

DRAFT

HIPAA

**Master Data Set for Health Care Claim Status Request
and Response Transactions (276/277)**

Decision Support 2000+

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**Survey and Analysis Branch
Division of State and Community Systems Development
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration**

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HIPAA
Health Care Claim Status Request
And Response Transactions (276-277)
Decision Support 2000+

I. Introduction

The Health Care Claim Status Request (276) and the Health Care Claim Status Response (277) transaction set is used to request the status of a health care claim(s) (276) and to respond with the information regarding the specified claim(s) (277).

Entities requesting health care claim status include 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.

This Master Data Set consists of

- an overview of the structure of the transaction;
- tables of the data elements (including definitions, codes, and attributes) that constitute the transaction;
- definitions of key terms and explanations of issues for understanding the information contained in the master data set; and
- a list of external code sources need for the transaction.

The Data Tables define terms, explain usage, and provide technical specifications for the data. Section V defines key terms and elaborates on important issues for this transaction.

Information in this Master Data Set is intended to provide a user-friendly summary of the data contained in the Health Care Claim Status Request and Response (276/277) transaction. When referenced in conjunction with the DS2000+ Handbook , the Master Data Set will help users construct a transaction. For additional technical information not provided in these documents, users should refer to the full Implementation Guide. All information in this Master Data Set has been taken directly from the Health Care Claim Status Request and Response (276/277) transaction. ¹

II. Overview of this Transaction

Uses of the Benefit Health Care Claim Status Request and Response (276/277) transaction

The Benefit Health Care Claim Status Request and Response (276/277) is a paired transaction set consisting of the Health Care Claim Status Request (276), which is used to request the current status of a specified claim(s), and the Health Care Claim Status Response (277) transaction, which is used as a solicited response to a health care claim status request (276).

The Health Care Claim Status Response (277) transaction can also be used as a notification about health care claim(s) status, including front end acknowledgments, and as a request for additional information about a health care claim(s). Unlike the Health Care Claim Status Response (277), the Health Care Claim Status Request (276) has only one use—in conjunction with the Health Care Claim Status Response (277). This handbook addresses the paired usage of the 276 as a request for claim status and the 277 as a response to that request. Separate handbooks were developed to detail using the 277 Health Care Payer Unsolicited Claim Status and the 277 Health Care Claim Request for Additional Information.

Claim status requests processed in a real time mode (see Key Terms below) 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

¹ Health Care Claim Status Request and Response (276/277) transaction, ASCX12N 276/277 (004010X093), Washington Publishing Company, May 2000.

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

Health Care Claim Status Request (276)

The Health Care Claim Status Request (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.

Health Care Claim Status Response (277)

The payer uses the Health Care Claim Status Response (277) 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.

The claim may be found in a variety of status locations within a payer's adjudication process, including the following (which are described in detail in the Key Terms section below):

- 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

Finalized claims may have various outcomes including finalized rejected claim(s), finalized denied claim(s), finalized approved claim(s) pre-payment, and finalized approved claim(s) post-payment.

Information Requirements

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 have been 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.

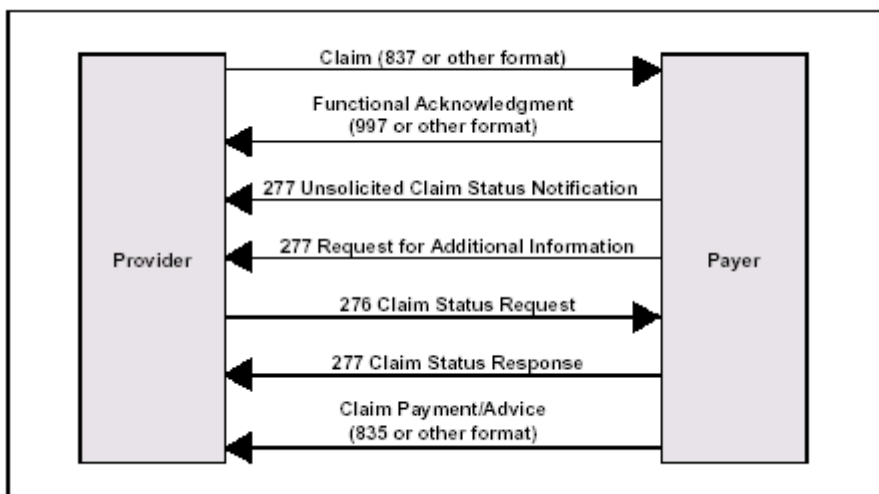
Information Flow and Interaction with other Transactions

Figure 1, 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 important that providers differentiate between the multiple uses of the 277 claim status. For this transaction set, the third, fourth, and final flows do not apply.

Submitting a claim, whether by using the Health Care Claim: Professional or Institutional (837) transaction or by 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 it 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. The Functional Acknowledgment (997) transaction is used upon request by one of the trading partners to acknowledge receipt of information. A 997 can be used by 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); or the provider to acknowledge receipt of a Health Care Claim Payment/Advice (835).

The Health Care Claim Request for Additional Information (277) transaction is used by payers to obtain information on a claim that has been suspended during the adjudication process because it is under medical or utilization review. This information is needed to supplement or support 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.

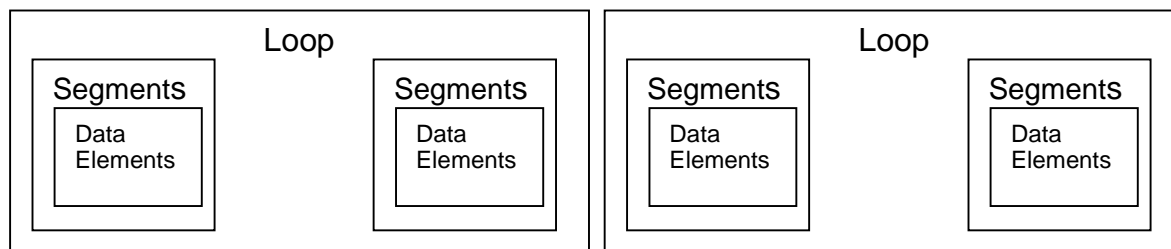
Figure 1. Claim Status Information Flow



Structure of the Transaction Sets

Under HIPAA, business transactions (such as a group of benefit enrollments sent from a sponsor to a payer or a health care claim submitted by a provider to a payer) are conducted through formal structures called “transaction sets”. Information is transmitted as discrete data elements grouped together into segments; segments are grouped into loops (see Figure 2).

Figure 2. Loops, Segments, and Data Elements



Transaction sets all adhere to the same format: a control segment called the header segment; loops of data segments, both in specified order; and a control segment called the trailer segment. Within each data segment, the data elements also follow a specified order. Similar transaction sets, called “functional groups,” can be sent together within a transmission; in this case, each transaction set has its own unique identifier that is transmitted as the first data element of the header segment.

The discussion below on data elements, segments, and loops is intended to help readers understand the structure of the transaction and the information presented in the Data Tables.

Data Elements

A data element corresponds to a data field in data processing terminology. Data elements are characterized by:

- name (e.g., “Identification Code”)
- usage (e.g., required or situational [which means that the element is required only under certain circumstances]);
- reference designator (e.g., NM109, which indicates that the element is in the NM1 segment and is the ninth data element in the segment);
- number (e.g., 67); and
- attributes.

The attributes are the condition designator in the X12 standard (i.e., mandatory [M], optional [O], relational [X])²; the type of data element (e.g., Numeric [Nn], Decimal [R], Identifier [ID], String [AN], Date [DT], Time [TM], Binary [B]); and the minimum and maximum length of the data (i.e., the number of character positions used for numeric, decimal, and binary elements).

For simplicity of presentation, we use the single term “attributes” in the data tables to refer to *all* the characteristics of a data element, i.e., usage, reference designator, number, X12 requirement designator, type, and length. For the data element “subscriber identification code” these “attributes” are listed sequentially as SITUATIONAL NM109 67 X AN 2/80. In this example, the meaning of the terms is as follows:

SITUATIONAL	required only under certain circumstances
NM109	the ninth element in the NM1 segment
X	a relational element in the X12 standard
AN	a string type of element
2/80	a minimum of 2 and a maximum of 80 characters are allowed

Segments

Logically related data elements are grouped together in units called segments. There are two types of segments—control segments and data segments. These segments have the same structure, but different uses. The control segments are used to convey information about the transaction and the data segments are used to convey the information that necessitated the transaction. Transaction sets always begin and end with a control segment between which are the data segments. The control segment that begins a transaction is called the header (ST) segment and is used to identify the

² The X12 condition designator defines the circumstances under which a data element may be required to be present or not present in a particular segment. The designation of mandatory (M) is absolute in the sense that there is no dependency on other data elements. The designation of optional (O) means that there is no requirement for a data element to be in the segment and that its presence is at the option of the sender. Relational conditions (X) may exist among two or more simple data elements within the same data segment (e.g., they may be paired or multiple so that if any element specified in the relational condition is present, then all the elements specified must be present).

sender and receiver; the control segment that ends a transaction is called the trailer (SE) segment and is used for verification and security purposes. (For more information on control segments, see Section IV. Key Terms)

Each transaction set contains many segments, analogous to a freight train: the segments are like the train's cars and each one has several data elements just as a train car might have many crates. The sequence of the data elements within one segment and the sequence of segments in the transaction set are both specified by the ASC X12 standard. In a more conventional computing environment, the segments would be equivalent to records, and the data elements equivalent to fields.

