277Claim Acknowledgement

(004010H01)

IMPLEMENTATION GUIDE HEALTH CARE INFORMATION STATUS NOTIFICATION

Highmark EDI Operations

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1 Purpose and Business Overview

1.1 Document Purpose

The purpose of this implementation guide is to provide data requirements and content for receivers of Highmark's version of the 277 - Claim Acknowledgement Transaction (ANSI ASC X12.317). This implementation guide focuses on use of the 277 as an acknowledgement to receipt of claim submission(s). This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables and specifying values applicable for the business focus of the 277 claim submission acknowledgement.

Throughout this implementation guide the reference to "claim(s)" means individual claims or encounters or groupings of claims or encounters.

Entities receiving this application of the 277 include, but are not limited to, hospitals, nursing homes, laboratories, physicians, dentists, allied health professional groups, and supplemental (i.e., other than primary payer) health care claims adjudication processors.

Other business partners affiliated with the 277 include billing services; consulting services; vendors of systems; software and EDI translators; EDI network intermediaries such as health care clearinghouses, value-added networks and telecommunication services.

1.2 Version and Release

This Highmark implementation guide is based on the October 1997 ASC X12 standard referred to as Version 4, Release 1, Sub-release 0 (004010). This is the first Highmark guide for this business function of the 277 Transaction set. For purposes of this business use, Highmark will identify the Version of this Transaction in the GS08 data element as '004010H01'.

1.3 Business Use

This implementation guide only addresses the business use of the 277 Claim Acknowledgement. The purpose of this transaction is to provide a system (application) level acknowledgement of electronic claims or encounters. This implementation guide is to be used specifically as an application acknowledgement response to the ASC X12N 837 Institutional and Professional claim/encounter submission transactions.

This 277 Claim Acknowledgement transaction will only be used to acknowledge 837 Institutional and Professional transactions where ISA08 = 54771. See the Payer ID Charts in the Professional Claim (837P) and Institutional Claim (837I) sections of the Provider EDI Reference Guide for more specific payer information.

1.3.1 Claim System Acknowledgement

The first level of acknowledgement by Highmark for the ASC X12 837 transactions will be the ASC X12 Functional Acknowledgement (997) transaction. The 997 transaction is designed to

notify the submitter of the receiver's ability or inability to process the entire 837 transaction based on ASC X12 syntax and structure rules.

The second level of acknowledgement by Highmark for the ASC X12 837 transaction will be the 277 Claim Acknowledgement. This is a system (application) acknowledgement of the business validity and acceptability of the claims. The level of editing in pre-adjudication programs will vary from system to system. Although the level of editing may vary, this transaction provides a standard method of reporting acknowledgements for claims. The application acknowledgement identifies claims that are transferred to another entity, accepted for adjudication, as well as those that are not accepted. The 277 transaction is the only notification of pre-adjudication claim status. Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system and therefore are never reported in the ASC X12 Health Care Claim Payment/Advice (835) transaction. Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to claims processing guidelines. Final adjudication of claims is reported in the ASC X12 Health Care Claim Payment/Advice (835) transaction.

2 Data Overview

This section introduces the structure of the 277 Claim Acknowledgement and describes the positioning of the business data within the structure. Familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure is recommended. Refer to Appendix A of any national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule for information on ASC X12 nomenclature, structure, etc.

2.1 Overall Data Architecture

The implementation view provided at the beginning of Section 3 displays only the segments and their designated health care names described in this implementation guide. The intent of the implementation view is to clarify the purpose and use of the segments.

The 277 Transaction set is divided into two levels, or tables. Table 1 (Heading) contains transaction control information, which includes the ST and BHT segments. The ST segment identifies the start of a transaction's business purpose. The BHT segment identifies the hierarchical structure used. Table 2 (Detail) contains the detail information for the business function of the transaction. See Section 2.3 - Claim Status Theory for specific information on the status reporting detail.

2.2 Data 'Usage' Definitions

Within the Transaction detail, 'Usage' for the various Loops, Segments and Elements will be defined as follows:

Required - This item will always be used.
Sit. (Situational) - The use of this item varies, depending on data content and business context. The defining rule is generally documented in syntax or usage notes attached to the item. *The item is used whenever the situation defined in the note is true; otherwise, the item is not used.
Not Used - This item is not used.

* **NOTE:** If no situational note is present, the item may be sent if the data is available.

Loop Usage: Loop usage within ASC X12 transactions can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.
If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop. If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

2.3 Claim Status Theory

The level of information potentially available for a Claim Status Response may vary drastically from Payer to Payer. The primary vehicle for the claim status information in the 277 transaction is the STC segment.

The STC segment contains three iterations of the Health Care Claim Status composite (C043) within elements STC01, STC10 and STC11. The standardized codes used in the composite acknowledge the acceptance of the claim or specify the reason(s) for rejection. The composite elements use industry codes from external Code Source 507, Health Care Claim Status Category Code, and Source 508, Health Care Claim Status Code. The primary distribution source for these codes is the Washington Publishing Company World Wide Web site (www.wpc-edi.com).

Within the STC segment, composite element STC01 is required; STC10 and STC11 are situational and used to provide additional claim status when needed. The composite element consists of three sub-elements.

The first element in the composite is the Health Care Claim Status Category Code, Code Source 507. The category code indicates the level of processing achieved by the claim. This element is Required for use when the composite is used. For the business purpose of this implementation guide, only codes from the 'Acknowledgment' category are supported. The 'Acknowledgment' Category Codes all begin with 'A'.

The second element is the Health Care Claim Status Code, Code Source 508. This element provides more detailed information about the rational for the claim or line item being in the category identified in the first element. This element is Required for use when the composite is used. Examples of status messages include "entity acknowledges receipt of claim/encounter," "missing/invalid data prevents payer from processing claim," and "business application currently not available."

The third element in the composite is the Entity Identifier Code. The code in this element identifies the entity referred to in the second element (Status Code). The code list identifies an organizational entity, a physical location, property, or an individual. This element is Situational for use when the composite is used. A list of appropriate Entity Identifier Code values is within the STC segment in Section 3.

3 Transaction Set

277 - Claim Acknowledgement

Heading:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
9	005	GS	Functional Group Header	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
10	010	ST	Transaction Set Header	R	1	
11	020	BHT	Beginning of Hierarchical Transaction	R	1	
			LOOP ID - 1000			1
12	040	NM1	Submitter Name	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
			LOOP ID - 2000A			1
13	010	HL	Information Source Hierarchical Level	R	1	
			LOOP ID – 2100A			1
14	050	NM1	Information Source Name	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
			LOOP ID - 2000B			1
15	010	HL	Information Receiver Hierarchical Level	R	1	
			LOOP ID – 2100B			1
16	050	NM1	Information Receiver Name	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
			LOOP ID - 2000C			>1
17	010	HL	Provider Hierarchical Level	R	1	
			LOOP ID – 2100C			1
18	050	NM1	Billing Provider Name	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
			LOOP ID - 2000D			>1
20	010	HL	Subscriber Hierarchical Level	R	1	
21	040	DMG	Demographic Information	S	1	
			LOOP ID – 2100D			1
22	050	NM1	Subscriber Name	R	1	
			LOOP ID – 2200D			>1
23	090	TRN	Claim Identification	S	1	
24	100	STC	Status Information	R	>1	
27	110	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
28	110	REF	Payer Claim Number	S	1	
29	120	DTP	Date or Time or Period	R	2	
			LOOP ID – 2220D			>1
30	180	SVC	Service Information	S	1	
32	190	STC	Status Information	R	>1	
35	200	REF	Service Identification	R	1	
36	210	DTP	Date or Time or Period	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
			LOOP ID - 2000E			>1
37	010	HL	Dependent Hierarchical Level	S	1	
38	040	DMG	Demographic Information	R	1	
			LOOP ID – 2100E			1
39	050	NM1	Dependent Name	R	1	
			LOOP ID – 2200E			>1
40	090	TRN	Claim Identification	R	1	
41	100	STC	Status Information	R	>1	
44	110	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
45	110	REF	Payer Claim Number	S	1	
46	120	DTP	Date or Time or Period	R	2	
			LOOP ID – 2220E			>1
47	180	SVC	Service Information	S	1	
49	190	STC	Status Information	R	>1	
52	200	REF	Service Identification	R	1	
533	210	DTP	Date or Time or Period	R	1	
54	270	SE	Transaction Set Trailer	R	1	

