ACTION CODE		NOT USED
R	STC04	TOTAL CLAIM CHARGE AMOUNT		Submitted claim charges
R	STC05	CLAIM PAYMENT AMOUNT		Pay amount
S	STC06	CLAIM ADJUDICATION DATE OR PAYMENT DATE		Claim Adjudication or Payment date
S	STC07	PAYMENT METHOD CODE	CHK	Check
S	STC08	CHECK ISSUE OR EFT EFFECTIVE DATE		Check Date
S	STC09	CHECK OR EFT TRACE NUMBER		Check Number
<b>S</b>	<b>REF</b>	<b>PAYER CLAIM IDENTIFICATION NUMBER</b>		This is the payer's assigned control number.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	1K	Payer's Claim Number
R	REF02	PAYER CLAIM CONTROL NUMBER		Dependent Payer Claim Number
<b>S</b>	<b>REF</b>	<b>INSTITUTIONAL BILL TYPE IDENTIFICATION</b>		Bill type is being sent in the inquiry request in connection with an institutional bill.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	BLT	Billing Type
R	REF02	BILL TYPE IDENTIFIER		Required institutional claim inquiries.
<b>S</b>	<b>REF</b>	<b>MEDICAL RECORD IDENTIFICATION</b>		This is the Medical Record number submitted on the original claim.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical Record Identification Number
R	REF02	MEDICAL RECORD NUMBER		Dependent Medical Record Number
<b>S</b>	<b>DTP</b>	<b>CLAIM SERVICE DATE</b>		The date is the statement from and through date. Required for institutional claims.
R	DTP01	DATE TIME QUALIFIER	232	Claims Statement Period Start - includes the claim statement period end.
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

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REQUIRED	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	DTP03	CLAIM SERVICE PERIOD		CCYYMMDD - CCYYMMDD
<b>Loop 2220D</b>	<b>S</b>	<b>SERVICE LINE INFORMATION</b>		
<b>S</b>	<b>SVC</b>	<b>SERVICE LINE INFORMATION</b>		
R	SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		SVC01-2 will contain the procedure code of the adjudicated claim.
R	SVC01-01	PRODUCT OR SERVICE ID QUALIFIER		Refer to 277 IG for full list of codes.
R	SVC01-02	SERVICE IDENTIFICATION CODE		Procedure Code = Service ID Qualifier is not equal to NU (National Uniform Billing Committee) UB92 Institutional Revenue Code= Service ID Qualifier = NU (National Uniform Billing Committee)
S	SVC01-03	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-04	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-05	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
S	SVC01-06	PROCEDURE MODIFIER		Required if submitted on the original claim service line.
R	SVC02	LINE ITEM CHARGE AMOUNT		This amount is the original submitted charge.
R	SVC03	LINE ITEM PROVIDER PAYMENT AMOUNT		Line Item Provider Payment Amount
S	SVC04	REVENUE CODE		If Service ID Qualifier is not equal to NU (National Uniform Billing Committee) UB92
S	SVC07	ORIGINAL UNITS OF SERVICE COUNT		
<b>S</b>	<b>STC</b>	<b>SERVICE LINE STATUS INFORMATON</b>		
R	STC01	HEALTH CARE CLAIM STATUS		
R	STC01-1	HEALTH CARE CLAIM STATUS CATEGORY		This is the Category code. Use <b>Code Source 507</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> . Level of processing achieved by the claim.
R	STC01-2	HEALTH CARE CLAIM STATUS CODE		This is the Category code. Use <b>Code Source 508</b> located at <a href="http://www.wpc-edi.com/hipaa/">www.wpc-edi.com/hipaa/</a> .
R	STC02	STATUS INFORMATION EFFECTIVE DATE		Date
NOT USED	STC03	ACTION CODE		NOT USED
R	STC04	TOTAL CLAIM CHARGE AMOUNT		Submitted claim charges
R	STC05	CLAIM PAYMENT AMOUNT		Pay amount

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<b>S</b>	<b>REF</b>	<b>SERVICE LINE ITEM IDENTIFICATION</b>	<b>1</b>	Required when available from the original claim.
R	REF01	REFERENCE IDENTIFICATION QUALIFIER	FJ	Line item control number
R	REF02	LINE ITEM CONTROL NUMBER		Line item control
<b>S</b>	<b>DTP</b>	<b>SERVICE LINE DATE</b>	<b>1</b>	
R	DTP01	DATE TIME QUALIFIER	472	Service
R	DTP02	DATE TIME PERIOD FORMAT QUALIFIER	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
R	DTP03	SERVICE LINE DATE		Service Line Date
		<b>TRANSACTION TRAILER</b>		
<b>R</b>	<b>SE</b>	<b>TRANSACTION SET TRAILER</b>		
R	SE01	TRANSACTION SEGMENT COUNT		Map generated
R	SE02	TRANSACTION SET CONTROL NUMBER		Same as ST02
		<b>FUNCTIONAL/INTERCHANGE TRAILERS</b>		
<b>R</b>	<b>GE</b>	<b>FUNCTIONAL GROUP TRAILER</b>		
R	GE01	NUMBER OF TRANSACTION SETS INCLUDED		Map Generated
R	GE02	GROUP CONTROL NUMBER		Same as GS06
<b>R</b>	<b>IEA</b>	<b>INTERCHANGE CONTROL TRAILER</b>		
R	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Map Generated
R	IEA02	INTERCHANGE CONTROL NUMBER		Same as ISA13