UnitedHealthcare

Standard Companion Guide

Refers to the Implementation Guide Based on X12 Version 005010X212

Health Care Claim Status Request and Response (276/277)

Version Number 6.0

February 20, 2025

CHANGE LOG

Version	Release Date	Changes
1.0	09/15/2010	Created 276/277 Companion Guide based on version 5010.
2.0	09/11/2017	Changed Clearinghouse name from Ingenix to OptumInsight; Updated all sections with current information, including hyperlinks and contacts.
3.0	09/28/2018	Updated Intelligent EDI hyperlink in sections 2.3In and 3.8; Updated hyperlink to EDI 270/271 page online in section 4.1.
4.0	11/01/2020	Updated Diagram 3.1, Update Diagram 3.2, Updated hyperlink to EDI Transaction Support Form in section 2.3, 3.5, 4.1 and 4.3, Updated Intelligent EDI hyperlink in sections 2.3 and 3.8.
5.0	05/28/2021	Updated 1.c Claim Submitted Charge in section 6.1 (276 Request)
5.1	03/13/2023	Replace the UnitedHealthcare logo and changed font.
6.0	2/20/2025	Updated TR3 in the entire document to now refer to as Implementation Guide
		Updated reference links to reflect the updated links
		Removed Hyperlink to EDI Support Form
		Removed Washington Publishing Clearinghouse and added X12.org
		Updated the Provider Services contact info
		Updated Claim Status and Category Codes in Section 6

PREFACE

This companion guide (CG) to the Implementation Guide (formerly referenced as the TR3) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare. Transactions based on this companion guide used in tandem with the Implementation Guide, also called 276/277 Claim Status Request and Response ASC X12N (005010X212), are compliant with both X12 syntax and related guides. This companion guide is intended to convey information that is within the framework of the Implementation Guide adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guide.

Table of Contents

1. INTRODUCTION

This section describes how the Implementation Guide, also called 276/277 Health Care Claim Status Request and Response ASC X12N (005010X212), adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has included, in addition to the information contained in the Implementation Guides. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the Implementation Guide's internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare.

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare'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.

The table below specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the Implementation Guide.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
45	**2100D**	**NM1**	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
57	**2100D**	**NM109**	Subscriber Primary Identifier		**2/80**	This type of row exists to limit the length of the specified data element.
62	**2200D**	**REF**	Subscriber Additional Identification			
69	**2210D**	**SVC01-01**	**Product/Service Identification Qualifier**	AD, ER, HC, HP, IV, N4, NU, WK		These are the only codes transmitted by UnitedHealth Group.
			Product/Service Identification Qualifier	**HC**		This type of row exists when a note for a particular code value is required. For example, this note may say that value HC is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
73	**2210D**	**REF**				
73	**2210D**	**REF01**	Reference Identifier Qualifier	**FJ**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

This document is to be used for the implementation of the Implementation Guide requirements for the HIPAA 5010 276 Claims Status Request and 277 Response (referred to as Claim Status in the rest of this document) for the purpose of submitting claim status requests electronically to UnitedHealthcare and to receive claim status responses electronically back from UnitedHealthcare. This document is to be used as a Companion Guide (CG) to the 276/277 Health Care Claim Status Request and Response ASC X12 (005010X212) Implementation Guides and is not intended to replace any requirements in the Implementation Guide.

1.2 OVERVIEW

This CG will replace, in total, the previous UnitedHealthcare CG versions for Health Care Claim Status Request and Response and must be used in conjunction with the Implementation Guide instructions. The CG is intended to assist you in implementing electronic claim status transactions that meet UnitedHealthcare processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library under the specific transaction at https://www.uhcprovider.com/en/resource-library/edi/edi-transactions.html

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 276/277 Health Care Claim Status Request and Response (005010X212) and to purchase a license to view the EDI Transactions Implementation Guides visit the X12 website at X12.org/products.

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non- standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on providers.

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE

UnitedHealthcare exchanges transactions with clearinghouses and direct submitters, also referred to as Trading Partners. Most EDI transactions go through the Optum clearinghouse, Optum Insight, the managed gateway for UnitedHealthcare EDI transactions.

2.2 CLEARINGHOUSE CONNECTION

Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss their ability to support the X12 Version 005010X212 276/277 claim status transaction, as well as associated timeframes, costs, etc. This includes protocols for testing the exchange of transactions with UnitedHealthcare through your clearinghouse.

Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct through Optum. For more information you can contact Optum at Medical Claims Management | Optum .

