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276/277 Claim Status Request and Response

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Chapter 5: 276 & 277 – Health Care Claim Status Request and Response

Overview

The ANSI X12N 276 and 277 Transactions are used in tandem - the 276 Transaction requests the current status of a specified claim or claims, and the 277 Transaction responds to that specified request. The transactions are parallel in structure, but distinct. The information in this chapter clarifies BCBSNC business and processing rules that are relevant to the implementation of the 276 and 277 Transactions. The chapter consists of three sections:

- a general section with material applicable to the processing of claim status inquiries and business edits performed by BCBSNC
- two tables outlining specific data format or content issues within both transaction; these tables also describe BCBSNC handling of specific data types
- a sample scenario of a 276 Transaction that is illustrated as both a data string and mapped transaction.

Blue Card and FEP Requests (Blue Exchange)

In order to manage inquiries for out-of-state Blue Card holders and Federal Employee Program (FEP) subscribers, BCBSNC accesses Blue Exchange, a data management system shared with Blue Cross and Blue Shield plans around the country. This system facilitates the routing of 276 Requests to the appropriate Blue Cross and Blue Shield Associate and the return of the 277 Response to the original submitter.



Important Notice:

Submitters will receive a 997 Acknowledgement from BCBSNC for all batches, including those inquiries for Blue Card and Federal Employee Program subscribers. However, 277 Responses for out-of-state subscribers may take longer to be returned than those in state. Submitters may expect 277 Responses to out-of-state inquiries within 24 hours, and in most cases, sooner.

If no response is received from Blue Exchange after 24 hours, the request is closed out. The table below displays the code values found concurrently in the STC segments of the 2200D or 2200E loops of the 277 Response to indicate the close-out within Blue Exchange:

Implementation Guide Element	Value Returned
STC01-1 (Claim Status Category Code)	E1 (Response not Possible)
STC01-2 (Claim Status Code)	0 (cannot provide further information electronically)
STC01-3 (Entity Identifier Code)	ZZ (This element is used only when the response is generated by Blue Exchange.)
STC02 Status Information Effective Date	Set to current date
STC04 Total Claim Charge Amount	Set to zero
STC05 Claim Payment Amount	Set to zero.

STC Code Values used by BCBSNC for Blue Exchange

Claim Status Request Processing

Requests are handled in batch mode only. BCBSNC does not handle real time processing of 276 Claim Status Requests.

The 277 Response provides claim status information at the claim level only, and not at the service line level. Possible responses are listed in the [Claims Status Category Codes](#) table presented on page 9. For detailed information about specific claims, submitters should review the 835 Remittance Advice, the Notification of Payment (NOP), or the Explanation of Payment (EOP).

Acknowledgements

The TA1 Interchange Acknowledgement and the 997 Functional Group Acknowledgement are returned upon the receipt of a 276 Claim Status Request. Receipt of a positive TA1 and 997 indicates that no Implementation Guide errors are contained within the ISA/IEA Interchange, the GS/GE Functional Group or the ST/SE Transaction Sets of the transmission. If Implementation Guide errors are found within the transmission, a negative TA1 or 997 is returned, identifying the error, and the batch is rejected. The Introduction to the Companion Guide contains more information on the use of the TA1 and 997 Transactions.

See the [Business Edits](#) section of this chapter for more information about returned transactions for BCBSNC business edits.

Data Retention

Data from a 276 Request is returned on the 277 Response. Submitters can send electronic inquiries and receive response data for up to 18 months from the time of the initial claim receipt date.

Frequency of Data Exchange

Submitters should allow 15 minutes to one hour for an electronic response to a 276 Inquiry although responses may be received sooner. Claims Inquiries for Blue Card or FEP beneficiaries may take up to 24 hours as these inquiries are sent to other BCBS Associations. Responses can be retrieved from the sender’s electronic ‘mailbox’. For more information about electronic connectivity and mailboxes, see Connectivity Media in the Introduction to the Companion Guide.



Important Notice:

The frequency of data exchange may be disrupted by system maintenance during weekend hours. Submitters should review the System Availability information contained in the Introduction to the Companion Guide. Access the section *Connectivity Media* and review the system availability under the connectivity mode applicable to you.

If a transmission is not returned within the expected time frame, contact your local BCBSNC Electronic Solutions field consultant or Electronic Solutions at (919) 765-3514 or (888) 333-8594.

Batch Volumes

BCBSNC recommends that no more than 99 requests per batch transmission be made at one time for a variety of reasons. Processing of smaller batches is more efficient and submitters are less likely to receive rejections on smaller batch bundles.

Vendor-Supported Claims

Claim status inquiries are not forwarded to vendors who are supporting mental health, dental claims, or pharmacy claims on behalf of BCBSNC. These 276 Inquiries should be sent directly to those vendors. If submitters have made a request of BCBSNC for a claim that should be handled by one of our vendors, submitters will receive a 277 Response indicating that the data could not be found. See the [Claim Status Category Code Table](#), code source 507 or 508, for more information about response codes used in the 277 Transaction.

Batch Processing

More than one 277 Response may be received to a 276 Request on a single claim because multiple claims may have been filed within a date range of a 276 Request. Submitters should verify the responses on all 277 transactions received. (See [Date Ranges](#) for important information about submitting date range requests.)

