**EDI 270 Eligibility, Coverage or Benefit Inquiry:**

The *EDI 270* Health Care Eligibility/Benefit Inquiry transaction set is used to request information from a healthcare insurance plan about a policy’s coverages, typically in relation to a particular plan subscriber.  
  
This transaction is typically sent by healthcare service providers, such as hospitals or medical facilities, and sent to insurance companies, government agencies like Medicare or Medicaid, or other organizations that would have information about a given policy.  
  
The 270 transaction is used for inquiries about what services are covered for particular patients (policy subscribers or their dependents), including required copay or coinsurance. It may be used to inquire about general information on coverage and benefits. It may also be used for questions about the coverage of specific benefits for a given plan, such as wheelchair rental, diagnostic lab services, physical therapy services, etc.  
  
The 270 document typically includes the following:

* Details of the sender of the inquiry (name and contact information of the information receiver)
* Name of the recipient of the inquiry (the information source)
* Details of the plan subscriber about to the inquiry is referring
* Description of eligibility or benefit information requested

The 270 transaction is used in conjunction with the [EDI 271 transaction](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/271). The 271 is the Health Care Eligibility/Benefit Response and is used to transmit the information requested in a 270.  
  
Healthcare providers used to contact insurance companies by phone to verify patient coverage for services, which limited the information exchange to simple yes/no questions. The adoption of EDI 270 and 271 transactions allowed for a greater level of detail of this information exchanged electronically. It also meant a reduction in the manual entry of such information, reducing related costs.  
  
Use of both 270 and 271 transactions allows healthcare service providers to create HIPAA-compliant files requesting eligibility details for a patient. As of March 31, 2012, healthcare providers must be compliant with version 5010 of the HIPAA EDI standards.

EDI 270 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to inquire about the eligibility, coverages or benefits associated with a benefit plan, employer, plan sponsor, subscriber or a dependent under the subscriber's policy. The transaction set is intended to be used by all lines of insurance such as Health, Life, and Property and Casualty.

**EDI 271 Eligibility, Coverage or Benefit Information:**

The *EDI 271* Health Care Eligibility/Benefit Response transaction set is used to provide information about healthcare policy coverages relative to a specific subscriber or the subscriber’s dependent seeking medical services. It is sent in response to a [270 inquiry transaction](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/270).  
  
This transaction is typically sent by insurance companies, government agencies like Medicare or Medicaid, or other organizations that would have information about a given policy. It is sent to healthcare service providers, such as hospitals or medical clinics that inquire to ascertain whether and to what extent a patient is covered for certain services.  
  
The 271 document typically includes the following:

* Details of the sender of the inquiry (name and contact information of the information receiver)
* Name of the recipient of the inquiry (the information source)
* Details of the plan subscriber about to the inquiry is referring
* Description of eligibility or benefit information requested

The combination of the 270 and 271 transaction sets represent the third-most used transactions in healthcare. Adoption of these transactions replaced the use of phone or fax for requesting and providing information on a patient’s coverage under a plan. By moving to the use of EDI and these specific transactions, service providers can submit the same inquiry to multiple insurance providers and will receive information in the same standardized 271 response format.  
  
Use of the 270 and 271 transactions also allows healthcare service providers to remain in compliance with HIPAA standards. Healthcare providers must be compliant with the latest version of the HIPAA EDI standards – version 5010 – as of March 31, 2012.

EDI 271 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Eligibility, Coverage or Benefit Information Transaction Set (271) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to communicate information about or changes to eligibility, coverage or benefits from information sources (such as - insurers, sponsors, payors) to information receivers (such as - physicians, hospitals, repair facilities, third party administrators, governmental agencies). This information includes but is not limited to: benefit status, explanation of benefits, coverages, dependent coverage level, effective dates, amounts for co-insurance, co-pays, deductibles, exclusions and limitations.

**EDI 834 Benefit Enrollment and Maintenance:**

The *EDI 834* transaction set represents a Benefit Enrollment and Maintenance document. It is used by employers, as well as unions, government agencies or insurance agencies, to enroll members in a healthcare benefit plan. The 834 has been specified by HIPAA 5010 standards for the electronic exchange of member enrollment information, including benefits, plan subscription and employee demographic information.  
  
