Standard Companion Guide
Transaction Information

Instructions Related to 277CA Health Care Claim Acknowledgment Based on ASC X12 Implementation Guides, Version 005010

ASC X12N 277 (005010X214)

Preface

Tufts Health Plan® is implementing the X12N 277 Health Care Claim Acknowledgment (hereafter referred to as the "277CA") as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The X12N 277 version of the 5010 Standards for Electronic Data Interchange Technical Report Type 3 and Errata (also referred to as Implementation Guides) for the Health Care Claim Acknowledgement has been established as the standard for Health Care claims transaction compliance.

This document has been prepared to serve as a Tufts Health Plan's specific companion guide to the 277 Transaction Set. This document supplements but does not contradict any requirements in the 277 Technical Report, Type 3. The primary focus of the document is to clarify specific segments and data elements that will be submitted by Tufts Health Plan to Trading Partners who submit the 837 Institutional & Professional Claim Transactions. This document will be subject to revisions as new versions of the 277 Health Care Claim Acknowledgement Technical Reports are released.

The 277CA transaction set is for a submitter who is already successfully submitting 837 claim (professional/institutional) transactions. This document contains Tufts Health Plan's specifications for the transaction as well as contact information and key points.
The intended audience for this document is the technical area responsible for programming to receive files and automatically post acknowledgements of claims rejected or accepted for

processing by Tufts Health Plan to the provider's information system. The decision to post 277CA transactions to the information system is solely the responsibility of the recipient.

Table of Contents

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

To receive a valid transaction, please refer to the National Electronic Data Interchange Transaction Set Technical Report & Errata for the Health Care Claim: Acknowledgement ASC X12N 277 (005010X214). The Technical Reports and/or Implementation Guides) can be ordered from the Washington Publishing Company's website at www.wpc-edi.com.

NOTE: This should not be confused with the response to the 276/277 Claims Status Inquiry or the 277 Request for Information.

For questions related to the Tufts Health Plan's 277CA Transaction, please contact the EDI Operations Department at 888-880-8699 x54042 or email your questions to EDI Operations@Tufts-health.com.

NOTE: Tufts Health Plan is not responsible for any software used by the receiver for the utilization of the ASC X12N 277 transaction.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X214	Health Care Claim Acknowledgement

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
BOLDED and SHADED rows represent “loops” or “segments” in the X12N implementation guides.
NON-SHADED rows represent “data elements” in the X12N implementation guides.

005010X214 Health Care Claims Acknowledgement

Loop ID	Reference	Name	Expected Value	Notes/Comments
2100A	**NM1**	**Information Source Name**		
	NM101	Entity Identification Code	PR	Payer Identification
	NM103	Name Last or Organization Name	TUFTS HEALTH PLAN	
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)
	NM109	Identification Code	170558746	Tufts Health Plan DUNS
2200A	**TRN**	**Transmission Receipt Control Identifier**		
	TRN02	Reference Identification		A unique trace number (combination of date, time and sequence number) will be sent
2100B	**NM1**	**Information Receiver Name**		
	NM101	Entity Code Identifier	41	Submitter
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)
	NM109	Identification Code	*XX0001*	Tufts Health Plan will continue using the six-digit submitter code (two-alphas followed by four numerics)

Loop ID	Reference	Name	Expected Value	Notes/Comments
2200B		**Information Receiver Application Trace Identifier**		
	TRN02	Reference Identification		Tufts Health Plan will use the value submitted in the BHT03 (ICN) data element from the 837
	STC	**Information Receiver Status Information**		
	STC01-1	Health Care Claim Status Category Codes	A0-A8	Only the 'Acknowledgment' Category Codes are used in this element
	STC01-2	Health Care Claim Status Codes		Refer to Section 6.5, Rejection Criteria/Error Messages on the 277CA Acknowledgement
	STC01-3	Entity Identifier Code	41	Submitter
	STC03	Action Code	WQ	We will assign "WQ" to indicate the type of action (i.e. accept or reject) applied to the electronic transmission status of the ST-SE envelope of the 837 transaction
2200C	**STC**	**Billing Provider Status Information**		
	STC01-1	Health Care Claim Status Category Code	A0-A8	Only the 'Acknowledgment' Category Codes are used in this element. Refer to Section 6.4, Claim Status Categories Table
	STC01-2	Health Care Claim Status Code		Refer to Section 6.5, Rejection Criteria/Error Messages on the 277CA Acknowledgement
	STC03	Action Code	U = Reject WQ = Accept	• "U" is used to indicate the submitter's group of claims has been rejected. • If any portion of the submitter's group of claims is accepted then the code "WQ" will be used
2200D	**TRN**	**Claim Status Tracking Number**		

Loop ID	Reference	Name	Expected Value	Notes/Comments
	TRN02	Referenced Transaction Trace Number		Patient Control Number: Populated with the value received from the 837; Loop 2300 CLM01 element
	STC	**Claim Level Status Information**		
	STC01-1	Health Care Claim Status Category Code	A0-A8	Only the 'Acknowledgment' Category Codes are used in this element
	STC01-2	Health Care Claim Status Code		Refer to Section 6.4, Rejection Criteria/Error Messages on the 277CA Acknowledgement
	STC03	Action Code	U = Reject WQ = Accept	
	STC10-1	Health Care Claim Status Category Code	A3, A6, A7, A8	Will be used when more than one claim level rejection reason needs to be communicated
	STC10-2	Health Care Claim Status Code		Refer to Section 6.4, Rejection Criteria/Error Messages on the 277CA Acknowledgement
	REF	**Payer Claim Control Number**		
	REF01	Payer Claim Control Number qualifier	1K	Tufts Health Plan Claim Number
	REF01	Claim Identifier Number for Clearinghouse and Other Transmission Intermediaries qualifier	D9	• Tufts Health Plan will populate this field with the value received from the 837 • Loop 2300 REF02 element
	REF01	Institutional Bill Type Identification qualifier	BLT	Even though the 277CA Implementation Guide notes that the loop-2200D REF- INSTUTUTIONAL BILL TYPE IDENTIFICATION segment should only be populated for 837 Institutional claims, Tufts Health Plan will populate the 277CA/Loop-2200D/REF01 and Loop-2200D/REF02 regardless if the transaction is an 837 I or P.