Submitters may send a 276 Claim Status Request on claims filed electronically (an 837 transaction) or on paper. BCBSNC does not distinguish between paper or electronic claims when issuing a 277 Response.



Important Notice:

BCBSNC does not rebind batches for response with the same inquiries as received. Submitters should provide the Claim Submitter Trace Number (2200D TRN02 or 2200E TRN02), also known as the Patient Account Number, so that they can associate submitted requests to their respective responses.

Provider Identifier

A 276 Request must include the NPI to receive a 277 Response (In the 276 Claim Status Request, see 2100C NM108, value "XX").

Medicare or Medicaid identification numbers are not used for processing.

Claim Identifier

To expedite the 277 Response, the BCBSNC Claim Control Number should always be given in the 276 Inquiry. The format of this claim identifier consists of a six-digit date, followed by a six-digit number (e.g. mmddy#####) for all claim types except for Medicare Supplemental policies, which use an yymmdd##### format. Electronic submitters have received this claim identifier on the Claims Audit Report, returned after submitting an 837 Claim Transaction. (See [Matching Criteria](#) for more information about the Claim Control Number).

Business Edits

BCBSNC business edits are effective after the transmission has passed Implementation Guide validation. BCBSNC business edits include levels of security validation at the Transaction Set level of

the transmission. Transactions that have identified business edit errors return a 277 Transaction with Status or Category Codes in the STC segments identifying the problem.

Validation of Dates

The 276 Transaction edits do not accept future dates within the body of the transaction. Errors are reported to the submitter via a 277 Transaction, using the appropriate Status or Category Codes. Future dates that occur within the transaction header (BHT04 Segment) cause the rejection of the entire batch. Reporting of the rejection is available through the sender’s mailbox account.

Date Ranges

Date ranges returned on the 277 Response (DTP03) are those submitted on the 276 Request and do not necessarily reflect the claim or service date adjudicated by BCBSNC. The 276 Requests that use date ranges for service dates receive all claims within the range, unless other qualifiers, such as claim numbers, preclude their return. **To avoid extraneous responses, users should enter date ranges for an inquiry only when the date range represents the dates of a single service or claim.**

Claim Status Boundaries

A Claim Status Response (277) returns information at the *claim level only*. If the 276 Request is for information at the procedural or diagnostic level, the 277 Response is still at the claim level. No procedure or diagnosis codes are reported on the 277 Claim Status Response. For detail information at the procedural level, submitters should review the 835 Transaction, the Notice of Payment or the Explanation of Payment.

Monetary Amounts

Monetary amounts returned on the 277 Response (STC04) are those submitted on the 276 Request, at either the service line or claim level. The STC05 returned on the 277 Response reflects the actual amount paid; however, if the adjudication process has not been completed, the amount is zero. For accurate payment information, submitters should review the 835 Transaction, the Notice of Payment or the Explanation of Payment.

If monetary amounts in the 277Response (2200 loops: STC04 and STC05 segments) are set to zero, this reflects that the Claim Status 276 Request was routed to Blue Exchange and that the Request was closed out after 24 hours. It does not reflect what was entered on the 276 Request. See [Blue Card and Federal Employee Program \(FEP\) Requests](#) for more information.

Matching Criteria

The matching criteria explain how BCBSNC identifies the patients and claims for which requests are made.

Claims Matching

Matching criteria for the claim in a 276 Request are comprised of the following:

Data Element for Claim Matching	Implementation Guide Location (Subscriber or Dependent Loop)
BCBSNC Service Provider Number	2100C NM109
Member Identification Number	2100D NM109 or 2100E NM109
Date(s) of Service	2200D, 2210D, 2200E, or 2210E DTP03
BCBSNC Claim Control Number* (if sent on inquiry)	2200D [Payer Claim ID], REF02, or 2200E [Payer Claim ID], REF02

*The BCBSNC Claim Control Number can be found on the Claims Audit Report returned after the initial 837 Health Care Claim was filed. The Claim Control Number is a twelve (12) digit number that

includes the receipt date in the first 6 digits. Submitters should send all 12 digits when submitting the Claim Control Number for processing.

Subscriber/Dependent Matching

Matching criteria to identify the subscriber or dependent in a 276 Request are comprised of the following:

Data Element for Patient Matching	Implementation Guide Location: Subscriber or Dependent Loop
Member Identification Number	2100D NM109 or 2100E NM109
Date of Birth	2000D, DMG02 or 2000E, DMG02
Member Last and First Name	2100D, NM103 & 04 or 2100E, NM103 & 04



Important Notices:

1. Member Identification Number Placement

If the Member Identification Number provided is found for either the Subscriber or a Dependent, that number will be used and returned in the appropriate loop of the 277 Response, regardless of the loop in which it was submitted (either the Subscriber or Dependent). The only exception to this rule is for Inquiries about paid claims for Blue Card (or out-of-state) Blue Cross and Blue Shield subscribers and Federal government employees, for whom BCBSNC does not have subscriber information.

2. Member Identification Number – Matching

The Member Identification Number must appear in the 276 Request as it appears on the Member's Identification Card. Depending on the policy for coverage, the patient's Identification Code may be identical to that of the subscriber or it may be unique. The Blue Cross Blue Shield identification code may include an alpha prefix and/or a numeric suffix, and may be up to 14 characters in length. For details about Member Identification Numbers, see the *BCBSNC Introduction to the Companion Guide*.

