API Extended X12 Claim Status Implementation Guide

Refers to the Implementation Guide

Based on X12 Version 005010X212

Health Care Claim
Status Request and Response

(276/277)

Version Number 2.2

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CHANGE LOG

1.0	5/12/2020	Initial Draft 277 API Expanded Claim Status Guide based on version 5010
1.1	5/26/2020	Updates to Sections 5.1, 6.1 and 6.2 and finalized draft for release
1.2	6/2/2020	Updates to Section 3.2 referencing descriptions for CheckNbr and draftPaidAmt and Section 3.3 claimNbr for check type on page 17
1.3	7/16/2020	Updates to multiple sections based on revised terminology and process changes
1.4	10/19/2020	Update to Introduction and Section 6 regarding contacts and resources
2.0	1/7/2021	Added additional information to Scope 1.1 section referencing trading partner guidelines
2.1	2/17/2021	Added additional information around payment mode and virtual card payment changes.
2.2	4/28/2021	Added additional information for claim received date, claim/line group codes, claim/line group code descriptions.

PREFACE

The API Extended X12 Claim Status Implementation Guide is meant to be used in conjunction with the UnitedHealth Care Claim Status Request and Response (276/277) Companion Guide. Additional claim status related information that is not available in the 276/277 transaction can be retrieved via a response extension file that is returned along with the 277 claim status response. This guide will provide information regarding how to request access to receive the extended data as well as provide the data definitions associated with the extended data elements.

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1. INTRODUCTION

In addition to retrieving the existing UnitedHealthcare 277 claim status response, trading partners may also request to have access to extended claim status data. The extended claim status data will be returned in the same response transmission as the corresponding 277 response but in a separate response extension section. The response extension section will return data at the claim and service line level and will contain claim, check and coordination of benefit (cob) related information.

In order to invoke a request for extension data, the Submitter must be authorized. Please refer to Section 5.2 for authorization instructions.

1.1 SCOPE

This document describes the request and response of the extended data that is returned in addition to the 277 claim status response. Refer to the UnitedHealth Care Claim Status Request and Response (276/277) Companion Guide for information regarding the 276/277 processing and the EDI X12 API Gateway Connectivity Guide for information regarding the 276/277 connection protocols and message formatting guideline.

The extended claim status functionality only applies to real time processing. Batch file processing is not currently offered.[BKA1]

The Extended Claim Status functionality applies to Medical claims for Commercial, Medicare and Medicaid under the following Payer IDs: 87726, 96385, 95467, 86050, 86047, 95378 and 94265.

Trading Partners should follow the below guidelines:

- Code with the ability to accept the extension response fields in any location/order in the response.
- Trading Partners may code the initial implementation of this functionality with the ability to ignore new fields that may be added to the extension response area in the future. This will ensure no impact if new fields are added in the future and the Trading Partner elects to initially not use the new field or never use the new field.

2. EXTENDED REQUEST

2.1 EXTENDED REQUEST GUIDELINES

To request extension data:

- Ensure the authorized Submitter id value is reflected in the ISA06 of the 276 request.
- Append the requestExtensions fields to the end of the 276 request after the parameters and message sections.

The following table identifies the request extension area and applicable field values:

Name	Valid Value	Description	Type (List or String)	Required/ Optional
requestExtensions				
extensions				
type	CLAIM_STATUS	Request to include claim, check and cob extended claim status data in addition to the 277 response.	String	Required

NOTEXTENDED REQUEST EXAMPLE

The example below contains the required 276 request using the standard messaging format identified in the EDI X12 API Gateway Connectivity Guide as well as the request extension area. (This is a example request, to see the format and not to be used.)


```
{
  "parameters": {
    "businessPartnerId": "BS237GRACEBI",
    "businessPartnerReferenceNumber": "12345",
    "businessPartnerUserId": "TESTUSR",
    "payer": "87726",
    "systemType": "T",
    "transactionVersion": "1.0",
    "typeOfRequest": "276"
  },
  "message": " ISA*00*          *00*          *ZZ* BS237GRACEBI       *ZZ*888888888
*050120*0701*^*00501*444444444*0*T*:~GS*HR*111111111*841162764*20150622*070100*44444444
4*X*005010X212~ST*276*473997565*005010X212~BHT*0010*13*473997565*20200501*070100~HL*1**
20*1~NM1*PR*2*UNITEDHEALTHCARE*****PI*87726~HL*2*1*21*1~NM1*41*2*HOSPITAL*****46*2222
22221~HL*3*2*19*1~NM1*1P*1*DOCTOR*MY****XX*1666666666~HL*4*3*22*0~DMG*D8*20200101~N
M1*IL*1*NAME*FIRST****MI*000000000~TRN*1*0123456789~REF*6P*000000~DTP*472*RD8*20200426
-20200427~SE*15*473997565~GE*1*444444444~IEA*1*444444444~",
  "requestExtensions": {
    "extensions": [
      {
        "type": "CLAIM_STATUS"
      }
    ]
  }
```

```
}
```