Summary:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
55	280	GE	Functional Group Trailer	R	1	

Segment: **GS** **Functional Group Header**
Position: 005
Loop:
Level: Heading
Usage: Required
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:
1 GS04 is the group date.
2 GS05 is the group time.
3 The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.
Notes: **Example:GS*HN*54771*999999*20020826*1101*22755*X*004010H01~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets ***HN*** ***Health Care Claim Status Notification (277)***	**M ID 2/2**
Required	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners '54771'	**M AN 2/15**
Required	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners This will always be the Highmark assigned Trading Partner Number for the entity receiving this transaction.	**M AN 2/15**
Required	**GS04**	**373**	**Date** Date expressed as CCYYMMDD	**M DT 8/8**
Required	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	**M TM 4/8**
Required	**GS06**	**28**	**Group Control Number** Assigned number originated and maintained by the sender	**M N0 1/9**
Required	**GS07**	**455**	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard ***X*** ***Accredited Standards Committee X12***	**M ID 1/2**
Required	**GS08**	**480**	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed '004010H01'	**M AN 1/12**

Segment: **ST** **Transaction Set Header**
Position: 010
Loop:
Level: Detail
Usage: Required
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: **1** The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Notes: **Example: ST*277*0001~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set ***277*** ***Health Care Claim Status Notification***	**M ID 3/3**
Required	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Numbers in ST02 and SE02 will be identical. This unique number also aids in error resolution research. Submitter could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS to GE) and interchange (ISA to IEA), but can be repeated in other groups and interchanges.	**M AN 4/9**

Segment: **BHT** **Beginning of Hierarchical Transaction**
Position: 020
Loop:
Level: Detail
Usage: Required
Max Use: 1
Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time
Syntax Notes:
Semantic Notes:
1 BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
2 BHT04 is the date the transaction was created within the business application system.
3 BHT05 is the time the transaction was created within the business application system.
Notes: **Example: BHT*0010*06**20020118**TH~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set ***0010*** ***Information Source, Information Receiver, Provider of Service, Subscriber, Dependent***	**M**	**ID 4/4**
Required	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set ***06*** ***Confirmation***	**M**	**ID 2/2**
Required	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier When a single 837 transaction (ST-SE) is submitted to Highmark in a Functional Group envelope (GS-GE), the Originator Application Transaction Identifier (BHT03) from the 837 being acknowledged is reported in this element. When multiple 837 transactions (ST-SE) are submitted to Highmark in a single Functional Group envelope (GS-GE), one 277 Claim Acknowledgement transaction will be returned acknowledging all the 837 transactions in that Functional Group. The Originator Application Transaction Identifier (BHT03) from the first 837 will be placed in this element.	**O**	**AN 1/30**
Required	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**BHT05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	**O**	**TM 4/8**
Required	**BHT06**	**640**	**Transaction Type Code** Code specifying the type of transaction ***TH*** ***Receipt Acknowledgment Advice***	**O**	**ID 2/2**

Segment: **NM1** **Submitter Name**

Position: 040
Loop: 1000 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: **Example: NM1*41*2*HIGHMARK*****NI*54771~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***41*** ***Submitter*** ***Entity transmitting transaction set***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***2*** ***Non-Person Entity***	**M**	**ID 1/1**
Required	**NM103**	**1035**	**Sender Name** Individual last name or organizational name "Highmark"	**O**	**AN 1/35**
Not Used	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN 1/25**
Not Used	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Not Used	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN 1/10**
Required	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) ***NI*** ***National Association of Insurance Commissioners (NAIC) Identification***	**X**	**ID 1/2**
Required	**NM109**	**67**	**Identification Code** Code identifying a party or other code "54771"	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID 2/3**

Segment: **HL** **Information Source Hierarchical Level**
Position: 010
Loop: 2000A Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments
Syntax Notes:
Semantic Notes:
Notes: There will only be one Information Source (Payer) per 277. All claims within a specific 277 were submitted to a single payer.
Example: HL*120*1~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure HL01 will begin with the value "1" and increment by one each time an HL is used in the transaction. Only numeric values will be sent in HL01.	**M AN 1/12**
Not Used	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	**O AN 1/12**
Required	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure ***20*** ***Information Source*** ***Identifies the payor, maintainer, or source of the information***	**M ID 1/2**
Required	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described ***1*** ***Additional Subordinate HL Data Segment in This Hierarchical Structure.***	**O ID 1/1**

Segment: **NM1** **Information Source Name**
Position: 050
Loop: 2100 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: This segment will always identify the Payer. This information matches the information supplied in the 2010BB loop of the original 837 claim.
Example: NM1*PR*2*HIGHMARK***NI*54771~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***PR*** ***Payer***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***2*** ***Non-Person Entity***	**M**	**ID 1/1**
Required	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name This identifies the Payer providing the confirmation of acceptance or rejection of the claim for adjudication.	**O**	**AN 1/35**
Not Used	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN 1/25**
Not Used	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Not Used	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN 1/10**
Required	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) ***NI*** ***National Association of Insurance Commissioners (NAIC) Identification***	**X**	**ID 1/2**
Required	**NM109**	**67**	**Payer NAIC Code** Code identifying a party or other code This is the NAIC code of the payer providing the confirmation. 54771 - Highmark Claims/Encounters	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID 2/3**

Segment: **HL** **Information Receiver Hierarchical Level**
Position: 010
Loop: 2000B Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments
Syntax Notes:
Semantic Notes:
Notes: This loop will identify the Highmark assigned Trading Partner Number that will receive the 277 information. There will only be one Information Receiver per 277. This loop identifies the provider/billing service/ clearinghouse that submitted the original 837 transaction for the related claims.
Example: HL*2*1*21*1~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from the previous HL01 elements within the transaction, incremented by 1.	**M AN 1/12**
Required	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will always point back to the Information Source. This will always be "1".	**O AN 1/12**
Required	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure ***21*** ***Information Receiver*** ***Identifies the provider or party(ies) who are the recipient(s) of the information***	**M ID 1/2**
Required	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described ***1*** ***Additional Subordinate HL Data Segment in This Hierarchical Structure.***	**O ID 1/1**

Segment: **NM1** **Information Receiver Name**
Position: 050
Loop: NM1 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: **Example: NM1*40*2******93*999999~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***40*** ***Receiver*** ***Entity to accept transmission***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***2*** ***Non-Person Entity***	**M**	**ID 1/1**
Not Used	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN 1/35**
Not Used	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN 1/25**
Not Used	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Not Used	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN 1/10**
Required	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) ***93*** ***Code assigned by the organization originating the transaction set***	**X**	**ID 1/2**
Required	**NM109**	**67**	**Trading Partner Number** Code identifying a party or other code This will always be the Highmark assigned Trading Partner Number for the entity that submitted the original 837 transaction.	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID 2/3**