Reporting

Acknowledgements

A TA1 Acknowledgement is returned at the ISA Level, upon the receipt of a batch transmission. If no errors are reported and the message is simply a positive confirmation of receipt, the TA105 Interchange Note Code indicates a "000" – no error. Note that the TA1 Transaction may also be used to provide error messages. For more information about TA1 and 997 transactions, see the [Acknowledgement](#) section and the [TA1 and 997](#) section of the Introduction to the Companion Guide.

Error Reporting

If submitters have made a request of BCBSNC for a claim that should be handled by one of our vendors, submitters will receive a 277 response indicating that the data could not be found. See [Vendor-Supported Claims](#) for more information.

Levels of Error Reporting

Incoming 276 Transactions are edited to ensure that they comply with HIPAA X12N regulation and with BCBSNC business and security processes. The table below illustrates the type of transaction used in response to different levels of error reporting.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"> Invalid Message Invalid Batch ID Inactive Message Improper Batch Structure 	TA1
<ul style="list-style-type: none"> GS/GE Segment ST/SE Segment Detail Segments 	HIPAA Implementation Guide Violations	997
Detail Segments	<ul style="list-style-type: none"> BCBSNC Business Edits (see 277 Data Element Table for details) Security Validation (See Security Validation Edits for details) 	277

Error Reporting Table

TA1 and 997 Transactions

The TA1 Interchange Control and 997 Functional Acknowledgement Transactions are used to indicate Implementation Guide errors. If a transaction is rejected at the Interchange Control (ISA/IEA) level, the batch returns a TA1 Interchange Acknowledgement that identifies the Implementation Guide error contained in the transmission. If a transaction is rejected at the Functional Group (GS/GE) or Transaction Set (ST/SE) level, the batch returns a 997 Functional Acknowledgement that identifies the Implementation Guide errors contained in the transmission. However, if the GS/GE level (Functional Group) of the transaction is corrupted such that a 997 cannot be created, a TA1 with a 05 value of "024" (Invalid Interchange Content). Note that this circumstance is the only situation where a TA1 is used to respond to a portion of the transmission other than the ISA/IEA.



Important Notices:

1. For Implementation Guide violations, BCBSNC returns the TA1 or 997 Acknowledgement Transactions ONLY. Trading partners who are unable to accept a 997 or TA1 transaction are not provided with alternative Implementation Guide error reporting mechanisms.
2. Trading Partners who do not transmit TA1 or 997 Acknowledgements for 277 Responses should inform the eSolutions HelpDesk at (919) 765-3514 or (888) 333-8594.

Security Validation Edits

BCBSNC has a variety of edits to ensure the security of data transmission within the Transaction Set or ST/SE portion of a transmission. These security checks or edits are in addition to the verification of identifiers within the Interchange Control envelope and Functional Group. The edits involve validating information that has been exchanged between BCBSNC and its business partners via the Electronic Connectivity Request form, as well as the approval letter returned by BCBSNC to verify security information. These edits stop the processing of a transaction prior to any business edits performed on the detailed segments of a transaction.

The table below identifies the Security Validation edits performed on the 276 Request and the possible modifications needed to correct the edit. The 277 Response uses the [Claim Status Category Codes](#)

[and Status Codes](#) to identify security validation requirement issues. Each edit listed in the table validates the Provider Identifier, except for the last edit, which validates the transmission date; the Provider Identifier validation is performed against the value in the 276, 2100C, NM109 (Service Provider Loop). Submitters receive an E0 Status Category Code and a 24 Claim Status Code returned in 2200D or 2200E, STC01 of the 277 Response if the Provider Identifier cannot be validated. Security Validation failures result in the rejection of all Claim Status Requests within the loop attached to the Provider Identifier in question.

If the suggested modifications identify no obvious errors, providers are advised to contact the eSolutions HelpDesk at (919) 765-3514 or (888) 333-8594, for more specific information.

Category and Status Codes	Possible Security Validation Errors	Modification Required
E0 -024	Provider ID (2100C, NM109) not authorized.	The Provider ID at the ST/SE level of the transaction cannot be validated. Verify that <ul style="list-style-type: none"> • an Electronic Connectivity Request (ECR) form has been completed • you have received an approval letter from BCBSNC • the Provider ID on the approval letter from BCBSNC is consistent with that on the transmission.
E0 -024	Provider ID (2100C, NM109) not authorized for production.	Business partners receive a letter from Electronic Solutions that approves them for either test or production transmission of the transaction in question. Verify the batch ID numbers as presented on this letter and the authorization to send a production transmission, or resubmit as a test.
E0 -024	Sender ID not authorized for this Provider ID (2100C, NM109).	No relationship between this Provider ID and the sender of the transmission has been communicated to BCBSNC. Verify all identifiers as they appear on the Electronic Connectivity Request form to ensure that they are correct.
E0 -024	Provider ID (2100C, NM109) not authorized for this transaction.	BCBSNC has not authorized this Provider ID. Verify that you have received an approval letter for the transmission of this specific transaction.
E0 -024	Provider ID (2100C, NM109) not authorized for this connectivity mode.	The Electronic Connectivity Request form completed by the provider has identified a different mode of connectivity than was set up in security. Verify the correct connectivity mode to be used.
E0 -024	Transaction not authorized for this date. (The transmission receipt date is validated.)	The authorization date on the BCBSNC notification letter is inconsistent with that on the transmission. Verify the transaction effective date on the approval letter.
E0-026	Entity Not Found.	The provider identifier sent in the file does not match any identifier for that provider in BCBSNC records. Contact BCBSNC Network Management department's NPI Hotline at 1-800-858-5966.

