HIPAA 276/277
Transactions & Code Sets

Companion guide to the HIPAA X12 Implementation Guide (version 005010X212)
Disclosure Statement

This Companion Guide is issued in an effort to provide Trading Partners of CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., collectively known as “CareFirst,” with the most up-to-date information related to standard transactions. Any and all information in this guide is subject to change at any time without notice. Each time you test or submit a standard transaction, we recommend that you refer to the most recently posted Companion Guide to ensure you are using the most current information available.
Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with CareFirst. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.
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</tbody>
</table>
1. Introduction

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. The purpose of the Administrative Simplification portion of HIPAA is to enable health information to be exchanged electronically and to adopt standards for those transactions.

1.1 Scope

This companion guide is intended for CareFirst Trading Partners interested in exchanging HIPAA compliant X12 claim status information (276/277 transactions) with CareFirst. It is intended to be used in conjunction with X12N Implementation Guides and is not intended to contradict or exceed X12 standards. It contains information about specific CareFirst requirements for processing the 276/277 X12 transactions.

All instructions in this document are written using information known at the time of publication and are subject to change. The most current version of the guide is available on the CareFirst website at carefirst.com/electronicclaims.

1.2 Overview

This Companion Guide is issued in an effort to provide CareFirst Trading Partners with the most up-to-date information related to standard transactions. Any and all information in this guide is subject to change at any time without notice.

This Companion Guide is applicable to all lines of business within CareFirst.

This document is designed to assist both technical and business areas of trading partners who wish to exchange HIPAA standard 276/277 transactions with CareFirst, Inc. It contains specifications for the transactions, contact information, and other information that is helpful.

1.3 References

This companion guide is an adjunct to the National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim Status Inquiry and Response 276/277 ASC X12N276/277 (005010X212).

Please be sure to use the most current version of the Companion Guide available at carefirst.com/electronicclaims. CareFirst is not responsible for the performance of software outside of its installations.

1.4 Additional Information

Please be sure to always use the most current version of the companion guide available at carefirst.com/electronicclaims > Guides.

Always feel free to contact CareFirst as described in Section 5.
2. Getting Started

2.1 Working with CareFirst

In general, there are three steps to submitting standard 276/277 transactions to the CareFirst production environment:

- Registration
- Testing & certification
- Production status

CareFirst accepts X12 standard transactions from any HIPAA covered entity with which it has an agreement. Prior to approving the exchange of the 276/277 transactions, the transactions are tested according to a specific test plan. Results are verified by both parties. Once test results are verified and approved, CareFirst advises the Trading Partner about submitting requests to the production environment.

A submitter is typically a company that has Trading Partner status with CareFirst (e.g., a service bureau or clearinghouse) or is a provider or a group health plan which has an agreement with CareFirst.

All potential CareFirst submitters must contact the EDI Operations Support Group (refer to the CareFirst Contact Information in Section 5) to initiate action and authorization and to receive the necessary information for proceeding.

2.2 Trading partner registration

To register to submit electronic transactions a Trading partner must contact CareFirst according to the instructions in Section 5.

The requested information on Trading Partner Information Form (see Section 3) must be filled out by the Trading Partner and emailed to the EDI Operations Support Group address listed in Section 5.

2.3 Testing & certification overview

CareFirst requires all potential submitters to participate in testing to ensure that transactions produce the desired results. CareFirst supplies the test data and access information to the test system. Successful completion and validation is an indication that all systems can properly submit and receive the transactions.

2.4 Production status

The EDI Operations Support Group will advise the new submitter when all conditions are satisfied and submission of production transactions can begin. At that time a production certificate of trust will be issued by CareFirst to the trading partner.
3. Testing

CareFirst requires all potential submitters to participate in testing to ensure that transactions produce the desired results. Successful completion and validation is an indication that all systems can properly submit and receive the transactions.

The CareFirst EDI Operations Support Group coordinates the testing activities and provides a detailed test plan and test data. Additional test cases may be added by the submitter.

The URL for submitting test transactions is:


OR

https://webapptt.carefirst.com:443/QA2TIBCO-BC/SOAP

NOTE: there are different URL's for test and production transactions. Test time is available from 9 a.m. to 5 p.m. ET, Monday–Friday.

A listing of test 276 requests and expected 277 responses used during testing is provided by the CareFirst test coordinator for review and validation. The successful completion of testing is verified and approved by the EDI Operations Support Staff.

During testing system security is verified with a certificate of trust attached to each transaction and verification of the submitter's IP address. CareFirst provides the certificate of trust for testing to the submitting trading partner. A separate certificate is used for production. The production certificate is issued at the successful completion of testing. The Trading Partner must provide a list IP addresses submitting test transactions.

The information below should be provided to CareFirst for setup so CareFirst can begin testing with Submitters. CareFirst will need to receive this information at least 30 days in advance.

<table>
<thead>
<tr>
<th>Trading Partner Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary EDI Support Contact:</td>
</tr>
<tr>
<td>Primary EDI Support Contact Phone #:</td>
</tr>
<tr>
<td>Primary EDI Support Contact Email:</td>
</tr>
<tr>
<td>Primary EDI Support Contact Address:</td>
</tr>
<tr>
<td>TP Test/Production IP Address(es) Submitting Transactions:</td>
</tr>
<tr>
<td>Transactions that will be submitted to CareFirst by Trading Partner:</td>
</tr>
</tbody>
</table>
4. Connectivity/Communications

4.1 Process flows

Trading partner transmits 276 Inquiry to CareFirst

CareFirst receives 276 and verifies trading partner

CareFirst verifies X12 format and content

CareFirst looks up patient information

CareFirst formats 277 Response into X12

CareFirst returns 277 Response to trading partner

The above illustrates the basic flow of the 276 Inquiry and 277 Response transactions.

4.2 Transmission administrative procedures

4.2.1 Schedule, availability and downtime notification

CareFirst production systems are available 24 hours per day, 7 days per week with the exception of 1:00 a.m. EST through 9:00 a.m. EST each Sunday for the real-time processing mode. There are no regularly scheduled downtimes except as indicated in the prior statement.

CareFirst Systems’ planned downtime will be communicated to all Trading Partners via an email message at least one week prior to the event. The following is an example of the message to be sent to announce planned downtime.

To: Trading Partners
From: CareFirst B2B Gateway
The CareFirst B2B Gateway will be unavailable on xx/xx/xxxx from x am to x pm for scheduled maintenance.
This outage will affect the following transactions: 270/271, 276/277.
We apologize for any inconvenience.