Segment: **HL** **Provider Hierarchical Level**
Position: 010
Loop: 2000C Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments
Syntax Notes:
Semantic Notes:
Notes: One Provider Hierarchical level will be written for each provider receiving claim confirmations. All claims for a specific provider are nested under that provider's hierarchical loop.
Example: HL*3*2*19*1~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	**M AN 1/12**
Required	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will always point back to the Information Receiver level. This will always contain "2".	**O AN 1/12**
Required	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure ***19*** ***Provider of Service***	**M ID 1/2**
Required	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described ***1*** ***Additional Subordinate HL Data Segment in This Hierarchical Structure.***	**O ID 1/1**

Segment: **NM1** **Billing Provider Name**
Position: 050
Loop: NM1 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: **Example: NM1*85*1*SMITH*JOHN*Q**MD*FI*123456789~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***85*** ***Billing Provider***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***1*** ***Person*** ***2*** ***Non-Person Entity***	**M**	**ID 1/1**
Required	**NM103**	**1035**	**Billing Provider Name** Individual last name or organizational name This is the complete billing provider name when NM102 is "2" and the billing provider last name when NM102 is "1".	**O**	**AN 1/35**
Sit.	**NM104**	**1036**	**Name First** Individual first name This is Required when NM102 is "1". This is not used when NM101 is "2".	**O**	**AN 1/25**
Sit.	**NM105**	**1037**	**Name Middle** Individual middle name or initial This is Required when NM102 is "1" and it is known. This is not used when NM101 is "2".	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Sit.	**NM107**	**1039**	**Name Suffix** Suffix to individual name This is Required when NM102 is "1" and it is known. This is not used when NM101 is "2".	**O**	**AN 1/10**
Required	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) ***FI*** ***Federal Taxpayer's Identification Number*** ***XX*** ***Health Care Financing Administration National Provider Identifier*** Used when the National Provider Identifier is submitted in the 837 or mandated for use.	**X**	**ID 1/2**
Required	**NM109**	**67**	**Identification Code** Code identifying a party or other code This will be the Federal Tax ID Number of the billing provider, unless the National Provider Identifier is submitted in the 837 or mandated for use.	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID 2/3**

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

Segment: **HL** **Subscriber Hierarchical Level**
Position: 010
Loop: 2000D Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments
Syntax Notes:
Semantic Notes:
Notes: **Example: HL*4*3*22*1~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	**M AN 1/12**
Required	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This must contain the Hierarchical ID Number for the 2000C loop that identifies the Billing Provider related to the claim identified under this subscriber or this subscriber's dependent.	**O AN 1/12**
Required	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure ***22*** ***Subscriber*** ***Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits***	**M ID 1/2**
Required	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described ***0*** ***No Subordinate HL Segment in This Hierarchical Structure.*** Required when the subscriber is the patient for the claim being confirmed, and there are no subservient 2000E Hierarchical Levels. ***1*** ***Additional Subordinate HL Data Segment in This Hierarchical Structure.*** Required when there are 2000E Hierarchical Levels subservient to this subscriber level identifying claims for dependents as patients.	**O ID 1/1**

Segment: **DMG** **Demographic Information**
Position: 040
Loop: 2000D Required
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: **1** If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: **1** DMG02 is the date of birth.
2 DMG07 is the country of citizenship.
3 DMG09 is the age in years.
Notes: Required when the subscriber is the patient for a claim being confirmed.
Example: DMG*D8*19581010~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format ***D8*** ***Date Expressed in Format CCYYMMDD***	**X**	**ID 2/3**
Required	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times This is the subscriber's (patient) Date of Birth in CCYYMMDD format.	**X**	**AN 1/35**
Not Used	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual	**O**	**ID 1/1**
Not Used	**DMG04**	**1067**	**Marital Status Code** Code defining the marital status of a person	**O**	**ID 1/1**
Not Used	**DMG05**	**1109**	**Race or Ethnicity Code** Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	**O**	**ID 1/1**
Not Used	**DMG06**	**1066**	**Citizenship Status Code** Code indicating citizenship status	**O**	**ID 1/2**
Not Used	**DMG07**	**26**	**Country Code** Code identifying the country	**O**	**ID 2/3**
Not Used	**DMG08**	**659**	**Basis of Verification Code** Code indicating the basis of verification	**O**	**ID 1/2**
Not Used	**DMG09**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**

Segment: **NM1** **Subscriber Name**
Position: 050
Loop: NM1 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: **Example: NM1*IL*1*JONES*STEPHEN*Q***MI*YYZ987654321~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***IL*** ***Insured or Subscriber***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***1*** ***Person***	**M**	**ID 1/1**
Required	**NM103**	**1035**	**Subscriber Last Name** Individual last name or organizational name	**O**	**AN 1/35**
Required	**NM104**	**1036**	**Subscriber First Name** Individual first name	**O**	**AN 1/25**
Sit.	**NM105**	**1037**	**Subscriber Middle Initial** Individual middle name or initial This will be provided when submitted on the 837 or when known from the database.	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Sit.	**NM107**	**1039**	**Name Suffix** Suffix to individual name This will be provided when submitted on the 837 or when known from the database.	**O**	**AN 1/10**
Required	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) ***MI*** ***Member Identification Number***	**X**	**ID 1/2**
Required	**NM109**	**67**	**Identification Code** Code identifying a party or other code This is the Payer's identification number for the subscriber.	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID 2/3**

Segment: **TRN** **Claim Identification**
Position: 090
Loop: TRN Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes: **1** TRN02 provides unique identification for the transaction.
2 TRN03 identifies an organization.
3 TRN04 identifies a further subdivision within the organization.
Notes: Required when the subscriber is the patient for a claim being confirmed.
Example: TRN*2*6352453~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced ***2*** ***Referenced Transaction Trace Numbers***	**M**	**ID 1/2**
Required	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Claim Submitter's Identifier from the original 837 claim (CLM01). At least 20 characters will be returned unaltered.	**M**	**AN 1/30**
Not Used	**TRN03**	**509**	**Originating Company Identifier** A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9	**O**	**AN 10/10**
Not Used	**TRN04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN 1/30**

Segment: **STC** **Status Information**
Position: 100
Loop: TRN Situational
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line
Syntax Notes:
Semantic Notes:
1 STC02 is the effective date of the status information.
2 STC04 is the amount of original submitted charges.
3 STC05 is the amount paid.
4 STC06 is the paid date.
5 STC08 is the check issue date.
6 STC12 allows additional free-form status information.
Notes: **Example: STC*A2:20***576~**
Example: STC*A8:18715*100******A8:189~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**STC01**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line	**M**	
Required	**STC01-1**	**1271**	**Claim Status Category Code** Code indicating a code from a specific industry code list This is from an external code list. Access www.wpc-edi.com for a complete listing of the codes. Only the 'Acknowledgment' Category Codes are used in the element.	**M**	**AN 1/30**
Required	**STC01-2**	**1271**	**Claim Status Reason Code** Code indicating a code from a specific industry code list This is an external code list. Access www.wpc-edi.com for a complete listing of the codes. 16 - Claim/encounter has been forwarded to entity. This code will be used when STC01-1 equals "A0". 20 - Accepted for Processing. This code will be used when STC01-1 equals "A2". 247 - Line Information. This code will be used when STC01-1 equals "A3" and the reason for the rejection is line specific.	**M**	**AN 1/30**
Sit.	**STC01-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC01-2 requires identification of the entity for complete understanding. ***40*** ***Receiver*** ***Entity to accept transmission*** ***41*** ***Submitter*** ***Entity transmitting transaction set*** ***71*** ***Attending Physician*** ***Physician present when medical services are performed*** ***72*** ***Operating Physician*** ***Doctor who performs a surgical procedure*** ***73*** ***Other Physician*** ***Physician not one of the other specified choices*** ***77*** ***Service Location*** ***82*** ***Rendering Provider*** ***85*** ***Billing Provider***	**O**	**ID 2/3**

