CareFirst
Family of health care plans

HIPAA Transactions & Code Sets Companion Guide

Refers to the Implementation Guides based on X12, version 5010, Companion Guide version 9.0

Disclosure Statement

This Companion Guide is issued in an effort to provide the trading partners of CareFirst, Inc. 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, Inc.

This document has been designed to assist both technical and business areas of our trading partners who wish to submit HIPAA standard transactions. It contains specifications of the transaction, contact information, and other information we believe may be helpful to our trading partners in working with us toward compliance with HIPAA transaction and code set requirements.

All instructions in this document were written using information known at the time of publication and may change. The most up-to-date version of the Companion Guide is available on the CareFirst, Inc. (CareFirst) website (**carefirst.com/electronicclaims**).

Please be sure that any printed version you use is the same as the latest version available at the CareFirst website. Most users will choose to test their systems and transmissions; the X12 file responses you receive during testing are not a guarantee of payment. CareFirst is not responsible for the performance of software you may use to complete these transactions.

Change Summary—Document History

Version	Date	Description
1.0	October 31, 2010	Original Issue
1.1	December 9, 2010	Updated Comments from Peer Review
2.0	February 7, 2011	Updated with additional information
3.0	February 8 , 2011	Move non HIPAA Information to Submitter Guide
3.1	February 17, 2011	Correct 837 2010 AB Information,277CA 2100D
4.0	March 17, 2011	Add 275 Transaction
5.0	April 13, 2011	Add Errata Version Information, QTY segment information
5.1	August 1, 2011	Update 275 Requirements
6.0	February 10, 2012	Update email address, transaction information
6.1	March 6, 2012	Update Rendering Name Suffix
7.0	August 24, 2012	Add COB Claims Information for 837P
8.0	January 10, 2014	Add Dental Transactions and ICD10 Changes
9.0	November 4, 2014	Add COB Claims Information for 837I

Table of Contents

1. Introduction

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Administrative Simplification provisions, the Secretary of the Department of Health and Human Services (HHS) was directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Audience

This document is intended to provide information to our trading partners about the submission of standard transactions to CareFirst. It contains specifications of the transactions, helpful guidance for getting started and testing your files as well as contact information. This document includes substantial technical information and should be shared with both technical and business staff.

Purpose of the Companion Guide

This Companion Guide to the ASC X12N Implementation Guides, inclusive of addenda, adopted under HIPAA clarifies and specifies the data content required when data is transmitted electronically to CareFirst. File transmissions should be based on this document, together with the X12N Implementation Guides.

This guide is intended to be used in conjunction with X12N Implementation Guides, not to replace them. Additionally, this Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

This HIPAA Transactions and Code Sets Companion Guide explain the procedures necessary for trading partners of CareFirst to conduct Electronic Data Interchange (EDI) transactions. These transactions include:

- Health Care Claim: Institutional ASC X12N 837I
- Health Care Claim: Professional ASC X12N 837P
- Health Care Claim: Dental ASC X12N 837D
- Health Care Claim Acknowledgement ASC X12N 277CA

All instructions in this document were written using information known at the time of publication and are subject to change. Future changes to the document will be available on the CareFirst website (**carefirst.com/electronicclaims**).

1.1 Implementation Guides

Implementation Guides are available from the Washington Publishing Company's website at **atwpc-edi.com/content/view/817/1**

1.2 Glossary

A glossary of terms related to HIPAA and the Implementation Guides is available from the Washington Publishing Company's website at **wedi.org/snip/public/articles/HIPAA_GLOSSARY.PDF**

1.3 Additional information

The CareFirst entities acting as health plans are covered entities under the HIPAA regulations. CareFirst is also a business associate of group health plans, providing administrative services (including enrollment and claims processing) to those group health plans. Submitters are generally either covered entities themselves, or are business associates of covered entities, and must comply with HIPAA privacy standards. As required by law, CareFirst has implemented and operational zed the HIPAA privacy regulations.

Therefore, it can be expected that protected health information (PHI) included in your test or live data provided in ACS X12N transactions will be handled in accordance with the privacy requirements, and we expect that submitters as covered entities or business associates of covered entities will also abide by the HIPAA privacy requirements.

2. Submitting Files

2.1 Submission process

CareFirst will be using TIBCO BusinessConnect™ enterprise-level B2B as the gateway to exchange HIPAA transactions via AS2 protocol. Trading Partners will be expected to provide 2 security certificates, one for Test and one for Production. Additional setup information such as the IP address of the sending system and Trading Partner Identifier will be requested.

3. Contact information

All inquiries regarding set-up, testing, and file submission should be directed to **edidirectsubmission@carefirst.com**.

4. Appendices and Support Documents

The Appendices include detailed file specifications and other information intended for technical staff. This section describes situational requirements for standard transactions as described in the X12N Implementation Guides (IGs) adopted under HIPAA. The tables contain a row for each segment of a transaction that CareFirst has something additional, over and above, the information contained in the IGs. That information can:

- Specify a sub-set of the IGs internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to electronic transactions with CareFirst.

In addition to the row for each segment, one or more additional rows may be used to describe CareFirst's usage for composite and simple data elements and for any other information.

Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

5. Appendix A: 275 Transaction Detail

Note: 275 transactions are not available for Dental transactions.