Each segment, whether a control or data segment, has its own name and its own purpose. A segment always has the same structure: it begins with a unique identifier, then has one or more logically related data elements, and ends with a segment terminator.

The Data Check List shows all the data elements within each data segment; the data segments within the transaction by segment ID, name, and usage (required or situational); and how the segments are grouped into loops.

Loops

Loops are groups of logically related data segments. The segments within a loop occur in a specified order; the first ("beginning") segment in the loop gives the loop its name and establishes whether the loop is required or situational. If the beginning segment in a loop is required, then the loop is required; if the beginning segment is situational, the loop is situational. Loops themselves are not actually sent in a transaction—only the data segments within the loop are sent. A loop (actually, the data segments that comprise the loop) may occur once, repeat an unlimited number of times, or repeat only a specified number of times.

Loop Hierarchy

The looping structure is hierarchical—i.e., certain loops are subordinated to others. Once the hierarchy is understood, the logic of the data in the transaction becomes apparent.

Figures 3a and 3b show the hierarchical organization of the data in these transactions. The 276 and 277 transaction sets are similar in structure but are not duplicates. Both are divided into two levels, or tables. Table 1, Header, contains transaction control information. Table 2, Detail, contains the detail information for the business function of the transaction.

For both the 276 and 277, Table 1, the Header Level, contains 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 hierarchical structure. For example, in the BHT segment, a 276 will have a value of 13 in the Transaction Set Purpose Code data element to indicate that the transaction is a request and a 277 will have a value of 08 to indicate that the transaction is a response. Since the 277 transaction is multi-functional, a Transaction Set Type Code data element is used, whereas the 276, which has only one function, does not use that data element.

Table 2, Detail Level, contains several nested loops. For both transactions, Loop 2000 identifies the participant and the relationship to other participants. Nested within Loop 2000 is Loop 2100 which contains the individual or entity name and Loop 2200 which contains specific claim details. It is at Loop 2200 that the 276 and 277 transactions begin to differ.

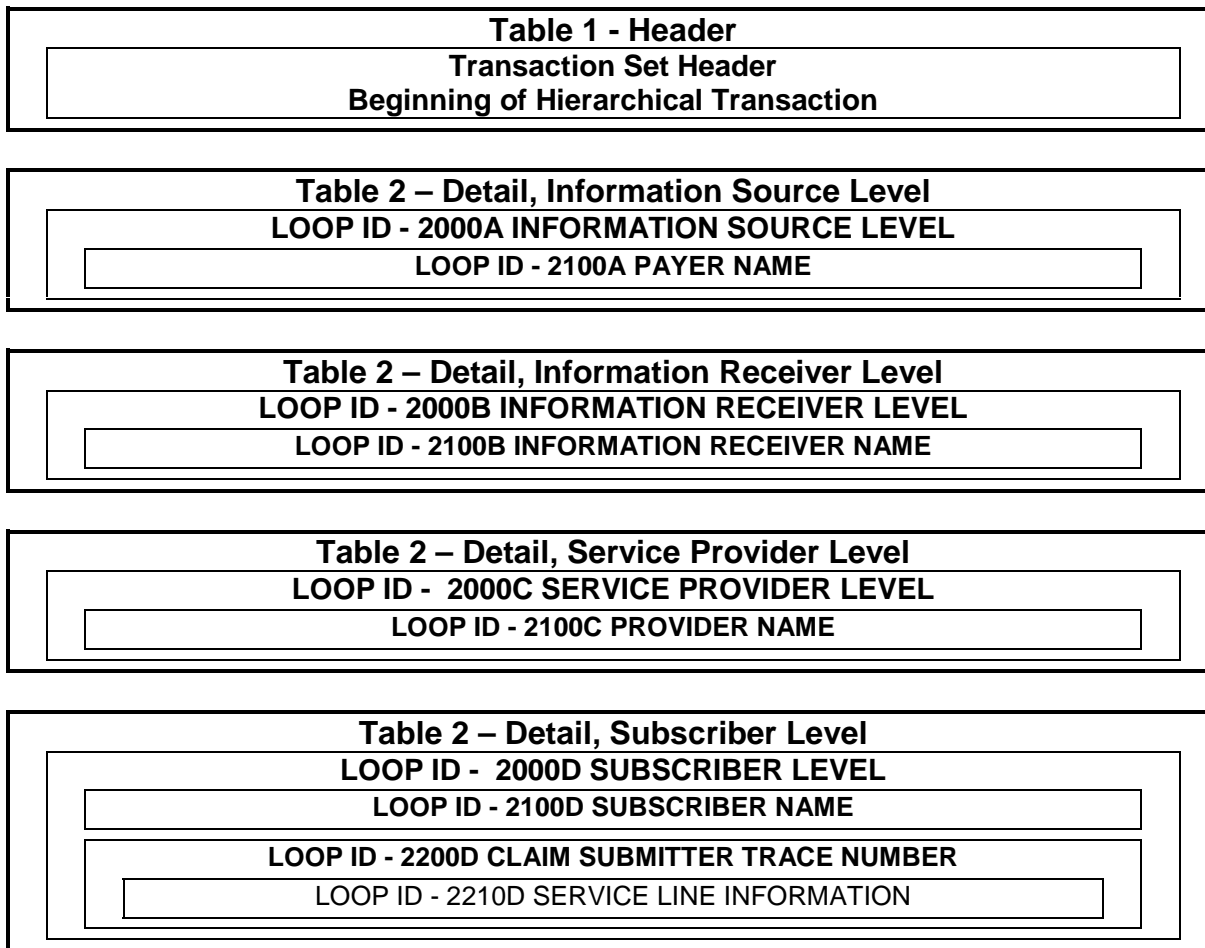
Although Loop 2200 contains segments in the 276 that are different from the 277 Health Care Claim Status Response, the intent of the loop is similar in both transactions. The specific claim identification parameters are found in Loop 2200. Because the provider and payer identify the claim using different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

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 2210 and in the 277 Health Care Claim Status Response Loop 2220.

Note that specific claim detail information is not given a hierarchical level. The specific claim(s) in question are described in Loop 2200 and the service information follows in Loop 2220. This claim(s) information is said to "float" and 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.

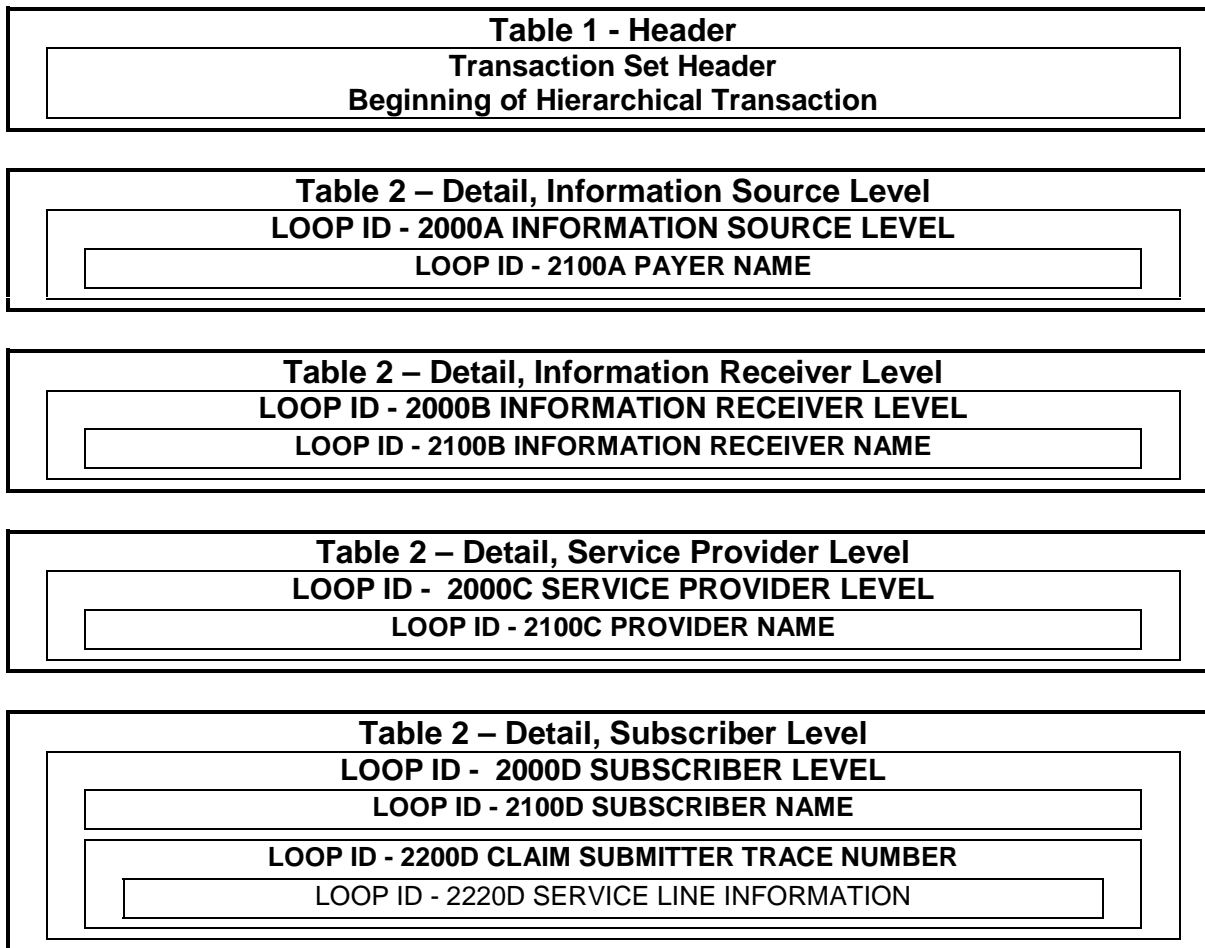
Figure 3a. Loop Hierarchy for the Health Care Claim Status Request (276)

