



CAQH CORE Claim Status (276/277)

Data Content Rule

Version CS.1.0

Review Work Group Ballot Draft

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**CAQH Committee on Operating Rules for Information Exchange (CORE)
Claim Status (276/277) Data Content Rule CS.1.0**

Revision History for Claim Status (276/277) Data Content Rule

Version	Revision	Description	Date
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1. Background Summary

1.1. CORE Overview

CORE is an industry-wide facilitator committed to creating and adopting healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans, and patients. Guided by over 100 participating organizations - including healthcare providers, health plans, government entities, vendors, associations, and standards development organizations - CORE Operating Rules drive a trusted, simple, and sustainable healthcare information exchange that evolves and aligns with market needs.

This cross-industry commitment has resulted in operating rules addressing 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 methodologies and addressing social determinants of health (SDOH).

2. Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

Widespread use of the X12 v5010X212 276 Health Care Claim Status Request (hereafter referred to as X12 v5010 276) and the X12 v5010X212 277 Health Care Claim Status Response (hereafter referred to as X12 v5010 277) has not produced the consistent, actionable claim status information as intended. Health plans vary in how they apply Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations, perpetuating manual follow-up (such as phone calls and portal checks) to support interpretation. Additionally, data misalignment - which may manifest as claim search and match requirements - can result in claim not found outcomes that delay corrective or follow-up actions. Further, variable search inputs (e.g., which patient and provider fields are needed) and payment-linkage elements (e.g., check number/check date) can have downstream impact on revenue cycle workflows.

Health plans would benefit from additional clarity in claim status requests and responses, specifically in the following areas:

- Lower administrative expenses through automation and standardization.
- Fewer provider inquiries and faster issue resolution.
- Improved provider satisfaction and operational efficiency.

Providers would benefit from additional clarity in claim status requests and responses, specifically in the following areas:

- Clearer insight into claim status to enable faster corrective actions through uniform CSCC and CSC combinations (Business Scenarios) with clear next steps.
- Confirmation health plans (or their agents) received the claim and successfully matched it using consistent search and match criteria.
- Reduced need for manual follow-up.
- Faster claim resolution and improved cash flow.

Patients would benefit from additional clarity in claim status requests and responses, specifically in the following areas:

- More accurate and timely billing.
- Fewer delays in account resolution and coverage updates.

Addressing these gaps benefits health plans, providers, and ultimately patients by improving administrative efficiency through reduced interpretation burden, preventing avoidable outreach, addressing reworks earlier in adjudication, and expediting cash flow.

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2.2. Focus of the CORE Claim Status (276/277) Data Content Rule

The following requirements for the data content of the claim status transaction are outlined:

- Requirements for uniform, scenario-based use of X12 Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) in the X12 v5010 277 when communicating claim status and business-level errors.
- This rule discourages the use of proprietary claim status codes. Any codes used must not conflict with or override the CSCC and CSC sets defined by X12 and Business Scenarios defined by CORE.
- Specification of a minimum set of information to include on the X12 v5010 276 and X12 v5010 277 that supports:
 - Accurate patient and/or claim search and match by Information Sources for claim status requests (e.g., consistent handling via key identifiers).
 - Reduction of “claim not found” responses and return of a single, clearly identifiable match where possible.
 - Clear communication of the claim’s status relative to adjudication (e.g., finalized—payment/no payment, denied, pending, errors).
 - Matching the response to its corresponding X12 v5010 837 transaction.
 - Association of paid claim status responses to their corresponding remittance advice (RA)/payment (e.g., Payer Claim Control Number, Patient Control Number, check number, check date, and, when available, payment amount) to support timely accounts receivable (AR) reconciliation.

3. Scope

3.1. What the Rule Applies To

The CORE Claim Status (276/277) Data Content Rule applies to the conduct of X12 005010 276/277 (hereafter referred to as X12 v5010 276/277) Health Care Claim Status Request/Response transactions.

The CORE Claim Status (276/277) Data Content Rule:

- Standardizes the use of Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations in the X12 277 Health Care Claim Status Response through ubiquitous business cases to establish actionable next steps for health plans and providers; and
- Specifies minimum, standardized data content requirements for the Health Care Claim Status Request and Response transactions across three use cases: Patient Search & Match Criteria, Claim Matching, and Remittance Advice & Check/Payment Information.