Loop ID	Reference	Name	Expected Value	Notes/Comments
2220D	**SVC**	**Service Line Information**		
	SVC01-2	Product/Service ID		This field will be populated with one of the following: • The value received from the 837P; Loop 2400 SV101-2 element • The value received from the 837I; Loop 2400 SV201 element • The value received from the 837I; Loop 2400 SV202-2 element
	SVC01-3	Procedure Modifier		This field will be populated with one of the following: • The value received from the 837I; Loop 2400 SV202-3 element • The value received from the 837P; Loop 2400 SV101-3 element
	SVC01-4	Procedure Modifier		Will be populated with one of the following: • The value received from the 837I; Loop 2400 SV202-4 element • The value received from the 837P; Loop 2400 SV101-4 element
	SVC01-5	Procedure Modifier		Will be populated with one of the following: • The value received from the 837I; Loop 2400 SV202-5 element • The value received from the 837P; Loop 2400 SV101-5 element
	SVC01-6	Procedure Modifier		Will be populated with one of the following: • The value received from the 837I; Loop 2400 SV202-6 element • The value received from the 837P; Loop 2400 SV101-6 element
	STC	**Service Line Level Status Information**		
	STC01-1	Health Care Claim Status Category Code	A3, A6, A7, A8	Will be used when more than one claim level rejection reason needs to be communicated
	STC01-2	Health Care Claim Status Code		Refer to Section 5.4, Rejection Criteria/Error Messages on the 277CA Acknowledgement

4 TI Additional Information

4.1 Business Scenarios

Please refer to the business scenarios presented in the Implementation Guides or visit http://www.wpc-edi.com/277 for additional or corrected examples.

Business scenarios can be found in Section 3, page 103 of the Implementation Guide. They include:

- Accepted file (some claims rejected)
- Clearinghouse example, rejected file (invalid submitter)
- Payer response – accepted file
- Payer response
- 1st provider – claims accepted
- 2nd provider – claims rejected

4.2 Payer Specific Business Rules and Limitations

4.2.1 Category 1: General Instructions

- New claims submitters must go through the appropriate set-up/authorization process in order to receive the 277 Claim Acknowledgement. Please refer to the Communications/Connectivity Component of this document for details.

4.2.2 Category 2: Acknowledgements

- When a compliant file is received, the 277CA – commonly referred to as “the claim acknowledgment report” - will typically be available within one business day.
- The 277CA Health Care Claim Acknowledgement includes basic file information:
  - Submission status
  - Submission date
  - Claims submitted
  - Claims rejected
  - Claims accepted
  - Reasons for claim rejections
  - Claim numbers for accepted claims

- For rejection criteria and associated error messages that are sent on the 277CA file, refer to Section 6, Communications/Connectivity Instruction.

Frequently Asked Questions

4.2.3 General Claim Acknowledgement Questions

Q. Will I get the 277CA if I submit through a clearinghouse?
A. No, not directly. Your clearinghouse should provide you with this information.

Q. Will I get the 277CA for paper claims?
A. No, this acknowledgment is only for electronic claims.

Q: What is the difference between this transaction and the 276/277 transaction (health care claims status inquiry)?
A: The 276/277 transaction gives the status (Paid/Pend/Deny) of a claim in the Tufts Health Plan adjudication system. The 277CA is a "receipt" of an electronically submitted claim – whether it was rejected or accepted for further processing and does not include pay, pend, or deny information.

Q: What is the file naming convention for the 277CA files?
A: <Trading Partner>-<Submitter ID>-<Doc ID>.request. Where the <Trading Partner> field is populated with the Submitter Mailbox Name, the Submitter ID and the <Doc ID> is populated with an internal numbering sequence.

4.2.4 Tufts Health Plan Product Type Questions

Q. Will I get the 277CA for each file I send?
A. Yes. You will get a 277CA for each file submitted.

4.2.5 Direct 837 Claims Questions

Q. How long will the 277CA Acknowledgement be available?
A. The 277CA Acknowledgement will be retained in your mailbox for 14 days.

4.3 Other Resources

No additional resources listed at this time.

5 TI Change Summary

Revision	Revision Date	Comments
1	11/2012	Version 5010
2	08/2015	Changed phone extensions to new 5 digit numbers
3	12/2016	Updates to Transaction details and Rejection Reason Codes

6 Communications/Connectivity (C/C) Instruction

6.1 Setup and Testing

Tufts Health Plan does not send test or sample 277 Claim Acknowledgement transactions. All 277 Claim Acknowledgement transactions are "live" as a result of processing an actual Test/Production file. The decision to post 277 Claim Acknowledgement transactions to the payee's test or production information system is solely the responsibility of the recipient.

6.1.1 NEHEN

If your organization is a NEHEN member via Massachusetts eHealth Collaborative, as of January 2017, all NEHEN members that submit their 837 claims through the Trizetto Clearinghouse (Trizetto), will receive the claim acceptance or rejection information through their Trizetto connection. Tufts Health Plan will send the 277CA to Trizetto and Trizetto will disseminate the information to your organization. Trizetto may disseminate the 277CA information they receive from Tufts Health Plan in their non-EDI proprietary report format. Please contact Trizetto for additional information at : TPS_NEHENSupport@trizetto.com

6.1.2 NEHENNet

To receive the 277 Claim Acknowledgement transaction via NEHENNet, you must subscribe to NEHENNet. For more information, visit www.nehennet.org.

6.1.3 Direct EDI

To receive the 277 Claim Acknowledgement transaction via Direct EDI, you must be a registered user with a password and already be submitting HIPAA-compliant 837 files (professional or institutional) directly to Tufts Health Plan.

6.2 Contact Information

The following sections provide contact information for any questions regarding HIPAA, 837 transactions, EDI, documentation, or training.

6.2.1 For General Claims Submission Questions

Go to http://www.tuftshealthplan.com/providers and select the Electronic Services link.

6.2.2 For 277CA Transaction Questions

The following table provides specific contact information by department and responsibility.

