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Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Eligibility Benefit Inquiry and Response (270/271)

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1 Purpose and Business Information

1.1 Implementation Purpose and Scope

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to explain the developers' intent when the Health Care Eligibility, Coverage, or Benefit Inquiry (270) and Health Care Eligibility, Coverage, or Benefit Information (271) transaction sets were designed and to give guidance on how they should be implemented in the health care industry. Specifically, this guide defines where data is put and when it is included for the ANSI ASC X12.281 and X12.282 transaction sets for the purpose of conveying health care eligibility and benefit information. This paired transaction set is comprised of two transactions: the 270, which is used to request (inquire) information, and the 271, which is used to respond with coverage, eligibility, and benefit information. The official names for these transactions are:

ANSI ASC X12.281 - Eligibility, Coverage, or Benefit Inquiry (270)

ANSI ASC X12.282 - Eligibility, Coverage, or Benefit Information (271)

This implementation guide is intended to provide assistance in the development and use of the electronic transfer of health care eligibility and benefit information. It is hoped that the entities that exchange eligibility information will work to develop and exchange standard formats within the health care industry and among their trading partners.

1.2 Version Information

This implementation guide is based on the October 2003 ASC X12 standards, referred to as Version 5, Release 1, Sub-release 0 (005010).

The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010**X279**.

The two-character Functional Identifier Codes for the transaction sets included in this implementation guide:

- ***HB Eligibility, Coverage or Benefit Information (271)***
- ***HS Eligibility, Coverage or Benefit Inquiry (270)***

The Version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted in the Functional Group Header (GS segment) that begins a functional group of these transaction sets. For more information, see the descriptions of GS01 and GS08 in Appendix C, EDI Control Directory.

1.3 Implementation Limitations

1.3.1 Batch and Real-time Usage

There are multiple methods available for sending and receiving business transactions electronically. Two common modes for EDI transactions are batch and real-time.

Batch - In a batch mode the sender does not remain connected while the receiver processes the transactions. Processing is usually completed according to a set schedule. If there is an associated business response transaction (such as a 271 Response to a 270 Request for Eligibility), the receiver creates the response transaction and stores it for future delivery. The sender of the original transmission reconnects at a later time and picks up the response transaction. This implementation guide does not set specific response time parameters for these activities.

Real Time - In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender. This implementation guide does not set specific response time parameters for implementers.

This implementation guide is intended to support use in batch and real-time mode. A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners.

1.3.2 Other Usage Limitations

Batch

It is required that the 270 transaction contains no more than ninety-nine patient requests when using the transaction in a batch mode (See the Exceeding The Number of Patient Requests section below for the exception). In a batch mode, it is possible to have patient requests in both the subscriber and dependent levels (e.g. subscriber and spouse). In a batch mode it is also possible to have more than one dependent patient requests (e.g. twins). In the case where there are patient requests at both the subscriber and dependent

levels or for multiple dependents, each patient request counts as one patient request toward the maximum number of ninety-nine patient requests (See Section 1.4.2 Patient subsection for additional information).

Real Time
It is required that the 270 transaction contain only one patient request when using the transaction in a real time mode (See the Exceeding The Number of Patient Requests section below for the exception). One patient is defined as either, one subscriber loop if the member is the patient, or one dependent loop if the dependent is the patient (See Section 1.4.2 Patient subsection for additional information).

Exceeding The Number of Patient Requests
Although it is not recommended, if the number of patients is to be greater than one for real time mode or greater than ninety-nine for batch mode, the trading partners (the Information Source, the Information Receiver and the switch the transaction is routed through, if there is one involved) must all agree to exceed the number of recommended patient requests and agree to a reasonable limit.

In the event the Information Receiver exceeds the maximum number of patient requests allowed, two possible scenarios arise. First, if the processor of the transaction (either the switch or the Information Source) detects the maximum has been exceeded, a 271 with a AAA segment with element AAA03 containing a code value "04" (Authorized Quantity Exceeded) will be issued. If this has been detected by a switch, use the AAA segment in the Information Source Level (Loop 2000A). If this has been detected by an Information Source, use the AAA segment in the Information Source Name loop (Loop 2100A). Second, the processor's system may actually fail, in which case it may not be possible to send any message back and trading partners should be aware of this possibility.

1.4 Business Usage

1.4.1 Background Information

Providers of medical services must currently submit health care eligibility and benefit inquiries in a variety of methods, either on paper, via phone, or electronically. The information requirements vary depending upon:

- type of insurance plan
- type of service performed

- where the service is performed
- where the inquiry is initiated
- where the inquiry is sent

The Health Care Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine (a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and (b) 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. Note, the identification of subscriber/dependent and associated relationship code values may or may not be the values needed to determine primary/secondary coverage for coordination of benefits on claims transactions.

To accomplish this, two Health Care Eligibility and Benefit transaction sets are used. The two ASC X12 transaction sets are:

- Health Care Eligibility and Benefit Inquiry (270) from a submitter (information receiver) to an information source organization
- Health Care Eligibility and Benefit Information (271) from an information source organization to a submitter (information receiver)

The eligibility transaction sets are designed to be flexible enough to encompass all the information requirements of the various entities. These entities may include:

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

Some submitters do not have ready access to enough information to generate an inquiry to a payer. An outside lab or pharmacy providing services to an institution may need to send an inquiry to the institutional provider to obtain enough information to identify to which payer a health care eligibility or benefit inquiry should be routed. Because of this type of situation, a 270 may be originated by a provider and sent to another provider, if the inquiry is supported by the receiving provider.

1.4.2 Basic Concepts

Information Source (2000A loop)
The information source is the entity that has the answer to the questions being asked in a 270 Eligibility or Benefit transaction. The information source is typically the insurer, or payer. In a managed care environment, the information source could possibly be a primary care physician or gateway provider. Regardless of the information source's actual role, they are the entity who maintains the information regarding the patient's coverage. The information source is not a clearinghouse, value added network or other intermediary, even if they hold the data for the true information source. The information source's role in the transaction is identified in the Information Source Name segment (2100A loop NM1).

Information Receiver (2000B loop)
The information receiver is the entity that is asking the questions in a 270 Eligibility or Benefit transaction. The information receiver is typically the medical service provider (e.g., physician, hospital, pharmacy, DME supplier, laboratory, etc.). The information receiver could also be another insurer or payer when they are attempting to verify other insurance coverage for their members. The information receiver could also be an employer inquiring on coverage of an employee. The information receiver's role in the transaction is identified in the Information Receiver Name segment (2100B NM1).

Subscriber (2000C loop)
The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient. See definition of patient below for further detail.

For example, Joe Smith is the primary policy holder and has a Member ID 1234501. He is considered a subscriber. Joe's wife, Jane Smith, is covered under Joe's policy and has a Member ID 1234502. Jane is considered a subscriber as well since she has a unique Member ID number (in this case the suffix is different).

NOTE
The terms Member Identification Number, Member ID Number and Member ID are used throughout this Implementation Guide. In addition to numeric values, they may contain characters associated with data type AN. See Appendix B Section B.1.1.3.1.4 - *String* for additional information.

Dependent (2000D loop)
The dependent is a person who cannot be uniquely identified to an information source by a unique Member Identification Number, but can be identified by an information source when associated with a subscriber. See definition of patient below for further detail.

For example, John Jones is the primary policy holder and has a Member ID 54321. He is considered a subscriber. John's wife, Susan Jones, is covered under John's policy and has a Member ID 54321. Susan is considered a dependent since she does not have a unique Member ID number and must be associated with John's Member ID number.

Patient
There is no HL loop dedicated to patient, rather, the patient can be either the subscriber or the dependent. Different types of information sources identify patients in different manners depending upon how their eligibility system is structured. There are two common approaches for the identification of patients by an information source.

The first approach is to assign each member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of 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 because a unique ID number exists to access eligibility information for this individual.

Some health plans create a suffix for each individual and append it to the end of the primary subscriber's identification number, which constitutes a unique ID number for the purposes of the 270/271 transaction making each individual uniquely identifiable to the information source.

The second approach is either to assign the actual member or contract holder (the primary subscriber) a unique ID number or utilize an existing number of theirs (such as Social Security Number or Employee Identification Number). This number is entered

into the eligibility system. Any related spouse, children, or dependents are identified through the primary subscriber's identification number and have no unique identification number of their own. In this approach, the primary subscriber would be identified at the subscriber level (2000C loop) and the actual patient (spouse, child, etc.) would be identified at the dependent level (2000D loop) which is sub-ordinate to the subscriber (2000C) loop.

Patient Request (2110C or 2110D)

The patient request is defined as the occurrence of one or more 2110 (EQ) loops for an individual. If the patient is the subscriber, the patient request is the existence of at least one 2110C loop. If the patient is the dependent, the patient request is the existence of at least one 2110D loop. In the event the patient has more than one occurrence of a 2110 (EQ) loop, that still constitutes one patient request.

Patient Response (2110C or 2110D)

The patient response is defined as the occurrence of one or more 2110 (EB) loops for an individual. If the patient is submitted as the subscriber and the Information Source locates the patient and determines that they are actually a dependent, the primary subscriber is to be returned in the 2100C loop and the patient is to be returned in the 2100D loop with the patient response information located in the 2110D loop.

Relationship to Subsequent X12 Transactions

One other factor Information Sources need to bear in mind is how they need the patient submitted in subsequent transactions such as a 278 Health Care Services Request for Review or an 837 Health Care Claim. The 278 transaction follows a similar model that if the patient can be uniquely identified they are considered the subscriber. Some Information Source's 837 claim processes however require Subscriber and Dependent information if the patient is a dependent, even if the dependent has their own unique ID. If the individual patient must be submitted as a subscriber in an 837 transaction, then the Information Source must return the patient in the 271 as the subscriber. If the individual patient must be submitted as a dependent in an 837 transaction, then the Information Source must return the patient in the 271 as a dependent. This enables the provider to populate their practice management system with the proper information to submit an 837 transaction. The patient must be returned in the correct loop (2000C or 2000D) based on how the Information Source requires the individual be submitted in subsequent transactions.

Patient Submitted as Subscriber But Returned as Dependent

If the patient is submitted as the subscriber in the 270 transaction and the Information Source locates the patient and determines that they are actually a dependent, the primary

subscriber is to be returned in the 271 2100C loop and the patient is to be returned in the 271 2100D loop with the patient response information located in the 2110D loop. See Section 1.4.7.1 - *Minimum Requirements For Implementation Guide Compliance* 271 item 4 for additional information.

If a TRN segment was submitted in the 270 2000C loop, it must be returned in the 271 2000D loop. If a REF segment with REF01 = "EJ" was submitted in the 270 2100C loop, it must be returned in the 271 2100D loop. See Section 1.4.6 - *Information Linkage*.

Patient Submitted as Dependent But Returned as Subscriber
If the patient is submitted as the dependent in the 270 transaction and the Information Source locates the patient and determines that they are actually a subscriber, the patient is to be returned in the 271 2100C loop. See Section 1.4.7.1 - *Minimum Requirements For Implementation Guide Compliance* 271 item 4 for additional information.

If a TRN segment was submitted in the 270 2000D loop, it must be returned in the 271 2000C loop. If a REF segment with REF01 = "EJ" was submitted in the 270 2100D loop, it must be returned in the 271 2100C loop. See Section 1.4.6 - *Information Linkage*.

1.4.3 Batch and Real Time

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time. The 270/271 Health Care Eligibility Benefit Inquiry and Response transactions can be used in either a batch mode or in a real time mode.

Batch
When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

Important: When in batch mode, the 999 Implementation Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see Section B.1.1.5.1 - *Interchange Acknowledgment, TA1* for details).

If the transaction set is to be used in a batch mode, the Information Receiver sends the 270 to the Information Source, typically through a clearinghouse (switch), but does not

remain connected while the Information Source processes the transactions. The Information Source creates a 271 for the Information Receiver off-line. The Information Receiver typically reconnects at a later time (the amount of time is determined by the information source or clearinghouse) and picks up the 271. It is required that the 270 transaction contains no more than ninety-nine patient requests when using the transactionin a batch mode (See the Exceeding The Number of Patient Requests section below for the exception). In a batch mode, it is possible to have patient requests in both the subscriber and dependent levels (e.g. subscriber and spouse). In a batch mode it is also possible to have more than one dependent patient requests (e.g. twins). In the case where there are patient requests at both the subscriber and dependent levels or for multiple dependents, each patient request counts as one patient request toward the maximum number of ninety-nine patient requests (See Section 1.4.2 Patient Request subsection for additional information). The 271 response can only contain eligibility and benefit information for the patient(s) identified in the 270 request unless the 270 request contained a value of "FAM" in 2100C EQ03 and this level of functionality is supported by the Information Source.

Real Time

Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a clearinghouse (switch), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the 271 response transaction, a 999 Implementation Acknowledgment, or a TA1 segment (for details on the TA1 segment, see Section B.1.1.5.1 - *Interchange Acknowledgment, TA1*).

If the transaction set is to be used in a real time mode, the Information Receiver sends the 270 transaction through some means of telecommunication (e.g. Async., TCP/IP, LU6.2, etc.) to the Information Source (typically through a clearinghouse - see Sections 1.4.13.2 and 1.4.13.3) and remains connected while the Information Source processes the transaction and returns a 271 to the Information Receiver. It is required that the 270 transaction contain only one patient request when using the transaction in a real time mode (See the Exceeding The Number of Patient Requests section below for the exception). One patient is defined as either, one subscriber loop if the member is the patient, or one dependent loop if the dependent is the patient (See Section 1.4.2 Patient for additional information). The 271 response can only contain eligibility and benefit information for the patient(s) identified in the 270 request unless the 270 request contained

a value of "FAM" in 2100C EQ03 and this level of functionality is supported by the Information Source.

Exceeding The Number of Patient Requests

Although it is not recommended, if the number of patients is to be greater than one for real time mode or greater than ninety-nine for batch mode, the trading partners (the Information Source, the Information Receiver and the clearinghouse the transaction is routed through, if there is one involved) must all agree to exceed the number of recommended patient requests and agree to a reasonable limit.

In the event the Information Receiver exceeds the maximum number of patient requests allowed, two possible scenarios arise. First, if the processor of the transaction (either the clearinghouse or the Information Source) detects the maximum has been exceeded, a 271 with a AAA segment with element AAA03 containing a code value "04" (Authorized Quantity Exceeded) will be issued. If this has been detected by a clearinghouse, use the AAA segment in the Information Source Level (Loop 2000A). If this has been detected by an Information Source, use the AAA segment in the Information Source Name loop (Loop 2100A). Second, the processor's system may actually fail, in which case it may not be possible to send any message back and trading partners should be aware of this possibility.

If trading partners are going to engage in both real time and batch eligibility, it is recommended that they identify the method they are using. One suggested way of identifying this is by using different identifiers for real time and batch in GS02 (Application Sender's Code) for the 270 transaction. A second suggested way is to add 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. Regardless of the methodology used, this will avoid the problems associated with batch eligibility transactions getting into a real time processing environment and vice versa.

1.4.4 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 detail of the health care eligibility or benefit information being requested by the inquiry submitter from the information source organization is identified in the Eligibility or Benefit Inquiry (EQ) data segment. To complete the detail of the eligibility request message, the submitter may

send additional data segment information within the 270 transaction sets at the subscriber and dependent levels.

An example of the overall structure of the 270 transaction set when used in a batch environment is:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Subscriber (Loop 2000C)
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry
Eligibility or Benefit Inquiry
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry

The corresponding 271 response follows the same structure displayed above, with the Eligibility or Benefit Information replacing the Eligibility or Benefit Inquiry.

Requesting Information (270)

The following examples illustrate the business functions that the 270 supports. The transaction set is not limited to these examples.

General Request Example

Submitter Type	Payer/Plan Benefits Requested
All Provider Types	All Medical/Surgical Benefits and Coverage Conditions

Categorical Request Example

Submitter Type	Payer/Plan Benefits Requested
Specific Provider type	All Benefits Pertinent to Provider Type

Specific Request Examples

Submitter Type	Payer/Plan Benefits Requested
Ambulatory Surgery Center	Hernia Repair
D.M.E	Wheelchair Rental
Dentist	Bonding
Free Standing Lab	Diagnostic Lab Service
Home Health	Nursing Visits
Hospital	Pre-Admission Testing
Hospital	Detoxification Services
Hospital	Psychiatric Treatment
Hospital	O.P. Surgery
Nursing Home	Physical Therapy Services
Other Allied Health Providers	Occupational Therapy
Pharmacy	Prescription Drugs
Physician	Well Baby Coverage
Physician	Hospital Visits

Reply Information (271)

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 available information that it may be able to provide.