3.2. When the Rule Applies

This rule applies when any HIPAA-covered entity or its agent uses, conducts, or processes the X12 v5010 276/277 claim status transaction to report a rejection, payment, denial, or pending status of a claim or claim status request by a health plan or its agent from a pre-adjudication or adjudication system.

3.3. What the Rule Does Not Address

This rule does not address:

- X12 005010X213 Health Care Claim Request for Additional Information (277), which is a health plan’s request for additional information to support a health care claim.
- X12 005010X214 Health Care Claim Acknowledgment (277CA), which is used by a health plan to acknowledge the receipt of a claim as it enters the health plan’s pre-adjudication or adjudication system.
- X12 005010X364 Data Reporting Acknowledgment (277), where the X12 v5010X364 is an acknowledgement of the X12 v5010X298 Post Adjudicated Claim Data Reporting: Professional

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(837), the X12 v5010X299 Post Adjudicated Claim Data Reporting: Institutional (837), the X12 v5010X300 Post Adjudicated Claim Data Reporting: Dental (837), and X326 transactions including and after v7030.

3.4. What the Rule Does Not Require

This rule does not require any HIPAA-covered entity to modify its use and content of other loops and data elements that may be submitted in the X12 v5010 276/277 that are not addressed in this rule.

3.5. Applicable Loops, Data Elements & Code Sources

This rule applies to the following data elements and loops in the X12 v5010 276/277 transactions. This rule establishes a minimum set of requirements and does not prohibit any entity from also reporting its service line status.

To support claim status reporting, this rule covers the following specified loops, segments, and data elements in the X12 v5010 277 transaction:

Table 1 – Applicable X12 v5010 277 Claim Status Reporting Loops and Segments	
Data Element	Loop & Segment
Health Care Claim Status Category Code	2200B-STC01-01
Health Care Claim Status Code	2200B-STC01-02
Health Care Claim Status Category Code	2200B-STC10-01
Health Care Claim Status Code	2200B-STC10-02
Health Care Claim Status Category Code	2200B-STC11-01
Health Care Claim Status Code	2200B-STC11-02
Health Care Claim Status Category Code	2200C-STC01-01
Health Care Claim Status Code	2200C-STC01-02
Health Care Claim Status Category Code	2200C-STC10-01
Health Care Claim Status Code	2200C-STC10-02
Health Care Claim Status Category Code	2200C-STC11-01
Health Care Claim Status Code	2200C-STC11-02
Health Care Claim Status Category Code	2200D-STC01-01
Health Care Claim Status Code	2200D-STC01-02
Health Care Claim Status Category Code	2200D-STC10-01
Health Care Claim Status Code	2200D-STC10-02
Health Care Claim Status Category Code	2200D-STC11-01
Health Care Claim Status Code	2200D-STC11-02
Health Care Claim Status Category Code	2220D-STC01-01
Health Care Claim Status Code	2220D-STC01-02
Health Care Claim Status Category Code	2220D-STC10-01
Health Care Claim Status Code	2220D-STC10-02
Health Care Claim Status Category Code	2220D-STC11-01
Health Care Claim Status Code	2220D-STC11-02
Health Care Claim Status Category Code	2200E-STC01-01
Health Care Claim Status Code	2200E-STC01-02
Health Care Claim Status Category Code	2200E-STC10-01
Health Care Claim Status Code	2200E-STC10-02
Health Care Claim Status Category Code	2200E-STC11-01
Health Care Claim Status Code	2200E-STC11-02
Health Care Claim Status Category Code	2220E-STC01-01
Health Care Claim Status Code	2220E-STC01-02
Health Care Claim Status Category Code	2220E-STC10-01
Health Care Claim Status Code	2220E-STC10-02
Health Care Claim Status Category Code	2220E-STC11-01

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Table 1 – Applicable X12 v5010 277 Claim Status Reporting Loops and Segments	
Data Element	Loop & Segment
Health Care Claim Status Category Code	2200B-STC01-01
Health Care Claim Status Code	2200B-STC01-02
Health Care Claim Status Category Code	2200B-STC10-01
Health Care Claim Status Code	2200B-STC10-02
Health Care Claim Status Category Code	2200B-STC11-01
Health Care Claim Status Code	2200B-STC11-02
Health Care Claim Status Category Code	2200C-STC01-01
Health Care Claim Status Code	2200C-STC01-02
Health Care Claim Status Category Code	2200C-STC10-01
Health Care Claim Status Code	2200C-STC10-02
Health Care Claim Status Category Code	2200C-STC11-01
Health Care Claim Status Code	2220E-STC11-02

