276/277 Claim Status Request and Response

276 & 277 – Health Care Claim Status Request and Response 2
Overview 2
Connectivity Transmission Options 2
System Availability 3
Frequency of Data Exchange 3
Claim Status Request Processing 3
Claim or Line Level Responses 4
Provider Identifier 4
Claim Identifier 4
Batch Volumes 4
Vendor-Supported Claims 4
Error Reporting 5
Batch Transmission Acknowledgements 5
Realtime Transmission Acknowledgements 6
Business Edits 6
Validation of Dates 6
Date Ranges 6
Monetary Amounts 6
Payer ID Not Eligible 6
Exception Handling 6
Claim Status Category Codes and Status Code 7
Inter-plan Program (IPP) and FEP Requests (Blue Exchange) 8
276 Data Element Table 10
277 Data Element Table 13
276-277 Transactions Samples 18
276 Business Scenario 18
276 Data String Example 19
276 File Map 20
Document Change Log 22

276 & 277 – Health Care Claim Status Request and Response

Overview

The 276 and 277 Transactions are used in tandem: the 276 Transaction is used to inquire about the current status of a specified claim or claims, and the 277 Transaction in response to that inquiry.

The information in this chapter clarifies BCBSNC business and processing rules that are relevant to the implementation of the 276 and 277 Transactions, version 5010 (as defined by the 276/277 Technical Report 3 [TR3]). The information contained here does not contradict or repeat the information available to the reader through the TR3 implementation guide for the 276-277 transactions. The chapter delivers BCBSNC-specific information about the handling of these 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.

Connectivity Transmission Options

The following connectivity options are available for transmission and receipt of X12 Health Eligibility 276/277 transactions – 5010 version. For more information about connectivity, see the *Introduction to the BCBSNC Companion Guide* at www.bcbsnc.com/content/providers/edi/hipaainfo/companionguuide.htm. See the CAQH website for more information about CAQH connectivity protocols.

Connectivity Mode	Medium	File Format	CAQH Certified
HTTPS	Secure Web Browser	X12 Batch	
FTP	Secure Web Service	X12 Batch	
SOAP + WSDL	Secure Web Service	X12 Realtime and Batch	X
HTTP + MIME	Secure Web Service	X12 Realtime and Batch	X

System Availability

Inquiries may be submitted 24 hours a day, seven days a week; however, we reserve the right to have occasional maintenance periods. If we are performing maintenance, you will receive the following values on the v5010 277 Claim Status response:

- Category Code of "E2" ("Information Holder is not resonding; resubmit at a later time.")
- Claim Status Code of 689 ("Entity was unable to respond within the expected time frame")
- Entity Code of "IN" (Insurer).

Frequency of Data Exchange

Real time processing typically takes no more than 20 seconds. If a response is not returned within 60 seconds, the connection is terminated.

Sender's batch transmissions can expect to receive a 277 response between 5 minutes to one hour of submitting the original 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 *BCBSNC 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.

Claim Status Request Processing

Data from a 276 Request is returned on the 277 Response. Submitters can send electronic inquiries and receive response data for dates of service that are less than 3 years from the today's date. 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.

Possible status responses are listed in the Claims Status Category Codes table in this document. For detailed information about specific claims, submitters should review the 835 Remittance Advice), or the Explanation of Payment (EOP).

For batch transactions, 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.) In addition, if there is not an exact match found for a claim identifier, the system will return claims that closely match and are in the same date range – with the exception of claims for members whose Member Identifier starts with YPS, YPQ, or YPU. Realtime 277 transactions cannot return multiple responses, based on date range. Only one 277 response is returned to a single, realtime 276 submitted.

Claim or Line Level Responses

277 Responses provide claim status information the line level for Professional commercial claims and line level for Institutional commercial claims; however, Institutional claims submitted with line level charges return line level status responses. Claims for Membership IDs starting with alpha prefixes YPS, YPQ, or YPU return statuses at either the claim or line level, based upon the request. Please note that senior segment business returns status at the line level only for Professional claims; senior segment Institutional claims return only claim level status 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

For all lines of business, with the exception in the note below, expedite the 277 Response by including the BCBSNC Claim Control Number in the 276 Inquiry. The format of this claim identifier consists of a six-digit date, followed by a six-digit number (e.g. mmddyy######) for all claim types except for Medicare Advantage and 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.

