

**HM Benefits Administrators
Provider EDI Reference Guide**

CLAIM STATUS (276 & 277)

VERSION 1.1



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12 Claim Status (276 & 277)

The 276 transaction is used to request the status of a health care claim(s), and the 277 transaction is used to respond with information regarding the specified claim(s). These implementation guides were designed to allow for standardized submission of data content for all users. Entities who can request health care claim status include, but are not limited to hospitals, nursing homes, laboratories, physicians, dentists, allied professional groups and Billing Services acting on behalf of Health Care Providers.

The national transaction set implementation guide and Addenda dated 10/2002 named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage and requirements. This supplemental document contains clarifications and payer specific requirements related to data usage and content when submitting a 276 transaction to HM Benefits Administrators, hereafter known as “The Organization”, or receiving a 277 transaction from the Organization.

Health care payer, and the corresponding EIN, is:

- HM Benefits Administrators - 25-1128451

12.1 General Instructions and Guidelines for 276 and 277

The sections below will provide guidelines about a 276 or 277 transaction. These sections provide minimum data requirements for submitting a 276 transaction status request, and what data the payer will respond with on the 277 transaction response transaction.

12.1.1 General Instructions and Guidelines for 276

The general instruction section will provide guidelines in submitting a successful 276 transaction. Detailed in the sections below are minimum data requirements that must be followed in order for the payer to process the 276 transaction request. Also, there is information on specified minimum data requirements and situational data elements, and limitations on submitting multiple requests.

12.1.1.1 General Description

All claim status requests will be processed in **batch** mode, and will only include information available on the payers' adjudication system not yet purged. The 276 health care claim request can be used to request a status at a claim level, or for specific service lines.

12.1.1.2 Data that is Not Used

While the claim status information listed below can be (and in some cases must be) contained in a standard claim status request transaction, this information may not be captured and used by the Organization:

2100A: Payer Name Loop

2100B: Information Receiver Name Loop. The Organization will manage this with TP Authentication during EDI setup agreements.

Provider name - NM1 (2100C) - payer will search for claims using the billing provider ID and provider name.

Subscriber and Patient name - NM1 (2100D/E) - payer will search for claims using the member ID or health insurance claim number, (HIC #) and the Subscriber or Patients name.

Service line information - SVC (2210D/E) - payer will use only the minimum/institutional elements described further in this EDI Reference Guide when searching for claims; the payer will not use the service line information reported in the SVC. Note that service line information will be returned in the response transaction if the claim is finalized.

12.1.1.3 Minimum Requirements

As specified in the national implementation guide, the following elements and data content must be submitted in order for the payer to begin a claim search:

Payer (2000A)

Requestor (2000B)

Provider (2000C)

Member ID (2100D)

Patient Gender (2000D/E)

Service Date (2200D/E or 2210D/E)

12.1.1.4 Situational Elements and Data Content

The payer will sequentially use the following elements and data content to narrow down the search when looking for claims:

Patient Date of Birth (2000D/E)

Patient Last and First Name (2100D/E)

Medical Record Number (2200D/E)

Claim Charge Amount (2200D/E)

12.1.1.5 Multiple Requests Per Transaction

The Claim Status process for the payers in this Reference Guide is limited to one Information Source, Information Receiver and Provider per ST - SE transaction.

Multiple subscribers for one provider and/or multiple dependents for one subscriber can be submitted and a response will be sent for each.

Requests for both the subscriber and that subscriber's dependent cannot be included in the same subscriber loop; rather, there must be one subscriber loop for the request concerning the subscriber and a second subscriber loop for the request concerning the dependent.

12.1.2 General Instructions and Guidelines for 277

The general instruction section will provide information regarding a 277 transaction. Detailed in the sections below is the data that will be sent on a 277 response by the payer. This section also addresses claim splits, when to call customer service and the maximum claims returned for one 276 claim status request.

12.1.2.1 General Description of 277

The 277 transaction transmits the current status of a claim within the adjudication process

12.1.2.2 Customer Service Requests

When it is determined that a request cannot be answered from the information provided, please change your search criteria or contact the customer service area (according to normal procedures).

12.1.2.3 Maximum Claim Responses per Subscriber/Patient/Dependent

Since the 276 might not uniquely identify a claim, the 277 response may include multiple claims that meet the parameters submitted on the status request.

12.1.2.4 Claim vs. Line Reporting of Status

Status may be requested on a 276 transaction at the line and/or claim level. The 276 request may include the payer claim number to obtain an exact match.

12.2 276/277 Data Detail Instructions

This section will provide the data detail that is required when submitting a 276 transaction. The segments below contain the minimum data requirements that must be followed in order for the payer to process the 276 claim status request transaction. This section also covers what data detail will be sent by the payer on the 277 response transaction.

12.2.1 Data Detail for Claim Status Request (276)

Specific segments and content detail must be included on the 276 health care claim requests in order for the payer to process the 276 claims status request. Please look over the data detail in this section before submitting a 276 health care claim request.

Segment: **GS Functional Group Header**

Loop:

4010 IG Page: B.8

Data Element Summary

Ref Des	Element Name	Element Note
GS02	Application Sender's Code	Sender's assigned trading partner number

Segment: **NM1 Submitter Name**

Loop: 2100A

4010 IG Page: 55,56

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	The payers' Claim Status routing process requires the use of the Federal Taxpayer's Identification Number, therefore code value "FI" must be used.
NM109	Submitter Identifier	Enter the payer's FI number from below. This must be the same number as identified in GS03. All 276 transactions for a functional group must be for the same payer.

FI - XXXXXXXXXX

Segment: **NM1** Information Receiver Name
Loop: 2100B
4010 IG Page: 63

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	The payers' Claim Status process requires the use of the Trading Partner Number as assigned by the Organization's EDI Operations. This must be designated by a code value in this data element of "46", Electronic Transmitter Identification Number.
NM109	Information Receiver Identification Number	Send Trading Partner Number as assigned by the Organization's EDI Operations. This must be the same number as identified in GS02. Multiple information Receivers require multiple Functional Groups.

Segment: **NM1** Payer Name
Loop: 2100C
4010 IG Page: 68,69

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Use qualifier FI, Federal Taxpayer's Identification Number
NM109	Payer Identifier	Enter your Federal Taxpayer Identification Number

Segment: **NM1** Payer Name
Loop: 2100D
4010 IG Page: 75, 76

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Use code value “MI”, Member Identification Number.
NM109	Subscriber Identifier	This is the identifier from the member's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.

Segment: **REF** Payer Claim ID Number
 2200D

Loop:
 2200E

4010 IG Page: 79

Data Element Summary

Ref Des	Element Name	Element Note
REF02	Payer Claim Identification Number	Enter the Payer’s Claim Control Number. Note1 - this is not the Patient Account Number. Note2 - When the Payer Claim Control Number is provided, the payer will limit its search to an exact match of that control number.

12.2.2 Data Detail for Claim Status Response (277)

The payer will return specific data content on the 277 health care claim response. The detail data listed in this section will be what is sent back on the 277 response transaction.

Segment: **GS** Functional Group Header
Loop:

4010 IG Page: B.8

Data Element Summary

Ref Des	Element Name	Element Note
GS02	Application Senders' Code	The Organization will send the EIN code.
GS03	Application Receiver's Code	The Organization's Trading Partner Number assigned to the receiver will be used.
GS06	Group Control Number	The Organization will send unique control numbers for each functional group.