CareFirst Systems’ unplanned downtime will be communicated to Trading Partners with an email as soon as possible. A second email will be dispatched when the system becomes available.

To: Trading Partners
From: CareFirst B2B Gateway
The CareFirst B2B Gateway is unavailable at this time due to a system outage.
This outage affects the following transactions: 270/271, 276/277.
We apologize for any inconvenience.

4.2.2 Re-transmission procedures

When a 276 inquiry transaction receives a reject code by CareFirst it must be corrected and re-submitted by the provider.
4.3 Communication protocol specifications

CareFirst receives and transmits transactions using HTTP/S.

The URL for submitting production transactions to CareFirst is:


OR

http://webapp.carefirst.com:13001/TIBCO-BC/SOAP

NOTE: there are different URL’s for test and production transactions.

4.4 Passwords

Logon and passwords are replaced by the use of security certificates. The Trading Partner must submit the certificate supplied by CareFirst with every transaction. There are separate certificates for test and production.

CareFirst security is maintained on three levels:

1. Verification of a certificate of trust attached to each transaction

2. Verification of the IP address submitting the transaction (supplied by the submitter)

3. Verification of the Trading Partner Id (in the ISA Segment) supplied by CareFirst.
5. CareFirst Contact Information

5.1 EDI customer service
All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the Helpdesk during normal business hours at 877- 526-8390 or at EDIdirectsubmission@carefirst.com.

5.2 EDI technical assistance
All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the Helpdesk during normal business hours at 877- 526-8390 or at EDIdirectsubmission@carefirst.com.

5.3 Provider service number
All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the Helpdesk during normal business hours at 877- 526-8390 or at EDIdirectsubmission@carefirst.com.

5.4 Applicable web-sites/email
All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the Helpdesk during normal business hours at 877- 526-8390 or at EDIdirectsubmission@carefirst.com.

The most current version of this companion guide is available at carefirst.com/electronicclaims.
6. Control Segments/Envelope

### 6.1 ISA–IEA

#### 6.1.1 The 276 Claim Status Inquiry

This section describes the values required by CareFirst in the ISA and IEA segments. Specifically noted all values are HIPAA compliant.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.3</td>
<td>ISA01</td>
<td>Authorization Information Qualifier</td>
<td>2</td>
<td>Must be “00”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA03</td>
<td>Security Information Qualifier</td>
<td>2</td>
<td>Must be “00”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA05</td>
<td>Interchange ID Qualifier</td>
<td>2</td>
<td>Must be “ZZ”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA06</td>
<td>Interchange Sender ID</td>
<td>15</td>
<td>Must be Trading Partner ID</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA07</td>
<td>Interchange ID Qualifier</td>
<td>2</td>
<td>Must be “ZZ”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA08</td>
<td>Interchange Receiver ID</td>
<td>15</td>
<td>Must be CareFirst ID</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA09</td>
<td>Interchange Date</td>
<td>6</td>
<td>Must be YYMMDD</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA10</td>
<td>Interchange Time</td>
<td>4</td>
<td>Must be HHMM</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA11</td>
<td>Interchange Control Standards Identifier</td>
<td>1</td>
<td>Must be “^”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA12</td>
<td>Interchange Control Version</td>
<td>9</td>
<td>Must be “00501”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA13</td>
<td>Interchange Control Number</td>
<td>9</td>
<td>ISA13 must be identical to IEA02</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA14</td>
<td>Acknowledgement Indicator</td>
<td>1</td>
<td>Must be “0”</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA15</td>
<td>Usage Indicator</td>
<td>1</td>
<td>Must be “T” or “P”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: test system rejects P; Production system rejects T.</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA 16</td>
<td>Component Element Separator</td>
<td>1</td>
<td>Must be “:”</td>
</tr>
<tr>
<td>C.10</td>
<td>IEA01</td>
<td>Number of included Functional Groups</td>
<td>1</td>
<td>Must be “1”</td>
</tr>
<tr>
<td>C.10</td>
<td>IEA02</td>
<td>Interchange Control Number</td>
<td>9</td>
<td>IEA02 must be identical to ISA13</td>
</tr>
</tbody>
</table>
### 6.1.2 The 277 Response

This section describes the values returned by CareFirst in the ISA segment.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.4</td>
<td>ISA01</td>
<td>Authorization Information Qualifier</td>
<td>2</td>
<td>“00”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA03</td>
<td>Security Information Qualifier</td>
<td>2</td>
<td>“00”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA05</td>
<td>Interchange ID Qualifier</td>
<td>2</td>
<td>“ZZ”</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA06</td>
<td>Interchange Sender ID</td>
<td>15</td>
<td>CareFirst ID</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA07</td>
<td>Interchange ID Qualifier</td>
<td>2</td>
<td>“ZZ”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA08</td>
<td>Interchange Receiver ID</td>
<td>15</td>
<td>Trading Partner ID</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA09</td>
<td>Interchange Date</td>
<td>6</td>
<td>YYMMDD</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA10</td>
<td>Interchange Time</td>
<td>4</td>
<td>HHMM</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA11</td>
<td>Interchange Control Standards Identifier</td>
<td>1</td>
<td>“^”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA12</td>
<td>Interchange Control Version</td>
<td>9</td>
<td>“00501”</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA13</td>
<td>Interchange Control Number</td>
<td>9</td>
<td>ISA13 will be identical to IEA02</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA14</td>
<td>Acknowledgement Indicator</td>
<td>1</td>
<td>“0”</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA15</td>
<td>Usage Indicator</td>
<td>1</td>
<td>Must be “T” or “P”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: test system rejects P; Production</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>system rejects T.</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA16</td>
<td>Component Element Separator</td>
<td>1</td>
<td>Must be “:”</td>
</tr>
<tr>
<td>C.10</td>
<td>IEA01</td>
<td>Number of included Functional Groups</td>
<td>1/5</td>
<td>“1”</td>
</tr>
<tr>
<td>C.10</td>
<td>IEA02</td>
<td>Interchange Control Number</td>
<td>9/9</td>
<td>IEA02 will be identical to ISA13</td>
</tr>
</tbody>
</table>
## 6. Control Segments/Envelope