NOTE: For claims where the member IDs has an alpha prefix YPS, YPQ, or YPU, including the BCBSNC Claim Control Number returns a response of only that claim with the control number, to the exclusion of all other possible responses. For a broader range of possible responses, use only the member ID, Date of Service, Charge Amount, and provider NPI for claims with member IDs starting with YPS, YPQ, or YPU.

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.

Important Notice:
BCBSNC does not rebind batches for response with the same inquiries as received. Submitters should provide the Patient Account Number (2200D, REF01), so that they can associate submitted requests to their respective responses.

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.

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	• Invalid Message or Information • Invalid Identifiers • Inactive Message • Improper Batch Structure	TA1 Acknowledgement
• GS/GE Segment • ST/SE Segment • Detail Segments	HIPAA TR3 Violations	999 Acknowledgement
Detail Segments	• BCBSNC Business Edits (see 277 Data Element Table for details) • Security Validation (See Security Validation Edits for details)	277

Error Reporting Table

Batch Transmission Acknowledgements

The TA1 Interchange Acknowledgement and the 999 Functional Group Acknowledgement are returned upon the receipt of a 276 Claim Status Request. Receipt of a positive TA1 and 999 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 TR3 errors are found within the transmission, a negative TA1 or 999 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 999 Transactions.

See the Business Edits section of this chapter for more information about returned transactions for BCBSNC business edits.

TA1 and 999 Transactions

The TA1 and 999 Functional Acknowledgement Transactions are used to indicate Technical Report (TR3) errors. If a transaction is rejected at the Interchange Control (ISA/IEA) level, the batch returns a TA1 Interchange Acknowledgement that identifies the TR3 error contained in the transmission. If a transaction is rejected at the Functional Group (GS/GE) or Transaction Set (ST/SE) level, a 999 Functional Acknowledgement that identifies the TR3 errors is returned. However, if the GS/GE level (Functional Group) of the transaction is corrupted such that a 999 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 Technical Report (TR3) violations, BCBSNC returns the TA1 or 999 acknowledgement Transactions ONLY. Trading partners who are unable to accept a 999 or TA1 transaction are not provided with alternative Technical Report (TR3) error reporting mechanisms.

Realtime Transmission Acknowledgements

When a compliant 276 Claim Status Inquiry is received, no positive 999 or TA1 is returned; confirmation is receipt of the 277 Response. Non-compliant 276 Inquiries receive a either a negative TA1 or a negative 999, depending on where in the x12 the error occurred.

Business Edits

BCBSNC business edits are affective after the transmission has passed TR3 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.**

Monetary Amounts

For all claim types except for Medicare Advantage, 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 277 Response (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.

Payer ID Not Eligible

For all claim types except for Medicare Advantage, if the 276 Claim Status request contains any value other than the BCBSNC Federal Tax ID (560894904) for the Payer ID (Loop 2100A NM109), the 277 Claim Status response will return an error of 'E0' (Response not possible - error on submitted request data), and a Claim Status Code of '109' (Entity not Eligible) and an Entity Code of 'IN' (Insurer).

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. If the member's id is unique, their information should be submitted in the subscriber loop, regardless of whether they are a subscriber or a dependent. If the dependent does not have a unique member id, submit the dependent's information in the dependent loop. 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/.

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 as unprocessable claim 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.	**35 –** Claim/Encounter cannot be found.
P1 – Pending/In Process The claim or encounter is in the adjudication system.	Can be any of the 508 codes as published by the Washington Publishing Company: http://www.wpc-edi.com/.
P2 – Pending/Payer Review The claim/encounter is suspended and is pending review. (eg. Medical review, repricing, third party administrator processing) No action should be taken by the provider upon receiving a P2 response.	Can be any of the 508 codes as published by the Washington Publishing Company: http://www.wpc-edi.com/.
P3 – Pending/Provider Requested Information Medical records are needed or have been requested for the claim. The Provider will need to provide additional information.	Can be any of the 508 codes as published by the Washington Publishing Company: http://www.wpc-edi.com/.
P4 - Pending/Patient Requested Information Payer has requested COB information or confirmation. Requesting other commercial insurance information from the patient to determine the insurance carrier's level of responsibility for the payment of a claim (primary, secondary, tertiary). The provider is not responsible for this information.	Can be any of the 508 codes as published by the Washington Publishing Company: http://www.wpc-edi.com/.

