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1 CAQH CORE Attachments Operating Rules: Background

1.1 CAQH CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation, and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans, and patients. Guided by more than 100 participating organizations – including providers, health plans representing 75 percent of insured Americans, government entities, vendors, associations and standards development organizations – CAQH CORE Operating Rules drive a trusted, simple and sustainable healthcare information exchange that evolves and aligns with market needs.[1] CAQH CORE Operating Rules are developed using a consensus-based approach among industry stakeholders, and are designed to facilitate interoperability, improve utilization of administrative transactions, enhance efficiency and lower the cost of information exchange in healthcare. To date, this cross-industry commitment has resulted in operating rules that address many pain points of healthcare business transactions including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution.

1.2 Industry Interest in Attachments Operating Rules

Attachments refer to the exchange of patient-specific medical information or supplemental documentation to support an administrative healthcare transaction and are the bridge between clinical and administrative data. They provide health plans vital information for adjudication of a subset of claims, prior authorizations, referrals, post-adjudication appeals, audits and more. However, the attachments workflow is primarily manual and a source of significant administrative burden. According to the 2020 CAQH Index, only 22 percent of attachments are processed using a fully electronic method.[2] The Index also estimated that adoption of electronic attachment transactions could reduce healthcare industry per-transaction costs for exchange of attachments by over $377 million annually, $4.09 per transaction.[3]

Industry has waited for federal action on an attachments standard for many years. In 1996, HIPPA mandated the adoption of an electronic standard for attachments, along with many other administrative transactions. In most cases, the HIPAA-mandated standards have been federally adopted, and companion operating rules have been developed to support these transactions. The extended wait for a federal attachment standard has driven a sense of uncertainty, deterred vendor development of a standardized approach, and resulted in a range of standards and specifications to support the exchange of attachments.

[1] In 2012, CAQH CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules under Section 1104 of the Patient Protection and Affordable Care Act (ACA).
[2] 2020 CAQH Index, CAQH.
[3] Ibid.

Since 2012, CAQH CORE has maintained a focus on attachments, collaborating with industry to provide education and gather insights on industry opportunities via operating rule development input, national webinars, and surveys. In 2019, CAQH CORE published the CAQH CORE Report on Attachments: Bridge to a Fully Automated Future to Share Medical Documentation, which examines the challenges associated with the exchange of medical information and supplemental documentation used for administrative transactions. The report identifies five areas to improve processes and accelerate the adoption of electronic attachments. These opportunity areas include workflows, data variability, exchange mechanisms, connectivity, security and infrastructure, and resources.

Building on the report findings, CAQH CORE launched a multi-stakeholder Attachments Advisory Group consisting of industry leaders representing health plans, providers, vendors government entities and advisors. The group evaluated pain points caused by the exchange of additional documentation across use cases, prioritizing a list of opportunity areas for operating rule development to reduce administrative burden for the Prior Authorization and Claims Attachments Use Cases.

2 Issues to be Addressed and Business Requirement Justification

2.1 Problem Space

Attachments uniquely combine data from two disparate systems – clinical and administrative. Due to limited administrative and clinical system integration, and the lack of a federally mandated electronic transaction standard for attachments by the Department of Health and Human Services (HHS), health plans, providers and vendors have been hesitant to develop standardized approaches to automate the exchange of attachments. This has led to varied and incomplete electronic solutions and work arounds.

The 2018 CAQH CORE Attachments Environmental Scan revealed that the majority of attachments today are submitted manually, as paper forms and records sent through the mail or by fax, presenting an incredible administrative burden to both health plans and providers. A regional health plan participating in the CAQH CORE Attachments Environmental Scan indicated that it takes 792 labor hours, the equivalent of nearly 20 people working full-time, to process the attachments it receives by mail, fax and web portal in the course of one week.

