

DRAFT

HIPAA

**Health Care Eligibility/Benefit Inquiry and
Information Response Handbook
(Transaction 270/271)**

Decision Support 2000+

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**Survey and Analysis Branch
Division of State and Community Systems Development
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration**



Table of Contents

I. Introduction	3
II. Overview of the Transactions	5
III. Eligibility, Coverage, or Benefit Inquiry (270) Data Check List	10
IV. Eligibility, Coverage, or Benefit Information (271) Data Check List.....	16
V. Eligibility, Coverage, or Benefit Inquiry (270) Data Element Tables.....	26
VI. Eligibility, Coverage, or Benefit Information (271) Data Element Tables.....	76
VII. Key Terms and Important Issues.....	173
VIII. List of External Code Sources Needed for the Transactions	182



HIPAA Handbook for Benefit Enrollment and Maintenance Transaction (270/271) Decision Support 2000+

I. Introduction

The HIPAA Health Care Eligibility Benefit Inquiry and Response Transaction (270/271) is a paired transaction set comprised of two transactions: the Eligibility, Coverage, or Benefit Inquiry (270) which is used to request (inquire) information, and the Eligibility, Coverage, or Benefit Information (271), which is used to respond with coverage, eligibility, and benefit information.¹

The Eligibility Benefit Inquiry and Response transactions are designed so that inquiry submitters (information receivers) can determine

- whether an information source organization (e.g., a payer, employer, or HMO) has a particular subscriber or dependent on file, and
- the health care eligibility and/or benefit information about that subscriber and/or dependent(s).

The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits.

A wide variety of entities may use this transaction:

- insurance companies
- health maintenance organizations (HMOs)
- preferred provider organizations (PPOs)
- health care purchasers (i.e., employers)
- professional review organizations (PROs)
- social worker organizations
- health care providers (e.g., physicians, hospitals, laboratories)
- third-party administrators (TPAs)
- health care vendors (e.g., practice management vendors, billing services)
- service bureaus (VANs or VABs)

¹ These transactions are also called the Health Care Coverage, Eligibility, and Benefit Inquiry (270) and the Health Care Coverage, Eligibility, and Benefit Information (271).



- government agencies such as Medicare, Medicaid, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

Some submitters do not have access to enough information to generate an inquiry to a payer (e.g., an outside lab or pharmacy providing services to an institution) and may need to send an inquiry to the institutional provider to obtain enough information to identify the payer to which a health care eligibility or benefit inquiry should be routed. In this situation, a 270 transaction may be originated by one provider and sent to another provider.

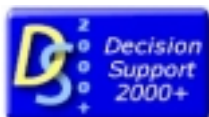
This Handbook consists of

- an overview of the structure of the transaction;
- tables of the data elements (including definitions, codes, and attributes) that constitute the transaction;
- definitions of key terms and explanations of issues for understanding the information contained in the master data set; and
- a list of external code sources need for the transaction.

The Data Tables define terms, explain usage, and provide technical specifications for the data. Section VII defines key terms and elaborates on important issues for this transaction.

Information in this Handbook is intended to provide a user-friendly summary of the data contained in the Health Care Eligibility Benefit Inquiry and Response Transaction (270/271). When referenced in conjunction with the DS2000+ Master Data Set, the Handbook will help users construct a transaction. For additional technical information not provided in these documents, users should refer to the full Implementation Guide. All information in this Handbook Set has been taken directly from the Health Care Eligibility Benefit Inquiry and Response Transaction (270/271) Implementation Guide.²

² Health Care Eligibility Benefit Inquiry and Response Transaction (270/271) Implementation Guide, ASC X12N 270/271 (004010X092), Washington Publishing Company, May 2000.



II. Overview of this Transaction

Uses of the Health Care Eligibility Benefit Inquiry and Response Transaction (270/271)

The Health Care Eligibility Benefit Inquiry and Response transactions are used to request and provide information on a person's eligibility, coverage, and benefits.

Structure of the Transaction Sets

Under HIPAA, business transactions (such as a provider asking an insurer about a patient's benefits, a sponsor sending a group of benefit enrollments to a payer or a provider submitting health care claims to a payer) are conducted through formal structures called "transaction sets". Information is transmitted as discrete data elements grouped together into segments; segments are grouped into loops (see Figure 1).

Figure 1. Loops, Segments, and Data Elements



Transaction sets all adhere to the same format: a control segment called the header segment; loops of data segments, both in specified order; and a control segment called the trailer segment. Within each data segment, the data elements also follow a specified order. Similar transaction sets, called "functional groups," can be sent together within a transmission; in this case, each transaction set has its own unique identifier that is transmitted as the first data element of the header segment.

The discussion below on data elements, segments, and loops is intended to help readers understand the structure of the transaction and the information presented in the Data Tables.

Data Elements

A data element corresponds to a data field in data processing terminology. Data elements are characterized by:

- name (e.g., "Identification Code")



- usage (e.g., required or situational [which means that the element is required only under certain circumstances]);
- reference designator (e.g., NM109, which indicates that the element is in the NM1 segment and is the ninth data element in the segment);
- number (e.g., 67); and
- attributes.

The attributes are the requirement designator in the X12 standard (i.e., mandatory [M], optional [O], relational [X]); the type of data element (e.g., Numeric [Nn], Decimal [R], Identifier [ID], String [AN], Date [DT], Time [TM], Binary [B]); and the minimum and maximum length of the data (i.e., the number of character positions used for numeric, decimal, and binary elements).

For simplicity of presentation, we use the single term “attributes” in the data tables to refer to *all* the characteristics of a data element, i.e., usage, reference designator, number, X12 requirement designator, type, and length. For the data element “subscriber identification code” these “attributes” are listed sequentially as SITUATIONAL NM109 67 X AN 2/80. In this example, the meaning of the terms is as follows:

SITUATIONAL	required only under certain circumstances
NM109	the ninth element in the NM1 segment
X	a relational element in the X12 standard
AN	a string type of element
2/80	a minimum of 2 and a maximum of 80 characters are allowed

Segments

Logically related data elements are grouped together in units called segments. There are two types of segments—control segments and data segments. These segments have the same structure, but different uses. The control segments are used to convey information about the transaction and the data segments are used to convey the information that necessitated the transaction. Transaction sets always begin and end with a control segment between which are the data segments. The control segment that begins a transaction is called the header (ST) segment and is used to identify the sender and receiver; the control segment that ends a transaction is called the trailer (SE) segment and is used for verification and security purposes. (For more information on control segments, see Section IV. Key Terms)

Each transaction set contains many segments, analogous to a freight train: the segments are like the train’s cars and each one has several data elements just as a train car might have many crates. The sequence of the data elements within one segment and the sequence of segments in the transaction set are both specified by the ASC X12 standard. In a more conventional computing environment, the segments would be equivalent to records, and the data elements equivalent to fields.



Each segment, whether a control or data segment, has its own name and its own purpose. A segment always has the same structure: it begins with a unique identifier, then has one or more logically related data elements, and ends with a segment terminator.

The Data Check List shows all the data elements within each data segment; the data segments within the transaction by segment ID, name, and usage (required or situational); and how the segments are grouped into loops.

Loops

Loops are groups of logically related data segments. The segments within a loop occur in a specified order; the first (“beginning”) segment in the loop gives the loop its name and establishes whether the loop is required or situational. If the beginning segment in a loop is required, then the loop is required; if the beginning segment is situational, the loop is situational. Loops themselves are not actually sent in a transaction—only the data segments within the loop are sent. A loop (actually, the data segments that comprise the loop) may occur once, repeat an unlimited number of times, or repeat only a specified number of times.

Loop Hierarchy

The looping structure is hierarchical—i.e., certain loops are subordinated to others. Once the hierarchy is understood, the logic of the data in the transaction becomes apparent.

Figures 2a and 2b show the hierarchical organization of the data in the transactions. First, the data are divided into two major levels or tables: Header and Detail. The Header Level, Table 1, contains transaction structure information and consists of two segments. The Detail Level, Table 2, contains specific information about the insurer, requester of information, insured, and dependents. It has four hierarchical levels, information source (Loop 2000A) for information about the insurer/payer; information receiver (Loop 2000B) for information about the medical service provider (e.g., physician, hospital, laboratory, etc.); subscriber (Loop 2000C) for information about the insured member (who may or may not be the patient); and dependent (Loop 2000D) for information about dependents of an insured member. The first two levels have two loops, a higher level loop with a subordinate loop “nested” in it. The last two levels have three nested loops. The Data Check List shows the hierarchical levels, the loops within the levels, the segments within the loops, and the data elements within the segments.



Figure 2a. Loop Hierarchy - Eligibility/Benefit Inquiry (Transaction 270)

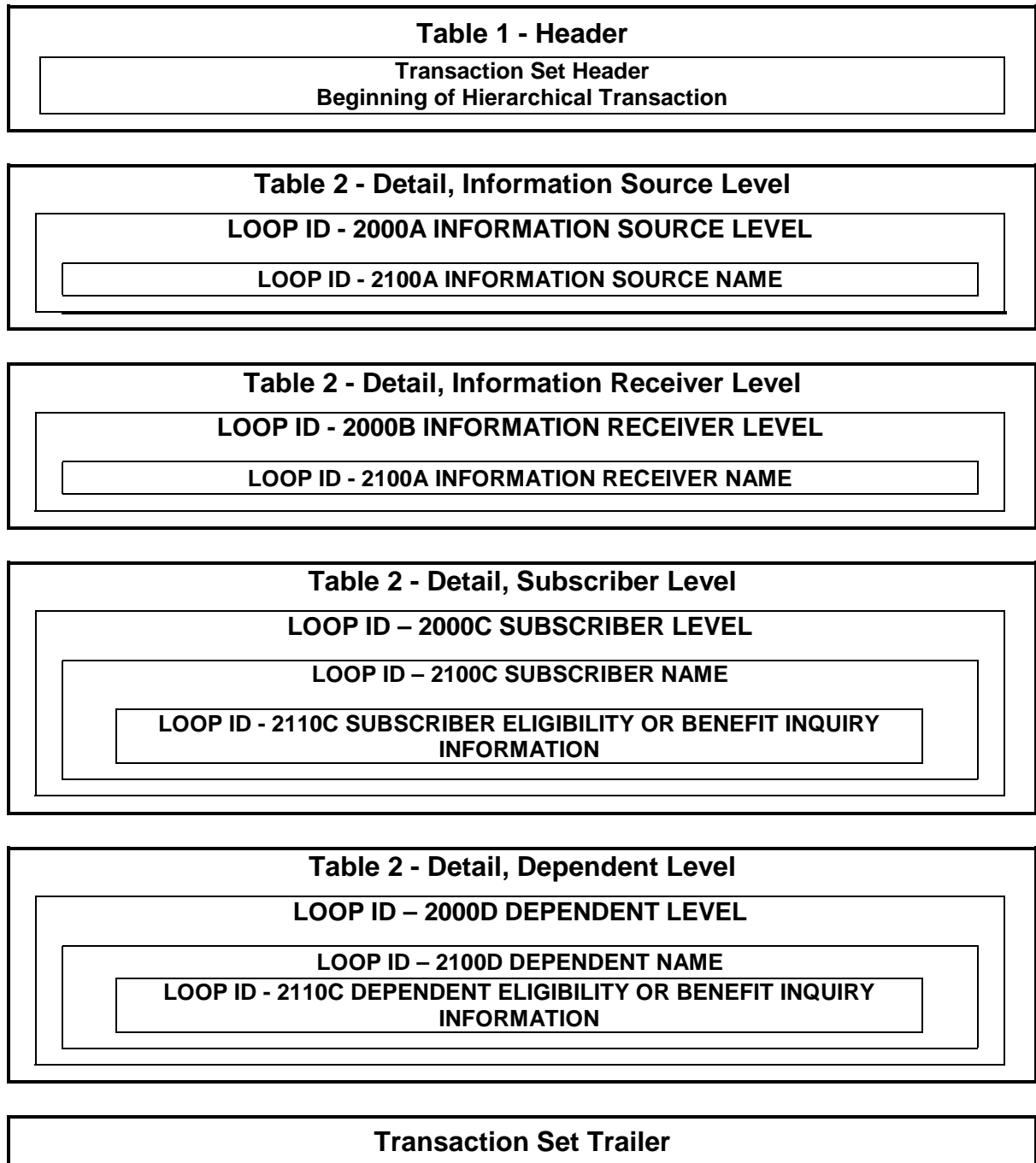
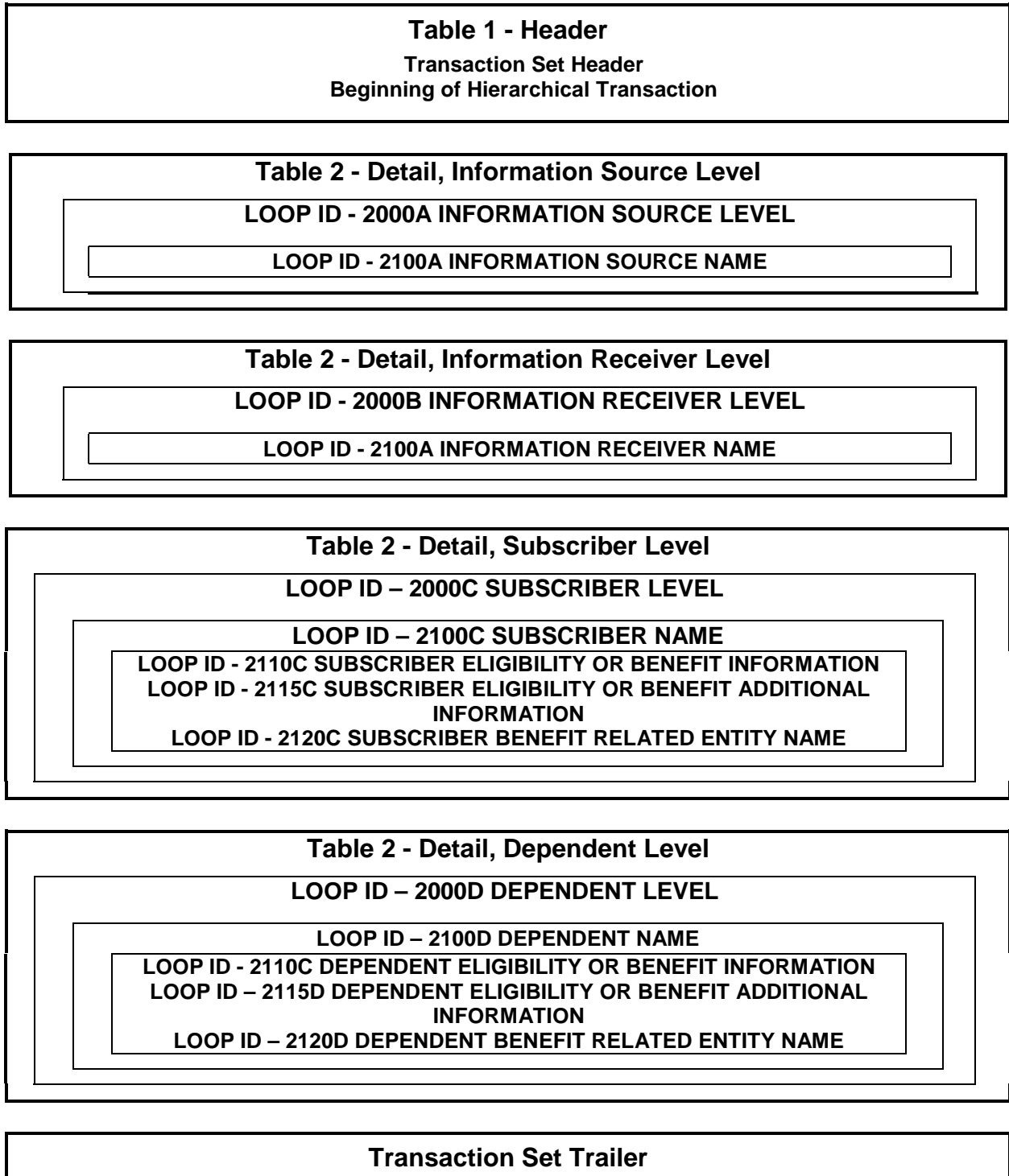


Figure 2b. Loop Hierarchy - Eligibility/Benefit Information Response (271)



III. 270 Data Check List

The Data Check List for each transaction shows the hierarchical levels, the loops within the levels, the segments within the loops, and the data elements within the segments. It helps ensure that users have or collect all the information they need to process the transaction.

Table 1 – Header		
SEG. ID	NAME	USAGE
ST	Transaction Set Header	R
	Transaction Set Identifier Code	R
	Transaction Set Control Number	R
BHT	Beginning of Hierarchical Transaction	R
	Hierarchical Structure Code	R
	Transaction Set Purpose Code	R
	Reference Identification	S
	Date	R
	Time	R
	Transaction Type Code	S

Table 2 – Detail		
LOOP 2000A INFORMATION SOURCE LEVEL		

SEG. ID	NAME	USAGE
HL	Information Source Level	R
	Hierarchical ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
LOOP 2100AA INFORMATION SOURCE NAME		
NM1	Information Source Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	R



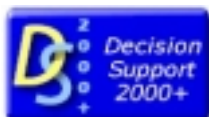
SEG. ID	NAME	USAGE
	Identification Code	R
LOOP ID 2000B INFORMATION RECEIVER LEVEL		
HL	Information Receiver Level	R
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
LOOP ID 2100B INFORMATION RECEIVER NAME		
NM1	Information Receiver Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	R
	Identification Code	R
REF	Information Receiver Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
N3	Information Receiver Address	S
	Address Information	R
	Address Information	S
N4	Information Receiver City/State/ZIP Code	S
	City Name	R
	State or Province Code	R
	Postal Code	R
	Country Code	S
PER	Information Receiver Contact Information	S
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
PRV	Information Receiver Provider Information	S
	Provider Code	R



SEG. ID	NAME	USAGE
	Reference Identification Qualifier	R
	Reference Identification	S
LOOP ID 2000C SUBSCRIBER LEVEL		
HL	Subscriber Level	R
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
TRN	Subscriber Trace Number	S
	Trace Type Code	R
	Reference Identification	R
	Originating Company Identifier	S
	Reference Identification	S
LOOP ID 2100C SUBSCRIBER NAME		
NM1	Subscriber Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	S
	Identification Code	S
REF	Subscriber Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
N3	Subscriber Address	S
	Address Information	R
	Address Information	S
N4	Subscriber City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
PRV	Provider Information	S
	Provider Code	R
	Reference Identification Qualifier	R
	Reference Identification	R
DMG	Subscriber Demographic Information	S
	Date Time Period Format Qualifier	S
	Date Time Period	S



SEG. ID	NAME	USAGE
	Gender Code	S
INS	Subscriber Relationship	S
	Yes/No Condition or Response Code	R
	Individual Relationship Code	R
	Number	R
DTP	Subscriber Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
LOOP ID 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY		
EQ	Subscriber Eligibility or Benefit Inquiry Information	S
	Service Type Code	S
	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	S
	Product/Service ID Qualifier	R
	Product/Service ID	R
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Coverage Level Code	S
	Insurance Type Code	S
AMT	Subscriber Spend Down Amount	S
	Amount Qualifier Code	R
	Monetary Amount	R
III	Subscriber Eligibility or Benefit Additional Inquiry	S
	Code List Qualifier Code	R
	Industry Code	R
REF	Subscriber Additional Information	S
	Reference Identification Qualifier	R
	Reference Identification	R
DTP	Subscriber Eligibility/Benefit Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
LOOP ID 2000D DEPENDENT LEVEL		
HL	Dependent Level	S
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R



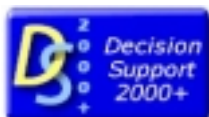
SEG. ID	NAME	USAGE
TRN	Dependent Trace Number	S
	Trace Type Code	R
	Reference Identification	R
	Originating Company Identifier	R
	Reference Identification	S
LOOP ID 2100D DEPENDENT NAME		
NM1	Dependent Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
REF	Dependent Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
N3	Dependent Address	S
	Address Information	R
	Address Information	S
N4	Dependent City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
PRV	Provider Information	S
	Provider Code	R
	Reference Identification Qualifier	R
	Reference Identification	R
DMG	Dependent Demographic Information	S
	Date Time Period Format Qualifier	S
	Date Time Period	S
	Gender Code	S



SEG. ID	NAME	USAGE
INS	Dependent Relationship	S
	Yes/No Condition or Response Code	R
	Individual Relationship Code	R
	Number	S
DTP	Dependent Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R

LOOP ID 2110D DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION

EQ	Dependent Eligibility or Benefit Inquiry Information	R
	Service Type Code	S
	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	S
	Product/Service ID Qualifier	R
	Product/Service ID	R
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Coverage Level Code	S
	Insurance Type Code	S
III	Dependent Eligibility or Benefit Additional Inquiry Information	S
	Code List Qualifier Code	R
	Industry Code	R
REF	Dependent Additional Information	S
	Reference Identification Qualifier	R
	Reference Identification	R
DTP	Dependent Eligibility/Benefit Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
SE	Transaction Set Trailer	R
	Number of Included Segments	R
	Transaction Set Control Number	R



IV. 271 Data Check List

The Data Check List for each transaction shows the hierarchical levels, the loops within the levels, the segments within the loops, and the data elements within the segments. It helps ensure that users have or collect all the information they need to process the transaction.