### 6.2 GS–GE

#### 6.2.1 The 276 Claim Status Inquiry

This section describes the values required by CareFirst in the GS segment.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7</td>
<td>GS01</td>
<td>Functional Identifier Code</td>
<td>2/2</td>
<td>Must be “HR”—Health Care Claim Status Request</td>
</tr>
<tr>
<td>C.7</td>
<td>GS02</td>
<td>Application Sender”s Code</td>
<td>2/15</td>
<td>Must be Trading Partner ID. Trading Partner ID must be appended with “R” for this element only.</td>
</tr>
<tr>
<td>C.7</td>
<td>GS03</td>
<td>Application Receiver”s Code</td>
<td>9</td>
<td>Must be CareFirst ID</td>
</tr>
<tr>
<td>C.7</td>
<td>GS04</td>
<td>Date</td>
<td>8/8</td>
<td>CCYMMDD</td>
</tr>
<tr>
<td>C.8</td>
<td>GS05</td>
<td>Time</td>
<td>4/8</td>
<td>HHMMSS or HHMMSSD or HHMMSSDD</td>
</tr>
<tr>
<td>C.8</td>
<td>GS06</td>
<td>Group Control Number</td>
<td>1/9</td>
<td>Functional group header control number must be identical to functional group trailer, GE02.</td>
</tr>
<tr>
<td>C.8</td>
<td>GS07</td>
<td>Responsible Agency Code</td>
<td>1/2</td>
<td>Must be “X”</td>
</tr>
<tr>
<td>C.8</td>
<td>GS08</td>
<td>Version/Release/ Industry Identifier Code</td>
<td>12</td>
<td>Must be “005010X212”</td>
</tr>
<tr>
<td>C.9</td>
<td>GE01</td>
<td>Number of Transaction Sets Included</td>
<td>1/6</td>
<td>Must be “1”</td>
</tr>
<tr>
<td>C.9</td>
<td>GE02</td>
<td>Group Control Number</td>
<td>1/9</td>
<td>Functional group trailer control number must be identical to functional group header, GS02.</td>
</tr>
</tbody>
</table>

#### 6.2.2 The 277 Response

This section describes the values returned by CareFirst in the GS segment.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7</td>
<td>GS01</td>
<td>Functional Identifier Code</td>
<td>2/2</td>
<td>Must be “HN”—Health Care Claim Status Response</td>
</tr>
<tr>
<td>C.7</td>
<td>GS02</td>
<td>Application Sender”s Code</td>
<td>2/15</td>
<td>CareFirst ID</td>
</tr>
<tr>
<td>C.7</td>
<td>GS03</td>
<td>Application Receiver”s Code</td>
<td>9</td>
<td>Trading Partner ID appended with “R”</td>
</tr>
<tr>
<td>C.7</td>
<td>GS04</td>
<td>Date</td>
<td>8/8</td>
<td>CCYMMDD</td>
</tr>
<tr>
<td>C.8</td>
<td>GS05</td>
<td>Time</td>
<td>4/8</td>
<td>HHMMSS</td>
</tr>
<tr>
<td>C.8</td>
<td>GS06</td>
<td>Group Control Number</td>
<td>1/9</td>
<td>Functional group header control number must be identical to functional group trailer, GE02.</td>
</tr>
<tr>
<td>C.8</td>
<td>GS07</td>
<td>Responsible Agency Code</td>
<td>1/2</td>
<td>Must be “X”</td>
</tr>
<tr>
<td>C.8</td>
<td>GS08</td>
<td>Version/Release/ Industry Identifier Code</td>
<td>12</td>
<td>Must be “005010X212”</td>
</tr>
<tr>
<td>C.9</td>
<td>GE01</td>
<td>Number of Transaction Sets Included</td>
<td>1/6</td>
<td>Must be “1”</td>
</tr>
<tr>
<td>C.9</td>
<td>GE02</td>
<td>Group Control Number</td>
<td>1/9</td>
<td>Functional group trailer control number must be identical to functional group header, GS02.</td>
</tr>
</tbody>
</table>
6.3 ST–SE

6.3.1 The 276 Claim Status Inquiry
CareFirst requires standard HIPAA values in the ST and SE segments.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>ST01</td>
<td>Transaction Set Identifier Code</td>
<td>3/3</td>
<td>Must be “276”</td>
</tr>
<tr>
<td>36</td>
<td>ST02</td>
<td>Transaction Set Control Number</td>
<td>4/9</td>
<td>The Transaction Set Control Numbers in ST02 and SE02 must be identical.</td>
</tr>
<tr>
<td>36</td>
<td>ST03</td>
<td>Implementation Convention Reference</td>
<td>1/35</td>
<td>Must be “005010X212.”</td>
</tr>
<tr>
<td>98</td>
<td>SE01</td>
<td>Number of Included Segments</td>
<td>1/10</td>
<td>Count of data segments including ST and SE Segments. In the event when this count does not match the exact number of data segments, a 999 is generated.</td>
</tr>
<tr>
<td>98</td>
<td>SE02</td>
<td>Transaction Set Control Number</td>
<td>4/9</td>
<td>The Transaction Set Control Numbers in ST02 and SE02 must be identical.</td>
</tr>
</tbody>
</table>

6.3.2 The 277 Response
CareFirst returns standard HIPAA values in the ST and SE segments.
7. CareFirst Specific Business Rules and Limitations

7.1 Real time processing mode
CareFirst supports only real time 276 inquiry and 277 response transactions.

7.2 Single patient inquiry
A real time transaction is limited to one patient per inquiry.

7.3 Error conditions
1. A TA1 acknowledgement is returned when there is a transmission or envelope error (other than a timeout).
2. A 999 acknowledgement is returned when there is a HIPAA or an X12 compliance error. The Trading Partner should correct the error and resubmit the transaction.
3. A 277 with an Error Code within Status Category in the STC segment is returned when there is a data error or when the system is unavailable. The Trading Partner should correct the error and resubmit the transaction.

7.4 DTP segment
The criteria for Dates of Service are as follows;
1. The “From Date” must be within 3 years of the current date.
2. The “From Date” and “To Date” cannot span more than 1 year.
3. The “To Date” cannot be greater than the current date.
The TA1 Interchange Acknowledgement is used to indicate a rejection (aka a negative acknowledgement) of the ISA/IEA Interchange containing the 276 Claim Status Inquiry Request.

If the 276 passes ISA/IEA compliance checking, but an error is found during the validation of the Functional Group(s) or Transaction Set(s) within a Functional Group, a 999 Functional Acknowledgement indicates a rejection (negative acknowledgement).