The content of the Health Care Coverage, Eligibility, and Benefit Information transaction set varies, depending on the level of data made available by the information source organization.

Note to receivers of 271 transactions: Due to the varying level of detail that can be returned in the 271, it is necessary to design your system to receive all of the data segments and data elements identified as used or situational, and account for the number of times a data segment can repeat.

General Inquiry

- 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

Specific Inquiry

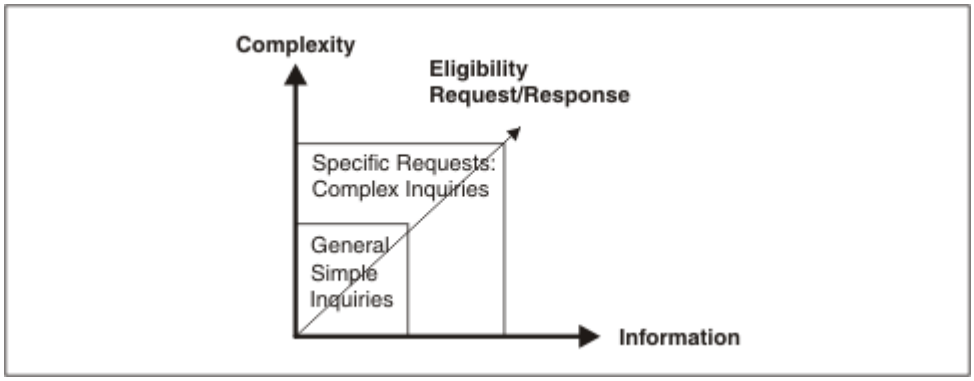
- procedure coverage dates
- procedure coverage maximum amount(s) allowed
- deductible amount(s)
- remaining deductible amount(s)
- co-insurance amount(s)
- co-pay amount(s)
- coverage limitation percentage
- patient responsibility amount(s)
- non-covered amount(s)

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 (See Figure 1.1 - *Information Requirements*). 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.

Figure 1.1 - Information Requirements



1.4.5 Unsupported Business Functions

The following business functions are not intended to be supported under the 270/271 transaction sets:

- medical services reservations
- authorization requirements
- certification requirements
- utilization management/review requirements

These functions are supported by the Health Care Services Review (ASC X12 278) transaction set developed and supported by X12N/TG2/WG10, the Health Care Services Review WG.

1.4.6 Information Linkage

1.4.6.1 Real Time Linkage

The 270 request transaction has several methods of providing linkage to the 271 response transaction when the transaction is being processed in Real Time (see Section 1.4.3 - *Batch and Real Time*). Values returned in the 271 response transaction must be returned exactly as submitted in the corresponding 270 request transaction.

Information Receiver

- BHT03 - Submitter Transaction Identifier. This is used to identify the transaction at a high level. This is particularly useful in reconciling 271 reject transactions that may not contain all of the HL Loops. This information is required for the information receiver if using the transaction in Real Time and the receiver of the 270 transaction (whether it is a clearinghouse or information source) must return it in the 271 BHT03.
- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. The information receiver may create one occurrence of the TRN segment at the lower of these levels.These segments are optional for the information receiver, however if the information source receives them, they must be returned in the 271 response transaction unless a AAA is generated in 2000A, 2100A or 2100B.
- Patient Account Number. A patient account number may be entered in REF02 of a REF segment (with REF01 being EJ) in either Loop 2100C or Loop 2100D, whichever is the patient. This information is optional for the information receiver, however if the information source receives the patient account number, they must return it in the 271 response transaction unless a AAA is generated in 2000A, 2100A or 2100B.

Information Source

- TRN segments in the 271 response transaction in either Loop 2000C or Loop 2000D, whichever is the patient. The information source may create one occurrence of the TRN segment at the lower of these levels. This segment is optional for the information source, however, this gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction.

Clearinghouse

- BHT03 - Submitter Transaction Identifier. This is used to identify the transaction at a high level. This is particularly useful in reconciling 271 reject transactions that may not

contain all of the HL Loops. This information is required for the clearinghouse if using the transaction in Real Time and the receiver of the 270 transaction (whether it is a clearinghouse or information source) must return it in the 271 BHT03.

- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. A clearinghouse may create one occurrence of the TRN segment at the lower of these levels. These segments are optional for a clearinghouse however if the information source receives them, they must be returned in the 271 response transaction unless a AAA is generated in 2000A, 2100A or 2100B. In the event that the 270 transaction passes through more than one clearinghouse, the second (and subsequent) clearinghouse may choose one of the following options. Option One: If the second or subsequent clearinghouse needs to assign their own TRN segment they may replace the received TRN segment belonging to the sending clearinghouse with their own TRN segment. Upon returning a 271 response to the sending clearinghouse, they must remove their TRN segment and replace it with the sending clearinghouses TRN segment. Identification of whose TRN segment is whose can be accomplished by utilizing TRN03, which is required for clearinghouses. If the clearinghouse intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to "1". Option Two: If the second or subsequent clearinghouse does not need to assign their own TRN segment, they should merely pass all TRN segments received in the 270 transaction and pass all TRN segments received in the 271 response transaction.

  NOTE: If the Information Source determines that the patient was submitted as a subscriber but is actually a dependent, the TRN segment(s) submitted in the 2000C loop, along with the patient information will be moved to the 2000D loop. If the Information Source determines that the patient was submitted as a dependent but is actually a subscriber, the TRN segment(s) submitted in the 2000D loop, along with the patient information will be moved to the 2000C loop. See Section 1.4.2 - *Basic Concepts* for additional information.

1.4.6.2 Batch Linkage

Given the nature of batch processing which may or may not respond to each of the requests in the same batch response, the 270 request transaction has fewer methods of providing linkage to the 271 response transaction when the transactions are being processed in Batch (see Section 1.4.3 - *Batch and Real Time*). Values returned in the 271 response transaction must be returned exactly as submitted in the corresponding 270 request transaction.

Information Receiver

- BHT03 - Submitter Transaction Identifier. This is used to identify the transaction at a high level. This is particularly useful in reconciling 271 reject transactions that may not contain all of the HL Loops. This information may be sent at the information receiver's discretion if using the transaction in a Batch mode. Due to the nature of batch transaction processing, the receiver of the 270 transaction (whether it is a clearinghouse or information source) may or may not be able to return the 270 BHT03 value in the 271 BHT03.
- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. The information receiver may create one occurrence of the TRN segment at the lower of these levels. These segments are optional for the information receiver, however if the information source receives them, they must be returned in the 271 response transaction unless a AAA is generated in 2000A, 2100A or 2100B.
- Patient Account Number. A patient account number may be entered in REF02 of a REF segment (with REF01 being EJ) in either Loop 2100C or Loop 2100D, whichever is the patient. This information is optional for the information receiver, however if the information source receives the patient account number, they must return it in the 271 response transaction unless a AAA is generated in 2000A, 2100A or 2100B.

Information Source

- TRN segments in the 271 response transaction in either Loop 2000C or Loop 2000D, whichever is the patient. The information source may create one occurrence of the TRN segment at the lower of these levels. This segment is optional for the information source, however, this gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction.

  NOTE: If the Information Source determines that the patient was submitted as a subscriber but is actually a dependent, the TRN segment(s) submitted in the 2000C loop, along with the patient information will be moved to the 2000D loop. If the Information Source determines that the patient was submitted as a dependent but is actually a subscriber, the TRN segment(s) submitted in the 2000D loop, along with the patient information will be moved to the 2000C loop. See Section 1.4.2 for additional information.

1.4.7 Implementation-Compliant Use of the 270/271 Transaction Set

The ANSI ASC X12N Implementation Guideline for 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, payer or other trading partner involved in the use of the 270/271. The super set identifies the framework an information source (typically a payer), can utilize. This Implementation Guide also identifies the minimum an information source or clearinghouse is required to support in order to offer an implementation-compliant 270/271 transaction. Identification of the person being inquired about can be found in Section 1.4.8 - *Search Options*.

The 271 transaction is designed to report a great deal more than "Yes, the patient is eligible today". Some of the items that can be returned if the conditions apply are: Co-payment, Co-insurance, Deductible amounts, Plan Beginning and Ending Dates, allowing for dates other than the current date and information about the Primary Care Provider. Additionally, specific service types and their related information can also be returned.

The 271 response can get as elaborate as identifying what days of the week a member can have a service performed and where, the number of benefits they are allowed to have and how many of them they have remaining, whether the benefit conditions apply to "in" or "out" of network, etc. Anything that is identified as situational in the 271 could possibly be returned, this is the super set. The Implementation Guide states that receivers of the 271 transaction need to "design their system to receive all of the data segments and data elements identified as used or situational, and account for the number of times a data segment can repeat." This allows the information source the flexibility to send back relevant information without the receiver having to reprogram their system for each different information source.

Just as the 271 response can be as elaborate as the information source wishes to return, the 270 request can also be very explicit. A provider could send a 270 request to 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 to 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 if their system is not capable of handling such requests. However, the more information an information source can provide the information receiver 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 as noted in this section and may not reject the transaction merely because they cannot process an explicit request. Willing trading partners are allowed to use any portion or all of the 270/271 super set; so long as they support the minimum data set, but are not allowed to add to or change it in order to remain compliant with this Implementation Guide.

1.4.7.1 Minimum Requirements For Implementation Guide Compliance

270

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in the "EQ" loop of the transaction. See section 1.4.7.2 for additional Service Type Code support information.

271

Unlike the 004010X092 270/271 Health Care Eligibility Benefit Request Response Implementation Guide which stated "An information source must respond with either an acknowledgment that the individual has active or inactive coverage or that the individual was not found in their system", the mandated response now has some additional requirements.

If the individual is located in the information source's system, the following must be returned:

1. If the individual has active coverage, the 346 Plan Begin date must be returned in 2100C/D DTP unless multiple plans apply to the individual or multiple plan periods apply, which must then be returned in the 2110C/D DTP. May alternately return a 291 Plan range of dates if known.

   If benefit dates are different from the 2100C/D Plan or Plan Begin date, either 348 Benefit Begin date or 292 Benefit date must be returned in the 2110C/D loop with the associated EB03 benefit.

   NOTE: Plan dates represent coverage dates in the plan or program that is being represented in the response. This date does not have to represent the historical beginning of eligibility for the plan, only the most recent plan date(s). For example, Medicaid may only report plan dates in one month periods of time.

2. For each plan for which the individual has active or inactive coverage, a 2110C/D loop is required with EB01 Status = 1, 2, 3, 4, 5, 6, 7 or 8 with 2110C/D EB03 Service Type Code = 30 (Health Benefit Plan Coverage) and Plan Name in EB05 if one exists.
3. If the patient is the subscriber, demographic information (Subscriber's First and Last Name, Subscriber's Date of Birth and Member ID) and any other information (e.g. Address) required to identify the individual on subsequent EDI transactions (e.g. 837 Health Care Claim or 278 Health Care Services Review - Request for Review) must be returned.
4. If the patient is a dependent, demographic information (Subscriber's Member ID, Dependent's First and Last Name, and Dependent's Date of Birth) and any other information (e.g. Address) required to identify the individual on subsequent EDI transactions (e.g. 837 Health Care Claim or 278 Health Care Services Review - Request for Review) must be returned.
5. Primary Care Provider in 2120C/D if applicable
6. Other payers or plans if known in 2120C/D. (Note: Do not return details of coverage or benefits associated with other payers or plans, the Information Receiver should initiate a separate 270 request to the other payer or plan to determine the level of coverage.)
7. The information source is also required to return information from any of the following segments supplied in the 270 request that was used to determine the 271 response:

   2100B N3 or N4
   2100B, 2100C or 2100D PRV
   2100C or 2100D HI
   2110C or 2110D loop (all segments)

   Examples of such information are, but not limited to, service type codes, procedure codes, diagnosis codes, facility type codes, dates and identification numbers.

   NOTE: If the information from the above listed segments in the 270 request was not used to determine the 271 response, that information from the 270 request must not be returned. In this instance, the information source may return this information from what they have on file.

8. If an information source receives a Service Type Code "30" submitted in the 270 EQ01 or a Service Type Code that they do not support, the following 2110C/D EB03 values must also be returned if they are a covered benefit category at a plan level.

   1 - Medical Care
   33 - Chiropractic

35 - Dental Care
47 - Hospital
86 - Emergency Services
88 - Pharmacy
98 - Professional (Physician) Visit - Office
AL - Vision (Optometry)
MH - Mental Health
UC - Urgent Care

The above codes must have the appropriate EB01 = 1-5. If it is not a covered benefit, the code must not be returned. The repetition function of EB03 must be used if only reporting the Active Status or if Patient Responsibility is the same across multiple benefits. If any of the above benefits are associated with an other entity (e.g. carve out) the information must be returned in 2120C/D if known.

If the information source's plan does not fall into any of the 10 Service Type Codes listed above, the plan must return the Active Status information and whatever additional appropriate service type code does define the benefit. If no service type code exists, the plan may return either the appropriate procedure code(s) in EB13 or a description in MSG01. EB03 and EB13 cannot both be used in the same EB segment. If an appropriate procedure code is available for use in EB13, MSG01 must not be used.

9. If an information source supports an explicit request for Service Type Codes "1", "33", "35", "47", "86", "88", "98", "AL", "MH" or "UC" submitted in the 270 EQ01, they are required to return the items identified in items 1 to 6, but are only required to return benefits associated with the submitted Service Type code and are not required to return any of the other service type codes identified in the generic response. If the service type code is supported, however the benefit is not covered, the appropriate response would be EB01 = "I", Non-Covered.

   Additional covered Service Type Codes may be returned at the information source's discretion; however their absence does not imply that they are not covered.

10. The response will be for the date the transaction is processed, unless a specific Plan date (prior, current or future) was used from the DTP of the 270. For example, prior dates are needed for Medicaid inquiries, so providers can determine if a patient's application for state medical assistance has been processed, claims can not be submitted until the benefit has been activated, which can be retroactive for qualifying recipients.

11. When an organization receives an eligibility request and can locate the patient, however if they are not the true information source (such as labor funds), return an

EB01 = "U" (Contact Following Entity for Eligibility or Benefit Information) with the true Information Source's contact information in the 2120 loop. In this case, neither a status of Active or Inactive, nor any of the other required items from this section are required to be returned.

12. Information Sources are not limited to returning the 10 Service Type Codes identified in 1.4.7.1 Item 8.

1.4.7.2 Recommended Additional Support

In addition to the mandated response components, it is highly recommended that the information source returns any known patient financial responsibility (e.g. Co-insurance, co-payment, deductible, etc) for benefits described. See Section 1.4.9 - *Patient Responsibility* for additional information.

Each of the 10 mandated Service Type Codes identified in Section 1.4.7.1 item 8 ("1", "33", "35", "47", "86", "88", "98", "AL", "MH" or "UC") can be broken into their components. This level of support can be used if an information receiver sends a 270 request with one of the 10 service type codes returned in a mandated 271 response. This will allow the information receiver to receive more detailed relevant information.

The following are some of the components that make up each of the 10 mandated service type codes. This is intended as guidance to show some of the service type codes that could be returned if one of the 10 listed service type codes is sent in a 270 transaction and not an all inclusive list. If this functionality is supported, the information source must still return all of the mandated components outlined above. This is not mandated, and if the information source cannot support this explicit level of request, they are to respond as if a 270 were received with an EQ01 = 30.

Codes 33 - Chiropractic, 86 - Emergency Services and UC - Urgent Care may have related components; however, those may be determined at the information sources discretion.

Service Type Code Components

1 - Medical Care

2 - Surgical
3 - Consultation
42 - Home Health Care
45 - Hospice
54 - Long Term Care

69 - Maternity
73 - Diagnostic Medical
76 - Dialysis
83 - Infertility
AG - Skilled Nursing Care
BT - Gynecological
BU - Obstetrical
BV - Obstetrical/Gynecological
DM - Durable Medical Equipment

35 - Dental

23 - Diagnostic Dental
24 - Periodontics
25 - Restorative
26 - Endodontics
27 - Maxillofacial Prosthetics
28 - Adjunctive Dental Services
36 - Dental Crowns
37 - Dental Accident
38 - Orthodontics
39 - Prosthodontics
40 - Oral Surgery
41 - Routine (Preventive) Dental

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

88 - Pharmacy

89 - Free Standing Prescription Drug
90 - Mail Order Prescription Drug
91 - Brand Name Prescription Drug
92 - Generic Prescription Drug
BW - Mail Order Prescription Drug: Brand Name
BX - Mail Order Prescription Drug: Generic
GF - Generic Prescription Drug - Formulary

GN - Generic Prescription Drug - Non-Formulary

98 - Professional (Physician) Visit - Office

BY - Physician Visit - Office: Sick
BZ - Physician Visit - Office: Well

MH - Mental Health

67 - Smoking Cessation
A4 - Psychiatric
A5 - Psychiatric - Room and Board
A6 - Psychotherapy
A7 - Psychiatric - Inpatient
A8 - Psychiatric - Outpatient
AI - Substance Abuse
AJ - Alcoholism
AK - Drug Addiction

1.4.7.3 Streamlining Responses

The 271 transaction contains an extensive amount of flexibility and ability to provide valuable data. As more data is supplied in the 271, the information sources should consider the advantage of streamlining the data to specifically fit the person whose benefits are being requested in the 270. Not only will this clarify the coverage for the information receiver but may reduce the length of the transaction. When an information source is returning additional information, above and beyond the requirements of this section, the following recommendations should be taken into consideration.