Table 1 – Header		
SEG. ID	NAME	USAGE
ST	Transaction Set Header	R
	Transaction Set Identifier Code	R
	Transaction Set Control Number	R
BHT	Beginning of Hierarchical Transaction	R
	Hierarchical Structure Code	R
	Transaction Set Purpose Code	R
	Reference Identification	S
	Date	R
	Time	R

Table 2 – Detail		
LOOP 2000A INFORMATION SOURCE LEVEL		

SEG. ID	NAME	USAGE
HL	Information Source Level	R
	Hierarchical ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
AAA	Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
LOOP 2100AA INFORMATION SOURCE NAME		
NM1	Information Source Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	R



SEG. ID	NAME	USAGE
	Identification Code	R
REF	Information Source Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
PER	Information Source Contact Information	S
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
AAA	Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
LOOP ID 2000B INFORMATION RECEIVER LEVEL		
HL	Information Receiver Level	S
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
LOOP ID 2100B INFORMATION RECEIVER NAME		
NM1	Information Receiver Name	R
	Entity Identifier Code	R
	Entity Identifier Code	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	R
	Identification Code	R
REF	Information Receiver Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
AAA	Request Validation	S
	Yes/No Condition or Response Code	R



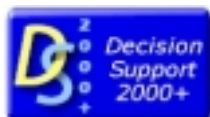
SEG. ID	NAME	USAGE
	Reject Reason Code	R
	Follow-up Action Code	R
LOOP ID 2000C SUBSCRIBER LEVEL		
HL	Subscriber Level	S
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R
	Hierarchical Level Code	R
	Hierarchical Child Code	R
TRN	Subscriber Trace Number	S
	Trace Type Code	R
	Reference Identification	R
	Originating Company Identifier	R
	Reference Identification	S
LOOP ID 2100C SUBSCRIBER NAME		
NM1	Subscriber Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Prefix	S
	Name Suffix	S
	Identification Code Qualifier	S
	Identification Code	S
REF	Subscriber Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
N3	Subscriber Address	S
	Address Information	R
	Address Information	S
N4	Subscriber City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
	Location Qualifier	S
	Location Identifier	S
PER	Subscriber Contact Information	S
	Contact Function Code	R



SEG. ID	NAME	USAGE
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
AAA	Subscriber Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
DMG	Subscriber Demographic Information	S
	Date Time Period Format Qualifier	S
	Date Time Period	S
	Gender Code	S
INS	Subscriber Relationship	S
	Yes/No Condition or Response Code	R
	Individual Relationship Code	R
	Maintenance Type Code	S
	Maintenance Reason Code	S
	Student Status Code	S
	Yes/No Condition or Response Code	S
	Number	S
DTP	Subscriber Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
LOOP ID 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION		
EB	Subscriber Eligibility or Benefit Inquiry Information	S
	Eligibility or Benefit Information	R
	Coverage Level Code	S
	Service Type Code	S
	Insurance Type Code	S
	Plan Coverage Description	S
	Time Period Qualifier	S
	Monetary Amount	S
	Percent	S
	Quantity Qualifier	S
	Quantity	S



SEG. ID	NAME	USAGE
	Yes/No Condition or Response Code	S
	Yes/No Condition or Response Code	S
	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	S
	Product/Service ID Qualifier	R
	Product/Service ID	R
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
HSD	Health Care Services Delivery	S
	Quantity Qualifier	S
	Quantity	S
	Unit or Basis for Measurement Code	S
	Sample Selection Modulus	S
	Time Period Qualifier	S
	Number of Periods	S
	Ship/Delivery or Calendar Pattern Code	S
	Ship/Delivery Pattern Time Code	S
REF	Subscriber Additional Information	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
DTP	Subscriber Eligibility/Benefit Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
AAA	Subscriber Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
MSG	Message Text	S
	Free-Form Message Text	R
LOOP ID 2115C SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION		
III	Subscriber Eligibility or Benefit Additional Information	S
	Code List Qualifier Code	R
	Industry Code	R
LS	Loop Header	S
	Loop Identifier Code	R



SEG. ID	NAME	USAGE
LOOP ID 2120C SUBSCRIBER BENEFIT RELATED ENTITY NAME		
NM1	Subscriber Benefit Related Entity Name	S
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	S
	Identification Code	S
N3	Subscriber Benefit Related Entity Address	S
	Address Information	R
	Address Information	S
N4	Subscriber Benefit Related City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
	Location Qualifier	S
	Location Identifier	S
PER	Subscriber Benefit Related Entity Contact Information	S
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
PRV	Subscriber Benefit Related Provider Information	S
	Provider Code	R
	Reference Identification Qualifier	R
	Reference Identification	R
LE	Loop Trailer	S
	Loop Identifier Code	R
LOOP ID 2000D DEPENDENT LEVEL		
HL	Dependent Level	S
	Hierarchical ID Number	R
	Hierarchical Parent ID Number	R



SEG. ID	NAME	USAGE
	Hierarchical Level Code	R
	Hierarchical Child Code	R
TRN	Dependent Trace Number	S
	Trace Type Code	R
	Reference Identification	R
	Originating Company Identifier	R
	Reference Identification	S
LOOP ID 2100D DEPENDENT NAME		
NM1	Dependent Name	R
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S
	Identification Code Qualifier	S
	Identification Code	S
REF	Dependent Name	S
	Reference Identification Qualifier	R
	Reference Identifier Code	R
	Reference Identification	R
	Description	S
N3	Dependent Address	S
	Address Information	R
	Address Information	S
N4	Dependent City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
PER	Dependent Contact Information	S
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S



SEG. ID	NAME	USAGE
AAA	Dependent Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
DMG	Dependent Demographic Information	S
	Date Time Period Format Qualifier	S
	Date Time Period	S
	Gender Code	S
INS	Dependent Relationship	S
	Yes/No Condition or Response Code	R
	Individual Relationship Code	R
	Maintenance Type Code	S
	Maintenance Reason Code	S
	Student Status Code	S
	Yes/No Condition or Response Code	S
	Number	S
DTP	Dependent Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
LOOP ID 2110D DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION		
EB	Dependent Eligibility or Benefit Information	R
	Eligibility or Benefit Information	R
	Coverage Level Code	S
	Service Type Code	S
	Insurance Type Code	S
	Plan Coverage Description	S
	Time Period Qualifier	S
	Monetary Amount	S
	Percent	S
	Quantity Qualifier	S
	Quantity	S
	Yes/No Condition or Response Code	S
	Yes/No Condition or Response Code	S
	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	S
	Product/Service ID Qualifier	R
	Product/Service	R
	Procedure Modifier	S
	Procedure Modifier	S



SEG. ID	NAME	USAGE
	Procedure Modifier	S
	Procedure Modifier	S
HSD	Health Care Services Delivery	S
	Quantity Qualifier	S
	Quantity	S
	Unit or Basis for Measurement Code	S
	Sample Selection Modulus	S
	Time Period Qualifier	S
	Number of Periods	S
	Ship/Delivery or Calendar Pattern Code	S
	Ship/Delivery Pattern Time Code	S
REF	Dependent Additional Identification	S
	Reference Identification Qualifier	R
	Reference Identification	R
	Description	S
DTP	Dependent Eligibility/Benefit Date	S
	Date/Time Qualifier	R
	Date Time Period Format Qualifier	R
	Date Time Period	R
AAA	Dependent Request Validation	S
	Yes/No Condition or Response Code	R
	Reject Reason Code	R
	Follow-up Action Code	R
MSG	Message Text	S
	Free-Form Message Text	R
LOOP ID 2115D DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION		
III	Dependent Eligibility or Benefit Additional Information	S
	Code List Qualifier Code	R
	Industry Code	R
LS	Dependent Eligibility or Benefit Information	S
	Loop Identifier Code	R
LOOP ID 2120D DEPENDENT BENEFIT RELATED ENTITY NAME		
NM1	Dependent Benefit Related Entity Name	S
	Entity Identifier Code	R
	Entity Type Qualifier	R
	Name Last or Organization Name	S
	Name First	S
	Name Middle	S
	Name Suffix	S



SEG. ID	NAME	USAGE
	Identification Code Qualifier	S
	Identification Code	S
N3	Dependent Benefit Related Entity Address	S
	Address Information	R
	Address Information	S
N4	Dependent Benefit Related Entity City/State/ZIP Code	S
	City Name	S
	State or Province Code	S
	Postal Code	S
	Country Code	S
	Location Qualifier	S
	Location Identifier	S
PER	Dependent Benefit Related Entity Contact Information	S
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
PRV	Dependent Benefit Related Provider Information	S
	Provider Code	R
	Reference Identification Qualifier	R
	Reference Identification	R
LE	Loop Trailer	S
	Loop Identifier Code	R
SE	Transaction Set Trailer	R
	Number of Included Segments	R
	Transaction Set Control Number	R



V. 270 Data Element Tables

The Data Element Tables give the purpose and definition, codes, and technical specifications for all the data elements in the Health Care Eligibility, Coverage, or Benefit Inquiry (270) Transaction. Section VII below explains and defines key terms. Readers should refer to the Implementation Guide for additional technical information.

TRANSACTION SET HEADER (ST)

REQUIRED

Marks the start of a transaction set and assigns a control number.

Name	Transaction Set Identifier Code
Purpose/Definition	Identifies this transaction is a 270 Eligibility, Coverage or Benefit Inquiry.
Codes	270 Eligibility, Coverage or Benefit Inquiry.
Attributes	REQUIRED ST01 143 M ID 3/3

Name	Transaction Set Control Number
Purpose/Definition	Unique control number for a transaction set assigned by the originator.
Codes	
Attributes	REQUIRED ST02 329 M AN 4/9

BEGINNING OF HIERARCHICAL TRANSACTION (BHT)

REQUIRED

Used to start the transaction set and indicate the sequence of the information that will follow.

Name	Hierarchical Structure Code
Purpose/Definition	Indicates the hierarchical structure of the transaction set (i.e., the order of information contained in the transaction).
Codes	0022 Information Source, Information Receiver, Subscriber, Dependent
Attributes	REQUIRED BHT01 1005 M ID 4/4



Name	Transaction Set Purpose Code
Purpose/Definition	Identifies the purpose of transaction set
Codes	01 Cancellation 13 Request 36 Authority to Deduct (Reply)
Attributes	REQUIRED BHT02 353 M ID 2/2

Name	Reference Identification
Purpose/Definition	Indicates the number assigned by the originator to identify the transaction within the originator's business application system.
Codes	
Attributes	SITUATIONAL BHT03 127 O AN 1/30

Name	Date
Purpose/Definition	Indicates the date the transaction was created within the business originator's application system.
Codes	
Attributes	REQUIRED BHT04 373 O DT 8/8

Name	Time
Purpose/Definition	Indicates the time the transaction set was generated.
Codes	
Attributes	REQUIRED BHT05 337 O TM 4/8

Name	Transaction Type Code
Purpose/Definition	Indicates the type of transaction.
Codes	RT Spend Down RU Medical Services Reservation
Attributes	SITUATIONAL BHT06 640 O ID 2/2



LOOP 2000A INFORMATION SOURCE LEVEL

INFORMATION SOURCE LEVEL (HL)

REQUIRED

Identifies the relationship between hierarchically related groups of data segments and indicates that the series of segments from this Hierarchical Level (HL) segment until the next HL segment are related to the information source.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates that the series of segments from this HL segment until the next occurrence of an HL segment are related to the information source.
Codes	20 Information Source
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	1 Additional Subordinate HL Data Segment in This Hierarchical Structure
Attributes	REQUIRED HL04 736 O ID 1/1



LOOP 2100A INFORMATION SOURCE NAME

INFORMATION SOURCE NAME (NMI)

REQUIRED

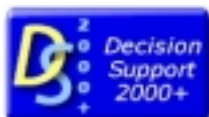
Identifies the eligibility or benefit information source.

Name	Entity Identifier Code
Purpose/Definition	Identifies the information source.
Codes	2B Third-Party Administrator 36 Employer GP Gateway Provider P5 Plan Sponsor PR Payer
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Identifies whether the information source is a person or an organization.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Information source last name or organizational name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Information source first name. Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

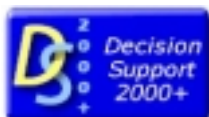


Name	Name Middle
Purpose/Definition	Information source middle name or initial. Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to Information source name. Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Designates the system/method of code structure used for the Identification Code in NM108.
Codes	24 Employer's Identification Number 46 Electronic Transmitter Identification Number (ETIN) FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification XV Health Care Financing Administration National PlanID XX Health Care Financing Administration National Provider Identifier
Attributes	REQUIRED NM108 66 X ID 1/2

Name	Identification Code
Purpose/Definition	Information source ID code as qualified by the preceding data element (NM108).
Codes	
Attributes	REQUIRED NM109 67 X AN 2/80



LOOP 2000B INFORMATION RECEIVER LEVEL

INFORMATION RECEIVER LEVEL (HL)

REQUIRED

Identifies the relationship between the hierarchically related groups of data segments in the Information Receiver level, and indicates that the series of segments from this Hierarchical Level (HL) segment until the next HL segment are related to the information receiver.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Parent ID Number
Purpose/Definition	Identification number of the next higher hierarchical data segment that this data segment is subordinate to.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates that the series of segments from this HL segment until the next occurrence of an HL segment are related to the information receiver.
Codes	21 Information Receiver
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	1 Additional Subordinate HL Data Segment in This Hierarchical Structure
Attributes	REQUIRED HL04 736 O ID 1/1



LOOP 2100B INFORMATION RECEIVER NAME

INFORMATION RECEIVER NAME (NMI)

REQUIRED

Identifies the eligibility/benefit information receiver (e.g., provider, medical group, employer, IPA, or hospital).

Name	Entity Identifier Code
Purpose/Definition	Code identifying the information receiver.
Codes	1P Provider 2B Third-Party Administrator 36 Employer 80 Hospital FA Facility GP Gateway Provider P5 Plan Sponsor PR Payer
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Indicates whether the information receiver is an individual or an organization.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Information receiver last name or organizational name. Use only if this information is needed to identify the receiver of eligibility or benefit information.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

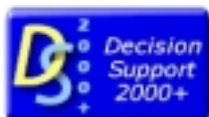


Name	Name First
Purpose/Definition	Information receiver first name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Information receiver middle name or initial. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to Information receiver name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Indicates the type of code used for the information receiver in NM108.
Codes	24 Employer's Identification Number 34 Social Security Number FI Federal Taxpayer's Identification Number PI Payor Identification PP Pharmacy Processor Number SV Service Provider Number XX Health Care Financing Administration National Provider Identifier
Attributes	REQUIRED NM108 66 X ID ½

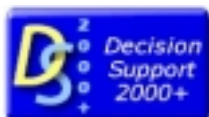


Name	Identification Code
Purpose/Definition	Code identifying the Information receiver.
Codes	
Attributes	REQUIRED NM109 67 X AN 2/80

INFORMATION RECEIVER ADDITIONAL IDENTIFICATION (REF) SITUATIONAL
Specifies additional identification numbers for the information receiver when needed.

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of code used for the information receiver in REF02.
Codes	0B State License Number 1C Medicare Provider Number 1J Facility ID Number 4A Personal Identification Number (PIN) CT Contract Number EL Electronic device pin number EO Submitter Identification Number HPI Health Care Financing Administration National Provider Identifier The Health Care Financing Administration National Provider Identifier may be used in this segment prior to being mandated for use JD User Identification N5 Provider Plan Network Identification Number N7 Facility Network Identification Number Q4 Prior Identifier Number SY Social Security Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Information receiver additional identifier
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30



Name	Description
Purpose/Definition	The two-character state ID of the state assigning the State License Number, if this code is used in REF02.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

INFORMATION RECEIVER ADDRESS (N3)

SITUATIONAL

Used if the information receiver is a provider who has multiple locations and the information is needed to identify the location relative to the request.

Name	Address Information
Purpose/Definition	Indicates the first line of the information receiver address information.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

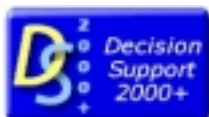
Name	Address Information
Purpose/Definition	Indicates the second line of the information receiver address information if a second address line exists.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

INFORMATION RECEIVER CITY/STATE/ZIP CODE (N4)

SITUATIONAL

Use this segment if the information receiver is a provider who has multiple locations and it is needed to identify the location relative to the request.

Name	City Name
Purpose/Definition	Free-form text for information receiver city name.
Codes	
Attributes	REQUIRED N401 19 O AN 2/30



Name	State or Province Code
Purpose/Definition	Information receiver State/Province code if located in the U.S. or Canada.
Codes	
Attributes	REQUIRED N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	Identifies the international postal zone code (zip code for United States).
Codes	
Attributes	REQUIRED N403 116 O ID 3/15

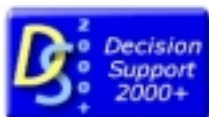
Name	Country Code
Purpose/Definition	Specifies the country of the information receiver's address, if other than the United States.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

INFORMATION RECEIVER CONTACT INFORMATION (PER)

SITUATIONAL

To identify a contact name and/or communications number for the information receiver. The segment allows for three contact numbers to be listed (e.g., telephone, extension, fax, EDI, or E-mail). If a telephone extension is sent, it should always be the communications number following the actual phone number.

Name	Contact Function Code
Purpose/Definition	Code identifying the major duty or responsibility of the person in PER02.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2

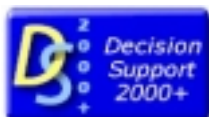


Name	Name
Purpose/Definition	Name to use when contacting the information receiver.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER04.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER06
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
Attributes	SITUATIONAL PER05 365 X ID 2/2



Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER08.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
Attributes	SITUATIONAL PER07 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80

INFORMATION RECEIVER PROVIDER INFORMATION (PRV) SITUATIONAL

To convey additional information about a provider's role in the eligibility/benefit being inquired about, if the Information Receiver is also the Provider.

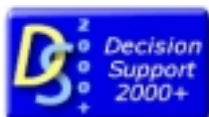
Name	Provider Code
Purpose/Definition	Code identifying the type of provider.



Codes	AD Admitting AT Attending BI Billing CO Consulting CV Covering H Hospital HH Home Health Care LA Laboratory OT Other Physician P1 Pharmacist P2 Pharmacy PC Primary Care Physician PE Performing R Rural Health Clinic RF Referring SB Submitting SK Skilled Nursing Facility SU Supervising
Attributes	REQUIRED PRV01 1221 M ID 1/3

Name	Reference Identification Qualifier
Purpose/Definition	Indicates the provider ID in PRV03 is from the “Health Care Provider Taxonomy” code list .
Codes	ZZ Mutually Defined
Attributes	REQUIRED PRV02 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Indicates the Provider ID.
Codes	
Attributes	REQUIRED PRV03 127 M AN 1/30



LOOP 2000C SUBSCRIBER LEVEL

SUBSCRIBER LEVEL (HL)

REQUIRED

Identifies the relationship between the groups of data segments in the subscriber level and indicates that the segments from this Hierarchical Level (HL) segment until the next HL segment are related to the subscriber.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Parent ID Number
Purpose/Definition	Identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the subscriber.
Codes	22 Subscriber
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	0 No Subordinate HL Segment in This Hierarchical Structure 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.
Attributes	REQUIRED HL04 736 O ID 1/1



SUBSCRIBER TRACE NUMBER (TRN)**SITUATIONAL**

Trace numbers assigned at the subscriber level are intended to allow tracing of an eligibility/benefit transaction when the subscriber is the patient.

Name	Trace Type Code
Purpose/Definition	Code identifying the number in TRN02 is the trace code.
Codes	1 Current Transaction Trace Numbers
Attributes	REQUIRED TRN01 481 M ID 1/2

Name	Reference Identification
Purpose/Definition	Identifies the trace or reference number assigned to the transaction.
Codes	
Attributes	REQUIRED TRN02 127 M AN 1/30

Name	Originating Company Identifier
Purpose/Definition	The unique identifier of the company assigning the trace number.
Codes	
Attributes	REQUIRED TRN03 509 O AN 10/10

Name	Reference Identification
Purpose/Definition	Identifies a further subdivision within the organization assigning the trace number.
Codes	
Attributes	SITUATIONAL TRN04 127 O AN 1/30



LOOP 2100C SUBSCRIBER NAME

SUBSCRIBER NAME (NMI)

REQUIRED

To supply the full name of the insured or subscriber.

Name	Entity Identifier Code
Purpose/Definition	Identifies that the individual in this segment is the insured or subscriber.
Codes	IL Insured or Subscriber
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Indicates whether the Insured or Subscriber is an individual or an organization.
Codes	1 Person
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Subscriber last name. Use if the subscriber is the patient and if utilizing the HIPAA search option.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Subscriber first name. Use if the subscriber is the patient and if utilizing the HIPAA search option.
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Subscriber middle name or initial.
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25



Name	Name Suffix
Purpose/Definition	Suffix to Subscriber's name.
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Designates the system/method of code structure used for Identification Code of the Subscriber in NM109
Codes	MI Member Identification Number ZZ Mutually Defined
Attributes	SITUATIONAL NM108 66 X ID 1/2

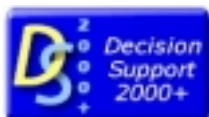
Name	Identification Code
Purpose/Definition	Indicates the subscriber primary identification number.
Codes	
Attributes	SITUATIONAL NM109 67 X AN 2/80

SUBSCRIBER ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

To convey additional subscriber identification numbers.

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of reference number that is used in REF02.
Codes	18 Plan Number 1L Group or Policy Number 1W Member Identification Number 49 Family Unit Number 6P Group Number A6 Employee Identification Number CT Contract Number EA Medical Record Identification Number EJ Patient Account Number F6 Health Insurance Claim (HIC) Number GH Identification Card Serial Number HJ Identity Card Number



	IG Insurance Policy Number N6 Plan Network Identification Number NQ Medicaid Recipient Identification Number SY Social Security Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Indicates the subscriber's supplemental identifier.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

SUBSCRIBER ADDRESS (N3)

SITUATIONAL

Specifies the address information for the subscriber if this information is known and will assist in identification of the subscriber..