If the 276 complies with the X12 standard syntax requirements, then the 276 Claim Status Response is returned to the submitter.

The STC segments in the 277 are used to report business level error situations.

The submitter of a 276 in real-time will receive only one acknowledgement/response from CareFirst: a TA1 (error); a 999 (error); or a 277.

8.1 Report inventory
Identification and documentation of reports requirements for all HIPAA transactions are being worked on separately.
9. Trading Partner Agreements

9.1 Trading partners
All inquiries and comments regarding trading partner relationships with CareFirst should be addressed by contacting CareFirst using the information in Section 5.
# 10. Transaction Information

## 10.1 The 276 claim status inquiry

This section describes the standard HIPAA values required by CareFirst in the BHT segment.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>BHT01</td>
<td>Hierarchical Structure Code</td>
<td>3/3</td>
<td>Must be &quot;0010&quot;</td>
</tr>
<tr>
<td>37</td>
<td>BHT02</td>
<td>Transaction Set Purpose Code</td>
<td>4/9</td>
<td>Must be &quot;13&quot;</td>
</tr>
<tr>
<td>37</td>
<td>BHT03</td>
<td>Reference Identification</td>
<td>1/30</td>
<td>Assigned by the Trading Partner</td>
</tr>
<tr>
<td>37</td>
<td>BHT04</td>
<td>Date</td>
<td>8/8</td>
<td>CCYYMMDD</td>
</tr>
<tr>
<td>38</td>
<td>BHT05</td>
<td>Time</td>
<td>8/8</td>
<td>HHMM or HHMMSS or HHMMSSDD, or HHMMSSDD</td>
</tr>
</tbody>
</table>

This section describes the values required by CareFirst in the HL segments.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>2000 A</td>
<td>HL01</td>
<td>Hierarchical ID number</td>
<td>Must be &quot;1&quot;</td>
<td>1/12</td>
<td>Initial HL Segment</td>
</tr>
<tr>
<td>39</td>
<td>2000 A</td>
<td>HL02</td>
<td>Hierarchical Parent ID number</td>
<td>Must be missing</td>
<td>1/12</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>2000 A</td>
<td>HL03</td>
<td>Hierarchical Level Code</td>
<td>Must be &quot;20&quot;</td>
<td>1/2</td>
<td>Information Source</td>
</tr>
<tr>
<td>40</td>
<td>2000 A</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>Must be &quot;1&quot;</td>
<td>1/1</td>
<td>Additional Subordinate HL Data Segment in this Hierarchical Structure</td>
</tr>
<tr>
<td>43</td>
<td>2000 B</td>
<td>HL01</td>
<td>Hierarchical ID number</td>
<td>Must be &quot;2&quot;</td>
<td>1/12</td>
<td>This number is incremented by one for each successive occurrence of the HL segment</td>
</tr>
<tr>
<td>43</td>
<td>2000 B</td>
<td>HL02</td>
<td>Hierarchical Parent ID number</td>
<td>Must be &quot;1&quot;</td>
<td>1/12</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>2000 B</td>
<td>HL03</td>
<td>Hierarchical Level Code</td>
<td>Must be &quot;21&quot;</td>
<td>1/2</td>
<td>Information Receiver</td>
</tr>
<tr>
<td>44</td>
<td>2000 B</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>Must be &quot;1&quot;</td>
<td>1/1</td>
<td>Additional Subordinate HL Data Segment in this Hierarchical Structure</td>
</tr>
<tr>
<td>47</td>
<td>2000 C</td>
<td>HL01</td>
<td>Hierarchical ID number</td>
<td>Must be &quot;3&quot;</td>
<td>1/12</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>2000 C</td>
<td>HL02</td>
<td>Hierarchical Parent ID number</td>
<td>Must be &quot;2&quot;</td>
<td>1/12</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>2000 C</td>
<td>HL03</td>
<td>Hierarchical Level Code</td>
<td>Must be &quot;19&quot;</td>
<td>1/2</td>
<td>Provider of Service</td>
</tr>
<tr>
<td>48</td>
<td>2000 C</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>Must be &quot;1&quot;</td>
<td>1/1</td>
<td>Additional Subordinate HL Data Segment in this Hierarchical Structure</td>
</tr>
</tbody>
</table>
### 10. Transaction Information

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>2000 D</td>
<td>HL01</td>
<td>Hierarchical ID number</td>
<td>Must be “4”</td>
<td>1/12</td>
<td>This number is incremented by one for each successive occurrence of the HL segment</td>
</tr>
<tr>
<td>53</td>
<td>2000 D</td>
<td>HL02</td>
<td>Hierarchical Parent ID number</td>
<td>Must be “3”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>2000 D</td>
<td>HL03</td>
<td>Hierarchical Level Code</td>
<td>Must be “22”</td>
<td>1/2</td>
<td>Subscriber</td>
</tr>
<tr>
<td>53</td>
<td>2000 D</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>Must be “1” OR “0”</td>
<td>1/1</td>
<td>Must be “1” when patient is dependent; “0” when subscriber is the patient</td>
</tr>
<tr>
<td>75</td>
<td>2000 E</td>
<td>HL01</td>
<td>Hierarchical ID number</td>
<td>Must be “5”</td>
<td>1/12</td>
<td>This loop must be used only when the patient is a dependent of a Member</td>
</tr>
<tr>
<td>75</td>
<td>2000 E</td>
<td>HL02</td>
<td>Hierarchical Parent ID number</td>
<td>Must be “4”</td>
<td>1/12</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>2000 E</td>
<td>HL03</td>
<td>Hierarchical Level Code</td>
<td>Must be “23”</td>
<td>1/2</td>
<td>Dependent</td>
</tr>
<tr>
<td>76</td>
<td>2000 E</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>Must be “0”</td>
<td>1/1</td>
<td></td>
</tr>
</tbody>
</table>

