Blue Cross and Blue Shield of Florida

Companion Document for Availity® Health Information Network Users
276/277 – Health Care Claim Status Request and Response
November 17, 2009

BlueCross BlueShield of Florida
Health Options®

About Availity, L.L.C. – Patients. Not paperwork.®

Availity optimizes the flow of information between health care professionals, health plans, and other health care stakeholders through a secure internet-based exchange. The Availity® Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the Web and electronic data interchange (EDI), and is HIPAA compliant. Availity is the recipient of several national and regional awards, including Consumer Directed Health Care, A.S.A.P. Alliance Innovation, eHealthcare Leadership, Northeast Florida Excellence in IT Leadership, E-Fusion, Emerging Technologies and Healthcare Innovations Excellence (TETHIE), and AstraZeneca-NMHCC Partnership. For more information, including an online demonstration, visit www.availity.com or call 1.800.AVAILITY (282.4548).

[1] Availity, L.L.C., is an independent company formed as a joint venture between Navigy, Inc., a wholly owned subsidiary of Blue Cross and Blue Shield of Florida, Inc., Health Care Service Corporation, and HUM-e-FL, Inc., a subsidiary of Humana, Inc. Blue Cross and Blue Shield of Florida has business arrangements with Availity with the goal of reducing costs in the Florida health care marketplace, simplifying provider workflow, improving patient experience and in providing HIPAA-AS compliant solutions. For more information or to register, visit Availity's website at *www.availity.com*.

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276/277 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

Availity

Trading Partner Agreement Companion Document Business Requirements

Blue Cross Blue Shield of Florida

276/277 ANSI X12 Version 004010X93A1

NOTE: These instructions are to be used in addition to the implementation guide.

DATE OF REVISION	COMMENTS
07/12/2007	• Added NPI dates and instruction (B2)
04/21/2008	• Updated NPI information (B2)
11/17/2009	• Cosmetic improvement

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	GLOBAL INFORMATION			
G1	**2000D Subscriber Demographic Information** Gender Code	DMG03	148	**F –** Female **M-** Male BCBSF requires that only the gender codes listed above be submitted, all others will be rejected.
G2	**2000E Dependent Demographic Information** Gender Code	DMG03	97	**F –** Female **M-** Male BCBSF requires that only the gender codes listed above be submitted, all others will be rejected.
G3	**Negative Values**			BCBSF will not process negative values (monetary amount fields) in any 276 files. Submission of any negative values (monetary amount fields) in 276 will not be processed or forwarded.
G4	**Date fields**			All dates submitted on an incoming 276 claim transaction must be a valid calendar date (not future date) in the appropriate format based on the respective implementation guide qualifier. Failure to do so will result in a claim/encounter not found message.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	GLOBAL INFORMATION			
G5	**All Segments**			Only loops, segments, and data elements valid for the **276** HIPAA-AS implementation guide **004010X93A1** will be translated. Submitting data not valid based on the implementation guide may cause files to be rejected and not sent for processing.
G6	**All Segments**		**Response:**	An outbound 277 HIPAA compliant claim status is contingent upon BCBSF'S receipt of an original ANSI X12 4010A1 837 claim. Therefore, if the claim was not received via a HIPAA compliant 837 claim, all relevant data elements and values are not available for return on the 277 transaction.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B1				If delays are encountered in updates by our claims processing systems, this could result in delays in receiving a timely claim status response.
B2	**2100C Provider Name** Qualifier Provider Identifier	NM108 NM109	68 69	All provider information loops must contain the NPI as of 5/17/08, if utilized **As of 5/17/08,** the XX qualifier is required in NM108 followed by the NPI number in NM109. **Note:** To receive a successful response when sending this transaction, the billing provider information should match either the Billing Provider ID, Loop 2010AA, REF segment or the Pay to Provider, Loop 2010AB, REF segment that was transmitted in the 837 transaction when the claim was submitted.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B3	**2100D Subscriber Name** Qualifier Subscriber Identifier	NM108 NM109	75 76	**NM108** **MI** - Member Identification Number BCBSF requires the submission of the above qualifier in this data element. **NM109** BCBSF requires the submission of the ID number (#) exactly as it appears on the BCBS ID card **without any embedded spaces**, (this includes any out-of-state Blue Card ID's) including any applicable alpha prefix or suffix. Failure to submit the data as indicated above, may result in a claim/encounter not found message.
B4	**2200D Claim Submitter Trace Number** Trace Number	TRN02	77 **Response:**	**TRN02** BCBSF requires the submission of the patient account number if available in this data element. BCBSF will return the number that was submitted in the 276 inquiry on the 277 response transaction.
B5	**2200D Payer Claim Identification Number** Reference Identification Qualifier Payer Claim Control Number	REF01 REF02	78 79	This segment should not be sent for a claim status inquiry if the provider has already received a statement on the claim, electronic or otherwise using the claim number. Submission of this segment when a statement has already been received may result in a mismatch condition.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B6	**2100E Dependent Name** Identification Code Qualifier Identification Code	NM108 NM109	99 100	**NM108** **MI-** Member Identification Number BCBSF requires the submission of the above qualifier in this data element. **NM109** BCBSF requires the submission of the ID number (#) exactly as it appears on the BCBS ID card **without any embedded spaces**, (this includes any out-of-state Blue Card ID's) including any applicable alpha prefix or suffix. Failure to submit the data as indicated above, may result in a claim/encounter not found message.
B7	**2200E Claim Submitter Trace Number** Trace Number	TRN02	101 **Response:**	**TRN02** BCBSF requires the submission of the patient account number if available in this data element. BCBSF will return the number that was submitted in the 276 inquiry on the 277 response transaction.
B8	**2200D Payer Claim Identification Number** Reference Identification Qualifier Payer Claim Control Number	REF01 REF02	103 103	This segment should not be sent for a claim status inquiry if the provider has already received a statement on the claim, electronic or otherwise using the claim number. Submission of this segment when a statement has already been received may result in a mismatch condition.

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Req #	Loop ID – Segment Description & Element Name	Reference Description	Implementation Guide Page(s)	Plan Requirement
	BUSINESS REQUIREMENTS			
B9	**2200D/E Claim Level Status Information** Check Number	STC09	**Response:** 163	BCBSF will not return a check number in this data element if multiple checks are issued for a paid claim. This is in compliance with the direction provided in the ANSI X12 4010A1 277 Implementation Guide.
B10			**Response:**	If the provider of services, has been assessed a lien, levy or garnishment all monies from claims payments will be withheld by BCBSF. If an ANSI X12 276 requests the status of a claim that meets this condition, the 277 response will provide the payment information that you would have received without the garnishment being applied.