Name	Address Information
Purpose/Definition	First line of the subscriber address information.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

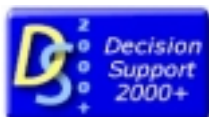
Name	Address Information
Purpose/Definition	Second line of subscriber address information.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

SUBSCRIBER CITY/STATE/ZIP CODE (N4)

SITUATIONAL

To specify the city, state, and ZIP code for the subscriber if this information is known and will assist in identification of the subscriber.

Name	City Name
Purpose/Definition	
Codes	Free-form text for city name.
Attributes	SITUATIONAL N401 19 O AN 2/30



Name	State or Province Code
Purpose/Definition	State/Province code if city name (N401) is in the U.S. or Canada.
Codes	
Attributes	SITUATIONAL N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	International postal zone code (zip code for United States).
Codes	
Attributes	SITUATIONAL N403 116 O ID 3/15

Name	Country Code
Purpose/Definition	Specifies the country of the subscriber's address, if other than the United States.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

PROVIDER INFORMATION (PRV)

SITUATIONAL

Used to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver, or to identify the provider ID numbers.

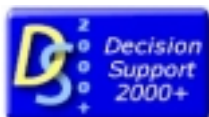
Name	Provider Code
Purpose/Definition	Identifies the type of provider.
Codes	AD Admitting AT Attending BI Billing CO Consulting CV Covering H Hospital HH Home Health Care LA Laboratory OT Other Physician



	P1 Pharmacist P2 Pharmacy PC Primary Care Physician PE Performing R Rural Health Clinic RF Referring SB Submitting SK Skilled Nursing Facility SU Supervising
Attributes	REQUIRED PRV01 1221 M ID 1/3

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of code used for the provider ID or specialty in PRV03.
Codes	9K Servicer D3 National Association of Boards of Pharmacy Number EI Employer's Identification Number HPI Health Care Financing Administration National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number ZZ Mutually Defined
Attributes	REQUIRED PRV02 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Provider or specialty code as qualified by the preceding data element (PRV02).
Codes	
Attributes	REQUIRED PRV03 127 M AN 1/30



SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)**SITUATIONAL**

Supplies birth date or gender information for the subscriber.

Name	Date Time Period Format Qualifier
Purpose/Definition	Code indicating the date format of the date of birth that follows in DMG02.
Codes	D8 Date Expressed in Format CCYYMMDD
Attributes	SITUATIONAL DMG01 1250 X ID 2/3

Name	Date Time Period
Purpose/Definition	Subscriber birth date.
Codes	
Attributes	SITUATIONAL DMG02 1251 X AN 1/35

Name	Gender Code
Purpose/Definition	Subscriber gender
Codes	F Female M Male
Attributes	SITUATIONAL DMG03 1068 O ID 1/1

SUBSCRIBER RELATIONSHIP (INS)**SITUATIONAL**

Provides benefit information if it is necessary to identify the birth sequence of the subscriber in the case of multiple births with the same birth date.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the insured is the subscriber:
Codes	Y Yes
Attributes	REQUIRED INS01 1073 M ID 1/1



Name	Individual Relationship Code
Purpose/Definition	Indicates the relationship between the subscriber and the insured.
Codes	18 Self
Attributes	REQUIRED INS02 1069 M ID 2/2

Name	Number
Purpose/Definition	Identifies the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.).
Codes	
Attributes	REQUIRED INS17 1470 O N0 1/9

SUBSCRIBER DATE (DTP)

SITUATIONAL

Conveys the eligibility, service or admission date(s) for the subscriber or the issue date of the subscriber's identification card for the information source (e.g., Medicaid ID card).

Name	Date/Time Qualifier
Purpose/Definition	Specifies the type of date in DTP03.
Codes	102 Issue 307 Eligibility 435 Admission 472 Service
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3



Name	Date Time Period
Purpose/Definition	Indicates the date, or date(s), as qualified by DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

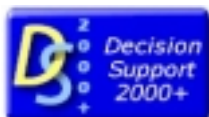
LOOP 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION

SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION (EQ)

SITUATIONAL

Indicates the beginning of the eligibility/benefit inquiry loop which is used when the subscriber is the patient whose eligibility or benefits are being verified.

Name	Service Type Code
Purpose/Definition	Identifies the classification of service for which an inquiry is being submitted.
Codes	<ul style="list-style-type: none"> 1 Medical Care 2 Surgical 3 Consultation 4 Diagnostic X-Ray 5 Diagnostic Lab 6 Radiation Therapy 7 Anesthesia 8 Surgical Assistance 9 Other Medical 10 Blood Charges 11 Used Durable Medical Equipment 12 Durable Medical Equipment Purchase 13 Ambulatory Service Center Facility 14 Renal Supplies in the Home 15 Alternate Method Dialysis 16 Chronic Renal Disease (CRD) Equipment 17 Pre-Admission Testing 18 Durable Medical Equipment Rental 19 Pneumonia Vaccine



	<p>20 Second Surgical Opinion</p> <p>21 Third Surgical Opinion</p> <p>22 Social Work</p> <p>23 Diagnostic Dental</p> <p>24 Periodontics</p> <p>25 Restorative</p> <p>26 Endodontics</p> <p>27 Maxillofacial Prosthetics</p> <p>28 Adjunctive Dental Services</p> <p>30 Health Benefit Plan Coverage</p> <p>32 Plan Waiting Period</p> <p>33 Chiropractic</p> <p>34 Chiropractic Office Visits</p> <p>35 Dental Care</p> <p>36 Dental Crowns</p> <p>37 Dental Accident</p> <p>38 Orthodontics</p> <p>39 Prosthodontics</p> <p>40 Oral Surgery</p> <p>41 Routine (Preventive) Dental</p> <p>42 Home Health Care</p> <p>43 Home Health Prescriptions</p> <p>44 Home Health Visit</p> <p>45 Hospice</p> <p>46 Respite Care</p> <p>47 Hospital</p> <p>48 Hospital - Inpatient</p> <p>49 Hospital - Room and Board</p> <p>50 Hospital - Outpatient</p> <p>51 Hospital - Emergency Accident</p> <p>52 Hospital - Emergency Medical</p> <p>53 Hospital - Ambulatory Surgical</p> <p>54 Long Term Car</p> <p>55 Major Medical</p> <p>56 Medically Related Transportation</p> <p>57 Air Transportation</p> <p>58 Cabulance</p>
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	<p>59 Licensed Ambulance</p> <p>60 General Benefits</p> <p>61 In-vitro Fertilization</p> <p>62 MRI/CAT Scan</p> <p>63 Donor Procedures</p> <p>64 Acupuncture</p> <p>65 Newborn Car</p> <p>66 Pathology</p> <p>67 Smoking Cessation</p> <p>68 Well Baby Care</p> <p>69 Maternity</p> <p>70 Transplant</p> <p>71 Audiology Exam</p> <p>72 Inhalation Therapy</p> <p>73 Diagnostic Medical</p> <p>74 Private Duty Nursing</p> <p>75 Prosthetic Device</p> <p>76 Dialysis</p> <p>77 Otological Exam</p> <p>78 Chemotherapy</p> <p>79 Allergy Testing</p> <p>80 Immunizations</p> <p>81 Routine Physical</p> <p>82 Family Planning</p> <p>83 Infertility</p> <p>84 Abortion</p> <p>85 AIDS</p> <p>86 Emergency Services</p> <p>87 Cancer</p> <p>88 Pharmacy</p> <p>89 Free Standing Prescription Drug</p> <p>90 Mail Order Prescription Drug</p> <p>91 Brand Name Prescription Drug</p> <p>92 Generic Prescription Drug</p> <p>93 Podiatry</p> <p>94 Podiatry - Office Visits</p> <p>95 Podiatry - Nursing Home Visits</p>
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	<p>96 Professional (Physician) 97 Anesthesiologist 98 Professional (Physician) Visit - Office 99 Professional (Physician) Visit - Inpatient A0 Professional (Physician) Visit - Outpatient A1 Professional (Physician) Visit - Nursing Home A2 Professional (Physician) Visit - Skilled Nursing Facility A3 Professional (Physician) Visit - Home A4 Psychiatric A5 Psychiatric - Room and Board A6 Psychotherapy A7 Psychiatric – Inpatient A8 Psychiatric - Outpatient A9 Rehabilitation AA Rehabilitation - Room and Board AB Rehabilitation - Inpatient AC Rehabilitation - Outpatient AD Occupational Therapy AE Physical Medicine AF Speech Therapy AG Skilled Nursing Care AH Skilled Nursing Care - Room and Board AI Substance Abuse AJ Alcoholism AK Drug Addiction AL Vision (Optometry) AM Frames AN Routine Exam AO Lenses AQ Nonmedically Necessary Physical AR Experimental Drug Therapy BA Independent Medical Evaluation BB Partial Hospitalization (Psychiatric) BC Day Care (Psychiatric) BD Cognitive Therapy BE Massage Therapy BF Pulmonary Rehabilitation</p>
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	BG Cardiac Rehabilitation BH Pediatric BI Nursery BJ Skin BK Orthopedic BL Cardiac BM Lymphatic BN Gastrointestinal BP Endocrine BQ Neurology BR Eye BS Invasive Procedures
Attributes	SITUATIONAL EQ01 1365 X ID 1/2

Name	COMPOSITE MEDICAL PROCEDURE IDENTIFIER
Purpose/Definition	Identifies a medical procedure (and any applicable modifiers) for which an inquiry is being submitted. Not used if EQ01 is used.
Codes	
Attributes	SITUATIONAL EQ02 C003 X

Name	Product/Service ID Qualifier
Purpose/Definition	Identifies the type or source of the descriptive number used in EQ02-2
Codes	AD American Dental Association Codes CJ Current Procedural Terminology (CPT) Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code ND National Drug Code (NDC) ZZ Mutually Defined NOT ADVISED
Attributes	REQUIRED EQ02 - 1 235 M ID 2/2



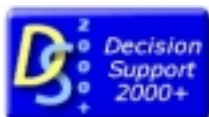
Name	Product/Service ID
Purpose/Definition	Identifying number for the procedure for which an inquiry is being submitted.
Codes	
Attributes	REQUIRED EQ02 - 2 234 M AN 1/48

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier required to further specify the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 3 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier required to further specify the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 4 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier required to further specify the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 5 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier required to further specify the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 6 1339 O AN 2/2



Name	Coverage Level Code
Purpose/Definition	Indicates which individuals are covered by the insurance plan.
Codes	CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
Attributes	SITUATIONAL EQ03 1207 O ID 3/3

Name	Insurance Type Code
Purpose/Definition	Identifies the specific type of insurance the inquiry applies to, if the information source has multiple insurance lines that apply to the person being inquired about.
Codes	AP Auto Insurance Policy CO Consolidated Omnibus Budget Reconciliation Act (COBRA) GP Group Policy HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) - Medicare Risk IP Individual Policy MA Medicare Part A MB Medicare Part B MC Medicaid PR Preferred Provider Organization (PPO) PS Point of Service (POS) SP Supplemental Policy WC Workers Compensation
Attributes	SITUATIONAL EQ04 1336 O ID 1/3



SUBSCRIBER SPEND DOWN AMOUNT (AMT)**SITUATIONAL**

Used when necessary to report a Spend Down amount. Under certain Medicaid programs, individuals must indicate the dollar amount that they wish to apply towards their deductible.

Name	Amount Qualifier Code
Purpose/Definition	Qualifies the amount in AMT02.
Codes	R Spend Down
Attributes	REQUIRED AMT01 522 M ID 1/3

Name	Monetary Amount
Purpose/Definition	Specifies the dollar spend down amount associated with this inquiry.
Codes	
Attributes	REQUIRED AMT02 782 M R 1/18

SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION (III)**SITUATIONAL**

Identifies diagnosis and/or facility type as they relate to the service or procedure for which an inquiry is being submitted.

Name	Code List Qualifier Code
Purpose/Definition	Identifies whether the code in III02 is a principal diagnosis code, a diagnosis code, or a facility type code.
Codes	BF Diagnosis BK Principal Diagnosis ZZ Mutually Defined
Attributes	REQUIRED III01 1270 X ID 1/3

Name	Industry Code
Purpose/Definition	Identifies the diagnosis code from ICD-9-CM or the Facility Type Code from external code source 237 for which an inquiry is being submitted.
Codes	
Attributes	REQUIRED III02 1271 X AN 1/30



SUBSCRIBER ADDITIONAL INFORMATION (REF)**SITUATIONAL**

To identify referral or prior authorization numbers for the subscriber when it is necessary for the benefit being inquired about.

Name	Reference Identification Qualifier
Purpose/Definition	Specifies the reference number in REF02 is the Referral Number or Prior Authorization Number.
Codes	9F Referral Number G1 Prior Authorization Number
Attributes	REQUIRED REF01 128 M ID 2/3

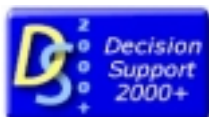
Name	Reference Identification
Purpose/Definition	Referral or prior authorization number
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

SUBSCRIBER ELIGIBILITY/BENEFIT DATE (DTP)**SITUATIONAL**

Specifies eligibility, admission, or service dates for the benefit being inquired about.

Name	Date/Time Qualifier
Purpose/Definition	Specifies the type of date in DTP03.
Codes	307 Eligibility 435 Admission 472 Service
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3



Name	Date Time Period
Purpose/Definition	The eligibility, admission, or service dates for the benefit being inquired about
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

LOOP 2000D DEPENDENT LEVEL

DEPENDENT LEVEL (HL)

SITUATIONAL

Identifies the relationship between hierarchically related groups of data segments and indicates that the series of segments from this Hierarchical Level (HL) segment until the next HL segment are related to the dependent.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Parent ID Number
Purpose/Definition	Identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the dependent.
Codes	23 Dependent
Attributes	REQUIRED HL03 735 M ID 1/2



Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	0 No Subordinate HL Segment in This Hierarchical Structure.
Attributes	REQUIRED HL04 736 O ID 1/1

DEPENDENT TRACE NUMBER (TRN)

SITUATIONAL

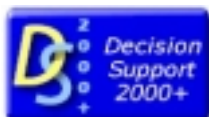
Trace numbers assigned at the dependent level are intended to allow tracing of an eligibility/benefit transaction when the dependent is the patient.

Name	Trace Type Code
Purpose/Definition	Code identifying the number in TRN02 is the transaction trace code.
Codes	1 Current Transaction Trace Numbers
Attributes	REQUIRED TRN01 481 M ID 1/2

Name	Reference Identification
Purpose/Definition	Identifies the dependent trace number assigned to the transaction.
Codes	
Attributes	REQUIRED TRN02 127 M AN 1/30

Name	Originating Company Identifier
Purpose/Definition	Identifies the organization assigning the trace number.
Codes	
Attributes	REQUIRED TRN03 509 O AN 10/10

Name	Reference Identification
Purpose/Definition	Identifies a further subdivision within the organization assigning the trace number.
Codes	
Attributes	SITUATIONAL TRN04 127 O AN 1/30



LOOP 2100D DEPENDENT NAME

DEPENDENT NAME (NMI)

REQUIRED

To identify the dependent of an insured or subscriber.

Name	Entity Identifier Code
Purpose/Definition	Code identifying the individual in this segment is the dependent.
Codes	03 Dependent
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Qualifies that the dependent is a person.
Codes	1 Person
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Dependent last name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Dependent first name.
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Dependent middle name or initial.
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25



Name	Name Suffix
Purpose/Definition	Suffix to dependent name.
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

DEPENDENT ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

Conveys identification numbers for the dependent.

Name	Reference Identification Qualifier
Purpose/Definition	Indicates the type of dependent identification number in REF02.
Codes	18 Plan Number 1L Group or Policy Number 6P Group Number A6 Employee Identification Number CT Contract Number EA Medical Record Identification Number EJ Patient Account Number F6 Health Insurance Claim (HIC) Number GH Identification Card Serial Number HJ Identity Card Number IF Issue Number IG Insurance Policy Number N6 Plan Network Identification Number SY Social Security Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Dependent supplemental ID code.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30



DEPENDENT ADDRESS (N3)**SITUATIONAL**

Specifies the address information for the dependent.

Name	Address Information
Purpose/Definition	The first line of the dependent address information.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

Name	Address Information
Purpose/Definition	Second line of the dependent address.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

DEPENDENT CITY/STATE/ZIP CODE (N4)**SITUATIONAL**

Specifies the city, state, and ZIP code for the dependent.

Name	City Name
Purpose/Definition	Free-form text for city name of dependent.
Codes	
Attributes	SITUATIONAL N401 19 O AN 2/30

Name	State or Province Code
Purpose/Definition	State or Province code if located in the U.S. or Canada.
Codes	
Attributes	REQUIRED N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	International postal zone code or zip code in the U.S..
Codes	
Attributes	SITUATIONAL N403 116 O ID 3/15



Name	Country Code
Purpose/Definition	Identifies the country of the dependent's address, if other than the United States.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

PROVIDER INFORMATION (PRV)

SITUATIONAL

Used to either identify a specific provider or associate a specialty type related to the service identified in the 2110D loop.

Name	Provider Code
Purpose/Definition	Code identifying the type of provider.
Codes	AD Admitting AT Attending BI Billing CO Consulting CV Covering H Hospital HH Home Health Care LA Laboratory OT Other Physician P1 Pharmacist P2 Pharmacy PC Primary Care Physician PE Performing R Rural Health Clinic RF Referring SB Submitting SK Skilled Nursing Facility SU Supervising
Attributes	REQUIRED PRV01 1221 M ID 1/3



Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of provider code in PRV03.
Codes	EI Employer's Identification Number HPI Health Care Financing Administration National Provider Identifier National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number ZZ Mutually Defined Health Care Provider Taxonomy Code list. 9K Servicer D3 National Association of Boards of Pharmacy Number
Attributes	REQUIRED PRV02 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Provider Identifier code.
Codes	
Attributes	REQUIRED PRV03 127 M AN 1/30

DEPENDENT DEMOGRAPHIC INFORMATION (DMG)

SITUATIONAL

Used when needed to convey the birth date or gender for the dependent.

Name	Date Time Period Format Qualifier
Purpose/Definition	Code indicating the date format in DMG02.
Codes	D8 Date Expressed in Format CCYYMMDD
Attributes	SITUATIONAL DMG01 1250 X ID 2/3

Name	Date Time Period
Purpose/Definition	Dependent birth date.
Codes	
Attributes	SITUATIONAL DMG02 1251 X AN 1/35



Name	Gender Code
Purpose/Definition	Code indicating the sex of the dependent.
Codes	F Female M Male
Attributes	SITUATIONAL DMG03 1068 O ID 1/1

DEPENDENT RELATIONSHIP (INS)

SITUATIONAL

Used only if it is necessary to identify the dependent's relationship to the subscriber identified in loop 2100C or the dependent's birth sequence in the case of multiple births with the same birth date.

Name	Yes/No Condition or Response Code
Purpose/Definition	Identifies whether the insured is the subscriber.
Codes	N No
Attributes	REQUIRED INS01 1073 M ID 1/1

Name	Individual Relationship Code
Purpose/Definition	Identifies the relationship between the subscriber and the dependent.
Codes	01 Spouse 19 Child 34 Other Adult
Attributes	REQUIRED INS02 1069 M ID 2/2

Name	Number
Purpose/Definition	Indicates the birth sequence number in the event of multiple births.
Codes	
Attributes	SITUATIONAL INS17 1470 O N0 1/9



DEPENDENT DATE (DTP)**SITUATIONAL**

Used to convey the eligibility, service or admission date(s) for the subscriber or for the issue date of the subscriber's identification card for the information source (e.g., Medicaid ID card).

Name	Date/Time Qualifier
Purpose/Definition	Code specifying type of date in DTP03.
Codes	102 Issue 307 Eligibility 435 Admission 472 Service
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Code indicating the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3

Name	Date Time Period
Purpose/Definition	Indicates the date, or date(s), as qualified by DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

LOOP 2110D DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION

DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION (EQ) REQUIRED

Used to begin the eligibility/benefit inquiry looping structure. If the EQ segment is used, either EQ01 – Service Type Code or EQ02 – Composite Medical Procedure Identifier must be used, but not both.