This section describes the values required by CareFirst in the NM1 segments.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>2100 A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Must be “PR”</td>
<td>2</td>
<td>Payer</td>
</tr>
<tr>
<td>41</td>
<td>2100 A</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>Must be “2”</td>
<td>1</td>
<td>Non-Person Entity</td>
</tr>
<tr>
<td>41</td>
<td>2100 A</td>
<td>NM103</td>
<td>Last Name or Organization Name</td>
<td>Must be “CareFirst BlueCross BlueShield”</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>2100 A</td>
<td>NM108</td>
<td>Identification CodeQualifier</td>
<td>Must be “PI” or “AD”</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>2100 A</td>
<td>NM109</td>
<td>Information Source Primary Identifier</td>
<td></td>
<td>2/80</td>
<td>BCBS Plan Code “080” or “190” CareFirst will accept any of the allowable values listed above.</td>
</tr>
<tr>
<td>45</td>
<td>2100 B</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Must be “41”</td>
<td>2</td>
<td>Submitter</td>
</tr>
<tr>
<td>45</td>
<td>2100 B</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>Must be “2”</td>
<td>1</td>
<td>Non-Person Entity</td>
</tr>
<tr>
<td>46</td>
<td>2100 B</td>
<td>NM103</td>
<td>Last Name or Organization Name</td>
<td></td>
<td>35</td>
<td>Must be Trading Partner ID</td>
</tr>
<tr>
<td>46</td>
<td>2100 B</td>
<td>NM108</td>
<td>Identification CodeQualifier</td>
<td>Must be “46”</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>2100 B</td>
<td>NM109</td>
<td>Information Submitter Primary Identifier</td>
<td>Must be a valid Tax ID</td>
<td>2/80</td>
<td>Submitter’s Federal Tax ID</td>
</tr>
<tr>
<td>50</td>
<td>2100 C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Must be “1P”</td>
<td>2</td>
<td>Provider</td>
</tr>
<tr>
<td>50</td>
<td>2100 C</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>Must be “1” OR “2”</td>
<td>1</td>
<td>1 Person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 Non- Person Entity</td>
</tr>
<tr>
<td>50</td>
<td>2100 C</td>
<td>NM103</td>
<td>Last Name or Organization Name</td>
<td></td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>2100 C</td>
<td>NM104</td>
<td>First Name</td>
<td></td>
<td>25</td>
<td>Required only when NM102 is 1.</td>
</tr>
<tr>
<td>IG Page</td>
<td>Loop ID</td>
<td>Reference</td>
<td>X12 Element Name</td>
<td>Codes</td>
<td>Length</td>
<td>Valid Values/Notes/Comments</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>-----------</td>
<td>------------------</td>
<td>-------</td>
<td>--------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>50</td>
<td>2100 C</td>
<td>NM105</td>
<td>Middle Name</td>
<td></td>
<td>25</td>
<td>Submit if available for the person.</td>
</tr>
<tr>
<td>51</td>
<td>2100 C</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>Must be “XX”</td>
<td>2</td>
<td>Health Care Financing Administration Identifier</td>
</tr>
<tr>
<td>51</td>
<td>2100 C</td>
<td>NM109</td>
<td>Provider Primary Identifier</td>
<td></td>
<td>2/80</td>
<td>Provider's Billing NPI Number</td>
</tr>
<tr>
<td>56</td>
<td>2100 D</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Must be “IL”</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>2100 D</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>Must be “1”</td>
<td>1</td>
<td>1 Person</td>
</tr>
<tr>
<td>57</td>
<td>2100 D</td>
<td>NM103</td>
<td>Last Name</td>
<td></td>
<td>35</td>
<td>Subscriber Last Name</td>
</tr>
<tr>
<td>57</td>
<td>2100 D</td>
<td>NM104</td>
<td>First Name</td>
<td></td>
<td>25</td>
<td>Subscriber First Name</td>
</tr>
<tr>
<td>57</td>
<td>2100 D</td>
<td>NM105</td>
<td>Middle Name</td>
<td></td>
<td>25</td>
<td>Submit if available for a subscriber.</td>
</tr>
<tr>
<td>57</td>
<td>2100 D</td>
<td>NM107</td>
<td>Identification Code Qualifier</td>
<td>Must be “MI”</td>
<td>2</td>
<td>Member Identification Number</td>
</tr>
<tr>
<td>57</td>
<td>2100 D</td>
<td>NM109</td>
<td>Subscriber Identifier</td>
<td></td>
<td>2/80</td>
<td>CareFirst Member/Subscriber ID; including 1–3 Character Alphanumeric Prefix shown on ID Card Two ways that IDs can be sent: 2) ABC123456789 3) 123456789 A valid FEP Membership ID format is R followed by 8 numeric characters. Member ID Suffix must not be submitted.</td>
</tr>
<tr>
<td>79</td>
<td>2100 E</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>Must be “QC”</td>
<td>2</td>
<td>Dependent</td>
</tr>
<tr>
<td>79</td>
<td>2100 E</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>Must be “1”</td>
<td>1</td>
<td>1 Person</td>
</tr>
<tr>
<td>79</td>
<td>2100 E</td>
<td>NM103</td>
<td>Last Name or Organization Name</td>
<td></td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>2100 E</td>
<td>NM104</td>
<td>First Name</td>
<td></td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

This section describes the values accepted by CareFirst in the REF segment. The REF segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>59–65 AND 82–88</td>
<td>2200D or 2200E</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>Must be “1K” or “BLT” or “EJ”</td>
<td>2</td>
<td>A REF Segment containing DCN Information is strongly recommended to be submitted on the 276 Transaction if available. A REF Segment at the Claim Level containing Institutional Type of Bill is strongly recommended to be submitted when applicable. When available, up to three REF Segments will be returned on 277.</td>
</tr>
</tbody>
</table>
This section describes the values required by CareFirst in the DMG segment. DMG Segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>54 &amp; 77</td>
<td>2000D or 2000E</td>
<td>DMG01</td>
<td>Date Time Period Format Qualifier</td>
<td>Must be “D8”</td>
<td>2/3</td>
<td>Date expressed in CCYYMMDD</td>
</tr>
<tr>
<td>55 &amp; 77</td>
<td>2000D or 2000E</td>
<td>DMG02</td>
<td>Date Time Period</td>
<td>CCYM MDD</td>
<td></td>
<td>Patient Date of Birth</td>
</tr>
<tr>
<td>55 &amp; 78</td>
<td>2000D or 2000E</td>
<td>DMG03</td>
<td>Gender</td>
<td>F or M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This section describes the values required by CareFirst in the TRN segment. TRN Segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 &amp; 81</td>
<td>2200D or 2200E</td>
<td>TRN01</td>
<td>Trace Type Code</td>
<td>Must be “1”</td>
<td>2/3</td>
<td>Current Transaction Trace Number. TRN segment in 2000D loop may be assigned if the subscriber is the patient. TRN segment in 2000E loop may be assigned if the Dependent is the patient.</td>
</tr>
<tr>
<td>58 &amp; 81</td>
<td>2200D or 2200E</td>
<td>TRN02</td>
<td>Reference Identification</td>
<td></td>
<td>1/30</td>
<td></td>
</tr>
</tbody>
</table>
This section describes the values required by CareFirst in the AMT segment. AMT Segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 &amp; 89</td>
<td>2200D or 2200E</td>
<td>AMT01</td>
<td>Amount Qualifier Code</td>
<td>Must be “T3”</td>
<td>3</td>
<td>Total Submitted Charges</td>
</tr>
<tr>
<td>66 &amp; 89</td>
<td>2200D or 2200E</td>
<td>AMT02</td>
<td>Monetary Amount</td>
<td></td>
<td>1/18</td>
<td>Must not be missing. $0 and $0.00 are valid values accepted by CareFirst.</td>
</tr>
</tbody>
</table>