			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient***		
				Individual receiving medical care		
Not Used	**STC02**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Sit.	**STC03**	**306**	**Action Code**		**O**	**ID 1/2**
			Code indicating type of action			
			This is required for claim rejections and not used otherwise.			
			15	***Correct and Resubmit Claim***		
			F	***Final***		
				Do not resubmit the claim.		
Required	**STC04**	**782**	**Claim Submitted Charge Amount**		**O**	**R 1/18**
			Monetary amount			
Not Used	**STC05**	**782**	**Monetary Amount**		**O**	**R 1/18**
			Monetary amount			
Not Used	**STC06**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Not Used	**STC07**	**591**	**Payment Method Code**		**O**	**ID 3/3**
			Code identifying the method for the movement of payment instructions			
Not Used	**STC08**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Not Used	**STC09**	**429**	**Check Number**		**O**	**AN 1/16**
			Check identification number			
Sit.	**STC10**	**C043**	**Health Care Claim Status**		**O**	
			Used to convey status of the entire claim or a specific service line			
			Required when a second Status Reason Code is necessary to explain the rejection reason.			
Required	**STC10-1**	**1271**	**Claim Status Category Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
			See STC01-1 for applicable values.			
Required	**STC10-2**	**1271**	**Claim Status Reason Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
			This is the external code list that is available from www.wpc-edi.com.			
Sit.	**STC10-3**	**98**	**Entity Identifier Code**		**O**	**ID 2/3**
			Code identifying an organizational entity, a physical location, property or an individual			
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.			
			40	***Receiver***		
				Entity to accept transmission		
			41	***Submitter***		
				Entity transmitting transaction set		
			71	***Attending Physician***		
				Physician present when medical services are performed		
			72	***Operating Physician***		
				Doctor who performs a surgical procedure		
			73	***Other Physician***		
				Physician not one of the other specified choices		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		

			PR	***Payer***		
			QC	***Patient***		
				Individual receiving medical care		
Sit.	**STC11**	**C043**	**Health Care Claim Status**		**O**	
			Used to convey status of the entire claim or a specific service line			
			Required when a third Status Reason Code is necessary to explain the rejection. Usage of the sub-elements matches the usage of STC10's sub-elements.			
Required	**STC11-1**	**1271**	**Industry Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
Required	**STC11-2**	**1271**	**Industry Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
Sit.	**STC11-3**	**98**	**Entity Identifier Code**		**O**	**ID 2/3**
			Code identifying an organizational entity, a physical location, property or an individual			
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.			
			40	***Receiver***		
				Entity to accept transmission		
			41	***Submitter***		
				Entity transmitting transaction set		
			71	***Attending Physician***		
				Physician present when medical services are performed		
			72	***Operating Physician***		
				Doctor who performs a surgical procedure		
			73	***Other Physician***		
				Physician not one of the other specified choices		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient***		
				Individual receiving medical care		
Sit.	**STC12**	**933**	**Free-Form Message Text**		**O**	**AN 1/264**
			Free-form message text			
			This is supplied ONLY when STC01, 10 or 11 identifies a Status Reason Code of 448 (Invalid Billing Combination). This text identifies the details of the invalid billing combination.			

Segment: **REF** **Claim Identification Number for Clearinghouses and Other Transmission Intermediaries**
Position: 110
Loop: TRN Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Notes: This segment will be used to return the unique claim tracking number when received in the 'Claim Identification Number for Clearinghouses and Other Transmission Intermediaries' REF Segment, Loop 2300, of the 837 Transaction.
Example: REF*D9*CH123456789~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification ***D9*** ***Claim Number*** ***Sequence number to track the number of claims opened within a particular line of business***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This will be the value submitted in the 'Claim Identification Number for Clearinghouses and Other Transmission Intermediaries' REF Segment, Loop 2300, of the 837 Transaction.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: REF Payer Claim Number

Position: 110
Loop: TRN Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Notes: This segment will only be returned in a real-time 277 Claim Acknowledgment when a real-time claim (837) was accepted for adjudication or estimation, but could not be finalized through the real-time 835.
Example: REF*1K*08123456789~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification *1K* ***Payor's Claim Number***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This will be the claim number assigned by the Payer for tracking purposes throughout the adjudication system.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: **DTP** **Date or Time or Period**
Position: 120
Loop: TRN Situational
Level: Detail
Usage: Required
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Notes: One iteration of this DTP segment identifying the receipt date of the claim is required. A second iteration identifying the claim statement period start date is required, except in cases where dates were not supplied on the original claim, such as in cases of dental predetermination of benefits.

Example: DTP*050*D8*20020118~
Example: DTP*232*D8*20020110~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			050 ***Received*** One iteration of the DTP segment with this qualifier and the related date in element DTP03 is required.	
			232 ***Claim Statement Period Start*** One iteration of the DTP segment with this qualifier and the related date in the DTP03 element is required for Institutional claims, and for professional and dental claims when no service detail is being returned (no service specific errors). For professional and dental claims, this will be the date of the first service line in the claim.	
Required	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format ***D8*** ***Date Expressed in Format CCYYMMDD***	**M ID 2/3**
Required	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times This is either the Claim Received Date (DTP01 equals "050") or the Claim Statement Period Start Date (DTP01 equals "232") in CCYYMMDD format.	**M AN 1/35**

Segment: **SVC** **Service Information**
Position: 180
Loop: SVC Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service
Syntax Notes:
Semantic Notes:
1 SVC01 is the medical procedure upon which adjudication is based.
2 SVC02 is the submitted service charge.
3 SVC03 is the amount paid this service.
4 SVC04 is the National Uniform Billing Committee Revenue Code.
5 SVC05 is the paid units of service.
6 SVC06 is the original submitted medical procedure.
7 SVC07 is the original submitted units of service.
Notes: This loop is REQUIRED when a claim is rejected for errors within a specific service. Only those services with errors will be reported. One 2220D loop will be provided for each service line with errors.
Example: SVC*HC:47605*576~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**SVC01**	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers	**M**
Required	**SVC01-1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) ***AD*** ***American Dental Association Codes*** ***This association's membership consists of U.S. dentists. It sets standards for the dental profession*** ***HC*** ***Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes*** ***HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments*** ***NU*** ***National Uniform Billing Committee (NUBC) UB92 Codes***	**M ID 2/2**
Required	**SVC01-2**	**234**	**Product/Service ID** Identifying number for a product or service This is the procedure or revenue code from the original claim/service line in the 837.	**M AN 1/48**
Sit.	**SVC01-3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O AN 2/2**
Sit.	**SVC01-4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O AN 2/2**
Sit.	**SVC01-5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O AN 2/2**
Sit.	**SVC01-6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service,	**O AN 2/2**

			as defined by trading partners This is required when the original claim submitted this modifier.		
Not Used	**SVC01-7**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN 1/80**
Required	**SVC02**	**782**	**Submitted Service Line Charge** Monetary amount	**M**	**R 1/18**
Not Used	**SVC03**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Sit.	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service This is required on institutional claims when both a procedure code and revenue code were submitted. In these cases, the procedure code is returned in SVC01 and the revenue code is returned in SVC04.	**O**	**AN 1/48**
Not Used	**SVC05**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**
Not Used	**SVC06**	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers	**O**	
Not Used	**SVC06-1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M**	**ID 2/2**
Not Used	**SVC06-2**	**234**	**Product/Service ID** Identifying number for a product or service	**M**	**AN 1/48**
Not Used	**SVC06-3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-7**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN 1/80**
Not Used	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**

