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# HIPAA EDI Companion Guide

For

## **276/277 Health Care Claim Status Request and Response**

Companion Guide Version: 3.0

ASCX12N National Electronic Data Interchange Transaction  
Set Implementation and Addenda Guides, Version 005010A1

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1-888-991-9023  
1101 Market Street, Suite 3000  
Philadelphia, PA 19107  
[JeffersonHealthPlans.com](http://JeffersonHealthPlans.com)

## Disclosure Statement

This document is intended to be a companion guide for use in conjunction with the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides. The information in this document is provided for Jefferson Health Plans and its associated Trading Partners.

This document contains clarifications as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard for Electronic Transactions. This document is not intended to convey information that exceeds the requirements or usages of data expressed in the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides defined by HIPAA.

**This document is not intended, and should not be regarded, as a substitute for the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides.**

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## **Preface**

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. This companion guide to the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides adopted under HIPAA will clarify and specify Jefferson Health Plans. communication protocols, business rules, and information applicable to the 276/277 Health Care Claim Status Request and Response transaction. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

## Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

#	Version	Date	Author	Updates
1	1.0	8/25/04	HP Operations Support	<ul style="list-style-type: none"> <li>Initial version of 276/277 Companion Guide Document. This version was also posted to the external website.</li> </ul>
2	2.0	1/27/07	HP Operations Support	<ul style="list-style-type: none"> <li>Added new company logo</li> <li>Updated ANSI fields tables to include NPI required data</li> </ul>
3	3.0	10/17/13	Claims Department	<ul style="list-style-type: none"> <li>Added new plan name and company logo.</li> </ul>
4	4.0	10/9/24	Claims Department	<ul style="list-style-type: none"> <li>Updated naming and contact information</li> </ul>

## **Introduction**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. The provisions for administrative simplification contained within HIPAA require the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions.

These transactions primarily occur between health care providers and health insurance plans or clearinghouses. HIPAA directs the Secretary of HHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

### **Scope**

This companion guide explains the procedures and requirements necessary for trading partners of Jefferson Health Plans to transmit the following HIPAA standard transactions:

- 276/277 Health Care Claim Status Request and Response

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

### **References**

Additional information on the HIPAA Final Rule for Standards for Electronic Transmissions and the endorsed Implementation Guides can be found at:

- <http://www.cms.gov/hipaa/hipaa2> (HIPAA Administrative Simplification)
- <http://www.wpc-edi.com> (Washington Publishing Company)

## **Contact information**

### **EDI Customer Service and Technical Assistance**

Electronic Data Interchange (EDI) customer service and technical assistance requests focus solely on the generation, processing, and/or transmission of a HIPAA standard transaction. EDI customer service and technical assistance requests will not focus on transaction results such as claim payment and remittance results.

Please contact Jefferson Health Plans EDI Department at [EDI@jeffersonhealthplans.com](mailto:EDI@jeffersonhealthplans.com) for technical assistance.

### **Non-EDI Customer Service and Assistance**

Non-EDI customer service and assistance requests focus solely on transaction results such as claim payment and remittance advice, member maintenance, or member eligibility. Non-EDI customer service and assistance requests will not focus on the generation, processing, and/or transmission of a HIPAA standard transaction.

Please contact Jefferson Health Plans Provider Services for non-EDI customer service and assistance.

## **Claim Status Request and Response (276/277)**

### **Claim Status Request (276)**

The purpose of generating a 276 is to obtain the current status of the claim(s) within the adjudication process. A claim is located by supplying Jefferson Health Plans with the following information:

- Member ID
- Provider ID
- Member Name and Date of Birth
- Member Gender

A service start and end date can also be supplied to further narrow the search for the claim(s). If no service date is supplied, then only claims from the previous 90 days will be returned.

**Data Necessary for Processing 276 Requests**

<b>Loop</b>	<b>Segment</b>	<b>Data Element</b>	<b>Field Description</b>	<b>Length</b>	<b>Mapping Comments</b>
0000	BHT	02	Transaction Set Purpose Code	2/2	'13'
2100B	NM1	03	Requesting Provider Last Name or Organization Name	1/35	INDIVIDUAL LAST NAME OR ORGANIZATION NAME
2100B	NM1	04	First Name	1/25	INDIVIDUAL FIRST NAME
2100B	NM1	08	Requesting Provider <b>Identification Code Qualifier</b>	1/2	'XX'
2100B	NM1	09	Requesting Provider ID <b>Identification Code</b>	2/80	USE APPROPRIATE NPI NUMBER
2100C	NM1	03	Service Provider Last Name or Organization Name	1/35	PROVIDER LAST NAME OR ORGANIZATION NAME
2100C	NM1	04	First Name	1/25	PROVIDER FIRST NAME
2100C	NM1	09	Service Provider ID	2/80	Jefferson Health Plans Provider Identification Number (up to 14 Digits Alpha Numeric)
2000D	DMG	02	Member Date of Birth	1/35	DATE EXPRESSED IN FORMAT CCYYMMDD
2000D	DMG	03	Member Gender	1/1	'M' or 'F'
2100D	NM1	03	Member Last Name	1/35	INDIVIDUAL LAST NAME
2100D	NM1	04	Member First Name	1/25	INDIVIDUAL FIRST NAME
2100D	NM1	09	Member ID	2/80	SUBSCRIBER IDENTIFICATION NUMBER
2200D	TRN	02	Request Trace Number	1/30	TRANSACTION TRACE NUMBER
2200D	DTP	03	Date(s) of Service	1/35	DATE EXPRESSED IN FORMAT CCYYMMDD