3. EXTENDED CLAIM STATUS RESPONSE

3.1 EXTENDED CLAIM STATUS RESPONSE GUIDELINES

The extended claim status response is returned immediately following the parameters and message areas that are standard with the 277 response.

If the extended claim status data is unavailable, the 277, 999 or TA1 will still be returned.

Within the “extensions” section of the response, multiple blocks of “type” data can be returned:

- The "type": "claim" section will contain data related to the claim at both the claim and service line level, such as relevant amount fields, remark codes and remark code descriptions.
- The "type": "cob" section will contain data related to coordination of benefit information pertaining to the submitted claim and the adjudicated claim.
- The "type": "check" section will contain data related to the check(s) that are associated to the claim, such as the check number, check issue date and payee name.

The “key” section will appear in multiple locations of the extended claim status response and can be used to correlate the extended claim status response data with the 277 response data:

- The “type”:”claim” section will contain two keys. One key will provide the corresponding 277 data related to the claim. The second key will provide the corresponding 277 data for each service line within the claim.
- Keys will also be provided in the “type”:”cob” and “type”:”check” sections with the corresponding 277 data related to the claim.

Amount fields returned in the extended claim status response will be returned in the same format as returned in the 277 (Refer to TR3 Section B.1.1.3.1.2).

Examples:

- 200
- 200.9
- 200.45

Response fields with no value will be represented with a value of “” in the JSON response.

If no data is being returned in an array area, an empty array will be returned, [].

3.2 EXTENDED RESPONSE DATA DEFINITIONS

Field Name	Field Description	Type
responseExtensions	Introduces the expanded area of the response object including the status.	
statusCode	The extension status. Valid values: 0, 1, 2, 3, 4, 5	String
statusDescription	The extension status. Valid values are listed after the numeric value: 0 - Success 1 - Not Authorized 2 - Internal Error 3 - Extension Not Applicable 4 - Extension Not Available At This time 5 - Invalid Request Extension Type	String
extensions	Introduces the extensions associated with the response	
"type"	A "type" value of "claim" introduces the claim category data	String
"data"	Introduces the data area associated with the claim "type".	Array
Claim Key *	**Field Description**	**Type**
claimNbr *	This field corresponds to the following field in the 277 response REF02 when REF01 = 1K 2200D or 2200E	String
patientAcctNbr *	This field corresponds to the following field in the 277 response REF02 when REF01 = EJ 2200D or 2200E	String
statusEffectiveDt *	This field corresponds to the following field in the 277 response STC02 2200D or 2200E	String
totalChrgAmt *	This field corresponds to the following field in the 277 response STC04 2200D or 2200E	**Decimal
Field Name	**Field Description**	**Type**
clmReceivedDt	Claim Received Date - The date the claim was received by United Healthcare	String

drg	Diagnosis Related Group - Type of bundle fee, prospective reimbursement method that pays the hospital based on the diagnosis classification of the patient. The hospital is paid a set dollar for each admission and stay or the number of services rendered. Each DRG corresponds to a patient's condition based on the primary diagnosis, secondary diagnosis, surgical procedures, age, gender and presence of complications. This reimbursement method was originated by Medicare; but has been accepted by other payers as their reimbursement to hospital.	String
clmProvWriteOffAmt	Claim Provider Write Off Amount - This is amounts reduced due to contract agreement. This will apply for both an In-network and out-of-network claim.	**Decimal
clmProvNotCovAmt	Provider Not Covered Amount - This is part of the Not covered amount which is attributed towards the provider. The patient is not liable for these amounts.	**Decimal
clmPatientNotCovAmt	Patient Not Covered Amount - This is part of the Not Covered amount which is attributed towards the patient for the claim. The patient is liable to pay these amounts to the provider.	**Decimal
clmAllowedAmt	Eligible expense, payment allowance, negotiated rate, allowable charge Maximum amount on which payment is based for covered health care services	**Decimal
clmDedAmt	Total Deductible Amount - The amount paid by the subscriber for covered health care services before the insurance plan pays.	**Decimal