Category Codes (507) STC01-1 (for F2 – STC10 and 11 are possible)	**Status Codes (508)** STC01-2 (for F2 – STC10 and 11 are possible)
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.	**104** – Processed according to plan provisions. **107 -** Processed according to contract provisions.
F2 – Finalized/Denied The claim/line has been denied.	Can be any of the 508 codes as published by the Washington Publishing Company: http://www.wpc-edi.com/.
F3 – Finalized/Revised 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.	Any of the following code are possible: **101 –** Claim was processed as an adjustment to previous claim **104 –** Processed according to plan provisions. **107 –** Processed according to contract provisions. **9 –** No payment will be made on this claim.
E0 – Error in Submitted Request Data	**23 –** Returned to Entity. **484 –** Business application currently not available. **26** – Entity not found. (Note: If you receive this code, 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.) **33** – Subscriber and subscriber ID not found **109** – Entity not eligible* **158** – Entity's Date of Birth **187** – Date(s) of service **691**– Multiple claims status requests cannot be processed in real time * Note that BCBSNC only uses this error code when the entity in question is the payer.
E1 – Response not possible – System Status	**90** – Entity not eligible for medical benefits for submitted dates of service. **487** – Claim not found; claim should have been submitted to/through entity. (This code is used for Dental Claims only.) **689** – Entity was unable to respond within the expected timeframe.
E2 - Information Holder is not responding; resubmit at a later time.	**689 –** Entity was unable to respond within the expected time frame.

Inter-plan Program (IPP) and FEP Requests (Blue Exchange)

In order to manage inquiries for out-of-state (IPP) 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 999 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 total charge amount
STC05 Claim Payment Amount	Set to zero.

STC Code Values used by BCBSNC when no response is received from Blue Exchange

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			
			03	Reference Identification	Number assigned by the originator to identify the transaction within the originator's business application system. Will be returned on the 277. Required
			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.
			05	Time	Time in Eastern time. Required. Can be received in HHMM or HHMMSS or HHMMSSD or HHMMSSDD format. Required.
2100A	NM1	Payer Name			
			03	Payer 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			
			08	Identification Code Qualifier	Use the XX code value for the NPI.
			09	Identification Code	Use the NPI. Discrepancies between the number submitted in NM109 and the number on file with BCBSNC will return an error code of E0-24 or EO-26.
2000D	Loop	Subscriber Loop			
					Dependent data may be sent in Subscriber Loop if the dependent is the patient and has a unique member ID. Submit the entire member ID and all other patient demographic information in the same loop.
2000D	DMG	Subscriber Level			
			02	Subscriber Birth Date	Dates must be expressed in the ccyymmdd format. An error code of E0-158 will be returned for future dates.

Transaction: 276 Claim Status Request					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			03	Gender Code	BCBSNC uses only M and F values.
2100D	NM1	Subscriber Name			
			02	Entity Type Qualifier	BCBSNC uses a code value of 1 (Person) only.
			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	Subscriber Identifier	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	Patient Control Number			
			01	Reference Identifier Qualifier	Use EJ for the Patient Account Number
			02	Patient Control Number	Include the Patient Account Number when one has been assigned by the service provider. This number is a maximum of 20 characters.
	DTP	Claim Service Date			
			03	Claim Service Period	Use a single date of service or a date range that applies to a single claim. 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			
			Entire Segment		**Claim Level or Line Level Responses:** BCBSNC responds at line level for Professional commercial lines of business, and at the claim level for Institutional commercial claims. If an Institutional claim includes line level charges, the status response includes the line level. Senior segment lines of business for Institutional claims are returned at the claim level only. For claims with member IDs of alpha prefix YPS, YPQ, or YPU, line level responses are returned only if requested, regardless of the claim type. Note: For Blue Exchange or FEP requests, the other plan will determine whether a claim level or line level response is returned.
			02	Line Item Charge Amount	Up to 18 characters are accepted.