1.4.7.4 Person Specific Benefit Responses

Many benefits are associated with the gender or age of a patient. It is encouraged that benefits supplied in the 271 are matched with the appropriate age or gender of the patient in the 270 request. For example, maternity benefits would only be sent on a female patient. Also, only the benefit matching the age of the patient should be sent.

1.4.7.5 Patient History Benefit Responses

There are different levels of benefits based on the number of services provided, the date the patient was last seen or other service related items. The information source may wish to consider providing the information receiver with the exact benefit level in effect at the time the request was made. The actual benefit applied could be different due to the timing of the request with respect to the consideration or payment of other services not known at the time of the eligibility request.

1.4.8 Search Options

Unlike many other X12 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. Obviously the more information that can be provided, the more likely the information source will find a match in their system. The developers of this implementation guide have defined a maximum data set that an information source may require and identified further elements the information source may use if they are provided. The maximum data set the Information Source may require is referred to throughout this Implementation Guide as the Primary Search Option. As noted in Section 1.4.2 - *Basic Concepts*, the patient may be identified in either loop 2100C or 2100D.

In most cases, the patient's ID card would identify if the person is uniquely identifiable to the payer or must be associated with the subscriber. For example, if the patient is a dependent, they are typically listed on the subscriber's ID card as dependents and do not receive their own ID card. If there is confusion as to whether the patient is a subscriber or a dependent, the transaction should be submitted with the patient as the subscriber.

1.4.8.1 Required Primary Search Options

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are:

Patient is Subscriber

Patient's Member ID (or the HIPAA Unique Patient Identifier if mandated for use)

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option.

When the patient is the subscriber, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

Patient is Dependent

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are:

Loop 2100C

Subscriber's Member ID

Loop 2100D

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option if their system does not have unique Member Identifiers assigned to dependents.

When the patient is the dependent, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

1.4.8.2 Required Alternate Search Options

In some instances all four pieces of information from the Primary Search Option are not available, such as in an emergency situation, or there are differences between the identifying information for the individual that the provider has and what the information source has (such as misspelled name). To accommodate these types of situations, and to provide a set of standardized alternate search options, the developers of this Implementation Guide have defined four alternate search options that an Information Source is required to support in addition to the Primary Search Option. The maximum data set the Information Source may require for these alternate search options is referred to throughout this Implementation Guide as the Required Alternate Search Options. The order of the search options does not imply that any search option should be used over any other, since they are to be used when one of the pieces of information from the Primary Search Option is missing.

Patient is Subscriber

If the patient is the subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in loop 2100C are:

Member ID/Date of Birth/Last Name Search Option
Loop 2100C
Patient's Member ID Number
Patient's Date of Birth
Patient's Last Name

Member ID/Name Search Option
Loop 2100C
Patient's Member ID Number
Patient's First Name
Patient's Last Name

Patient is Dependent
If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in loop 2100C and 2100D are:

Member ID/Date of Birth/Last Name Search Option
Loop 2100C

Subscriber's Member ID Number

Loop 2100D

Patient's Date of Birth
Patient's Last Name

Member ID/Name Search Option
Loop 2100C

Subscriber's Member ID Number

Loop 2100D

Patient's First Name
Patient's Last Name

If all of the elements for one of the Required Alternate Search Options are present, the Information Source is required to search for the patient in their system and if a unique match for an individual can be made, the Information Source is required to return the appropriate eligibility response as outlined in Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set*.

If an Information Source is unable to identify a unique individual in their system (more than one individual matches the information from the Required Alternate Search Option),

the Information Source is required to reject the transaction and identify in the 2100C or 2100D AAA segment the additional information from the Primary Search Option that is needed to identify a unique individual in the Information Source's system.

Search Options and Error Handling Matrix

This table identifies the Required Alternate Search Option used and how to respond when there is a unique individual or multiple individuals found in the Information Source's system. When multiple individuals are found, the 271 response must contain the error code indicating which item is needed from the Primary Search Option to eliminate the multiple matches and ensure the correct individual is returned. This table is for 270 transactions that do not have errors for invalid Member ID (MID), Name (First/Last) or Date of Birth (DOB).

Search Option	Patient is Subscriber	Patient is Dependent	Match Results	271 Returned	Error Code
MID/DOB/ Last Name	Yes	No	Unique Multiple	2110C EB 2100C AAA	None AAA03 = 73
Name/MID	Yes	No	Unique Multiple	2110C EB 2100C AAA	None AAA03 = 58
MID/DOB/ Last Name	No	Yes	Unique Multiple	2110D EB 2100D AAA	None AAA03 = 65
Name/MID	No	Yes	Unique Multiple	2110D EB 2100D AAA	None AAA03 = 58

1.4.8.3 Name/Date of Birth Search Option

In some instances all pieces of information from the Primary Search Option or one of the Required Alternate Search Options are not available, such as in an emergency situation or if the patient has forgotten to bring their identification card. To accommodate these types of situations, and to provide guidance on standardized alternate search options, the developers of this Implementation Guide have defined a Name/Date of Birth Search Option that an Information Source may, at their discretion but are not required to, support in addition to the Primary Search Option and Required Alternate Search Options.

Patient is Subscriber

If the patient is the subscriber, the maximum data elements that can be required by an information source for a Name/Date of Birth Search Option to identify a patient in loop 2100C are:

Name/Date of Birth Search Option

Patient's First Name
Patient's Last Name
Patient's Date of Birth

Patient is Dependent

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source for a Name/Date of Birth Search Option to identify a patient in loop 2100D are:

Name/Date of Birth Search Option

Loop 2100D
Patient's First Name
Patient's Last Name
Patient's Date of Birth

NOTE: When using the Patient is Dependent variant of the Name/Date of Birth Search Option, a 2000C and 2100C loop must be created with the dependent information sent in the 2100D loop.

Search Options and Error Handling Matrix

This table identifies the Name/Date of Birth Search Option used and how to respond when there is a unique individual or multiple individuals found in the Information Source's system. When multiple individuals are found, the 271 response must contain the error code indicating which item is needed from the Primary Search Option to eliminate the multiple matches and ensure the correct individual is returned. This table is for 270 transactions that do not have errors for invalid Name (First/Last) or Date of Birth (DOB).

Patient is Subscriber	Dependent is Patient	Match Results	271 Returned	Error Code
Yes	No	Single	2110C EB	None
Yes	No	Multiple	2100C AAA	AAA03 = 72
No	Yes	Single	2110D EB	None

Patient is Subscriber	Dependent is Patient	Match Results	271 Returned	Error Code
No	Yes	Multiple	2100C AAA	AAA03 = 72

Minimum Response for a unique match

Section 1.4.7.1 identifies the Minimum Requirements for Implementation Compliance for a 271 response. If the Name/Date of Birth Search Option was utilized, the Information Source is not required to return all of the information outlined in section 1.4.7.1 with the exception of the following:

1. For each plan for which the individual has coverage, a 2110C/D loop is required with EB01 Status = 1, 2, 3, 4, 5, 6, 7 or 8 with 2110C/D EB03 Service Type Code = 30 (Health Benefit Plan Coverage) and Plan Name in EB05 if one exists.

Recommended Additional Response Information

In addition to the above, Information Sources are encouraged to return the following at their discretion:

1. Any or all of the information contained in Section 1.4.7.1 (including but not limited to the Member ID number, Patient's Address and any other information that might help the provider ensure that the person returned is the patient for which the provider requested eligibility).

2. If the Member ID is not returned, a 2110C/D with EB01 = "U" (Contact the following Entity for Eligibility or Benefit Information) and a customer support phone number in 2120C/D.

Provider Validation

When the Name/Date of Birth Search Option is used, the provider must use reasonable effort in comparing the information returned in the 271 response to information they have available (e.g. demographic information in their system or directly asking the patient) to validate the information returned on the 271 is for correct patient.

1.4.8.4 Member ID Number/Date of Birth Search Option

In some instances all pieces of information from the Primary Search Option or one of the Required Alternate Search Options are not available, or there are differences between the identifying information for the individual that the provider has and what the information source has (such as misspelled name). To accommodate these types of situations, and

to provide guidance on standardized alternate search options, the developers of this Implementation Guide have defined a Member ID/Date of Birth Search Option that an Information Source may, at their discretion but are not required to, support in addition to the Primary Search Option and Required Alternate Search Options.

Patient is Subscriber
If the patient is the subscriber, the maximum data elements that can be required by an information source for a Member ID/Date of Birth Search Option to identify a patient in loop 2100C are:

Member ID/Date of Birth Search Option
Patient's Member ID Number
Patient's Date of Birth

Patient is Dependent
If the patient is a dependent of a subscriber, the maximum data elements that an be required by an information source for a Member ID/Date of Birth Search Option to identify a patient in loop 2100C and 2100D are:

Member ID/Date of Birth Search Option
Loop 2100C
Subscriber's Member ID Number

Loop 2100D
Patient's Date of Birth

Search Options and Error Handling Matrix
This table identifies the Member ID/Date of Birth Search Option used and how to respond when there is a unique individual or multiple individuals found in the Information Source's system. When multiple individuals are found, the 271 response must contain the error code indicating which item is needed from the Primary Search Option to eliminate the multiple matches and ensure the correct individual is returned. This table is for 270 transactions that do not have errors for invalid Member ID Number or Date of Birth (DOB).

Patient is Subscriber	Patient is Dependent	Match Results	271 Returned	Error Code
Yes	No	Single	2110C EB	None
Yes	No	Multiple	2100C AAA	AAA03 = 73

Patient is Subscriber	Patient is Dependent	Match Results	271 Returned	Error Code
No	Yes	Single	2110D EB	None
No	Yes	Multiple	2100D AAA	AAA03 = 65

Minimum Response for a unique match

Section 1.4.7.1 identifies the Minimum Requirements for Implementation Compliance for a 271 response. If the Member ID/Date of Birth Search Option was utilized, the Information Source is not required to return all of the information outlined in section 1.4.7.1 with the exception of the following:

1. For each plan for which the individual has coverage, a 2110C/D loop is required with EB01 Status = 1, 2, 3, 4, 5, 6, 7 or 8 with 2110C/D EB03 Service Type Code = 30 (Health Benefit Plan Coverage) and Plan Name in EB05 if one exists.

Recommended Additional Response Information

In addition to the above, Information Sources are encouraged to return the following at their discretion:

1. Any or all of the information contained in Section 1.4.7.1 (including but not limited to the Patient's Name, Patient's Address and any other information that might help the provider ensure that the person returned is the patient for which the provider requested eligibility).

2. If the Patient's Name is not returned, a 2110C/D with EB01 = "U" (Contact the following Entity for Eligibility or Benefit Information) and a customer support phone number in 2120C/D.

Provider Validation

When the Member ID Number/Date of Birth Search Option is used, the provider must use reasonable effort in comparing the information returned in the 271 response to information they have available (e.g. demographic information in their system or directly asking the patient) to validate the information returned on the 271 is for correct patient.

1.4.8.5 Additional Alternate Search Options

Information sources are encouraged to support additional alternate search options to assist in locating a patient in the absence of all four pieces of information from the Primary

Search Option or when one of the Required Alternate Search Options does not locate a unique match for an individual in their system. Other alternate search options can utilize any of the data elements in the 2100C loop for a subscriber or the 2100D loop for a dependent such as Social Security Number, Address or Gender.

The information source should attempt to look up the patient if there is a reasonable amount of information present. An information source may outline additional search options available in their trading partner agreement; however under no circumstances may they require the use of a search option that differs from the ones outlined in the Required Primary Search Options section above.

NOTE
The information source is required to return all information used from the 270 transaction to locate the patient.

1.4.8.6 Insufficient Identifying Elements

In the event that insufficient identifying elements are sent to the information source, the information source will return a 271 identifying the missing data elements in a AAA segment.

1.4.8.7 Multiple Matches

In the event that 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 must not return all the matches found. In this case, the information source must return a 271 AAA segment, identifying the missing data elements necessary to provide an exact match.

1.4.9 Patient Responsibility

Health Plans have many different ways of identifying the patient's monetary responsibility when services are rendered. Depending on the type of plan the patient is enrolled in such as an HMO, PPO or traditional indemnity plan, the types of patient responsibility will vary. The most common of these are Co-Payment, Co-Insurance and Deductible. Loops 2110C and 2110D use the EB01 Eligibility or Benefit Information Code to begin the loop establishing what the patient responsibility is. For each of the EB01 code values that represent either a dollar or percentage based patient responsibility, codes and their definitions have been identified and instructions on how to use them in conjunction with this Implementation Guide are included below.

NOTE

Some health plans may use these terms differently than identified in this Implementation Guide, and the Implementation Guide definitions take precedence when used in conjunction with this transaction.

Eligibility or Benefit Information Code Definitions

A - Co-Insurance:

Co-Insurance represents the patient's portion of responsibility for a benefit and is represented as a percentage in EB08. The co-insurance percentage is typically found in a fee for service environment and is based on a percentage of the total amount the provider would be paid for the service(s). Since the actual amount that would be paid to the provider may not be known until after the claim has been processed, a percentage is used, rather than an actual dollar amount. For example, a patient may have a 20% co-insurance for a physician office visit if the provider is in the plan the patient belongs to or patient may have a 40% co-insurance for a physician office visit if the provider is not in the plan the patient belongs to. The provider may calculate an estimated amount to collect from the patient, or may wait until after the claim has been processed to collect the actual amount from the patient (requirements may vary from plan to plan). If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB08. Negative numbers are prohibited.

B - Co-Payment

Co-Payment represents the patient's portion of responsibility for a benefit and is represented as a dollar amount in EB07. The co-payment amount is typically a fixed amount and is customarily collected upon receipt of service (however the requirements may vary from plan to plan). For example, a patient may have a $10 co-payment for a physician office visit or a $50 co-payment for an Emergency Room visit. If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB07. Negative numbers are prohibited.

C - Deductible

Deductible represents the total amount of the patient's portion of responsibility for a benefit and is represented as a dollar amount in EB07. The deductible amount is typically found in a fee for service environment and is based on the total amount the patient will have to pay before their benefits begin (which may then require co-insurance or co-payment). If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB07. Negative numbers are prohibited.

G - Out of Pocket (Stop Loss)

Out of Pocket (Stop Loss) represents the maximum amount of the patient's portion of responsibility before a benefit is covered with no additional payments from the patient, up to the maximum covered by the health plan. The Out of Pocket (Stop Loss) amount typically represents the combined total amount of deductible and co-insurance payments made by the patient. Some health plans have Out of Pocket (Stop Loss) amount for the individual patient and a higher amount for the entire family. The Out of Pocket (Stop Loss) amount is represented as a dollar amount in EB07. If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB07. Negative numbers are prohibited.

J - Cost Containment

Cost Containment represents the total amount of the patient's portion of responsibility for a benefit and is represented as a dollar amount in EB07. Cost Containment is typically found in the Medicaid environment and represents the total amount the patient will have to pay out of their own pocket before their benefits begin (which may or may not then require co-insurance or co-payment). If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB07. Negative numbers are prohibited.

Y - Spend Down

Spend Down represents the total amount of the patient's portion of responsibility for a benefit and is represented as a dollar amount in EB07. Spend Down is typically found in the Medicaid environment and represents the total amount the patient will have to pay out of their own pocket before their benefits begin (which may or may not then require co-insurance or co-payment). If the patient's portion of responsibility for a benefit is nothing, "0" is to be placed in EB07. Negative numbers are prohibited.