For Questions Regarding…	Contact	Phone Number	Email Address
EDI Claims Submission (i.e., file submissions, claim rejections)	Tufts Health Plan EDI Operations	(888) 880-8699 x54042	EDI_Operations@tufts-health.com

6.3 Enveloping Specifications

Trading Partner1 (SENDER)	170558746
Trading Partner2 (RECEIVER)	<Sender ID>
APRF (Application Reference)	277CA
Segment Terminator (OPTIONAL)	Carriage Return (CR)
Element Separator (OPTIONAL)	*
Component Element Separator (OPTIONAL)	~

6.3.1 ISA (Interchange Control Header Segment)

The ISA is a fixed record length segment and all positions within each of the data elements are required. The first element separator defines the element separator used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

The **Input Data** column below contains text in *[bracketed italics],* which indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
ISA01	2	Authorization Information Qualifier	**00**	No Authorization Information Present
ISA02	10	Authorization Information	*[Submitter-specific ID number, or ten-space placeholder]*	If no Authorization Information number is present, enter ten spaces in this field
ISA03	2	Security Information Qualifier	**00**	No Security Information Present
ISA04	10	Security Information/Password	*[Submitter-specific ID number, or ten-space placeholder]*	If no Authorization Information number is present, enter ten spaces in this field
ISA05	2	Interchange ID Qualifier/Trading Partner Qualifier	**01**	DUNS (Dun & Bradstreet)
ISA06	15	Interchange Sender ID/ Trading Partner ID	**170558746**	Tufts Health Plan DUNS
ISA07	2	Interchange ID Qualifier/Tufts Health Plan Qualifier	**ZZ**	Mutually Agreed
ISA08	15	Interchange Receiver ID/Tufts Health Plan ID	*[Tufts Health Plan Submitter ID]*	Receiver ID (Provided by Tufts Health Plan)
ISA09	6	Interchange Date	YYMMDD	Date of the interchange
ISA10	4	Interchange Time	HHMM	Time of the interchange

Elements	Size	Name	Input Data	Remarks
ISA11	1	Repetition Separator		• The repetition separator is a delimiter and not a data element • This field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure • This value must be different than the data element separator, component element separator, and the segment terminator
ISA12	5	Interchange Control Version Number		Version Number
ISA13	9	Interchange Control Number/Last Control Number	<auto generated>	Assigned and maintained by the interchange sender, must be identical to the associated Interchange Trailer, IEA-02
ISA14	1	Acknowledgement Request	0	0 - No Acknowledgment Requested
ISA15	1	Interchange Usage Indicator/ Acknowledgment Test Indicator	*[Enter either T or P]*	T - Test Data P - Production Data
ISA16	1	Component Element Separator (Sub-Element)	~	• Used to separate component data elements within a composite data structure; must be unique • ASCII Value - Component element separator

6.3.2 IEA (Interchange Control Trailer Segment)

This segment defines the end of an interchange of zero or more functional groups and interchange-related control segments.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
IEA01	1/5	Number of Included Functional Groups	*[Submitter-specific ID number]*	A count of the number of functional groups included in an interchange
IEA02	9	Interchange Control Number	*[Submitter-specific ID number]*	A control number assigned by the interchange sender

6.3.3 GS (Functional Group Header Segment)

This segment indicates the beginning of a functional group and to provide control information.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GS01	2	Functional Identifier Code	HC	Health Care Claim
GS02	2/15	Application Sender's Code	170558746	Code identifying party sending transmission
GS03	2/15	Application Receiver's Code	*[Tufts Health Plan Submitter ID]*	Code identifying party receiving transmission
GS04	8	Date	*[Enter the date using the format YYYYMMDD; for example, January 1, 2012 would be entered as 20120101]*	Functional Group creation date
GS05	4/8	Time	*[Enter the time using the format HHMM; for example, 1:30 PM would be entered as 1330]*	Functional Group creation time. Time expressed in 24-hour clock
GS06	1/9	Group Control Number/Last Control Number	*[Submitter-specific number]*	Assigned and maintained by the sender, must be identical to the associated functional group trailer, GE-02
GS07	1/2	Responsible Agency Code	X	Accredited Standards Committee X12
GS08	1/12	Version/Release/Industry Identification Code	005010X214	Health Care Claim Acknowledgment

6.3.4 GE (Functional Group Trailer Segment)

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GE01	1/6	Number of Transaction Sets Included	*[Submitter-specific number]*	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element
GE02	1/9	Group Control Number	*[Submitter-specific number]*	Assigned number originated and maintained by the sender

6.4 Claim Status Categories Table

Code	Claim Status Category Description
A0	Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.
A1	Acknowledgement/Receipt – The claim/encounter has been received.
A2	Acknowledgement/Acceptance – The claim/encounter has been accepted.
A3	Acknowledgement/Returned as unprocessable claim – The claim/encounter has been rejected. The claim must be resubmitted.
A4	Acknowledgement/Not Found – The claim/encounter cannot be found
A6	Acknowledgement/Rejected for Missing Information – The claim/encounter is missing the information specified in the Status details and has been rejected
A7	Acknowledgement/Rejected for Invalid Information – The claim/encounter has invalid information as specified in the Status details and has been rejected.
A8	Acknowledgement/Rejected for relational field in error.

6.5 Rejection Criteria/Error Messages on the 277CA Acknowledgement

Claim Reject Code	Claim Reject Code Description
0	Cannot provide further status electronically.
1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
8	No payment due to contract/plan provisions.
9	No payment will be made for this claim.
10	All originally submitted procedure codes have been combined.
11	Some originally submitted procedure codes have been combined.
12	One or more originally submitted procedure codes have been combined.
13	All originally submitted procedure codes have been modified.
14	Some all originally submitted procedure codes have been modified.
15	One or more originally submitted procedure code have been modified.
16	Claim/encounter has been forwarded to entity. Note: This code requires use of an Entity Code.
17	Claim/encounter has been forwarded by third party entity to entity. Note: This code requires use of an Entity Code.
18	Entity received claim/encounter, but returned invalid status. Note: This code requires use of an Entity Code.

19	Entity acknowledges receipt of claim/encounter. Note: This code requires use of an Entity Code.
20	Accepted for processing.
21	Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.
22	... before entering the adjudication system.
23	Returned to Entity. Note: This code requires use of an Entity Code.
24	Entity not approved as an electronic submitter. Note: This code requires use of an Entity Code.
25	Entity not approved. Note: This code requires use of an Entity Code.
26	Entity not found. Note: This code requires use of an Entity Code.
27	Policy canceled.
28	Claim submitted to wrong payer.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber id mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber id not found.
34	Subscriber and policyholder name not found.
35	Claim/encounter not found.
37	Predetermination is on file, awaiting completion of services.
38	Awaiting next periodic adjudication cycle.
39	Charges for pregnancy deferred until delivery.
40	Waiting for final approval.
41	Special handling required at payer site.
42	Awaiting related charges.
44	Charges pending provider audit.
45	Awaiting benefit determination.
46	Internal review/audit.
47	Internal review/audit - partial payment made.
48	Referral/authorization.d 761.</i><
49	Pending provider accreditation review.
50	Claim waiting for internal provider verification.
51	Investigating occupational illness/accident.
52	Investigating existence of other insurance coverage.
53	Claim being researched for Insured ID/Group Policy Number error.
54	Duplicate of a previously processed claim/line.
55	Claim assigned to an approver/analyst.
56	Awaiting eligibility determination.
57	Pending COBRA information requested.
59	Non-electronic request for information. This change effective 7/1/2011: Information was requested by a non-electronic method. Note: At least one other status code is required to identify the requested information.