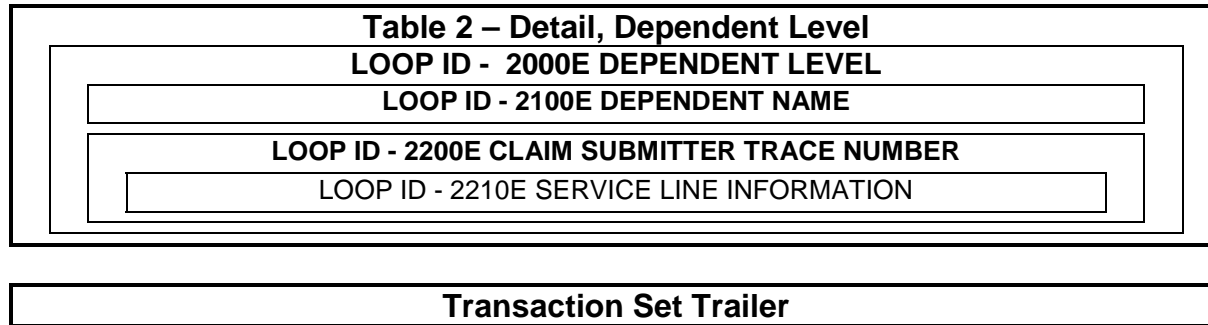


<p align="center">Table 2 – Detail, Dependent Level</p> <p align="center">LOOP ID - 2000E DEPENDENT LEVEL</p> <p align="center">LOOP ID - 2100E DEPENDENT NAME</p> <p align="center">LOOP ID - 2200E CLAIM SUBMITTER TRACE NUMBER</p> <p align="center">LOOP ID - 2210E SERVICE LINE INFORMATION</p>

Transaction Set Trailer

Figure 3b. Loop Hierarchy for the Health Care Claim Status Response (277) transaction set





The Data Element Tables in Section III show the the loops within the levels, the segments within the loops, and the data elements within the segments.

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
-	TRANSACTION SET HEADER (ST)		To indicate the start of a transaction set and to assign a control number	REQUIRED
		Transaction Set Identifier Code	Code uniquely identifying a Transaction Set. 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).	REQUIRED ST01 143 M ID 3/3
		276 Health Care Claim Status Request 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.	REQUIRED ST02 329 M AN 4/9
	BEGINNING OF HIERARCHICAL TRANSACTION (BHT)		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	REQUIRED
		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	REQUIRED BHT01 1005 M ID 4/4
		0010 Information Source, Information Receiver, Provider of Service, Subscriber, Transaction Set Purpose Code	Code identifying purpose of transaction set.	REQUIRED BHT02 353 M ID 2/2
13 Request Date		Date expressed as CCYYMMDD. BHT04 is the date the transaction was created within the business application system.	REQUIRED BHT04 373 O DT 8/8	
2000A- INFORMATION SOURCE LEVEL	INFORMATION SOURCE LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
	20 Information Source			

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Hierarchical Child Code 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
2100A- PAYER NAME	PAYER NAME (NM1)		To supply the full name of an individual or organizational entity. Payers with multiple locations or multiple lines of business may require that the payer name be completed.	REQUIRED
		Entity Identifier Code PR Payer	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name. This data element will be required until the National Payer Identifier is active.	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier 21 Health Industry Number (HIN) 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	Code designating the system/method of code structure used for Identification Code (67). 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 CODE SOURCE 121: Health Identification Number 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 NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code. For Medicare use, this is the carrier/fiscal intermediary-assigned code.	REQUIRED NM109 67 X AN 2/80

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	PAYER CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. If either PER03 or PER04 is present, then the other is required. If either PER05 or PER06 is present, then the other is required. If either PER07 or PER08 is present, then the other is required. 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. By definition of standard, if PER03 is used, PER04 is required. Required only if needed for identification of contact at the payer site when known prior to transmission of the 276 claim status request.	SITUATIONAL
		Contact Function Code	Code identifying the major duty or responsibility of the person or group named	REQUIRED PER01 366 M ID 2/2
		IC Information Contact Name	Free-form name. This element is required when a specific person or department is the contact for the response in order to clarify requests concerning additional 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).	SITUATIONAL PER02 93 O AN 1/60
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail TE Telephone	Code identifying the type of communication number. Required when PER04 is used.	REQUIRED PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. 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.	REQUIRED PER04 364 X AN 1/80
		Communication Number Qualifier EX Telephone Extension	Code identifying the type of communication number. Required when PER06 is used.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Use PER06 to supply telephone extensions only. International Codes, Area Codes (within U.S.), Exchanges, and telephone numbers should be placed	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier	Code identifying the type of communication number. Required when PER08 is used.	SITUATIONAL PER07 365 X ID 2/2

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		EX Telephone Extension FX Facsimile Communication Number	Complete communications number including country or area code when applicable. Required when necessary to provide another telephone extension or fax number.	SITUATIONAL PER08 364 X AN 1/80
2000B - INFORMATION RECEIVER LEVEL (HL)	INFORMATION RECEIVER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. This entity expects response from the information source.	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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	REQUIRED HL03 735 M ID 1/2
		21 Information Receiver Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
	1 Additional Subordinate HL Data Segment in This Hierarchical Structure.			
2100B - INFORMATION RECEIVER NAME (NM1)	INFORMATION RECEIVER NAME (NM1)		To supply the full name of an individual or organizational entity. If either NM108 or NM109 is present, then the other is required. If NM111 is present, then NM110 is required. This is the individual or organization requesting to receive the	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		41 Submitter Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
	1 Person			

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67).	REQUIRED NM108 66 X ID 1/2
		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.	
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
2000C - SERVICE PROVIDER LEVEL (HL)	SERVICE PROVIDER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
		19 Provider of Service Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		1 Additional Subordinate HL Data Segment in This Hierarchical Structure.		
2100C - PROVIDER NAME	PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. This is the billing provider from the original submitted claim.	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		1P Provider		
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		1 Person 2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name. 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 NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name. 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 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	REQUIRED NM108 66 X ID 1/2
		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.	
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
2000D - SUBSCRIBER LEVEL	SUBSCRIBER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. If the subscriber and the patient are the same person, do not use the next HL (HL23) for the claim information.	REQUIRED

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
		22 Subscriber Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. 0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	REQUIRED HL04 736 O ID 1/1
	SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level. If either DMG01 or DMG02 is present, then the other is required. Required when the subscriber is the patient. Not used when the subscriber is not the patient.	SITUATIONAL
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	REQUIRED DMG01 1250 X ID 2/3
		D8 Date Expressed in Format CCYYMMDD Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. DMG02 is the date of birth.	REQUIRED DMG02 1251 X AN 1/35
		Gender Code	Code indicating the sex of the individual	REQUIRED DMG03 1068 O ID 1/1
		F Female		