103
104 To support effective patient search and matching, this rule covers the following specified loops,
105 segments, and data elements in the X12 v5010 276 transaction:

Table 2 – Applicable X12 v5010 276 Patient Search & Match Criteria Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Patient Date of Birth	2000D-DMG02 (Subscriber) 2000E-DMG02 (Dependent)
Patient Gender Code	2000D-DMG03 (Subscriber) 2000E-DMG03 (Dependent)
Patient Last Name	2100D-NM103 (Subscriber) 2100E-NM103 (Dependent)
Patient First Name	2100D-NM104 (Subscriber) 2100E-NM104 (Dependent)
Subscriber ID	2100D-NM109 (Subscriber)

106
107 To support effective patient search and matching, this rule covers the following specified loops,
108 segments, and data elements in the X12 v5010 277 transaction:

Table 3 – Applicable X12 v5010 277 Patient Search & Match Criteria Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Patient Last Name	2100D-NM103 (Subscriber) 2100E-NM103 (Dependent)
Patient First Name	2100D-NM104 (Subscriber) 2100E-NM104 (Dependent)
Subscriber ID	2100D-NM109 (Subscriber)

109
110 To support effective claim matching, this rule covers the following specified loops, segments, and data
111 elements in the X12 v5010 276 transaction:

Table 4 – Applicable X12 v5010 276 Claim Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Provider Name/ID Code	2100C-NM103/09
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Patient Control Number	2200D-REF02 (Subscriber)

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Table 4 – Applicable X12 v5010 276 Claim Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
	2200E-REF02 (Dependent)
Claim Identification for Clearinghouses and Other Transmission Intermediaries	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Claim Service Date	2200D-DTP03 (Subscriber) 2200E-DTP03 (Dependent)

112

113 To support effective claim matching, this rule covers the following specified loops, segments, and data
114 elements in the X12 v5010 277 transaction:

Table 5 – Applicable X12 v5010 277 Claim Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Provider Name/ID Code	2100C-NM103/09
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Patient Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Claim Identification for Clearinghouses and Other Transmission Intermediaries	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Claim Service Date	2200D-DTP03 (Subscriber) 2200E-DTP03 (Dependent)

115

116 To support effective remittance advice & check/payment information matching, this rule covers the
117 following specified loops, segments, and data elements in the X12 v5010 276 transaction:

Table 6 – Applicable X12 v5010 276 Remittance Advice & Check/Payment Information Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Provider Name/ID Code	2100C-NM103/09
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)
Total Claim Charge Amount	2200D-AMT02 (Subscriber) 2200E-AMT02 (Dependent)

118

119 To support effective remittance advice & check/payment information matching, this rule covers the
120 following specified loops, segments, and data elements in the X12 v5010 277 transaction:

Table 7 – Applicable X12 v5010 277 Remittance Advice & Check/Payment Information Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Provider Name/ID Code	2100C-NM103/09
Total Claim Charge Amount	2200D-STC04 (Subscriber) 2200E-STC04 (Dependent)
Claim Payment Amount	2200D-STC05 (Subscriber) 2200E-STC05 (Dependent)
Check Date	2200D-STC08 (Subscriber) 2200E-STC08 (Dependent)
Check Number	2200D-STC09 (Subscriber) 2200E-STC09 (Dependent)

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Table 7 – Applicable X12 v5010 277 Remittance Advice & Check/Payment Information Matching Loops and Segments	
Data Element Name	Loop/Segment/Data Element
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)

This rule covers the following external code sources specified in the X12 v5010 276/277 transaction for the data elements listed in the table above:

- X12 External 507 Health Care Claim Status Category Codes in each STC Status Information Segment of the Loops identified above.¹
- X12 External 508 Health Care Claim Status Codes in each STC Status Information Segment of the Loops identified above.²

3.6. Maintenance of this Rule

Any substantive updates to the rule (i.e., changes to rule requirements) are determined based on industry need as supported by the CORE Participants per the [CORE Change and Maintenance Process](#).