60	Electronic request for information. This change effective 7/1/2011: Information was requested by an electronic method. Note: At least one other status code is required to identify the requested information.
61	Eligibility for extended benefits.
64	Re-pricing information.
65	Claim/line has been paid.
66	Payment reflects usual and customary charges.
67	Payment made in full.
68	Partial payment made for this claim.
69	Payment reflects plan provisions.
70	Payment reflects contract provisions.
71	Periodic installment released.
72	Claim contains split payment.
73	Payment made to entity, assignment of benefits not on file. Note: This code requires use of an Entity Code.
78	Duplicate of an existing claim/line, awaiting processing.
81	Contract/plan does not cover pre-existing conditions.
83	No coverage for newborns.
84	Service not authorized.
85	Entity not primary. Note: This code requires use of an Entity Code.
86	Diagnosis and patient gender mismatch.
87	Denied: Entity not found. (Use code 26 with appropriate Claim Status category Code)
88	Entity not eligible for benefits for submitted dates of service. Note: This code requires use of an Entity Code.
89	Entity not eligible for dental benefits for submitted dates of service. Note: This code requires use of an Entity Code.
90	Entity not eligible for medical benefits for submitted dates of service. Note: This code requires use of an Entity Code.
91	Entity not eligible/not approved for dates of service. Note: This code requires use of an Entity Code.
92	Entity does not meet dependent or student qualification. Note: This code requires use of an Entity Code.
93	Entity is not selected primary care provider. Note: This code requires use of an Entity Code.
94	Entity not referred by selected primary care provider. Note: This code requires use of an Entity Code.
95	Requested additional information not received. claim status code identifying the requested information.
96	No agreement with entity. Note: This code requires use of an Entity Code.
97	Patient eligibility not found with entity. Note: This code requires use of an Entity Code.
98	Charges applied to deductible.
99	Pre-treatment review.
100	Pre-certification penalty taken.

101	Claim was processed as adjustment to previous claim.
102	Newborn's charges processed on mother's claim.
103	Claim combined with other claim(s).
104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)
105	Claim/line is capitated.
106	This amount is not entity's responsibility. Note: This code requires use of an Entity Code.
107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)
108	Coverage has been canceled for this entity. (Use code 27)
109	Entity not eligible. Note: This code requires use of an Entity Code.
110	Claim requires pricing information.
111	At the policyholder's request these claims cannot be submitted electronically.
112	Policyholder processes their own claims.
113	Cannot process individual insurance policy claims.
114	Claim/service should be processed by entity. Note: This code requires use of an Entity Code.
115	Cannot process HMO claims
116	Claim submitted to incorrect payer.
117	Claim requires signature-on-file indicator.
118	TPO rejected claim/line because payer name is missing. (Use status code 21 and status code 125 with entity code IN)
119	TPO rejected claim/line because certification information is missing. (Use status code 21 and status code 252)
120	TPO rejected claim/line because claim does not contain enough information. (Use status code 21)
122	Missing/invalid data prevents payer from processing claim. (Use CSC Code 21)
123	Additional information requested from entity. Note: This code requires use of an Entity Code.
124	Entity's name, address, phone and id number. Note: This code requires use of an Entity Code.
125	Entity's name. Note: This code requires use of an Entity Code.
126	Entity's address. Note: This code requires use of an Entity Code.
127	Entity's Communication Number. Note: This code requires use of an Entity Code. 06/06/2010<
128	Entity's tax id. Note: This code requires use of an Entity Code.
129	Entity's Blue Cross provider id. Note: This code requires use of an Entity Code.
130	Entity's Blue Shield provider id. Note: This code requires use of an Entity Code.
131	Entity's Medicare provider id. Note: This code requires use of an Entity Code.
132	Entity's Medicaid provider id. Note: This code requires use of an Entity Code.
133	Entity's UPIN. Note: This code requires use of an Entity Code.
134	Entity's CHAMPUS provider id. Note: This code requires use of an Entity Code.
135	Entity's commercial provider id. Note: This code requires use of an Entity Code.

136	Entity's health industry id number. Note: This code requires use of an Entity Code.
137	Entity's plan network id. Note: This code requires use of an Entity Code.
138	Entity's site id . Note: This code requires use of an Entity Code.
139	Entity's health maintenance provider id (HMO). Note: This code requires use of an Entity Code.
140	Entity's preferred provider organization id (PPO). Note: This code requires use of an Entity Code.
141	Entity's administrative services organization id (ASO). Note: This code requires use of an Entity Code.
142	Entity's license/certification number. Note: This code requires use of an Entity Code.
143	Entity's state license number. Note: This code requires use of an Entity Code.
144	Entity's specialty license number. Note: This code requires use of an Entity Code.
145	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code.
146	Entity's anesthesia license number. Note: This code requires use of an Entity Code.
147	Entity's qualification degree/designation (e.g. RN,PhD,MD). Note: This code requires use of an Entity Code.
148	Entity's social security number. Note: This code requires use of an Entity Code.
149	Entity's employer id. Note: This code requires use of an Entity Code.
150	Entity's drug enforcement agency (DEA) number. Note: This code requires use of an Entity Code.
152	Pharmacy processor number.
153	Entity's id number. Note: This code requires use of an Entity Code.
154	Relationship of surgeon & assistant surgeon.
155	Entity's relationship to patient. Note: This code requires use of an Entity Code.
156	Patient relationship to subscriber
157	Entity's Gender. Note: This code requires use of an Entity Code.
158	Entity's date of birth. Note: This code requires use of an Entity Code.
159	Entity's date of death. Note: This code requires use of an Entity Code.
160	Entity's marital status. Note: This code requires use of an Entity Code.
161	Entity's employment status. Note: This code requires use of an Entity Code.
162	Entity's health insurance claim number (HICN). Note: This code requires use of an Entity Code.
163	Entity's policy number. Note: This code requires use of an Entity Code.
164	Entity's contract/member number. Note: This code requires use of an Entity Code.
165	Entity's employer name, address and phone. Note: This code requires use of an Entity Code.
166	Entity's employer name. Note: This code requires use of an Entity Code.
167	Entity's employer address. Note: This code requires use of an Entity Code.