clmCopayAmt	Total Copay Amount - A fixed amount ($20, for example) paid for a covered health care service after the deductible has been met.	**Decimal
clmCoinsAmt	Total Coinsurance Amount - The percentage of costs paid by a Subscriber for a covered health care service (20%, for example) after the deductible has been met.	**Decimal
clmPatientResponsibilityAmt	Patient Responsibility - This includes the copay, coinsurance, deductible and patient not covered amount.	**Decimal
Claim Level Remark Code Occur Area	**Field Description**	**Type**
claimRemark	Introduces the claimRemark occur area	
clmRemarkCodeInd	Identifies the type of Remark Code being returned. Valid clmRemarkCodeInd field values: RC - Remark Code RA - RARC CA - CARC PC - Pend Code 507 - Claim Status Category Code 508 - Claim Status Code	String
clmRemarkGrpCd	Claim Remark Group Code – Identifies the group code associate with the claim. Valid clmRemarkGrpCd field values: PR – Patient Responsibility CO – Contractual Obligation OA – Other Adjustment PI – Payor Initiated Reductions	String
clmRemarkGrpCdDesc	Claim Remark Group Code Description	String
clmRemarkCode	Remark Code	String
clmRemarkCodeDesc	Remark Code Description The 507 and 508 descriptions may be different from the description associated with the 276/277 Implementation Guide.	String
ServiceLine - Key *	**Field Description**	**Type**
lineItemControlNbr*	REF02 when REF01 = FJ 2220D/2220E	String
lineChrgAmt*	SVC02 2220D/2220E	**Decimal

lineProvNotCovAmt	Service Line Provider Not Covered Amount - This is part of the Not covered amount which is attributed towards the provider. The patient is not liable for these amounts.	**Decimal
lineProvWriteOffAmt	Service Line Provider Write Off Amount - This is amounts reduced due to contract agreement. This will apply for both an In-network and out-of-network claim.	**Decimal
linePatientNotCovAmt	Service Line Patient Not Covered Amount - This is part of the Not Covered amount which is attributed towards the patient for the claim. The patient is liable to pay these amounts to the provider.	**Decimal
lineAllowedAmt	Service Line Allowed Amount -Eligible expense, payment allowance, negotiated rate, allowable charge Maximum amount on which payment is based for covered health care services	**Decimal
lineCopayAmt	Service Line Copay Amount - Total Copay Amount - A fixed amount ($20, for example) paid for a covered health care service after the deductible has been met.	**Decimal
lineDedAmt	Service Line Deductible Amount - The amount paid by the subscriber for covered health care services before the insurance plan pays.	**Decimal
lineCoinsAmt	Service Line Coinsurance Amount - The percentage of costs paid by a Subscriber for a covered health care service (20%, for example) after the deductible has been met.	**Decimal
linePatientResponsibilityAmt	Service Line Patient Responsibility Amount Includes Patient not covered + Copay + Ded + Coins	**Decimal
Begin of Service Line Level Remark Code Occur maximum of 5	**Field Description**	**Type**
lineRemarkCodeInd	Identifies the type of Remark Code being returned. Valid clmRemarkCodeInd field values: RC - Remark Code RA - RARC CA - CARC PC - Pend Code CC - Closure Code 507 - Claim Status Category Code 508 - Claim Status Code	String

lineRemarkGrpCd	Line Remark Group Code – Identifies the group code associate with the claim line. Valid lineRemarkGrpCd field values: PR – Patient Responsibility CO – Contractual Obligation OA – Other Adjustment PI – Payor Initiated Reductions	String
lineRemarkGrpCdDesc	Line Remark Group Code Description	String
lineRemarkCode	Service Line Remark Code	String
lineRemarkCodeDesc	Remark Code Description The 507 and 508 descriptions may be different from the description associated with the 276/277 Implementation Guide.	String
"type"	A "type" value of "cob" introduces the cob category data.	String
"data"	The "data" Introduces the data area of the cob type.	Array