3.6.1. CORE Process for Maintaining CORE-Defined Claim Status Category Code & Claim Status Code Combinations

The Health Care Claim Status Category Code (CSCC) is used to organize Health Care Claim Status Codes (CSC) into logical groupings, conveying to Information Receivers a comprehensive status of an entire health care claim or a service line within a health care claim. The Health Care Claim Status Category Code and Health Care Claim Status Code lists are code lists maintained by an organization external to the ASC X12 Standards Committee. As such, these code lists are subject to revision and maintenance three times a year. Such revision and maintenance activities can result in new codes, revisions to an existing code's definition and description, or the assignment of a stop date to a code, after which it should no longer be used.

Given this code list maintenance activity, CORE recognizes that the focus of this rule, coupled with this unique maintenance activity, will require a process and policy to enable the various Health Care Claim Status Category Code and Health Care Claim Status Code combinations specified in the companion document of this rule, the *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx* document, be revised and modified.

CORE will use its existing [CORE Code Combinations Maintenance Process](#). This process is modeled after the well-established maintenance of the CORE-required Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) combinations and is designed to:

- Incorporate updates to external code lists (e.g., X12 Code Source 507 and 508)
- Review draft combinations in the context of CORE-defined Business Scenarios
- Address changes in payer or provider workflows, policy updates, or regulatory shifts
- Support a transparent, consensus-based approach to updates

As part of this process, it is expected that all stakeholders (e.g., health plans, providers, vendors, trading partners, etc.) will submit any additional business scenarios that providers or their agents frequently use but are not already covered by this rule to CORE. The CORE Participants are committed to continually improving the process for consistently and uniformly reporting claim status to providers across the industry. To further this commitment, CORE will continue to collaborate and take lessons learned from the industry to develop and enhance an ongoing quality improvement process for maintaining, updating, and supporting a stable code set.

¹ See [X12 External 507 Health Care Claim Status Category Codes](#) for a complete list of Claim Status Category Codes.

² See [X12 External 508 Health Care Claim Status Codes](#) for a complete list of Claim Status Codes.

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This process will maintain CSCC and CSC combinations associated with the Claim Status Data Content Rule, ensuring they remain current and aligned with evolving business needs.

3.7. Abbreviations and Definitions Used in this Rule³

CORE-defined Claim Status Business Scenarios: In general, a business scenario provides a complete description of a business problem such that requirements can be reviewed in relation to one another in the context of the overall problem. Business scenarios offer a means for the industry to describe processes or situations that address common problems and identify technical solutions. By clearly defining needs and reasons, trading partners and vendors can resolve problems using open standards and leverage each other's skills.

Thus, in the context of this CORE rule, a CORE-defined Claim Status Business Scenario describes at a high level the category of the status of a health care claim within the health plan's adjudication system to which various combinations of Claim Status Category Codes and Claim Status Codes can be applied so details can be conveyed to the Information Receiver using the X12 v5010 277 response transaction. The CORE-defined Claim Status Business Scenarios are specified in the *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx* document.

3.8. Assumptions

The goal of this rule is to adhere to the principles of electronic data interchange (EDI) to ensure transactions sent are accurately received and to facilitate the correction of errors for electronically submitted health care claims.

The following assumptions apply to this rule:

- A successful communication connection has been established between all trading partners.
- This rule is a component of the larger set of CORE Claim Status (276/277) Operating Rules.
- The CORE Guiding Principles apply to this rule and all other rules.⁴
- This rule is not a comprehensive companion document addressing any content requirements of the X12 v5010 276 or X12 v5010 277 transactions.
- Compliance with all CORE Operating Rules is a minimum requirement; any entity is free to offer more than the requirements of this rule.
- Claim status transactions are submitted electronically using the X12 v5010 276/277 transaction standard with all required data elements.
- Health plans and their agents follow all directions stated in the definitions and descriptions of the Claim Status Category Codes and Claim Status Codes.

4. Technical Requirements

4.1. Uniform Use of CORE-Claim Status Business Scenarios with Claim Status Category Codes & Claim Status Codes

This section outlines the requirements for health plans and their agents when sending the X12 v5010 277 in response to the X12 v5010 276 claim status request, submitted in either real-time or batch mode.

4.1.1. CORE-Defined Claim Status Business Scenarios

At a high level, the CORE-defined Claim Status Business Scenarios describe the category of the status of a health care claim within the health plan's adjudication system to which various combinations of Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) can be applied so that details can be conveyed to the Information Receiver using the X12 v5010 277 response transaction. The CORE-defined

³ Any abbreviations are cited in the text of the rule with the fully documented name.