Security Validation for 276 Requests

Exception Handling

If the demographic information of the 276 Request is found for either the subscriber or dependent, that information will be returned in the appropriate loop of the 277 Response, regardless of the loop in which that information has been submitted. This exception holds for all requests regarding BCBSNC subscribers; however, requests regarding out-of-state, Blue Card, or Federal Employee Plan

subscribers will have the subscriber and dependent information returned in whichever loop they were sent.

Claim Status Category Codes and Status Code

The 277 Response uses the Claim Status Category Codes and Status Codes to identify security validation requirement issues and to indicate BCBSNC business edits. The following table lists all codes supported by BCBSNC within the 277 Transaction, Loop 2200D or 2200E, Elements STC01-1 and STC01-2. The first column lists the codes used for the STC01-1 element and the corresponding STC01-2 value appears in the second column. For Category Code Value F2, a much larger number of Status Codes may be returned, as well as up to three iterations of the Health Care Claims Status Composite (STC01, STC10, and/or STC11). The complete list of those codes and their explanations is available on the next page. Complete code sets are available from the Washington Publishing Company's Web site at <http://www.wpc-edi.com/codes/Codes.asp>.

Category Codes (507) STC01-1 (for F2 – STC10 and 11 are possible)	Status Codes (508) STC01-2 (for F2 – STC10 and 11 are possible)
A1 - Acknowledgement/ Receipt The claim or encounter has been received. This does not mean that the claim has been accepted for adjudication.	0 – Cannot provide further status electronically.
A3 – Acknowledgement/ Returned The claim/encounter has been rejected and has not been entered into the adjudication system.	0 – Cannot provide further status electronically.
A4 – Acknowledgement/ Not Found The claim/encounter cannot be found in the adjudication system.	0 – Cannot provide further status electronically.
P1 – Pending/In Process The claim or encounter is in the adjudication system.	0 – Cannot provide further status electronically, or 101 – Claim was processed as an adjustment to previous claim.
P3 – Pending/Requested Information The claim or encounter is waiting for information that has already been requested.	0 – Cannot provide further status electronically
F0 – Finalized The claim/encounter has completed the adjudication cycle and no more action will be taken.	3 - Claim has been adjudicated and is awaiting payment cycle.
F1 – Finalized/Payment The claim/ line has been paid.	3 - Claim has been adjudicated and is awaiting payment cycle. 107 - Processed according to contract/plan provisions.

Category Codes (507) STC01-1 (for F2 – STC10 and 11 are possible)	Status Codes (508) STC01-2 (for F2 – STC10 and 11 are possible)
<p>F2 – Finalized/Denied</p> <p>The claim/line has been denied.</p>	<p>Any of the following codes are possible; see table below for explanations:</p> <p>1, 7, 9, 12, 16, 21, 24, 27, 28, 29, 33, 41, 42, 45, 46, 48, 50, 51, 52, 54, 56, 65, 67, 68, 69, 81, 83, 84, 85, 86, 88, 89, 90, 92, 93, 94, 95, 96, 97, 98, 100, 101, 107, 109, 110, 114, 116, 121, 122, 123, 124, 125, 145, 155, 158, 159, 174, 180, 182, 183, 184, 185, 186, 187, 193, 217, 218, 228, 234, 249, 250, 255, 258, 263, 265, 273, 274, 279, 280, 286, 287, 290, 295, 297, 298, 299, 300, 305, 306, 308, 310, 311, 312, 316, 317, 319, 323, 333, 335, 345, 363, 365, 366, 397, 411, 413, 414, 428, 430, 441, 443, 446, 448, 453, 454, 472, 474, 475, 483, 487, 488, 498, 585, 596, 638, 656, 670, 674</p>
<p>F3 – Finalized/Revised</p> <p>Adjudication information has been changed. This includes internal adjustments that may have been made for system data requirements. Submitters should note that this modification may not significantly change data sent, nor may it be noted on the EOP.</p>	<p>3 - Claim has been adjudicated and is awaiting payment cycle. 9 - No payment will be made for this claim. 107 - Processed according to contract/plan provisions.</p>
<p>F3F – Finalized/Forwarded</p> <p>The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records.</p>	<p>1– For more detailed information, see remittance advice.</p>
<p>E0 – Error in Submitted Request Data</p>	<p>24 – Entity not approved as an electronic transmitter 26 – Entity not found. 33 – Subscriber and subscriber ID not found 109 – Entity not eligible* 158 – Entity's Date of Birth 187 – Date(s) of service</p> <p>* Note that BCBSNC only uses this error code when the entity in question is the payer.</p>
<p>E1 – Response not possible – System Status</p>	<p>90 – Entity not eligible for medical benefits for submitted dates of service. 487 – Claim not found; claim should have been submitted to/through another entity. (This code is used for Dental Claims only.)</p>

Possible Status Codes for Category Code F2

Status Code Number	Status Code Explanation
1	For more detailed information, see Remittance Advice.
3	Claim has been adjudicated and is awaiting payment cycle.
9	No payment will be made for this claim.
12	One or more originally submitted procedure codes have been combined.
16	Claim/encounter has been forwarded to entity.
21	Missing or invalid information.
24	Entity not approved as an electronic submitter.
28	Claim submitted to wrong payer.
33	Subscriber and Subscriber ID not found.
41	Special handling required at payer site.
46	Internal review/audit.