168	Entity's employer phone number. Note: This code requires use of an Entity Code.
169	Entity's employer id.
170	Entity's employee id. Note: This code requires use of an Entity Code.
171	Other insurance coverage information (health, liability, auto, etc.).
172	Other employer name, address and telephone number.
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber. Note: This code requires use of an Entity Code.
174	Entity's student status. Note: This code requires use of an Entity Code.
175	Entity's school name. Note: This code requires use of an Entity Code.
176	Entity's school address. Note: This code requires use of an Entity Code.
177	Transplant recipient's name, date of birth, gender, relationship to insured.
178	Submitted charges.
179	Outside lab charges.
180	Hospital s semi-private room rate.
181	Hospital s room rate.
182	Allowable/paid from other entities coverage NOTE: This code requires the use of an entity code. 01/24/2010
183	Amount entity has paid. Note: This code requires use of an Entity Code.
184	Purchase price for the rented durable medical equipment.
185	Rental price for durable medical equipment.
186	Purchase and rental price of durable medical equipment.
187	Date(s) of service.
188	Statement from-through dates.
189	Facility admission date
190	Facility discharge date
191	Date of Last Menstrual Period (LMP)
192	Date of first service for current series/symptom/illness.
193	First consultation/evaluation date.
194	Confinement dates.
195	Unable to work dates/Disability Dates.
196	Return to work dates.
197	Effective coverage date(s).
198	Medicare effective date.
199	Date of conception and expected date of delivery.
200	Date of equipment return.
201	Date of dental appliance prior placement.
202	Date of dental prior replacement/reason for replacement.
203	Date of dental appliance placed.
204	Date dental canal(s) opened and date service completed.
205	Date(s) dental root canal therapy previously performed.
206	Most recent date of curettage, root planing, or periodontal surgery.
207	Dental impression and seating date.
208	Most recent date pacemaker was implanted.
209	Most recent pacemaker battery change date.

210	Date of the last x-ray.
211	Date(s) of dialysis training provided to patient.
212	Date of last routine dialysis.
213	Date of first routine dialysis.
214	Original date of prescription/orders/referral.
215	Date of tooth extraction/evolution.
216	Drug information.
217	Drug name, strength and dosage form.
218	NDC number.
219	Prescription number.
220	Drug product id number. (Use code 218)
221	Drug days supply and dosage.
222	Drug dispensing units and average wholesale price (AWP).
223	Route of drug/myelogram administration.
224	Anatomical location for joint injection.
225	Anatomical location.
226	Joint injection site.
227	Hospital information.
228	Type of bill for UB claim.
229	Hospital admission source.
230	Hospital admission hour.
231	Hospital admission type.
232	Admitting diagnosis.
233	Hospital discharge hour.
234	Patient discharge status.
235	Units of blood furnished.
236	Units of blood replaced.
237	Units of deductible blood.
238	Separate claim for mother/baby charges.
239	Dental information.
240	Tooth surface(s) involved.
241	List of all missing teeth (upper and lower).
242	Tooth numbers, surfaces, and/or quadrants involved.
243	Months of dental treatment remaining.
244	Tooth number or letter.
245	Dental quadrant/arch.
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.
247	Line information.
248	Accident date, state, description and cause.
249	Place of service.
250	Type of service.
251	Total anesthesia minutes.

252	Authorization/certification number. This change effective 11/1/2011: Entity's authorization/certification number. Note: This code requires the use of an Entity Code.
253	Procedure/revenue code for service(s) rendered. Use codes 454 or 455.
254	Primary diagnosis code. This change effective 11/1/2011: Principal Diagnosis code..
255	Diagnosis code.
256	DRG code(s).
257	ADSM-III-R code for services rendered.
258	Days/units for procedure/revenue code.
259	Frequency of service.
260	Length of medical necessity, including begin date.
261	Obesity measurements.
262	Type of surgery/service for which anesthesia was administered.
263	Length of time for services rendered.
264	Number of liters/minute & total hours/day for respiratory support.
265	Number of lesions excised.
266	Facility point of origin and destination - ambulance.
267	Number of miles patient was transported.
268	Location of durable medical equipment use.
269	Length/size of laceration/tumor.
270	Subluxation location.
271	Number of spine segments.
272	Oxygen contents for oxygen system rental.
273	Weight.
274	Height.
275	Claim.
276	UB04/HCFA-1450/1500 claim form 10/31/2006<
277	Paper claim.
278	Signed claim form.
279	Itemized claim. This change effective 7/1/2011: Claim/service must be itemized
280	Itemized claim by provider
281	Related confinement claim.
282	Copy of prescription.
283	Medicare entitlement information is required to determine primary coverage.
284	Copy of Medicare ID card.
285	Vouchers/explanation of benefits (EOB).
286	Other payer's Explanation of Benefits/payment information.
287	Medical necessity for service.
288	Reason for late hospital charges. This change effective 7/1/2011: Hospital late charges
289	Reason for late discharge.
290	Pre-existing information.
291	Reason for termination of pregnancy.
292	Purpose of family conference/therapy.

293	Reason for physical therapy.
294	Supporting documentation. This change effective 7/1/2011: Supporting documentation. Note: At least one other status code is required to identify the supporting documentation.
295	Attending physician report.
296	Nurse's notes.
297	Medical notes/report.
298	Operative report.
299	Emergency room notes/report.
300	Lab/test report/notes/results.
301	MRI report.
302	Refer to codes 300 for lab notes and 311 for pathology notes
303	Physical therapy notes. Use code 297:6O (6 'OH' - not zero)
304	Reports for service.
305	Radiology/x-ray reports and/or interpretation.
306	Detailed description of service.
307	Narrative with pocket depth chart.
308	Discharge summary.
309	Code was duplicate of code 299.
310	Progress notes for the six months prior to statement date.
311	Pathology notes/report.
312	Dental charting.
313	Bridgework information.
314	Dental records for this service.
315	Past perio treatment history.
316	Complete medical history.
317	Patient's medical records.
318	X-rays. This change to be effective 7/1/2011: X-rays/radiology films
319	Pre/post-operative x-rays/photographs.
320	Study models.
321	Radiographs or models. (Use codes 318 and/or 320)
322	Recent fm x-rays. This change effective 7/1/2011: Recent Full Mouth X-rays
323	Study models, x-rays, and/or narrative.
324	Recent x-ray of treatment area and/or narrative.
325	Recent fm x-rays and/or narrative.
326	Copy of transplant acquisition invoice.
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.
328	Speech therapy notes. Use code 297:6R
329	Exercise notes.
330	Occupational notes.
331	History and physical. 08/01/2007<
332	Authorization/certification (include period covered). (Use code 252)
333	Patient release of information authorization.
334	Oxygen certification.
335	Durable medical equipment certification.