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		M Male U Unknown		
2100D - SUBSCRIBER NAME	SUBSCRIBER NAME (NM1)		To supply the full name of an individual or organizational entity.	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual IL Insured or Subscriber QC Patient Use this code only when the subscriber is the patient.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103. 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 NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name. 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 NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name. 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 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67) 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 NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
2200D - CLAIM SUBMITTER TRACE NUMBER	CLAIM SUBMITTER TRACE NUMBER (TRN)		To uniquely identify a transaction to an application. Use of this segment is required if the subscriber is the patient. 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. The TRN segment is required by the ASC X12 syntax when Loop ID- 2200 is used.	REQUIRED
		Trace Type Code 1 Current Transaction Trace Numbers	Code identifying which transaction is being referenced	REQUIRED TRN01 481 M ID 1/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. TRN02 provides unique identification for the transaction.	REQUIRED TRN02 127 M AN 1/30
	PAYER CLAIM IDENTIFICATION NUMBER (REF)		To specify identifying information. Use this only if the subscriber is the patient. 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.	SITUATIONAL
		Reference Identification Qualifier 1K Payor's Claim Number	Code qualifying the Reference Identification. Examples of this element include ICN, DCN, CCN. Submit this element if the payer supplied it previously. This data element corresponds to the value given in the ANSI ASC X12N 837 transaction in CLM01.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	REQUIRED REF02 127 X AN 1/30
	INSTITUTIONAL BILL TYPE IDENTIFICATION (REF)		To specify identifying information. 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. 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.	SITUATIONAL
		Reference Identification Qualifier BLT Billing Type	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 - record 40 - 4. Found on 837 CLM-05. Found on UB92 paper form locator	REQUIRED REF02 127 X AN 1/30
	MEDICAL RECORD IDENTIFICATION (REF)		To specify identifying information. This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim. Use this only if the subscriber is the patient.	SITUATIONAL
		Reference Identification Qualifier EA Medical Record Identification Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3

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III. Data Elements Table for Health Care Claim Status Request (276)				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 record 20 field 25. Found on 837 CLM-05. Found on UB92 paper form locator	REQUIRED REF02 127 X AN 1/30
	CLAIM SUBMITTED CHARGES (AMT)		To indicate the total monetary amount. Required when the subscriber is the patient. 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.	SITUATIONAL
		Amount Qualifier Code T3 Total Submitted Charges	Code to qualify 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	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount	REQUIRED AMT02 782 M R 1/18
	CLAIM SERVICE DATE (DTP)		To specify any or all of a date, a time, or a time period. Required for institutional claims. The date is the statement from and through date. 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.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time. Use this element for the dates of service submitted on the original claim. This includes the claim statement period end.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format. 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.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
2210D-SERVICE LINE INFORMATION	SERVICE LINE INFORMATION (SVC)		To supply payment and control information to a provider for a particular service. Use this segment to request status information about a service line. 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). 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	SITUATIONAL

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		COMPOSITE MEDICAL PROCEDURE IDENTIFIER	To identify a medical procedure by its standardized codes and applicable modifiers	REQUIRED SVC01 C003 M
		Product/Service ID Qualifier AD American Dental Association Codes CI Common Language Equipment Identifier (CLEI) HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format N3 National Drug Code in 5-4-1 Format N4 National Drug Code in 5-4-2 Format ND National Drug Code (NDC) NH National Health Related Item Code NU National Uniform Billing Committee (NUBC) UB92 Codes RB National Uniform Billing Committee (NUBC) UB82 Codes	Code identifying the type/source of the descriptive number used in Product/Service ID (234). 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. 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 CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 134: National Drug Code This code is the NUBC Revenue Code. CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	REQUIRED SVC01 - 1 235 M ID 2/2
		Product/Service ID	Identifying number for a product or service. 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.	REQUIRED SVC01 - 2 234 ID M AN 1/48
		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.	SITUATIONAL SVC01 - 3 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 4 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 5 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 6 1339 O AN 2/2
		Monetary Amount	Monetary amount. SVC02 is the submitted service charge. This amount is the original submitted charge.	REQUIRED SVC02 782 M R 1/18

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Product/Service ID	Identifying number for a product or service. SVC 04 is the National Uniform Billing Committee Revenue Code. This is the NUBC Revenue Code. When SVC-01 equals "NU", then the NUBC Revenue Code belongs in SVC01-2.	SITUATIONAL SVC04 234 O AN 1/48
		Quantity	Numeric value of quantity. 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.	SITUATIONAL SVC07 380 O R 1/15
	SERVICE LINE ITEM IDENTIFICATION (REF)		To specify identifying information. Use this segment if the subscriber is the patient. 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. 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.	SITUATIONAL
		Reference Identification Qualifier FJ Line Item Control Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. May or may not help the payer in the	REQUIRED REF02 127 X AN 1/30
	SERVICE LINE DATE (DTP)		To specify any or all of a date, a time, or a time period. When the 2210D loop is used this segment must be present.	REQUIRED
		Date/Time Qualifier 472 Service	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
2000E-DEPENDENT LEVEL	DEPENDENT LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. 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. Required when	SITUATIONAL
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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	REQUIRED HL01 628 M AN 1/12

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code 23 Dependent	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
	DEPENDENT DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) Level. If either DMG01 or DMG02 is present, then the other is required.	REQUIRED
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times DMG02 is the date of birth.	REQUIRED DMG02 1251 X AN 1/35
		Gender Code F Female M Male U Unknown	Code indicating the sex of the individual	REQUIRED DMG03 1068 O ID 1/1
2100E-DEPENDENT NAME		DEPENDENT NAME (NM1)		To supply the full name of an individual or organizational entity. If either NM108 or NM109 is present, then the other is required. If NM111 is present, then NM110 is required.
	Entity Identifier Code QC Patient		Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
	Entity Type Qualifier 1 Person		Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
	Name Last or Organization Name		Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
	Name First		Individual first name. Required if additional name information is needed to identify the patient.	SITUATIONAL NM104 1036 O AN 1/25
	Name Middle		Individual middle name or initial. Required if additional name information is needed to identify the patient.	SITUATIONAL NM105 1037 O AN 1/25
	Name Prefix		Prefix to individual name. Required if additional name information is needed to identify the patient.	SITUATIONAL NM106 1038 O AN 1/10
	Name Suffix		Suffix to individual name. Required if additional name information is needed to identify the patient.	SITUATIONAL NM107 1039 O AN 1/10
	Identification Code Qualifier MI Member Identification Number		Code designating the system/method of code structure used for Identification Code (67) Required if NM109 is used.	SITUATIONAL NM108 66 X ID 1/2

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 <u>standard individual identifier for use in this transaction.</u>	
		Identification Code	Code identifying a party or other code. 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).	SITUATIONAL NM109 67 X AN 2/80
2200E-CLAIM SUBMITTER TRACE NUMBER	CLAIM SUBMITTER TRACE NUMBER (TRN)		To uniquely identify a transaction to an application. Use of this segment is required if the patient is someone other than the subscriber. 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. The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.	REQUIRED
		Trace Type Code 1 Current Transaction Trace Numbers	Code identifying which transaction is being referenced	REQUIRED TRN01 481 M ID 1/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier TRN02 provides unique identification for the transaction.	REQUIRED TRN02 127 M AN 1/30
	PAYER CLAIM IDENTIFICATION NUMBER (REF)		To specify identifying information. Use this only if the subscriber is the patient. 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.	SITUATIONAL
		Reference Identification Qualifier 1K Payor's Claim Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	REQUIRED REF02 127 X AN 1/30
	INSTITUTIONAL BILL TYPE IDENTIFICATION (REF)		To specify identifying information. This segment is the institutional type of bill as submitted on the original claim, and the payer may use it as a lookup key. 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.	SITUATIONAL
		Reference Identification Qualifier BLT Billing Type	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 - record 40 - 4. Found on 837 CLM-05. Found on UB92 paper form locator	REQUIRED REF02 127 X AN 1/30

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	MEDICAL RECORD IDENTIFICATION (REF)		To specify identifying information. This is the Medical Record number submitted on the original claim and should be sent when available from the submitted claim. Use this segment if the patient is someone other than the subscriber.	SITUATIONAL
		Reference Identification Qualifier EA Medical Record Identification Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 record 20 field 25. Found on 837 CLM-05. Found on UB92 paper form locator	REQUIRED REF02 127 X AN 1/30
	CLAIM SUBMITTED CHARGES (AMT)		To indicate the total monetary amount. Use this segment if the service line SVC segment, loop 2210E is not used. 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.	SITUATIONAL
		Amount Qualifier Code T3 Total Submitted Charges	Code to qualify amount	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary 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 - XAO Record field 12. Found on HCFA 1500 - Block 28.	REQUIRED AMT02 782 M R 1/18
	CLAIM SERVICE DATE (DTP)		To specify any or all of a date, a time, or a time period. Required for institutional claims. The date is the statement from and through date. 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. For additional information on the date range use, refer to Section 2.2.3.9 in the front section of this guide.	SITUATIONAL
		Date/Time Qualifier 232 Claim Statement Period Start	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Code indicating the date format, time format, or date and time format. 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.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
2210E-SERVICE LINE INFORMATION	SERVICE LINE INFORMATION (SVC)		To supply payment and control information to a provider for a particular service. Use this segment to request status information about a service line. 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). 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	SITUATIONAL