Name	Service Type Code
Purpose/Definition	Identifies the type of service for which an inquiry is being submitted.
Codes	<ul style="list-style-type: none"> 1 Medical Care 2 Surgical 3 Consultation 4 Diagnostic X-Ray 5 Diagnostic Lab 6 Radiation Therapy 7 Anesthesia 8 Surgical Assistance 9 Other Medical 10 Blood Charges 11 Used Durable Medical Equipment 12 Durable Medical Equipment Purchase 13 Ambulatory Service Center Facility 14 Renal Supplies in the Home 15 Alternate Method Dialysis 16 Chronic Renal Disease (CRD) Equipment 17 Pre-Admission Testing 18 Durable Medical Equipment Rental 19 Pneumonia Vaccine 20 Second Surgical Opinion 21 Third Surgical Opinion 22 Social Work 23 Diagnostic Dental 24 Periodontics 25 Restorative 26 Endodontics 27 Maxillofacial Prosthetics 28 Adjunctive Dental Services 30 Health Benefit Plan Coverage 32 Plan Waiting Period 33 Chiropractic 34 Chiropractic Office Visits 35 Dental Care 36 Dental Crowns



	<p>37 Dental Accident</p> <p>38 Orthodontics</p> <p>39 Prosthodontics</p> <p>40 Oral Surgery</p> <p>41 Routine (Preventive) Dental</p> <p>42 Home Health Care</p> <p>43 Home Health Prescriptions</p> <p>44 Home Health Visits</p> <p>45 Hospice</p> <p>46 Respite Care</p> <p>47 Hospital</p> <p>48 Hospital – Inpatient</p> <p>49 Hospital – Room and Board</p> <p>50 Hospital – Outpatient</p> <p>51 Hospital – Emergency Accident</p> <p>52 Hospital – Emergency Medical</p> <p>53 Hospital – Ambulatory Surgical</p> <p>54 Long Term Care</p> <p>55 Major Medical</p> <p>56 Medically Related Transportation</p> <p>57 Air Transportation</p> <p>58 Cabulance</p> <p>59 Licensed Ambulance</p> <p>60 General Benefits</p> <p>61 In-vitro Fertilization</p> <p>62 MRI/CAT Scan</p> <p>63 Donor Procedures</p> <p>64 Acupuncture</p> <p>65 Newborn Care</p> <p>66 Pathology</p> <p>67 Smoking Cessation</p> <p>68 Well Baby Care</p> <p>69 Maternity</p> <p>70 Transplants</p> <p>71 Audiology Exam</p> <p>72 Inhalation Therapy</p> <p>73 Diagnostic Medical</p>
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	<p>74 Private Duty Nursing</p> <p>75 Prosthetic Device</p> <p>76 Dialysis</p> <p>77 Otological Exam</p> <p>78 Chemotherapy</p> <p>79 Allergy Testing</p> <p>80 Immunizations</p> <p>81 Routine Physical</p> <p>82 Family Planning</p> <p>83 Infertility</p> <p>84 Abortion</p> <p>85 AIDS</p> <p>86 Emergency Services</p> <p>87 Cancer</p> <p>88 Pharmacy</p> <p>89 Free Standing Prescription Drug</p> <p>90 Mail Order Prescription Drug</p> <p>91 Brand Name Prescription Drug</p> <p>92 Generic Prescription Drug</p> <p>93 Podiatry</p> <p>94 Podiatry – Office Visits</p> <p>95 Podiatry – Nursing Home Visits</p> <p>96 Professional (Physician)</p> <p>97 Anesthesiologist</p> <p>98 Professional (Physician) Visit – Office</p> <p>99 Professional (Physician) Visit – Inpatient</p> <p>A0 Professional (Physician) Visit – Outpatient</p> <p>A1 Professional (Physician) Visit – Nursing Home</p> <p>A2 Professional (Physician) Visit – Skilled Nursing Facility</p> <p>A3 Professional (Physician) Visit – Home</p> <p>A4 Psychiatric</p> <p>A5 Psychiatric – Room and Board</p> <p>A6 Psychotherapy</p> <p>A7 Psychiatric – Inpatient</p> <p>A8 Psychiatric – Outpatient</p> <p>A9 Rehabilitation</p> <p>AA Rehabilitation – Room and Board</p>
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	AB Rehabilitation – Inpatient AC Rehabilitation – Outpatient AD Occupational Therapy AE Physical Medicine AF Speech Therapy AG Skilled Nursing Care AH Skilled Nursing Care – Room and Board AI Substance Abuse AJ Alcoholism AK Drug Addiction AL Vision (Optometry) AM Frames AN Routine Exam AO Lenses AQ Nonmedically Necessary Physical AR Experimental Drug Therapy BA Independent Medical Evaluation BB Partial Hospitalization (Psychiatric) BC Day Care (Psychiatric) BD Cognitive Therapy BE Massage Therapy BF Pulmonary Rehabilitation BG Cardiac Rehabilitation BH Pediatric BI Nursery BJ Skin BK Orthopedic BL Cardiac BM Lymphatic BN Gastrointestinal BP Endocrine BQ Neurology BR Eye BS Invasive Procedures
Attributes	SITUATIONAL EQ01 1365 X ID 1/2



Name	COMPOSITE MEDICAL PROCEDURE IDENTIFIER
Purpose/Definition	Identifies the procedure for which an inquiry is being submitted and any applicable modifiers. Not used if EQ01 is used.
Codes	
Attributes	SITUATIONAL EQ02 C003 X

Name	Product/Service ID Qualifier
Purpose/Definition	Identifies the type/source of the descriptive number used in EQ02-2.
Codes	AD American Dental Association Codes CJ Current Procedural Terminology (CPT) Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Common Procedural Coding System ID International Classification of Diseases Clinical Modification (ICD-9-CM) – Procedure Clinical Mod (ICD-9-CM) Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code Product/Service Code List ND National Drug Code (NDC) ZZ Mutually Defined
Attributes	REQUIRED EQ02 - 1 235 M ID 2/2

Name	Product/Service ID
Purpose/Definition	Identifying number for a procedure being inquired about.
Codes	
Attributes	REQUIRED EQ02 - 2 234 M AN 1/48

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier related to the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 3 1339 O AN 2/2



Name	Procedure Modifier
Purpose/Definition	Identifies a modifier related to the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 4 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier related to the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 5 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies a modifier related to the procedure in EQ02-2.
Codes	
Attributes	SITUATIONAL EQ02 - 6 1339 O AN 2/2

Name	Coverage Level Code
Purpose/Definition	Indicates which individuals are covered by the insurance plan.
Codes	CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
Attributes	SITUATIONAL EQ03 1207 O ID 3/3



Name	Insurance Type Code
Purpose/Definition	Identifies the type of insurance policy within a specific insurance program.
Codes	AP Auto Insurance Policy C1 Commercial CO Consolidated Omnibus Budget Reconciliation Act (COBRA) GP Group Policy HM Health Maintenance Organization (HMO) IP Individual Policy OT Other PR Preferred Provider Organization (PPO) PS Point of Service (POS) SP Supplemental Policy WC Workers Compensation004010X092
Attributes	SITUATIONAL EQ04 1336 O ID 1/3

DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION (III)

SITUATIONAL

Used to identify diagnosis and/or facility type as they relate to the information provided in the EQ segment.

Name	Code List Qualifier Code
Purpose/Definition	Identifies whether the code in III02 is a principal diagnosis code, a diagnosis code, or a facility type code.
Codes	BF Diagnosis BK Principal Diagnosis ZZ Mutually Defined
Attributes	REQUIRED III01 1270 X ID 1/3

Name	Industry Code
Purpose/Definition	Diagnosis code from ICD-9-CM, or place of service code from code source 237.
Codes	
Attributes	REQUIRED III02 1271 X AN 1/30



DEPENDENT ADDITIONAL INFORMATION (REF)**SITUATIONAL**

Used to identify referral or prior authorization numbers for the dependent when it is necessary to provide this information number for the benefit being inquired about.

Name	Reference Identification Qualifier
Purpose/Definition	Code qualifying the identification number in REF02.
Codes	9F Referral Number G1 Prior Authorization Number
Attributes	REQUIRED REF01 128 M ID 2/3

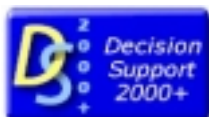
Name	Reference Identification
Purpose/Definition	Prior authorization or referral number.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

DEPENDENT ELIGIBILITY/BENEFIT DATE (DTP)**SITUATIONAL**

Used to convey eligibility, admission, or service dates associated with the information contained in the corresponding EQ segment.

Name	Date/Time Qualifier
Purpose/Definition	Code specifying type of date in DTP03.
Codes	307 Eligibility 435 Admission 472 Service
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Code indicating the date format in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3



Name	Date Time Period
Purpose/Definition	Date or range of dates as specified in DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

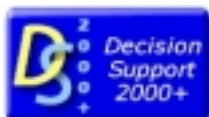
TRANSACTION SET TRAILER (SE)

REQUIRED

Used to mark the end of a transaction set and provide control information on the total number of segments included in the transaction set.

Name	Number of Included Segments
Purpose/Definition	Identifies the total number of segments included in a transaction set including ST and SE segments.
Codes	
Attributes	REQUIRED SE01 96 M NO 1/10

Name	Transaction Set Control Number
Purpose/Definition	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set.
Codes	
Attributes	REQUIRED SE02 329 M AN 4/9



VI. Data Element Tables for the Health Care Eligibility, Coverage, or Benefit Information Transaction (271)

The Data Element Tables give the purpose and definition, codes, and technical specifications for all the data elements in the Health Care Eligibility, Coverage, or Benefit Information Transaction. Section VII below explains and defines key terms. Readers should refer to the Implementation Guide for additional technical information.

TRANSACTION SET HEADER (ST)

REQUIRED

Used to mark the start of a transaction set. One ST segment exists for every transaction set that occurs within a functional group.

Name	Transaction Set Identifier Code
Purpose/Definition	Identifies that this transaction is the Eligibility, Coverage or Benefit Information.
Codes	271 Eligibility, Coverage or Benefit Information
Attributes	REQUIRED ST01 143 M ID 3/3

Name	Transaction Set Control Number
Purpose/Definition	Identifies the unique control number for the transaction set assigned by the originator.
Codes	
Attributes	REQUIRED ST02 329 M AN 4/9

BEGINNING OF HIERARCHICAL TRANSACTION (BHT)

REQUIRED

Used to start the transaction set and indicate the sequence of the information to follow.

Name	Hierarchical Structure Code
Purpose/Definition	Indicates the hierarchical structure of the transaction set (i.e., the order of information contained in the transaction).
Codes	0022 Information Source, Information Receiver, Subscriber, Dependent
Attributes	REQUIRED BHT01 1005 M ID 4/4

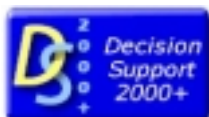


Name	Transaction Set Purpose Code
Purpose/Definition	Identifies the purpose of the transaction set.
Codes	11 Response
Attributes	REQUIRED BHT02 353 M ID 2/2

Name	Reference Identification
Purpose/Definition	Indicates the number assigned by the origination to identify the transaction.
Codes	
Attributes	SITUATIONAL BHT03 127 O AN 1/30

Name	Date
Purpose/Definition	Indicates the date the transaction was created.
Codes	
Attributes	REQUIRED BHT04 373 O DT 8/8

Name	Time
Purpose/Definition	Indicates the time the transaction was generated.
Codes	
Attributes	REQUIRED BHT05 337 O TM 4/8



LOOP 2000A INFORMATION SOURCE LEVEL

INFORMATION SOURCE LEVEL (HL)

REQUIRED

Identifies the relationship between hierarchically related groups of data segments and indicates that the series of segments from this Hierarchical Level (HL) to the next HL segment are related to the information source.

Name	Hierarchical ID Number
Purpose/Definition	Identifies the unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the information source.
Codes	20 Information Source
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.
Attributes	REQUIRED HL04 736 O ID 1/1



REQUEST VALIDATION (AAA)**SITUATIONAL**

Used when a request could not be processed at a system or application level to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1

Name	Reject Reason Code
Purpose/Definition	Code assigned by issuer to identify reason why the transaction was unable to be processed successfully.
Codes	04 Authorized Quantity Exceeded 41 Authorization/Access Restrictions 42 Unable to Respond at Current Time 79 Invalid Participant Identification
Attributes	REQUIRED AAA03 901 O ID 2/2

Name	Follow-up Action Code
Purpose/Definition	Used to instruct the recipient about what action needs to be taken based the validity and reject reason code.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed P Please Resubmit Original Transaction R Resubmission Allowed S Do Not Resubmit; Inquiry Initiated to a Third Party Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1



LOOP 2100A INFORMATION SOURCE NAME

INFORMATION SOURCE NAME (NMI)

REQUIRED

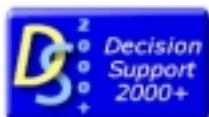
Identifies the eligibility or benefit information source (e.g., insurance company, HMO, IPA, employer).

Name	Entity Identifier Code
Purpose/Definition	Identifies the information source.
Codes	2B Third-Party Administrator 36 Employer GP Gateway Provider P5 Plan Sponsor PR Payer
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Qualifies the person or organization in NM103.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Information source last name or organizational name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Information source first name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

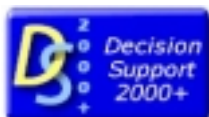


Name	Name Middle
Purpose/Definition	Information source middle name or initial. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to information source name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Identifies the system/method of code structure used in NM109.
Codes	24 Employer's Identification Number 46 Electronic Transmitter Identification Number (ETIN) FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification XV Health Care Financing Administration National PlanID National PlanID XX Health Care Financing Administration National Provider Identifier
Attributes	REQUIRED NM108 66 X ID 1/2

Name	Identification Code
Purpose/Definition	Indicates the information source identifier as qualified by the preceding data element (NM108).
Codes	
Attributes	REQUIRED NM109 67 X AN 2/80



INFORMATION SOURCE ADDITIONAL IDENTIFICATION (REF) SITUATIONAL

Used when needed to convey other or additional identification numbers for the information source.

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of identification number used in REF02.
Codes	18 Plan Number 55 Sequence Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Indicates the information source additional plan identifier.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

Name	Description
Purpose/Definition	Information source plan name.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

INFORMATION SOURCE CONTACT INFORMATION (PER) SITUATIONAL

Identifies the person or office to whom administrative communications should be directed when the eligibility question cannot be answered electronically and the information source wishes to provide a contact for further inquiry. This segment allows for three contact numbers to be listed. If telephone extension is sent, it should always be the communications number following the actual phone number.

Name	Contact Function Code
Purpose/Definition	Code identifying the major duty or responsibility of the person in PER02.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2



Name	Name
Purpose/Definition	Information source contact name.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER04.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER06.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
Attributes	SITUATIONAL PER05 365 X ID 2/2



Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER08.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
Attributes	SITUATIONAL PER07 365 X ID 2/2

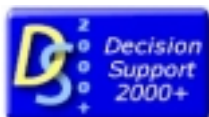
Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80

REQUEST VALIDATION (AAA)

SITUATIONAL

Used to indicate problems in processing the transaction specifically related to the information source data and to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid or invalid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1



Name	Reject Reason Code
Purpose/Definition	Identifies the reason why the transaction was unable to be processed successfully (i.e. problems with the system, the application or the data content).
Codes	04 Authorized Quantity Exceeded 41 Authorization/Access Restrictions 42 Unable to Respond at Current Time 79 Invalid Participant Identification 80 No Response received - Transaction Terminated T4 Payer Name or Identifier Missing
Attributes	REQUIRED AAA03 901 O ID 2/2

Name	Follow-up Action Code
Purpose/Definition	Instructs the recipient about what action needs to be taken based on the validity and reject reason code.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed P Please Resubmit Original Transaction R Resubmission Allowed S Do Not Resubmit; Inquiry Initiated to a Third Party W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1



LOOP 2000B INFORMATION RECEIVER LEVEL

INFORMATION RECEIVER LEVEL (HL)

SITUATIONAL

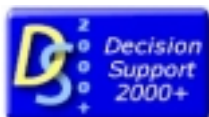
Identifies the relationship between the hierarchically related groups of data segment in the Information Receiver level, and indicates that the series of segments from this HL until the next HL segment are related to the information receiver.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Parent ID Number
Purpose/Definition	Identification number of the next higher hierarchical data segment that this segment described is subordinate to.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the information receiver.
Codes	21 Information Receiver
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.
Attributes	REQUIRED HL04 736 O ID 1/1



LOOP 2100B INFORMATION RECEIVER NAME

INFORMATION RECEIVER NAME (NM1)

REQUIRED

Identifies the eligibility/benefit information receiver (e.g., provider, medical group, IPA, or hospital).

Name	Entity Identifier Code
Purpose/Definition	Code identifying the information receiver.
Codes	1P Provider 2B Third-Party Administrator 36 Employer 80 Hospital FA Facility GP Gateway Provider P5 Plan Sponsor PR Payer
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Indicates whether the information receiver is an individual or an organization.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Information receiver last name or organizational name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Information receiver first name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25



Name	Name Middle
Purpose/Definition	Information receiver middle name or initial. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to information receiver name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Indicates the type of code structure used for the information receiver in NM109. Identification Code (67).
Codes	24 Employer's Identification Number 34 Social Security Number FI Federal Taxpayer's Identification Number PI Payor Identification PP Pharmacy Processor Number SV Service Provider Number XV Health Care Financing Administration National PlanID CODE SOURCE 540: Health Care Financing Administration National PlanID XX Health Care Financing Administration National Provider Identifier
Attributes	REQUIRED NM108 66 X ID 1/2

Name	Identification Code
Purpose/Definition	Indicates the identification code for the information receiver.
Codes	
Attributes	REQUIRED NM109 67 X AN 2/80



INFORMATION RECEIVER ADDITIONAL IDENTIFICATION (REF) SITUATIONAL

Specifies additional identification numbers for the information receiver when needed.

Name	Reference Identification Qualifier
Purpose/Definition	Code qualifying the code for the information receiver in REF02.
Codes	0B State License Number 1C Medicare Provider Number 1D Medicaid Provider Number 1J Facility ID Number 4A Personal Identification Number (PIN) CT Contract Number EL Electronic device pin number EO Submitter Identification Number HPI Health Care Financing Administration National Provider Identifier N5 Provider Plan Network Identification Number N7 Facility Network Identification Number Q4 Prior Identifier Number SY Social Security Number TJ Federal Taxpayer's Identification Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Information receiver additional identifier.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

Name	Description
Purpose/Definition	The two-character state ID of the state assigning the State License Number, if that code is used in REF02.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80



INFORMATION RECEIVER REQUEST VALIDATION (AAA)**SITUATIONAL**

Used to indicate problems in processing and to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1

Name	Reject Reason Code
Purpose/Definition	Identifies the reason why the transaction was unable to be processed successfully.
Codes	15 Required application data missing 41 Authorization/Access Restrictions 43 Invalid/Missing Provider Identification 44 Invalid/Missing Provider Name 45 Invalid/Missing Provider Specialty 46 Invalid/Missing Provider Phone Number 47 Invalid/Missing Provider State 48 Invalid/Missing Referring Provider Identification Number 50 Provider Ineligible for Inquiries 51 Provider Not on File 79 Invalid Participant Identification 97 Invalid or Missing Provider Address T4 Payer Name or Identifier Missing
Attributes	REQUIRED AAA03 901 O ID 2/2



Name	Follow-up Action Code
Purpose/Definition	Instructs the recipient of the 271 about what action needs to be taken based the validity and reject reason code. .
Codes	C Please Correct and Resubmit N Resubmission Not Allowed R Resubmission Allowed S Do Not Resubmit; Inquiry Initiated to a Third Party W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1

LOOP 2000C SUBSCRIBER LEVEL

SUBSCRIBER LEVEL (HL)

SITUATIONAL

Identifies the relationship between the groups of data segments in the subscriber level and indicates that the segments from this HL until the next HL segment are related to the subscriber.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12

Name	Hierarchical Parent ID Number
Purpose/Definition	Identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12



Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the subscriber.
Codes	22 Subscriber
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.
Attributes	REQUIRED HL04 736 O ID 1/1

SUBSCRIBER TRACE NUMBER (TRN)

SITUATIONAL

Identifies the trace or reference number that allows tracing of an eligibility/benefit transaction.

Name	Trace Type Code
Purpose/Definition	Identifies whether the trace number in TRN02 was assigned by the creator of the 271 transaction (current) or originally sent in the 270 Benefit Inquiry (referenced).
Codes	1 Current Transaction Trace Numbers 2 Referenced Transaction Trace Numbers
Attributes	REQUIRED TRN01 481 M ID 1/2

Name	Reference Identification
Purpose/Definition	Trace number as specified in TRN01.
Codes	
Attributes	REQUIRED TRN02 127 M AN 1/30



Name	Originating Company Identifier
Purpose/Definition	If TRN01=1, this is the unique identifier of the organization assigning the trace number. If TRN01=2, this is the value received in the original 270 transaction.
Codes	
Attributes	REQUIRED TRN03 509 O AN 10/10

Name	Reference Identification
Purpose/Definition	If TRN01 is = 2, this is the value received in the original 270 transaction. If TRNO1 = 1, this is an additional identifier for the company identified in TRN03.
Codes	
Attributes	SITUATIONAL TRN04 127 O AN 1/30

LOOP 2100C SUBSCRIBER NAME

SUBSCRIBER NAME (NM1)

REQUIRED

To supply the full name of the insured or subscriber.

Name	Entity Identifier Code
Purpose/Definition	Identifies that the individual referred to in this segment is the insured or subscriber.
Codes	IL Insured or Subscriber
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Indicates that the insured or subscriber is a person.
Codes	1 Person
Attributes	REQUIRED NM102 1065 M ID 1/1



Name	Name Last or Organization Name
Purpose/Definition	Subscriber last name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Subscriber first name.
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Subscriber middle name or initial.
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Prefix
Purpose/Definition	Prefix to subscriber name.
Codes	
Attributes	SITUATIONAL NM106 1038 O AN 1/10

Name	Name Suffix
Purpose/Definition	Suffix to subscriber name.
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Identifies the type of code in NM109.
Codes	MI Member Identification Number ZZ Mutually Defined
Attributes	SITUATIONAL NM108 66 X ID1/2



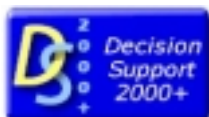
Name	Identification Code
Purpose/Definition	Subscriber ID code.
Codes	
Attributes	SITUATIONAL NM109 67 X AN 2/80

SUBSCRIBER ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

Used to supply a subscriber identification number other than, or in addition to, the Member Identification Number.