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
x		**INTERCHANGE CONTROL HEADER**						
x	ISA01	Authorization Information Qualifier	REQ		2/2			00
x	ISA02	Authorization Information	REQ		10/10			
x	ISA03	Security Information Qualifier	REQ		2/2			00
x	ISA04	Security Information	REQ		10/10			
x	ISA05	Interchange ID Qualifier	REQ		2/2			ZZ
x	ISA06	Interchange Sender ID	REQ		15/15			CareFirst assigned submitter ID
x	ISA07	Interchange ID Qualifier	REQ		2/2			ZZ
x	ISA08	Interchange Receiver ID	REQ		15/15			00580—DC Professional 00690— MD Professional 0080—DC Institutional 0190—MD Professional
x	ISA09	Interchange Date	REQ	YYMMDD	6/6			Same as in claim
x	ISA10	Interchange Control Number	REQ	HHMM	4/4			Same as in claim
x	ISA11	Interchange Control Standards Identifier	REQ		1/1		U	Same as in claim
x	ISA12	Interchange Control Version Number	REQ		5/5		00401	Same as in claim
x	ISA13	Interchange Control Number	REQ		9/9			Same as in claim
x	ISA14	Acknowledgment Requested	REQ		1/1			Same as in claim
x	ISA15	Usage Indicator	REQ		1/1			Same as in claim
x	ISA16	Component Element Separator	REQ		1/1			Same as in claim

5. Appendix A: 275 Transaction Detail

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
x		**FUNCTIONAL GROUP HEADER**						
x	GS01	Functional Identifier Code	REQ		2/2			PI
x	GS02	Application Sender's Code	REQ		2/15			00580—DC Professional 00690—MD Professional 0080—DC Institutional 0190—MD Professional
x	GS03	Application Receiver's Code	REQ		2/15			00580—DC Professional 00690—MD Professional 0080—DC Institutional 0190—MD Professional
x	GS04	Date	REQ	CCYYMMDD	8/8			Same as in claim
x	GS05	Time	REQ	HHMM, HHMMSS, HHMMSSD, HHMMSSDD	4/8			Same as in claim
x	GS06	Group Control Number	REQ		1/9			Same as in claim
x	GS07	Responsible Agency Code	REQ		2/2		X	Same as in claim
x	GS08	Version / Release / Industry Identifier Code	REQ		1/12		005010 X0210	Same as in claim
x		**Transaction Set Header**	REQ					
x	ST01	Transaction set identifier code	REQ		3/3		275	275
x	ST02	Transaction set control number	REQ		4/9			Incremental number
x		**Beginning Segment**	REQ					
x	BGN01	Transaction Set Purpose Code	REQ		2/2		02	
x	BGN02	Reference Identification	REQ		1/50			Incremental
x	BGN03	Date	REQ		8/8	Transaction set creation date		System date

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
		LOOP ID—1000A PAYER NAME						
1000 A		**Transaction Receiver**	REQ					
1000 A	NM101	Entity Identifier Code	REQ		2/3			
1000 A	NM102	Entity Type Qualifier	REQ		1/1			
1000 A	NM103	Last Name or Organization Name	REQ		1/35	Payer name		CareFirst BCBS (Maryland)
1000 A	NM105	Name Middle	SIT		1/25	Submitter middle name		
1000 A	NM108	Identification Code Qualifier	REQ		1/2		PI	
1000 A	NM109	Identification Code	REQ		2/80	Payer identifier		CARE, NASCO, FLEXX, FEP FLEXX, FACETS
		LOOP ID—1000B SUBMITTER INFORMATION						
1000 B		**Submitter Information**	REQ					
1000 B	NM101	Entity Identifier Code	REQ		2/3		41	
1000 B	NM102	Entity Type Qualifier	REQ		1/1		2	
1000 B	NM103	Name Last or Organization Name	REQ		1/35	Submitter name		
1000 B	NM108	Identification Code Qualifier	REQ		1/2		46	
1000 B	NM109	Identification Code	REQ		2/80	Submitter identifier		
		Loop ID 1000C— PROVIDER NAME INFORMATION						
1000 C	NM101	Entity Identifier Code	REQ		2/3		1P	
1000 C	NM102	Entity Type Qualifier	REQ		1/1		1 or 2	
1000 C	NM103	Name Last or Organization Name	REQ		1/35	Provider last or organization name		Billing provider name (same as claim info)
1000 C	NM104	Name First	SIT		1/35	Provider first name		
1000 C	NM105	Name Middle	SIT		1/35	Provider middle name		

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
1000 C	NM108	Identification Code Qualifier	SIT		1/2		XX	
1000 C	NM109	Identification Code	REQ		2/80	Provider identifier		NPI—If NPI is not in the claim, provide the identification with appropriate qualifier
		PRV—PROVIDER TAXONOMY INFORMATION	SIT					
1000 C	PRV01	Provider Code	REQ		1/3	0	BI	
1000 C	PRV02	Reference Identification Qualifier	REQ		2/3		PXC	
1000 C	PRV03	Reference Identification	REQ		1/30	Provider taxonomy code		Optional now
		PROVIDER IDENTIFICATION						
1100 C	NX101	Entity Identifier Code	REQ		2/3		1P	
		PROVIDER ADDRESS						
1100 C	N301	Address Information	REQ		1/55	0		Address information
1100 C	N302	Address Information	SIT		1/55	0		
		PROVIDER CITY, STATE, ZIP CODE						
1100 C	N401	City Name	REQ		2/30			
1100 C	N402	State or Province Code	SIT		2/2			
1100 C	N403	Postal Code	SIT		3/15			
1100 C	N404	Country Code	SIT		2/3			
1100 C	N407	Country Subdivision Code	SIT		1/3			
		Loop ID 1000D—Patient Name						
1000 D	NM101	Entity Identifier Code	REQ		2/3		QC	
1000 D	NM102	Entity Type Qualifier	REQ		1/1		1	

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
1000 D	NM103	Name Last or Organization Name	REQ		1/35	Patient last name		
1000 D	NM104	Name First	SIT		1/35	Patient first name		
1000 D	NM105	Name Middle	SIT		1/35	Patient middle name		
1000 D	NM107	Name Suffix	SIT		1/35	Patient name suffix		
1000 D	NM108	Identification Code Qualifier	REQ		1/2		MI	
1000 D	NM109	Identification code	REQ		2/80	Patient primary identifier		Patient-ID or Member-ID
		PATIENT CONTROL NUMBER						
1000 D	REF01	Reference Identification Qualifier	REQ		2/3		EJ	
1000 D	REF02	Reference Identification	REQ		1/30	Patient account number		Match clm02
		MEDICAL RECORD NUMBER	SIT					
1000 D	REF01	Reference Identification Qualifier	SIT		2/3		EA	
1000 D	REF02	Reference Identification	SIT		1/30	Medical record number		Will send if MRN is available
		Institutional Claim Service Date						
1000 D	DTP01	Date Time Qualifier	REQ		3/3	Date time qualifier	472	
1000 D	DTP02	Date Time Period Format Qualifier	REQ		2/3		D8/RD8	
1000 D	DTP03	Date Time Period	REQ	CCYYMMDD	1/35	Claim service period		
2000 A		**LOOP ID—2000A ASSIGNED NUMBER**	REQ					
		Assigned Number						
2000 A	LX01	Line Counter Assigned Number	REQ		1/6			Number of attachment