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		COMPOSITE MEDICAL PROCEDURE IDENTIFIER	To identify a medical procedure by its standardized codes and applicable modifiers. SVC01 will contain the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted	REQUIRED SVC01 C003 M
		Product/Service ID Qualifier AD American Dental Association Codes CI Common Language Equipment Identifier (CLEI) HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format N3 National Drug Code in 5-4-1 Format N4 National Drug Code in 5-4-2 Format ND National Drug Code (NDC) NH National Health Related Item Code NU National Uniform Billing Committee (NUBC) UB92 Codes RB National Uniform Billing Committee (NUBC) UB82 Codes	Code identifying the type/source of the descriptive number used in Product/Service ID (234) CODE SOURCE 135: American Dental Association 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 CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 134: National Drug Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	REQUIRED SVC01 - 1 235 M ID 2/2
		Product/Service ID	Identifying number for a product or service. If the value in SVC01 is "NU", then this is an NUBC Revenue Code. If a value is present here, then SVC04 is not used.	REQUIRED SVC01 - 2 234 M AN 1/48
		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.	SITUATIONAL SVC01 - 3 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 4 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 5 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 6 1339 O AN 2/2
		Monetary Amount	Monetary amount. SVC02 is the submitted service charge. This amount is the original submitted charge.	REQUIRED SVC02 782 M R 1/18

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III. Data Elements Table for Health Care Claim Status Request (276)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Product/Service ID	Identifying number for a product or service. 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.	SITUATIONAL SVC04 234 O AN 1/48
		Quantity	Numeric value of quantity. 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.	SITUATIONAL SVC07 380 O R 1/15
	SERVICE LINE ITEM IDENTIFICATION (REF)		To specify identifying information. 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.	SITUATIONAL
		Reference Identification Qualifier FJ Line Item Control Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference	REQUIRED REF02 127 X AN 1/30
	SERVICE LINE DATE (DTP)		To specify any or all of a date, a time, or a time period. When the 2210E loop is used this segment must be present. For institutional claims, this is the statement period. Will be required if SVC segment is used.	SITUATIONAL
		Date/Time Qualifier 472 Service	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Code indicating the date format, time format, or date and time format. 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.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
	TRANSACTION SET TRAILER (SE)		To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)	REQUIRED
		Number of Included Segments	Total number of segments included in a transaction set including ST and SE segments	REQUIRED SE01 96 M N0 1/10
		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.	REQUIRED SE02 329 M AN 4/9

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES	
	TRANSACTION SET HEADER (ST)		To indicate the start of a transaction set and to assign a control number	REQUIRED	
		Transaction Set Identifier Code	Code uniquely identifying a Transaction Set. 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)	REQUIRED ST01 143 M ID 3/3	
		277 Health Care Claim Status Notification 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	REQUIRED ST02 329 M AN 4/9	
	BEGINNING OF HIERARCHICAL TRANSACTION (BHT)			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	REQUIRED
		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	REQUIRED BHT01 1005 M ID 4/4	
		0010 Information Source, Information Receiver, Provider of Service, Subscriber, Transaction Set Purpose Code	Code identifying purpose of transaction set	REQUIRED BHT02 353 M ID 2/2	
		08 Status Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. BHT03 is the number assigned by the originator to identify the transaction within the originator's	REQUIRED BHT03 127 O AN 1/30	
		Date	Date expressed as CCYYMMDD. BHT04 is the date the transaction was created within the business application	REQUIRED BHT04 373 O DT 8/8	
		Transaction Type Code DG Response	Code specifying the type of transaction	REQUIRED BHT06 640 O ID 2/2	
	2000A-INFORMATION SOURCE LEVEL	INFORMATION SOURCE LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments	REQUIRED
Hierarchical ID Number			A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12	
Hierarchical Level Code			Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2	
		20 Information Source			

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Hierarchical Child Code 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
2100A-PAYER NAME	PAYER NAME (NM1)		To supply the full name of an individual or organizational entity. Payers with multiple locations or lines of business	REQUIRED
		Entity Identifier Code PR Payer	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier 21 Health Number (HIN) 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	Code designating the system/method of code structure used for Identification Code (67). 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 CODE SOURCE 121: Health Identification Number 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	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	PAYER CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. 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. By definition of the standard, if PER03 is used, PER04 is required. Required only if needed for identification of contact at the payer site. If either PER03 or PER04 is present, then the other is required. If either PER05 or PER06 is present, then the other is required. If either	SITUATIONAL
		Contact Function Code	Code identifying the major duty or responsibility of the person or group named	REQUIRED PER01 366 M ID 2/2
		IC Information Contact Name	Free-form name. This element is required when a specific person or department is the contact for the response in order to clarify requests concerning additional 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).	SITUATIONAL PER02 93 O AN 1/60
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail TE Telephone	Code identifying the type of communication number. Required when PER04 is used.	REQUIRED PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. 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.	REQUIRED PER04 364 X AN 1/80
		Communication Number Qualifier EX Telephone Extension	Code identifying the type of communication number. Required when PER06 is used.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Use PER06 to supply telephone extensions only. International Codes, Area Codes (within U.S.), Exchanges, and telephone numbers should be placed	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier EX Telephone Extension FX Facsimile	Code identifying the type of communication number. Required when PER08 is used.	SITUATIONAL PER07 365 X ID 2/2

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Communication Number	Complete communications number including country or area code when applicable. Required when necessary to provide another telephone extension or fax number.	SITUATIONAL PER08 364 X AN 1/80
2000B-INFORMATION RECEIVER LEVEL	INFORMATION RECEIVER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
		21 Information Receiver Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
		1 Additional Subordinate HL Data Segment in This Hierarchical Structure.		
2100B-INFORMATION RECEIVER NAME	INFORMATION RECEIVER NAME (NM1)		To supply the full name of an individual or organizational entity. This is the individual or organization requesting to receive the status information. If either NM108 or NM109 is present, then the other is required. If NM111 is present, then	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		41 Submitter Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		1 Person 2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Middle	Individual middle name or initial. The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name. Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a	SITUATIONAL NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name. Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 46 Electronic Transmitter Identification Number (ETIN) FI Federal Taxpayer's Identification Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67) Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code.	REQUIRED NM109 67 X AN 2/80
2000C-SERVICE PROVIDER LEVEL	SERVICE PROVIDER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
		19 Provider of Service	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
	1 Additional Subordinate HL Data Segment in This Hierarchical Structure.			

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
2100C-PROVIDER NAME	PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. If either NM108 or NM109 is present, then the other is required. If NM111 is present, then NM110 is required.	REQUIRED
		Entity Identifier Code 1P Provider	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name. Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a	SITUATIONAL NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name. Required if additional name information is needed to identify the provider of service. Recommended if the value in the entity type qualifier is a	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier FI Federal Taxpayer's Identification Number SV Service Provider Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67) 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. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	REQUIRED NM108 66 X ID 1/2

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
2000D-SUBSCRIBER LEVEL	SUBSCRIBER LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. If the subscriber and the patient are the same person, do not use the next HL (HL23) for claim information.	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2
		Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. 0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	REQUIRED HL04 736 O ID 1/1

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information. The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level. If either DMG01 or DMG02 is present, then the other is required.	REQUIRED
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.. DMG02 is the date of birth.	REQUIRED DMG02 1251 X AN 1/35
		Gender Code F Female M Male U Unknown	Code indicating the sex of the individual	REQUIRED DMG03 1068 O ID 1/1
2100D-SUBSCRIBER NAME	SUBSCRIBER NAME (NM1)		To supply the full name of an individual or organizational entity. If either NM108 or NM109 is present, then the other is required. If NM111 is present, then NM110 is required.	REQUIRED
		Entity Identifier Code IL Insured or Subscriber QC Patient	Code identifying an organizational entity, a physical location, property or an individual Use this only when the subscriber is the patient.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103. 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 NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. The first name is required when the value in NM102 is '1' and the person has a first name.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. The middle name or initial is required when the value in NM102 is '1' and the person has a middle name or initial. Under most circumstances, this element is expected to be sent.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name. Required if additional name information is needed to identify the subscriber. Recommended if the value in the entity type qualifier is a person.	SITUATIONAL NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name. 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 O AN 1/10
		Identification Code Qualifier 24 Employer's Identification Number	Code designating the system/method of code structure used for Identification Code (67)	REQUIRED NM108 66 X ID 1/2

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 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 3O Children's Rehabilitation 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 3V AIDS/ARC Unit 3W Specialized Outpatient Program for 3X Alcohol/Drug Abuse or Dependency Inpatient Unit		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 Catheterization 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 Facility 4L Genetic Counseling/Screening Services 4M Adult Day Care Program Facility 4N Alzheimer's Diagnostic/Assessment 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 5B Histopathology 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 5Q Megavoltage Radiation Therapy Unit 5R Radioactive Implants Unit		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		5S Therapeutic Radioisotope Facility 5T X-Ray Radiation Therapy Unit 5U CT Scanner Unit 5V Diagnostic Radioisotope Facility 5W Magnetic Resonance Imaging (MRI) 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 6C Single Photon Emission Computerized Tomography (SPECT) Unit 6D Organized Social Work Service Facility 6E Outpatient Social Work Services 6F Emergency Department Social Work 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 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		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 TQ Third Party Reviewing Organization 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	Used to identify the geographic location where a patient is transferred or diverted.	
		Date	Date expressed as CCYYMMDD. STC02 is the effective date of the status information. Use this date for the effective date of status.	REQUIRED STC02 373 O DT 8/8
		Monetary Amount	Monetary amount. 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.	REQUIRED STC04 782 O R 1/18
		Monetary Amount	Monetary amount. 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 "	REQUIRED STC05 782 O R 1/18
		Date	Date expressed as CCYYMMDD. STC06 is the paid date. Use this element for the date of denial or payment. Use this date if the payment determination is complete.	SITUATIONAL STC06 373 O DT 8/8