Segment: **STC** **Status Information**
Position: 190
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line
Syntax Notes:
Semantic Notes:
1 STC02 is the effective date of the status information.
2 STC04 is the amount of original submitted charges.
3 STC05 is the amount paid.
4 STC06 is the paid date.
5 STC08 is the check issue date.
6 STC12 allows additional free-form status information.
Notes: **Example: STC*A3:477~**
Example: STC*A8:187*******A8:189~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**STC01**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line	**M**	
Required	**STC01-1**	**1271**	**Service Status Category Code** Code indicating a code from a specific industry code list This is from an external code list. Access www.wpc-edi.com for a complete listing of the codes. Only the 'Acknowledgment' Category Codes are used in this element.	**M**	**AN 1/30**
Required	**STC01-2**	**1271**	**Service Status Reason Code** Code indicating a code from a specific industry code list This is a code from the code list available from www.wpc-edi.com.	**M**	**AN 1/30**
Sit.	**STC01-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC01-2 requires identification of the entity for complete understanding. ***40*** ***Receiver*** ***Entity to accept transmission*** ***41*** ***Submitter*** ***Entity transmitting transaction set*** ***71*** ***Attending Physician*** ***Physician present when medical services are performed*** ***72*** ***Operating Physician*** ***Doctor who performs a surgical procedure*** ***73*** ***Other Physician*** ***Physician not one of the other specified choices*** ***77*** ***Service Location*** ***82*** ***Rendering Provider*** ***85*** ***Billing Provider*** ***87*** ***Pay-to Provider*** ***DN*** ***Referring Provider*** ***IL*** ***Insured or Subscriber*** ***MSC*** ***Mammography Screening Center*** ***PR*** ***Payer*** ***QC*** ***Patient*** ***Individual receiving medical care***	**O**	**ID 2/3**
Not Used	**STC02**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC03**	**306**	**Action Code**	**O**	**ID 1/2**

			Code indicating type of action		
Not Used	**STC04**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Not Used	**STC05**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Not Used	**STC06**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC07**	**591**	**Payment Method Code** Code identifying the method for the movement of payment instructions	**O**	**ID 3/3**
Not Used	**STC08**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC09**	**429**	**Check Number** Check identification number	**O**	**AN 1/16**
Sit.	**STC10**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line Required when a second status reason is necessary to identify the rejection. Use the same instructions as for STC01 for the elements of this composite.	**O**	
Required	**STC10-1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Required	**STC10-2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Sit.	**STC10-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC10-2 requires identification of the entity for complete understanding. ***40*** ***Receiver*** ***Entity to accept transmission*** ***41*** ***Submitter*** ***Entity transmitting transaction set*** ***71*** ***Attending Physician*** ***Physician present when medical services are performed*** ***72*** ***Operating Physician*** ***Doctor who performs a surgical procedure*** ***73*** ***Other Physician*** ***Physician not one of the other specified choices*** ***77*** ***Service Location*** ***82*** ***Rendering Provider*** ***85*** ***Billing Provider*** ***87*** ***Pay-to Provider*** ***DN*** ***Referring Provider*** ***IL*** ***Insured or Subscriber*** ***MSC*** ***Mammography Screening Center*** ***PR*** ***Payer*** ***QC*** ***Patient*** ***Individual receiving medical care***	**O**	**ID 2/3**
Sit.	**STC11**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line Required when a third status reason is necessary to identify the rejection. Use the same instructions as for STC01 for the elements of this composite.	**O**	
Required	**STC11-1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Required	**STC11-2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Sit.	**STC11-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC11-2 requires identification of the entity for complete understanding.	**O**	**ID 2/3**

			40	***Receiver*** ***Entity to accept transmission***		
			41	***Submitter*** ***Entity transmitting transaction set***		
			71	***Attending Physician*** ***Physician present when medical services are performed***		
			72	***Operating Physician*** ***Doctor who performs a surgical procedure***		
			73	***Other Physician*** ***Physician not one of the other specified choices***		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient*** ***Individual receiving medical care***		
Sit.	**STC12**	**933**	**Free-Form Message Text** Free-form message text Used only when a Service Status Reason Code identified a reason of 448 (Invalid billing combination). This text message identifies the specific details of the invalid combination.		**O**	**AN 1/264**

Segment: **REF** **Service Identification**
Position: 200
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Notes: This REF segment will supply either the Line Item Control Number, also known as Provider Control Number, from the original claim or the line item sequence number when no Line Item Control Number was supplied.
Example: REF*6R*7364563~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification ***6R*** ***Provider Control Number*** ***Number assigned by information provider company for tracking and billing purposes***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Provider Control Number supplied in the 837 using the same REF01 qualifier of 6R for this service. If no line item control number was supplied, the line item sequence number will be supplied.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: **DTP** **Date or Time or Period**
Position: 210
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Notes: The Service Start Date will always be supplied.
For institutional claims, if a service date was not reported, this will be derived from the Claim Statement Start Date.
Example: DTP*472*D8*20020114~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time ***472*** ***Service*** ***Begin and end dates of the service being rendered*** This is used for the start date only.	**M ID 3/3**
Required	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format ***D8*** ***Date Expressed in Format CCYYMMDD***	**M ID 2/3**
Required	**DTP03**	**1251**	**Service Start Date** Expression of a date, a time, or range of dates, times or dates and times This is the start date for the service from the original claim.	**M AN 1/35**

Segment: **HL** **Dependent Hierarchical Level**
Position: 010
Loop: 2000E Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments
Syntax Notes:
Semantic Notes:
Notes: Required when the dependent is the patient.
Example: HL*5*4*23*0~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	**M AN 1/12**
Required	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will contain the Hierarchical ID Number for the 2000D Loop that identifies the Subscriber related to the claim identified under this dependent.	**O AN 1/12**
Required	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure ***23*** ***Dependent*** ***Identifies the individual who is affiliated with the subscriber, such as spouse, child, etc., and therefore may be entitled to benefits***	**M ID 1/2**
Required	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described ***0*** ***No Subordinate HL Segment in This Hierarchical Structure.***	**O ID 1/1**

Segment: **DMG** **Demographic Information**
Position: 040
Loop: 2000E Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: **1** If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: **1** DMG02 is the date of birth.
2 DMG07 is the country of citizenship.
3 DMG09 is the age in years.
Notes:

Example: DMG*D8*19911207~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format ***D8*** ***Date Expressed in Format CCYYMMDD***	**X**	**ID 2/3**
Required	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times This is the Dependent's (patient) Date of Birth in CCYYMMDD format.	**X**	**AN 1/35**
Not Used	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual	**O**	**ID 1/1**
Not Used	**DMG04**	**1067**	**Marital Status Code** Code defining the marital status of a person	**O**	**ID 1/1**
Not Used	**DMG05**	**1109**	**Race or Ethnicity Code** Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	**O**	**ID 1/1**
Not Used	**DMG06**	**1066**	**Citizenship Status Code** Code indicating citizenship status	**O**	**ID 1/2**
Not Used	**DMG07**	**26**	**Country Code** Code identifying the country	**O**	**ID 2/3**
Not Used	**DMG08**	**659**	**Basis of Verification Code** Code indicating the basis of verification	**O**	**ID 1/2**
Not Used	**DMG09**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**