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of code used in REF02.
Codes	18 Plan Number 1L Group or Policy Number 1W Member Identification Number 3H Case Number 49 Family Unit Number 6P Group Number A6 Employee Identification Number A6 Employee Identification Number EA Medical Record Identification Number EJ Patient Account Number F6 Health Insurance Claim (HIC) Number GH Identification Card Serial Number HJ Identity Card Number IF Issue Number IG Insurance Policy Number ML Military Rank/Civilian Pay Grade Number Military Health Systems Functional Area Manual -Data. N6 Plan Network Identification Number NQ Medicaid Recipient Identification Number Q4 Prior Identifier Number SY Social Security Number
Attributes	REQUIRED REF01 128 M ID 2/3



Name	Reference Identification
Purpose/Definition	Additional subscriber ID number.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

Name	Reference Identification
Purpose/Definition	Plan sponsor name.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

SUBSCRIBER ADDRESS (N3)

SITUATIONAL

Used to identify address information for a subscriber.

Name	Address Information
Purpose/Definition	Subscriber address information, line 1.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

Name	Address Information
Purpose/Definition	Subscriber address information, line 2.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

SUBSCRIBER CITY/STATE/ZIP CODE (N4)

SITUATIONAL

Used to identify the city, state and ZIP Code for the subscriber.

Name	City Name
Purpose/Definition	Free-form text for subscriber's city name.
Codes	
Attributes	SITUATIONAL N401 19 O AN 2/30



Name	State or Province Code
Purpose/Definition	State/Province code if city name in N401 is in the US or Canada.
Codes	
Attributes	SITUATIONAL N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	International postal zone code (zip code for United States).
Codes	CODE SOURCE 51: ZIP Code
Attributes	SITUATIONAL N403 116 O ID 3/15

Name	Country Code
Purpose/Definition	Code identifying the country if other than the United States.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

Name	Location Qualifier
Purpose/Definition	Identifies the type of additional subscriber location information provided in N406.
Codes	CY County/Parish FI Federal Information Processing Standards (FIPS) 55 (Named Populated Places)
Attributes	SITUATIONAL N405 309 X ID 1/2

Name	Location Identifier
Purpose/Definition	Additional information about subscriber location as specified in N405.
Codes	
Attributes	SITUATIONAL N406 310 O AN 1/30



SUBSCRIBER CONTACT INFORMATION (PER)**SITUATIONAL**

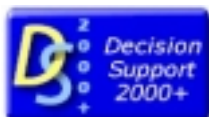
To identify a contact name and/or communications number for the subscriber identified. This segment allows for three contact numbers to be listed. If telephone extension is sent, it should always be the communications number following the actual phone number.

Name	Contact Function Code
Purpose/Definition	Code identifying the major duty or responsibility of the person named in PER02.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2

Name	Name
Purpose/Definition	Name of the person to whom communication should be directed.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER04.
Codes	HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80

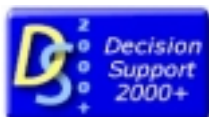


Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER06.
Codes	EX Telephone Extension HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER05 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER08.
Codes	EX Telephone Extension HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER07 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80



SUBSCRIBER REQUEST VALIDATION (AAA)**SITUATIONAL**

Used to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's subscriber name loop (Loop 2100C) and to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1

Name	Reject Reason Code
Purpose/Definition	Identifies the reason why the transaction was unable to be processed successfully.
Codes	15 Required application data missing 42 Unable to Respond at Current Time 43 Invalid/Missing Provider Identification 45 Invalid/Missing Provider Specialty 47 Invalid/Missing Provider State 48 Invalid/Missing Referring Provider Identification Number 49 Provider is Not Primary Care Physician 51 Provider Not on File 52 Service Dates Not Within Provider Plan Enrollment 56 Inappropriate Date 57 Invalid/Missing Date(s) of Service 58 Invalid/Missing Date-of-Birth 60 Date of Birth Follows Date(s) of Service 61 Date of Death Precedes Date(s) of Service 62 Date of Service Not Within Allowable Inquiry Period 63 Date of Service in Future 64 Invalid/Missing Patient ID 65 Invalid/Missing Patient Name 66 Invalid/Missing Patient Gender Code 67 Patient Not Found



	68 Duplicate Patient ID Number 71 Patient Birth Date Does Not Match That for the Patient on the Database 72 Invalid/Missing Subscriber/Insured ID 73 Invalid/Missing Subscriber/Insured Name 74 Invalid/Missing Subscriber/Insured Gender Code 75 Subscriber/Insured Not Found 76 Duplicate Subscriber/Insured ID Number 77 Subscriber Found, Patient Not Found 78 Subscriber/Insured Not in Group/Plan Identified
Attributes	REQUIRED AAA03 901 O ID 2/2

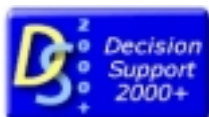
Name	Follow-up Action Code
Purpose/Definition	Used to instruct the recipient of the 271 about what action needs to be taken.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed R Resubmission Allowed Use only when AAA03 is "42". S Do Not Resubmit; Inquiry Initiated to a Third Party W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1

SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)

SITUATIONAL

Used to convey birth date or gender information for the subscriber if the subscriber is the patient.

Name	Date Time Period Format Qualifier
Purpose/Definition	Code indicating the date format used in DMG02.
Codes	D8 Date Expressed in Format CCYYMMDD
Attributes	SITUATIONAL DMG01 1250 X ID 2/3



Name	Date Time Period
Purpose/Definition	Subscriber birth date.
Codes	
Attributes	SITUATIONAL DMG02 1251 X AN 1/35

Name	Gender Code
Purpose/Definition	Code indicating the sex of the subscriber.
Codes	F Female M Male U Unknown
Attributes	SITUATIONAL DMG03 1068 O ID 1/1

SUBSCRIBER RELATIONSHIP (INS)

SITUATIONAL

Used to convey insurance related information about the subscriber or to identify that the information source has changed some of the identifying elements for the subscriber that the information receiver submitted in the original 270 transaction.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the insured is the subscriber.
Codes	Y Yes
Attributes	REQUIRED INS01 1073 M ID 1/1

Name	Individual Relationship Code
Purpose/Definition	Indicates the relationship between the subscriber and the insured.
Codes	18 Self
Attributes	REQUIRED INS02 1069 M ID 2/2

Name	Maintenance Type Code
Purpose/Definition	Identifies elements for the subscriber have been changed from those submitted in the 270.
Codes	001 Change
Attributes	SITUATIONAL INS03 875 O ID 3/3

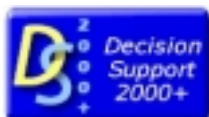


Name	Maintenance Reason Code
Purpose/Definition	Identifies the reason for the change in subscriber information.
Codes	25 Change in identifying Data Elements
Attributes	SITUATIONAL INS04 1203 O ID 2/3

Name	Student Status Code
Purpose/Definition	Indicates the student status of the patient if 19 years of age or older, not handicapped and not the insured.
Codes	F Full-time N Not a Student N Not a Student
Attributes	SITUATIONAL INS09 1220 O ID 1/1

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the subscriber is handicapped.
Codes	N No Y Yes
Attributes	SITUATIONAL INS10 1073 O ID 1/1

Name	Number
Purpose/Definition	Indicates birth order number in the event of multiple births.
Codes	
Attributes	SITUATIONAL INS17 1470 O N0 1/9



SUBSCRIBER DATE (DTP)**SITUATIONAL**

To convey information about relevant dates (which dates are conveyed is indicated by the format qualifier in DTP01).

Name	Date/Time Qualifier
Purpose/Definition	Identifies the type of date in DTP03.
Codes	102 Issue 152 Effective Date of Change 291 Plan 307 Eligibility 318 Added 340 Consolidated Omnibus Budget Reconciliation Act (COBRA) Begin 341 Consolidated Omnibus Budget Reconciliation Act (COBRA) End 342 Premium Paid to Date Begin 343 Premium Paid to Date End 346 Plan Begin 347 Plan End 356 Eligibility Begin 357 Eligibility End 382 Enrollment 435 Admission 442 Date of Death 458 Certification 472 Service 539 Policy Effective 540 Policy Expiration 636 Date of Last Update 771 Status
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3



Name	Date Time Period
Purpose/Definition	Indicates the date, or date(s), as qualified by DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

LOOP 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION (EB) SITUATIONAL

Indicates the beginning of the eligibility/benefit information looping structure and conveys information about the patient whose eligibility or benefits are being verified.

Name	Eligibility or Benefit Information
Purpose/Definition	Identifies the reference in eligibility or benefit information EB06 through EB10.
Codes	1 Active Coverage 2 Active - Full Risk Capitation 3 Active - Services Capitated 4 Active - Services Capitated to Primary Care Physician 5 Active - Pending Investigation 6 Inactive 7 Inactive - Pending Eligibility Update 8 Inactive - Pending Investigation A Co-Insurance B Co-Payment C Deductible CB Coverage Basis D Benefit Description E Exclusions F Limitations G Out of Pocket (Stop Loss) H Unlimited I Non-Covered J Cost Containment K Reserve



	L Primary Care Provider M Pre-existing Condition MC Managed Care Coordinator N Services Restricted to Following Provider O Not Deemed a Medical Necessity P Benefit Disclaimer Q Second Surgical Opinion Required R Other or Additional Payor S Prior Year(s) History T Card(s) Reported Lost/Stolen U Contact Following Entity for Eligibility or Benefit Information V Cannot Process W Other Source of Data X Health Care Facility Y Spend Down
Attributes	REQUIRED EB01 1390 M ID 1/2

Name	Coverage Level Code
Purpose/Definition	Indicates which individuals are covered by the insurance plan.
Codes	CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
Attributes	SITUATIONAL EB02 1207 O ID 3/3



Name	Service Type Code
Purpose/Definition	Identifies the classification of service for which the inquiry was submitted.
Codes	<ul style="list-style-type: none"> 1 Medical Care 2 Surgical 3 Consultation 4 Diagnostic X-Ray 5 Diagnostic Lab 6 Radiation Therapy 7 Anesthesia 8 Surgical Assistance 9 Other Medical 10 Blood Charges 11 Used Durable Medical Equipment 12 Durable Medical Equipment Purchase 13 Ambulatory Service Center Facility 14 Renal Supplies in the Home 15 Alternate Method Dialysis 16 Chronic Renal Disease (CRD) Equipment 17 Pre-Admission Testing 18 Durable Medical Equipment Rental 19 Pneumonia Vaccine 20 Second Surgical Opinion 21 Third Surgical Opinion 22 Social Work 23 Diagnostic Dental 24 Periodontics 25 Restorative 26 Endodontics 27 Maxillofacial Prosthetics 28 Adjunctive Dental Services 30 Health Benefit Plan Coverage



	<p>32 Plan Waiting Period</p> <p>33 Chiropractic</p> <p>34 Chiropractic Office Visits</p> <p>35 Dental Care</p> <p>36 Dental Crowns</p> <p>37 Dental Accident</p> <p>38 Orthodontics</p> <p>39 Prosthodontics</p> <p>40 Oral Surgery</p> <p>41 Routine (Preventive) Dental</p> <p>42 Home Health Care</p> <p>43 Home Health Prescriptions</p> <p>44 Home Health Visits</p> <p>45 Hospice</p> <p>46 Respite Care</p> <p>47 Hospital</p> <p>48 Hospital - Inpatient</p> <p>49 Hospital - Room and Board</p> <p>50 Hospital - Outpatient</p> <p>51 Hospital - Emergency Accident</p> <p>52 Hospital - Emergency Medical</p> <p>53 Hospital - Ambulatory Surgical</p> <p>54 Long Term Care</p> <p>55 Major Medical</p> <p>56 Medically Related Transportation</p> <p>57 Air Transportation</p> <p>58 Cabulance</p> <p>59 Licensed Ambulance</p> <p>60 General Benefits</p> <p>61 In-vitro Fertilization</p> <p>62 MRI/CAT Scan</p> <p>63 Donor Procedures</p> <p>64 Acupuncture</p> <p>65 Newborn Care</p> <p>66 Pathology</p> <p>67 Smoking Cessation</p> <p>68 Well Baby Care</p> <p>69 Maternity</p> <p>70 Transplants</p> <p>71 Audiology Exam</p> <p>72 Inhalation Therapy</p> <p>73 Diagnostic Medical</p> <p>74 Private Duty Nursing</p>
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	75 Prosthetic Device 76 Dialysis 77 Otological Exam 78 Chemotherapy 79 Allergy Testing 80 Immunizations 81 Routine Physical 82 Family Planning 83 Infertility 84 Abortion 85 AIDS 86 Emergency Services 87 Cancer 88 Pharmacy 89 Free Standing Prescription Drug 90 Mail Order Prescription Drug 91 Brand Name Prescription Drug 92 Generic Prescription Drug 93 Podiatry 94 Podiatry - Office Visits 95 Podiatry - Nursing Home Visits 96 Professional (Physician) 97 Anesthesiologist 98 Professional (Physician) Visit - Office 99 Professional (Physician) Visit - Inpatient A0 Professional (Physician) Visit - Outpatient A1 Professional (Physician) Visit - Nursing Home A2 Professional (Physician) Visit - Skilled Nursing Facility A3 Professional (Physician) Visit - Home A4 Psychiatric
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	A5 Psychiatric - Room and Board A6 Psychotherapy A7 Psychiatric - Inpatient A8 Psychiatric - Outpatient A9 Rehabilitation AA Rehabilitation - Room and Board AB Rehabilitation - Inpatient AC Rehabilitation - Outpatient AD Occupational Therapy AE Physical Medicine AF Speech Therapy AG Skilled Nursing Care AH Skilled Nursing Care - Room and Board AI Substance Abuse AJ Alcoholism AK Drug Addiction AL Vision (Optometry) AM Frames AN Routine Exam AO Lenses AQ Nonmedically Necessary Physical AR Experimental Drug Therapy BA Independent Medical Evaluation BB Partial Hospitalization (Psychiatric) BC Day Care (Psychiatric) BD Cognitive Therapy BE Massage Therapy BF Pulmonary Rehabilitation BG Cardiac Rehabilitation BH Pediatric BI Nursery BJ Skin BK Orthopedic BL Cardiac BM Lymphatic BN Gastrointestinal BP Endocrine BQ Neurology BR Eye BS Invasive Procedures
Attributes	SITUATIONAL EB03 1365 O ID 1/2



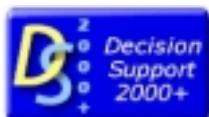
Name	Insurance Type Code
Purpose/Definition	Identifies the type of insurance policy within a specific insurance program.
Codes	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan 14 Medicare Secondary, No-fault Insurance including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary AP Auto Insurance Policy C1 Commercial CO Consolidated Omnibus Budget Reconciliation Act (COBRA) CP Medicare Conditionally Primary D Disability DB Disability Benefits EP Exclusive Provider Organization FF Family or Friends GP Group Policy HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) - Medicare Risk HS Special Low Income Medicare Beneficiary IN Indemnity IP Individual Policy LC Long Term Care LD Long Term Policy LI Life Insurance LT Litigation MA Medicare Part A MB Medicare Part B



	MC Medicaid MH Medigap Part A MI Medigap Part B MP Medicare Primary OT Other PE Property Insurance - Personal PL Personal PP Personal Payment (Cash - No Insurance) PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary RP Property Insurance - Real SP Supplemental Policy TF Tax Equity Fiscal Responsibility Act (TEFRA) WC Workers Compensation WU Wrap Up Policy
Attributes	SITUATIONAL EB04 1336 O ID 1/3

Name	Plan Coverage Description
Purpose/Definition	Used to convey the specific product name for an insurance plan.
Codes	
Attributes	SITUATIONAL EB05 1204 O AN 1/50

Name	Time Period Qualifier
Purpose/Definition	Identifies the time period category for the benefits being described, when needed to qualify benefit availability.
Codes	6 Hour 7 Day 13 24 Hours 21 Years 21 Years 21 Years 23 Calendar Year 24 Year to Date 25 Contract 26 Episode 27 Visit 28 Outlier

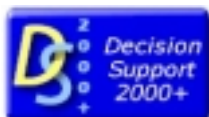


	29 Remaining 30 Exceeded 31 Not Exceeded 32 Lifetime 33 Lifetime Remaining 34 Month 35 Week 36 Admission
Attributes	SITUATIONAL EB06 615 O ID 1/2

Name	Monetary Amount
Purpose/Definition	Identifies a monetary amount as qualified in EB01 (i.e. deductible or co-payment).
Codes	
Attributes	SITUATIONAL EB07 782 O R 1/18

Name	Percent
Purpose/Definition	Identifies a benefit percent as qualified in EB01 (i.e. co-insurance).
Codes	
Attributes	SITUATIONAL EB08 954 O R 1/10

Name	Quantity Qualifier
Purpose/Definition	Identifies the type of units in EB10.
Codes	99 Quantity Used CA Covered - Actual CE Covered - Estimated DB Deductible Blood Units DY Days HS Hours LA Life-time Reserve - Actual LE Life-time Reserve - Estimated MN Month



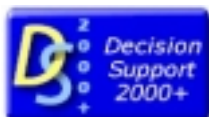
	P6 Number of Services or Procedures QA Quantity Approved S7 Age, High Value S8 Age, Low Value VS Visits YY Years
Attributes	SITUATIONAL EB09 673 X ID 2/2

Name	Quantity
Purpose/Definition	Identifies the Benefit Quantity as qualified in EB09.
Codes	
Attributes	SITUATIONAL EB10 380 X R 1/15

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether an authorization or certification is required by the plan provisions.
Codes	N No U Unknown Y Yes
Attributes	SITUATIONAL EB11 1073 O ID 1/1

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the benefits are considered "In-Plan-Network."
Codes	N No U Unknown Y Yes
Attributes	SITUATIONAL EB12 1073 O ID 1/1

Name	COMPOSITE MEDICAL PROCEDURE IDENTIFIER
Purpose/Definition	Identifies the medical procedure by its standardized codes and applicable modifiers for which an inquiry was submitted.
Codes	
Attributes	SITUATIONAL EB13 C003 O



Name	Product/Service ID Qualifier
Purpose/Definition	Code identifying the type/source of the procedure code used in EB13-2.
Codes	AD American Dental Association Codes CJ Current Procedural Terminology (CPT) Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ZZ Mutually Defined
Attributes	REQUIRED EB13 - 1 235 M ID 2/2

Name	Product/Service ID
Purpose/Definition	Procedure code as qualified in EB13-1.
Codes	
Attributes	REQUIRED EB13 - 2 234 M AN 1/48

Name	Procedure Modifier
Purpose/Definition	Identifies the procedure modifier for the procedure in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 3 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies the procedure modifier for the procedure in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 4 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Identifies the procedure modifier for the procedure in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 5 1339 O AN 2/2



Name	Procedure Modifier
Purpose/Definition	Identifies the procedure modifier for the procedure in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 6 1339 O AN 2/2

HEALTH CARE SERVICES DELIVERY (HSD)

SITUATIONAL

Specifies the delivery pattern of health care services when benefits identified in either EB03 or EB13 have a specific delivery or usage pattern associated with the benefit. For example, if the patient is to receive a total of 24 visits, 3 visits per week for two months, every Monday Wednesday and Friday AM, then HSD01=VS, HSD02=24, HSD03=WK, HSD04=3, HSD05=34, HSD06=2, HSD07=SZ and HSD08=D.

Name	Quantity Qualifier
Purpose/Definition	Identifies the unit of services provided.
Codes	DY Days FL Units HS Hours MN Month VS Visits
Attributes	SITUATIONAL HSD01 673 X ID 2/2

Name	Quantity
Purpose/Definition	Identifies the quantity of units specified in HSD01.
Codes	
Attributes	SITUATIONAL HSD02 380 X R 1/15



Name	Unit or Basis for Measurement Code
Purpose/Definition	Specifies the time period in which the service is being provided (e.g., a certain number of services every 2 <u>weeks</u> or every 6 <u>months</u>).
Codes	DA Days MO Months VS Visit WK Week YR Years
Attributes	SITUATIONAL HSD03 355 O ID 2/2

Name	Sample Selection Modulus
Purpose/Definition	Specifies the frequency of the service period defined in HSD03 (e.g., every 3 <u>months</u> or every 2 <u>weeks</u>).
Codes	
Attributes	SITUATIONAL HSD04 1167 O R 1/6

Name	Time Period Qualifier
Purpose/Definition	Specifies the period of time over which the service is being delivered (e.g., for 2 <u>months</u>)
Codes	6 Hour 7 Day 21 Years 22 Service Year 23 Calendar Year 24 Year to Date 25 Contract 26 Episode 27 Visit 28 Outlier 29 Remaining 30 Exceeded 31 Not Exceeded 32 Lifetime 33 Lifetime Remaining 34 Month 35 Week
Attributes	SITUATIONAL HSD05 615 X ID 1/2



Name	Number of Periods
Purpose/Definition	Identifies the total number of periods of service as defined in HSD05 (e.g., for <u>3</u> months).
Codes	
Attributes	SITUATIONAL HSD06 616 O N0 1/3

Name	Ship/Delivery or Calendar Pattern Code
Purpose/Definition	Specifies the pattern for delivery of the health care service.
Codes	1 1st Week of the Month 2 2nd Week of the Month 3 3rd Week of the Month 4 4th Week of the Month 5 5th Week of the Month 6 1st & 3rd Weeks of the Month 7 2nd & 4th Weeks of the Month 8 1st Working Day of Period 9 Last Working Day of Period A Monday through Friday B Monday through Saturday C Monday through Sunday D Monday E Tuesday F Wednesday G Thursday H Friday J Saturday K Sunday L Monday through Thursday M Immediately N As Directed O Daily Mon. through Fri. P 1/2 Mon. & 1/2 Thurs. Q 1/2 Tues. & 1/2 Thurs. R 1/2 Wed. & 1/2 Fri. S Once Anytime Mon. through Fri. SG Tuesday through Friday SL Monday, Tuesday and Thursday SP Monday, Tuesday and Friday SX Wednesday and Thursday



	SY Monday, Wednesday and Thursday SZ Tuesday, Thursday and Friday T 1/2 Tue. & 1/2 Fri. U 1/2 Mon. & 1/2 Wed. V 1/3 Mon., 1/3 Wed., 1/3 Fri. W Whenever Necessary X 1/2 By Wed., Bal. By Fri. Y None (Also Used to Cancel or Override a Previous Pattern)
Attributes	SITUATIONAL HSD07 678 O ID 1/2

Name	Ship/Delivery Pattern Time Code
Purpose/Definition	Specifies the time for routine delivery of health care services.
Codes	A 1st Shift (Normal Working Hours) B 2nd Shift C 3rd Shift D A.M. E P.M. F As Directed G Any Shift Y None (Also Used to Cancel or Override a Previous Pattern)
Attributes	SITUATIONAL HSD08 679 O ID 1/1

SUBSCRIBER ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

To identify additional reference numbers for the subscriber related to this subscriber or benefit information loop.