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Payment Method Code ACH Automated Clearing House (ACH) BOP Financial Institution Option CHK Check FWT Federal Reserve Funds/Wire Transfer – Non-repetitive NON Non-Payment Data	Code identifying the method for the movement of payment instructions. Will be used when claim has a dollar payment to the provider of service. 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. Use this code to indicate that the third party processor will choose the method of payment based on end point requests or capabilities. Use this code to indicate that a check was issued for payment. Use this code to indicate that the funds were sent through the wire system. Use this code to indicate that this is information only and no dollars are to be moved.	SITUATIONAL STC07 591 O ID 3/3
		Date	Date expressed as CCYYMMDD. 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 STC08 373 O DT 8/8
		Check Number	Check identification 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 STC09 429 O AN 1/16
		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.	SITUATIONAL STC10 C043 O
		Industry Code	Code indicating a code from a specific industry code list. This is the Category code. Use code source 507. Required if STC10 is used.	REQUIRED STC10 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific industry code list. This is the Status code. Use code source 508. Required if STC10 is used.	REQUIRED STC10 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. STC10-3 further modifies the status code in STC10-2. See code value list in STC01-3.	SITUATIONAL STC10 - 3 98 O ID 2/3
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line. Use this element if a third claim status is needed.	SITUATIONAL STC11 C043 O

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Industry Code	Code indicating a code from a specific industry code list. This is the Category code. Use code source 507. Required if STC11 is used.	REQUIRED STC11 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific industry code list. This is the Status code. Use code source 508. Required if STC11 is used.	REQUIRED STC11 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.	SITUATIONAL STC11 - 3 98 O ID 2/3
	PAYER CLAIM IDENTIFICATION NUMBER (REF)		To specify identifying information. Use this only if the subscriber is the patient. 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.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification. Examples of this include: ICN, DCN and CCN. This data element corresponds to the value given in the ANSI ASC X12 837 transaction in CLM01.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	REQUIRED REF02 127 X AN 1/30
	INSTITUTIONAL BILL TYPE IDENTIFICATION (REF)		To specify identifying information. This is the institutional type of bill from the original submitted claim, and it is returned when it is available. Use when subscriber is the patient. At least one of REF02 or REF03 is required.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification BLT Billing Type	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 - record 40 - 4. Found on 837 CLM-05. Found on UB92 paper form locator 4. Required on institutional claim inquiries.	REQUIRED REF02 127 X AN 1/30
	MEDICAL RECORD IDENTIFICATION (REF)		To specify identifying information. This is the Medical Record number submitted on the original claim and should be returned when available from the submitted claim. . Use this only when the subscriber is the patient.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification EA Medical Record Identification Number	REQUIRED REF01 128 M ID 2/3

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Found on UB92 record 20 field 25. Found on 837 REF-02. Found on UB92 paper form locator 23.	REQUIRED REF02 127 X AN 1/30
	CLAIM SERVICE DATE (DTP)		To specify any or all of a date, a time, or a time period. Use this segment for the institutional claim statement period. Use this segment if the subscriber is the patient. 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.	SITUATIONAL
		Date/Time Qualifier 232 Claim Statement Period Start	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03. If there is a single date of service, the begin date equals the end date.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
2220D-SERVICE LINE INFORMATION	SERVICE LINE INFORMATION (SVC)		To supply payment and control information to a provider for a particular service. Use this segment to report information about a service line. 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. 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).	SITUATIONAL
		COMPOSITE MEDICAL PROCEDURE IDENTIFIER	To identify a medical procedure by its standardized codes and applicable modifiers. 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 C003 M
		Product/Service ID Qualifier AD American Dental Association Codes CI Common Language Equipment Identifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234) CODE SOURCE 135: American Dental Association Codes	REQUIRED SVC01 - 1 235 M ID 2/2

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) -Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format N3 National Drug Code in 5-4-1 Format N4 National Drug Code in 5-4-2 Format ND National Drug Code (NDC) NH National Health Related Item Code NU National Uniform Billing Committee RB National Uniform Billing Committee	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 CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format CODE SOURCE 134: National Drug Code CODE SOURCE 132: National Uniform Billing Committee CODE SOURCE 132: National Uniform Billing Committee	
		Product/Service ID	Identifying number for a product or service. 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.	REQUIRED SVC01 - 2 234 M AN 1/48
		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.	SITUATIONAL SVC01 - 3 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 4 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 5 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 6 1339 O AN 2/2
		Monetary Amount	Monetary amount. SVC02 is the submitted service charge. This amount is the original submitted charge.	REQUIRED SVC02 782 M R 1/18
		Monetary Amount	Monetary amount. 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	REQUIRED SVC03 782 O R 1/18

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Product/Service ID	Identifying number for a product or service. SVC04 is the National Uniform Billing Committee Revenue Code. This is the NUBC Revenue Code. When SV01-1 equals "NU" the NUBC Revenue Code belongs in SVC01-2.	SITUATIONAL SVC04 234 O AN 1/48
		Quantity	Numeric value of quantity. 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. This element is required when the submitted units are	SITUATIONAL SVC07 380 O R 1/15
	SERVICE LINE STATUS INFORMATION (STC)		To report the status, required action, and paid information of a claim or service line. Use this segment if the subscriber is the patient. This segment is used when an information source system has the capability to provide line item information.	SITUATIONAL
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	REQUIRED STC01 C043 M
		Industry Code	Code indicating a code from a specific industry code list. This is the Category code. Use code source 507.	REQUIRED STC01 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific industry code list. This is the Status code. Use code source 508.	REQUIRED STC01 - 2 1271 M AN 1/30
		Entity Identifier Code 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	Code identifying an organizational entity, a physical location, property or an individual. STC01-3 further modifies the value in STC01-2.	SITUATIONAL STC01 - 3 98 O ID 2/3

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		2K Partnership 2P Public Health Service Facility 2Q Veterans Administration Facility 2S Public Health Service Indian Service 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 3O Children's Rehabilitation 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 Catheterization Laboratory 4D Open-Heart Surgery Facility		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 5B Histopathology 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 5Q Megavoltage Radiation Therapy Unit 5R Radioactive Implants Unit 5S Therapeutic Radioisotope Facility 5T X-Ray Radiation Therapy Unit 5U CT Scanner Unit 5V Diagnostic Radioisotope Facility 5W Magnetic Resonance Imaging (MRI) 5X Ultrasound Unit 5Y Rehabilitation Inpatient Unit 5Z Rehabilitation Outpatient Services		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 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		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 TQ Third Party Reviewing Organization 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	Used to identify the geographic location where a patient is transferred or diverted.	
		Date	Date expressed as CCYYMMDD STC02 is the effective date of the status information.	REQUIRED STC02 373 O DT 8/8
		Monetary Amount	Monetary amount STC04 is the amount of original submitted charges.	SITUATIONAL STC04 782 O R 1/18
		Monetary Amount	Monetary amount STC05 is the amount paid.	SITUATIONAL STC05 782 O R 1/18
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	SITUATIONAL STC10 C043 O
		Code	Code indicating a code from a specific code list Required if STC10 is used.	REQUIRED STC10 - 1 1271 M AN 1/30
		Code	Code indicating a code from a specific code list Required if STC10 is used.	REQUIRED STC10 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	SITUATIONAL STC10 - 3 98 O ID 2/3
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	SITUATIONAL STC11 C043 O
		Code	Code indicating a code from a specific code list Required if STC11 is used.	REQUIRED STC11 - 1 1271 M AN 1/30
		Code	Code indicating a code from a specific code list Required if STC11 is used.	REQUIRED STC11 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	SITUATIONAL STC11 - 3 98 O ID 2/3

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES	
	SERVICE LINE ITEM IDENTIFICATION (REF)		To specify identifying information. 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.	SITUATIONAL	
		Reference Identification Qualifier FJ Line Item Control Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3	
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference	REQUIRED REF02 127 X AN 1/30	
	SERVICE LINE DATE (DTP)			To specify any or all of a date, a time, or a time period. This is the date of service from the original submitted claim for a specific line item. Whenever the 2220D loop is used this segment must be present, unless reported in the claim level, Loop 2200D (Claim Service Dates).	SITUATIONAL
		Date/Time Qualifier 472 Service		Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date/Time Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		Code specifying type of date or time, or both date and time DTP02 is the date or time or period format that will appear in DTP03. If there is a single date of service, the begin date equals the end date.	REQUIRED DTP01 374 M ID 3/3
Date/Time Qualifier			Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3	
2000E — DEPENDENT LEVEL	DEPENDENT LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. 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. Required when	SITUATIONAL	
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. 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	REQUIRED HL01 628 M AN 1/12	
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12	
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. 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.	REQUIRED HL03 735 M ID 1/2	
		23 Dependent			