Combinations of Patient Responsibility

Many health plans will use a combination of these items to express the patient's benefit coverage. By way of an example, the patient's deductible might be $150 for the individual and $300 for the family, their co-insurance might be 20 percent, and their Out of Pocket Maximum (Stop Loss) might be $1,500 for the individual and $3,000 for the family. During a plan year, the health plan does not pay any benefit until one of the following happens: a) the first $150 in health care expenses has been paid by the subscriber for the patient addressed by the claim, or b) the subscriber has paid a total of $300 for covered health care services for all the individuals covered by the subscriber's policy. After that, the subscriber pays 20% of the covered health care expenses for the patient until that 20% leads to $1500 in expenses (or $3000 across patients covered by the contract) then the insurance benefits increase, typically to full coverage up to the maximum benefit.

1.4.10 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. This is 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 999 Implementation Acknowledgement.

The AAA Request Validation segment is used to identify why an EB Eligibility or Benefit Information segment has not been generated or in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically an AAA segment is generated as a result of either an error in the data being detected (e.g. Missing Subscriber ID) or no matching information in the database (e.g. Subscriber Not Found). The difference is subtle, but they generate different types of messages. If data is missing or invalid, it must be corrected and a new transaction must be generated. If an entity is not found in the database however, it could mean one of two things. The first would be that the Information Receiver should review what was submitted to verify that it was correct and if it was incorrect take the necessary steps to correct and resubmit the transactions. The second would be, if it is determined that the data was correct, the entity is not associated with the Information Source or clearinghouse processing the transaction and a definitive answer has been generated. One other use of the AAA segment is to identify a problem with the processing system itself (e.g. the Information Source's system is down). In this case, validation of data may or may not have taken place, so the assumption is made that the data is correct (AAA01 would be "Y" since it cannot point out where the error is), but the transaction will likely have to be resent (as determined by AAA04).

There are three elements that are used in the AAA segment. AAA01 is a Yes/No indicator (identifies if the data content was valid). AAA02 is not used. AAA03 is a Reject Reason Code (identifies why the transaction did not generate an EB segment). AAA04 is a Follow-up Action Code (identifies what further action should be taken).

AAA01 is used to indicate if errors were detected with the data or the transaction as a whole. A "Y" indicates that no data errors were detected and the transaction was processed as far as it could go. An "N" indicates that errors were detected in the data and corrective action is needed. The reason AAA01 would have a "Y" in the event there is a system problem is because no errors were detected in the transaction itself.

AAA03 is used to indicate why an EB segment was not generated. This is in essence an error code.

AAA04 is used to indicate what action, if any, the Information Receiver should take.

1.4.11 Disclaimers Within the Transactions

The developers of this Implementation Guideline strongly discourage the transmission of a disclaimer as a part of the transaction. Any disclaimers necessary should be outlined in the agreement between trading partners. Under no circumstances should there be more than one disclaimer segment returned per individual response.

1.4.12 Message Segments

Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements (including combinations of multiple data elements and segments). If the information cannot be codified, then cautionary use of the MSG segment is allowed as a short term solution. It is highly recommended that the entity needing to use the MSG segment approach X12N with data maintenance to solve the long term business need, so the use of the MSG segment can be avoided for that issue.

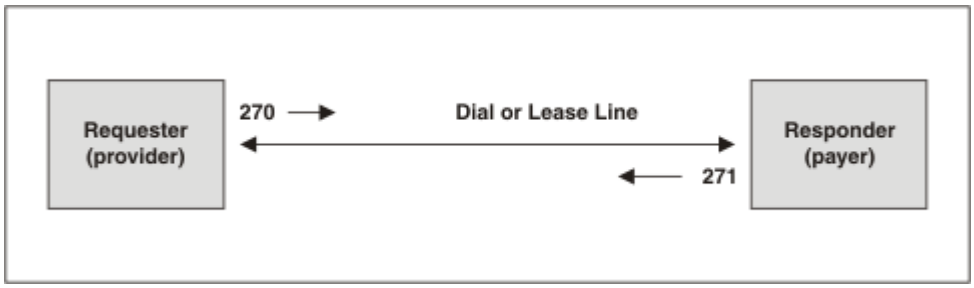
1.4.13 Information Flows

Following are several scenarios where response transactions are exchanged by trading partners in different environments. The roles vary from direct connections, to connecting through communications services like VANS or other intermediaries. Requesters will operate in a variety of application environments. The following scenarios show a variety of environments using a hospital and a small physician's practice as role players.

1.4.13.1 Basic Information Flow

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.

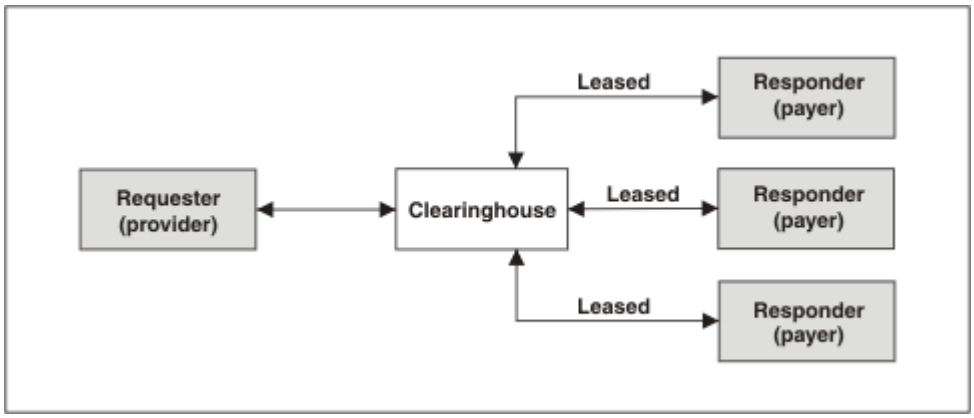
Figure 1.2 - Basic Information Flow



1.4.13.2 Intermediaries

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

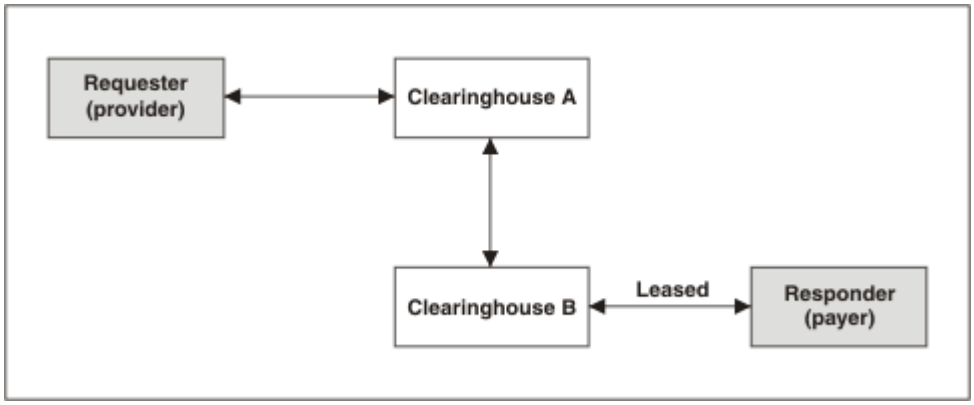
Figure 1.3 - Intermediaries



1.4.13.3 Multiple Intermediaries

In some business relationships, the clearinghouse will provide access to all payers for a provider, but may not have a direct connection with all payers. The clearinghouse may have a relationship with another clearinghouse who does have a direct connection with some payers. In this case, Clearinghouse "A" will pass the message to Clearinghouse "B" to route the transaction to the responder.

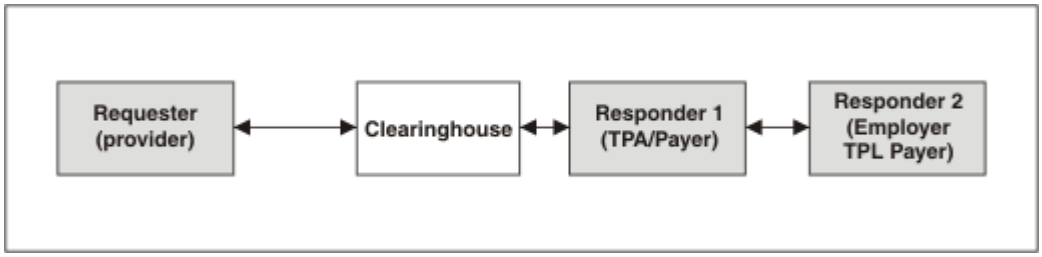
Figure 1.4 - Multiple Intermediaries



1.4.13.4 Multiple Responders

In some instances, the requester will query a responder, who in turn will also query a responder for additional information. An example of this situation would be when the first responder is a Third Party Administrator (TPA), and they in turn may query an employer or a payer to ensure that the patient or subscriber is still actively enrolled. When returning the second responder's transaction to the requester, the TPA may add information to the response. Another example might be when the first responder is a payer who knows that there may be a third party liability (TPL) payer; they might first query the TPL before responding to the requester.

Figure 1.5 - Multiple Responders



1.4.13.5 Value Added Service Organizations

With the rising need for information exchange between many organizations within the health care community, there are emerging service organizations that are enabling communication for all members of the community. Because there are many different ways to communicate with the various players in health care, service organizations will normalize communication solutions, data requirements, and transactions formats for their business partners. In these situations, the service organization will often need to open the transactions to reformat them or add needed information. In some cases, these Third Parties will perform database look-ups to determine what formats and additional information is required. They will then direct the transactions on to the appropriate responder or requester.

There can be other layers of complexity here, when clearinghouses might also be involved.

Figure 1.6 - Value Added Service Organizations

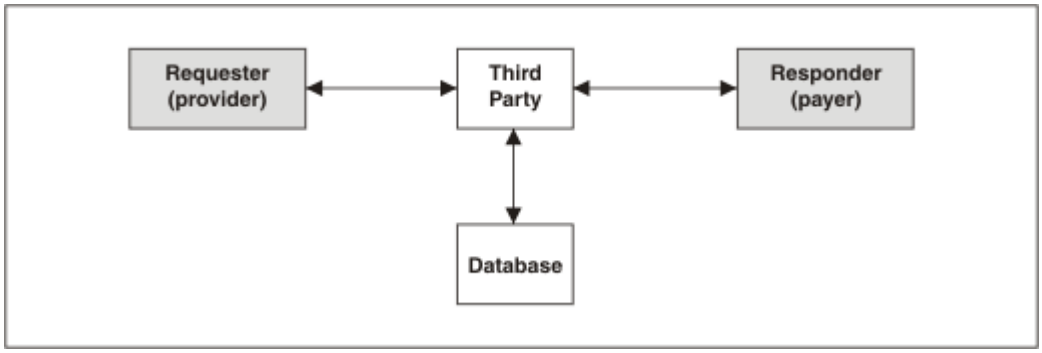
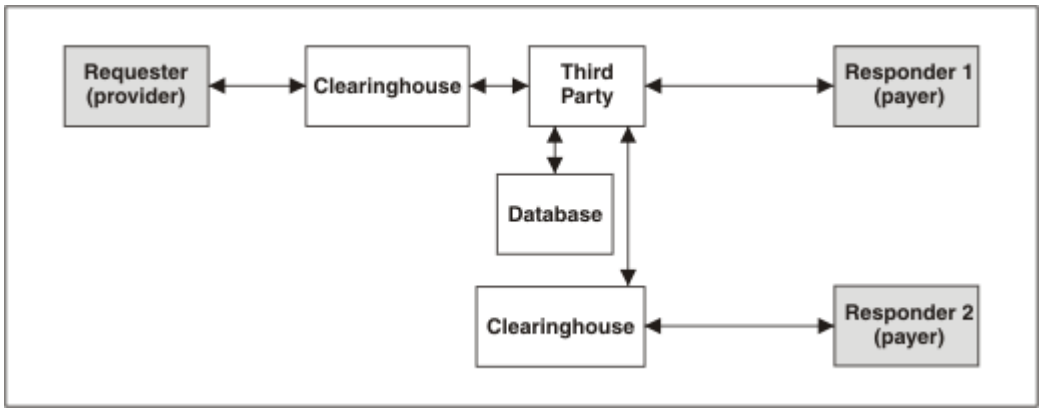


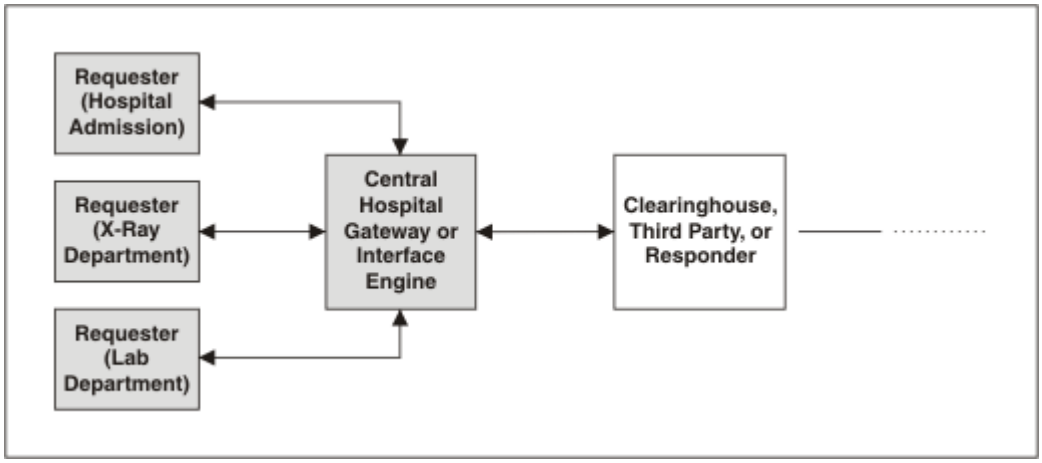
Figure 1.7 - Value Added Service Organizations with Clearinghouses



1.4.13.6 Complex Requester Environments

There are also considerations for complex requester environments for transaction routing. Hospitals and Integrated Health Networks (IHN) are good examples of this need. The hospital or IHN may have many systems within its enterprise or environment from which it receives requests. It then delivers these requests to a service organization or payers. For example, an IHN may include a hospital, a free standing clinic, a reference lab, and an x-ray department each having its own information system, but a common interface engine to the payers or VAN or service organization. In some cases, this interface engine may also be performing data and communication transformations, for example taking HL7 transactions and converting them to X12 transactions.

Figure 1.8 - Complex Requester Environments



1.5 Business Terminology

Batch

When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time. See Section 1.4.3 - *Batch and Real Time* for business usage of Batch transactions.

Dependent

The dependent is a person who cannot be uniquely identified to an information source by a unique Member Identification Number, but can be identified by an information source when associated with a subscriber. See definition of patient below for further detail. See Section 1.4.2 - *Basic Concepts* for business usage of dependent.

Information Receiver

The information receiver is the entity that is asking the questions in a 270 Eligibility or Benefit transaction. The information receiver is typically the medical service provider (e.g., physician, hospital, pharmacy, DME supplier, laboratory, etc.). The information receiver could also be another insurer or payer when they are attempting to verify other insurance coverage for their members. The information receiver could also be an employer inquiring on coverage of an employee. The information receiver's role in the transaction is identified in the Information Receiver Name segment (2100B NM1).

Information Source

The information source is the entity that has the answer to the questions being asked in a 270 Eligibility or Benefit transaction. The information source is typically the insurer, or payer. In a managed care environment, the information source could possibly be a primary care physician or gateway provider. Regardless of the information source's actual role, they are the entity who maintains the information regarding the patient's coverage. The information source is not a clearinghouse, value added network or other intermediary, even if they hold the data for the true information source. The information source's role in the transaction is identified in the Information Source Name segment (2100A loop NM1).

Patient

The patient is the person who the inquiry and response are for. There is no HL loop dedicated to patient, rather, the patient can be either the subscriber or the dependent. Different types of information sources identify patients in different manners depending upon how their eligibility system is structured. See Section 1.4.2 - *Basic Concepts* for business usage of patient.

Real Time

Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a clearinghouse (switch), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute. See Section 1.4.3 - *Batch and Real Time* for business usage of Real Time transactions.

Subscriber

The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient. See definition of patient above for further detail. See Section 1.4.2 - *Basic Concepts* for business usage of subscriber.

1.6 Transaction Acknowledgments

There are several acknowledgment implementation transactions available for use. The IG developers have noted acknowledgment requirements in this section. Other recommendations of acknowledgment transactions may be used at the discretion of the

trading partners. A statement that the acknowledgment is not required does not preclude its use between willing trading partners.

1.6.1 997 Functional Acknowledgment

The 997 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

A 997 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.2 999 Implementation Acknowledgment

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the implementation guide compliance.