Status Code Number	Status Code Explanation
48	Referral/authorization.
50	Claim waiting for internal provider verification.
52	Investigating existence of other insurance coverage.
54	Duplicate of a previously processed claim/line.
56	Awaiting eligibility determination.
81	Contract/plan does not cover pre-existing conditions.
83	No coverage for newborns.
84	Service not authorized.
88	Entity not eligible for benefits for submitted dates of service.
89	Entity not eligible for dental benefits for submitted dates of service.
92	Entity does not meet dependent or student qualification.
94	Entity not referred by selected primary care provider.
95	Requested additional information not received.
97	Patient eligibility not found with entity.
98	Charges applied to deductible.
100	Pre-certification penalty taken.
101	Claim was processed as adjustment to previous claim.
107	Processed according to contract/plan provisions.
114	Should be handled by entity.
116	Claim submitted to incorrect payer.
122	Missing/invalid data prevents payer from processing claim.
123	Additional information requested from entity.
159	Entity's date of death
182	Allowable/paid from primary coverage.
184	Purchase price for the rented durable medical equipment.
280	Itemized claim by provider.
287	Medical necessity for service.
317	Patient's medical records.
363	Will worker's compensation cover submitted charges?
365	Is service the result of an accident?
414	Need for more than one physician to treat patient.
454	Procedure code for services rendered.
474	Procedure code and patient gender mismatch.
483	Maximum coverage amount met or exceeded for benefit period.
487	Claim not found; claim should have been submitted to/through another entity. (This code is used for Dental Claims only.)

Possible Status Codes for Category Code Values of F2

276 Data Element Table

This Element Table presents a matrix of only those HIPAA Implementation Guide elements that require annotation about BCBSNC business processes. The matrix identifies the element in question according to its loop, segment, and element identifiers within the ASC X12N Implementation Guides. Adjacent to the element's identifiers is the BCBSNC business rule specific to that data element.

Transaction: 276 Claim Status Request					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
	BHT	Beginning of Hierarchical Transaction (p. 50)			
			04	Date	All dates must be expressed in the ccyymmdd format. Future or invalid dates are not accepted. See the "Business Edits" in the Introduction of the 276/7 Chapter for Error Messages.
2100A	NM1	Payer Name (p.54)			
			03	Last name or Organization Name	Use "Blue Cross and Blue Shield of NC".
			08	Identification Code Qualifier	Use the FI (Federal Tax ID) value.
			09	Identification Code	Use a value of 560894904. (Submitters receive an error Code of 109 in STC01-2 if this identification code is incorrect.)
2100C	NM1	Provider Name (p.67)			
			08	Identification Code Qualifier	Use the XX code value for the NPI.
			09	Identification Code	Use the NPI (See Matching Criteria for more details.) Discrepancies between the number submitted in NM109 and the number on file with BCBSNC will return an error code of E0-24.
2000D	DMG	Subscriber Demographic information (p. 72)			
			02	Date Time Period	An error code of E0-158 will be returned for future dates.
			03	Gender Code	<ul style="list-style-type: none"> BCBSNC uses only M and F values. This value defaults to the BCBSNC record for the subscriber in question, regardless of the value sent.
2100D	NM1	Subscriber Name (p.74)			
			02	Entity Type Qualifier	BCBSNC uses a code value of 1 (Person) only.
			06	Name Prefix	BCBSNC does not use this value.
			07	Name Suffix	Include the suffix if it appears on the Member's BCBSNC Identification Card. The suffix should appear in the 276 as it appears on the member's card.
			08	Identification Code Qualifier	BCBSNC uses a value of MI (Member Identification) only.

Transaction: 276 Claim Status Request					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
			09	Identification Code	Use the ID number filed on the claim, which should be consistent with the ID on the Subscriber's BCBSNC subscriber card. (For more information about subscriber identifiers, see the Introduction to the Companion Guide.)
2200D	REF	Payer Claim Identification Number (p. 78)			
			02	Reference Identification	Use the BCBSNC Claim Number. Note that the format in the Claim Audit Report for Medicare Supplemental policies is yyymmdd##### and may include an alpha character. For all other claims, the format is mmddy#####. Submit the entire 12 digit number for the Claim Control Number.
	DTP	Claim Service Date (p. 86)			
			03	Date Time Period	Use a date range only if that range applies to a single claim for which the service was provided. (For more information on the efficacy of date range inquiries, see Date Ranges .)
2210D	SVC	Service Line Information (p.88)			
				Entire Segment	Although a Request may be made at the line level, the Response (277) will be made at the claim level only.
			02	Monetary Amount	Whatever amount is sent in this element is returned on the 277 Response at the Claim level – 2200D or 2200E, STC04.
2000E	DMG	Dependent Demographic information (p. 96)			
			02	Date Time Period	An error code of E0-158 will be returned for future dates.
			03	Gender Code	BCBSNC uses only M and F values.
2100E	NM1	Dependent Name (p.98)			
			06	Name Prefix	BCBSNC does not use this value.
			07	Name Suffix	Include the suffix if it appears on the Member's BCBSNC Identification Card. The suffix should appear in the 276 as it appears on the member's card.
			08	Identification Code Qualifier	BCBSNC uses a value of MI (Member Identification) only.
			09	Identification Code	Use the ID number filed on the claim. Use the ID number filed on the claim, which should be consistent with the ID on the Subscriber or Member's BCBSNC card. (For more information about subscriber identifiers, see the Introduction to the Companion Guide.)
2200E	REF	Payer Claim Identification Number (p. 103)			
			02	Reference Identification	Use the BCBSNC Claim Number. Note that the format in the Claim Audit Report for