Transaction: 276 Claim Status Request					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
	REF	Service Line Item Identification			
			02	Line Item Control Number	Up to 50 characters are allowed.
	DTP	Service Line Date			
			03	Service Line Date	Use the format: CCYYMMDD-CCYYMMDD or CCYYMMDD
2000E	DMG	Dependent Demographic information			
			02	Patient Birth Date	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			
			07	Patient 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	This is no longer used. The member's information will appear in the subscriber loop.
			09	Identification Code	Not used.
2200E	REF	Payer Claim Control Number			
			02	Payer Claim Identification Number	Use the BCBSNC Claim Number. Note that the format in the Claim Audit Report for Medicare Advantage and Medicare Supplemental policies is yymmdd###### and may include an alpha character. For all other claims, the format is mmddyy######. Submit all 12 digits for the Claim Number.
	DTP	Claim Service Date			
			03	Claim Service Period	Use the format: CCYYMMDD-CCYYMMDD or CCYYMMDD
2210E	SVC	Service Line Information			

Transaction: 276 Claim Status Request					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			Entire Segment		**Claim Level or Line Level Responses:** BCBSNC responds at line level for Professional commercial lines of business, and at the claim level for Institutional commercial claims. If an Institutional claim includes line level charges, the status response includes the line level. Senior segment lines of business for Institutional claims are returned at the claim level only. For claims with member IDs of alpha prefix YPS, YPQ, or YPU, line level responses are returned only if requested, regardless of the claim type. Note: For Blue Exchange or FEP requests, the other plan will determine whether a claim level or line level response is returned.
			02	Line Item Charge Amount	Whatever amount is sent in this element is returned on the 277 Response at the Claim level – 2200E, STC04.
	DTP	Service Line Date			
			03	Service Line Date	Use the format: CCYYMMDD-CCYYMMDD or CCYYMMDD

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**
	BHT	Beginning of Hierarchical Transaction			
			03	Reference Identification	Number assigned by the originator to identify the transaction within the originator's business application system. Value from the 276 will be returned.

Transaction: 277 Health Care Claim Status Response					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			05	Time	Time in Eastern time. Can be received in HHMM or HHMMSS or HHMMSSD or HHMMSSDD format. Required.
2100A	NM1	Payer Name			
			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 PI code value, regardless of the value sent in the 276.
			09	Identification Code	BCBSN returns a value of 560894904.
2100B	NM1	Information Receiver Name			
			08	Identification Code Qualifier	The 277 returns the 46 [ETIN] which was entered on the 276 (2100B, NM1-08).
2100C	NM1	Provider Name			
			08	Identification Code Qualifier	BCBSNC returns the XX code sent in the 276
			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.
2100D	NM1	Subscriber Name			
			03	Subscriber Last Name	• 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 Exchange 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	Subscriber 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 may be 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.

Transaction: 277 Health Care Claim Status Response					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			09	Subscriber Identifier	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	Professional claim requests will produce a response at the line level. Institutional claim requests will produce a response at the claim level. Note: For Blue Exchange or FEP, the other plan will determine whether a claim level or line level response is returned.
2200D	STC	Claim Level Status Information			
			01-1	Health Care Claim Status Category Code	See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-1 responses.
			01-2	Status Code	See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-2 responses.
			01-3	Entity Identifier Code	A value of ZZ indicates this response was generated by Blue Exchange. Sent when clarification of the entity is required.
			04	Monetary Amount	• BCBSNC returns the claim 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.
			05	Monetary Amount	• This monetary amount reflects the actual adjudicated amount paid; however, if the adjudication process has not completed, the amount is zero.
			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 or F3, a status code may appear here as a second iteration for the response.
			11	Claim Status	If STC01 = F2 or F3, a status code may appear here as a third iteration for the response.
	REF	Payer Claim Identification Number			
			02	Reference Identification	The Claim Control Number returned may change from the Claim Control Number sent in the 276, 2200D, REF02.
	DTP	Claim Service Date			

Transaction: 277 Health Care Claim Status Response					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
				(Entire Segment)	Professional claim requests will produce a response at the line level. Institutional claim requests will produce a response at the claim level. Note: For Blue Exchange or FEP, the other plan will determine whether a claim level or line level response is returned.
			03	Claim Service Period	If the claim is found, the date returned will be from our internal system. If the claim is not found, the date sent on the 276 Inquiry is the date returned.
2100E	NM1	Dependent Name			
			03	Patient Last 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 may be 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			
			01-1	Health Care Claim Status Category Code	See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-1 responses.
			01-2	Status Code	See the Claims Status Category and Status Codes listed in this chapter for a complete list of STC01-2 responses.
			01-3	Entity Identifier Code	A value of ZZ is sent if Blue Exchange generated the response.
			04	Monetary Amount	• BCBSNC returns the claim 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