In late 2019, CAQH CORE conducted an industry-wide survey to further inform the development of operating rules to support a more standardized workflow. Surveys were received from over 340 organizations across three stakeholder types: providers, health plans and vendors/clearinghouses. The results, which showed wide variability in how attachments are exchanged, highlighted the prevalence of mail and fax with nearly 60% of organizations using mail and fax to exchange prior authorization and claims attachments.[4]

Health plans and providers participating in CAQH CORE attachments research identified multiple pain points throughout the attachments workflow. For example, providers are often unaware of the clinical documentation required by the health plan to complete a prior authorization or claim submission and frequently send unsolicited attachments with too much, too little or incorrect information to health plans based on past experience with the provision of a specific service. Health plans must sort through

[4] CAQH CORE Attachments Survey Issue Brief.

the clinical information sent by the provider and establish what is required to complete the prior authorization or claim submission, and what is incorrect or missing from the submission. Once all the necessary clinical documentation is received from the provider, which may require multiple communications back and forth between provider and health plan, the health plan must spend additional time linking the original submission with the relevant attachments. Throughout this process, providers are often not aware whether an attachment was received by the health plan, resulting in further unnecessary duplicate attachments sent to the health plan and manual follow up by providers who want to confirm if the additional documentation was received successfully.

Clearly defined exchange standards, accurate data and supporting infrastructure requirements are needed to ensure attachments flow seamlessly through the healthcare system. During the development of the CAQH CORE Attachments Operating Rules, the following priorities rose to the top:

- Enhance attachments workflow process via electronic methods for identifying attachment-specific data to support adjudication of a claim or prior authorization.
- Establish standard codes for providers to communicate when additional documentation is being sent to a health plan.
- Streamline attachment documentation requests and reassociation of attachments.
- Establish requirements for acknowledgements, data errors and response times by health plans when attachments are sent electronically.
- Develop data file format requirements for quality, readability and size efficiency.

2.2 Business Requirement Justification and Focus of the CAQH CORE Attachments (275/837) Health Care Claims Data Content Rule

The purpose of this operating rule is to identify and standardize the data used for exchanging attachments to support X12 005010X222 Health Care Claim (837) Professional, X12 005010X223 Health Care Claim (837) Institutional, and X12 005010X224 Health Care Claim (837) Dental transactions and their associated errata (collectively hereafter referenced as X12 v5010 837).

When attachments are not submitted in parallel with the original X12 v5010 837 Claim submission, the attachment and request must be linked, or reassociated. This reflects one of the most significant problem areas in the attachments workflow. The requirements in this operating rule address these issues by reducing the unnecessary back and forth between providers and health plans, enable shorter adjudication timeframes and reduce staff resources spent on manual follow up.

The following requirements included in the rule addressing data content of attachments and additional documentation to support an X12 v5010 837 Claim submission:

- Additional guidance for the use of the **X12 824 transaction to communicate data and processing errors**, allowing for more specificity when providers adjust the submission due to errors.
- Streamline the reassociation and identification process with the use of **Code EL** on the X12 v5010 837 Claim submission and **Common Reference Data** on the X12 v6020X314 275 attachment.

- Use of appropriate **LOINCs** to request additional information when using the X12 v6020X313 277 RFAI.
- Use of **Common CORE Connectivity Headers and Common CORE Data Elements** when sending additional documentation with the X12 275 transaction.

Additionally, given attachments serve as the bridge between clinical and administrative data, CAQH CORE Attachments Subgroup participants decided to scope this operating rule for attachments sent using the X12 v6020X314 275 transaction and additional documentation sent without using the X12 v6020X314 275 transaction (i.e., using CORE Connectivity as the exchange method and any non-X12 payload including, HL7 FHIR Resources, HL7 C-CDA, .PDF, etc.) to support the convergence of clinical and administrative data as the healthcare industry continues to move towards a more interoperable ecosystem.