### **Claim Status Response (277)**

The following are the Claims Status Response Values utilized by Jefferson Health Plans:

- Requesting and Submitting Provider ID Number
- Member Name and Date of Birth
- Member ID Number and Gender
- Claim Status and Date of Service
- Claim Number and EOP Codes
- Billed Amount, Paid Amount and Check Number

If the 276 request does not uniquely identify the claim within Jefferson Health Plans system, the response may include multiple claims that meet the identification parameters supplied by the requester.

In the event that the member or the claim(s) are not found in Jefferson Health Plans database, Jefferson Health Plans will return a 277 transaction set containing a STC segment identifying the element which was not found.

The Claims Category and Status Codes that Jefferson Health Plans will support are located at [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes).

**Sample Claim Status Response Screen**

The following is an example of what a Claim Status Response screen might look like:

<b>Claim Status Notification</b>	<b>HealthPartners Plans PA</b>
<b>Request: Insured = Jane Doe Member ID = 111111111</b>	<b>DOB = 01/01/01 Provider ID = 00018</b>

WebMD Trace Number :111111111

<b>Patient : Member Name</b>	<b>Provider : TEMPLE UNIVERSITY HOSPITAL</b>
Member ID : 111111111	Service Provider # : 00018
DOB : 01/01/01	
Gender : Female	
	<b>Submitter : TEMPLE UNIVERSITY HOSPITAL</b>
	Electronic Transmitter ID : 00018

<b>Claim# :</b>	
Status :	
Status Information Effective Date :	
Total Claim Charge Amount : \$ 0.00	
Claim Payment Amount : \$ 0.00	
Claim Statement Period Start : 01/01/2004-03/30/2004	

### Data Necessary for Sending 277 Responses

Loop	Segment	Data Element	Field Description	Length	Mapping Comments
0000	BHT	02	Transaction Set Purpose Code	2/2	'08'
2100A	NM1	03	Organization Name	1/35	'Jefferson Health PLANS'
2100B	NM1	03	Requesting Provider Last Name	1/35	INDIVIDUAL LAST NAME OR ORGANIZATION NAME
2100B	NM1	04	First Name	1/25	INDIVIDUAL FIRST NAME
2100B	NM1	08	Requesting Provider Identification Code Qualifier	1/2	'XX'
2100B	NM1	09	Requesting Provider Identification Code	2/80	USE APPROPRIATE NPI NUMBER
2100C	NM1	03	Service Provider Last Name	1/35	PROVIDER LAST NAME OR ORGANIZATION NAME
2100C	NM1	04	First Name	1/25	PROVIDER FIRST NAME
2100C	NM1	08	Servicing Provider Identification Code Qualifier	1/2	'XX'
2100C	NM1	09	Servicing Provider Identification Code	2/80	Jefferson Health Plans Provider Identification Number (up to 14 Digits Alpha Numeric)
2000D	DMG	02	Member Date of Birth	1/35	DATE EXPRESSED IN FORMAT CCYYMMDD
2000D	DMG	03	Member Gender	1/1	'M' or 'F'
2100D	NM1	03	Member Last Name	1/35	INDIVIDUAL LAST NAME
2100D	NM1	04	Member First Name	1/25	INDIVIDUAL FIRST NAME
2100D	NM1	09	Member ID	2/80	SUBSCRIBER IDENTIFICATION NUMBER
2200D	TRN	02	Request Trace Number	1/30	TRANSACTION TRACE NUMBER
2200D	STC	01	Claim Status	1/30	
2200D	STC	01	Claim Status	1/30	'D0:33' = Member not found 'D0:35' = Claim not found 'E0:153:40' = Invalid Receiving Provider 'E0:153:SJ' = Invalid Service Provider
2200D	STC	01-3	EOP Codes	2/3	STANDARD STATUS CODES
2200D	STC	04	Total Billed Amount	1/18	TOTAL CLAIM CHARGE AMOUNT
2200D	STC	05	Claim Payment Amount	1/18	CLAIM PAYMENT AMOUNT
2200D	STC	08	Check Date	8/8	DATE EXPRESSED IN FORMAT CCYYMMDD
2200D	STC	09	Check Number	1/16	CHECK OR EFT TRACE NUMBER
2200D	REF	02	Patient Account Number	1/30	PAYOR'S CLAIM NUMBER
2200D	REF	01	Reference Identification Qualifier	1/30	'EA'
2200D	REF	02	Medical Record Identification Number	1/30	MEDICAL RECORD NUMBER
2200D	DTP	03	Date(s) of Service	1/35	DATE EXPRESSED IN FORMAT CCYYMMDD