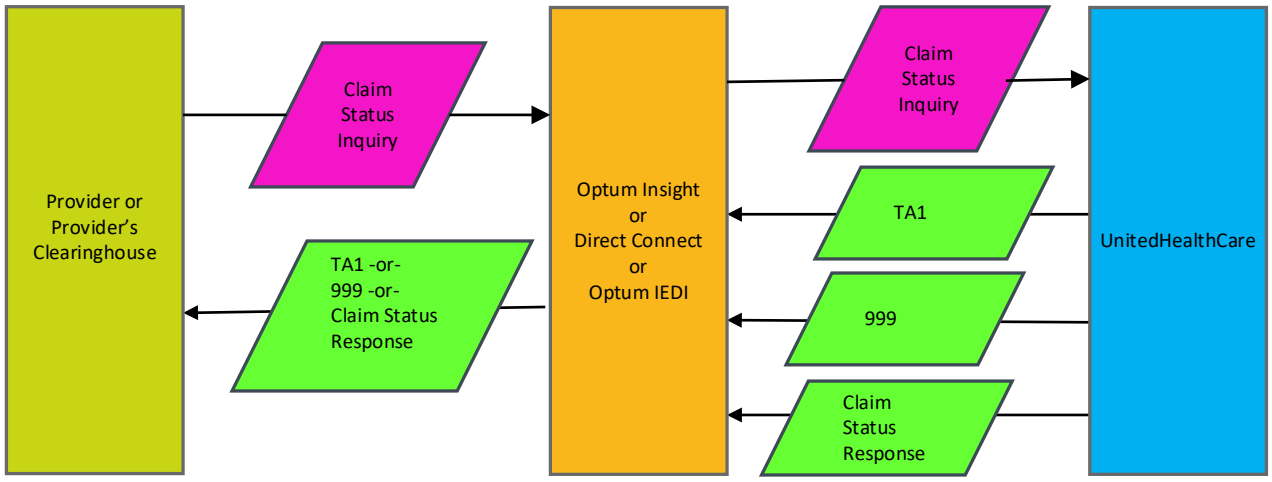
Go to Electronic Data Interchange (EDI) | Digital Solutions for health care professionals for more information on clearinghouses and Optum solutions.

3. CONNECTIVITY AND COMMUNICATION PROTOCOLS

3.1 PROCESS FLOW: BATCH CLAIM STATUS REQUEST AND RESPONSE

The response to a batch of claim status transactions will consist of:

1. First level response – TA1 will be generated when errors occur within the envelope.
2. Second level response – 999 Functional Acknowledgement may contain both positive and negative responses. Positive responses indicate conformance with the Implementation Guide requirements; negative responses indicate non-compliance with the Implementation Guide requirements.
3. Third level response – A single batch containing 277 responses for each 276 transaction that passes the compliance check in the second level response. This includes 277 responses with STC errors.



When a batch of claim status transactions is received, the individual transactions within the batch are first checked for format compliance. A 999 Functional Acknowledgement transaction is then created indicating number of transactions that passed and failed the initial edits. Data segment AK2 identifies the transaction set and data segment IK5 identifies if the transaction set in AK2 accepted or rejected. AK9 indicates the number of transaction sets received and accepted.

Transactions that pass envelope validation are then de-batched and processed individually. Each transaction is sent through another map to validate the individual eligibility transaction. Transactions that fail this compliance check will generate a 999 with an error message indicating that there was a compliance error.

Transactions that pass the compliance check but fail during the processing phase will generate a 277 response including a Service Type Code (STC) segment indicating the error reason.