Segment: **NM1** **Dependent Name**
Position: 050
Loop: NM1 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Notes: **Example: NM1*03*1*JONES*SAMANTHA*T~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual ***03*** ***Dependent***	**M**	**ID 2/3**
Required	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity ***1*** ***Person***	**M**	**ID 1/1**
Required	**NM103**	**1035**	**Dependent Last Name** Individual last name or organizational name	**O**	**AN 1/35**
Required	**NM104**	**1036**	**Dependent First Name** Individual first name	**O**	**AN 1/25**
Sit.	**NM105**	**1037**	**Dependent Middle Initial** Individual middle name or initial This will be provided when submitted on the 837 or when known from the database.	**O**	**AN 1/25**
Not Used	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN 1/10**
Sit.	**NM107**	**1039**	**Name Suffix** Suffix to individual name This will be provided when submitted on the 837 or when known from the database.	**O**	**AN 1/10**
Sit.	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) Required when NM109 is used. ***MI*** ***Member Identification Number***	**X**	**ID 1/2**
Sit.	**NM109**	**67**	**Identification Code** Code identifying a party or other code This is the Payer's identification number for the Member, when the member has an ID different than the Subscriber. This is required when the dependent has a unique ID with the payer.	**X**	**AN 2/80**
Not Used	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X**	**ID 2/2**
Not Used	**NM111**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID 2/3**

Segment: **TRN** **Claim Identification**
Position: 090
Loop: TRN Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes: **1** TRN02 provides unique identification for the transaction.
2 TRN03 identifies an organization.
3 TRN04 identifies a further subdivision within the organization.
Notes:

Example: TRN*2*837484783~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced ***2*** ***Referenced Transaction Trace Numbers***	**M**	**ID 1/2**
Required	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Claim Submitter's Identifier from the original 837 claim (CLM01). At least 20 characters will be returned unaltered.	**M**	**AN 1/30**
Not Used	**TRN03**	**509**	**Originating Company Identifier** A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9	**O**	**AN 10/10**
Not Used	**TRN04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN 1/30**

Segment: **STC** **Status Information**
Position: 100
Loop: TRN Required
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line
Syntax Notes:
Semantic Notes:
1 STC02 is the effective date of the status information.
2 STC04 is the amount of original submitted charges.
3 STC05 is the amount paid.
4 STC06 is the paid date.
5 STC08 is the check issue date.
6 STC12 allows additional free-form status information.
Notes: **Example: STC*A3:247**15*576~**
Example: STC*A8:18715*100******A8:189~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**STC01**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line	**M**	
Required	**STC01-1**	**1271**	**Claim Status Category Code** Code indicating a code from a specific industry code list This is from an external code list. Access www.wpc-edi.com for a complete listing of codes. Only the 'Acknowledgment' Category Codes are used in this element.	**M**	**AN 1/30**
Required	**STC01-2**	**1271**	**Claim Status Reason Code** Code indicating a code from a specific industry code list This is an external code list. Access www.wpc-edi.com for a complete listing of the codes. 16 - Claim/encounter has been forwarded to entity. This code will be used when STC01-1 equals "A0". 20 - Accepted for Processing. This code will be used whenever STC01-1 equals "A2". 247 - Line Information. This code will be used whenever STC01-1 equals "A3" and the reason for the rejection is line specific.	**M**	**AN 1/30**
Sit.	**STC01-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC01-2 requires identification of the entity for complete understanding.	**O**	**ID 2/3**

40	***Receiver*** ***Entity to accept transmission***
41	***Submitter*** ***Entity transmitting transaction set***
71	***Attending Physician*** ***Physician present when medical services are performed***
72	***Operating Physician*** ***Doctor who performs a surgical procedure***
73	***Other Physician*** ***Physician not one of the other specified choices***
77	***Service Location***
82	***Rendering Provider***

			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
				This will be used when STC01-1 equals "A0".		
			QC	***Patient***		
				Individual receiving medical care		
Not Used	**STC02**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Sit.	**STC03**	**306**	**Action Code**		**O**	**ID 1/2**
			Code indicating type of action			
			This is required for claim rejections and not used otherwise.			
			15	***Correct and Resubmit Claim***		
			F	***Final***		
				Do not resubmit the claim.		
Required	**STC04**	**782**	**Claim Submitted Charge Amount**		**O**	**R 1/18**
			Monetary amount			
Not Used	**STC05**	**782**	**Monetary Amount**		**O**	**R 1/18**
			Monetary amount			
Not Used	**STC06**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Not Used	**STC07**	**591**	**Payment Method Code**		**O**	**ID 3/3**
			Code identifying the method for the movement of payment instructions			
Not Used	**STC08**	**373**	**Date**		**O**	**DT 8/8**
			Date expressed as CCYYMMDD			
Not Used	**STC09**	**429**	**Check Number**		**O**	**AN 1/16**
			Check identification number			
Sit.	**STC10**	**C043**	**Health Care Claim Status**		**O**	
			Used to convey status of the entire claim or a specific service line			
			Required when a second status reason is necessary to explain the rejection.			
Required	**STC10-1**	**1271**	**Claim Status Category Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
			See STC01-1 for applicable values.			
Required	**STC10-2**	**1271**	**Claim Status Reason Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
			This is the external list that is available from www.wpc-edi.com.			
Sit.	**STC10-3**	**98**	**Entity Identifier Code**		**O**	**ID 2/3**
			Code identifying an organizational entity, a physical location, property or an individual			
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.			
			40	***Receiver***		
				Entity to accept transmission		
			41	***Submitter***		
				Entity transmitting transaction set		
			71	***Attending Physician***		
				Physician present when medical services are performed		
			72	***Operating Physician***		
				Doctor who performs a surgical procedure		
			73	***Other Physician***		
				Physician not one of the other specified choices		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		

			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient***		
				Individual receiving medical care		
Sit.	**STC11**	**C043**	**Health Care Claim Status**		**O**	
			Used to convey status of the entire claim or a specific service line			
			Required when a third status reason is necessary to explain the rejection. Usage of the sub-elements matches the usage of STC10's sub-elements.			
Required	**STC11-1**	**1271**	**Industry Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
Required	**STC11-2**	**1271**	**Industry Code**		**M**	**AN 1/30**
			Code indicating a code from a specific industry code list			
Sit.	**STC11-3**	**98**	**Entity Identifier Code**		**O**	**ID 2/3**
			Code identifying an organizational entity, a physical location, property or an individual			
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.			
			40	***Receiver***		
				Entity to accept transmission		
			41	***Submitter***		
				Entity transmitting transaction set		
			71	***Attending Physician***		
				Physician present when medical services are performed		
			72	***Operating Physician***		
				Doctor who performs a surgical procedure		
			73	***Other Physician***		
				Physician not one of the other specified choices		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient***		
				Individual receiving medical care		
Sit.	**STC12**	**933**	**Free-Form Message Text**		**O**	**AN 1/264**
			Free-form message text			
			This is supplied ONLY when STC01, 10 or 11 identifies a Status Reason Code of 448 (Invalid Billing Combination). This text identifies the details of the invalid billing combination.			

Segment: **REF** **Claim Identification Number for Clearinghouses and Other Transmission Intermediaries**
Position: 110
Loop: TRN Required
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Notes: This segment will be used to return the unique claim tracking number when received in the 'Claim Identification Number for Clearinghouses and Other Transmission Intermediaries' REF Segment, Loop 2300, of the 837 Transaction.
Example: REF*D9*CH123456789~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification ***D9*** ***Claim Number*** ***Sequence number to track the number of claims opened within a particular line of business***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This will be the value submitted in the 'Claim Identification Number for Clearinghouses and Other Transmission Intermediaries' REF Segment, Loop 2300, of the 837 Transaction.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: REF Payer Claim Number

Position: 110
Loop: TRN Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Notes: This segment will only be returned in a real-time 277 Claim Acknowledgment when a real-time claim (837) was accepted for adjudication or estimation, but could not be finalized through the real-time 835.
Example: REF*1K*08123456789~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification *1K* ***Payor's Claim Number***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This will be the claim number assigned by the Payer for tracking purposes throughout the adjudication system.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: **DTP** **Date or Time or Period**
Position: 120
Loop: TRN Required
Level: Detail
Usage: Required
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Notes: One iteration of this DTP segment identifying the received date of the claim is required. A second iteration identifying the claim statement period start date is required except in cases where dates were not supplied on the original claim, such as in cases of dental predetermination of benefits.