Transaction: 276 Claim Status Request					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
					Medicare Supplemental policies is yymmdd##### and may include an alpha character. For all other claims, the format is mmdyy#####. Submit all 12 digits for the Claim Number.
2210E	SVC	Service Line Information (p. 113)			
			Entire Segment		BCBSNC responds at the claim level only.
			02	Monetary Amount	Whatever amount is sent in this element is returned on the 277 Response at the Claim level – 2200E, STC04.

277 Data Element Table

This Element Table presents a matrix of only those HIPAA Implementation Guide elements that require annotation about BCBSNC business processes. The matrix identifies the element in question according to its loop, segment, and element identifiers within the ASC X12N Implementation Guides. Adjacent to the element’s identifiers is the BCBSNC business rule specific to that data element.

Transaction: 277 Health Care Claim Status Response					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
2100A	NM1	Payer Name (p.130)			
			03	Last name or Organization Name	BCBSNC returns Blue Cross and Blue Shield of NC, regardless of the value in 276
			08	Identification Code Qualifier	BCBSNC returns the FI code value, regardless of the value sent in the 276.
			09	Identification Code	BCBSN returns a value of 560894904.
2100B	NM1	Information Receiver Name (p.138)			
			08	Identification Code Qualifier	The 277 returns either FI [Federal Taxpayer’s Identification Number] or 46 [ETIN], whichever was entered on the 276 (2100B, NM1-08).
2100C	NM1	Provider Name (p. 143)			
			08	Identification Code Qualifier	BCBSNC returns the XX code sent in the 276

Transaction: 277 Health Care Claim Status Response					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
			09	Identification Code	BCBSNC returns the NPI which was filed on the 276 Request. If this ID is not verified in our system, an error message of E0-24 or E0-26 (STC01-1 and STC01-2) is returned in the 2200D or 2200E STC segment.
2000D	DMG	Subscriber Demographic information (p. 148)			
			02	Date Time Period	<ul style="list-style-type: none"> All dates are expressed in the format of ccyyymmdd. Future dates for DOB are not accepted and return an error code of E0-158 in the 2200D or 2200E STC segment. Either our system record for the date of birth, or the dependant's date of birth is returned if no subscriber DOB has been submitted on the 276 Request.
2100D	NM1	Subscriber Name (p.150)			
			03	Last Name or Organization Name	<ul style="list-style-type: none"> If the value sent in the 276 for this element is different from BCBSNC system records, the value is corrected to comply with our data. The only exceptions to this rule are Blue Card holders and Federal Government employees. Note that if the person's name contains a suffix, such as Jr., the suffix may be attached to the Last Name without separating spaces.
			04	Name First	If the value sent in the 276 for this element is different from BCBSNC system records, the value is corrected to comply with our data. (see above)
			07	Name Suffix	If a suffix is attached to the subscriber's name, it is returned in NM103 as part of the Last Name value.
			08	Identification Code Qualifier	BCBSNC returns a value of MI (Member Identification Number) regardless of what was sent on the 276.
			09	Identification Code	A valid Member ID Number contains all characters (alpha and numeric) displayed on the Subscriber's BCBSNC ID card. An error code of E0-33 is returned in the STC segment for invalid Member ID Numbers.
2200D	Loop	Claim Submitter Trace Number			
				Entire Loop	276 Requests made at the Service Line level will receive 277 Responses at the Claim level only.
2200D	STC	Claim Level Status Information (p. 154)			