336	Chiropractic certification.
337	Ambulance certification/documentation.
338	Home health certification. Use code 332:4Y
339	Enteral/parenteral certification.
340	Pacemaker certification.
341	Private duty nursing certification.
342	Podiatric certification.
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.
344	Documentation that provider of physical therapy is Medicare Part B approved.
345	Treatment plan for service/diagnosis
346	Proposed treatment plan for next 6 months.
347	Refer to code 345 for treatment plan and code 282 for prescription
348	Chiropractic treatment plan. (Use 345:QL)
349	Psychiatric treatment plan. Use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P
350	Speech pathology treatment plan. Use code 345:6R 07/09/2007 | Stop: 02/28/1997<
351	Physical/occupational therapy treatment plan. Use codes 345:6O (6 'OH' - not zero), 6N
352	Duration of treatment plan.
353	Orthodontics treatment plan.
354	Treatment plan for replacement of remaining missing teeth.
355	Has claim been paid?
356	Was blood furnished?
357	Has or will blood be replaced?
358	Does provider accept assignment of benefits? (Use code 589)
359	Is there a release of information signature on file? (Use code 333)
360	Is there an assignment of benefits signature on file? This change effective 7/1/2011: Benefits Assignment Certification Indicator
361	Is there other insurance?
362	Is the dental patient covered by medical insurance?
363	Will worker's compensation cover submitted charges? This change effective 7/1/2011: Possible Worker's Compensation
364	Is accident/illness/condition employment related?
365	Is service the result of an accident?
366	Is injury due to auto accident?
367	Is service performed for a recurring condition or new condition?
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?
369	Does patient condition preclude use of ordinary bed?
370	Can patient operate controls of bed?
371	Is patient confined to room?
372	Is patient confined to bed?
373	Is patient an insulin diabetic?
374	Is prescribed lenses a result of cataract surgery?

375	Was refraction performed?
376	Was charge for ambulance for a round-trip?
377	Was durable medical equipment purchased new or used?
378	Is pacemaker temporary or permanent?
379	Were services performed supervised by a physician?
380	Were services performed by a CRNA under appropriate medical direction? This change effective 7/1/2011: CRNA supervision/medical direction.
381	Is drug generic?
382	Did provider authorize generic or brand name dispensing?
383	Was nerve block used for surgical procedure or pain management? This change effective 7/1/2011: Nerve block use (surgery vs. pain management)
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?
385	Is appliance upper or lower arch & is appliance fixed or removable?
386	Is service for orthodontic purposes? This change effective 7/1/2011: Orthodontic Treatment/Purpose Indicator
387	Date patient last examined by entity. Note: This code requires use of an Entity Code.
388	Date post-operative care assumed
389	Date post-operative care relinquished
390	Date of most recent medical event necessitating service(s)
391	Date(s) dialysis conducted
392	Date(s) of blood transfusion(s)
393	Date of previous pacemaker check
394	Date(s) of most recent hospitalization related to service
395	Date entity signed certification/recertification Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified:
396	Date home dialysis began
397	Date of onset/exacerbation of illness/condition
398	Visual field test results
399	Report of prior testing related to this service, including dates
400	Claim is out of balance
401	Source of payment is not valid
402	Amount must be greater than zero. Note: At least one other status code is required to identify which amount element is in error.
403	Entity referral notes/orders/prescription
404	Specific findings, complaints, or symptoms necessitating service
405	Summary of services
406	Brief medical history as related to service(s)
407	Complications/mitigating circumstances
408	Initial certification
409	Medication logs/records (including medication therapy)
410	Explain differences between treatment plan and patient's condition
411	Medical necessity for non-routine service(s)
412	Medical records to substantiate decision of non-coverage
413	Explain/justify differences between treatment plan and services rendered.

414	Need for more than one physician to treat patient. This change effective 7/1/2011: Necessity for concurrent care (more than one physician treating the patient)
415	Justify services outside composite rate
416	Verification of patient's ability to retain and use information
417	Prior testing, including result(s) and date(s) as related to service(s)
418	Indicating why medications cannot be taken orally
419	Individual test(s) comprising the panel and the charges for each test
420	Name, dosage and medical justification of contrast material used for radiology procedure
421	Medical review attachment/information for service(s)
422	Homebound status
423	Prognosis
424	Statement of non-coverage including itemized bill
425	Itemize non-covered services
426	All current diagnoses
427	Emergency care provided during transport
428	Reason for transport by ambulance
429	Loaded miles and charges for transport to nearest facility with appropriate services
430	Nearest appropriate facility
431	Provide condition/functional status at time of service. This change effective 7/1/2011: Patient's condition/functional status at time of service.
432	Date benefits exhausted
433	Copy of patient revocation of hospice benefits
434	Reasons for more than one transfer per entitlement period
435	Notice of Admission
436	Short term goals
437	Long term goals
438	Number of patients attending session
439	Size, depth, amount, and type of drainage wounds
440	why non-skilled caregiver has not been taught procedure
441	Entity professional qualification for service(s)
442	Modalities of service
443	Initial evaluation report
444	Method used to obtain test sample
445	Explain why hearing loss not correctable by hearing aid
446	Documentation from prior claim(s) related to service(s)
447	Plan of teaching
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.
449	Projected date to discontinue service(s)
450	Awaiting spend down determination
451	Preoperative and post-operative diagnosis

452	Total visits in total number of hours/day and total number of hours/week
453	Procedure Code Modifier(s) for Service(s) Rendered
454	Procedure code for services rendered.
455	Revenue code for services rendered.
456	Covered Day(s)
457	Non-Covered Day(s)
458	Coinsurance Day(s)
459	Lifetime Reserve Day(s)
460	NUBC Condition Code(s)
461	NUBC Occurrence Code(s) and Date(s)
462	NUBC Occurrence Span Code(s) and Date(s)
463	NUBC Value Code(s) and/or Amount(s)
464	Payer Assigned Claim Control Number
465	Principal Procedure Code for Service(s) Rendered
466	Entities Original Signature. Note: This code requires use of an Entity Code. This change effective 11/1/2011: Entity's Original Signature. Note: This code requires use of an Entity Code.
467	Entity Signature Date. Note: This code requires use of an Entity Code.
468	Patient Signature Source
469	Purchase Service Charge
470	Was service purchased from another entity? Note: This code requires use of an Entity Code.
471	Were services related to an emergency?
472	Ambulance Run Sheet
473	Missing or invalid lab indicator
474	Procedure code and patient gender mismatch
475	Procedure code not valid for patient age
476	Missing or invalid units of service
477	Diagnosis code pointer is missing or invalid
478	Claim submitter's identifier
479	Other Carrier payer ID is missing or invalid
480	Entity's claim filing indicator. Note: This code requires use of an Entity Code.
481	Claim/submission format is invalid.
482	Date Error, Century Missing
483	Maximum coverage amount met or exceeded for benefit period.
484	Business Application Currently Not Available
485	More information available than can be returned in real time mode. Narrow your current search criteria.
486	Principal Procedure Date
487	Claim not found, claim should have been submitted to/through 'entity'. Note: This code requires use of an Entity Code.
488	Diagnosis code(s) for the services rendered.
489	Attachment Control Number
490	Other Procedure Code for Service(s) Rendered