Example: DTP*232*D8*20020115~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time ***050*** ***Received*** One iteration of the DTP segment with this qualifier and the related date in element DTP03 is required. ***232*** ***Claim Statement Period Start*** One iteration of the DTP segment with this qualifier and the related date in the DTP03 element is required for Institutional claims, and for professional and dental claims when no service detail is being returned (no service specific errors). For professional and dental claims, this will be the date of the first service line in the claim.	**M ID 3/3**
Required	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format ***D8*** ***Date Expressed in Format CCYYMMDD***	**M ID 2/3**
Required	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times This is either the Claim Received Date (DTP01 equals "050") or the Claim Statement Period Start Date (DTP01 equals "232") in CCYYMMDD format.	**M AN 1/35**

Segment: **SVC** **Service Information**
Position: 180
Loop: SVC Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service
Syntax Notes:
Semantic Notes:
1 SVC01 is the medical procedure upon which adjudication is based.
2 SVC02 is the submitted service charge.
3 SVC03 is the amount paid this service.
4 SVC04 is the National Uniform Billing Committee Revenue Code.
5 SVC05 is the paid units of service.
6 SVC06 is the original submitted medical procedure.
7 SVC07 is the original submitted units of service.
Notes: This loop is required when a claim is rejected for errors within a specific service. Only those services with errors will be reported. One 2220E loop will be provided for each service line with errors.
Example: SVC*HC:47605*576~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**SVC01**	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers	**M**	
Required	**SVC01-1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) ***AD*** ***American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession*** ***HC*** ***Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments*** ***NU*** ***National Uniform Billing Committee (NUBC) UB92 Codes***	**M**	**ID 2/2**
Required	**SVC01-2**	**234**	**Product/Service ID** Identifying number for a product or service This is the procedure or revenue code from the original claim/service line in the 837.	**M**	**AN 1/48**
Sit.	**SVC01-3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O**	**AN 2/2**
Sit.	**SVC01-4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O**	**AN 2/2**
Sit.	**SVC01-5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	**O**	**AN 2/2**
Sit.	**SVC01-6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service,	**O**	**AN 2/2**

			as defined by trading partners This is required when the original claim submitted this modifier.		
Not Used	**SVC01-7**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN 1/80**
Required	**SVC02**	**782**	**Submitted Service Line Charge** Monetary amount	**M**	**R 1/18**
Not Used	**SVC03**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Sit.	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service This is required on institutional claims where both a procedure code and revenue code were submitted. In these cases, the procedure code is returned in SVC01 and the revenue code is returned in SVC04.	**O**	**AN 1/48**
Not Used	**SVC05**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**
Not Used	**SVC06**	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers	**O**	
Not Used	**SVC06-1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M**	**ID 2/2**
Not Used	**SVC06-2**	**234**	**Product/Service ID** Identifying number for a product or service	**M**	**AN 1/48**
Not Used	**SVC06-3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN 2/2**
Not Used	**SVC06-7**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN 1/80**
Not Used	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R 1/15**

Segment: **STC** **Status Information**
Position: 190
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line
Syntax Notes:
Semantic Notes:
1 STC02 is the effective date of the status information.
2 STC04 is the amount of original submitted charges.
3 STC05 is the amount paid.
4 STC06 is the paid date.
5 STC08 is the check issue date.
6 STC12 allows additional free-form status information.
Notes: **Example: STC*A3:21*********A3:454~**
Example: STC*A8:187*******A8:189~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**STC01**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line	**M**	
Required	**STC01-1**	**1271**	**Service Status Category Code** Code indicating a code from a specific industry code list This is from an external code list. Access www.wpc-edi.com for a complete listing of codes. Only the 'Acknowledgment' Category Codes are used in this element.	**M**	**AN 1/30**
Required	**STC01-2**	**1271**	**Service Status Reason Code** Code indicating a code from a specific industry code list This is a code from the code list available from www.wpc-edi.com.	**M**	**AN 1/30**
Sit.	**STC01-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when an entity type is necessary to further identify the reason for the rejection.	**O**	**ID 2/3**
			40 ***Receiver*** ***Entity to accept transmission***		
			41 ***Submitter*** ***Entity transmitting transaction set***		
			71 ***Attending Physician*** ***Physician present when medical services are performed***		
			72 ***Operating Physician*** ***Doctor who performs a surgical procedure***		
			73 ***Other Physician*** ***Physician not one of the other specified choices***		
			77 ***Service Location***		
			82 ***Rendering Provider***		
			85 ***Billing Provider***		
			87 ***Pay-to Provider***		
			DN ***Referring Provider***		
			IL ***Insured or Subscriber***		
			MSC ***Mammography Screening Center***		
			PR ***Payer***		
			QC ***Patient*** ***Individual receiving medical care***		
Not Used	**STC02**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC03**	**306**	**Action Code**	**O**	**ID 1/2**

			Code indicating type of action		
Not Used	**STC04**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Not Used	**STC05**	**782**	**Monetary Amount** Monetary amount	**O**	**R 1/18**
Not Used	**STC06**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC07**	**591**	**Payment Method Code** Code identifying the method for the movement of payment instructions	**O**	**ID 3/3**
Not Used	**STC08**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT 8/8**
Not Used	**STC09**	**429**	**Check Number** Check identification number	**O**	**AN 1/16**
Sit.	**STC10**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line Required when a second status reason is necessary to identify the rejection. Use the same instructions as for STC01 for the elements of this composite.	**O**	
Required	**STC10-1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Required	**STC10-2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Sit.	**STC10-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC10-2 requires identification of the entity for complete understanding. ***40*** ***Receiver*** ***Entity to accept transmission*** ***41*** ***Submitter*** ***Entity transmitting transaction set*** ***71*** ***Attending Physician*** ***Physician present when medical services are performed*** ***72*** ***Operating Physician*** ***Doctor who performs a surgical procedure*** ***73*** ***Other Physician*** ***Physician not one of the other specified choices*** ***77*** ***Service Location*** ***82*** ***Rendering Provider*** ***85*** ***Billing Provider*** ***87*** ***Pay-to Provider*** ***DN*** ***Referring Provider*** ***IL*** ***Insured or Subscriber*** ***MSC*** ***Mammography Screening Center*** ***PR*** ***Payer*** ***QC*** ***Patient*** ***Individual receiving medical care***	**O**	**ID 2/3**
Sit.	**STC11**	**C043**	**Health Care Claim Status** Used to convey status of the entire claim or a specific service line Required when a third status reason is necessary to identify the rejection. Use the same instructions as for STC01 for the elements of this composite.	**O**	
Required	**STC11-1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Required	**STC11-2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN 1/30**
Sit.	**STC11-3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This is required when the value in STC11-2 requires identification of the entity for complete understanding.	**O**	**ID 2/3**

			40	***Receiver*** ***Entity to accept transmission***		
			41	***Submitter*** ***Entity transmitting transaction set***		
			71	***Attending Physician*** ***Physician present when medical services are performed***		
			72	***Operating Physician*** ***Doctor who performs a surgical procedure***		
			73	***Other Physician*** ***Physician not one of the other specified choices***		
			77	***Service Location***		
			82	***Rendering Provider***		
			85	***Billing Provider***		
			87	***Pay-to Provider***		
			DN	***Referring Provider***		
			IL	***Insured or Subscriber***		
			MSC	***Mammography Screening Center***		
			PR	***Payer***		
			QC	***Patient*** ***Individual receiving medical care***		
Sit.	**STC12**	**933**	**Free-Form Message Text** Free-form message text Used only when a Service Status Reason Code identified a reason of 448 (Invalid billing combination). This text message identifies the specific details of the invalid combination.		**O**	**AN 1/264**