⁴ The CORE Operating Rules are available at: <https://www.caqh.org/core/operating-rules>.

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Claim Status Business Scenarios were developed from the descriptions of the CSCCs to be consistent with industry terminology.

Health plans and their agents must align internal adjudication outcomes to the CORE-defined Claim Status Business Scenarios and the CSCC and CSC combinations specified in §4.1.1 of this rule and the *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx* to communicate the status at the claim and service-line levels on the X12 v5010 277. Health plans and their agents are non-compliant with this rule if a CSCC and CSC combination that is already defined by a CORE-defined Claim Status Business Scenario is used in a manner that is inconsistent with that Business Scenario.

The five CORE-defined Claim Status Business Scenarios are outlined in Table 8.

Table 8 – CORE-Defined Claim Status Business Scenarios		
Business Scenario	CORE-Defined Claim Status Business Scenario Description	CORE Business Scenario Definition
Business Scenario #1	Claim Finalized – Payment Will Be Made	Provider submits a claim, the claim is accepted into the adjudication system, and the health plan confirms payment is approved.
Business Scenario #2	Claim Finalized – No Payment Will Be Made	Provider submits a claim, the claim is accepted into the adjudication system, the claim has been processed, but the health plan determines no payment is due. The claim has not been denied.
Business Scenario #3	Claim Denied – No Payment Will Be Made	Provider submits a claim, the claim is accepted into the adjudication system, the claim has been fully processed, and the health plan confirms that payment is not approved (e.g., due to missing information or non-covered services).
Business Scenario #4	Claim Pended	Provider submits a claim, the claim is accepted into the adjudication system, and the health plan pends the claim for review (e.g., medical necessity, prior authorization, additional validation). Pended claims can include those in which no remittance advice has been issued, only part of the claim has been paid, suspended claims, and claims awaiting review.
Business Scenario #5	Errors	Provider submits a claim, but the claim is rejected and not accepted into the adjudication system due to formatting issues or missing/invalid data elements. When the provider submits a claim status request to check on the status of the claim, the health plan responds with one of the following: • A claim status response indicating that the claim was rejected and never accepted for adjudication, or • An error response pointing to issue(s) with the request itself, such as invalid or missing data in the request transaction.

4.1.2. Uniform Use of CORE-defined Claim Status Category & Claim Status Codes Combinations

Specific details about the status of a claim are conveyed to providers and their agents by health plans and their agents in the X12 v5010 277 response, using one or more specified Claim Status Category Codes (CSCC) in combination with specified Claim Status Codes (CSC). These code combinations are

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defined as CORE-defined Claim Status Category and Claim Status Code Combinations, which can be found in the *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx* document.

Health plans and their agents shall map their internal codes and corresponding business scenarios to the CORE-defined Claim Status Business Scenarios specified in §4.1.1 and the CSCC and CSC combinations specified in the *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx*.

Health plans and their agents must support the CORE-defined CSCC and CSC combinations in their X12 v5010 277 responses. The *CORE-required Claim Status Code Combinations for CORE-defined Claim Status Business Scenarios.xlsx* document outlines a minimum required data set for industry use. These combinations are established as a best practice to promote consistency and clarity in claim status responses across trading partners. When specific CORE-defined CSCC and CSC combinations are not applicable to meet the health plans and their agents' business requirements, it is not required to use them. Health plans and their agents may develop additional CSCC and CSC combinations to report the status of a claim and may send as many STC segments as necessary to detail the accurate status of a claim fully. Deactivated CSCCs or CSCs must not be used.

4.2. Association and Alignment of Returned Status to Claim and Line

4.2.1. Level of Return

Health plans and their agents shall return claim status at the appropriate level of granularity. When the status applies to the entire claim, the entity shall report the Claim Status Category Code (CSCC) and Claim Status Code (CSC) combinations in the claim-level STC segments (e.g., 2200D/2200E). When the status applies to one or more service lines, the entity shall report the CSC and CSCC combinations in the line-level STC segments (e.g., 2220D/2220E). When both claim-level and line-level statuses are returned for the same claim, the line-level detail shall be refined and shall not conflict with the claim-level status.

4.2.2. Association to the Originating Request and to the Health Plan's Record

For every X12 v5010 277 response carrying claim or line status, health plans and their agents shall include identifiers sufficient to: (a) associate the response to the originating X12 v5010 276 request (e.g., subscriber identification number, Patient Control Number, date(s) of service), and (b) associate the response to a health plan and its agents claim and, when applicable, service-line record (e.g., Payer Claim Control Number at the claim level and line identifiers where supported). Exact loop/segment usage appears in §3.5 of this rule for data elements that are specified in §4.3.