This section describes the values required by CareFirst in the DTP segment. DTP Segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>67 &amp; 90</td>
<td>2200D or 2200E</td>
<td>DTP01</td>
<td>Date/Time Qualifier</td>
<td>Must be “472”</td>
<td>3</td>
<td>Service</td>
</tr>
<tr>
<td>67 &amp; 90</td>
<td>2200D or 2200E</td>
<td>DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>Must be “RD8”</td>
<td>3</td>
<td>Range of Dates Expressed in Format CCYMDDCCYMDD</td>
</tr>
</tbody>
</table>
| 68 & 91 | 2200D or 2200E| DTP03     | Dates of Service       |         | 17     | The following situations must be met for dates to be considered valid.  
|         |               |           |                        |        |        | a) The “From Date” must be within 3 years of the current date.  
|         |               |           |                        |        |        | b) The “From Date” and “To Date” cannot span more than 1 year.  
|         |               |           |                        |        |        | c) The “To Date” cannot be greater than the current date.     |
10.2 The 277 Response

The following describes the CareFirst utilization of segments and elements when there is some type of uniqueness or restriction. All other values comply with HIPAA regulations.

This section describes the values returned by CareFirst in the NM1 segments.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>2100 A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>“PR”</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>111</td>
<td>2100 A</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>“2”</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>112</td>
<td>2100 A</td>
<td>NM103</td>
<td>Entity Description</td>
<td>30</td>
<td></td>
<td>“CareFirst BlueCross BlueShield”</td>
</tr>
<tr>
<td>112</td>
<td>2100 A</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>“PI”</td>
<td>2</td>
<td>Payor Identification</td>
</tr>
<tr>
<td>112</td>
<td>2100 A</td>
<td>NM109</td>
<td>Information Source Primary Identifier</td>
<td>6</td>
<td>BCBS Plan Code – “080” or “190” CareFirst will respond on the 277 Response with the same Plan Code received on the 276 Request.</td>
<td></td>
</tr>
<tr>
<td>118</td>
<td>2100 B</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>“41”</td>
<td>2</td>
<td>From the 276</td>
</tr>
<tr>
<td>119</td>
<td>2100 B</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>“46”</td>
<td>2</td>
<td>Electronic Transmitter Identification Number (ETIN)</td>
</tr>
<tr>
<td>119</td>
<td>2100 B</td>
<td>NM109</td>
<td>Information Receiver Primary Identifier</td>
<td>2/80</td>
<td>Trading Partner ID From the 276</td>
<td></td>
</tr>
<tr>
<td>127</td>
<td>2100 C</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>“1P”</td>
<td>2</td>
<td>From the 276</td>
</tr>
<tr>
<td>128</td>
<td>2100 C</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>“XX”</td>
<td>2</td>
<td>Health Care Financing Administration National Provider Identifier</td>
</tr>
<tr>
<td>128</td>
<td>2100 C</td>
<td>NM109</td>
<td>Provider Primary Identifier</td>
<td>2/80</td>
<td>Provider’s NPI Number</td>
<td></td>
</tr>
<tr>
<td>135</td>
<td>2100 D</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>“IL”</td>
<td>2</td>
<td>From the 276</td>
</tr>
<tr>
<td>136</td>
<td>2100 D</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>“MI”</td>
<td>2</td>
<td>Member Identification Number</td>
</tr>
<tr>
<td>136</td>
<td>2100 D</td>
<td>NM109</td>
<td>Subscriber Identifier</td>
<td>2/80</td>
<td>CareFirst Member/Subscriber ID</td>
<td></td>
</tr>
<tr>
<td>175</td>
<td>2100 E</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>“QC”</td>
<td>2</td>
<td>From the 276</td>
</tr>
<tr>
<td>175</td>
<td>2100 E</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td>“1”</td>
<td>1</td>
<td>Person</td>
</tr>
<tr>
<td>176</td>
<td>2100 E</td>
<td>NM103</td>
<td>Last Name</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>176</td>
<td>2100 E</td>
<td>NM104</td>
<td>First Name</td>
<td>25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This section describes the values returned by CareFirst in the TRN segment. TRN Segment will appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>137 &amp; 177</td>
<td>2200D or 2200E</td>
<td>TRN01</td>
<td>Trace Type Code</td>
<td>Must be “2”</td>
<td>2/3</td>
<td>Referenced Transaction Trace Number</td>
</tr>
<tr>
<td>137 &amp; 177</td>
<td>2200D or 2200E</td>
<td>TRN02</td>
<td>Reference Identification</td>
<td></td>
<td>1/30</td>
<td>From 276</td>
</tr>
</tbody>
</table>