3 Scope

3.1 What the Rule Applies To

This CAQH CORE Attachments (275/837) Health Care Claims Data Content Rule applies to the exchange of patient-specific information or supplemental documentation sent to support health care claims sent via the X12 005010X222 Health Care Claim (837) Professional, X12 005010X223 Health Care Claim (837) Institutional, and X12 005010X224 Health Care Claim (837) Dental transactions and their associated errata (collectively hereafter referenced as X12 v5010 837).

To support the efficient exchange of additional information or documentation to support a health care claim sent in either Batch or Real Time Processing Mode, the rule also applies to the conduct of the following X12 transactions:

- X12 v6020X290 999 Implementation Acknowledgement for Health Care Insurance Technical Report Type 3 (hereafter referred to as X12 v6020X290 999).
- X12 v6020X257 824 Application Advice Technical Report Type 3 (hereafter referred to as X12 v6020X257 824).
- X12 v6020X313 277 Health Care Claim Request for Additional Information Technical Report Type 3 (hereafter referred to as X12 v6020X313 277)

In addition, the rule applies across the following electronic attachment submission methods:

X12 Attachment Submission Method:

- X12 006020X314 275 Additional Information to Support a Health Care Claim or Encounter Technical Report Type 3 (hereafter referred to as X12 v6020X314 275).[5,6]

Electronic Non-X12 Additional Documentation Payload Format and Submission Methods:

- Other payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity.

[5] Given the X12 attachment standards have not been mandated under HIPAA, health plans, providers and vendors and their agents are not federally required to support the X12 6020X314 275 transaction.
[6] Stakeholders and their agents may choose to implement higher versions of the X12 X314 275 transaction but must also continue to support X12 v6020X314 275 in accordance with this rule.

3.2 When the Rule Applies

This CAQH CORE Attachments (275/837) Health Care Claims Data Content Rule applies when:

- A provider and its agent electronically send patient-specific information or supplemental documentation (solicited or unsolicited) to a health plan to support a X12 v5010 837 Health Care Claim.

And

- A health plan and its agent electronically process patient-specific information or supplemental documentation and respond to a provider to support a X12 v5010 837 Health Care Claim.

3.3 What the Rule Does Not Require

While the rule requirements address the optional use of non-X12 additional documentation submission format methods, the rule does not require any entity or its agent to:

- Exchange documentation using an electronic, non-X12 additional documentation submission format method (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity.

3.4 Maintenance of This Rule

Any substantive updates to ~~change~~ this rule (i.e., change to rule requirements) will be made in alignment with ~~CAQH CORE~~ federal processes for updating versions of the operating rules, as determined by industry need, or by CAQH CORE Participants.

3.5 Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that clinical information sent is accurately received and to facilitate correction of errors for electronically submitted additional documentation requests.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CAQH CORE Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v6020X314 275, X12 v6020X313 277, X12 v6020X257 824, X12 v5010 837, X12 v6020X290 999, or HL7 C-CDA.
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any HIPAA-covered entity is free to offer more than what is required in the rule.

4 Data Content Rule Requirements for Attachments using the X12 275 Transaction

The rule requirements in this section apply only when an entity and their agent use an X12 attachment method listed in §3.1.

4.1 Reassociation Requirements

To speed up the adjudication of an X12 v5010X 837 Health Care Claim, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010 837 transaction, typically referred to as an unsolicited attachment, to support the claim submission.[7]

There are two submission methods a provider can use to deliver an attachment that are addressed in the rule:

1. Using the X12 v6020X314 275 transaction to provide additional documentation.
2. Using CORE Connectivity[8] as the payload exchange method without an X12 payload format.

The following requirements address the X12 submission method for the reassociation of solicited and unsolicited attachments sent to support a X12 v5010 837 Health Care Claim.