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DEPENDENT DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information	REQUIRED
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times DMG02 is the date of birth.	REQUIRED DMG02 1251 X AN 1/35
		Gender Code F Female M Male U Unknown	Code indicating the sex of the individual	REQUIRED DMG03 1068 O ID 1/1
2100E — DEPENDENT NAME	DEPENDENT NAME (NM1)		To supply the full name of an individual or organizational entity	REQUIRED
		Entity Identifier Code <u>QC Patient</u>	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person	Code qualifying the type of entity	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name Required if additional name information is needed to identify the patient.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial Required if additional name information is needed to identify the patient.	SITUATIONAL NM105 1037 O AN 1/25
		Name Prefix	Prefix to individual name Required if additional name information is needed to identify the patient.	SITUATIONAL NM106 1038 O AN 1/10
		Name Suffix	Suffix to individual name Required if additional name information is needed to identify the patient.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier MI Member Identification Number ZZ Mutually Defined	Code designating the system/method of code structure used for Identification Code (67) The value 'ZZ' when used in this data element shall be	SITUATIONAL NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code	SITUATIONAL NM109 67 X AN 2/80
2200E — CLAIM SUBMITTER TRACE NUMBER	CLAIM SUBMITTER TRACE NUMBER (TRN)		To uniquely identify a transaction to an application. Use of this segment is required if the patient is someone other than the subscriber. 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. The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.	SITUATIONAL
		Trace Type Code 2 Referenced Transaction Trace Numbers	Code identifying which transaction is being referenced	REQUIRED TRN01 481 M ID 1/2
		Reference Identification	Reference information as defined for a particular	REQUIRED TRN02 127 M AN 1/30

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
			TRN02 provides unique identification for the transaction.	
	CLAIM LEVEL STATUS INFORMATION (STC)		To report the status, required action, and paid information of a claim or service line. Use this segment to request additional information about a claim or a service line. Use this if the patient is someone other than the subscriber.	SITUATIONAL
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	REQUIRED STC01 C043 M
		Code	Code indicating a code from a specific code list	REQUIRED STC01 - 1 1271 M AN 1/30
		Code	Code indicating a code from a specific code list	REQUIRED STC01 - 2 1271 M AN 1/30
		Entity Identifier Code 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	Code identifying an organizational entity, a physical location, property or an individual	SITUATIONAL STC01 - 3 98 O ID 2/3

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		2S Public Health Service Indian Service 2Z Hospital Unit of an Institution (prison) 30 Service Supplier 36 Employer 3A Hospital Unit Within an Institution for the 3C Tuberculosis and Other Respiratory 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 3N Children's Eye, Ear, Nose and Throat 3O Children's Rehabilitation 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 3V AIDS/ARC Unit 3W Specialized Outpatient Program for 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 Catheterization 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 4L Genetic Counseling/Screening Services 4M Adult Day Care Program Facility 4N Alzheimer's Diagnostic/Assessment 4O Comprehensive Geriatric Assessment		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 5B Histopathology 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 5Q Megavoltage Radiation Therapy Unit 5R Radioactive Implants Unit 5S Therapeutic Radioisotope Facility 5T X-Ray Radiation Therapy Unit 5U CT Scanner Unit 5V Diagnostic Radioisotope Facility 5W Magnetic Resonance Imaging (MRI) 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 6G Sports Medicine Clinic/Services 6H Hospital Auxiliary Unit 6I Patient Representative Services		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 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 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		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		GK Previous Insured GM Spouse Insured GY Treatment Facility HF Healthcare Professional Shortage Area 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 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 diverted. TQ Third Party Reviewing Organization TT Transfer To TU Third Party Repricing Organization (TPO) UH Nursing Home		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		X3 Utilization Management Organization X4 Spouse X5 Durable Medical Equipment Supplier ZZ Mutually Defined		
		Date	Date expressed as CCYYMMDD STC02 is the effective date of the status information.	REQUIRED STC02 373 O DT 8/8
		Monetary Amount	Monetary amount STC04 is the amount of original submitted charges.	REQUIRED STC04 782 O R 1/18
		Monetary Amount	Monetary amount STC05 is the amount paid.	REQUIRED STC05 782 O R 1/18
		Date	Date expressed as CCYYMMDD STC06 is the paid date.	SITUATIONAL STC06 373 O DT 8/8
		Payment Method Code ACH Automated Clearing House (ACH) BOP Financial Institution Option CHK Check FWT Federal Reserve Funds/Wire Transfer NON Non-Payment Data	Code identifying the method for the movement of payment 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. Use this code to indicate that the third party processor will Use this code to indicate that a check was issued for Use this code to indicate that the funds were sent through Use this code to indicate that this is information only and no	SITUATIONAL STC07 591 O ID 3/3
		Date	Date expressed as CCYYMMDD STC08 is the check issue date.	SITUATIONAL STC08 373 O DT 8/8
		Check Number	Check identification number Required with a Finalized and PAID claim when the entire	SITUATIONAL STC09 429 O AN 1/16
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific	SITUATIONAL STC10 C043 O
		Code	Code indicating a code from a specific code list Required if STC10 is used.	REQUIRED STC10 - 1 1271 M AN 1/30
		Code	Code indicating a code from a specific code list	REQUIRED STC10 - 2 1271 M AN 1/30

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
			Required if STC10 is used.	
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	SITUATIONAL STC10 - 3 98 O ID 2/3
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	SITUATIONAL STC11 C043 O
		Code	Code indicating a code from a specific code list Required if STC11 is used.	REQUIRED STC11 - 1 1271 M AN 1/30
		Code	Code indicating a code from a specific code list Required if STC11 is used.	REQUIRED STC11 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	SITUATIONAL STC11 - 3 98 O ID 2/3
	PAYER CLAIM IDENTIFICATION NUMBER (REF)		To specify identifying information. Use this only if the subscriber is the patient. This is the payer's assigned control number, also known as, Internal Control Number (ICN), Document Control Number (DCN), or Claim Control	SITUATIONAL
		Reference Identification Qualifier 1K Payor's Claim Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference	REQUIRED REF02 127 X AN 1/30
	INSTITUTIONAL BILL TYPE IDENTIFICATION (REF)		To specify identifying information. This is the institutional type of bill from the original submitted claim, and it is returned when it is available. This is used if the dependent	SITUATIONAL
		Reference Identification Qualifier BLT Billing Type	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Reference Identification	Reference information as defined for a particular Required institutional claim inquiries.	REQUIRED REF02 127 X AN 1/30
	MEDICAL RECORD IDENTIFICATION (REF)		To specify identifying information. This is the Medical Record number submitted on the original claim and should be returned when available from the submitted claim. Use this if the patient is someone other than the subscriber.	SITUATIONAL
		Reference Identification Qualifier EA Medical Record Identification Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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 FA	REQUIRED REF02 127 X AN 1/30
	CLAIM SERVICE DATE (DTP)		To specify any or all of a date, a time, or a time period. Use this segment for the institutional claim statement period. This is used if the dependent is the patient. 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.	SITUATIONAL
		Date/Time Qualifier 232 Claim Statement Period Start	Code specifying type of date or time, or both date and time. This data element also includes the Claim Statement Period End Date.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03. If there is a single date of service, the begin date equals the end date.	REQUIRED DTP02 1250 M ID 2/3

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
2210E — SERVICE LINE INFORMATION	SERVICE LINE INFORMATION (SVC)		To supply payment and control information to a provider for a particular service. Use this segment to report information about a service line. 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.	SITUATIONAL
		COMPOSITE MEDICAL PROCEDURE IDENTIFIER	To identify a medical procedure by its standardized codes and applicable modifiers. 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 C003 M
		Product/Service ID Qualifier AD American Dental Association Codes CI Common Language Equipment Identifier (CLEI) HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Mod (ICD-9-CM) - Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format	Code identifying the type/source of the descriptive number used in Product/Service ID (234) CODE SOURCE 135: American Dental Association Codes Because CPT codes or 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 CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List CODE SOURCE 240: National Drug Code by Format CODE SOURCE 240: National Drug Code by Format	REQUIRED SVC01 - 1 235 M ID 2/2

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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	
		Product/Service ID	Identifying number for a product or service. 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.	REQUIRED SVC01 - 2 234 M AN 1/48
		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.	SITUATIONAL SVC01 - 3 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 4 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 5 1339 O AN 2/2
		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.	SITUATIONAL SVC01 - 6 1339 O AN 2/2
		Monetary Amount	Monetary amount. SVC02 is the submitted service charge.	REQUIRED SVC02 782 M R 1/18
		Monetary Amount	Monetary amount. SVC03 is the amount paid this service. If the adjudication process is not complete, this is zero-filled.	REQUIRED SVC03 782 O R 1/18