This section describes the values returned by CareFirst in the STC segments.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>138 &amp; 178</td>
<td>2200D or 2200E</td>
<td>STC01</td>
<td>Health Care Claim Status</td>
<td></td>
<td>1/30</td>
<td>STC01-1 is the Category code. STC01-2 is the Status code. STC segment in 2000D loop may be assigned if the subscriber is the patient. STC segment in 2000E loop may be assigned if the Dependent is the patient.</td>
</tr>
<tr>
<td>145 &amp; 185</td>
<td>2200D or 2200E</td>
<td>STC02</td>
<td>Date</td>
<td></td>
<td>8</td>
<td>Effective Date of Status Information</td>
</tr>
<tr>
<td>145 &amp; 185</td>
<td>2200D or 2200E</td>
<td>STC04</td>
<td>Monetary Amount</td>
<td></td>
<td>1/18</td>
<td>Total Claim Charge Amount</td>
</tr>
<tr>
<td>145 &amp; 185</td>
<td>2200D or 2200E</td>
<td>STC05</td>
<td>Monetary Amount</td>
<td></td>
<td>1/18</td>
<td>Claim Payment Amount</td>
</tr>
<tr>
<td>145 &amp; 185</td>
<td>2200D or 2200E</td>
<td>STC06</td>
<td>Date</td>
<td></td>
<td>8/8</td>
<td>Claim Payment Date</td>
</tr>
<tr>
<td>146 &amp; 186</td>
<td>2200D or 2200E</td>
<td>STC07</td>
<td>Payment Method Code</td>
<td></td>
<td>3/3</td>
<td>Will be used when claim has a dollar payment to the provider of Service.</td>
</tr>
<tr>
<td>146 &amp; 186</td>
<td>2200D or 2200E</td>
<td>STC08</td>
<td>Date</td>
<td></td>
<td>8/8</td>
<td>Check Issue or EFT Effective Date</td>
</tr>
<tr>
<td>146 &amp; 186</td>
<td>2200D or 2200E</td>
<td>STC09</td>
<td>Check Number</td>
<td></td>
<td>1/16</td>
<td>For paid claims CareFirst will return the check number for non FACETS and voucher number for FACETS claims. If the payment is EFT (electronic file transfer), this number will be the trace number for all claims. For pending or rejected claims CareFirst will not return this element for any claims.</td>
</tr>
</tbody>
</table>
## 10. Transaction Information

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>161 &amp; 201</td>
<td>2200D or 2200E</td>
<td>STC01</td>
<td>Health Care Claim Status</td>
<td></td>
<td>1/30</td>
<td>STC01-1 is the Category code. STC01-2 is the Status code. STC segment in 2000D loop may be assigned if the subscriber is the patient. STC segment in 2000E loop may be assigned if the Dependent is the patient.</td>
</tr>
<tr>
<td>168 &amp; 208</td>
<td>2200D or 2200E</td>
<td>STC02</td>
<td>Date</td>
<td></td>
<td>8</td>
<td>Effective Date of Status Information</td>
</tr>
<tr>
<td>168 &amp; 208</td>
<td>2200D or 2200E</td>
<td>STC04</td>
<td>Monetary Amount</td>
<td></td>
<td>1/18</td>
<td>Line Item Charge Amount will not be returned.</td>
</tr>
<tr>
<td>168 &amp; 208</td>
<td>2200D or 2200E</td>
<td>STC05</td>
<td>Monetary Amount</td>
<td></td>
<td>1/18</td>
<td>Line Item Provider Payment Amount will not be returned.</td>
</tr>
</tbody>
</table>

This section describes the values returned by CareFirst in the REF segments. REF Segment will be returned only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page &amp; 189–194</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>149–154</td>
<td>2200D or 2200E</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>“1K” or “BLT” or “EJ”</td>
<td>2</td>
<td>When available, up to three REF Segments will be returned on 277. In an event when 276 is submitted with an invalid DCN format, then in addition to supplying the DCN identified within the requested service date range on the 276, the 277 will also address the invalid DCN submitted on the 276 by returning (A4:35) Claim not found status for it. In an event when correct DCN is submitted on the 276, the 277 will return the most recent DCN identified within the service date range and will repeat the claim status one more time for that one particular DCN requested on the 276 Transaction.</td>
</tr>
</tbody>
</table>
10. Transaction Information

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>149–154 &amp; 189–194</td>
<td>2200D or 2200E</td>
<td>REF02</td>
<td>Reference Identification</td>
<td></td>
<td>1/30</td>
<td>CareFirst will return a claim number when the claim has been finalized, or pended. CareFirst will return only the most recent DCN when adjustments have been made to the claim. Any other associated DCNs will not be returned. This is in compliance with the BCBSA mandates. CareFirst will return an institutional type of bill from the original submitted claim, when it is available.</td>
</tr>
<tr>
<td>171 &amp; 211</td>
<td>2220D or 2220E</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>“FJ”</td>
<td>2/3</td>
<td>Line Item Control Number</td>
</tr>
<tr>
<td>171 &amp; 121</td>
<td>2220D or 2220E</td>
<td>REF02</td>
<td>Reference Identification</td>
<td></td>
<td>1/30</td>
<td>CareFirst will return this when available from the original claim.</td>
</tr>
</tbody>
</table>

This section describes the values returned by CareFirst in the DTP segment. DTP Segment may appear only at the subscriber or dependent level.

<table>
<thead>
<tr>
<th>IG Page</th>
<th>Loop ID</th>
<th>Reference</th>
<th>X12 Element Name</th>
<th>Codes</th>
<th>Length</th>
<th>Valid Values/Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>155 &amp; 195</td>
<td>2200D or 2200E</td>
<td>DTP01</td>
<td>Date/Time Qualifier</td>
<td>Must be “472”</td>
<td>3</td>
<td>Service</td>
</tr>
<tr>
<td>155 &amp; 195</td>
<td>2200D or 2200E</td>
<td>DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>Must be “RD8”</td>
<td>3</td>
<td>Range of Dates Expressed in Format CCYYMMDDCCYYMMDD</td>
</tr>
<tr>
<td>156 &amp; 196</td>
<td>2200D or 2200E</td>
<td>DTP03</td>
<td>Dates of Service</td>
<td></td>
<td>17</td>
<td>Date Service Period</td>
</tr>
<tr>
<td>172 &amp; 212</td>
<td>2220D or 2220E</td>
<td>DTP01</td>
<td>Date/Time Qualifier</td>
<td>Must be “472”</td>
<td>3</td>
<td>Service</td>
</tr>
<tr>
<td>172 &amp; 212</td>
<td>2220D or 2220E</td>
<td>DTP02</td>
<td>Date Time Period Format Qualifier</td>
<td>Must be “RD8”</td>
<td>3</td>
<td>Range of Dates Expressed in Format CCYYMMDDCCYYMMDD</td>
</tr>
<tr>
<td>172 &amp; 212</td>
<td>2220D or 2220E</td>
<td>DTP03</td>
<td>Dates of Service</td>
<td></td>
<td>17</td>
<td>Service Line Date</td>
</tr>
</tbody>
</table>
11. Appendices

**Appendix A**

**Implementation Checklist**

CareFirst has three Preferred Trading Partners – RealMed, Allscripts (Meddata) and Emdeon for the 276/277 Claim Status Transaction. Please contact one of our preferred vendors to submit 276 transactions to CareFirst.