The Implementation Acknowledgment (999) transaction is required as a response to receipt of a batch transaction compliant with this implementation guide. The 999 Implementation Acknowledgement will also report Implementation Guide errors that cannot otherwise be reported in a 271 AAA segment if the transaction is rejected. See Section 1.4.10 - *Rejected Transactions*.

The Implementation Acknowledgment (999) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide. The 999 Implementation Acknowledgment is required only if a real-time transaction is rejected for Implementation Guide errors that cannot otherwise be reported in a 271 AAA segment. See Section 1.4.10 - *Rejected Transactions*.

A 999 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.3 824 Application Advice

The 824 informs the submitter of the results of the receiving application system's data content edits of transaction sets.

The Application Advice (824) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Application Advice (824) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

An 824 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.7 Related Transactions

There are no transactions related to the transactions described in this implementation guide.

1.8 Trading Partner Agreements

Trading partner agreements are used to establish and document the relationship between trading partners. A trading partner agreement must not override the specifications in this implementation guide if a transmission is reported in GS08 to be a product of this implementation guide.

1.9 HIPAA Role in Implementation Guides

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191 - known as HIPAA) direct the Secretary of Health and Human Services to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

This implementation guide has been developed for use as an insurance industry implementation guide. At the time of publication it has not been adopted as a HIPAA standard. Should the Secretary adopt this implementation guide as a standard, the Secretary will establish compliance dates for its use by HIPAA covered entities.

1.10 Data Overview

1.10.1 Overall Data Architecture

NOTE
See Appendix B, *Nomenclature*, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

1.10.2 Data Use by Business Use

The 270/271 transactions are divided into two levels, or tables. See Section 2 *Transaction Set*, for a description of the transaction sets.

The Header Level, Table 1, contains transaction structure information.

The Detail Level, Table 2, contains specific information about the insurer, requester of information, insured, and dependents. This implementation uses four different ways to use the segments in table 2. Each HL is assigned a number identifying its purpose.

- Loop 2000A (information source) contains information typically about the insurer/payer.
- Loop 2000B (information receiver) contains information typically about the medical service provider. (e.g., physician, hospital, laboratory, etc.).
- Loop 2000C (subscriber) contains information about the individual who can be uniquely identified to the information source (who may or may not be the patient).
- Loop 2000D (dependent) contains information about dependents of an insured member.

1.11 HIPAA Privacy

The HIPAA Privacy Rule requires covered entities to use the "minimum necessary" individually identifiable health information to complete the task at hand. Prior to this requirement, many senders simplified the inquiry process by transmitting all available information to all trading partners. Now, covered entities must send the minimum necessary individually identifiable information to each trading partner.

This Implementation Guide in many cases prohibits sending individually identifiable information unless the sender is certain that the information is needed for the successful completion of the transaction. While this may aid a covered entity in determining what

information is minimally necessary, it remains the sole responsibility of the sender to ensure that they comply with the HIPAA Privacy Rule.

1.12 About the Authors

This transaction set and implementation guide have been developed by the Eligibility Work Group (WG1) which is part of the Health Care Task Group (TG2) within Insurance Subcommittee of X12 (X12N), which is an Accredited Standards Committee (ASC) under ANSI (American National Standards Institute). X12 is responsible for writing transaction standards for EDI. WG1 is comprised of numerous representatives from the health industry, including:

- health insurance companies
- health care providers
- health care systems vendors
- information network providers
- independent health care consultants
- state and federal health agencies
- translation software vendors

This implementation guide represents the best efforts of these organizations to bring forward the information and business requirements associated with this business process. As new or refined business requirements are identified, changes to this implementation guide will be made through this WG. Anyone wishing to make changes or additions to this implementation guide should contact one of the co-chairs of the WG. Co-chairs are listed with DISA (Data Interchange Standards Association), which is the secretariat for X12.

2 Transaction Set

NOTE
See Appendix B, Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

2.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable.

This implementation guide uses a format that depicts both the generalized standard and the insurance industry-specific implementation. In this implementation guide, **IMPLEMENTATION** specifies the requirements for this implementation. **X12 STANDARD** is included as a reference only.

The transaction set presentation is comprised of two main sections with subsections within the main sections:

2.3 Transaction Set Listing

There are two sub-sections under this general title. The first sub-section concerns this implementation of a generic X12 transaction set. The second sub-section concerns the generic X12 standard itself.

IMPLEMENTATION

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail.

STANDARD

This section is included as a reference.

2.4 Segment Detail

There are three sub-sections under this general title. This section repeats once for each segment used in this implementation providing segment specific detail and X12 standard detail.

SEGMENT DETAIL

This section is included as a reference.

DIAGRAM

This section is included as a reference. It provides a pictorial view of the standard and shows which elements are used in this implementation.

ELEMENT DETAIL

This section specifies the implementation details of each data element.

These illustrations (Figures 2.1 through 2.5) are examples and are not extracted from the Section 2 detail in this implementation guide. Annotated illustrations, presented below in the same order they appear in this implementation guide, describe the format of the transaction set that follows.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

8XX Insurance Transaction Set

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	0100	ST	Transaction Set Header	R	1	
54	0200	BPR	Financial Information	R	1	
60	0400	TRN	Reassociation Key	R	1	
62	0500	CUR	Non-US Dollars Currency	S	1	
65	0600	REF	Receiver ID	S	1	
66	0600	REF	Version Number	S	1	
68	0700	DTM	Production Date	S	1	
			PAYER NAME			1
70	0800	N1	Payer Name	R	1	
72	1000	N3	Payer Address	S	1	
75	1100	N4	Payer City, State, Zip	S	1	
76	1200	REF	Additional Payer Reference Number	S	1	
78	1300	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	0800	N1	Payee Name	R	1	
81	1000	N3	Payee Address	S	1	
82	1100	N4	Payee City, State, Zip	S	1	
84	1200	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 2.1. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix B.1, ASC X12 Nomenclature* for a complete description of the standard

8XX Insurance Transaction Set

Functional Group ID: XX

This Draft Standard for Trial Use contains the format and establishes the data contents of the Insurance Transaction Set (8XX) within the context of the Electronic Data Interchange (EDI) environment.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BPR	Beginning Segment	M	1	
0300	NTE	Note/Special Instruction	O	>1	
0400	TRN	Trace	O	1	

Figure 2.2. Transaction Set Key — Standard

SEGMENT DETAIL

Industry assigned Segment Name → **NM1 - PATIENT NAME**

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

See section B.1.1.3.8 for a description of these values

Industry assigned Loop ID and Loop Name

Industry Loop Repeat

Industry Segment Repeat

Loop:	**2100B — PATIENT NAME Loop Repeat: 1**
Segment Repeat:	**1**
Industry usage → Usage:	**SITUATIONAL**
Situational Rule:	**Required when the patient is different from the insured. If not required by this implementation guide, do not send.**
TR3 Notes:	**1. Any necessary identification number must be provided in NM109.**
TR3 Example:	**NM1*QC*1*Shepard*Sam*A***34*452114586~**

Situational Rule

Industry Notes

Example

Figure 2.3. Segment Key — Implementation

DIAGRAM

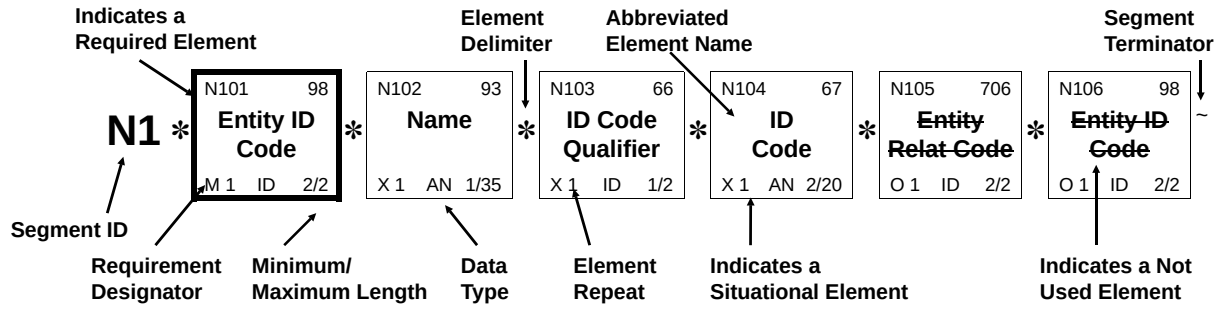


Figure 2.4. Segment Key — Diagram

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	Element Repeat	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **Use the Primary Payer's adjudicated Medical Procedure Code.**	**M 1**	
REQUIRED	**SVC01 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) IMPLEMENTATION NAME: **Product or Service ID Qualifier** **The value in SVC01-1 qualifies the values in SVC01-2, SVC01-3, SVC01-4, SVC01-5, and SVC01-6.**	**M**	**ID 2/2**
NOT USED	**SVC01 - 3**	**1339**	**Procedure Modifier**	**O**	**AN 2/2**
NOT USED	**SVC01 - 4**	**1339**	**Procedure Modifier**	**O**	**AN 2/2**
NOT USED	**SVC01 - 5**	**1339**	**Procedure Modifier**	**O**	**AN 2/2**
NOT USED	**SVC01 - 6**	**1339**	**Procedure Modifier**	**O**	**AN 2/2**
NOT USED	**SVC01 - 7**	**352**	**Description**	**O**	**AN 1/80**
REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount SEMANTIC: SVC02 is the submitted service charge. **This value can not be negative.**	**M 1**	**R 1/18**
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O 1**	**R 1/18**
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code. SITUATIONAL RULE: ***Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **National Uniform Billing Committee Revenue Code**	**O 1**	**AN 1/48**

CODE	DEFINITION
AD	**American Dental Association Codes** CODE SOURCE **135:** American Dental Association
HP	**Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code** CODE SOURCE **716:** Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

Reference Designator

Composite Number

Industry Usage: See the following page for complete descriptions

Industry Note

Selected Code Values

See Appendix A for external code source reference

Data Element Number

X12 Semantic Note

Situational Rule

Implementation Name See Appendix E for definition

Figure 2.5. Segment Key — Element Summary

2.2 Implementation Usage

2.2.1 Industry Usage

Industry Usage describes when loops, segments, and elements are to be sent when complying with this implementation guide. The three choices for Usage are required, not used, and situational. To avoid confusion, these are named differently than the X12 standard Condition Designators (mandatory, optional, and relational).

Required This loop/segment/element must always be sent.

Required segments in Situational loops only occur when the loop is used.

Required elements in Situational segments only occur when the segment is used.

Required component elements in Situational composite elements only occur when the composite element is used.

Not Used This element must never be sent.

Situational Use of this loop/segment/element varies, depending on data content and business context as described in the defining rule. The defining rule is documented in a Situational Rule attached to the item.

There are two forms of Situational Rules.

The first form is “Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender’s discretion, but cannot be required by the receiver.” The data qualified by such a situational rule cannot be required or requested by the receiver, transmission of this data is solely at the sender’s discretion.

The alternative form is “Required when <explicit condition statement>. If not required by this implementation guide, do not send.” The data qualified by such a situational rule cannot be sent except as described in the explicit condition statement.

2.2.1.1 Transaction Compliance Related to Industry Usage

A transmitted transaction complies with an implementation guide when it satisfies the requirements as defined within the implementation guide. The presence or absence of an item (loop, segment, or element) complies with the industry usage specified by this implementation guide according to the following table.

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

This table specifies how an entity is to evaluate a transmitted transaction for compliance with industry usage. It is not intended to require or imply that the receiver must reject non-compliant transactions. The receiver will handle non-compliant transactions based on its business process and any applicable regulations.

2.2.2 Loops

Loop requirements depend on the context or location of the loop within the transaction. See Appendix B for more information on loops.

- A nested loop can be used only when the associated higher level loop is used.
- The usage of a loop is the same as the usage of its beginning segment.
  - If a loop's beginning segment is Required, the loop is Required and must occur at least once unless it is nested in a loop that is not being used.
  - If a loop's beginning segment is Situational, the loop is Situational.
- Subsequent segments within a loop can be sent only when the beginning segment is used.
- Required segments in Situational loops occur only when the loop is used.

2.3 Transaction Set Listing

2.3.1 Implementation

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail. Refer to section 2.1 Presentation Examples for detailed information on the components of the Implementation section.

IMPLEMENTATION

270 Health Care Eligibility Benefit Inquiry

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
61	0100	ST	Transaction Set Header	R	1	
63	0200	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Information Source Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
66	0100	HL	Information Source Level	R	1	
			LOOP ID - 2100A INFORMATION SOURCE NAME			1
69	0300	NM1	Information Source Name	R	1	

Table 2 - Information Receiver Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
72	0100	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
75	0300	NM1	Information Receiver Name	R	1	
79	0400	REF	Information Receiver Additional Identification	S	9	
81	0600	N3	Information Receiver Address	S	1	
82	0700	N4	Information Receiver City, State, ZIP Code	S	1	
84	0900	PRV	Information Receiver Provider Information	S	1	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SUBSCRIBER LEVEL			>1
86	0100	HL	Subscriber Level	R	1	
90	0200	TRN	Subscriber Trace Number	S	2	
			LOOP ID - 2100C SUBSCRIBER NAME			1
92	0300	NM1	Subscriber Name	R	1	
97	0400	REF	Subscriber Additional Identification	S	9	
100	0600	N3	Subscriber Address	S	1	
101	0700	N4	Subscriber City, State, ZIP Code	S	1	
103	0900	PRV	Provider Information	S	1	
107	1000	DMG	Subscriber Demographic Information	S	1	
110	1100	INS	Multiple Birth Sequence Number	S	1	
113	1150	HI	Subscriber Health Care Diagnosis Code	S	1	

122	1200	DTP	Subscriber Date	S	2	
			LOOP ID - 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY			99
124	1300	EQ	Subscriber Eligibility or Benefit Inquiry	S	1	
136	1350	AMT	Subscriber Spend Down Amount	S	1	
137	1350	AMT	Subscriber Spend Down Total Billed Amount	S	1	
138	1700	III	Subscriber Eligibility or Benefit Additional Inquiry Information	S	1	
142	1900	REF	Subscriber Additional Information	S	1	
144	2000	DTP	Subscriber Eligibility/Benefit Date	S	1	

Table 2 - Dependent Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D DEPENDENT LEVEL			>1
146	0100	HL	Dependent Level	S	1	
149	0200	TRN	Dependent Trace Number	S	2	
			LOOP ID - 2100D DEPENDENT NAME			1
151	0300	NM1	Dependent Name	R	1	
154	0400	REF	Dependent Additional Identification	S	9	
157	0600	N3	Dependent Address	S	1	
158	0700	N4	Dependent City, State, ZIP Code	S	1	
160	0900	PRV	Provider Information	S	1	
164	1000	DMG	Dependent Demographic Information	S	1	
167	1100	INS	Dependent Relationship	S	1	
170	1150	HI	Dependent Health Care Diagnosis Code	S	1	
179	1200	DTP	Dependent Date	S	2	
			LOOP ID - 2110D DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY			99
181	1300	EQ	Dependent Eligibility or Benefit Inquiry	R	1	
192	1700	III	Dependent Eligibility or Benefit Additional Inquiry Information	S	1	
196	1900	REF	Dependent Additional Information	S	1	
198	2000	DTP	Dependent Eligibility/Benefit Date	S	1	
200	2100	SE	Transaction Set Trailer	R	1	

2.3.2 X12 Standard

This section is included as a reference. The implementation guide reference clarifies actual usage. Refer to section 2.1 Presentation Examples for detailed information on the components of the X12 Standard section.

STANDARD

270 Eligibility, Coverage or Benefit Inquiry

Functional Group ID: HS

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.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BHT	Beginning of Hierarchical Transaction	M	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
0100	HL	Hierarchical Level	M	1	
0200	TRN	Trace	O	9	
		LOOP ID - 2100			>1
0300	NM1	Individual or Organizational Name	M	1	
0400	REF	Reference Information	O	9	
0500	N2	Additional Name Information	O	1	
0600	N3	Party Location	O	1	
0700	N4	Geographic Location	O	1	
0800	PER	Administrative Communications Contact	O	3	
0900	PRV	Provider Information	O	1	
1000	DMG	Demographic Information	O	1	
1100	INS	Insured Benefit	O	1	
1150	HI	Health Care Information Codes	O	1	
1200	DTP	Date or Time or Period	O	9	
1250	MPI	Military Personnel Information	O	9	
		LOOP ID - 2110			99
1300	EQ	Eligibility or Benefit Inquiry	O	1	
1350	AMT	Monetary Amount Information	O	2	
1400	VEH	Vehicle Information	O	1	
1500	PDR	Property Description - Real	O	1	
1600	PDP	Property Description - Personal	O	1	
1700	III	Information	O	10	
1900	REF	Reference Information	O	1	
2000	DTP	Date or Time or Period	O	9	
2100	SE	Transaction Set Trailer	M	1	

NOTE:

2/0200 If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

2.4 270 - Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Refer to section 2.1 Presentation Examples for detailed information on the components of the Segment Detail section.