491	Entity not eligible for encounter submission. Note: This code requires use of an Entity Code.
492	Other Procedure Date
493	Version/Release/Industry ID code not currently supported by information holder
494	Real-Time requests not supported by the information holder, resubmit as batch request
495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.
496	Submitter not approved for electronic claim submissions on behalf of this entity. Note: This code requires use of an Entity Code.
497	Sales tax not paid
498	Maximum leave days exhausted
499	No rate on file with the payer for this service for this entity Note: This code requires use of an Entity Code.
500	Entity's Postal/Zip Code. Note: This code requires use of an Entity Code.
501	Entity's State/Province. Note: This code requires use of an Entity Code.
502	Entity's City. Note: This code requires use of an Entity Code.
503	Entity's Street Address. Note: This code requires use of an Entity Code.
504	Entity's Last Name. Note: This code requires use of an Entity Code.
505	Entity's First Name. Note: This code requires use of an Entity Code.
506	Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse. Note: This code requires use of an Entity Code.
507	HCPCS
508	ICD9 NOTE: At least one other status code is required to identify the related procedure code or diagnosis code.
509	E-Code. This change effective 11/1/2011: External Cause of Injury Code (E-code).
510	Future date. Note: At least one other status code is required to identify the data element in error.
511	Invalid character. Note: At least one other status code is required to identify the data element in error.
512	Length invalid for receiver's application system. Note: At least one other status code is required to identify the data element in error.
513	HIPPS Rate Code for services Rendered
514	Entities Middle Name Note: This code requires use of an Entity Code. This change effective 11/1/2011: Entity's Middle Name Note: This code requires use of an Entity Code.
515	Managed Care review
516	Other Entity's Adjudication or Payment/Remittance Date. Note: An Entity code is required to identify the Other Payer Entity, i.e. primary, secondary.
517	Adjusted Repriced Claim Reference Number
518	Adjusted Repriced Line item Reference Number
519	Adjustment Amount
520	Adjustment Quantity

521	Adjustment Reason Code
522	Anesthesia Modifying Units
523	Anesthesia Unit Count
524	Arterial Blood Gas Quantity
525	Begin Therapy Date
526	Bundled or Unbundled Line Number
527	Certification Condition Indicator
528	Certification Period Projected Visit Count
529	Certification Revision Date
530	Claim Adjustment Indicator
531	Claim Disproportinate Share Amount
532	Claim DRG Amount
533	Claim DRG Outlier Amount
534	Claim ESRD Payment Amount
535	Claim Frequency Code
536	Claim Indirect Teaching Amount
537	Claim MSP Pass-through Amount
538	Claim or Encounter Identifier
539	Claim PPS Capital Amount
540	Claim PPS Capital Outlier Amount
541	Claim Submission Reason Code
542	Claim Total Denied Charge Amount
543	Clearinghouse or Value Added Network Trace
544	Clinical Laboratory Improvement Amendment
545	Contract Amount
546	Contract Code
547	Contract Percentage
548	Contract Type Code
549	Contract Version Identifier
550	Coordination of Benefits Code
551	Coordination of Benefits Total Submitted Charge
552	Cost Report Day Count
553	Covered Amount
554	Date Claim Paid
555	Delay Reason Code
556	Demonstration Project Identifier
557	Diagnosis Date
558	Discount Amount
559	Document Control Identifier
560	Entity's Additional/Secondary Identifier. Note: This code requires use of an Entity Code.
561	Entity's Contact Name. Note: This code requires use of an Entity Code.
562	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
563	Entity's Tax Amount. Note: This code requires use of an Entity Code.

564	EPSDT Indicator
565	Estimated Claim Due Amount
566	Exception Code
567	Facility Code Qualifier
568	Family Planning Indicator
569	Fixed Format Information
570	Free Form Message Text
571	Frequency Count
572	Frequency Period
573	Functional Limitation Code
574	HCPCS Payable Amount Home Health
575	Homebound Indicator
576	Immunization Batch Number
577	Industry Code
578	Insurance Type Code
579	Investigational Device Exemption Identifier
580	Last Certification Date
581	Last Worked Date
582	Lifetime Psychiatric Days Count
583	Line Item Charge Amount
584	Line Item Control Number
585	Denied Charge or Non-covered Charge
586	Line Note Text
587	Measurement Reference Identification Code
588	Medical Record Number
589	Medicare Assignment Code. This change to be effective 7/1/2011: Provider Accept Assignment Code
590	Medicare Coverage Indicator
591	Medicare Paid at 100% Amount
592	Medicare Paid at 80% Amount
593	Medicare Section 4081 Indicator
594	Mental Status Code
595	Monthly Treatment Count
596	Non-covered Charge Amount
597	Non-payable Professional Component Amount
598	Non-payable Professional Component Billed Amount
599	Note Reference Code
600	Oxygen Saturation Qty
601	Oxygen Test Condition Code
602	Oxygen Test Date
603	Old Capital Amount
604	Originator Application Transaction Identifier
605	Orthodontic Treatment Months Count
606	Paid From Part A Medicare Trust Fund Amount
607	Paid From Part B Medicare Trust Fund Amount