**Appendix B**

**DCN Formats**

<table>
<thead>
<tr>
<th>FACETS</th>
<th>FEP</th>
<th>CARE</th>
<th>DC</th>
<th>NASCO</th>
<th>BX</th>
</tr>
</thead>
</table>
| Initial Claim | 10 digit followed by '00' Suffix  
Example: 1234567890 00 | 10 digit followed by a P or F  
Example: 1234567890P3120198765F | 13 digits  
Example: 11R9142612345 | 10 digits  
Example: 0407900123 | 14 digits  
Example: RRYYJJIJ3BBNNQQ  
The initial claim is assigned a Qualifier number '00' at QQ or 13th & 14th positions. | Sccf# |

| Adjusted Claim | 10 digit and incremental suffix. The Suffix is incremented by one for each successive adjustment  
Example: Original claim# 1234567890 00  
First Adjusted Claim# 1234567890 01  
Second Adjusted Claim# 1234567890 02 | 10 digit followed by a P or F  
Example: 1234567890P3120198765F | 13 digits  
Example: 11R9142612345 | 8 digits followed by two alpha characters. (EA, EF, IF, IA) followed by M followed by alpha sequence  
Example: First Adjustment: 40790123EA  
Second Adjustment: 40790123EAMA  
Twenty-Seventh Adjustment: 40790123EAMZ  
Twenty-Eighth Adjustment: 40790123EAMAA | The first adjustment to the original record is assigned a Qualifier number '02' at QQ or 13th & 14th positions.  
The second adjustment is assigned a Qualifier number '04' and any subsequent '06' at QQ or 13th & 14th positions. |
### Appendix C

**The claim status category and claim status codes**

The most recent list of Claim Status Category and Specific Codes can be found at the Washington Publishing Company website.


### Appendix D

#### Definitions, acronyms and abbreviations

The following is a list of key terms commonly associated with the Health Insurance Portability and Accountability Act (HIPAA).

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>276</td>
<td>Health Care Claim Status Request</td>
</tr>
<tr>
<td>277</td>
<td>Health Care Claim Status Response</td>
</tr>
<tr>
<td>999</td>
<td>The X12 standard transaction to notify a Trading Partner when there is a format problem with an incoming (276) request.</td>
</tr>
<tr>
<td>Accredited Standards Committee (ACS)</td>
<td>ACS is an organization accredited by the American National Standards Institute (ANSI) for the development of American National Standards.</td>
</tr>
<tr>
<td>Accredited Standards Committee X12 (ASC X12)</td>
<td>ASC X12 is a group accredited by the American National Standards Institute (ANSI) that defines electronic data interchange (EDI) standards for many American industries, including health care insurance.</td>
</tr>
<tr>
<td>Accredited Standards Committee X12N (ASC X12N)</td>
<td>ASC X12N is a subcommittee of X12 that defines electronic data interchange (EDI) standards for the insurance industry, including health care insurance.</td>
</tr>
<tr>
<td>American National Standards Institute (ANSI)</td>
<td>ANSI is an organization that accredits various standards-setting committees, and monitors their compliance. HIPAA prescribes that, whenever practical, ANSI-accredited bodies develop mandated standards.</td>
</tr>
<tr>
<td>BOL</td>
<td>Business Objects Layer</td>
</tr>
<tr>
<td>CGW</td>
<td>Claims Gateway is CareFirst access point for electronic commerce.</td>
</tr>
<tr>
<td>CMDB</td>
<td>Common Member Data Base</td>
</tr>
<tr>
<td>DDE</td>
<td>Direct Data Entry</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>FEP</td>
<td>Federal Employee Program</td>
</tr>
<tr>
<td>FEPOC</td>
<td>Federal Employee Program Operations Center. It is the central location where all FEP claims must be sent in order to receive responses/answers to claims that have been billed/processed by FEP.</td>
</tr>
<tr>
<td>FLEXX</td>
<td>Claims processing system used for Commercial and FEP claims.</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability Accountability Act of 1996</td>
</tr>
<tr>
<td>FACETS</td>
<td>Claims processing system for commercial business</td>
</tr>
<tr>
<td>FEP Thin</td>
<td>FCC (FEP Claims Centralization) It is the level below the pipeline that contains touchpoints (pricer, ODS, claimcheck, etc) for FEP processing prior to sending those claims to the FEPOC.</td>
</tr>
<tr>
<td>NASCO</td>
<td>Claims processing system for national and Bluecard business</td>
</tr>
<tr>
<td>Nasco InterAct</td>
<td>NASCO’s core business application and claims adjudication engine.</td>
</tr>
<tr>
<td>NASCO Processing System (NPS)</td>
<td>NASCO’s core business application and claims adjudication engine.</td>
</tr>
<tr>
<td>HWS</td>
<td>HIPAA Web Service</td>
</tr>
<tr>
<td>IACS</td>
<td>Inquiry, Analysis and Control System</td>
</tr>
<tr>
<td>IG</td>
<td>National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim Status Request and Response 276/277</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identification number</td>
</tr>
<tr>
<td>TA1</td>
<td>The X12 transaction to notify a Trading Partner when there is an interchange problem.</td>
</tr>
<tr>
<td>TP</td>
<td>Trading Partner</td>
</tr>
<tr>
<td>X12</td>
<td>A standard transmission protocol and data format used for EDI transactions.</td>
</tr>
<tr>
<td>XML</td>
<td>Extensible Markup Language</td>
</tr>
<tr>
<td>ICC</td>
<td>Integration Competency Center</td>
</tr>
<tr>
<td>HTTPS</td>
<td>Hypertext Transfer Protocol Secure</td>
</tr>
<tr>
<td>Claims Status Category Codes</td>
<td>Claim Status Category codes indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed in the Claim Status Codes.</td>
</tr>
<tr>
<td>Claims Status Codes</td>
<td>Health Care Claim Status Codes convey the status of an entire claim or a specific service line.</td>
</tr>
</tbody>
</table>
Appendix E Change Summary
The following chart includes the summary of changes made to the Companion Guide.

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Status</th>
<th>Page</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/18/12</td>
<td>Version 2.0</td>
<td>Addition</td>
<td></td>
<td>Updates made to incorporate the CORE Companion Guide Template Rule changes.</td>
</tr>
</tbody>
</table>

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). ® Registered trademark of the Blue Cross and Blue Shield Association.

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