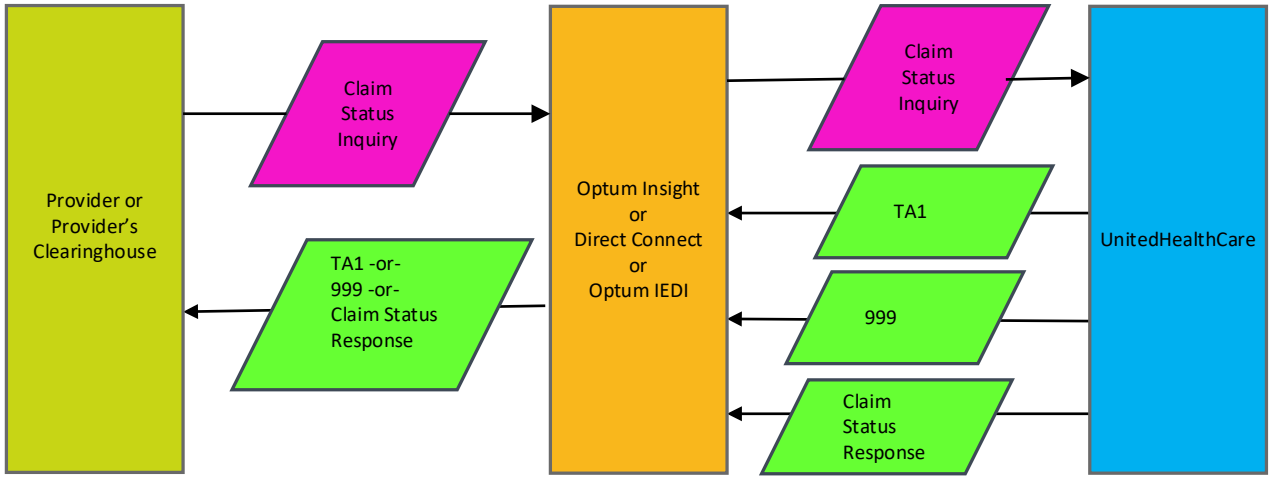
Transactions that pass compliance checks and process successfully will return claim status information in the 277 response.

All of the response transactions including those resulting from the initial edits (999s and 277) from each of the 276 requests are batched together and sent to the submitter.

3.2 PROCESS FLOW: REAL-TIME CLAIM STATUS INQUIRY AND RESPONSE

The response to a real-time claim status transaction will consist of:

1. First level response – TA1 will be generated when errors occur within the outer envelope.
2. Second level response – 999 will be generated when errors occur during 276 compliance validation.
3. Third level response – 277 response indicating the claim status in a STC segment or STC segment indicating the reason for the error.



Each transaction is validated to ensure that the 276 complies with the 005010X212. Transactions which fail this compliance check will generate a real-time 999 message back to the sender with an error message indicating that there was a compliance error.

Transactions that pass compliance checks but fail during the processing phase will generate a real-time 277 response transaction including a STC segment indicating the reason for the error.

Transactions that pass compliance checks and do not have errors in a STC segment will generate a 277 with the STC indicating the status of the claim.

3.3 TRANSMISSION ADMININSTRATIVE PROCEDURES

UnitedHealthcare supports both batch and real-time 276/277 transmissions.

3.4 RE-TRANSMISSION PROCEDURES

Please follow the instructions within the 277 STC segment for information on whether resubmission is allowed or what data corrections need to be made for a successful response.

3.5 COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse for communication protocols with UnitedHealthcare.

Optum: For communication protocols please contact your Optum account manager. If you do not have an account manager, please visit Medical Claims Management | Optum .

3.6 PASSWORDS

1. Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss password policies.

3.7 SYSTEM AVAILABILITY

UnitedHealthcare is generally up 24 hours, 7 days a week. However, there may be times when the main system or backend systems are down for general maintenance and upgrades. During these times our ability to process incoming 276/277 EDI transactions may be impacted. The codes returned in the STC segment of the 277 responses will instruct the trading partner if any action is required.

Unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming 276 transactions. UnitedHealthcare will send an email communication to our direct trading partners for scheduled and unplanned outages.

3.8 COSTS TO CONNECT

Clearinghouse Connection: Physicians, facilities, and health care professionals should contact their current clearinghouse vendor to discuss costs.

Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct through Optum. For more information, please contact your Optum account manager. If you do not have an account manager you can contact Optum at Medical Claims Management | Optum.

4. CONTACT INFORMATION

4.1 EDI SUPPORT

Most questions can be answered by referring to the EDI section of our resource library. View the EDI 276/277 page for information specific to claim status transactions.

If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 276/277 or invalid data in the 277 response, please contact EDI Support by using our EDI Transaction Support Form , sending an email to supportedi@uhc.com or call us at 800-842-1109.

If you have questions related to submitting transactions through a clearinghouse, please

contact your clearinghouse or software vendor directly.

4.2 EDI TECHNICAL SUPPORT

When receiving the 277 responses from a clearinghouse, please contact the clearinghouse.

4.3 PROVIDER SERVICES

For chat options and contact information, visit UHCprovider.com/contactus

4.4 APPLICABLE WEBSITES/EMAIL

Companion Guides: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html

UnitedHealthcare EDI Support: supportedi@uhc.com

UnitedHealthcare EDI Transaction Support Form Electronic Data Interchange (EDI) | Digital Solutions for health care professionals (uhcprovider.com) , select the form under EDI support and contacts.