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
		Payer's Control Number/ Provider's Control Number						
2000 A	TRN01	Trace Type Code	REQ		1/1		1	
2000 A	TRN02	Reference Identification	REQ		1/50	Payer or provider's control number		For claim attachments send tracking number. PWK06 loop 2300 of the 837 For appeal attachment send DCN associated with the appeal
		Service Line Item Identification						
2000 A	REF01	Reference Identification Qualifier	REQ		2/3		6R	For claim attachments use qualifier "6R" For appeal attachments use qualifier "FJ"
2000 A	REF02	Reference Identification	REQ		1/30	Line item control number		For claim attachments segment will be inserted and DCN, will be populated by CF Pipeline. For appeal attachment send confirmation or control number returned by the appeal process.
2100 A	DTP	Professional Date of Service			35		472	Required for professional claims
		LOOP ID— 2100B DATE ADDITIONAL INFORMATION WAS SUBMITTED						
2100 B	DTP01	Date Time Qualifier	REQ		3/3	Date time qualifier	368	
2100 B	DTP02	Date Time Period Format Qualifier	REQ		2/3		D8	
2100 B	DTP03	Date Time Period	REQ	CCYYMMDD	1/35	Additional information submitted date		Submitted date

Loop ID	Data Element ID	Loop/Segment/ Element Name	Required	Format	Min/ Max	Industry Name	Default Values	Default Values
		CATEGORY OF PATIENT INFORMATION SERVICE						
2100 B	CAT01	Report Type Code	REQ		2/2	Attachment report type code	AE	
2100 B	CAT02	Report Transmission Code	REQ		1/2	Attachment information format code	MB	
		LOOP ID—2110B ELECTRONIC FORMAT IDENTIFICATION						
2110 B	EFI01	**Security Level Code**	REQ				05	
		BINARY DATA SEGMENT						
2110 B	BIN01	Length of Binary Data	REQ		1/15	Binary data length number		
2110 B	BIN02	Binary Data	REQ		1/ (1E+ 15)-1	Billing provider additional identifier		
x		**Transaction Set Trailer**	REQ					
x	SE01	Number of Included Segments	REQ		1/10	Transaction segment count		Same as in claim
x	SE02	Transaction Set Control Number	REQ		4/9			Same as in claim
x		**FUNCTIONAL GROUP TRAILER**						
x	GE01	Number of Transaction Sets Included	REQ		1/6			Same as in claim
x	GE02	Group Control Number	REQ		1/9			Same as in claim
x		**INTERCHANGE CONTROL TRAILER**						
x	IEA01	Number of Included Functional Groups	REQ		1/5			Same as in claim
x	IEA02	Interchange Control Number	REQ		9/9			Same as in claim

6. Appendix B: 837 I Transaction Detail

6.1 Control segments/envelopes

6.1.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

6.1.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers. CareFirst requires one claim per St-SE.

6.1.4 Acknowledgements and/or reports

A 999 Acknowledgement will be created for each file submitted for processing. In addition, a 277CA file will be created for each claim submitted for processing.

Transaction detail table

Legend: SHADED rows represent "segments" in the X12N implementation guide. **NON-SHADED** rows represent "data elements" in the X12N implementation guide. "Loop-specific" comments should be indicated in the first segment of the loop.

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
	ISA01	Authorization Information Qualifier	2	00	Submit qualifier "00"
	ISA02	Authorization Information	10		Submit 10 blank spaces
	ISA03	Security Information Qualifier	2	00	Submit qualifier "00"
	ISA04	Security Information	10		Submit 10 blank spaces
	ISA05	Interchange ID qualifier	2	ZZ	
	ISA06	Interchange Sender ID	15		Must match the submitter ID assigned by CareFirst
	ISA07	Interchange ID Qualifier	2	ZZ	
	ISA08	Interchange Receiver ID	15		00080 for CareFirst DC 00190 for CareFirst MD Including trailing spaces to equal 15
	ISA13	Interchange Control Number	9		The Interchange Control Number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected.
	ISA16	Component Element Separator	1		CareFirst recommends always use ' : ' [colon]
	GS02	Application Sender's Code	15		Must match the submitter ID assigned by CareFirst
	GS03	Application Receiver Code	15		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD
	GS08	Version Identifier Code	12		005010X223A2
	ST01	Transaction Set Identified	3		837
	ST02	Unique identifier within each ISA-IEA			CareFirst expects 1 claim per ST/SE combination
	ST03	Version	35		005010X223A2
1000A—SUBMITTER					
1000	NM103	Name Last or Organization Name (Submitter Name)			Submit the Clearinghouse name
1000	NM109	Submitter Identifier			Must match the submitter ID assigned by CareFirst
1000	PER02	Submitter Contact Name			Must be different from NM103 above, otherwise leave blank
1000B—HEADER—RECEIVER NAME LEVEL					
1000	NM103	Name Last or Organization Name (Receiver Name)	35		CareFirst recommends set to "CareFirst"
1000	NM109	Identification Code (Receiver Primary Identifier)	80		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2000A—DETAIL—BILLING PROVIDER SPECIALTY INFORMATION					
2000	PRV01	Provider Code	3	BI	Indicates the following information is for the billing provider
2000	PRV02	Reference Identification Qualifier	3	PXC	Indicates health care taxonomy
2000	PRV03	Reference Identification	50		Provider taxonomy
2010AA—DETAIL—BILLING PROVIDER NAME LEVEL					
2010	NM108	Identification Code Qualifier	2	XX	Identification code qualifier—NPI
2010	NM109	Identification Code	80		Organizational NPI for the billing provider
2010	N301	Billing Provider Address			Submit the street address associated with organizational NPI listed in NM109
2010	N403	Billing Provider Zip Code			Submit the complete 9 digit zip code
2010	REF01	Reference Identification Qualifier	3	EI	Tax ID identifier code
2010	REF02	Additional Billing Provider Information	30		Tax ID number
2010AB—DETAIL—PAY-TO ADDRESS (Only submit this loop is address is different from 2010AA loop)					
2000B SUBSCRIBER INFORMATION					
2000	SBR01	Payer Responsibility Sequence Number Code	2		CareFirst accepts P and S. For Medicare crossover claims, use S.
2000	SBR09	Claim Filing Indicator			CareFirst accepts all HIPAA values. For Medicare crossover claims, use BL only.
2000	CLM07	Provider Accept Assignment		A	Should represent whether the provider accepts assignment with Medicare.
2010BA—DETAIL—SUBSCRIBER NAME LEVEL					
2010	NM108	Identification Code Qualifier	2	MI	Submit 'MI' for plan 00080 (DC) and 00190 (MD).
2010	NM109	Identification Code (Subscriber Primary Identifier)	80		Submit the identification code including the 1–3 character alpha prefix as shown on customer ID card
2010BB—PAYER NAME					
2010	REF01	Billing Provider Secondary Identification Reference Identification Qualifier	3	G2	Submit one instance of qualifier "G2"
2010	REF02	Reference Identification (Billing Provider Additional Identifier)	30		CareFirst recommends for the segment with qualifier G2 3-digit regional provider ID
2000C PATIENT INFORMATION					
2000	PAT01	Individual Relationship Code			01, 19, 20, 21, 39, 40, 53, G8
2300—DETAIL—CLAIM INFORMATION LEVEL (CareFirst recommends submit services related to only one accident, LMP or medical emergency per claim)					
2300	CLM05-3	Claim Frequency Type Code (Claim Frequency Code)	1		
2300	CLM07	Provider Accept Assignment		A	CareFirst advises that this indicates whether the provider accepts assignment from the payer. If assignment is not accepted, payment may be sent to the patient