SEGMENT DETAIL

ST - TRANSACTION SET HEADER

X12 Segment Name: Transaction Set Header

X12 Purpose: To indicate the start of a transaction set and to assign a control number

Segment Repeat: **1**

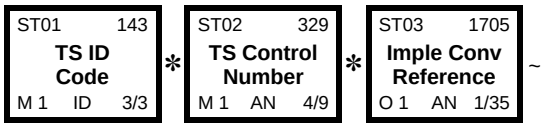
Usage: **REQUIRED**

TR3 Notes:

1. **Use this control segment to mark the start of a transaction set. One ST segment exists for every transaction set that occurs within a functional group.**

TR3 Example: **ST*270*0001*005010X279~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). OD: **270B1__ST01__TransactionSetIdentifierCode** **Use this code to identify the transaction set ID for the transaction set that will follow the ST segment. Each X12 standard has a transaction set identifier code that is unique to that transaction set.** CODE / DEFINITION **270** **Eligibility, Coverage or Benefit Inquiry**	**M 1 ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: **270B1__ST02__TransactionSetControlNumber** **The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with the number, for example "0001", and increment from there. This number must be unique within a specific group and interchange, but can repeat in other groups and interchanges.** **Use the corresponding value in SE02 for this transaction set.**	**M 1 AN 4/9**

REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention	**O**	**1**	**AN**	**1/35**

SEMANTIC: The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.

OD: **270B1__ST03__ImplementationConventionReference**

This element must be populated with 005010X279.

This element contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST/SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.

SEGMENT DETAIL

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

X12 Segment Name: Beginning of Hierarchical Transaction

X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Segment Repeat: **1**

Usage: **REQUIRED**

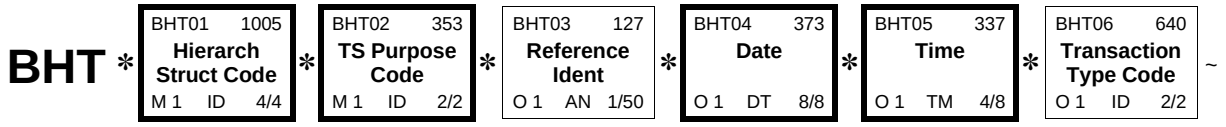
TR3 Notes:

1. **Use this segment to start the transaction set and indicate the sequence of the hierarchical levels of information that will follow in Table 2.**

TR3 Example: **BHT*0022*13*199800114000001*19980101*1400~**

TR3 Example: **BHT*0022*01**19980101*1400*RT~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	**M 1 ID 4/4**

OD: **270B1__BHT01__HierarchicalStructureCode**

Use this code to specify the sequence of hierarchical levels that may appear in the transaction set. This code only indicates the sequence of the levels, not the requirement that all levels be present. For example, if code "0022" is used, the dependent level may or may not be present for each subscriber.

CODE	DEFINITION
0022	**Information Source, Information Receiver, Subscriber, Dependent**

REQUIRED **BHT02** **353** **Transaction Set Purpose Code** **M 1 ID 2/2**
Code identifying purpose of transaction set

OD: **270B1__BHT02__TransactionSetPurposeCode**

CODE	DEFINITION
01	**Cancellation**
	Use this code to cancel a previously submitted 270 transaction that used a BHT06 code of "RT". Only 270 transactions that used a BHT06 code of "RT" can be canceled. The cancellation 270 transaction must also contain a BHT06 of "RT".
13	**Request**

SITUATIONAL **BHT03** **127** **Reference Identification** **O 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

SITUATIONAL RULE: ***Required when the transaction is processed in Real Time. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.***

OD: **270B1__BHT03__SubmitterTransactionIdentifier**

IMPLEMENTATION NAME: **Submitter Transaction Identifier**

Due to the nature of batch transaction processing, the receiver of the 270 transaction (whether it is a clearinghouse or information source) may or may not be able to return the 270 BHT03 value in the 271 BHT03. See Section 1.4.6 Information Linkage for additional information and requirements.

This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. This identifier is to be returned in the corresponding 271 transaction's BHT03. This identifier will only be returned by the last entity to handle the 270. This identifier will not be passed through the complete life of the transaction.

REQUIRED **BHT04** **373** **Date** **O 1 DT 8/8**
Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

OD: **270B1__BHT04__TransactionSetCreationDate**

IMPLEMENTATION NAME: **Transaction Set Creation Date**

Use this date for the date the transaction set was generated.

REQUIRED **BHT05** **337** **Time** **O 1 TM 4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

OD: **270B1__BHT05__TransactionSetCreationTime**

IMPLEMENTATION NAME: **Transaction Set Creation Time**

Use this time for the time the transaction set was generated.

SITUATIONAL **BHT06** **640** **Transaction Type Code** **O 1 ID 2/2**

Code specifying the type of transaction

SITUATIONAL RULE: ***Required when the Information Source supports Spend Down transactions and the Information Receiver is using this transaction for Spend Down purposes. If not required by this implementation guide, do not send.***

OD: **270B1__BHT06__TransactionTypeCode**

Certain Medicaid programs support additional functionality for Spend Down. Use this code when necessary to further specify the type of transaction to a Medicaid program that supports this functionality.

CODE	DEFINITION
RT	**Spend Down**
	“Spend Down” is a term used by certain Medicaid programs when a recipient must pay a predetermined amount out of his or her own pocket before full coverage benefits are applied. In order to decrement the amount the recipient must pay out of pocket, a 270 transaction must be sent in with this code. **In the event that the service is not rendered and the Spend Down amount is returned to the recipient, an additional 270 must be sent in with a BHT02 with a code “01" to cancel the Spend Down.**

SEGMENT DETAIL

HL - INFORMATION SOURCE LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000A — INFORMATION SOURCE LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

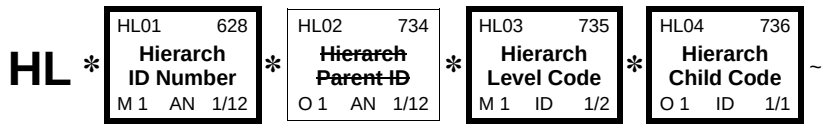
2. **In a batch environment, only one Loop 2000A (Information Source) loop is to be created for each unique information source in a transaction. Each Loop 2000B (Information Receiver) loop that is subordinate to an information source is to be contained within only one Loop 2000A loop. There has been a misuse of the HL structure creating multiple Loops 2000As for the same information source. This is not the developer's intended use of the HL structure, and defeats the efficiencies that are designed into the HL structure.**

3. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry

TR3 Example: **HL*1**20*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. OD: **270B1_2000A_HL01__HierarchicalIDNumber** **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction must begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~**	**M 1 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. OD: **270B1_2000A_HL03__HierarchicalLevelCode** **All data that follows this HL segment is associated with the Information Source identified by the level code. This association continues until the next occurrence of an HL segment.**	**M 1 ID 1/2**

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **270B1_2000A_HL04__HierarchicalChildCode**

Because of the hierarchical structure, and there will always be an Information Receiver HL subordinate to this Information Source HL the code value in the HL04 at the Loop 2000A level must always be "1".

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - INFORMATION SOURCE NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100A — INFORMATION SOURCE NAME Loop Repeat: 1**

Segment Repeat: **1**

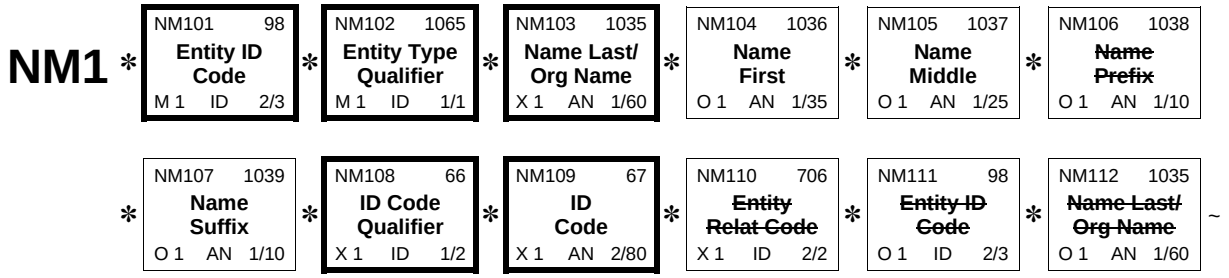
Usage: **REQUIRED**

TR3 Notes:

1. **Use this NM1 loop to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility or benefit information source, (e.g., insurance company, HMO, IPA, employer).**

TR3 Example: **NM1*PR*2*ACE INSURANCE COMPANY*****PI*87728~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **270B1_2100A_NM101__EntityIdentifierCode**

CODE	DEFINITION
2B	**Third-Party Administrator**
36	**Employer**
GP	**Gateway Provider**
P5	**Plan Sponsor**
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M 1**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

OD: 270B1_2100A_NM102__EntityTypeQualifier

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**
	Use this code only if the information source is a Gateway Provider and an individual.
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**X 1**	**AN**	**1/60**

SYNTAX: C1203

OD: 270B1_2100A_NM103__InformationSourceLastorOrganizationName

IMPLEMENTATION NAME: Information Source Last or Organization Name

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O 1**	**AN**	**1/35**

SITUATIONAL RULE: ***Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.***

OD: 270B1_2100A_NM104__InformationSourceFirstName

IMPLEMENTATION NAME: Information Source First Name

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1**	**AN**	**1/25**

SITUATIONAL RULE: ***Required when NM102 is "1" and the identifier in 2100A NM109 and Last Name in 2100A NM103 and First Name in 2100A NM104 and Name Suffix in 2100A NM107 if sent, are not sufficient to identify the source of eligibility or benefit information. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: 270B1_2100A_NM105__InformationSourceMiddleName

IMPLEMENTATION NAME: Information Source Middle Name

NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**1**	**AN**	**1/10**

SITUATIONAL RULE: ***Required when NM102 is "1" and the identifier in 2100A NM109 and Last Name in 2100A NM103 and First Name in 2100A NM104 and Middle Name in 2100A NM105 if sent, are not sufficient to identify the source of eligibility or benefit information. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: 270B1_2100A_NM107__InformationSourceNameSuffix

IMPLEMENTATION NAME: Information Source Name Suffix

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**1**	**ID**	**1/2**

SYNTAX: P0809

OD: 270B1_2100A_NM108__IdentificationCodeQualifier

Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Use code value "XX" if the information source is a provider and the CMS National Provider Identifier is mandated for use. Otherwise one of the other appropriate code values may be used.

CODE	DEFINITION
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	**Centers for Medicare and Medicaid Services PlanID** **CODE SOURCE 540:** Centers for Medicare and Medicaid Services PlanID
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare & Medicaid Services National Provider Identifier

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**1**	**AN**	**2/80**

SYNTAX: P0809

OD: 270B1_2100A_NM109__InformationSourcePrimaryIdentifier

IMPLEMENTATION NAME: Information Source Primary Identifier

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

SEGMENT DETAIL

HL - INFORMATION RECEIVER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000B — INFORMATION RECEIVER LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

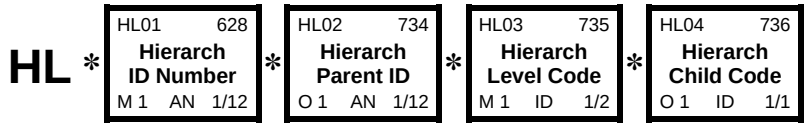
2. **In a batch environment, only one Loop 2000B (Information Receiver) loop is to be created for each unique information receiver within an Loop 2000A (Information Source) loop. Each Loop 2000C (Subscriber) loop that is subordinate to an information receiver is to be contained within only one Loop 2000B loop. There has been a misuse of the HL structure creating multiple Loop 2000Bs for the same information receiver within an information source loop. This is not the developer's intended use of the HL structure, and defeats the efficiencies that are designed into the HL structure.**

3. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry

TR3 Example: **HL*2*1*21*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. OD: **270B1_2000B_HL01__HierarchicalIDNumber** **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction must begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~**	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. OD: **270B1_2000B_HL02__HierarchicalParentIDNumber** **Use this code to identify the specific Information Source to which this Information Receiver is subordinate.**	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: 270B1_2000B_HL03__HierarchicalLevelCode

All data that follows this HL segment is associated with the Information Receiver identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: 270B1_2000B_HL04__HierarchicalChildCode

Because of the hierarchical structure, and there will always be a Subscriber HL subordinate to this Information Receiver HL, the code value in the HL04 at the Loop 2000B level must always be "1".

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - INFORMATION RECEIVER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100B — INFORMATION RECEIVER NAME Loop Repeat: 1**

Segment Repeat: **1**

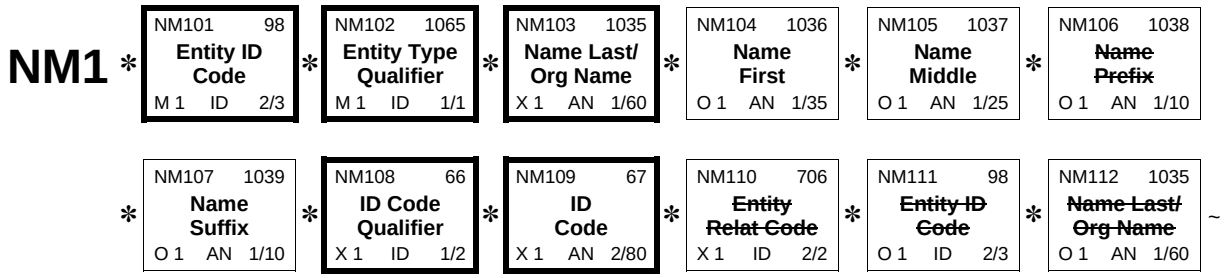
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility/benefit information receiver (e.g., provider, medical group, employer, IPA, or hospital).**

TR3 Example: **NM1*1P*1*JONES*MARCUS***MD*34*111223333~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **270B1_2100B_NM101__EntityIdentifierCode**

CODE	DEFINITION
1P	**Provider**
2B	**Third-Party Administrator**
36	**Employer**
80	**Hospital**
FA	**Facility**

			GP	**Gateway Provider**			
			P5	**Plan Sponsor**			
			PR	**Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. OD: **270B1_2100B_NM102__EntityTypeQualifier** **Use this code to indicate whether the entity is an individual person or an organization.**		**M 1**	**ID**	**1/1**
			CODE	**DEFINITION**			
			1	**Person**			
			2	**Non-Person Entity**			
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 OD: **270B1_2100B_NM103__InformationReceiverLastorOrganizationName** IMPLEMENTATION NAME: **Information Receiver Last or Organization Name**		**X 1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name SITUATIONAL RULE: ***Required when 2100B NM102 is "1". If not required by this implementation guide, do not send.*** OD: **270B1_2100B_NM104__InformationReceiverFirstName** IMPLEMENTATION NAME: **Information Receiver First Name**		**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: ***Required when 2100B NM104 is present and Name Suffix in 2100B NM107 if sent, are not sufficient to identify the information receiver. If not required by this implementation guide and NM104 is present, may be provided at sender's discretion, but cannot be required by the receiver.*** OD: **270B1_2100B_NM105__InformationReceiverMiddleName** IMPLEMENTATION NAME: **Information Receiver Middle Name**		**O 1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**		**O 1**	**AN**	**1/10**

SITUATIONAL **NM107** **1039** **Name Suffix** **O 1 AN 1/10**
Suffix to individual name

SITUATIONAL RULE: ***Required when 2100B NM104 is present and Middle Name in 2100B NM105 if sent, are not sufficient to identify the information receiver. If not required by this implementation guide and NM104 is present, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **270B1_2100B_NM107__InformationReceiverNameSuffix**

IMPLEMENTATION NAME: **Information Receiver Name Suffix**

Use this only if NM102 is "1".

REQUIRED **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

OD: **270B1_2100B_NM108__IdentificationCodeQualifier**

Use this element to qualify the identification number submitted in NM109. This is the number that the information source associates with the information receiver. Because only one number can be submitted in NM109, the following hierarchy must be used. Additional identifiers are to be placed in the REF segment. If the information receiver is a provider and the National Provider ID is mandated for use and the provider is a covered health care provider under the mandate, code value "XX" must be used. Otherwise, one of the following codes may be used with the following hierarchy applied: Use the first code that applies: "SV", "PP", "FI", "34". The code "SV" is recommended to be used prior to the mandated use of the National Provider ID. If the information receiver is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, use code value "PI". If the information receiver is an employer, use code value "24".