4.1.1 Reassociation of an Unsolicited X12 275 to an X12 837 Claim Submission[9]

When a HIPAA-covered provider and its agent send an unsolicited X12 v6020X314 275 in support of an X12 v5010 837 Institutional or Professional Claim submission, PWK02 Code EL in Loop 2300/ Loop 2400 in the X12 v5010 837 Institutional or Professional Claim must be used to notify a HIPAA-covered health plan and its agent that additional documentation is being transmitted electronically using the Binary Data Segment (BDS) in X12 v6020X314 275.[10,11]

NOTE: This requirement does not apply to X12 v5010 837 Dental Claim submissions.

4.1.1.1 Common Reference Data Used to Reassociate a X12 275 and an X12 837 Claim Submission

When a provider sends a X12 v6020X314 275 to support an X12 v5010 837 Health Care Claim submission, CAQH CORE recommends the use of the following common reference data to be included on the X12 v6020X314 275 for patient identification and reassociation purposes.

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[7] Given the X12 attachments standards have not been mandated under HIPAA, providers and their agents are not federally required to send additional documentation via the X12 v6020X314 275 attachment transaction; h~~H~~owever, if a provider and its agent send an X12 v6020X314 275 attachment to a health plan and its agent, the health plan and its agent must follow the reassociation requirements for the X12 v5010 837 and X12 v6020X314 275 specified in this rule.

[8] CORE Connectivity specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content being transmitted.

[9] This rule does not require providers and their agent to send an unsolicited X12 v6020X314 275 attachment in support of a claim submission; h~~H~~owever, if an unsolicited X12 v6020X314 275 attachment is sent by a provider or its agent, the rule requirement must be followed.

[10] While this requirement does not prohibit providers and their agents from using alternative methods to submit the unsolicited additional documentation (e.g., ~~CORE Connectivity,~~ FHIR, DIRECT messaging, web portals, etc.), it specifies the use of PWK02 Code EL if the additional documentation is sent via a X12 v6020X314 275 transaction.

[11] PWK values may be used for other scenarios as defined in specific companion guides and agreed upon by trading partners.

This list of recommendations is not intended to be either exhaustive or prohibitive. The terms included in the list below are defined in Appendix §6.1*:*

- ACN or Claim Control #
- Case Reference/ID #
- Claim #
- Date of Birth (DOB)
- Date of Service (DOS)
- Member ID
- Member Name
- Patient Control ID

4.1.2 Reassociation of a Solicited X12 275 to an X12 837 Claim Submission

If a HIPAA-covered health plan utilizes the X12 v6020X313 277 Health Care Claim Request for Additional Information to request additional information to support the adjudication of an X12 v5010 837 Claim, the health plan should use the appropriate LOINC to request the most specific additional information needed to support the adjudication of an X12 837 Claim submission.

5 Data Content Rule Requirements for Attachments using the Non-X12 Method

The rule requirements in this section apply only when an entity and their agent use the most recent version of CORE Connectivity without an X12 payload format, such as those listed in §3.1*,* to exchange an electronic attachment.

5.1 Reassociation Requirements

To speed up the adjudication of an X12 v5010 837 Health Care Claim submission, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010 837 claim transaction, typically referred to as an unsolicited attachment to support the claim submission. There are two submission methods a provider can use to deliver an attachment that are addressed in this rule:

1. Using the X12 v6020X314 275 transaction to provide additional documentation.
2. Using CORE Connectivity[12] as the payload exchange method without an X12 payload format.

The following requirements address the non-X12 submission method for the reassociation of solicited and unsolicited attachments sent to support an X12 v5010 837 Health Care Claim submission.

[12] CORE Connectivity specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content being transmitted.

5.1.1 Use of CORE Connectivity Headers to Reassociate Additional Documentation using the Non-X12 Method

Reassociation of additional documentation sent via a non-X12 format for the original X12 v5010 837 Health Care Claims sSubmission varies greatly depending on the submission mode of the additional documentation method. CORE Connectivity includes requirements for the exchange of messages using SOAP and REST that is payload agnostic, meaning the SOAP and REST services are not aware of the content being transmitted. HIPAA-covered providers and their agents using the most recent version of CORE Connectivity to transmit a non-X12 payload must follow the appropriate header requirements to notify health plans and their agents that additional documentation is being transmitted electronically.