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2300	CLM08	Benefits Assignment Certification Indicator			Patient authorizes payment to the provider
2300	CLM09	Release of Information Code	1	Y	CareFirst requires release of information to = Y
2300	PWK01	Attachment Code Indicator		OZ	When implementing the CareFirst attachment edits use code OZ
2300	PWK06	Attachment Control Number			Required when submitting an attachment
2300	REF02	Reference Identification (Claim Original Reference Number)	30	F8	CareFirst requires the original claim number assigned by CareFirst be submitted if the claim is an adjustment
2300	REF02	Clearinghouse Trace Number	30	D9	CareFirst requires a unique id assigned to each claim
2300	NTE	Billing Note		ADD	Enter notes here when the revenue code requires remarks
2300 DIAGNOSIS CODES (may be repeated up to 12 times)					
2300	HI01-1	Principle Diagnosis Type Code		BK ABK	Principle diagnosis code—use ICD-9 codes until 10/01/2015
2300	HI01-2	Industry Code (Principle Diagnosis Code)	30		CareFirst requires a specific ICD-9 code
2300	HI01-9	Present on Admission Indicator		N,U,W,Y	CareFirst requires this information on inpatient claims
2300	HI01-1 through HI12-1	Admitting Diagnosis	3	BJ ABJ	Submit on inpatient claims only.
2300	HI01-1 through HI12-1	Patient Reason for Visit	3	PR	Patient reason for visit is required on outpatient claims effective 01/01/2012
2300	HI01-1 through HI12-1	External Cause of Injury	3	BN	Must use E Code when submitting this qualifier. CareFirst accepts ICD9 only. ICD-10 date is 10/01/2015.
2300	HI01-1 through HI12-1	Other Diagnosis	3	BF	CareFirst accepts ICD-9 only. ICD-10 date is 10/01/2015.
2300	HI01-9	Present on Admission Indicator		N,U,W,Y	CareFirst requires this information on inpatient claims
2300	HI01-1 through HI12-1	Code List Qualifier Code (Principal Procedure Code)	3	BR BBR	If inpatient, CareFirst requires value “BR”
2300	HI01-1 through HI12-1	Code List Qualifier Code (Other Procedure Code)	3	BQ BBQ	If inpatient, CareFirst requires value “BQ” if additional procedures were performed.
2310A—DETAIL—ATTENDING PHYSICIAN NAME LEVEL					
2310	NM101	Entity Type Qualifier		71	
2310	NM108	Identification Code Qualifier		XX	Submit attending provider NPI if known
2310	NM109	National Provider Identifier			Submit NPI number
2310B—DETAIL—OPERATING PHYSICIAN NAME LEVEL					
2310	NM101	Entity Type Qualifier		72	
2310	NM108	Identification Code Qualifier		XX	Submit operating provider NPI if known
2310	NM109	National Provider Identifier			Submit NPI number