When more than one status condition applies to the same unit of work, health plans and their agents shall return additional STC occurrences (STC10 and STC11, as applicable) to fully communicate all applicable conditions at the claim and/or line level.

4.2.3. Payment Linkage When a Paid Status Is Indicated

When the returned status indicates that payment has been or will be made, health plans and their agents shall include payment-linkage data in the specified STC elements, including the check date and check number, to support timely AR reconciliation. Where available, health plans and their agents should also return recommended monetary amounts (e.g., claim payment amount, submitted charges) without delaying the status response.

4.2.4. Identifier Consistency

All entities should maintain consistency of persistent identifiers across subsequent X12 v5010 277 responses for the same claim, including, at a minimum, the Patient Control Number and the Payer Claim Control Number, to preserve a stable association over time.

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4.3. Data Alignment Requirements

This section standardizes the minimum set of data elements - designated Required or Recommended - to improve match rates, reduce “claim not found” responses, and enable earlier, actionable follow-up across three use cases: Patient Search & Match Criteria, Claim Matching, and Remittance Advice & Check/Payment Matching. There is no implied hierarchy across the matching use cases. The rule is written so the use cases can be applied independent of each other or work together in any combination.

Data elements marked as “required” are the primary matching criteria for each use case and must be supported and populated. To be compliant with this rule, they must be supported and populated as specified according to the directions associated with each use case. Recommended elements are encouraged to be supported and populated to enhance match quality and information sharing.

4.3.1. Patient Search & Match Criteria

This set of data elements establishes consistent inputs for the X12 v5010 276 and is echoed in the X12 v5010 277, allowing responders to reliably locate the patient/claim and return a single, clearly identifiable match. While some elements are marked as “required,” the X12 v5010 276 should still be accepted if the submitted data is sufficient to produce a unique match, even if not all required fields are present. In this context, “required” elements are conditionally required: they are only needed when necessary to ensure an unambiguous match.⁵

4.3.1.1. Data Elements in the X12 v5010 276 Request (in hierarchical order)

Table 9 – Data Elements in the X12 v5010 276 Request for Patient Search & Match Criteria		
Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Patient Date of Birth	2000D-DMG02 (Subscriber) 2000E-DMG02 (Dependent)	Requirement
Patient Gender Code	2000D-DMG03 (Subscriber) 2000E-DMG03 (Dependent)	Recommendation
Patient Last Name	2100D-NM103 (Subscriber) 2100E-NM103 (Dependent)	Recommendation
Patient First Name	2100D-NM104 (Subscriber) 2100E-NM104 (Dependent)	Recommendation
Subscriber ID	2100D-NM109 (Subscriber)	Requirement

4.3.1.2. Data Elements in the X12 v5010 277 Response (in hierarchical order)

Table 10 – Data Elements in the X12 v5010 277 Response for Patient Search & Match Criteria		
Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Patient Last Name	2100D-NM103 (Subscriber) 2100E-NM103 (Dependent)	Recommendation
Patient First Name	2100D-NM104 (Subscriber) 2100E-NM104 (Dependent)	Recommendation
Subscriber ID	2100D-NM109 (Subscriber)	Requirement

4.3.2. Claim Matching

This set of data elements helps ensure that the X12 v5010 277 can be matched back to the originating X12 v5010 276 and to a health plan's and its agent's internal claim record, supporting stable follow-up and status history. While some elements are marked as “required,” the X12 v5010 276 should still be accepted if the submitted data is sufficient to produce a unique match, even if not all required fields are

⁵ The CORE-defined requirements and recommendations represent the data necessary to ensure an accurate match. Implementation of these criteria should fully align with the X12 v5010 276/277 TR3 and maintain consistency with all situational and required elements define by X12.

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present. In this context, “required” elements are conditionally required: they are only needed when necessary to ensure an unambiguous match.⁶

Implementers are only required to use the Payer Claim Control Number or the Patient Control Number for Claim Matching. Implementers are free to choose the most appropriate of these data elements (Payer Claim Control Number only, Patient Control Number only, or both). All other data elements are recommended.