CODE	DEFINITION
24	**Employer's Identification Number**
	Use this code only when the 270/271 transaction sets are used by an employer inquiring about eligibility and benefits of their employees.
34	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
FI	**Federal Taxpayer's Identification Number**
PI	**Payor Identification**
	Use this code only when the 270/271 transaction sets are used between two payers.
PP	**Pharmacy Processor Number**
SV	**Service Provider Number**
	Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.

			XV	**Centers for Medicare and Medicaid Services PlanID** CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID			
			XX	**Centers for Medicare and Medicaid Services National Provider Identifier** CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 OD: **270B1_2100B_NM109__InformationReceiverIdentificationNumber** IMPLEMENTATION NAME: **Information Receiver Identification Number**		**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**		**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**		**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**		**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - INFORMATION RECEIVER ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2100B — INFORMATION RECEIVER NAME**

Segment Repeat: **9**

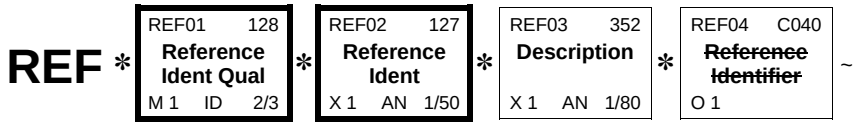
Usage: **SITUATIONAL**

Situational Rule: **Required when the information in 2100B NM1 is not sufficient to identify the information receiver. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Notes: **1. Use this segment when needed to convey other or additional identification numbers for the information receiver. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100B loop.**

TR3 Example: **REF*EO*477563928~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **270B1_2100B_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02.

Only one occurrence of each REF01 code value may be used in the 2100B loop.

CODE	DEFINITION
0B	**State License Number**
	The state assigning the license number must be identified in REF03.
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	**Centers for Medicare and Medicaid Services National Provider Identifier**
				The Centers for Medicare and Medicaid Services National Provider Identifier may be used in this segment prior to being mandated for use.
				CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier
			JD	**User Identification**
			N5	**Provider Plan Network Identification Number**
			N7	**Facility Network Identification Number**
			Q4	**Prior Identifier Number**
			SY	**Social Security Number**
				The social security number may not be used for any Federally administered programs such as Medicare.
			TJ	**Federal Taxpayer's Identification Number**
REQUIRED	**REF02**	**127**	**Reference Identification**	**X 1 AN 1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			SYNTAX: R0203	
			OD: **270B1_2100B_REF02__InformationReceiverAdditionalIdentifier**	
			IMPLEMENTATION NAME: **Information Receiver Additional Identifier**	
			Use this reference number as qualified by the preceding data element (REF01).	
SITUATIONAL	**REF03**	**352**	**Description**	**X 1 AN 1/80**
			A free-form description to clarify the related data elements and their content	
			SYNTAX: R0203	
			SITUATIONAL RULE: ***Required when the identifier supplied in REF02 is the State License Number. If not required by this implementation guide, do not send.***	
			OD: **270B1_2100B_REF03__InformationReceiverAdditionalIdentifierState**	
			IMPLEMENTATION NAME: **Information Receiver Additional Identifier State**	
			Use this element for the two character state ID of the state assigning the identifier supplied in REF02. See Code source 22: States and Outlying Areas of the U.S.	
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

N3 - INFORMATION RECEIVER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2100B — INFORMATION RECEIVER NAME**

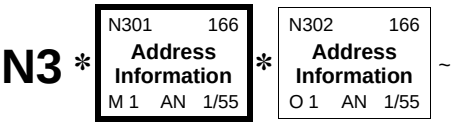
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver is a provider who has multiple locations and it is needed to identify the location relative to the request. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Example: **N3*201 PARK AVENUE*SUITE 300~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **270B1_2100B_N301__InformationReceiverAddressLine**	
			IMPLEMENTATION NAME: **Information Receiver Address Line**	
			Use this information for the first line of the address information.	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when a second address line exists. If not required by this implementation guide, do not send.***	
			OD: **270B1_2100B_N302__InformationReceiverAdditionalAddressLine**	
			IMPLEMENTATION NAME: **Information Receiver Additional Address Line**	

SEGMENT DETAIL

N4 - INFORMATION RECEIVER CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2100B — INFORMATION RECEIVER NAME**

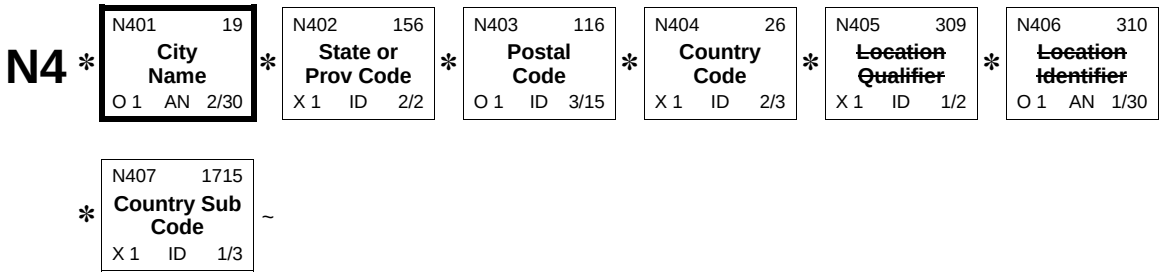
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver is a provider who has multiple locations and it is needed to identify the location relative to the request. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. OD: **270B1_2100B_N401__InformationReceiverCityName** IMPLEMENTATION NAME: **Information Receiver City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

SITUATIONAL RULE: ***Required when address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

OD: 270B1_2100B_N402__InformationReceiverStateCode

IMPLEMENTATION NAME: Information Receiver State Code

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

OD: 270B1_2100B_N403__InformationReceiverPostalZoneorZIPCode

IMPLEMENTATION NAME: Information Receiver Postal Zone or ZIP Code

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

OD: 270B1_2100B_N404__CountryCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

NOT USED	**N405**	**309**	**Location Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1**	**AN**	**1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD: 270B1_2100B_N407__CountrySubdivisionCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

PRV - INFORMATION RECEIVER PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: **1. P0203**
If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100B — INFORMATION RECEIVER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

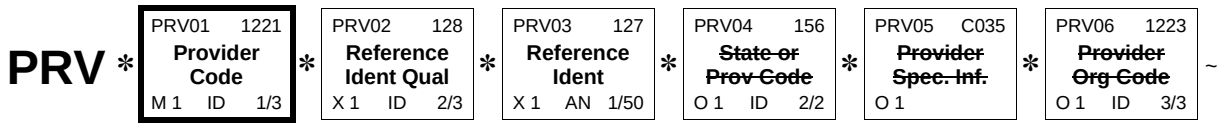
Situational Rule: **Required when the Information Receiver believes Provider Information is relevant to the request and is necessary to convey the provider's role in or taxonomy code related to the eligibility/benefit being inquired about and the provider is also the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Notes: **1. For example, if the Information Receiver is also the Referring Provider, this PRV segment would be used to identify the provider's role.**

2. PRV02 qualifies PRV03.

TR3 Example: **PRV*RF*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **270B1_2100B_PRV01__ProviderCode**

CODE	DEFINITION
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**			
SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 SITUATIONAL RULE: ***Required when the Information Receiver believes Provider Information is relevant to the request and is necessary to convey the provider's taxonomy code in relation to the eligibility/benefit being inquired about and the provider is also the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.*** OD: **270B1_2100B_PRV02__ReferenceIdentificationQualifier**	**X 1**	**ID**	**2/3**
			CODE / DEFINITION				
			PXC	**Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy			
SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when the Information Receiver believes Provider Information is relevant to the request and is necessary to convey the provider's taxonomy code in relation to the eligibility/benefit being inquired about and the provider is also the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.*** OD: **270B1_2100B_PRV03__ReceiverProviderTaxonomyCode** IMPLEMENTATION NAME: **Receiver Provider Taxonomy Code**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

HL - SUBSCRIBER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000C — SUBSCRIBER LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:

1. **If the transaction set is to be used in a real time mode (see section 1.4.3 for additional detail), it is required that the 270 transaction contain only one patient request (except as allowed in Section 1.4.3 Exceeding the Number of Patient Requests). One patient request (See Section 1.4.2) is defined as the occurrence of one or more 2110 (EQ) loops for an individual. If the patient is the subscriber, the patient request is the existence of at least one 2110C loop. If the patient is the dependent, the patient request is the existence of at least one 2110D loop. In the event the patient has more than one occurrence of a 2110 (EQ) loop, that still constitutes one patient request.**

   If the transaction set is to be used in a batch mode (see section 1.4.3 for additional detail), it is required that the 270 transaction contain a maximum of ninety-nine patient requests (except as allowed in Section 1.4.3 Exceeding the Number of Patient Requests). One patient request (See Section 1.4.2) is defined as the occurrence of one or more 2110 (EQ) loops for an individual. If the patient is the subscriber, the patient request is the existence of at least one 2110C loop. If the patient is the dependent, the patient request is the existence of at least one 2110D loop. In the event the patient has more than one occurrence of a 2110 (EQ) loop, that still constitutes one patient request.

   Although it is not recommended, if the number of patients is to be greater than one for real time mode or greater than ninety-nine for batch mode, the trading partners (the Information Source, the Information Receiver and the clearinghouse the transaction is routed through, if there is one involved) must all agree to exceed the number of patient requests and agree to a reasonable limit. See Section 1.4.3 Exceeding the Number of Patient Requests for additional information.

2. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

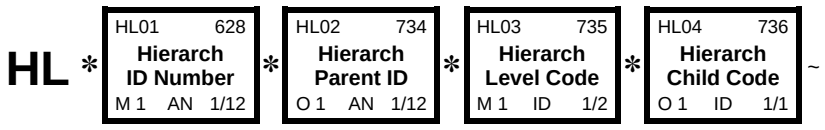
   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

3. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry

TR3 Example: **HL*3*2*22*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. OD: **270B1_2000C_HL01__HierarchicalIDNumber** **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction must begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~** **HL*3*2*22*1~** **NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~** **HL*4*3*23*0~** **NM1*03*1*SMITH*MARY*LOU~** **Eligibility/Benefit Data** **HL*5*2*22*0~** **NM1*IL*1*BROWN*JOHN*E***MI*22211333301~** **Eligibility/Benefit Data**	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. OD: **270B1_2000C_HL02__HierarchicalParentIDNumber** **Use this code to identify the specific Information Receiver to which this Subscriber is subordinate.**	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: **270B1_2000C_HL03__HierarchicalLevelCode**

All data that follows this HL segment is associated with the Subscriber identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
22	**Subscriber**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **270B1_2000C_HL04__HierarchicalChildCode**

If there is a Loop 2000D (Dependent) level subordinate to the current Loop 2000C, the value must be “1". If there is no Loop 2000D (Dependent) level subordinate to the current Loop 2000C, the value must be ”0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

TRN - SUBSCRIBER TRACE NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

X12 Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

Loop: **2000C — SUBSCRIBER LEVEL**

Segment Repeat: **2**

Usage: **SITUATIONAL**

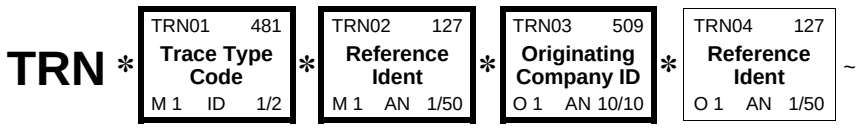
Situational Rule: **Required when information receiver or clearinghouse intends to use the TRN segment as a tracing mechanism for the eligibility transaction and the subscriber is the patient. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The information receiver may assign one TRN segment in this loop if the subscriber is the patient. A clearinghouse may assign one TRN segment in this loop if the subscriber is the patient. See Section 1.4.6 Information Linkage.**
2. **This segment must not be used if the subscriber is not the patient. See section 1.4.2. Basic Concepts.**
3. **Trace numbers assigned at the subscriber level are intended to allow tracing of an eligibility/benefit transaction when the subscriber is the patient.**

TR3 Example:
TRN*1*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M 1 ID 1/2**

OD: **270B1_2000C_TRN01__TraceTypeCode**

CODE	DEFINITION
1	**Current Transaction Trace Numbers**

REQUIRED **TRN02** **127** **Reference Identification** **M 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN02 provides unique identification for the transaction.

OD: 270B1_2000C_TRN02__TraceNumber

IMPLEMENTATION NAME: Trace Number

Use this number for the trace or reference number assigned by the information receiver or clearinghouse.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O 1 AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SEMANTIC: TRN03 identifies an organization.

OD: 270B1_2000C_TRN03__TraceAssigningEntityIdentifier

IMPLEMENTATION NAME: Trace Assigning Entity Identifier

Use this number for the identification number of the company that assigned the trace or reference number specified in the previous data element (TRN02).

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL **TRN04** **127** **Reference Identification** **O 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

SITUATIONAL RULE: ***Required when it is necessary to further identify a specific component of the company identified in the previous data element (TRN03). If not required by this implementation guide, do not send.***

OD: 270B1_2000C_TRN04__TraceAssigningEntityAdditionalIdentifier

IMPLEMENTATION NAME: Trace Assigning Entity Additional Identifier

This information allows the originating company to further identify a specific division or group within that organization that was responsible for assigning the trace or reference number.

SEGMENT DETAIL

NM1 - SUBSCRIBER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100C — SUBSCRIBER NAME Loop Repeat: 1**

Segment Repeat: **1**

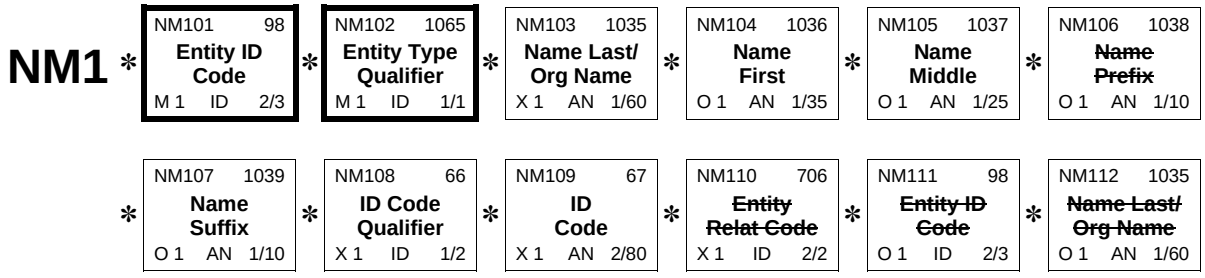
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name and/or identification number. Use this NM1 loop to identify the insured or subscriber.**
2. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **NM1*IL*1*SMITH*JOHN*L***MI*444115555~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **270B1_2100C_NM101__EntityIdentifierCode**

CODE	DEFINITION
IL	**Insured or Subscriber**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M 1**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

OD: 270B1_2100C_NM102__EntityTypeQualifier

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**X 1**	**AN**	**1/60**

SYNTAX: C1203

SITUATIONAL RULE: ***Required when the subscriber is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the subscriber is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Last Name (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: 270B1_2100C_NM103__SubscriberLastName

IMPLEMENTATION NAME: Subscriber Last Name

Use this name for the subscriber's last name.

Information sources cannot require subscriber's suffix be sent as a part of the subscriber's last name.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O 1**	**AN**	**1/35**

SITUATIONAL RULE: ***Required when the subscriber is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the subscriber is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's First Name (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: 270B1_2100C_NM104__SubscriberFirstName

IMPLEMENTATION NAME: Subscriber First Name

Use this name for the subscriber's first name.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**1**	**AN**	**1/25**

SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).***
If not required by this implementation guide, do not send.

OD: **270B1_2100C_NM105__SubscriberMiddleNameorInitial**

IMPLEMENTATION NAME: **Subscriber Middle Name or Initial**

Use this name for the subscriber's middle name or initial.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**1**	**AN**	**1/10**

SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).***
If not required by this implementation guide, do not send.

OD: **270B1_2100C_NM107__SubscriberNameSuffix**

IMPLEMENTATION NAME: **Subscriber Name Suffix**

Use this for the suffix to an individual's name; e.g., Sr., Jr. or III.

SITUATIONAL **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**

Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

SITUATIONAL RULE: ***Required when either the subscriber or dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when either the subscriber or dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: **270B1_2100C_NM108__IdentificationCodeQualifier**

Use this element to qualify the identification number submitted in NM109. This is the primary number that the information source associates with the subscriber.