Submitted Claim COB Payer Occur Area Can occur up to 10 times		
COB Key*	Field Description	Type
submittedClmCobInd*	Primary Impact On Claims Indicates the sequence of various payers depending on their responsibility based on the preadjudicated/as submitted claim. Valid values "P" - Primary, "S" - Secondary or "T" - Tertiary Example is UHC could be primary and Medicare could be secondary.	String
submittedClmPayerName*	Payer Name associated with the submittedClmCobInd	String

adjudicatedCobInd	Adjudicated COB Indicator Indicates whether the adjudicated claim had UHC pay primary or any other sequence on these claims Valid Values: P - Primary S - Secondary T - Tertiary If claim not adjudicated, field is not valued.	String
"type"	A "type" value of "check" introduces the cob category data	Array
"data"	The "data" Introduces the data area of the cob type.	String
Check Key*	Field Description	Type
claimNbr *	This field corresponds to the following field in the 277 response REF02 when REF01 = 1K 2200D or 2200E	String
patientAcctNbr *	This field corresponds to the following field in the 277 response REF02 when REF01 = EJ 2200D or 2200E	String
statusEffectiveDt *	This field corresponds to the following field in the 277 response STC02 2200D or 2200E	String
totalChrgAmt *	This field corresponds to the following field in the 277 response STC04 2200D or 2200E	**Decimal
checkDetail introduces the occur area.	Introduces the Submitted Claim Check area. This occurrence area reflects the claim payment information related to the issued check. If a claim is adjusted, multiple checkDetail occurrences can be returned reflecting the claim payment and check information associated with each adjustment. The check area in the expanded structure will include all the check/EFT transactions for that claim/ICN	Array
Field Name	Field Description	Type
checkNbr	Check Number, EFT Trace Number, or Virtual Card Payment Number	String

checkAmt	Check Amount	**Decimal
checkIssueDt	Check Date	String, yyyy-mm-dd
draftNbr	Draft number when applicable is used for financial tracking of claim iterations where there's multiple iterations for a single claim. Reasons for multiple iterations include adjustments, split claims, readjudicated claims, claim recovery	String
draftPaidAmt	Original claim = claim paid amount Adjusted claim = amount that reflects the difference between the original payment and the new adjudication of the claim (can be positive or negative amount).	**Decimal
payeeNameInd	This fields identifies who is being paid. Valid values: A-Alternate Payee (special payee) P-Provider I-Individual/member/subscriber	String
paymentMode	This field identifies the type of payment. Valid values: CHK-Check ACH-Electronic Funds Transfer VCP-Virtual Card Payment ""-(blank)	String
payeeNm	Payee Name Identifies the name on the check. The payee could be the provider or the member.	String

3.3 EXTENDED RESPONSE SUCCESSFUL


```
{
 "parameters": {
  "businessPartnerId": " BS237GRACEBI",
  "businessPartnerReferenceNumber": "12345",
  "businessPartnerUserId": "TESTUSER",
  "payer": "87726",
  "systemType": "T",
  "transactionVersion": "1.0",
  "typeOfRequest": "276"
 },
```

"message": " ISA*00*   *00*   *ZZ* BS237GRACEBI   *ZZ*061118515
*200121*0137*^*00501*985075356*1*T*:~GS*HR*BS237GRACEBI*061118515*20200121*0137*1*X*005010X
212~ST*276*000000001*005010X212~BHT*0010*13*189708849*20200121*0137~HL*1**20*1~NM1*PR*2*U
NITEDHEALTHCARE*****PI*87726~HL*2*1*21*1~NM1*41*2******46*222222221~HL*3*2*19*1~NM1*1P*2*
*****XX*1666666666~HL*4*3*22*0~DMG*D8*19581208*F~NM1*IL*1*NAME*FIRST****MI*000000000~TRN
*1*CSBCID62726896~DTP*472*RD8*20200102-20200102~SE*14*000000001~GE*1*1~IEA*1*985075356~",
"requestExtensions": {
"extensions": [
{
"type": "CLAIM_STATUS"
}
]
}
}

RESPONSE:

{
"parameters": {
"businessPartnerId": "",
"businessPartnerReferenceNumber": "nexAPI1",
"returnCode": "000",
"returnCodeDescription": "Success",
"trackingId": "039-1588969332941-1661992220",
"transactionVersion": "1.0",
"typeOfRequest": "276",
"typeOfResponse": "277"
},
"message": " ISA*00*   *00*   *33*87726   *ZZ*BS321GRACEZI
*200508*1522*^*00501*169335353*0*P*:~GS*HN*061118515*BS237GRACEBI*20200508*1522*1*X*005010
X212~ST*277*000000001*005010X212~BHT*0010*08*189708849*20200508*15221537*DG~HL*1**20*1~NM
1*PR*2*UNITEDHEALTHCARE*****PI*87726~HL*2*1*21*1~NM1*41*2******46*222222221~HL*3*2*19*1~N
M1*1P*2******XX*1666666666~HL*4*3*22*0~NM1*IL*1*NAME*FIRST****MI*000000000~TRN*2*CSBCID62
726896~STC*F1:104*20200122**372*84.17*20200114**20200122*C0000006~REF*1K*9918046987~REF*BLT*
343~REF*EJ*897327846920~DTP*472*D8*20200102~SVC*HC:T1030*372*84.17*0551***1~STC*F1:104*20200
122~REF*FJ*3877537099Z1~DTP*472*D8*20200102~SE*21*000000001~GE*1*1~IEA*1*169335353~",
"responseExtensions": {
"statusCode": "0",
"statusDescription": "SUCCESS",
"extensions": [
{
"type": "claim",
"data": [{
"key": {
"claimNbr": "9918046987",
"patientAcctNbr": "897327846920",
"statusEffectiveDt": "2020-01-22",

"totalChrgAmt": "372"
},
"clmReceivedDt": "2021-04-26",
"drg": "",
"clmProvWriteOffAmt": "287.83",
"clmProvNotCovAmt": "0",
"clmPatientNotCovAmt": "0",
"clmAllowedAmt": "84.17",
"clmDedAmt": "0",
"clmCopayAmt": "0",
"clmCoinsAmt": "0",
"clmPatientResponsibilityAmt": "0",
"claimRemark": [

{
"clmRemarkCodeInd": "507",
"clmRemarkGrpCd": ""
"clmRemarkGrpCdDesc": ""
"clmRemarkCode": "F1",
"clmRemarkCodeDesc": "Finalized/Payment-The claim/line has been paid."
},
{
"clmRemarkCodeInd": "508",
"clmRemarkGrpCd": ""
"clmRemarkGrpCdDesc": ""
"clmRemarkCode": "104",
"clmRemarkCodeDesc": "Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)"
}
],
"serviceLine": [{
"key": {
"lineItemControlNbr": "3877537099Z1",
"lineChrgAmt": "372"
},
"lineProvNotCovAmt": "0",
"lineProvWriteOffAmt": "287.83",
"linePatientNotCovAmt": "0",
"lineAllowedAmt": "84.17",
"lineCopayAmt": "0",
"lineDedAmt": "0",
"lineCoinsAmt": "0",
"linePatientResponsibilityAmt": "0",
"lineRemark": [
{
"lineRemarkCodeInd": "CA",
"lineRemarkGrpCd": "PR"
"lineRemarkGrpCdDesc": "PATIENT RESPONSIBILITY"
"lineRemarkCode": "1",

"lineRemarkCodeDesc": "DEDUCTIBLE AMOUNT"
},
{
"lineRemarkCodeInd": "CA",
"lineRemarkGrpCd": "CO"
"lineRemarkGrpCdDesc": "CONTRACTUAL OBLIGATION"
"lineRemarkCode": "23",
"lineRemarkCodeDesc": "THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDING PAYMENTS AND/OR ADJUSTMENTS."
},
{
"lineRemarkCodeInd": "507",
"lineRemarkGrpCd": ""
"lineRemarkGrpCdDesc": ""
"lineRemarkCode": "F1",
"lineRemarkCodeDesc": "Finalized/Payment-The claim/line has been paid."
},
{
"lineRemarkCodeInd": "508",
"lineRemarkGrpCd": ""
"lineRemarkGrpCdDesc": ""
"lineRemarkCode": "104",
"lineRemarkCodeDesc": "Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)"
}
]
}]
}]
},
{
"type": "cob",
"data": [{
"key": {
"claimNbr": "9918046987",
"patientAcctNbr": "897327846920",
"statusEffectiveDt": "2020-01-22",
"totalChrgAmt": "372"
},
"submittedClmCob": [{
"submittedClmCobInd": "P",
"submittedClmPayerName": "UHC"
}],
"adjudicatedCobInd": "P"
}]
},
{
"type": "check",
"data": [{
"key": {

"claimNbr": "9918046987",
"patientAcctNbr": "897327846920",
"statusEffectiveDt": "2020-01-22",
"totalChrgAmt": "372"
},
"checkDetail": [{
"checkNbr": "C0000006",
"checkAmt": "465.86",
"checkIssueDt": "2020-01-22",
"draftNbr": “”,
"draftPaidAmt": "84.17",
"payeeNameInd": "P",
“paymentMode”:”VCP”,
"payeeNm": "MY DOCTOR"
}]
}]
}
]
}
}