Transaction: 277 Health Care Claim Status Response					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
			01-1	Industry Code	<ul style="list-style-type: none"> See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-1 responses. An error code of E0 appears here if the value in the 276 Request, 2100B, 2100C, 2100D, or 2100E NM109 is invalid. An error code of E1 (Response not Possible) appears here if the subscriber's coverage is for dental or life insurance coverage only or if Blue Exchange closed out the request (for out-of-state or Federal Employee Program [FEP] subscribers). If STC01-3, Entity Identifier Code, has been used, the response has been returned from Blue Exchange.
			01-2	Industry Code	<ul style="list-style-type: none"> See the Claims Status Category and Status Codes and the Possible Status Codes for Category Codes F2 and F3 Table listed in this chapter for a complete list of STC01-2 responses. An error code of 024 appears here if the value in the 276 Request, 2100C NM109 is invalid. An error code of 90 is returned when the subscriber has only life insurance coverage. An error code of 487 appears here if the subscriber's coverage is for dental only. An error code of 0 appears here if Blue Exchange closed out the request. See Blue Card and FEP Requests for more information.
			01-3	Entity Identifier Code	A value of ZZ indicates this response was generated by Blue Exchange
			04	Monetary Amount	<ul style="list-style-type: none"> BCBSNC returns the claim amount sent in the 276 Request regardless of the amount being reimbursed as stated in the Notice of Payment. Note that the amount appears in this loop only if the patient is the subscriber. If Blue Exchange generated the response (See STC01-3), this value is set to zero.
			05	Monetary Amount	<ul style="list-style-type: none"> If the response is generated by Blue Exchange (See STC01-3), this value is set to zero. This monetary amount reflects the actual adjudicated amount paid; however, if the adjudication process has not completed, the amount is

Transaction: 277 Health Care Claim Status Response					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
					zero.
			07	Payment Method Code	BCBSNC returns only two possible values: ACH (electronic funds transfer) or CHK (check).
			09	Check Number	The check number may be omitted for some status requests if the claim has been adjusted or revised, or if the response is to a Blue Card or Federal Employee Program (FEP) 276 Request.
			10	Claim Status	If STC01 = F2, a status code may appear here as a second iteration for the response. See Possible Status Codes for F2 Value Table .
			11	Claim Status	If STC01 = F2, a status code may appear here as a third iteration for the response. See Possible Status Codes for F2 Value Table .
	REF	Payer Claim Identification Number (p.165)			
			02	Reference Identification	The Claim Control Number returned may be slightly modified from the Claim Control Number sent in the 276, 2200D, REF02.
	DTP	Claim Service Date (p. 171)			
				(Entire Segment)	Inquiries made at the service line level will receive response at the Claim level only.
			03	Date Time Period	The date sent on the 276 Inquiry is the date returned, regardless of claim date(s) retained on our internal systems.
2000E	DMG	Dependent Demographic information (p.192)			
			02	Date Time Period	All dates are expressed in the ccyyymmdd format. Future dates are not accepted and return an error code of E0-158 in the STC segment.
2100E	NM1	Dependent Name (p.194)			
			03	Last name or Organization Name	If the person's name contains a suffix, such as Jr., it may be returned in the Last Name without separating spaces.
			07	Name Suffix	If a suffix is attached to the subscriber's name, it is returned in NM103 as part of the Last Name value.
			08	Identification Code Qualifier	BCBSNC returns a value of MI (Member Identification Number) regardless of what was sent on the 276.
2200E	STC	Claim Level Status Information (p.199)			
			01-1	Industry Code	<ul style="list-style-type: none"> See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-1 responses. An error code of E0 appears here if the value in the 276 Request, 2100B, 2100C, 2100D, or 2100E NM109 is invalid.

Transaction: 277 Health Care Claim Status Response					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Rules
					<ul style="list-style-type: none"> An error code of E1 appears here if the dependent's coverage is for dental only.
			01-2	Industry Code	<ul style="list-style-type: none"> See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-2 responses. An error code of 024 appears here if the value in the 276 Request, 2100C NM109 is invalid. An error code of 90 is returned when the subscriber has only life insurance coverage. An error code of 487 appears here if the dependent's coverage is for dental only.
			01-3	Entity Identifier Code	A value of ZZ is sent if Blue Exchange generated the response.
			04	Monetary Amount	<ul style="list-style-type: none"> BCBSNC returns the claim amount sent in the 276 transaction regardless of the amount being reimbursed as stated in the Notice of Payment. Note that the amount appears in this loop only if the patient is the dependent. This value reflect the monetary amount sent on the 276 Request
			05	Monetary Amount	This element reflects the actual payment amount. However, if the adjudication process is not finished, the amount is zero.
			07	Payment Method Code	BCBSNC returns only two possible values: ACH (electronic funds transfer) or CHK (check).
			10	Claim Status	Not used.
			11	Claim Status	Not used.
2200E	REF	Payer Claim Identification Number (p. 210)			
			02	Reference Identification	This element is required for Version 4010A1; however, it is not always possible to return a real value. When a claim is not found and the Payer Claim ID has not been included on the 276 Inquiry, this element is returned with zeros.
	DTP	Claim Service Date (p. 216)			
			03	Date Time Period	The date sent on the 276 Inquiry is the date returned, regardless of claim date(s) retained on our internal systems.

276-277 Transactions Samples

276 Business Scenario

The following sample data is used to present a high-level scenario where the Information Receiver is an orthopedic clinic. The patient is a dependent and only one claim is included in the Request.