UnitedHealthcare EDI Education website: https://www.uhcprovider.com/en/resource-library/edi.html

Optum: https://www.optum.com/

X12 Standards and Information: Home | X12

Optum Medical Claims Management | Optum

5. CONTROL SEGMENTS/ENVELOPES

5.1 ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the Implementation Guide should be reviewed for that information.

IG Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	**None**	**ISA**	**ISA Interchange Control Header**		
C.5		ISA08	Interchange Receiver ID	**87726**	UnitedHealthcare Payer ID -Right pad as needed with spaces to 15 characters.

C.6		ISA15	Usage Identifier	**P**	Code indicating whether data enclosed is production or test.

5.2 GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in a transmission may vary.

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the Implementation Guide should be reviewed for that information.

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**		**Required Header**
C.7		GS03	Application Receiver's Code	**87726**	UnitedHealthcare Payer ID Code
C.8		GS08	Version/Releases/Industry Identifier Code	**005010X212**	Version expected to be received by UnitedHealthcare

5.3 ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. A 276 file can only contain 276 transactions.

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the Implementation Guide should be reviewed for that information.

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
36	**None**	**ST**	**Transaction Set Header**		**Required Header**
36		ST03	Implementation Convention Reference	**005010X212**	

5.4 CONTROL SEGMENT HIERARCHY

ISA – Interchange Control Header segment
GS – functional Group Header segment
ST – Transaction Set Header segment
First 276 Transaction
SE – Transaction Set Trailer segment

ST – Transaction Set Header segment
Second 276 Transaction
SE – Transaction Set Trailer segment

ST – Transaction Set Header segment
Third 276 Transaction
SE – Transaction Set Trailer segment
GE – Functional Group Trailer segment
IEA – Interchange Control Trailer Segment

5.5 CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled with space.

1. The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
2. The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
3. ISA16 defines the component element.

5.6 FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Please contact UnitedHealthcare if there is a need to use a delimiter other than the following:

1. Data Segment: The recommended data segment delimiter is a tilde (~)
2. Data Element: The recommended data element delimiter is an asterisk (*)
3. Component Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a carrot (^)

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 276 REQUEST

For batch and real-time 276 requests, submit:

- One claim inquiry within each ST/SE transaction set request.
- One occurrence of the 2000A, 2000B, 2000C, 2100C, 2000D, 2200D
- 2000E and 2200E loops per each ST/SE transaction set request

1. **Subscriber and Dependent Date of Birth Requirements:**
    a. The subscriber date of birth is situational in the 276 request. If the dependent data is not submitted, the 276 request must have the subscriber date of birth in order for the transaction to process. If the 276 request does not have the subscriber date of birth, the transaction will reject for the entity's date of birth. The 277 response will have STC*D0:21*Current Date. The 276 request will need to be resubmitted with the subscriber's date of birth in order for the transaction to process.
    b. The dependent date of birth is required in the 276 request if the dependent loop is submitted. If the date of birth for the dependent is not submitted in the 276 request, the transaction will reject for the entity's date of birth. The 277 response will have STC*D0:21*Current Date. The 276 request will need to be resubmitted with the dependents date of birth in order for the transaction to process.
2. **Date Derivation Logic:**
    a. If Claim Level from and to date(s) are submitted in the 276 request, these are the date(s) that will be used when searching for claims.
    b. If the Claim Level from and to date(s) are not submitted in the 276 request, the date or range of dates used when searching for claims will be derived from the service line information received in the 276 request using the following logic:
        i. The dates of service on each service line will be reviewed. The earliest date of service will be used for the "from date" and the latest date of service will be used for the "to date" of service.
3. **No Dates on the 276 Request:** If dates are not submitted in the 276 request at the claim or service line level, the 276 transaction will reject for Dates of Service. The 277 will have STC*E0:187*Current date. The 276 will need to be resubmitted with date(s) at the claim or service line level.
4. **Future Date on the 276 Request:** If the 276 request submitted has a from or to date at the claim or service line level that is a future date, the 276 transaction will reject for Dates of Service. The 277 will have STC*E0:187*Current date. The 276 will need to be corrected and resubmitted for processing.
5. **276 Request for Claim Date Older Than 18 Months:** The system will first calculate the oldest date that the 'from' date can be in order to be considered within 18 months. The current system date and time stamp will be used to count back 18 months and set the day to the first day of the month. This system derived date will then be compared to the 'from' date. If the 'from' date is equal to or later than the system derived date, then the 276 request is within the 18 month time frame. Otherwise, the request will reject for Dates of Service. The 277 will have STC*E0:187*Current date. The 276 will need to be corrected and resubmitted for processing.
6. **276 Request Date Range Greater than 31 Days:** If the difference between the 'from' date and 'to' date submitted on the 276 request is greater than 31 days, the system will reduce the range to 31 days by reducing the 'to' date.
7. **Claim Submitted Information**
    a. **Submitted Charge Amount:**
    The Claim Submitted Charges are optional in the 276 request. Claim Charges may be utilized if submitted in the 276 request along with other submitted criteria. If no claims are found with any of the submitted criteria, the 276 transaction will reject for "claim not found." The 277 will have STC*A4. The 276 will need to be corrected and resubmitted for processing.
    b. **Submitted Claim Number:**
    The claim number is situational/optional in 276 request but it intends for the search criteria to be narrowed to a specific claim along with other request parameters such as