Name	Reference Identification Qualifier
Purpose/Definition	Qualifies the Reference Identification number in REF02.
Codes	18 Plan Number 1L Group or Policy Number 1W Member Identification Number 49 Family Unit Number 6P Group Number 9F Referral Number A6 Employee Identification Number F6 Health Insurance Claim (HIC) Number G1 Prior Authorization Number



	IG Insurance Policy Number N6 Plan Network Identification Number NQ Medicaid Recipient Identification Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Subscriber Eligibility or Benefit Identifier
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

Name	Description
Purpose/Definition	Plan sponsor name
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

SUBSCRIBER ELIGIBILITY/BENEFIT DATE

SITUATIONAL

To convey dates associated with the information contained in this subscriber Eligibility or Benefit Information (EB) loop (which dates are conveyed is determined by the format qualifier in DTP01)..

Name	Date/Time Qualifier
Purpose/Definition	Code specifying type of date in DTP03.
Codes	193 Period Start 194 Period End 198 Completion 290 Coordination of Benefits 292 Benefit 295 Primary Care Provider 304 Latest Visit or Consultation 307 Eligibility 318 Added 348 Benefit Begin 349 Benefit End 356 Eligibility Begin



	357 Eligibility End 435 Admission 472 Service 636 Date of Last Update
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3

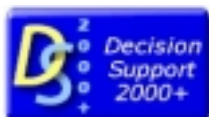
Name	Date Time Period
Purpose/Definition	Identifies the date, or range of dates specified in DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

SUBSCRIBER REQUEST VALIDATION (AAA)

SITUATIONAL

To indicate problems in processing the transaction specifically related to data contained in the original 270 transaction's subscriber eligibility/benefit inquiry information loop (Loop 2110C) and to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1



Name	Reject Reason Code
Purpose/Definition	Assigned by issuer to identify the reason the transaction was unable to be processed successfully.
Codes	15 Required application data missing 52 Service Dates Not Within Provider Plan Enrollment 53 Inquired Benefit Inconsistent with Provider Type 54 Inappropriate Product/Service ID Qualifier 55 Inappropriate Product/Service ID 56 Inappropriate Date 57 Invalid/Missing Date(s) of Service 60 Date of Birth Follows Date(s) of Service 61 Date of Death Precedes Date(s) of Service 62 Date of Service Not Within Allowable Inquiry Period 63 Date of Service in Future 69 Inconsistent with Patient's Age 70 Inconsistent with Patient's Gender
Attributes	REQUIRED AAA03 901 O ID 2/2

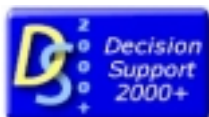
Name	Follow-up Action Code
Purpose/Definition	Identifies what action the recipient of the 271 should take.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed R Resubmission Allowed W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1

MESSAGE TEXT (MSG)

SITUATIONAL

Allows the transmission of text information. Free form text or description fields are not recommended and are not sent under most circumstances.

Name	Free-Form Message Text
Purpose/Definition	Free-form message text.
Codes	
Attributes	REQUIRED MSG01 933 M AN 1/264



LOOP 2115C SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION (III)

SITUATIONAL

Used to begin the Subscriber Eligibility or Benefit Additional Information looping structure.

Name	Code List Qualifier Code
Purpose/Definition	Identifies whether the code in III02 is a principal diagnosis code, a diagnosis code, or a facility type code.
Codes	BF Diagnosis BK Principal Diagnosis ZZ Mutually Defined
Attributes	REQUIRED III01 1270 X ID 1/3

Name	Industry Code
Purpose/Definition	Diagnosis code from ICD-9-CM, or place of service code from code source 237.
Codes	
Attributes	REQUIRED III02 1271 X AN 1/30

LOOP 2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

LOOP HEADER (LS)

SITUATIONAL

Used to identify the beginning of the Subscriber Benefit Related Entity Name loop.

Name	Loop Identifier Code
Purpose/Definition	Identifies the 2120 loop - value must be 2120.
Codes	
Attributes	REQUIRED LS01 447 M AN 1/6



LOOP 2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME

SUBSCRIBER BENEFIT RELATED ENTITY NAME (NM1)

SITUATIONAL

Used to identify a provider, a payer, or another information source when applicable to the eligibility response.

Name	Entity Identifier Code
Purpose/Definition	Identifies the information source applicable to the eligibility response.
Codes	13 Contracted Service Provider 1P Provider 2B Third-Party Administrator 36 Employer 73 Other Physician FA Facility GP Gateway Provider IL Insured or Subscriber LR Legal Representative P3 Primary Care Provider P4 Prior Insurance Carrier P5 Plan Sponsor PR Payer PRP Primary Payer SEP Secondary Payer TTP Tertiary Payer VN Vendor X3 Utilization Management Organization
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Qualifies the person or organization in NM103.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1



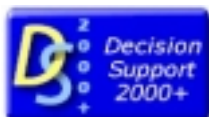
Name	Name Last or Organization Name
Purpose/Definition	Individual last name or organizational name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Individual first name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Individual middle name or initial. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to individual name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Identifies the code system used in NM109.
Codes	24 Employer's Identification Number 34 Social Security Number 46 Electronic Transmitter Identification Number (ETIN) FA Facility Identification FI Federal Taxpayer's Identification Number MI Member Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification PP Pharmacy Processor Number SV Service Provider Number



	XV Health Care Financing Administration National PlanID XX Health Care Financing Administration National Provider Identifier ZZ Mutually Defined
Attributes	SITUATIONAL NM108 66 X ID 1/2

Name	Identification Code
Purpose/Definition	Identifies the benefit related entity.
Codes	
Attributes	SITUATIONAL NM109 67 X AN 2/80

SUBSCRIBER BENEFIT RELATED ENTITY ADDRESS (N3) SITUATIONAL

Identifies address information for the organization or individual in loop 2120C NM1.

Name	Address Information
Purpose/Definition	Address of subscriber benefit related entity.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

Name	Address Information
Purpose/Definition	Second line of address information.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

SUBSCRIBER BENEFIT RELATED CITY/STATE/ZIP CODE (N4) SITUATIONAL

Identifies the city, state and ZIP Code for organization or individual in loop 2120C NM1.

Name	City Name
Purpose/Definition	Free-form text for city name.
Codes	
Attributes	SITUATIONAL N401 19 O AN 2/30



Name	State or Province Code
Purpose/Definition	Standard State/Province code if city is in the U.S or Canada.
Codes	
Attributes	SITUATIONAL N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	International postal zone code (zip code for United States).
Codes	
Attributes	SITUATIONAL N403 116 O ID 3/15

Name	Country Code
Purpose/Definition	To specify the country if other than the United States.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

Name	Location Qualifier
Purpose/Definition	Used for CHAMPUS/TRICARE or CHAMPVA to communicate the Department of Defense Health Services Region for a primary care provider.
Codes	RJ Region
Attributes	SITUATIONAL N405 309 X ID ½

Name	Location Identifier
Purpose/Definition	Department of Defense Health Service Region for the primary care provider.
Codes	
Attributes	SITUATIONAL N406 310 O AN 1/30



SUBSCRIBER BENEFIT RELATED ENTITY CONTACT INFORMATION (PER)

SITUATIONAL

Identifies a contact name and/or communications number for the benefit related entity. Allows for up to three communication numbers to be identified. If telephone extension is sent, it should always be the communications number following the actual phone number

Name	Contact Function Code
Purpose/Definition	Identifies the major duty or responsibility of the person named in PER02.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2

Name	Name
Purpose/Definition	Name of the person to whom communication should be directed.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

Name	Communication Number Qualifier
Purpose/Definition	Identifies the type of communication number in PER04.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80



Name	Communication Number Qualifier
Purpose/Definition	Identifies the type of communication number in PER06.
Codes	
Attributes	SITUATIONAL PER05 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Identifies the type of communication number in PER08.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER07 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80



SUBSCRIBER BENEFIT RELATED PROVIDER INFORMATION (PRV)

SITUATIONAL

Identifies a specific provider, or associate a specialty type, related to the service identified in the 2110C loop. If identifying a specific provider, use this segment to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver.

Name	Provider Code
Purpose/Definition	Identifies the type of provider.
Codes	AT Attending BI Billing CO Consulting CV Covering H Hospital HH Home Health Care LA Laboratory OT Other Physician P1 Pharmacist P2 Pharmacy PC Primary Care Physician PE Performing R Rural Health Clinic RF Referring SK Skilled Nursing Facility
Attributes	REQUIRED PRV01 1221 M ID 1/3

Name	Reference Identification Qualifier
Purpose/Definition	Specifies the identifier used in PRV03.
Codes	9K Servicer EI Employer's Identification Number HPI Health Care Financing Administration National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number ZZ Mutually Defined Health Care Provider Taxonomy Code list.
Attributes	REQUIRED PRV02 128 M ID 2/3



Name	Reference Identification
Purpose/Definition	Provider identifier.
Codes	
Attributes	REQUIRED PRV03 127 M AN 1/30

LOOP 2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION (LE) SITUATIONAL

Used to identify the end of the Subscriber Benefit Related Entity Name loop.

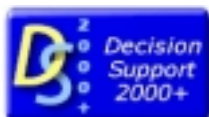
Name	Loop Identifier Code
Purpose/Definition	Identifies the end of the 2120 loop - value must be 2120.
Codes	
Attributes	REQUIRED LE01 447 M AN 1/6

LOOP 2000D — DEPENDENT LEVEL

DEPENDENT LEVEL (HL) SITUATIONAL

Identifies the relationship between the hierarchically related groups of data segments, and indicates that the series of segments from this Hierarchical Level (HL) segment until the next HL segment are related to the dependent.

Name	Hierarchical ID Number
Purpose/Definition	A unique number assigned by the sender to identify this data segment in the hierarchical structure.
Codes	
Attributes	REQUIRED HL01 628 M AN 1/12



Name	Hierarchical Parent ID Number
Purpose/Definition	Identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
Codes	
Attributes	REQUIRED HL02 734 O AN 1/12

Name	Hierarchical Level Code
Purpose/Definition	Indicates the series of segments from this HL segment until the next occurrence of an HL segment are related to the dependent.
Codes	23 Dependent
Attributes	REQUIRED HL03 735 M ID 1/2

Name	Hierarchical Child Code
Purpose/Definition	Indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.
Codes	
Attributes	REQUIRED HL04 736 O ID 1/1

LOOP 2000D — DEPENDENT LEVEL

DEPENDENT LEVEL (TRN)

SITUATIONAL

Used to provide a unique identifier for the transaction.

Name	Trace Type Code
Purpose/Definition	Identifies whether the trace number in TRN02 was assigned by the creator of the 271 transaction (current) or originally sent in the 270 Benefit Inquiry (referenced).
Codes	1 Current Transaction Trace Numbers 2 Referenced Transaction Trace Numbers
Attributes	REQUIRED TRN01 481 M ID 1/2



Name	Reference Identification
Purpose/Definition	Identifies a trace number as specified in TRN01.
Codes	
Attributes	REQUIRED TRN02 127 M AN 1/30

Name	Originating Company Identifier
Purpose/Definition	If TRN01=1, this is the identifier of the company assigning the trace number. If TRN01=2, this is the value received in the original 270 transaction.
Codes	
Attributes	REQUIRED TRN03 509 O AN 10/10

Name	Reference Identification
Purpose/Definition	If TRN01 = 1, this is an additional identifier for the organization identified in TRN03. If TRN01 is = 2, this is the value received in the original 270 transaction.
Codes	
Attributes	SITUATIONAL TRN04 127 O AN 1/30

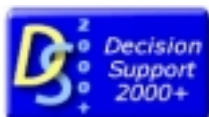
LOOP 2100D — DEPENDENT NAME

DEPENDENT NAME (NM1)

REQUIRED

To identify the dependent of an insured or subscriber.

Name	Entity Identifier Code
Purpose/Definition	Identifies that the individual named in this segment is the dependent.
Codes	03 Dependent
Attributes	REQUIRED NM101 98 M ID 2/3



Name	Entity Type Qualifier
Purpose/Definition	Qualifies that the entity in NM103 is a person.
Codes	1 Person
Attributes	REQUIRED NM102 1065 M ID 1/1

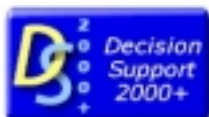
Name	Name Last or Organization Name
Purpose/Definition	Dependent last name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Dependent first name.
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Dependent middle name or initial.
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to dependent name.
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10

Name	Identification Code Qualifier
Purpose/Definition	Designates the code structure used in NM109.
Codes	MI Member Identification Number ZZ Mutually Defined
Attributes	SITUATIONAL NM108 66 X ID 1/2



Name	Identification Code
Purpose/Definition	Dependent ID code.
Codes	
Attributes	SITUATIONAL NM109 67 X AN 2/80

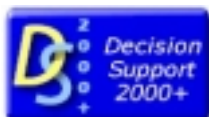
DEPENDENT ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

To supply an additional identification number for the dependent

Name	Reference Identification Qualifier
Purpose/Definition	Qualifies the type of code used in REF02.
Codes	18 Plan Number 1L Group or Policy Number 1W Member Identification Number 49 Family Unit Number 6P Group Number EA Medical Record Identification Number EJ Patient Account Number F6 Health Insurance Claim (HIC) Number GH Identification Card Serial Number IF Issue Number IG Insurance Policy Number M7 Medical Assistance Category N6 Plan Network Identification Number NQ Medicaid Recipient Identification Number Q4 Prior Identifier Number SY Social Security Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Additional dependent ID number.
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30



Name	Description
Purpose/Definition	Plan sponsor name.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

DEPENDENT ADDRESS (N3)

SITUATIONAL

Identifies address information for a dependent.

Name	Address Information
Purpose/Definition	Dependent address information.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55

Name	Address Information
Purpose/Definition	Dependent address information, line 2.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

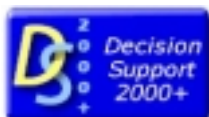
DEPENDENT CITY/STATE/ZIP CODE (N4)

SITUATIONAL

Identifies the city, state and ZIP Code for a dependent.

Name	City Name
Purpose/Definition	Dependent city name.
Codes	
Attributes	SITUATIONAL N401 19 O AN 2/30

Name	State or Province Code
Purpose/Definition	Standard State/Province if address is in the U.S. or Canada.
Codes	
Attributes	SITUATIONAL N402 156 O ID 2/2



Name	Postal Code
Purpose/Definition	International postal zone code (zip code for United States).
Codes	
Attributes	SITUATIONAL N403 116 O ID 3/15

Name	Country Code
Purpose/Definition	Identifies the country if address is outside the U.S.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3

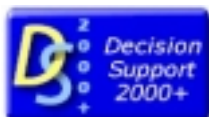
DEPENDENT CONTACT INFORMATION (PER)

SITUATIONAL

Identifies a contact name and/or communications number for the dependent identified. This segment allows for three contact numbers to be listed. If telephone extension is sent, it should always be in the communications number following the actual phone number.

Name	Contact Function Code
Purpose/Definition	Code identifying the major duty or responsibility of the person named in PER02.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2

Name	Name
Purpose/Definition	Name of the person to whom communication should be directed.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

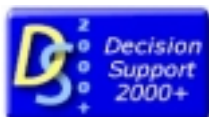


Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER04.
Codes	HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER06.
Codes	EX Telephone Extension HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER05 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80



Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER08.
Codes	EX Telephone Extension HP Home Phone Number TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER07 365 X ID 2/2

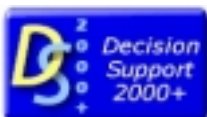
Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80

DEPENDENT REQUEST VALIDATION (AAA)

SITUATIONAL

Used to indicate problems and to indicate what action the originator of the request transaction should take and to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's dependent name loop (Loop 2100D).

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1



Name	Reject Reason Code
Purpose/Definition	Identifies why the transaction was unable to be processed successfully.
Codes	15 Required application data missing 42 Unable to Respond at Current Time 43 Invalid/Missing Provider Identification 45 Invalid/Missing Provider Specialty 47 Invalid/Missing Provider State 48 Invalid/Missing Referring Provider Identification Number 49 Provider is Not Primary Care Physician 51 Provider Not on File 52 Service Dates Not Within Provider Plan Enrollment 56 Inappropriate Date 57 Invalid/Missing Date(s) of Service 58 Invalid/Missing Date-of-Birth 60 Date of Birth Follows Date(s) of Service 61 Date of Death Precedes Date(s) of Service 62 Date of Service Not Within Allowable Inquiry Period 63 Date of Service in Future 64 Invalid/Missing Patient ID 65 Invalid/Missing Patient Name 66 Invalid/Missing Patient Gender Code 67 Patient Not Found 68 Duplicate Patient ID Number 71 Patient Birth Date Does Not Match That for the Patient on the Database
Attributes	REQUIRED AAA03 901 O ID 2/2

Name	Follow-up Action Code
Purpose/Definition	To instruct the recipient about what action needs to be taken based the validity and reject reason code.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed R Resubmission Allowed Use only when AAA03 is "42".



	S Do Not Resubmit; Inquiry Initiated to a Third Party W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1

DEPENDENT DEMOGRAPHIC INFORMATION (DMG)

SITUATIONAL

To supply the birth date or gender information for the dependent.

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format used in DMG02.
Codes	D8 Date Expressed in Format CCYYMMDD
Attributes	SITUATIONAL DMG01 1250 X ID 2/3

Name	Date Time Period
Purpose/Definition	Dependent birth date.
Codes	
Attributes	SITUATIONAL DMG02 1251 X AN 1/35

Name	Gender Code
Purpose/Definition	Dependent gender.
Codes	F Female M Male U Unknown
Attributes	SITUATIONAL DMG03 1068 O ID 1/1



DEPENDENT RELATIONSHIP (INS)**SITUATIONAL**

To convey insurance related information about the dependent or to identify that the information source has changed some of the identifying elements for the dependent that the information receiver submitted in the original 270 transaction.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the insured is the subscriber (No indicates the insured is the dependent.)
Codes	N No
Attributes	REQUIRED INS01 1073 M ID 1/1

Name	Individual Relationship Code
Purpose/Definition	Indicates the relationship between two subscriber and dependent.
Codes	01 Spouse 19 Child 21 Unknown 34 Other Adult
Attributes	REQUIRED INS02 1069 M ID 2/2

Name	Maintenance Type Code
Purpose/Definition	Identifies that elements for the dependent have been changed from those submitted in the 270.
Codes	001 Change
Attributes	SITUATIONAL INS03 875 O ID 3/3

Name	Maintenance Reason Code
Purpose/Definition	Indicates a change has been made to the primary elements that identify the dependent (first name, last name, date of birth, or ID numbers).
Codes	25 Change in Identifying Data Elements
Attributes	SITUATIONAL INS04 1203 O ID 2/3



Name	Student Status Code
Purpose/Definition	Indicates the student status of the dependent if 19 years of age or older, not handicapped and not the insured.
Codes	F Full-time N Not a Student P Part-time
Attributes	SITUATIONAL INS09 1220 O ID 1/1

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the dependent is handicapped.
Codes	N No Y Yes
Attributes	SITUATIONAL INS10 1073 O ID 1/1

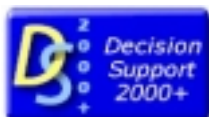
Name	Number
Purpose/Definition	Indicates the birth number in the event of multiple births.
Codes	
Attributes	SITUATIONAL INS17 1470 O N0 1/9

DEPENDENT DATE (DTP)

SITUATIONAL

To convey any relevant dates (which dates are conveyed is determined by the format qualifier in DTP01).

Name	Date/Time Qualifier
Purpose/Definition	Qualifies the date that will appear in DTP03.
Codes	102 Issue 152 Effective Date of Change 291 Plan 307 Eligibility 318 Added 340 Consolidated Omnibus Budget Reconciliation Act (COBRA) Begin 341 Consolidated Omnibus Budget Reconciliation Act (COBRA) End



	342 Premium Paid to Date Begin 343 Premium Paid to Date End 346 Plan Begin 347 Plan End 382 Enrollment 435 Admission 442 Date of Death 458 Certification 472 Service 539 Policy Effective 540 Policy Expiration 636 Date of Last Update
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3

Name	Date Time Period
Purpose/Definition	Indicates the date, or date(s), as qualified by DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35



LOOP 2110D DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION

DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION (EB) SITUATIONAL

This segment begins the eligibility/benefit information looping structure and is used to convey information about the dependent whose eligibility or benefits are being verified.