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Product/Service ID	Identifying number for a product or service. SVC04 is the National Uniform Billing Committee Revenue Code. When SVC01-1 equals "NU" the NUBC Revenue Code belongs in SVC01-2.	SITUATIONAL SVC04 234 O AN 1/48
		Quantity	Numeric value of quantity. SVC07 is the original submitted units of service. This element is required when the submitted units are greater than 1.	SITUATIONAL SVC07 380 O R 1/15
	SERVICE LINE STATUS INFORMATION (STC)		To report the status, required action, and paid information of a claim or service line. This is for the service status information. This segment is used when an information source system has the capability to provide line item information.	SITUATIONAL
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line	REQUIRED STC01 C043 M
		Industry Code	Code indicating a code from a specific code list. This is the Category code. Use code source 507.	REQUIRED STC01 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific code list. This is the Status code. Use code source 508.	REQUIRED STC01 - 2 1271 M AN 1/30
		Entity Identifier Code 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	Code identifying an organizational entity, a physical location, property or an individual. STC01-3 further modifies the value in STC01-2.	SITUATIONAL STC01 - 3 98 O ID 2/3

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 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 3O Children's Rehabilitation 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 3V AIDS/ARC Unit		

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 Catheterization 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 5B Histopathology 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		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 5Q Megavoltage Radiation Therapy Unit 5R Radioactive Implants Unit 5S Therapeutic Radioisotope Facility 5T X-Ray Radiation Therapy Unit 5U CT Scanner Unit 5V Diagnostic Radioisotope Facility 5W Magnetic Resonance Imaging (MRI) 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 6W Emergency Medical Technician 6X Disciplinary Contact 6Y Case Manager 71 Attending Physician 72 Operating Physician		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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		

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		IMR 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 TQ Third Party Reviewing Organization 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	Used to identify the geographic location where a patient is transferred or diverted.	
		Date	Date expressed as CCYYMMDD. STC02 is the effective date of the status information.	REQUIRED STC02 373 O DT 8/8

HIPAA Master Data Set for Health Care Claim Status Request and Response Transactions (276/277) Decision Support 2000+

IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. STC04 is the amount of original submitted charges.	SITUATIONAL STC04 782 O R 1/18
		Monetary Amount	Monetary amount. STC05 is the amount paid. Use this element for the line item paid amount.	SITUATIONAL STC05 782 O R 1/18
		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	SITUATIONAL STC10 C043 O
		Industry Code	Code indicating a code from a specific code list. This is the Category code. Use code source 507. Required if STC10 is used.	REQUIRED STC10 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific code list. This is the Status code. Use code source 508. Required if STC10 is	REQUIRED STC10 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.	SITUATIONAL STC10 - 3 98 O ID 2/3
		HEALTH CARE CLAIM STATUS	Used to convey status of the entire claim or a specific service line. Use this element if a third claim status is	SITUATIONAL STC11 C043 O
		Industry Code	Code indicating a code from a specific code list. Required if STC11 is used. This is the Category code. Use code source 507.	REQUIRED STC11 - 1 1271 M AN 1/30
		Industry Code	Code indicating a code from a specific code list. Required if STC11 is used. This is the Status code. Use code source	REQUIRED STC11 - 2 1271 M AN 1/30
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. STC11-3 further modifies the status code in STC11-2. See code value list in STC01-3.	SITUATIONAL STC11 - 3 98 O ID 2/3

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES	
	SERVICE LINE ITEM IDENTIFICATION (REF)		To specify identifying information. 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.	SITUATIONAL	
		Reference Identification Qualifier FJ Line Item Control Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3	
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	REQUIRED REF02 127 X AN 1/30	
	SERVICE LINE DATE (DTP)			To specify any or all of a date, a time, or a time period. This is the date of service from the original submitted claim for a specific line item. Whenever the 2220E loop is used this segment must be present, unless reported in the Claim Level, Loop 2200E (Claim Service Date).	SITUATIONAL
		Date/Time Qualifier 472 Service		Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
Date Time Period Format Qualifier RD8 Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD			Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03. If there is a single date of service, the begin date equals the end date.	REQUIRED DTP02 1250 M ID 2/3	
Date Time Period			Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35	
_____	TRANSACTION SET TRAILER (SE)		To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)	REQUIRED	
		Number of Included Segments	Total number of segments included in a transaction set including ST and SE segments	REQUIRED SE01 96 M NO 1/10	

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IV. Data Elements Table for Health Care Claim Status Notification (277)

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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	REQUIRED SE02 329 M AN 4/9

V. Key Terms and Issues

A. Business Definitions

1. Participants in the Transaction

Information Source

The information source is the entity who is the decision maker in this business transaction — the payer. Note that the term “information source” does not refer to the entity 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.

Information Receiver

The information receiver is the entity that expects the response from the information source. In this business use, the information receiver can be a service bureau, claims clearinghouse, provider or provider group, employer, agency, etc.

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. In other instances, the Information Receiver also is the Service Provider.

Subscriber

The subscriber is a person who can be uniquely identified to an information source, traditionally referred to as a member. The subscriber may or may not be the patient.

Dependent

The dependent is a person who cannot be uniquely identified to an information source, but can be identified by an information source when associated with a subscriber.

Patient

The patient is the person who received the services. The additional information is being sent to support the claim or encounter related to those services. The patient can be either the subscriber or the dependent.

Payer/Insurer

The payer is the party that pays claims and/or administers the insurance coverage, benefit, or product. A payer can be an insurance company; Health Maintenance Organization (HMO); Preferred Provider Organization (PPO); a government agency, such as Medicare or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or another organization contracted by one of these groups.

Provider

Health care providers are individuals and organizations that provide health care services. Health care providers can include physicians, hospitals, clinics, pharmacies, and long-term care facilities. The legal definition of health care provider is included in section 262, Administrative Simplification, of the Health Insurance Portability and Accountability Act of 1996.

Submitter

The submitter is the sender of the transaction. For this business use, it can be a provider, a provider group, a Claims Clearinghouse, a service bureau, an agency, an employer, etc.

Third Party Administrator (TPA)

A sponsor may elect to contract with a Third Party Administrator (TPA) or other vendor to handle collecting insured member data if the sponsor chooses not to perform this function.

Transaction Receiver

The transaction receiver is the decision maker in the business transaction. For this business use, this entity is the payer, even when the transaction is sent to a clearinghouse for forwarding to a payer.

2. Elements of the Claim Adjudication Process

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.

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.

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) and at this point 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.

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.

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.

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.

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.

B. Technical Definitions and Issues

Data Standards

In the HIPAA framework, the transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. These rules are contained in the ASC X12 standards.

Data standards may not be modified by specific trading partners. However, since the transactions in each trading partner's individual system will vary from site to site (e.g., payer to payer), it is important that trading partners communicate their processing capacity in trading partner agreements.

Control Segments

There are two types of transaction control segments, the header segment (the ST segment) and the trailer segment (the SE segment). Header and trailer segments are used to identify the sender and receiver; allow for authorization and security information; and specify various technical features of the transaction.

The header segment identifies the start of a transaction and the transaction set. The trailer segment identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

If similar transaction sets (i.e., functional groups) are sent together in a transmission, the functional group is delineated by the functional group header (GS) segment and the functional group trailer (GE) segment. The functional group header segment 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.

Use of Data Segments and Elements Marked “Situational”

Many data segments and elements are marked “situational”; users should consult the notes in the implementation guide to determine when they should be used.

Character Sets and Delimiters

Transactions use commonly accepted basic characters sets, although encoding schemes other than those specified in the Implementation Guides may be used as long as a common mapping is available and the parties to the transaction agree. Delimiters are characters used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data. They are specified in the interchange header segment and must not be used in a data element value elsewhere in the interchange. Character sets and delimiters are shown in the full Implementation Guide.

Batch Transactions

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 and the original sender reconnects at a later time to pick 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. 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.

Real Time Transactions

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. The 997 Functional Acknowledgment transaction and the TA1 segment must also be used as in batch mode.

Version

This handbook is derived from the implementation guide 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.

VI. List of External Code Sources Needed for Transactions 276 and 277

- 5 Countries, Currencies and Funds
- 22 States and Outlying Areas of the U.S
- 51 ZIP Code
- 77 X12 Directories
- 121 Health Industry Identification Number
- 130 Health Care Financing Administration Common Procedural Coding System
- 131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
- 132 National Uniform Billing Committee (NUBC) Codes
- 134 National Drug Code
- 135 American Dental Association Codes
- 139 Claim Adjustment Reason Code
- 235 Claim Frequency Type Code
- 240 National Drug Code by Format
- 245 National Association of Insurance Commissioners (NAIC) Code
- 507 Health Care Claim Status Category Code
- 508 Health Care Claim Status Code
- 513 Home Infusion EDI Coalition (HIEC) Product/Service Code List
- 540 Health Care Financing Administration National PlanID