Charge amount, Date of service etc. If the Claim number is not submitted in the request, we still continue to invoke the services and return the claim information if any claims returned for the submitted Member/Provider combination in that service date range.

8. **Provider Matching:** The provider's last name or organization name and the provider first name are not required to be submitted in the 276 request. If the system finds multiple providers when searching for claims by using NPI, Tax ID or Service Provider Number only, the 276 transaction will reject for the entity's name. The 277 will have STC*D0:125:1P*Current Date. The 276 will need to be corrected and resubmitted for processing.
9. **Member Search:** The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). It is recommended that the maximum search data elements are used. This will result in the best chance of finding a member, however, all data elements aren't required. Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 277 response will be sent indicating to the user, if possible, what criteria needs to be supplied to find a match.

The following table describes the data received for each search scenario that will be supported. If the necessary data elements are not sent to satisfy one of the below scenarios, a 277 with STC*D0*33 'Subscriber Insured Not Found' will be returned and a subsequent 276 request with the required additional data elements will need to be submitted.

SCENARIO	Patient/Member ID	Last Name	First Name	Patient DOB
1	X	x	x	x
2	X	x		x
3	X		x	x
4	X			x
5	X	x	x	
6		x	x	x

6.2 277 RESPONSE

If the 277 response transaction has an STC*E3, please contact EDI Support for assistance. For research purposes and quality customer service, our team will require the 276 submitted with the corresponding 277 received. This information will assist us in resolving the issue more expediently.

6.3 CAQH CERTIFICATION

UnitedHealthcare is certified and in conformance with the CAQH CORE Operating Rules for the Claim Status Transaction.

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 REPORT INVENTORY

None identified at this time.

8. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, billing service, software vendor, clearinghouse, employer group, financial institution, etc.) that transmits to, or receives electronic data from UnitedHealth Group.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

9. TRANSACTION SPECIFIC INFORMATION

This section describes how the Implementation Guide's adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has something additional, over and above, the information in the Implementation Guide's. That information can:

1. Limit the repeat of loops or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide's internal code listings.
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In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare'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.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the Implementation Guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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57	**2100D**	**NM109**	Subscriber Primary Identifier		**2/80**	This type of row exists to limit the length of the specified data element.
62	**2200D**	**REF**	Subscriber Additional Identification			
69	**2210D**	**SVC01-1**	**Product/Service Identification Qualifier**	AD, ER, HC, HP, IV, N4, NU, WK		These are the only codes transmitted by UnitedHealth Group.

			Product/Service Identification Qualifier	**HC**		This type of row exists when a note for a particular code value is required. For example, this note may say that value HC is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
73	**2210**	**REF**				
73	**2210D**	**REF01**	Reference Identifier Qualifier	**FJ**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

10. APPENDECIES

10.1 IMPLEMENTATION CHECKLIST

The implementation checklist will vary depending on your choice of connection: Clearinghouse, Direct Connect or CAQH CORE Connectivity. A basic checklist would be to:

1. Register with trading partner.
2. Create and sign contract with trading partner.
3. Establish connectivity.
4. Send test transactions.
5. If testing succeeds, proceed to send production transactions.