Payer (Information Source)	BCBSNC Payer Identification Number: 560894904
Provider (Information Receiver)	The Bone and Joint Clinic NPI 1234567893 Facility Network Identification Number: 234000 Address: Durham, NC, 27707 Communication Contact Name: Billing Dept. Phone Number: 919-555-1212 Extension: 2805 FAX: 919-555-1213
Individual Physician (Service Provider)	Marcus Helby, MD NPI 1234567893 Provider Plan Network Identification Number: 129 Communication Contact Name: M. Murphy Phone Number 919-555-1212, Extension 3694 FAX 919-555-1214
Service Information	DOS: 20021021 Billing date: 20021031
Subscriber	Barnard Rubble - Subscriber Member Identification Number: 111223301 Group or Policy Number 599119 Address: 29 Brontosaurus Road, Flintville, NC, 27713 DOB: 05/19/1951
Dependent/Patient	BamBam Rubble - Dependent (Patient) Member Identification Number: 111223303 Address: 29 Brontosaurus Road, Flintville, NC, 27713 DOB: 10/14/1988

276 Data String Example

The following transmission example represents the data string that would be sent as the 276 Request. The example illustrates the file formats used for the EDI transaction, which include delimiters and data element. For more information about file formats and application control structures, see "Appendix A: ASSC X12 Nomenclature" in the *ASC X12N 276/277 Implementation Guide*.

```

ST*276*0123~
BHT*0010*13**20021031~
HL*1**20*1~
NM1*PR*2*Blue Cross and Blue Shield of NC****FI*560894904~
HL*2*1*21*1~
NM1*41*2*BONE AND JOINT CLINIC****46* NPI 1234567893~
HL*3*2*19*1~
NM1*1P*1*HELBY*MARCUS**MD*XX* NPI 1234567893~
HL*4*3*22*1~
DMG*D8*19510519*M~
NM1*IL*1*RUBBLE*BARNARD***MI*111223301~
HL*5*4*23~
DMG*D8*19881014*M~
NM1*QC*1*RUBBLE*BAMBAM***MI*111223303~
TRN*1*XXX123~
REF*1K*MMDDYY123456
REF*BLT*111~
AMT*73*2500~
SE*19*0123

```

276 File Map

Loop ID		Segments		Elements																
1		Transaction Set Header	ST	ST01	ST02															
				276	0123															
1		Beginning of Hierarchical Transaction	BHT	BHT01	BHT02	BHT03	BHT04													
				0010	13	*	20021031													
1	2000A	Information Source Level	HL	HL01	HL02	HL03	HL04													
				1	*	20	1													
1	2100A	Payer Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				PR	2	BCBSNC	*	*	*	*	FI	560894904								
1	2000B	Information Receiver Level	HL	HL01	HL02	HL03	HL04													
				2	1	21	1													
1	2100B	Information Receiver Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				41	2	The Bone and Joint Clinic	*	*	*	*	XX	1234567893								
1	2000C	Service Provider Level	HL	HL01	HL02	HL03	HL04													
				3	2	19	1													
1	2100C	Provider Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				1P	1	HELBY	MARCUS	*	*	MD	XX	1234567893								
1	2000D	Subscriber Level	HL	HL01	HL02	HL03	HL04													
				4	3	22	1													
1	2000D	Subscriber Demographic Information	DMG	DMG01	DMG02	DMG03														
				D8	19510519	M														
1	2100D	Subscriber Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				IL	1	RUBBLE	BARNARD	*	*	*	MI	111223301								
1	2000E	Dependent Level	HL	HL01	HL02	HL03														
				5	4	23														
1	2000E	Dependent Demographic Information	DMG	DMG01	DMG02	DMG03														
				D8	19881014	M														

Loop ID		Segments		Elements								
1	2100E	Dependent Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
				QC	1	RUBBLE	BAMBAM	*	*	*	MI	111223303
1	2200E	Claim Submitter Trace Number	TRN	TRN01	TRN02							
				1	XXX123							
1	2200E	Payer Claim Identification Number	REF	REF01	REF02							
				1K	mmddy123456							
1	2200E	Institutional Bill Type Identification	REF	REF01	REF02							
				BLT	111							
1	2200E	Claim Submitted Charger	AMT	AMT01	AMT02							
				73	2500							
1	2200E	Claim Service Date	DTP	DTP01	DTP02	DTP03						
				232	RD8	20021021						
1		Transaction Set Trailer	SE	SE01	SE02							
				19	0123							

Document Change Log

The following change log identifies changes that have been made from version 1.0 of *Chapter 5: 276-277 Claim Status Request and Response*.

Chapter Section	Page Number	Change Description
Claim Status Category Codes and Status Codes	9	Added Status Code (508) value of "101" to Category Code (507) value of "P1".
Claim Status Category Codes and Status Codes	10	Deleted Status Code (508) value of "0"
Monetary Amounts	5	Modified to clarify that the "Amount Paid" through adjudication is included in the STC05 element of the 277 Response.
277 Data Element Table	15	Modified the STC04 and STC05 elements of both the 2200D and 2200E loops to clarify "Amount Paid".
Claim Status Category Codes and Status Codes	9,10	Added the table - Possible Status Codes for Category Codes F2 or F3 – and revised the original Claims Status and Category Codes table.
277 Data Element Table	15	Modified the STC10 and STC11 elements to allow for additional iterations of claim status codes.
276 and 277 Data Element Table	12, 14, 15	Modifications made for acceptance and return of NPI for NM109 values.
Security Validation Edits	8	Addition of E0-026 as a Status Category Code used for STC01 and STC02 values.
276 and 277 Data Element Tables and Provider Identifier	12-15, 4	Modifications for integration of Medicare Supplemental formats and removal of BCBSNC proprietary identifier references.
Global		Changed "BCBSNC Customer Support" to "eSolutions HelpDesk".