608	Paid Service Unit Count
609	Participation Agreement
610	Patient Discharge Facility Type Code
611	Peer Review Authorization Number
612	Per Day Limit Amount
613	Physician Contact Date
614	Physician Order Date
615	Policy Compliance Code
616	Policy Name
617	Postage Claimed Amount
618	PPS-Capital DSH DRG Amount
619	PPS-Capital Exception Amount
620	PPS-Capital FSP DRG Amount
621	PPS-Capital HSP DRG Amount
622	PPS-Capital IME Amount
623	PPS-Operating Federal Specific DRG Amount
624	PPS-Operating Hospital Specific DRG Amount
625	Predetermination of Benefits Identifier
626	Pregnancy Indicator
627	Pre-Tax Claim Amount
628	Pricing Methodology
629	Property Casualty Claim Number
630	Referring CLIA Number
631	Reimbursement Rate
632	Reject Reason Code
633	Related Causes Code. This change to be effective 7/1/2011: Related Causes Code (Accident, auto accident, employment)
634	Remark Code
635	Repriced Ambulatory Patient Group Code
636	Repriced Line Item Reference Number
637	Repriced Saving Amount
638	Repricing Per Diem or Flat Rate Amount
639	Responsibility Amount
640	Sales Tax Amount
641	Service Adjudication or Payment Date. Note: Use code 516.
642	Service Authorization Exception Code
643	Service Line Paid Amount
644	Service Line Rate
645	Service Tax Amount
646	Ship, Delivery or Calendar Pattern Code
647	Shipped Date
648	Similar Illness or Symptom Date
649	Skilled Nursing Facility Indicator
650	Special Program Indicator
651	State Industrial Accident Provider Number

652	Terms Discount Percentage
653	Test Performed Date
654	Total Denied Charge Amount
655	Total Medicare Paid Amount
656	Total Visits Projected This Certification Count
657	Total Visits Rendered Count
658	Treatment Code
659	Unit or Basis for Measurement Code
660	Universal Product Number
661	Visits Prior to Recertification Date Count CR702
662	X-ray Availability Indicator
663	Entity's Group Name. Note: This code requires use of an Entity Code.
664	Orthodontic Banding Date
665	Surgery Date
666	Surgical Procedure Code
667	Real-Time requests not supported by the information holder, do not resubmit
668	Missing Endodontics treatment history and prognosis
669	Dental service narrative needed.
670	Funds applied from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts
671	Funds may be available from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts
672	Other Payer's payment information is out of balance
673	Patient Reason for Visit
674	Authorization exceeded
675	Facility admission through discharge dates
676	Entity possibly compensated by facility. Note: This code requires use of an Entity Code.
677	Entity not affiliated. Note: This code requires use of an Entity Code.
678	Revenue code and patient gender mismatch
679	Submit newborn services on mother's claim
680	Entity's Country. Note: This code requires use of an Entity Code.
681	Claim currency not supported
682	Cosmetic procedure
683	Awaiting Associated Hospital Claims
684	Rejected. Syntax error noted for this claim/service/inquiry. See Functional or Implementation Acknowledgement for details. (Note: Only for use to reject claims or status requests in transactions that were 'accepted with errors' on a 997 or 999 Acknowledgement.)
685	Claim could not complete adjudication in real time. Claim will continue processing in a batch mode. Do not resubmit.
686	The claim/ encounter has completed the adjudication cycle and the entire claim has been voided

687	Claim estimation can not be completed in real time. Do not resubmit.
688	Present on Admission Indicator for reported diagnosis code(s).
689	Entity was unable to respond within the expected time frame. Note: This code requires use of an Entity Code.
690	Multiple claims or estimate requests cannot be processed in real time.
691	Multiple claim status requests cannot be processed in real time.
692	Contracted funding agreement-Subscriber is employed by the provider of services
693	Amount must be greater than or equal to zero. Note: At least one other status code is required to identify which amount element is in error.
694	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error.
695	Entity's Country Subdivision Code. Note: This code requires use of an Entity Code.
696	Claim Adjustment Group Code.
697	Invalid Decimal Precision. Note: At least one other status code is required to identify the data element in error.
698	Form Type Identification
699	Question/Response from Supporting Documentation Form
700	ICD10. Note: At least one other status code is required to identify the related procedure code or diagnosis code.
701	Initial Treatment Date
702	Repriced Claim Reference Number
703	Advanced Billing Concepts (ABC) code
704	Claim Note Text
705	Repriced Allowed Amount
706	Repriced Approved Amount
707	Repriced Approved Ambulatory Patient Group Amount
708	Repriced Approved Revenue Code
709	Repriced Approved Service Unit Count
710	Line Adjudication Information. Note: At least one other status code is required to identify the data element in error.
711	Stretcher purpose
712	Obstetric Additional Units
713	Patient Condition Description
714	Care Plan Oversight Number
715	Acute Manifestation Date
716	Repriced Approved DRG Code
717	This claim has been split for processing.
718	Claim/service not submitted within the required timeframe (timely filing).
719	NUBC Occurrence Code(s)
720	NUBC Occurrence Code Date(s)
721	NUBC Occurrence Span Code(s)
722	NUBC Occurrence Span Code Date(s)
723	Drug days supply

724	Drug dosage
725	NUBC Value Code(s)
726	NUBC Value Code Amount(s)
727	Accident date
728	Accident state
729	Accident description
730	Accident cause
731	Measurement value/test result
732	Information submitted inconsistent with billing guidelines. Note: At least one other status code is required to identify the inconsistent information.
733	Prefix for entity's contract/member number.
734	Verifying premium payment
735	This service/claim is included in the allowance for another service or claim.
736	A related or qualifying service/claim has not been received/adjudicated.
737	Current Dental Terminology (CDT) Code
738	Home Infusion EDI Coalition (HEIC) Product/Service Code
739	Jurisdiction Specific Procedure or Supply Code
740	Drop-Off Location
741	Entity must be a person. Note: This code requires use of an Entity Code.
742	Payer Responsibility Sequence Number Code
743	Entity's credential/enrollment information. Note: This code requires use of an Entity Code.
744	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
745	Identifier Qualifier Note: At least one other status code is required to identify the specific identifier qualifier in error.
746	Duplicate Submission Note: use only at the information receiver level in the Health Care Claim Acknowledgement transaction.
747	Hospice Employee Indicator
748	Corrected Data Note: Requires a second status code to identify the corrected data.
749	Date of Injury/Illness
750	Invalid Auto Accident State or Province Code. This change effective 11/1/2011: Auto Accident State or Province Code
751	Invalid Ambulance Pick-up State or Province Code. This change effective 11/1/2011: Ambulance Pick-up State or Province Code
752	Invalid Ambulance Drop-off State or Province Code. This change effective 11/1/2011: Ambulance Drop-off State or Province Code
753	Co-pay status code.
754	Entity Name Suffix. Note: This code requires the use of an Entity Code.
755	Entity's primary identifier. Note: This code requires the use of an Entity Code.
756	Entity's Received Date. Note: This code requires the use of an Entity Code.
757	Last seen date.
758	Repriced approved HCPCS code.
759	Round trip purpose description.

760	Tooth status code.
761	Entity's referral number. Note: This code requires the use of an Entity Code.