The 834 transaction may be used for any of the following functions relative to health plans:

* New enrollments
* Changes in a member’s enrollment
* Reinstatement of a member’s enrollment
* Disenrollment of members (i.e., termination of plan membership)

The information is submitted, typically by the employer, to healthcare payer organizations who are responsible for payment of health claims and administering insurance and/or benefits. This may include insurance companies, healthcare professional organizations such as HMOs or PPOs, government agencies such as Medicare and Medicaid.  
  
A typical 834 document may include the following information:

* Subscriber name and identification
* Plan network identification
* Subscriber eligibility and/or benefit information
* Product/service identification

The recipient of an 834 transaction must respond with a [999 Implementation Acknowledgement](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/999), which confirms that the file was received and provides feedback on the acceptance of the document.  
  
EDI 834 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Benefit Enrollment and Maintenance Transaction Set (834) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to establish communication between the sponsor of the insurance product and the payer. Such transaction(s) may or may not take place through a third party administrator (TPA). For the purpose of this standard, the sponsor is the party or entity that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association, or insurance agency. The payer refers to an entity that pays claims, administers the insurance product or benefit, or both. A payer can be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Champus, etc.), or an entity that may be contracted by one of these former groups. For the purpose of the 834 transaction set, a third party administrator (TPA) can be contracted by a sponsor to handle data gathering from those covered by the sponsor if the sponsor does not elect to perform this function itself.

**EDI 835 Health Care Claim Payment/Advice:**

The *EDI 835* transaction set is called Health Care Claim Payment and Remittance Advice. It has been specified by HIPAA 5010 requirements for the electronic transmission of healthcare payment and benefit information.  
  
The 835 is used primarily by Healthcare insurance plans to make payments to healthcare providers, to provide Explanations of Benefits (EOBs), or both. When a healthcare service provider submits an [837 Health Care Claim](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/837), the insurance plan uses the 835 to detail the payment to that claim, including:

* What charges were paid, reduced or denied
* Whether there was a deductible, co-insurance, co-pay, etc.
* Any bundling or splitting of claims or line items
* How the payment was made, such as through a clearinghouse

A particular 835 document may not necessarily match up one-for-one with a specific 837. In fact, it is not uncommon for multiple 835 transactions to be used in response to a single 837, or for one 835 to address multiple 837 submissions. As a result, the 835 is important to healthcare providers, to track what payments were received for services they provided and billed.

EDI 835 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

**EDI 837 Health Care Claim:**

The *EDI 837* transaction set is the format established to meet HIPAA requirements for the electronic submission of healthcare claim information. The claim information included amounts to the following, for a single care encounter between patient and provider:

* A description of the patient
* The patient’s condition for which treatment was provided
* The services provided
* The cost of the treatment

## As of March 31, 2012, healthcare providers must be compliant with version 5010 of the HIPAA EDI standards. The 5010 standards divide the 837 transaction set into three groups, as follows: 837P for professionals, 837I for institutions and 837D for dental practices. The 837 is no longer used by retail pharmacies. This transaction set is sent by the providers to payers, which include insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), or government agencies such as Medicare, Medicaid, etc. These transactions may be sent either directly or indirectly via clearinghouses. Health insurers and other payers send their payments and coordination of benefits information back to providers via the [EDI 835](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/835) transaction set. EDI 837 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

**EDI 999 Implementation Acknowledgment:**

The *EDI 999* transaction set is an Implementation Acknowledgement document, developed specifically to replace the[997 Functional Acknowledgement](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/997) document for use in healthcare. Both the 997 and 999 are used to confirm that a file was received. However, the 999 includes additional information about whether the received transaction had errors. This includes whether the transaction is in compliance with HIPAA requirements.  
  
The 999 Acknowledgement may produce three results:

* Accepted (A)
* Rejected (R)
* Accepted with errors (E)

As a result, the 999 may acknowledge receipt of a transaction, such as a healthcare claim, but it does not necessarily mean that transaction will be processed. The 999 can also report on exactly what syntax issues caused the errors in the original transaction.   
  
The 999 transaction set becomes the standard acknowledgement document for healthcare as of March, 2012, when version 5010 of the HIPAA EDI standards take effect. The exception to this is the use of a [277 Healthcare Status Notification](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/277) transaction, used specifically to confirm the receipt of a [276 Health Claim Status Request](http://www.1edisource.com/learn-about-edi/transaction-sets/tset/276) transaction.

EDI 999 Specification:

This X12 Transaction Set contains the format and establishes the data contents of the Implementation Acknowledgment Transaction Set (999) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical and relational analysis of the electronically encoded documents, based upon a full or implemented subset of X12 transaction sets. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.