3.4 EXTENDED RESPONSE UNSUCCESSFUL


```
{
  "parameters":   {
    "businessPartnerId": "API12PARTNER",
    "businessPartnerReferenceNumber": "nexAPI1",
    "returnCode": "000",
    "returnCodeDescription": "Success",
    "trackingId": "036-1588188514359-632190027",
    "transactionVersion": "1.0",
    "typeOfRequest": "276",
    "typeOfResponse": "277"
  },
  "message": " ISA*00*          *00*          *33*87726          *ZZ*BS321GRACEZI
*200429*1437*^*00501*189021181*0*P*:~GS*HN*841162764*621249087*20200429*1437*473997565*X*005010X
212~ST*277*473997565*005010X212~BHT*0010*08*473997565*20200429*14370114*DG~HL*1**20*1~NM1*PR*2
*UNITEDHEALTHCARE*****PI*87726~HL*2*1*21*1~NM1*41*2*HOSPITAL*****46*222222221~HL*3*2*19*1~NM1*
1P*1*DOCTOR*MY****XX*1666666666~HL*4*3*22*0~NM1*IL*1*NAME*FIRST****MI*000000000~TRN*2*E123456
789~STC*F1:65*20190821**500*250*20190726**20190821*TR10326325~REF*1K*0000002345~REF*EJ*LINKB2C
CRP~DTP*472*D8*20190527~SVC*HC:99213*500*250****1~STC*F0:98*20190821~REF*FJ*000001~DTP*472*D8*201
90527~TRN*2*E123456789~STC*F1:65*20190821**500*250*20190726**20190821*TR10326325~REF*1K*00000012
35~REF*EJ*LINKB2C
CRP~DTP*472*D8*20190526~SVC*HC:99213*500*250****1~STC*F0:98*20190821~REF*FJ*000001~DTP*472*D8*201
90526~SE*29*473997565~GE*1*473997565~IEA*1*189021181~",
  "responseExtensions":   {
    "statusCode": "1",
    "statusDescription": "Not Authorized"
  }
}
```


statusCode	statusDescription
0	Success
1	Not Authorized
2	Internal Server Error
3	Extension Not Applicable
4	Extension not available at this time
5	Invalid Request Extension Type

4. COTIVITY AND COMMUNICATIONS PROTOCOLS

To establish connectivity for API Extended X12 data, a direct connection to UnitedHealthcare is required. We will provide the connectivity guide to establish new connections when needed. A direction connection is not required if you are receiving API Extended X12 data from your clearinghouse.

4.1 EXTENDED API SYSTEM AVAILABILITY

Normal business hours: Monday - Friday, 5 am to 9 pm CST
Weekend hours: Saturday - Sunday, 5 am to 6 pm CST (exceptions may occur)

UnitedHealthcare systems may be 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 response will instruct the trading partner if any action is required.

In addition, 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 for scheduled and unplanned outages.

5. TRADING PARTNER AGREEMENTS

5.1 TRADING PARTNERS

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.

EDI data sharing agreements are required through your existing clearinghouse or UnitedHealthcare. To establish a connection to UnitedHealthcare for API Extended X12 data, a Trading Partner Agreement is required. If you are receiving API Extended X12 data from your clearinghouse and not directly from UnitedHealthcare, an agreement isn't necessary.

5.2 AUTHORIZATION FOR API EXTENDED X12 DATA

If interested in obtaining API Extended X12 data, send an email to physician_esolutions@uhc.com to request a consultation. Include your name, title, company, email address and phone number.

We will contact you to discuss API options, compatibility and connection terms. Once approved, you will be connected with the API development team for onboarding.

6. CONTACTS AND RESOURCES

6.1 EDI AND API 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. Go to UHCprovider.com/api for details on API Extended Data.

If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 276/277 transaction or receive invalid data in the 277 response, please contact EDI Support. A complete list of EDI contacts is online at UHCprovider.com/edicontacts.

If you have questions related to submitting transactions through a clearinghouse, please contact your clearinghouse or software vendor directly.

6.2 PROVIDER SERVICES

Provider Services should be contacted at 877-842-3210 instead of EDI Support if you have questions regarding the details of a member's benefits. Provider Services is available Monday - Friday, 7 am - 7 pm in the provider's time zone.