Name	Eligibility or Benefit Information
Purpose/Definition	Identifies the eligibility or benefit information such as the eligibility status of the dependent or the benefit related category that is described in this segment. EB01 qualifies EB06 through EB10.
Codes	1 Active Coverage 2 Active - Full Risk Capitation 3 Active - Services Capitated 4 Active - Services Capitated to Primary Care Physician 5 Active - Pending Investigation 6 Inactive 7 Inactive - Pending Eligibility Update 8 Inactive - Pending Investigation A Co-Insurance B Co-Payment C Deductible CB Coverage Basis D Benefit Description E Exclusions F Limitations G Out of Pocket (Stop Loss) H Unlimited I Non-Covered J Cost Containment K Reserve L Primary Care Provider M Pre-existing Condition MC Managed Care Coordinator N Services Restricted to Following Provider O Not Deemed a Medical Necessity P Benefit Disclaimer Q Second Surgical Opinion Required



	R Other or Additional Payor S Prior Year(s) History T Card(s) Reported Lost/Stolen U Contact Following Entity for Eligibility or Benefit Information V Cannot Process W Other Source of Data X Health Care Facility Y Spend Down
Attributes	REQUIRED EB01 1390 M ID 1/2

Name	Coverage Level Code
Purpose/Definition	Indicates which individuals are covered by the insurance plan.
Codes	CHD Children Only DEP Dependents Only ECH Employee and Children ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
Attributes	SITUATIONAL EB02 1207 O ID 3/3

Name	Service Type Code
Purpose/Definition	Identifies the type of service for which the eligibility status is being supplied.
Codes	1 Medical Care 2 Surgical 3 Consultation 4 Diagnostic X-Ray 5 Diagnostic Lab 6 Radiation Therapy 7 Anesthesia 8 Surgical Assistance 9 Other Medical 10 Blood Charges



	<p>11 Used Durable Medical Equipment 12 Durable Medical Equipment Purchase 13 Ambulatory Service Center Facility 14 Renal Supplies in the Home 15 Alternate Method Dialysis 16 Chronic Renal Disease (CRD) Equipment 17 Pre-Admission Testing 18 Durable Medical Equipment Rental 19 Pneumonia Vaccine 20 Second Surgical Opinion 21 Third Surgical Opinion 22 Social Work 23 Diagnostic Dental 24 Periodontics 25 Restorative 26 Endodontics 27 Maxillofacial Prosthetics 28 Adjunctive Dental Services 30 Health Benefit Plan Coverage 32 Plan Waiting Period 33 Chiropractic 34 Chiropractic Office Visits 35 Dental Care 36 Dental Crowns 37 Dental Accident 38 Orthodontics 39 Prosthodontics 40 Oral Surgery 41 Routine (Preventive) Dental 42 Home Health Care 43 Home Health Prescriptions 44 Home Health Visits 45 Hospice 46 Respite Care 47 Hospital 48 Hospital - Inpatient 49 Hospital - Room and Board 50 Hospital - Outpatient 51 Hospital - Emergency Accident 52 Hospital - Emergency Medical 53 Hospital - Ambulatory Surgical 54 Long Term Care</p>
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	<p>55 Major Medical</p> <p>56 Medically Related Transportation</p> <p>57 Air Transportation</p> <p>58 Cabulance</p> <p>59 Licensed Ambulance</p> <p>60 General Benefits</p> <p>61 In-vitro Fertilization</p> <p>62 MRI/CAT Scan</p> <p>63 Donor Procedures</p> <p>64 Acupuncture</p> <p>65 Newborn Care</p> <p>66 Pathology</p> <p>67 Smoking Cessation</p> <p>68 Well Baby Care</p> <p>69 Maternity</p> <p>70 Transplants</p> <p>71 Audiology Exam</p> <p>72 Inhalation Therapy</p> <p>73 Diagnostic Medical</p> <p>74 Private Duty Nursing</p> <p>75 Prosthetic Device</p> <p>76 Dialysis</p> <p>77 Otological Exam</p> <p>78 Chemotherapy</p> <p>79 Allergy Testing</p> <p>80 Immunizations</p> <p>81 Routine Physical</p> <p>82 Family Planning</p> <p>83 Infertility</p> <p>84 Abortion</p> <p>85 AIDS</p> <p>86 Emergency Services</p> <p>87 Cancer</p> <p>88 Pharmacy</p> <p>89 Free Standing Prescription Drug</p> <p>90 Mail Order Prescription Drug</p> <p>91 Brand Name Prescription Drug</p> <p>92 Generic Prescription Drug</p> <p>93 Podiatry</p> <p>94 Podiatry - Office Visits</p>
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	<p> 95 Podiatry - Nursing Home Visits 96 Professional (Physician) 97 Anesthesiologist 98 Professional (Physician) Visit - Office 99 Professional (Physician) Visit - Inpatient A0 Professional (Physician) Visit - Outpatient A1 Professional (Physician) Visit - Nursing Home A2 Professional (Physician) Visit - Skilled Nursing Facility A3 Professional (Physician) Visit - Home A4 Psychiatric A5 Psychiatric - Room and Board A6 Psychotherapy A7 Psychiatric - Inpatient A8 Psychiatric - Outpatient A9 Rehabilitation AA Rehabilitation - Room and Board AB Rehabilitation - Inpatient AC Rehabilitation - Outpatient AD Occupational Therapy AE Physical Medicine AF Speech Therapy AG Skilled Nursing Care AH Skilled Nursing Care - Room and Board AI Substance Abuse AJ Alcoholism AK Drug Addiction AL Vision (Optometry) AM Frames AN Routine Exam AO Lenses AQ Nonmedically Necessary Physical AR Experimental Drug Therapy BA Independent Medical Evaluation BB Partial Hospitalization (Psychiatric) BC Day Care (Psychiatric) BD Cognitive Therapy BE Massage Therapy BF Pulmonary Rehabilitation BG Cardiac Rehabilitation BH Pediatric BI Nursery BJ Skin </p>
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	BK Orthopedic BL Cardiac BM Lymphatic BN Gastrointestinal BP Endocrine BQ Neurology BR Eye BS Invasive Procedures
Attributes	SITUATIONAL EB03 1365 O ID ½

Name	Insurance Type Code
Purpose/Definition	Identifies the type of insurance policy within a specific insurance program.
Codes	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan 14 Medicare Secondary, No-fault Insurance including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary AP Auto Insurance Policy C1 Commercial CO Consolidated Omnibus Budget Reconciliation Act (COBRA) CP Medicare Conditionally Primary D Disability DB Disability Benefits EP Exclusive Provider Organization FF Family or Friends GP Group Policy HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) – Medicare Risk



	HS Special Low Income Medicare Beneficiary IN Indemnity IP Individual Policy LC Long Term Care LD Long Term Policy LI Life Insurance LT Litigation MA Medicare Part A MB Medicare Part B MC Medicaid MH Medigap Part A MI Medigap Part B MP Medicare Primary OT Other PE Property Insurance - Personal PL Personal PP Personal Payment (Cash - No Insurance) PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary RP Property Insurance - Real SP Supplemental Policy TF Tax Equity Fiscal Responsibility Act (TEFRA) WC Workers Compensation WU Wrap Up Policy
Attributes	SITUATIONAL EB04 1336 O ID 1/3

Name	Plan Coverage Description
Purpose/Definition	A specific product name that identifies the plan or coverage.
Codes	
Attributes	SITUATIONAL EB05 1204 O AN 1/50



Name	Time Period Qualifier
Purpose/Definition	Identifies the time period for the benefits being described, when needed to qualify benefit availability
Codes	6 Hour 7 Day 13 24 Hours 21 Years 22 Service Year 23 Calendar Year 24 Year to Date 25 Contract 26 Episode 27 Visit 28 Outlier 29 Remaining 30 Exceeded 31 Not Exceeded 32 Lifetime 33 Lifetime Remaining 34 Month 35 Week 36 Admission
Attributes	SITUATIONAL EB06 615 O ID 1/2

Name	Monetary Amount
Purpose/Definition	Identifies the benefit amount (e.g., deductible, co-payment) as qualified by EB01.
Codes	
Attributes	SITUATIONAL EB07 782 O R 1/18

Name	Percent
Purpose/Definition	Identifies the benefit percent (e.g., co-insurance) as qualified by EB01.
Codes	
Attributes	SITUATIONAL EB08 954 O R 1/10



Name	Quantity Qualifier
Purpose/Definition	Identifies the type of units related to the number in EB10.
Codes	99 Quantity Used CA Covered - Actual CE Covered - Estimated DB Deductible Blood Units DY Days HS Hours LA Life-time Reserve - Actual LE Life-time Reserve - Estimated MN Month P6 Number of Services or Procedures QA Quantity Approved S7 Age, High Value S8 Age, Low Value VS Visits YY Years
Attributes	SITUATIONAL EB09 673 X ID 2/2

Name	Quantity
Purpose/Definition	Identifies the number of units related to the benefit conveyed in EB09.
Codes	
Attributes	SITUATIONAL EB10 380 X R 1/15

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether an authorization or certification is required by plan provisions.
Codes	N No U Unknown Y Yes
Attributes	SITUATIONAL EB11 1073 O ID 1/1



Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the benefits identified are considered In-Plan-Network.
Codes	N No U Unknown Y Yes
Attributes	SITUATIONAL EB12 1073 O ID 1/1

Name	COMPOSITE MEDICAL PROCEDURE IDENTIFIER
Purpose/Definition	Identifies a medical procedure by its standardized codes and applicable modifiers. Allows for a very specific response to a very specific benefit inquiry, such as based on a diagnosis or procedure code.
Codes	
Attributes	SITUATIONAL EB13 C003 O

Name	Product/Service ID Qualifier
Purpose/Definition	Identifies the external code source for the descriptive number used in EB13-2.
Codes	AD American Dental Association Codes CJ Current Procedural Terminology (CPT) Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure ND National Drug Code (NDC) ZZ Mutually Defined
Attributes	REQUIRED EB13 - 1 235 M ID 2/2

Name	Product/Service ID
Purpose/Definition	Identifying number for the product or service.
Codes	
Attributes	REQUIRED EB13 - 2 234 ID M AN 1/48



Name	Procedure Modifier
Purpose/Definition	Modifies the procedure code in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 3 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Modifies the procedure code in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 4 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Modifies the procedure code in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 5 1339 O AN 2/2

Name	Procedure Modifier
Purpose/Definition	Modifies the procedure code in EB13-2.
Codes	
Attributes	SITUATIONAL EB13 - 6 1339 O AN 2/2



HEALTH CARE SERVICES DELIVERY (HSD)**SITUATIONAL**

To specify the delivery pattern of health care services when benefits identified in either EB03 or EB13 have a specific delivery or usage pattern associated with the benefit. For example, if the patient is to receive a total of 24 visits, 3 visits per weeks for two months, every Monday Wednesday and Friday AM, then HSD01=VS, HSD02=24, HSD03=WK, HSD04=3, HSD05=34, HSD06=2, HSD07=SZ and HSD08=D.

Name	Quantity Qualifier
Purpose/Definition	Identifies the type of service unit quantity specified in HSD02.
Codes	DY Days FL Units HS Hours MN Month VS Visits\
Attributes	SITUATIONAL HSD01 673 X ID 2/2

Name	Quantity
Purpose/Definition	Identifies the quantity of service units specified in HSD01.
Codes	
Attributes	SITUATIONAL HSD02 380 X R 1/15

Name	Unit or Basis for Measurement Code
Purpose/Definition	Specifies the time period in which the service is being provided (e.g., a certain number of services every 2 <u>weeks</u> or every 6 <u>months</u>).
Codes	DA Days MO Months VS Visit WK Week YR Years
Attributes	SITUATIONAL HSD03 355 O ID 2/2



Name	Sample Selection Modulus
Purpose/Definition	Specifies the frequency of the service period defined in HSD03 (e.g., every <u>3</u> months or every <u>2</u> weeks).
Codes	
Attributes	SITUATIONAL HSD04 1167 O R 1/6

Name	Time Period Qualifier
Purpose/Definition	Specifies the period of time over which the service is being delivered (e.g., for <u>2 months</u>)
Codes	6 Hour 7 Day 21 Years 22 Service Year 23 Calendar Year 24 Year to Date 25 Contract 26 Episode 27 Visit 28 Outlier 29 Remaining 30 Exceeded 31 Not Exceeded 32 Lifetime 33 Lifetime Remaining 34 Month 35 Week
Attributes	SITUATIONAL HSD05 615 X ID 1/2

Name	Number of Periods
Purpose/Definition	Identifies the total number of periods of service as defined in HSD05 (e.g., for <u>3</u> months).
Codes	
Attributes	SITUATIONAL HSD06 616 O N0 1/3



Name	Ship/Delivery or Calendar Pattern Code
Purpose/Definition	Specifies the pattern for delivery of the health care service.
Codes	1 1st Week of the Month 2 2nd Week of the Month 3 3rd Week of the Month 4 4th Week of the Month 5 5th Week of the Month 6 1st & 3rd Weeks of the Month 7 2nd & 4th Weeks of the Month 8 1st Working Day of Period 9 Last Working Day of Period A Monday through Friday B Monday through Saturday C Monday through Sunday D Monday E Tuesday F Wednesday G Thursday H Friday J Saturday K Sunday L Monday through Thursday M Immediately N As Directed O Daily Mon. through Fri. P 1/2 Mon. & 1/2 Thurs. Q 1/2 Tues. & 1/2 Thurs. R 1/2 Wed. & 1/2 Fri. S Once Anytime Mon. through Fri. SG Tuesday through Friday SL Monday, Tuesday and Thursday SP Monday, Tuesday and Friday SX Wednesday and Thursday SY Monday, Wednesday and Thursday



	SZ Tuesday, Thursday and Friday T 1/2 Tue. & 1/2 Fri. U 1/2 Mon. & 1/2 Wed. V 1/3 Mon., 1/3 Wed., 1/3 Fri. W Whenever Necessary X 1/2 By Wed., Bal. By Fri. Y None (Also Used to Cancel or Override a Previous Pattern)
Attributes	SITUATIONAL HSD07 678 O ID 1/2

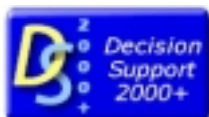
Name	Ship/Delivery Pattern Time Code
Purpose/Definition	Specifies the time for routine delivery of health care services.
Codes	A 1st Shift (Normal Working Hours B 2nd Shift C 3rd Shift D A.M. E P.M. F As Directed G Any Shift Y None (Also Used to Cancel or Override a Previous Pattern)
Attributes	SITUATIONAL HSD08 679 O ID 1/1

DEPENDENT ADDITIONAL IDENTIFICATION (REF)

SITUATIONAL

To identify additional reference numbers for the dependent.

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of reference number that appears in REF02.
Codes	8 Plan Number 1L Group or Policy Number 1W Member Identification Number 49 Family Unit Number 6P Group Number 9F Referral Number A6 Employee Identification Number



	F6 Health Insurance Claim (HIC) Number G1 Prior Authorization Number IG Insurance Policy Number N6 Plan Network Identification Number NQ Medicaid Recipient Identification Number
Attributes	REQUIRED REF01 128 M ID 2/3

Name	Reference Identification
Purpose/Definition	Dependent Eligibility or benefit identifier, as qualified in REF01
Codes	
Attributes	REQUIRED REF02 127 X AN 1/30

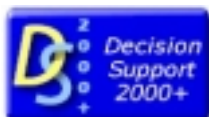
Name	Description
Purpose/Definition	Specifies the Plan Sponsor Name.
Codes	
Attributes	SITUATIONAL REF03 352 X AN 1/80

DEPENDENT ELIGIBILITY/BENEFIT DATE (DTP)

SITUATIONAL

To convey dates associated with the information contained in the corresponding Eligibility or Benefit Information (EB) loop (which dates are conveyed is determined by the format qualifier in DTP01).

Name	Date/Time Qualifier
Purpose/Definition	Specifies the type of date in DTP03.
Codes	193 Period Start 194 Period End 198 Completion 290 Coordination of Benefits 292 Benefit 295 Primary Care Provider 304 Latest Visit or Consultation 307 Eligibility 318 Added 348 Benefit Begin 349 Benefit End



	356 Eligibility Begin 357 Eligibility End 435 Admission 472 Service 636 Date of Last Update 771 Status
Attributes	REQUIRED DTP01 374 M ID 3/3

Name	Date Time Period Format Qualifier
Purpose/Definition	Indicates the date format that will appear in DTP03.
Codes	D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
Attributes	REQUIRED DTP02 1250 M ID 2/3

Name	Date Time Period
Purpose/Definition	Indicates the date, or date(s), as qualified by DTP01.
Codes	
Attributes	REQUIRED DTP03 1251 M AN 1/35

DEPENDENT REQUEST VALIDATION (AAA)

SITUATIONAL

To indicate problems in processing the transaction specifically related to eligibility/benefit inquiry data contained in the original 270 transaction's dependent eligibility/benefit inquiry information loop (Loop 2110D).and to indicate what action the originator of the request transaction should take.

Name	Yes/No Condition or Response Code
Purpose/Definition	Indicates whether the request is valid.
Codes	N No Y Yes
Attributes	REQUIRED AAA01 1073 M ID 1/1



Name	Reject Reason Code
Purpose/Definition	Identifies the reason why the transaction was unable to be processed successfully.
Codes	15 Required application data missing 52 Service Dates Not Within Provider Plan Enrollment 53 Inquired Benefit Inconsistent with Provider Type 54 Inappropriate Product/Service ID Qualifier 55 Inappropriate Product/Service ID 56 Inappropriate Date 57 Invalid/Missing Date(s) of Service 60 Date of Birth Follows Date(s) of Service 61 Date of Death Precedes Date(s) of Service 62 Date of Service Not Within Allowable Inquiry Period 63 Date of Service in Future 69 Inconsistent with Patient's Age 70 Inconsistent with Patient's Gender
Attributes	REQUIRED AAA03 901 O ID 2/2

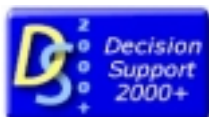
Name	Follow-up Action Code
Purpose/Definition	Instructs the recipient about what action needs to be taken based the validity and reject reason code.
Codes	C Please Correct and Resubmit N Resubmission Not Allowed R Resubmission Allowed W Please Wait 30 Days and Resubmit X Please Wait 10 Days and Resubmit Y Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly
Attributes	REQUIRED AAA04 889 O ID 1/1

MESSAGE TEXT (MSG)

SITUATIONAL

Allows the transmission of free-form text. Under most circumstances, this segment is not sent.

Name	Free-Form Message Text
Purpose/Definition	Free-form message text.
Codes	
Attributes	REQUIRED MSG01 933 M AN 1/264



LOOP 2115D DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION (III)

SITUATIONAL

To return information that was received in III segments in Loop 2110D of the 270 Inquiry that was used in the determination of the eligibility or benefit response, and/or to identify limitations in the benefits explained in the corresponding Loop 2110D, such as if benefits are limited to a type of facility or for a specific diagnosis code.

Name	Code List Qualifier Code
Purpose/Definition	Identifies whether the code in III02 is a principal diagnosis code, a diagnosis code, or a facility type code.
Codes	BF Diagnosis BK Principal Diagnosis ZZ Mutually Defined
Attributes	REQUIRED III01 1270 X ID 1/3

Name	Industry Code
Purpose/Definition	Diagnosis code from ICD-9-CM, or place of service code from code source 237.
Codes	
Attributes	REQUIRED III02 1271 X AN 1/30



LOOP 2110D DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION

DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION (LS) SITUATIONAL

To identify the beginning of the Dependent Benefit Related Entity Name loop.

Name	Loop Identifier Code
Purpose/Definition	Identifies the beginning of the 2120 loop – value must be 2120.
Codes	
Attributes	REQUIRED LS01 447 M AN 1/6

LOOP 2120D DEPENDENT BENEFIT RELATED ENTITY NAME

DEPENDENT BENEFIT RELATED ENTITY NAME (NMI) SITUATIONAL

To identify a provider, another payer, or another information source when applicable to the eligibility response.

Name	Entity Identifier Code
Purpose/Definition	ID code for the dependent benefit related entity.
Codes	13 Contracted Service Provider 1P Provider 2B Third-Party Administrator 36 Employer 73 Other Physician FA Facility GP Gateway Provider IL Insured or Subscriber LR Legal Representative P3 Primary Care Provider P4 Prior Insurance Carrier



	P5 Plan Sponsor PR Payer PRP Primary Payer SEP Secondary Payer TTP Tertiary Payer VN Vendor X3 Utilization Management Organization
Attributes	REQUIRED NM101 98 M ID 2/3

Name	Entity Type Qualifier
Purpose/Definition	Qualifies the dependent benefit related entity in NM103.
Codes	1 Person 2 Non-Person Entity
Attributes	REQUIRED NM102 1065 M ID 1/1

Name	Name Last or Organization Name
Purpose/Definition	Individual last name or organizational name.
Codes	
Attributes	SITUATIONAL NM103 1035 O AN 1/35

Name	Name First
Purpose/Definition	Individual first name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM104 1036 O AN 1/25

Name	Name Middle
Purpose/Definition	Individual middle name or initial. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM105 1037 O AN 1/25

Name	Name Suffix
Purpose/Definition	Suffix to individual name. Use only if NM102 is "1".
Codes	
Attributes	SITUATIONAL NM107 1039 O AN 1/10



Name	Identification Code Qualifier
Purpose/Definition	Code designating the system/method of code structure used for in NM109.
Codes	24 Employer's Identification Number 34 Social Security Number 46 Electronic Transmitter Identification Number (ETIN) FA Facility Identification FI Federal Taxpayer's Identification Number MI Member Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification PP Pharmacy Processor Number SV Service Provider Number XV Health Care Financing Administration National PlanID XX Health Care Financing Administration National Provider Identifier ZZ Mutually Defined
Attributes	SITUATIONAL NM108 66 X ID 1/2

Name	Identification Code
Purpose/Definition	ID code for the benefit related entity.
Codes	
Attributes	SITUATIONAL NM109 67 X AN 2/80

DEPENDENT BENEFIT RELATED ENTITY ADDRESS (N3) SITUATIONAL

To identify address information for a dependent benefit related entity.