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2310C—DETAIL—OTHER PROVIDER NAME LEVEL					
2310	NM101	Entity Type Qualifier		ZZ	
2310	NM108	Identification Code Qualifier		XX	Submit attending provider NPI if known
2310	NM109	National Provider Identifier			Submit NPI number
2310D—DETAIL—RENDERING PROVIDER NAME LEVEL					
2310	NM101	Entity Type Qualifier		82	
2310	NM108	Identification Code Qualifier		XX	Submit attending provider NPI if known
2310	NM109	National Provider Identifier			Submit NPI number
2310E—FACILITY ADDRESS (Required when service location is different from billing provider address)					
2310	NM101	Entity Type Qualifier		77	
2310	N301	Laboratory or Facility Address			
2310	N403	Postal Code			Include full 9 position zip code. For FEP claims must be within the local service area.
2310F REFERRING PROVIDER NAME LEVEL					
2310	NM101	Entity Type Qualifier		DN	Referring physician
2310	NM108	Identification Code Qualifier		XX	Submit attending provider NPI if known
2310	NM109	National Provider Identifier			Submit NPI number
2320 OTHER SUBSCRIBER INFORMATION					
2320	SBR01	Payer Responsibility Sequence			Enter P or S. For Medicare crossover claims this is the information related to primary payer.
2320	SBR09	Claim Filing Indicator			For Medicare crossover claims use MA for institutional claims .
2320	AMT01	Qualifier		D	
2320	AMT02	Other Payer Paid Amount			Insert the other payer paid amount here. Include AMT*D*0 if claim was processed but not paid. Do not include deductible, coinsurance, copayments or other adjustments.
2320	CAS01	Adjustment Group Code		CO OA PR	For inpatient institutional claims include all CAS segments. One segment per group code.
2320	CAS02, 05, 08, 11, 14, 17	Claim Adjustment Reason Code			
2320	CAS03, 06, 09, 12, 15, 18,	Claim Adjustment Amount			
2320	MOA03-07	Outpatient Adjudication Information			Report remark codes returned by Medicare on the 835 or payment advice
2320	MIA	Inpatient Adjudication Information			Report remark codes returned by Medicare on the 835 or payment advice
2330 OTHER PAYER					
2330B	DTP01	Remittance Date Qualifier		573	

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2330B	DTP02	Remittance Date			Date claim adjudicated by primary payer—required on inpatient secondary claims
2400 INSTITUTIONAL SERVICE LINE					
2400	SV201-1	Product or Service ID Qualifier		HC	CareFirst accepts HCPCS codes
2400—DETAIL—SERVICE LINE LEVEL (Service line payment information required for outpatient institutional crossover claims)					
2430	SVD02	Service Line Payment Information			Prior payer paid amount
2430	CAS01	Claim Adjustment Group Code			Add one line for each group code. Required when SVD02 is not equal to CLM02
2430	CAS02, 05 08, 11, 14, 17	Claim Adjustment Reason Code			From the 835 or Medicare EOMB
2430	CAS03, 06, 09, 12,15, 18	Claim Adjustment Monetary Amount			From the 835 or Medicare EOMB
2430	DTP01	Check or Remittance Date Qualifier		573	
2430	DTP02	Check or Remittance Date			Date of primary payment from 835 or EOB primary payment
2410—DETAIL—DRUG IDENTIFICATION LEVEL (Submit a NDC code for prescribed drugs and biologics where required by government regulation)					
2410	LIN03	National Drug Code			Enter a valid NDC code in this field

7. Appendix C: 837 D Transaction Detail

7.1 Control segments/envelopes

CareFirst does not support real time 835 transactions.

7.1.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

7.1.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes

7.1.3 ST-SE

This section describes CareFirst's use of transaction set control numbers. CareFirst requires one claim per St-SE.

7.1.4 Acknowledgements and/or reports

A 999 Acknowledgement will be created for each file submitted for processing. In addition, a 277CA file will be created for each claim submitted for processing.

7. Appendix C: 837 D Transaction Detail

Legend: SHADED rows represent "segments" in the X12N implementation guide. **NON-SHADED** rows represent "data elements" in the X12N implementation guide. "Loop-specific" comments should be indicated in the first segment of the loop.

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
	ISA01	Authorization Information Qualifier	2	00	Submit qualifier "00"
	ISA02	Authorization Information	10		Submit 10 blank spaces
	ISA03	Security Information Qualifier	2	00	Submit qualifier "00"
	ISA04	Security Information	10		Submit 10 blank spaces
	ISA05	Interchange ID qualifier	2	ZZ	00580
	ISA06	Interchange Sender ID	15		Must match the submitter ID assigned by CareFirst
	ISA07	Interchange ID Qualifier	2	ZZ	
	ISA08	Interchange Receiver ID	15		00580
	ISA13	Interchange Control Number	9		The interchange control number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected.
	ISA16	Component Element Separator	1		CareFirst recommends always use ' : ' [colon]
	GS02	Application Sender's Code	15		Must match the submitter ID assigned by CareFirst
	GS03	Application Receiver Code	15		CareFirst recommends set to 00580
	GS08	Version Identifier Code	12		005010X224A2
	ST01	Transaction Set Identified	3		837
	ST02	Unique identifier within each ISA-IEA			CareFirst expects 1 claim per ST/SE combination
	ST03	Version	35		005010X224A2
1000A—SUBMITTER					
1000	NM103	Name Last or Organization Name (Submitter Name)			Submit the Clearinghouse name
1000	NM109	Submitter Identifier			Must match the submitter ID assigned by CareFirst
1000	PER02	Submitter Contact Name			Must be different from NM103 above, otherwise leave blank
1000B—HEADER—RECEIVER NAME LEVEL					
1000	NM103	Name Last or Organization Name (Receiver Name)	35		CareFirst recommends set to "CareFirst"
1000	NM109	Identification Code (Receiver Primary Identifier)	80		CareFirst recommends set to 00580
2000A—DETAIL—BILLING PROVIDER SPECIALTY INFORMATION					
2000	PRV01	Provider Code	3	BI	Indicates the following information is for the billing provider
2000	PRV02	Reference Identification Qualifier	3	PXC	Indicates health care taxonomy