In the unsolicited non-X12 scenario using CORE Connectivity as the submission method, a provider and its agent can indicate using SOAP or REST headers that an attachment was sent and specify the attachment body type (e.g., .pdf or HL7 C-CDA, etc.).

When sending a non-X12 unsolicited attachment using CORE SOAP Connectivity Requirements §4.4.3 *<SDO>_<PayloadType>_<Version>_<Sub-version>* the provider and its agent may identify the <PayloadType> from the following list:

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg
- Additional formats are acceptable

When sending a non-X12 unsolicited attachment using CORE REST Connectivity Requirements §5.3.2 Specifications for REST API URI Path Endpoints for Payload Types the provider and its agent may identify the REST API URI Path Endpoint from the following list:

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg
- Additional formats are acceptable

As the industry continues to evolve, this rule may be updated to include requirements for additional non-X12 submission methods and attachment types.

5.1.1.1 Attachment Data Elements of Unsolicited Additional Documentation using the Non-X12 Method

For health plans to effectively match attachment payloads (e.g., HL7 C-CDA, .pdf, .doc, etc.) to the correct administrative transaction the need for a uniform identifier data set is required to facilitate reassociation.

Table 1. Attachment Data Elements identify and define the data elements necessary for successful reassociation of the non-X12 attachment payload ~~and~~ to the original X12 v5010 837. A provider and its agent must include all available Attachment Data Elements as part of the attachment payload when sending additional information to facilitate reassociation to a ~~H~~health ~~C~~care ~~C~~claims transaction. Available data elements can be included in some fashion (e.g., a separate document along with the payload or included in the payload document itself) as part of the attachment payload.

This rule does not prohibit a provider and its agent and a health plan and its agent from mutually agreeing to exchange more data in addition to the required minimum data needed for reassociation.

NOTE: Data elements included in Table 1 are only required if available to the provider at time of submission of the attachment. The provider must return as many elements as possible to ensure reassociation with the claim.

Table 1. Attachment Data Elements for Reassociation using Non-X12 Attachment Methods

#	Element	CAQH CORE Element Definition
1	**Attachment Control Number (ACN)**	An alphanumeric value used to associate documentation exchanged electronically between trading partners to a specific transaction.
2	**Billed Amount/Charged Amount**	Billed Amount/Charged Amount is the amount charged for each service performed by the provider., i.e., it is the total charge value of the claim. The billed amount for a specific procedure code is based on the provider; it may vary from place to place and is not common across all the states.
3	**Claim #**	Refers to a unique identifier assigned by either the provider's system upon claim generation or a health plan upon receipt.
4	**Claim Attachment Indicator**	An attachment indicator alerts claims processing that a submitted claim will have an attachment submitted to support the claim.
5	**Date of Birth (DOB)**	Date of Birth
6	**Date of Service (DOS)**	The date of service is the specific date at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record.
7	**Member ID**	Identifier assigned to the patient by the health plan. Health plans may assign: • a unique identifier to all individuals covered by the contract **or** • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix

#	Element	CAQH CORE Element Definition
		There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.
8	**NPI**	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identifier for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
9	**Patient ID**	The glossary of the accreditation manual defines a **patient identifier** as "Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended."
10	**Patient Name**	Patient name includes a set of words by which a person is known, i.e. First, Middle, and Last or Family Name. A legal name identifies a person for administrative and other official purposes, like insurance payments. It is generally the name that appears on a person's birth certificate but may change over time, as individuals adopt nicknames. Last name/surname: Generational titles such as Jr, Sr, III are considered part of the last name, and should be included in this field.
11	**TIN**	The federal taxpayer identification number (**TIN**) that identifies the physician/practice/supplier to whom payment is made for the line-item service. This number may be an employer identification number (EIN) or social security number (SSN).