Transaction: 277 Health Care Claim Status Response					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			05	Monetary Amount	This element reflects the actual payment amount. However, if the adjudication process is not finished, the amount is zero.
			10	Claim Status	If STC01 = F2 or F3, a status code may appear here as a second iteration for the response.
			11	Claim Status	If STC01 = F2 or F3, a status code may appear here as a second iteration for the response.
2200E	REF	Patient Control Number			
			01	Reference Identification Qualifier	EJ indicates Patient Account Number.
			02	Patient Control Number	Included when one has been assigned by the service provider. This number is a maximum of 20 characters.
	DTP	Claim Service Date			
			03	Date Time Period	If the claim is found, the date returned will be from our internal system. If the claim is not found, the date sent on the 276 Inquiry is the date returned.
	DTP	Service Line Date			
			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*005010X212~
BHT*0010*13*ABC276XXX*20021031*1425~
HL*120*1~**
NM1*PR*2*Blue Cross and Blue Shield of NC***PI*560894904~**
HL*2*1*21*1~
NM1*41*2*BONE AND JOINT CLINIC***46*1234567893~**
HL*3*2*19*1~
NM1*1P*1*HELBY*MARCUS*MD*XX*1234567893~**
HL*4*3*22*1~
NM1*IL*1*RUBBLE*BARNARD**MI*111223301~**
HL*5*4*23~
DMG*D8*19881014*M~
NM1*QC*1*RUBBLE*BAMBAM~
TRN*1*XXX123~
REF*1K*MMDDYY123456~
REF*BLT*111~
AMT*T3*2500~
DTP*472*D8*20021021~
SE*19*0123~

276 File Map

	Loop ID		Segments		Elements								
1		**Transaction Set Header**	**ST**		**ST01**	**ST02**							
					276	0123	005010X212						
1		**Beginning of Hierarchical Transaction**	**BHT**		**BHT01**	**BHT02**	**BHT03**	**BHT04**	**BHT05**				
					0010	13	ABC276XXX	20021031	1425				
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	*	*	*	*	PI	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	Bone and Joint Clinic	*	*	*	*	46	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	**2100D**	**Subscriber Name**	**NM1**		**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
					IL	1	RUBBLE	BARNARD	*	*	*	MI	111223301

	Loop ID		Segments		Elements								
1	**2000E**	**Dependent Level**	**HL**		**HL01**	**HL02**	**HL03**						
					5	4	23						
1	**2000E**	**Dependent Demographic Information**	**DMG**		**DMG01**	**DMG02**	**DMG03**						
					D8	19881014	M						
1	**2100E**	**Dependent Name**	**NM1**		**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
					QC	1	RUBBLE	BAMBAM					
1	**2200E**	**Claim Submitter Trace Number**	**TRN**		**TRN01**	**TRN02**							
					1	XXX123							
1	**2200E**	**Payer Claim Identification Number**	**REF**		**REF01**	**REF02**							
					1K	mmddyy123456							
1	**2200E**	**Institutional Bill Type Identification**	**REF**		**REF01**	**REF02**							
					BLT	111							
1	**2200E**	**Claim Submitted Charger**	**AMT**		**AMT01**	**AMT02**							
					T3	2500							
1	**2200E**	**Claim Service Date**	**DTP**		**DTP01**	**DTP02**	**DTP03**						
					472	D8	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*.

Section	Change Description	Date of Change	Version
Claim Status Category Codes and Status Codes	Added STC01 (507) value of E2 with corresponding 508 code value	May 2011	1.0
Acknowledgements	Removal of references to 997 Acknowledgements, which are not returned	Sept. 2011	1.1
Connectivity Transmission Options Claim Status Request Processing Claim Status Category Codes and Status Codes	The inclusion of realtime Claim Status processing, includes the following changes: • Connectivity options expanded; • Claim Status Request Processing modified • Addition of 691 as a Claim Status Category Code.	Oct. 2012	1.2
SRM Edits	Section removed as SRM edits no longer apply.	Sept. 2013	1.3
Claim or Line Level Response Claim Identifier; 276 Data Element Table	• Added Claim or Line Level Response section. • Additional comments made referencing alpha prefixes of YPS, YPQ, and YPU. • Revisions to SVC segment comments	April 2014	1.4
276 Data Element Table	Clarification of 2100D loop submission when used for patient data.	January 2015	1.5