7. Appendix C: 837 D Transaction Detail

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2000	PRV03	Reference Identification	50		Provider taxonomy If the billing provider is the rendering provider, send the billing provider taxonomy code.
2010AA—DETAIL—BILLING PROVIDER NAME LEVEL					
2010	NM108	Identification Code Qualifier	2	XX	Identification code qualifier—NPI
2010	NM109	Identification Code	80		Organizational NPI for the billing provider
2010	N301	Billing Provider Address			Submit the street address associated
2010	N403	Billing Provider Zip Code			Submit the complete 9 digit zip code
2010	REF01	Reference Identification Qualifier	3	EI	Tax ID identifier code
2010	REF02	Additional Billing Provider Information	30		Tax ID number
2000B SUBSCRIBER INFORMATION					
2000	SBR01	Payer Responsibility Sequence Number Code	2		Valid values are P
2000	SBR09	Claim Filing Indicator			CareFirst accepts HIPAA values
2010BA—DETAIL—SUBSCRIBER NAME LEVEL					
2010	NM108	Identification Code Qualifier	2	MI	Submit 'MI'
2010	NM109	Identification Code (Subscriber Primary Identifier)	80		Submit the identification code including the 1–3 character alpha prefix as shown on customer ID card if present
2300—DETAIL—CLAIM INFORMATION LEVEL					
2300	CLM05-3	Claim Frequency Type Code (Claim Frequency Code)	1		
2300	CLM07	Provider Accept Assignment		A	CareFirst advises that this indicates whether the provider accepts assignment from the payer. If assignment is not accepted, payment may be sent to the patient.
2300	CLM08	Benefits Assignment Certification Indicator			Patient authorizes payment to the provider
2300	CLM09	Release of Information Code	1	Y	CareFirst requires release of information to = Y
2300	CLM19	Claim Submission Reason Code		PB	Use this code for predetermination 837Ds
2300	DTP03	Appliance Placement Date or Ortho Banding Date		452	Required for procedure codes D8070, D8080 and D8090
2300	DTP03	Service Date		472	Dates apply to all services on this claim. Not required for predetermination.
2300	DN102	Ortho Treatment Months Remaining Count			Required for procedure codes D8070, D8080 and D8090
2300	REF02	Claim Number from Clearinghouse		D9	
2300	PWK01	Report Type Code		Oz	
2300	PWK02	Report Transmission Code		FT	
2300	PWK05	Identification Code Qualifier		AC	
2300	PWK06	Identification Code			This should be the NEA document number provided on the ADA form

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2300	NTE02	Description		ADD	Attachments supported by NEA. This should be the document identification number for the specific document.
2300	NTE02	Description			Add treatment duration and months remaining. Format: treatment duration.
2300	NTE02	Description		ADD	Required for procedure codes D2999, D3999, D4999, D6999, D7999, D8999 and D0999
2400—DETAIL—SERVICE LINE LEVEL					
2400	SV301-1	ADA Code Validation			Must be present. Must be a valid ADA code with 5 positions. First position must include a capital D.
2400	SV304-1 to SV304-5	Arch			Must be present for specific codes
2400	SV304-1 to SV304-5	Quadrant			Must be present for specific codes
2400	SV306	Procedure Count			Required for D0230, D2951, D2957, D3426, D3430, D3450, D5730, D6976, D6977, D9221, D9242; otherwise default to 1
2400	TOO02	Tooth Code			Required for specific codes. Do not send tooth numbers for codes that are not on the Tooth No & Surface Requirements worksheet. Refer to Tooth No & Surface Requirements workbook for codes that require teeth numbers. **When the TOO segment is used multiple times send the tooth segments in ascending tooth number order. Refer to example in Notes.**
2400	TOO03-2 to TOO03-5	Tooth Surface Codes			Required for specific codes, must be a valid surface (B, D, F, I, L, M, O) and must contain the exact number of surfaces required for reported code. See exception in Notes column. Do not send if code on Tooth Number Requirements workbook does not require a surface. Refer to Tooth Number and Surface Requirements document.

8. Appendix D: 837 P Transaction Detail

8.1 Control segments/envelopes

8.1.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

8.1.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

8.1.3 ST-SE

CareFirst requires one claim per ST/SE.

8.1.4 Acknowledgements and/or reports

A 999 Acknowledgement will be created for each file submitted for processing. A 277CA will be created at the end of each business day.

8.2 Transaction detail table

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
	ISA01	1	Authorization Information Qualifier	2		Submit qualifier “00”
	ISA02	2	Authorization Information	10		Submit 10 blank spaces
	ISA03	3	Security Information Qualifier	2	“00”	Submit qualifier “00”
	ISA04	4	Security Information	10		Submit 10 blank spaces
	ISA06	5	Interchange Sender ID	2		Must match the Submitter ID assigned by CareFirst
	ISA07	7	Interchange ID Qualifier	2	“ZZ”	Submit ZZ
	ISA08	8	Interchange Receiver ID	15		00580 for CareFirst DC 00690 for CareFirst MD Including trailing spaces to equal 15
	ISA13	13	Interchange Control Number	9		The interchange control number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected
	ISA16	16	Component Element Separator	1		CareFirst recommends always use ‘ : ‘ [colon]
	GS02	2	Application Sender’s Code	15		Must match the submitter ID assigned by CareFirst
	GS03	3	Application Receiver's Code	15		CareFirst recommends set to 00580 for CareFirst DC 00690 for CareFirst MD
	GS08					005010X222A1
	ST01		Transaction Set Identified	3		837
	ST02		Unique identifier within each ISA-IEA			CareFirst expects 1 claim per ST/SE combination
	ST03		Version	35		005010X222A1
1000A—SUBMITTER						
1000	NM103		Name Last or Organization Name (Submitter Name)			Submit the Clearinghouse name
1000	NM109		Submitter Identifier			Must match the submitter ID assigned by CareFirst
1000	PER02		Submitter Contact Name			Must be different from NM103 above, otherwise leave blank
1000B—DETAIL—RECEIVER NAME LEVEL						
1000	NM103	3	Name Last or Organization Name (Receiver Name)	35		CareFirst recommends set to “CareFirst” for all plan codes
1000	NM109	9	Identification Code (Receiver Primary Identifier)	80		CareFirst recommends set to 00580 for CareFirst DC 00690 for CareFirst MD