#	Element	CAQH CORE Element Definition
12	**Subscriber/Dependent First & Last Name**	The X12 ASC standard describes subscriber and dependent as follows: • The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient. • The dependent is a person who cannot be uniquely identified to an information source by a unique Member Identification Number but can be identified by an information source when associated with a subscriber. First and last names are generally the name that appears on a person's birth certificate but may change over time, as individuals adopt nicknames.

6 *Appendix*

The terms defined below were selected by CAQH CORE Participants as data elements that most commonly assist with patient identification and reassociation when used by a provider to send a X12 v6020X314 275 attachment to support an X12 v5010 837 health care claim. The data elements are referenced in §4.1.1.1.

This list is based on the X12 transaction implementation guides for the identified transactions used to address the provider/health plan exchange of additional documentation to support a health care claim. It is informational only. Implementers should rely on the published X12 transaction specifications. The list is not intended to be either exhaustive or prohibitive.

Table 6.1 X12 TR3 Data Element and Reference Identification Mapping

#	Reference Metadata	Description	277 v6020X313 Health Care Claim Request for Additional Information	275 v6020X314 Additional Information to Support Health Care Claim
1	**ACN (Attachment Control Number)** *Also known as Payer's Claim Control Number or Provider's Attachment Control Trace Number.*	An alphanumeric value used to associate documentation exchanged electronically between trading partners to a specific transaction.	Loop 2200D Payer Claim Control Number/Loop 2220D Service Line Information Loop 2200D is required TRN02 Payer Claim Control Number required - Must be returned in 275 Response in Loop 2000A TRN02 Loop 2220D is situational Required only when request is for Service Line information	Loop 2000A TRN Payer Claim Trace Control Number/Provider Attachment Control Trace Number Segment

2	**Case Reference/ID #**	An identifier assigned by the payer to link related attachment requests which may involve single or multiple patients and/or providers.	Loop 2200D Payer Claim Control Number REF Case Reference Identifier Segment	Loop 2000A Assigned Number REF Case Reference Identifier Segment
3	**Claim #**	Refers to a unique identifier assigned by either the provider's system upon claim generation or a health plan upon receipt.	Loop 2200D Payer Claim Control Number REF Provider's Assigned Claim Identifier	Loop 1000D Patient Name REF Provider's Assigned Claim Identifier REF Claim Identifier for Transmission Intermediaries
4	**DOB (Date of Birth)**	Patient date of birth	N/A - Not used in the 277 v6020X313	N/A - Not used in the 275 v6020X314
5	**DOS (Date of Service)**	The date of service is the specific time at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record. It also matters for insurance purposes, since health insurers base their reimbursement or payment on the date of service, along with other billing factors. Also known as Event Date – meaning the proposed or actual date or range of dates services will be provided to a patient.	Loop 2200D Payer Claim Control Number/Loop 2220D Service Line Information DTP Service Date Segment	Loop 1000D Patient Name/Loop 2100A Service Line Service Date DTP Service Date Segment
6	**Member ID**	Identifier assigned to the patient by the health plan. Health plans may assign • a unique identifier to all individuals covered by the contract, or • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix. There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.	Loop 2100D Patient Name/NM1 Patient Name Segment	Loop 1000D Patient Name/NM1 Patient Name Segment
7	**Member Name**	Name of patient; patient could be either the health plan subscriber or a dependent of the subscriber.	Loop 2100D Patient Name/NM1 Patient Name Segment	Loop 1000D Patient Name/NM1 Patient Name Segment

8	**Patient Control ID**	The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. Recommended identifier to be used in the billing submitter's patient management system. A common practice is for submitters use unique numbers for this field for each individual claim.	N/A - Not used in the 277 v6020X313	N/A - Not used in the 275 v6020X314