Should implementers choose to use Provider (billing or rendering) for Claim Matching, they should select the same Provider transmitted in the claim file. This is to maintain consistency across transactions and revenue cycle processes.

If the X12 v5010 276 contains a specific Patient Control Number, providers and their agents intend the search criteria to be narrowed to a specific claim. Health plans and their agents must respond with the claim status of the claims associated with that specific Patient Control Number.

4.3.2.1. Data Elements in the X12 v5010 276 Request (in hierarchical order)

Table 11 – Data Elements in the X12 v5010 276 Request for Claim Matching

Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Provider Name/ID Code	2100C-NM103/09	Recommendation - Use the same provider from the claim file.
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Patient Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Claim Identification for Clearinghouses and Other Transmission Intermediaries	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Recommendation
Claim Service Date	2200D-DTP03 (Subscriber) 2200E-DTP03 (Dependent)	Recommendation

4.3.2.2. Data Elements in the X12 v5010 277 Response (in hierarchical order)

Table 12 – Data Elements in the X12 v5010 277 Response for Claim Matching

Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Provider Name/ID Code	2100C-NM103/09	Recommendation - Use the same provider from the claim file.
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Patient Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Claim Identification for Clearinghouses and Other Transmission Intermediaries	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Recommendation
Claim Service Date	2200D-DTP03 (Subscriber) 2200E-DTP03 (Dependent)	Recommendation

⁶ Ibid

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4.3.3. Remittance Advice & Check/Payment Matching

This set of data elements supports earlier AR reconciliation and targeted follow-up by including payment linkage information when a claim status indicates a payment. While some elements are marked as “required,” the X12 v5010 276 should still be accepted if the submitted data is sufficient to produce a unique match, even if not all required fields are present. In this context, “required” elements are conditionally required: they are only needed when necessary to ensure an unambiguous match.⁷

Implementers are only required to use the Payer Claim Control Number or the Patient Control Number for Remittance Advice & Check/Payment Matching. Implementers are free to choose the most appropriate of these data elements (Payer Claim Control Number only, Patient Control Number only, or both). All other data elements are recommended; however, if the Check Date and Check Number are known at the time of the claim status request, Information Sources must return this information in the claim status response.

4.3.3.1. Data Elements in the X12 v5010 276 Request (in hierarchical order)

Table 13 – Data Elements in the X12 v5010 276 Request for Remittance Advice & Check/Payment Matching		
Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Provider Name/ID Code	2100C-NM103/09	Recommendation
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Patient Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Total Claim Charge Amount	2200D-AMT02 (Subscriber) 2200E-AMT02 (Dependent)	Recommendation

4.3.3.2. Data Elements in the X12 v5010 277 Response (in hierarchical order)

Table 14 – Data Elements in the X12 v5010 277 Request for Remittance Advice & Check/Payment Matching		
Data Element Name	Loop/Segment/Data Element	Requirement/Recommendation
Provider Name/ID Code	2100C-NM103/09	Recommendation
Total Claim Charge Amount	2200D-STC04 (Subscriber) 2200E-STC04 (Dependent)	Recommendation
Claim Payment Amount	2200D-STC05 (Subscriber) 2200E-STC05 (Dependent)	Recommendation
Check Date	2200D-STC08 (Subscriber) 2200E-STC08 (Dependent)	Requirement - Must be returned if known at the time of request.
Check Number	2200D-STC09 (Subscriber) 2200E-STC09 (Dependent)	Requirement - Must be returned if known at the time of request.
Payer Claim Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.
Patient Control Number	2200D-REF02 (Subscriber) 2200E-REF02 (Dependent)	Requirement - Must use either the Payer Claim Control Number, Patient Control Number, or both.

⁷ Ibid

4.4. Requirements for Receivers of X12 v5010 277 Responses

The receiver of a X12 v5010 277 Response (defined in the context of this CORE rule as the system originating the X12 276 Request) is required to detect and extract all data elements, data element codes, and corresponding code definitions to which this rule applies as returned by the health plan and its agent in the 277 Response.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 277 Response data content. "Appropriately available" refers to the display of the X12 v5010 277 response data to Information Receiver end users. To make the X12 v5010 277 response data useful and accessible to end users, the Information Receiver must determine the most suitable method to present the data (e.g., dashboard, widget, report, etc.).

5. Conformance Requirements

Conformance with this rule is considered achieved when all the required detailed step-by-step test scripts specified in the Claim Status CORE Certification Test Suite are successfully passed.