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
2000A—DETAIL—BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						
2000	PRV01		PRV01	3	BI	Indicates the following information is for the billing provider
2000	PRV02		PRV02	3	PXC	Indicates health care provider taxonomy
2000	PRV03		PRV03	30		Provider taxonomy
2010AA—DETAIL—BILLING PROVIDER NAME LEVEL (CareFirst expects the 2010AA loop to identify the billing agent or billing service if applicable)						
2010	NM108		Identification Code Qualifier	2	XX	Identification code qualifier—NPI NPI is required
2010	NM109		Identification Code	80		Organizational NPI for the billing provider
2010	N301		Billing Provider Address			CareFirst recommends the address associated with Organizational NPI listed in NM109
2010	N403		Billing Provider Zip Code			Submit the complete 9 digit zip code
2010	REF01		Reference Identification Qualifier	3	EI Or SY	Tax identifier code Or SSN identifier code
2010	REF02		Additional Billing Provider Information	30		Tax ID or SSN
2010AB—DETAIL—PAY-TO ADDRESS LOOP (Only submit this loop if address is different from 2010AA loop)						
2000B—DETAIL—SUBSCRIBER HIERARCHICAL LEVEL						
2000	SBR01		Payer Responsibility Sequence Number Code		S	CareFirst accepts P and S. S will be a future enhancement for Medicare crossover claims use S
2000	SBR09	9	Claim Filing Indicator Code	2	BL	CareFirst accepts all HIPAA values for Medicare crossover claims use BL
2010BA—DETAIL—SUBSCRIBER NAME LEVEL						
2010	NM108	2	Identification Code Qualifier	2	MI	
2010	NM109	9	Identification Code (Subscriber Primary Identifier)	80		Submit the identification code including the 1–3 character alpha prefix as shown on the customer ID card
2010BB—PAYER NAME						
2010	REF01		Billing Provider Secondary Identification Reference Identification Qualifier		G2	Submit one instance of G2
2010	REF02		Reference Identification (Billing Provider Additional Identifier		30	CareFirst recommends for the segment with qualifier “G2” Regional provider ID type in position 1, ID number in positions 2–10, and member number in positions 11–14. Example 41234 0001

8. Appendix D: 837 P Transaction Detail

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
2000C—PATIENT INFORMATION						
2000	PAT01		Individual Relationship Codes			01.19.20.21.39.40.53.GB
2300—DETAIL—CLAIM INFORMATION LEVEL (CareFirst recommends submit services related to only one accident, LMP or medical emergency per claim)						
2300	CLM05	1	Claim Frequency Type Code (Claim Frequency Code)	1		CareFirst requires that the claim frequency type cannot be value "0" (encounter)
2300	CLM05-2		Facility Code Qualifier		B	Use B for professional claims
2300	CLM07		Provider Accept Assignment		A	CareFirst advises if assignment is not accepted, payment may be sent to the patient. For Medicare secondary claims, provider must accept assignment to send claims electronically.
2300	CLM08		Benefits Assignment Certification Indicator			Patient authorizes payment to the provider
2300	CLM09	9	Release of Information Code	1		CareFirst requires the subscriber's signature to be on file
2300	CLM11	1	Related Causes Code (Related Causes Code)	3		CareFirst recommends for all plan codes to submit related causes code information for accidental injuries
2300	DTP01	1	Date/Time Qualifier (Date Time Qualifier)	3	431	If known, CareFirst recommends for all plan codes to submit onset of current illness/symptom date information
2300	DTP01	1	Date/Time Qualifier (Date Time Qualifier)	3	439	If services rendered are related to an accident, submit accident date information
2300	DTP01	1	Date/Time Qualifier (Date Time Qualifier)	3	484	If services rendered are related to maternity care, submit last menstrual period information
2300	DTP01	1	Date/Time Qualifier (Date Time Qualifier	3	435	Admission date required on inpatient claims
2300	DTP01	1	Date/Time Qualifier (Date Time Qualifier)	3	096	CareFirst recommends for all plan codes to submit discharge date information for inpatient claims
2300	PWK01		Attachment Code Indicator		OZ	Use when implementing the CareFirst business rules for sending attachments
2300	REF01	1	Reference Identification Qualifier	3	9F	
2300	REF02	2	Reference Identification (Claim Original Reference Number)	30	F8	REF01= F8 CareFirst requires the original claim number assigned if claim is an adjustment
2300	REF02		Clearinghouse Trace Number		D9	CareFirst requires a unique id assigned by clearinghouse to each claim

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
2300—DIAGNOSIS INFORMATION						
2300	HI101-1		Diagnosis type Code		BK	Principle diagnosis code. CareFirst accepts ICD9 only. ICD10 is a future project.
2300	HI101-1		Diagnosis type Code		BF	Additional diagnosis code. Principle diagnosis code. CareFirst accepts ICD9 only. ICD10 is a future project.
2300	HI101-1		Anesthesia Related Procedure Code		BP	Anesthesia related procedure code
2300	HI102-1		Anesthesia Related Surgical Procedure		BO	Additional anesthesia related procedure code
2300	HI101-1		Condition Information		BG	Condition information
2310A—DETAIL—REFERRING PROVIDER NAME LEVEL						
2310	NM108	1	Identification Code Qualifier	3	XX	NPI
2310	NM109	2	NPI	30		Submit NPI if known
2310B—DETAIL—RENDERING PROVIDER NAME LEVEL (Submit only one rendering provider per claim. Do not submit on the claim line.)						
2310	NM103	**3**	Last Name/ Organization Name (Rendering Provider Last or Organization Name)	35		CareFirst recommends enter rendering provider last name
2310	NM104	4	Name First (Rendering Provider First Name)	25		CareFirst recommends enter rendering provider first name
2310	NM107		Name Suffix			CareFirst recommends including the professional title (MD RN CRNA) to facilitate NPI resolution
2310	NM108		Identification Code Qualifier	2	XX	Identification code qualifier—NPI
2310	NM109		Identification Code	80		Individual's NPI for the rendering provider
2310	PRV02		Reference Identification Qualifier	3	ZZ	Indicates health care provider taxonomy
2310	PRV03		Reference Identification	30		Provider taxonomy
2310C—SERVICE FACILITY LOOP (Required when service location is different from billing provider address)						
2310	NM101		Entity Type Qualifier		77	
2300	N301		Laboratory or Facility Address			
2300	N403		Postal Code			Include full 9 position zip code. For FEP claims must be within the local service area.
2310E—AMBULANCE PICK UP LOCATION						
2310	NM101		Entity Qualifier Code		PW	
2310	NM301		Address Information			Ambulance pick up address
2310	NM403		Postal Code			Zip code