Segment: **REF** **Service Identification**
Position: 200
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Notes: This REF segment will supply either the Line Item Control Number, also known as Provider Control Number, from the original claim or the line item sequence number when no Line Item Control Number was supplied.
Example: REF*6R*34562973~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes	
Required	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification ***6R*** ***Provider Control Number*** ***Number assigned by information provider company for tracking and billing purposes***	**M**	**ID 2/3**
Required	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Provider Control Number supplied in the 837 using the same REF01 qualifier of 6R for this service. If no line item control number was supplied, the line item sequence number will be supplied.	**X**	**AN 1/30**
Not Used	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content	**X**	**AN 1/80**
Not Used	**REF04**	**C040**	**Reference Identifier** To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	**O**	
Not Used	**REF04-1**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID 2/3**
Not Used	**REF04-2**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN 1/30**
Not Used	**REF04-3**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-4**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**
Not Used	**REF04-5**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X**	**ID 2/3**
Not Used	**REF04-6**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN 1/30**

Segment: **DTP** **Date or Time or Period**
Position: 210
Loop: SVC Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Notes: The Service Start Date will always be supplied.
For institutional claims, if a service date was not submitted, this will be derived from the Claim Statement Start Date.
Example: DTP*472*D8*20020114~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**DTP01**	**374**	**Date/Time Qualifier**	**M ID 3/3**
			Code specifying type of date or time, or both date and time	
			472 ***Service***	
			Begin and end dates of the service being rendered	
			This is used for the start date only.	
Required	**DTP02**	**1250**	**Date Time Period Format Qualifier**	**M ID 2/3**
			Code indicating the date format, time format, or date and time format	
			D8 ***Date Expressed in Format CCYYMMDD***	
Required	**DTP03**	**1251**	**Service Start Date**	**M AN 1/35**
			Expression of a date, a time, or range of dates, times or dates and times	
			This is the start date for the service from the original claim.	

Segment: **SE** **Transaction Set Trailer**
Position: 270
Loop:
Level: Detail
Usage: Required
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Syntax Notes:
Semantic Notes:
Notes: **Example: SE*27*0001~**

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
Required	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Numbers in ST02 and SE02 will be identical. The number will be unique within a specific functional group (GS to GE) and interchange (ISA to IEA), but can be repeated in other groups and interchanges. This unique number also aids in error resolution research.	**M AN 4/9**

Segment: **GE** **Functional Group Trailer**
Position: 280
Loop:
Level: Summary
Usage: Required
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: **1** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Notes: **Example: GE*1*22755***

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
Required	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M N0 1/6**
Required	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender	**M N0 1/9**

External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES
235/CH, 26, 100
SOURCE
Codes for Representation of Names of Countries, ISO 3166-(Latest Release)
Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)
AVAILABLE FROM
American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036
ABSTRACT
This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES
66/SJ, 771/009, 235/A5, 156
SOURCE
National Zip Code and Post Office Directory
AVAILABLE FROM
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013
ABSTRACT
Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:
AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec

SK - Saskatchewan
YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES
66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116
SOURCE
National ZIP Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
AVAILABLE FROM
U.S Postal Service
Washington, DC 20260
New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
ABSTRACT
The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.
The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES
721, 725
SOURCE
X12.3 Data Element Dictionary
X12.22 Segment Directory
AVAILABLE FROM
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852
ABSTRACT
The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES
128/HI, 66/21, I05/20, 1270/HI
SOURCE
Health Industry Number Database
AVAILABLE FROM
Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018
ABSTRACT
The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospitals and other provider organizations - the customers of health industry manufacturers

and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES
235/HC, 1270/BO, 1270/BP
SOURCE
Health Care Finance Administration Common Procedural Coding System
AVAILABLE FROM
www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
ASC X12N • INSURANCE SUBCOMMITTEE 004010X093 • 276/277
IMPLEMENTATION GUIDE HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE
MAY 2000 C.3
7500 Security Boulevard
Baltimore, MD 21244-1850
ABSTRACT
HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES
235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD
SOURCE
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
AVAILABLE FROM
U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105
ABSTRACT
The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
235/RB, 235/NU, 1270/BE, 1270/BG, 1270/BH, 1270/BI
SOURCE
National Uniform Billing Data Element Specifications
AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697
ABSTRACT
Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.
004010X093 • 276/277 ASC X12N • INSURANCE SUBCOMMITTEE
HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE IMPLEMENTATION GUIDE
C.4 MAY 2000

134 National Drug Code

SIMPLE DATA ELEMENT/CODE REFERENCES
235/ND, 1270/NDC
SOURCE

Blue Book, Price Alert, National Drug Data File
AVAILABLE FROM
First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066
ABSTRACT
The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
235/AD, 1270/JO, 1270/JP
SOURCE
Current Dental Terminology (CDT) Manual
AVAILABLE FROM
Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678
ABSTRACT
The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1034
SOURCE
National Health Care Claim Payment/Advice Committee Bulletins
AVAILABLE FROM
www.wpc-edi.com
Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116
ABSTRACT
Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1325
SOURCE
National Uniform Billing Data Element Specifications Type of Bill Position 3
AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697
ABSTRACT
A variety of codes explaining the frequency of the bill submission.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES
235/N1, 235/N2, 235/N3, 235/N4, 1270/NDC, 235/N5, 235/N6
SOURCE
Drug Establishment Registration and Listing Instruction Booklet
AVAILABLE FROM
Federal Drug Listing Branch HFN-315
5600 Fishers Lane

Rockville, MD 20857
ABSTRACT
Publication includes manufacturing and labeling information as well as drug packaging sizes.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES
128/NF
SOURCE
National Association of Insurance Commissioners Company Code List Manual
AVAILABLE FROM
National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925
ABSTRACT
Codes that uniquely identify each insurance company.

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1271
SOURCE
Health Care Claim Status Category Code
AVAILABLE FROM
Washington Publishing Company
http://www.wpc-edi.com
ABSTRACT
Code used to organize the Health Care Claim Status Codes into logical groupings

508 Health Care Claim Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1271
SOURCE
Health Care Claim Status Code
AVAILABLE FROM
Washington Publishing Company
http://www.wpc-edi.com
ABSTRACT
Code identifying the status of an entire claim or service line

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES
235/IV
SOURCE
Home Infusion EDI Coalition (HIEC) Coding System
AVAILABLE FROM
HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018
ABSTRACT
This list contains codes identifying home infusion therapy products/services.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XV
SOURCE

PlanID Database
AVAILABLE FROM
Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850
ABSTRACT
The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.
004010X093 • 276/277 ASC X12N • INSURANCE SUBCOMMITTEE
HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE IMPLEMENTATION GUIDE
C.8 MAY 2000

Appendix

277 Claim Acknowledgement Guide Changes for December 1, 2008

The changes listed were revised in this December 1, 2008 version of the guide.

Page	Segment/Element	Description
8	277CA Structure	Added the 2200D and 2200E REF Segments for Payer Claim Number
28	Loop 2200D REF – Payer Claim Number	Added a Payer Claim Number REF Segment to be returned in a Real Time 277CA
45	Loop 2200E REF – Payer Claim Number	Added a Payer Claim Number REF Segment to be returned in a Real Time 277CA
28 - 55		Existing page number changed due to the addition of 2 new segments