837P Submission Checklist

A practical create → validate → submit → acknowledge → correct → reconcile workflow.

Professional electronic claim workflow

1. Build the claim	Confirm patient/subscriber, billing/rendering provider, diagnoses, service lines, dates, POS, charges, units and payer IDs before generating X12.
2. Create valid envelopes	Reconcile ISA/IEA, GS/GE and ST/SE control numbers and counts.
3. Validate structure	Check required loops/segments, qualifiers, IDs, dates and service-line relationships against the current implementation/companion guide.
4. Submit securely	Transmit through the payer, clearinghouse or approved channel; retain submission/control identifiers.
5. Read technical acknowledgments	Review TA1 when used and the 999 implementation acknowledgment for interchange/transaction syntax status.
6. Read claim acknowledgment	Review 277CA when provided for front-end claim/service-line acceptance or rejection.
7. Correct and resubmit	Fix rejected file/claim issues; do not create duplicate claims when a correction/replacement workflow is required.
8. Track adjudication	Front-end acceptance is not payment. Continue to payer claim status/remittance (for example 835/ERA) and reconcile results.

Current Medicare FFS reference: CMS identifies the 837 Professional implementation as ASC X12 005010X222A1; companion-guide and trading-partner requirements still control routing and payer-specific edits.

Official references: CMS Medicare EDI: cms.gov/medicare/coding-billing/electronic-billing · Medicare Claims Processing Manual Ch. 24