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
2310F—AMBULANCE DROP OFF LOCATION						
2310	NM101		Entity Qualifier Code		45	
2310	NM301		Address Information			Ambulance drop off address
2310	NM403		Postal Code			Zip code
2320—OTHER SUBSCRIBER INFORMATION						
2320	SBR01		Payer Responsibility Sequence		P	Enter P or S. For Medicare crossover claims this is the information related to the primary payer.
2320	SBR09		Claim Filing Indicator		MB	For Medicare crossover claims use MB only
2320	AMT		Claim Level Paid Amount		D	Insert the other payer paid amount here
2400—DETAIL—SERVICE LINE LEVEL (CareFirst recommends submit services related to only one accident, LMP or medical emergency per claim)						
2400	SV101		Product or Service ID		HC	
2400	SV102	**1**	Monetary Amount (Line Item Charge Amount)	18		Amount must always be greater than 0
2400	SV103	3	Unit or Basis for Measurement Code	2		Always use 'MJ'* when related to the administration of anesthesia (procedure codes 00100-01995, or 01999, 02100-02101)
2400	SV104	4	Quantity (Service Unit Count)	15		Always use whole number(s) greater than 0
2400	NTE01	1	Note Reference Code	3		CareFirst requires value "ADD" if an NOC (not otherwise classified) procedure code was reported in loop 2400 SV101–2 procedure code
2400	**NTE02**	**2**	Description (Line Note Text)	80		CareFirst requires the narrative description if an NOC (not otherwise classified) procedure code was reported in loop 2400 SV101–2 procedure code
2400	PWK01		Attachment Code Indicator		OZ	When implementing the CareFirst attachment edits use code OZ
2400	PWK02		Attachment Control Indicator			Required when submitting an attachment
2400	QTY01	2	Obstetric Anesthesia Additional Units		FL	Used for informational purposes to report additional complexity. Claim will be paid based on procedure/ modifier combinationin the SV1 loop above.
2400	QTY02		Obstetric Anesthesia Additional Units			See above

Loop ID	Reference	Field #	X12 Element Name	Length	Codes	Notes/Comments
2410—DETAIL—DRUG IDENTIFICATION LEVEL (CareFirst recommends that a NDC code be submitted for prescribed drugs and biologics when required by government regulation.)						
2430—LINE ADJUDICATION INFORMATION						
2430	SVD02		Service Line Adjudication Information			Line level payment information required for Medicare crossover claims
2430	CAS01		Line Level Adjustments		CO, PR, OA	
2430	CAS02, 05, 08, 11, 14, 17		Claim Adjustment Code			
2430	CAS03, 06, 09, 12, 15, 18		Claim Adjustment Monetary Amount			
2430	DTP01		Adjudication Date Qualifier		573	Qualifier
2430	DTP02		Adjudication Date for Primary Payer			Payment date

9. Appendix E: 277CA Transaction Detail

Effective 07/01/2011—the 277CA will be the response to both 4010 and 5010 claims transactions.

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
	GS02	Application Sender's ID			This will be the payer ID
	G203	Application Receiver's Code			This is the submitter ID assigned by CareFirst
2100A—INFORMATION SOURCE NAME—PAYER INFORMATION					
2100A	NM101	Entity Identifier Code		PR	Set to PR
	NM102	Entity Type Qualifier		2	
	NM103	Organization Name			Set to CareFirst DC or CareFirst MD
	NM108	Identification Code Qualifier		PI	Set to PI
	NM109	Information Source Identifier			This will match the payer ID in the IS08
2200A—INFORMATION SOURCE PROCESS DATE					
2200A	DPT01	Date Time Period		50	
	DPT03	Date Time Period			Receipt of the file
	DTP01			009	
	DTP03				Date sent to adjudication system
2100B—INFORMATION RECEIVER NAME—SUBMITTER INFORMATION					
2100B	NM101	Submitter		41	
	NM102				From 837 loop 1000A NM102
	NM103				From 837 loop 1000A NM103
	NM108			46	Electronic transmitter identification number
	NM109				837 1000A NM109
2200B—INFORMATION RECEIVER STATUS					
2200B	STC01-1	Healthcare Claim Status Category Code			A2 for accepted claims A3 for rejected claims
2200B	STC01-2	Healthcare Claim Status Code			If A2 then 20 If A3 then 23
2200B	STC01-3	Entity Identifier		PR	
2200B	STC03	Action Code			Set to WQ for accept and U for reject
2200B	STC04	Total Submitted Charges			Sum of all the claim dollars in the CLM02 records
2100C—BILLING PROVIDER INFORMATION					
2100C	NM101	Entity Identifier Code		85	Set to 85
	NM102	Entity type qualifier			Populate from 837,2010AA NM102
	NM103				Populate from 837, 2010AA NM103
	NM108	Entity Code Qualifier		XX	Populate from 837 2010AA, NM108
	NM109	Identification Code			Populate from 837 2010AA, NM109

9. Appendix E: 277CA Transaction Detail

LOOP ID	Reference	X12 Element Name		Codes	Notes/Comments
2100D—PATIENT LOOP					
	NM101	Entity Identifier Qualifier		QC	Set To QC
	NM102	Entity Type Qualifier			Set to 1
	NM103	Last Name			Populate from 837 2010BA NM103
	NM104	First Name			Populate from 837 2010BA NM104
	NM108			MI	Set to MI
	NM109				Populate from 837 2010BA, NM109
2200D—CLAIM LEVEL INFORMATION					
2200D	STC01-1	Industry Code			Set to A3 when claim is in error, A2 if accepted
2200D	STC01-2	Health Care Claim Status Code		247	Set to 20 if accepted, otherwise claim status code will be sent
2200D	STC12	Free-form Message Text		264	CareFirst message codes will be sent in this segment
2200D	REF	Payer Claim Control Number		1K	CareFirst assigned DCN number
2200D	REF	Clearinghouse Tracking Number		D9	Unique identifier submitted by the clearinghouse

10. Appendix F: Reading the 999 Acknowledgement

CareFirst will produce an Industry Standard 999 Report. Refer to the Implementation Guide for details on how to read this transaction: **wpc-edi.com/content/view/817/1**.

CUT0284-1E (11/18)