Name	Address Information
Purpose/Definition	Dependent benefit related entity address information.
Codes	
Attributes	REQUIRED N301 166 M AN 1/55



Name	Address Information
Purpose/Definition	Address information, line 2.
Codes	
Attributes	SITUATIONAL N302 166 O AN 1/55

**DEPENDENT BENEFIT RELATED ENTITY CITY/STATE/ZIP
CODE (N4)**

SITUATIONAL

To identify the city, state and ZIP Code for the dependent benefit related entity.

Name	City Name
Purpose/Definition	Free-form text for city name.
Codes	
Attributes	SITUATIONAL N401 19 O AN 2/30

Name	State or Province Code
Purpose/Definition	Standard State/Province if address is in the U.S. or Canada.
Codes	
Attributes	SITUATIONAL N402 156 O ID 2/2

Name	Postal Code
Purpose/Definition	International postal zone code (zip code for United States).
Codes	
Attributes	SITUATIONAL N403 116 O ID 3/15

Name	Country Code
Purpose/Definition	Identifies the country if address is outside the U.S.
Codes	
Attributes	SITUATIONAL N404 26 O ID 2/3



Name	Location Qualifier
Purpose/Definition	Used for CHAMPUS/TRICARE or CHAMPVA to communicate the Department of Defense Health Services Region for a primary care provider.
Codes	RJ Region
Attributes	SITUATIONAL N405 309 X ID 1/2

Name	Location Identifier
Purpose/Definition	Department of Defense Health Services Region Code for the primary care provider.
Codes	
Attributes	SITUATIONAL N406 310 O AN 1/30

DEPENDENT BENEFIT RELATED ENTITY CONTACT INFORMATION (PER)

SITUATIONAL

To identify a contact name and/or communications number for the dependent related entity. This segment allows for three contact numbers to be listed. If telephone extension is sent, it should always be the communications number following the actual phone number.

Name	Contact Function Code
Purpose/Definition	Code identifying the major duty or responsibility of the person or group named.
Codes	IC Information Contact
Attributes	REQUIRED PER01 366 M ID 2/2

Name	Name
Purpose/Definition	Name of the person to whom communication should be directed.
Codes	
Attributes	SITUATIONAL PER02 93 O AN 1/60

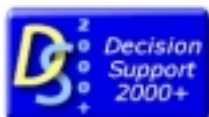


Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER04.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER03 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER04 364 X AN 1/80

Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER06.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER05 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER06 364 X AN 1/80



Name	Communication Number Qualifier
Purpose/Definition	Code identifying the type of communication number in PER08.
Codes	ED Electronic Data Interchange Access Number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone WP Work Phone Number
Attributes	SITUATIONAL PER07 365 X ID 2/2

Name	Communication Number
Purpose/Definition	Complete communications number including country or area code when applicable.
Codes	
Attributes	SITUATIONAL PER08 364 X AN 1/80



**DEPENDENT BENEFIT RELATED PROVIDER
INFORMATION (PRV)**

SITUATIONAL

To identify a specific provider or associate a specialty type related to the service identified in the 2110D loop, and/or to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver.

Name	Provider Code
Purpose/Definition	Identifies the type of provider.
Codes	AT Attending BI Billing CO Consulting CV Covering H Hospital HH Home Health Care LA Laboratory OT Other Physician P1 Pharmacist P2 Pharmacy PC Primary Care Physician PE Performing R Rural Health Clinic RF Referring SK Skilled Nursing Facility
Attributes	REQUIRED PRV01 1221 M ID 1/3

Name	Reference Identification Qualifier
Purpose/Definition	Identifies the type of code used in PRV03.
Codes	9K Servicer D3 National Association of Boards of Pharmacy Number EI Employer's Identification Number HPI Health Care Financing Administration National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number ZZ Mutually Defined Health Care Provider Taxonomy Code list
Attributes	REQUIRED PRV02 128 M ID 2/3



Name	Reference Identification
Purpose/Definition	Provider identification number.
Codes	
Attributes	REQUIRED PRV03 127 M AN 1/30

LOOP 2110D LOOP TRAILER

LOOP TRAILER (LE)

SITUATIONAL

To identify the end of the Dependent Benefit Related Entity Name loop.

Name	Loop Identifier Code
Purpose/Definition	Identifies the end of the 2120 loop – the value must be 2120.
Codes	
Attributes	REQUIRED LE01 447 M AN 1/6

TRANSACTION SET TRAILER (SE)

REQUIRED

Marks the end of the transaction set and provides control information on the total number of segments included in the transaction set.

Name	Number of Included Segments
Purpose/Definition	Indicates the total number of segments included in this transaction set including ST and SE segments.
Codes	
Attributes	REQUIRED SE01 96 M N0 1/10

Name	Transaction Set Control Number
Purpose/Definition	Identifies a control number that must be unique within the transaction set functional group assigned by the originator for a transaction set and must match the transaction set control number in the ST segment that begins the transaction.
Codes	
Attributes	REQUIRED SE02 329 M AN 4/9



VII. Key Terms and Issues

A. Business Definitions

Information Source

The information source is the entity with the answer to the questions being asked, typically the insurer, or payer. The information source could also be a primary care physician or gateway provider. Regardless of the information source's actual role, it is the entity who maintains the information regarding the patient's coverage. (Note: the information source is not a clearinghouse, value added network or other intermediary, even if they hold the data for the true information source.)

Information Receiver

The information receiver is the entity asking the questions, typically the medical service provider (e.g., physician, hospital, laboratory, etc.). The information receiver could also be another insurer or payer who is attempting to verify other insurance coverage for its members, or an employer inquiring on coverage of an employee.

Subscriber

The subscriber is a person who can be uniquely identified to an information source, traditionally referred to as a member. The subscriber may or may not be the patient.

Dependent

The dependent is a person who cannot be uniquely identified to an information source, but can be identified by an information source when associated with a subscriber.

Patient

The patient can be either the subscriber or the dependent. Information sources identify patients in different ways, depending on the structure of their eligibility systems: (1) The information source assigns each family member (and plan) a unique ID number that can be used to identify and access that individual's information whether he or she is a child, spouse, or the actual subscriber to the plan. In this approach, the patient will be identified at the subscriber hierarchical level of the transaction because a unique ID number exists to access eligibility information for this individual. (2) The information source either assigns the actual member or contract holder (the true subscriber) a unique ID number or utilizes an existing number such as Social Security Number or Employee Identification Number. Any related spouse, children, or dependents are identified through the subscriber's identification number and have no unique identification number of their own.

Providers

Health care providers are individuals and organizations that provide health care services. Health care providers can include physicians, hospitals, clinics, pharmacies, and long-term care facilities. The legal definition of health care provider is included in section 262,



Administrative Simplification, of the Health Insurance Portability and Accountability Act of 1996.

Payer/Insurer

The payer is the party that pays claims and/or administers the insurance coverage, benefit, or product. A payer can be an insurance company; Health Maintenance Organization (HMO); Preferred Provider Organization (PPO); a government agency, such as Medicare or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or another organization contracted by one of these groups.

B. Technical Definitions and Issues

Data Standards

In the HIPAA framework, the transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. These rules are contained in the ASC X12 standards.

Data standards may not be modified by specific trading partners. However, since the transactions in each trading partner's individual system will vary from site to site (e.g., payer to payer), it is important that trading partners communicate their processing capacity in trading partner agreements.

Control Segments

There are two types of transaction control segments, the header segment (the ST segment) and the trailer segment (the SE segment). Header and trailer segments are used to identify the sender and receiver; allow for authorization and security information; and specify various technical features of the transaction.

The header segment identifies the start of a transaction and the transaction set. The trailer segment identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

If similar transaction sets (i.e., functional groups) are sent together in a transmission, the functional group is delineated by the functional group header (GS) segment and the functional group trailer (GE) segment. The functional group header segment starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

Use of Data Segments and Elements Marked "Situational"

Many data segments and elements are marked "situational"; users should consult the notes in the implementation guide to determine when they should be used.



Character Sets and Delimiters

Transactions use commonly accepted basic characters sets, although encoding schemes other than those specified in the Implementation Guides may be used as long as a common mapping is available and the parties to the transaction agree. Delimiters are characters used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data. They are specified in the interchange header segment and must not be used in a data element value elsewhere in the interchange. Character sets and delimiters are shown in the full Implementation Guide.

Batch and Real Time Transmission

The Health Care Eligibility Benefit Inquiry and Response transactions can be used in either a batch mode or in a real time mode. Batch mode transactions are typically grouped together in large quantities and processed en-masse for the next business day if received by a predetermined cut off time. When transmissions are sent in batch mode, the receiver must return the 997 Functional Acknowledgment transaction as quickly as possible to acknowledge receipt and support the TA1 segment for interchange level errors. In batch mode, the information receiver sends the 270 to the Information Source (typically through a switch) but does not remain connected while the Information Source processes the transactions. The Information Source creates, off-line, a 271 for the information receiver who reconnects at a later time (determined by the information source or switch) to pick up the 271. A batch mode 270 transaction may contain no more than ninety-nine patient requests.

Real time transactions typically require an immediate response. The information receiver sender sends a request transaction either directly or through a switch (clearinghouse), and remains connected while the Information Source processes the transaction and returns a response, typically in about thirty seconds. As in batch mode, a 997 Functional Acknowledgment or a TA1 segment are required to indicate receipt. In real time mode, the transaction may contain only one patient request.

In both modes, trading partners (the Information Source, the information receiver and the switch through which the transaction is routed) may all agree to exceed the recommended number of requests and agree to a reasonable limit. If trading partners are going to engage in both real time and batch eligibility, they should identify the method they are using either by using different identifiers for real time and batch in GS02 (Application Sender's Code) for the 270 transaction or by adding an extra letter to the identifier in GS02 (Application Sender's Code) for the 270 transaction, such as "B" for batch and "R" for real time. These modifications prevent problems with batch eligibility transactions getting into a real time processing environment and vice versa.



Supported Business Functions

The 270 transaction set is used to inquire about health care eligibility or benefit information associated with a subscriber or dependent under the subscriber's payer and group. The specific information detail requirements and any type of health care eligibility, benefit inquiry or reply message is established by the business relationship between the transaction set's submitter and recipient organization. The business functions that the 270 supports include general requests such as:

- eligibility status (i.e., active or not active in the plan)
- maximum benefits (policy limits)
- exclusions
- in-plan/out-of-plan benefits
- C.O.B information
- deductible
- co-pays

It also supports specific requests such as:

- procedure coverage dates
- procedure coverage maximum amount(s) allowed
- deductible amount(s)
- remaining deductible amount(s)
- co-insurance amount(s)
- co-pay amount(s)
- coverage limitation percentage
- patient responsibility amount(s)
- non-covered amount(s)

The Health Care Eligibility transaction sets are designed to satisfy the needs of a simple eligibility status inquiry (is the subscriber/dependent eligible?) or a request for more complex benefit amounts, co-insurance, co-pays, deductibles, exclusions, and limitations related to a specific procedure. To support this broad range of health care eligibility or benefit inquiry needs, the transaction sets can be viewed as a cone of information requirements and responses to support the submitting and receiving organizations' business needs. As more complex health care eligibility or benefit information is requested from the recipient or organization, the 270 transaction set submitter may need to supply more detailed information in the request, and the recipient may be expected to return more information in the 271 transaction set reply. The specific information detail requirements and any type of health care eligibility or benefit inquiry or reply message is established by the business relationship between the transaction sets submitter and recipient organization.



Reply Information

The eligibility or benefit reply information from the information source organization (i.e., payer or employer) is contained in the 271 in an Eligibility or Benefit Information (EB) data segment. The information source can also return other information about eligibility and benefits based on its business agreement with the inquiry submitter and information that it can provide. Consequently, the content of the transaction set varies depending on the level of data made available by the information source organization and receivers of 271 transactions should design their systems to receive *all* data segments and data elements (i.e., situational as well as required) and account for the number of times a data segment can repeat.

Unsupported Business Functions

The business functions below are supported by the Health Care Services Review (ASC X12 278) transaction set, not the 270/271 transaction sets:

- authorization requirements
- certification requirements
- utilization management/review requirements

Compliance with the Super Set

The Health Care Eligibility Benefit Inquiry and Response 270/271 transaction set contains a super set of data segments, elements and codes which represent its full functionality. This super set covers a great number of business scenarios and does not necessarily represent the business needs of an individual provider, payor or other trading partner. The super set identifies the framework an information source (typically a payor), can utilize.

At a minimum, HIPAA requires information sources to support a generic request for eligibility (which is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in the "EQ" loop of the transaction. The information source must respond with either an acknowledgment that the individual has active or inactive coverage or that the individual was not found in its system as of the date the transaction was processed (except for Medicaid inquiries which require prior dates so providers can determine if a patient's application for state medical assistance has been processed). What this equates to is, "Yes, the patient is an eligible member today" so that a provider's office does not have to make a phone call to the payor to determine the patient's insurance status.

However, since the minimum requirement does not meet all business needs, the 271 transaction is designed to report a great deal more than "Yes, the patient is eligible today" including co-payment, co-insurance, deductible amounts, eligibility beginning and ending dates, dates of service, information about the Primary Care Provider, and specific service types and their related information. The 271 response can become as elaborate as identifying what days of the week a member can have a service performed and where,



the number of benefits the member is allowed, the number of benefits remaining, and whether the benefit conditions apply to “in” or “out” of network providers. In short, the super set includes anything identified as situational. Therefore, a receiver of 271 transactions must design its system so it can receive all data segments and data elements (including repeats) without having to reprogram the system for different information sources.

Similarly, the 270 request can be very explicit. A provider can ask whether a particular patient is eligible for a particular procedure with a particular diagnosis code, identify who the provider of the service will be and even identify when and where the requested service will be performed. An information source is not required to generate an explicit response to an explicit request, although the more information an information source can provide regarding specific questions, the more both parties will be able to reduce phone calls and long interruptions. The information source is required to at least respond with the minimum compliant response (“Yes, the patient is eligible today” or “No, the patient is not eligible today”) and may not reject the transaction merely because it cannot process an explicit request. The information source is also required to return any information supplied in the 270 request that was used to determine the 271 response. Examples of such information include service type codes, procedure codes, diagnosis codes, facility type codes, dates and identification numbers.

Willing trading partners are allowed to use any portion or all of the 270/271 super set, as long as they support the minimum data set, but are not allowed to add to or change it.

Search Options

Unlike many other transactions, the 270 transaction has the built in flexibility of allowing a user to enter whatever patient information they have on hand to identify them to an information source to enhance the likelihood that the information source will find a match in its system.

The maximum data elements that can be required by an information source to identify a patient (found in loop 2100C when the patient is the subscriber and in loops 2100C and 21000D when the patient is a dependent) are:

- Subscriber’s Member ID (if patient is not the subscriber)
- Patient’s Member ID
- Patient’s First Name
- Patient’s Last Name
- Patient’s Date of Birth

If the information source receives all four elements, it must generate a response if the patient is in its database. All information sources are required to support the above search option even if its systems do not have unique member identifiers assigned to dependents.



In the absence of all of the above pieces of information, such as in an emergency situation or if the patient has forgotten to bring his/her identification card, a 270 may be sent with as many of the above pieces of data that are available as well as any of the other items identified in the transaction (such as Social Security Number, subscriber's name when the patient is not the subscriber, relationship to insured). The information source must attempt to look up the patient if a reasonable amount of information is present. An information source may outline additional search options available in its trading partner agreements, however under no circumstances may it require the use of a search option that differs from the ones outlined above.

If insufficient identifying elements are sent to the information source, the information source returns a 271 identifying the missing data elements (in an AAA segment). If multiple matches are found in the information source's database (this should be due only to utilizing a search option other than the required search option), the information source should not return all the matches found and instead return a 271 identifying the duplicates found (in an AAA segment) and the missing data elements necessary to provide an exact match (in another AAA segment).

Rejected Transactions

A 271 Eligibility, Coverage or Benefit Information response transaction must contain at least one EB (Eligibility or Benefit Information) segment or one AAA (Request Validation) segment, assuming that the 270 Eligibility, Coverage or Benefit Inquiry has passed syntax error checking without any errors and has not been identified as rejected in a 997 Functional Acknowledgment.

The AAA Request Validation segment is used to identify why an EB Eligibility or Benefit Information segment has not been generated—i.e., why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically an AAA segment is generated under two conditions: (1) when an error in the data is detected (e.g. Missing Subscriber ID) or (2) there is no matching information in the database (e.g. Subscriber Not Found). The difference between these conditions is subtle, but they generate different types of messages. If data are missing or invalid, they should be corrected and a new transaction must be generated. If an entity is not found in the database there could be two explanations. First, the data submitted was incorrect (in which case it should be corrected and resubmitted). Second, the entity is not associated with the information source and a definitive answer cannot be generated. The AAA segment may also be used to identify a problem with the processing system itself (e.g. the Information Source's system is down) and the transaction will have to be resent.



Information Flows

Response transactions may be exchanged by trading partners in different environments ranging from direct connections to connections through communications services like VANS or other intermediaries. Requesters also operate in a variety of application environments.

The basic flow is for a requester (usually a provider) to ask a responder (usually a payer) about health care coverage eligibility and associated benefits. The requester is normally asking about one individual, who may be the dependent of a health plan subscriber. Sometimes the responder is a third party administrator, or a Utilization Review Organization, or a self-paying employer. However, in all cases the basic flow is the same — a request sent and a response received.

A more complicated flow is from a requester (provider) to a switch service and from the switch service to the responder (payer). Links may also vary, for example, a requester may have an indirect link to a variety of responders via a transaction switch service and a requester may have a dial-up, or leased line, or a private virtual circuit to the switch, and the switch may have a leased line to the responder. The switch may be independent or owned by a payer.

In some business relationships, the switch will provide access to all payers for a Provider. If the switch does not have a direct connection with all payers, it may have a relationship with another switch who does—in which case Switch “A” will pass the message to Switch “B” to route the transaction to the responder.

In some instances, the requester will query a responder, who, in turn, will also query a responder for additional information. For example, the requester queries a Third Party Administrator (TPA) who then queries an employer or payer to determine whether the patient is still actively enrolled. Similarly, the first responder knows there is a third party liability (TPL) payer and queries the TPL before responding to the requester.

Value Added Service Organizations

Increased needs for information exchange between many health care organizations has led to the emergence of service organizations that can normalize communication solutions, data requirements, and transactions formats for their business partners. Service organizations often need to open the transactions to reformat them or add needed information. They also perform database look-ups to determine what formats and additional information are required and then direct the transactions on to the appropriate responder or requester.

Complex Requester Environments

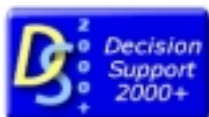
The current organization of health care also creates complex requester environments for transaction routing. For example, hospitals and Integrated Health Networks (IHN) may



have many different systems within their larger organizational structure from which they receive requests that are then delivered to a service organization or directly to payers. For example, an IHN may include a hospital, a free standing clinic, a reference lab, and an x-ray department; each component has its own information system, but, through the IHN, a common interface engine to the payers or VAN or service organization. In some cases, this interface engine may perform data and communication transformations such as converting HL7 transactions to X12 transactions.

Version

This Handbook is derived from the implementation guide based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010). The transactions were approved by ASC X12 as a Draft Standard for Trial Use (DSTU) in February 1993. The implementation guide for Version 3 release 5.1 (003051) written by WEDI (the Work Group on Electronic Data Interchange) and dated January 1996 was used as the foundation for the HIPAA implementation guide. Changes were made to the transaction set in version 003052 for the Property and Casualty, and Worker's Compensation industries. The X12 community also made changes to the NM1, REF, PRV, EQ, and INS segments for other industries. Changes made to the PRV segment directly affect the 270/271 transaction sets. Changes to the INS segment have added functions, one of which has been adopted by the Eligibility Work Group. All other segments that have changes do not affect the implementation of 270/271 transaction sets. The implementation guide also reflects changes that were suggested by industry review and the ASC X12N TG2 WG1 since the WEDI implementation guide was published.



VIII. List of External Code Sources Used in these Transactions

5	Countries, Currencies and Funds
22	States and Outlying Areas of the U.S
43	FIPS-55 (Named Populated Places)
51	ZIP Code
77	X12 Directories
121	Health Industry Identification Number
130	Health Care Financing Administration Common Procedural Coding System
131	International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
133	Current Procedural Terminology (CPT) Codes
134	National Drug Code
135	American Dental Association Codes
237	Place of Service from Health Care Financing Administration Claim Form
307	National Association of Boards of Pharmacy Number
411	Remittance Remark Codes
507	Health Care Claim Status Category Code
508	Health Care Claim Status Code
513	Home Infusion EDI Coalition (HIEC) Product/ Service Code List
530	National Council for Prescription Drug Programs Reject/Payment Codes
537	Health Care Financing Administration National Provider Identifier
540	Health Care Financing Administration National PlanID
DOD1	Military Rank and Health Care Service Region
DOD2	Paygrade