10.2 FREQUENTLY ASKED QUESTIONS

1. **Does this Companion Guide apply to all UnitedHealthcare payers?**
   No. It's applicable to UnitedHealthcare Commercial, UnitedHealthcare Community Plan and UnitedHealthcare Medicare and Retirement.
2. **How does UnitedHealthcare support, monitor and communicate expected and unexpected connectivity outages?**
   Our systems do have planned outages. We will send an email communication for scheduled and unplanned outages.
3. **If a 276 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?**
   No. UnitedHealthcare will always send a response. Even if UnitedHealthcare's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.3 FILE NAMING CONVENTIONS

Node	Description	Value
ZipUnzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES		
ZipUnzip	Responses will be sent as either zipped or unzipped depending on how UnitedHealthcare received the inbound batch file	**N - Unzipped Z - Zipped**
ResponseType	Identifies the file response type	**TA1 – Interchange Acknowledgement 999 – Implementation Acknowledgement**

Batch ID	Response file will include the batch number from the inbound batch file specified in ISA13	**ISA13 Value from Inbound File**
Submitter ID	The submitter ID on the inbound transaction must be equal to ISA06 value in the Interchange Control Header within the File	**ISA08 Value from Inbound File**
DateTimeStamp	Date and time format is in the next column (time is expressed in military format as CDT/CST)	**MMDDYYYYHHMMSS**

10.4 DEFINITIONS

Term	Definition
999	Functional Acknowledgment for HIPAA 837 file. B2B sends the 999 to TSO when an 837 file is received.
5010	The August 2006 ASC X12 standard format, Version 5, Release 1, Sub-release 0 (00[5010]).
Acknowledgment	The acknowledgment is the electronic response (aka 999 or Functional Acknowledgment).
ANSI ASC X12 ASC X12 X12	The official designation of the U.S. national standards body for the development and maintenance of EDI standards. EDI X12 is a data format based on ASC X12 standards. It is used to exchange specific data between two or more trading partners.
CAQH	An unprecedented nonprofit alliance of health plans and trade associations and is a catalyst for industry collaboration on initiatives that simplify healthcare administration. CAQH solutions promote quality interactions between plans, providers, and other stakeholders. Additionally, their solutions reduce costs and frustrations associated with healthcare administration, facilitate administrative healthcare information exchange and encourage administrative and clinical data integration.
Companion Guide	A handbook providing information and instructions on a particular EDI transaction.
EDI	Electronic Data Interchange is the computer-to- computer exchange of business or other information between two organizations (trading partners). The data may be in a standard or proprietary format. EDI is also known as electronic commerce.
EDI X12 Standards and Releases	EDI X12 is governed by standards released by ASC X12 (The Accredited Standards Committee). Each release contains a set of message types, such as invoice, purchase order, healthcare claim, etc. Each message type has a specific transaction number assigned to it instead of a name, e.g. an invoice is 810, a healthcare claim is 837, and eligibility a 270. Every new release contains a new version number, e.g. 5010, 5030. Major releases start with a new first number, as 5010, while 5030 is considered a minor release. Minor releases contain few changes or improvements over major releases which usually require a significant number of modifications. To translate or validate EDI X12 data, you need to know transaction number (message numeric name) and the release version number. Both of those numbers are inside the file.

HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law intended to improve the availability and continuity of health insurance coverage that, among other things, places limits on exclusions for pre-existing medical conditions, permits certain individuals to enroll for available group health care coverage when they lose other health coverage or have a new dependent, prohibits discrimination in group enrollment based on health status, provides privacy standards relating to individuals' personally identifiable claim-related information, guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets, requires availability of non-group coverage for certain individuals whose group coverage is terminated and establishes standards for electronic transmissions.
Protocols	Protocols are codes of correct conduct for a given situation.
Qualifier	A qualifier is a word, number or character that modifies or limits the meaning of another word or group of words or dates.
Segment	A string of data elements that contain specific values based on the loop and data element on the file which is separated into specific sections.
Third Party Administrator (TPA)	TPAs are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process. They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, no enrollment and other administrative activities. A hospital or provider organization desiring to set up its own health plan will often outsource certain responsibilities to a TPA.
Trading Partner	A Trading Partner may represent an organization, group of organizations or some other entity. In most cases, it is simply an organization or company.
Trading Partner Requirements	The EDI X12 standard covers a number of requirements for data structure, separators, control numbers, etc. However, many big trading partners impose their own rules and requirements which are usually more strict and regimented, such as specific data format requirements for some elements and requirements to contain specific segments (segments that are not mandatory in EDI X12 standard being made mandatory). Specific trading partner requirements are usually listed in a Companion Guide document. It is essential to follow these documents exactly when implementing EDI systems.
COB	Coordination of benefits.
EOB	Explanation of benefits.