CODE	DEFINITION
II	**Standard Unique Health Identifier for each Individual in the United States**
	Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services may adopt a standard individual identifier for use in this transaction.
MI	**Member Identification Number**
	This code may only be used prior to the mandated use of code "II". This is the unique number the payer or information source uses to identify the insured (e.g., Health Insurance Claim Number, Medicaid Recipient ID Number, HMO Member ID, etc.).

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: ***Required when either the subscriber or dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).*** ***OR*** ***Required when either the subscriber or dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options (See Section 1.4.8).*** ***OR*** ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).*** ***If not required by this implementation guide, do not send.*** OD: **270B1_2100C_NM109__SubscriberPrimaryIdentifier** IMPLEMENTATION NAME: **Subscriber Primary Identifier** **Use this reference number as qualified by the preceding data element (NM108).**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - SUBSCRIBER ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Notes:

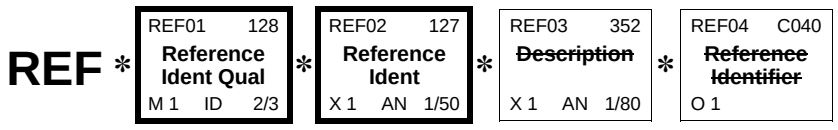
1. **Use this segment when needed to convey identification numbers other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100C loop.**

2. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

3. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **REF*1L*660415~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **270B1_2100C_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02.

Only one occurrence of each REF01 code value may be used in the 2100C loop.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
1W	**Member Identification Number**
	Use only after the Unique Patient Identifier is available and has been provided in the NM109, but use of the UPI has not been mandated.
3H	**Case Number**
	Uses this code to identify the Case Number assigned to the subscriber by the information source.
6P	**Group Number**
CT	**Contract Number**
	This code is to be used only to identify the provider's contract number of the provider identified in the PRV segment of Loop 2100C. This code is only to be used once the CMS National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.
EA	**Medical Record Identification Number**
EJ	**Patient Account Number**
F6	**Health Insurance Claim (HIC) Number**
	See segment note 2.
GH	**Identification Card Serial Number**
	Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.

			HJ	**Identity Card Number**			
				Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.			
			IG	**Insurance Policy Number**			
			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number**			
				See segment note 2.			
			SY	**Social Security Number**			
				The social security number may not be used for any Federally administered programs such as Medicare.			
			Y4	**Agency Claim Number**			
				This code is only to be used when submitting an eligibility request to a Property and Casualty payer. Use this code to identify the Property and Casualty Claim Number associated with the subscriber. This code is not a HIPAA requirement as of this writing.			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 OD: **270B1_2100C_REF02__SubscriberSupplementalIdentifier** IMPLEMENTATION NAME: **Subscriber Supplemental Identifier** **Use this reference number as qualified by the preceding data element (REF01).**	**X 1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

N3 - SUBSCRIBER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2100C — SUBSCRIBER NAME**

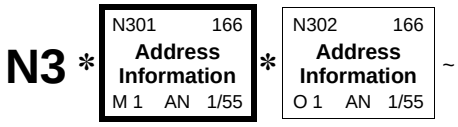
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Example: **N3*15197 BROADWAY AVENUE*APT 215~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **270B1_2100C_N301__SubscriberAddressLine**	
			IMPLEMENTATION NAME: **Subscriber Address Line**	
			Use this information for the first line of the address information.	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).*** ***If not required by this implementation guide, do not send.***	
			OD: **270B1_2100C_N302__SubscriberAddressLine**	
			IMPLEMENTATION NAME: **Subscriber Address Line**	
			Use this information for the second line of the address information.	
			Required if a second address line exists.	

SEGMENT DETAIL

N4 - SUBSCRIBER CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2100C — SUBSCRIBER NAME**

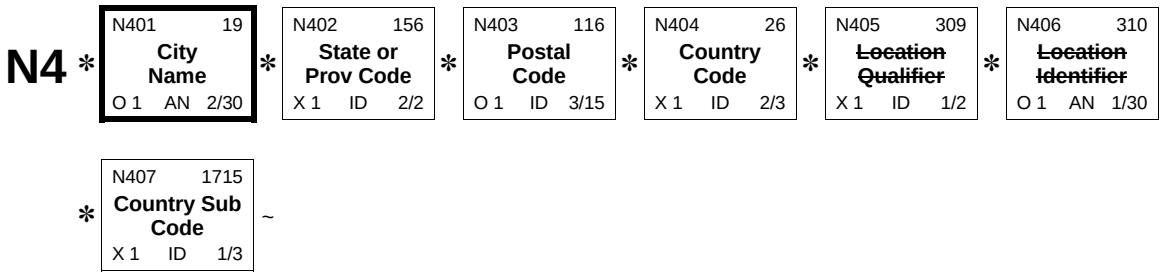
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **OD: 270B1_2100C_N401__SubscriberCityName** **IMPLEMENTATION NAME: Subscriber City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

SITUATIONAL RULE: ***Required when address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

OD: 270B1_2100C_N402__SubscriberStateCode

IMPLEMENTATION NAME: Subscriber State Code

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

OD: 270B1_2100C_N403__SubscriberPostalZoneorZIPCode

IMPLEMENTATION NAME: Subscriber Postal Zone or ZIP Code

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

OD: 270B1_2100C_N404__CountryCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

NOT USED	**N405**	**309**	**Location Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1**	**AN**	**1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD: 270B1_2100C_N407__CountrySubdivisionCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

PRV - PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax:
1. **P0203**
   If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

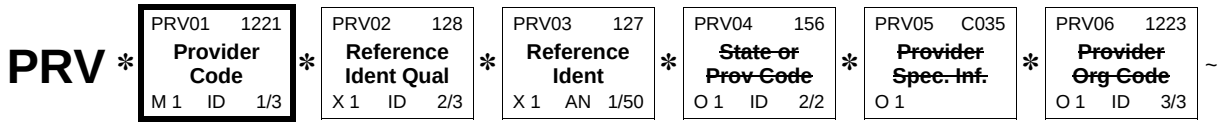
Usage: **SITUATIONAL**

Situational Rule: **Required when the information source is known to process this information in creating a 271 response and the information receiver feels it is necessary to identify a specific provider or to associate a specialty type related to the service identified in the 2110C loop. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Notes:
1. **This segment must not be used to identify the information receiver or the information receiver's specialty type, unless the information is different from that sent in the 2100B loop.**
2. **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. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110C, use code PXC in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

TR3 Example:
PRV*RF*EI*9991234567~
PRV*RF*PXC*207Q00000X~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **270B1_2100C_PRV01__ProviderCode**

CODE	DEFINITION
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**
SK	**Skilled Nursing Facility**
SU	**Supervising**

SITUATIONAL **PRV02** **128** **Reference Identification Qualifier** **X 1** **ID** **2/3**
Code qualifying the Reference Identification

SYNTAX: P0203

SITUATIONAL RULE: ***Required when the information source is known to process this information in creating a 271 response and the information receiver feels it is necessary to identify a specific provider or to associate a specialty type related to the service identified in the 2110C loop. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **270B1_2100C_PRV02__ReferenceIdentificationQualifier**

If this segment is used to identify a specific provider and the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

If this segment is used to identify a type of specialty associated with the services identified in loop 2110C, use code PXC.

CODE	DEFINITION
9K	**Servicer**
	Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.
D3	**National Council for Prescription Drug Programs Pharmacy Number**
	CODE SOURCE **307:** National Council for Prescription Drug Programs Pharmacy Number
EI	**Employer's Identification Number**
HPI	**Centers for Medicare and Medicaid Services National Provider Identifier**
	Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
	CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier
PXC	**Health Care Provider Taxonomy Code**
	CODE SOURCE **682:** Health Care Provider Taxonomy
SY	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
TJ	**Federal Taxpayer's Identification Number**

SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when PRV02 is used. If not required by this implementation guide, do not send.*** OD: **270B1_2100C_PRV03__ProviderIdentifier** IMPLEMENTATION NAME: **Provider Identifier** **Use this reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

DMG - SUBSCRIBER DEMOGRAPHIC INFORMATION

X12 Segment Name: Demographic Information

X12 Purpose: To supply demographic information

X12 Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.
2. **P1011**
   If either DMG10 or DMG11 is present, then the other is required.
3. **C1105**
   If DMG11 is present, then DMG05 is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

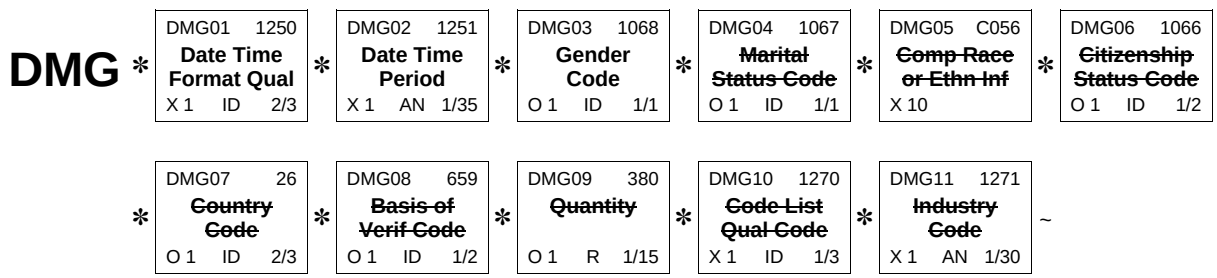
Situational Rule: **Required when the subscriber is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).**
OR
Required when the subscriber is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

TR3 Notes:

1. **Use this segment when needed to convey birth date or gender demographic information for the subscriber.**
2. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **DMG*D8*19430917*M~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X 1 ID 2/3**

SYNTAX: P0102

SITUATIONAL RULE: ***Required when the subscriber is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the subscriber is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: **270B1_2100C_DMG01__DateTimePeriodFormatQualifier**

Use this code to indicate the format of the date of birth that follows in DMG02.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X 1 AN 1/35**

SYNTAX: P0102

SEMANTIC: DMG02 is the date of birth.

SITUATIONAL RULE: ***Required when the subscriber is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the subscriber is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: **270B1_2100C_DMG02__SubscriberBirthDate**

IMPLEMENTATION NAME: **Subscriber Birth Date**

Use this date for the date of birth of the subscriber.

SITUATIONAL	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual	**O 1**	**ID**	**1/1**

SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).***
If not required by this implementation guide, do not send.

OD: **270B1_2100C_DMG03__SubscriberGenderCode**

IMPLEMENTATION NAME: **Subscriber Gender Code**

Use this code to indicate the subscriber's gender.

CODE	DEFINITION
F	**Female**
M	**Male**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X 10**		
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O 1**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O 1**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O 1**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O 1**	**R**	**1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X 1**	**ID**	**1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X 1**	**AN**	**1/30**

SEGMENT DETAIL

INS - MULTIPLE BIRTH SEQUENCE NUMBER

X12 Segment Name: Insured Benefit

X12 Purpose: To provide benefit information on insured entities

X12 Syntax: **1. P1112**
If either INS11 or INS12 is present, then the other is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

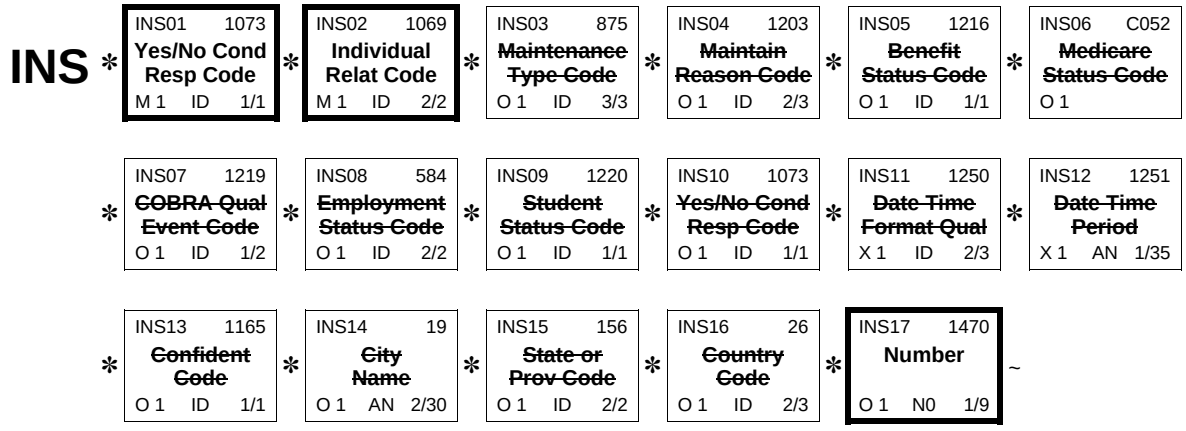
Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes it is necessary to identify the birth sequence of the subscriber in the case of multiple births with the same birth date for an Alternate Search Option supported by the Information Source (See Section 1.4.8). If not required by this implementation guide, do not send.**

TR3 Notes: **1. This segment must not be used if the subscriber is not part of a multiple birth.**

TR3 Example: **INS*Y*18**********3~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1**	**ID**	**1/1**
			SEMANTIC: INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent.			
			OD: **270B1_2100C_INS01__InsuredIndicator**			
			IMPLEMENTATION NAME: **Insured Indicator**			
			The value Y is used to satisfy X12 syntax.			
			CODE / DEFINITION			
			Y — **Yes**			
			The value Y is used to satisfy X12 syntax. This data has no business purpose and must not be used to indicate if the insured is a subscriber.			
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**M 1**	**ID**	**2/2**
			OD: **270B1_2100C_INS02__IndividualRelationshipCode**			
			The value 18 is used only to satisfy X12 syntax.			
			CODE / DEFINITION			
			18 — **Self**			
			The value 18 is used to satisfy X12 syntax. This data has no business purpose and must not be used to indicate the Individual's relationship to the insured.			
NOT USED	**INS03**	**875**	**Maintenance Type Code**	**O 1**	**ID**	**3/3**
NOT USED	**INS04**	**1203**	**Maintenance Reason Code**	**O 1**	**ID**	**2/3**
NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS06**	**C052**	**MEDICARE STATUS CODE**	**O 1**		
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O 1**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS09**	**1220**	**Student Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS10**	**1073**	**Yes/No Condition or Response Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X 1**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X 1**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS14**	**19**	**City Name**	**O 1**	**AN**	**2/30**
NOT USED	**INS15**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS16**	**26**	**Country Code**	**O 1**	**ID**	**2/3**

REQUIRED **INS17** **1470** **Number** **O 1** **N0** **1/9**

A generic number

SEMANTIC: INS17 is 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.).

OD: 270B1_2100C_INS17__BirthSequenceNumber

IMPLEMENTATION NAME: Birth Sequence Number

Use to indicate the birth order in the event of multiple births in association with the birth date supplied in DMG02.

SEGMENT DETAIL

HI - SUBSCRIBER HEALTH CARE DIAGNOSIS CODE

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

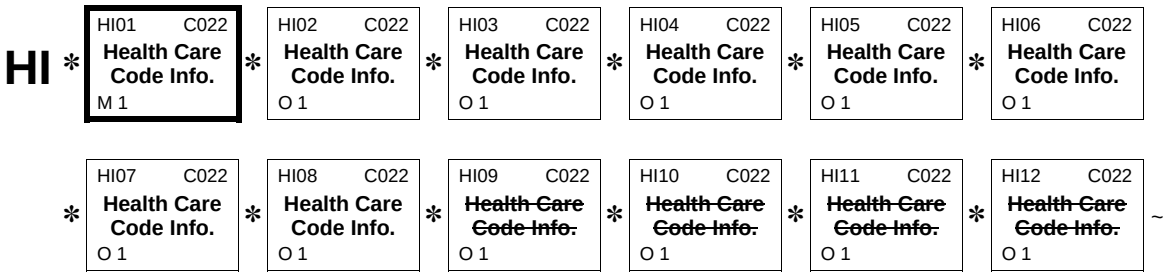
Situational Rule: **Required when the information receiver believes the Diagnosis information is relevant to the inquiry, the information is available and if the information source supports or is believed to support this level of functionality. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use the HI segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment. The information source must not use information in an HI segment of the 270 transaction in the determination of eligibility or benefits for the subscriber if that information cannot be returned in the 271 response.**
2. **Use this segment to identify Diagnosis codes as they relate to the information provided in the EQ segments.**
3. **Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.**

TR3 Example: **HI*BK:8901*BF:87200*BF:5559~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities SYNTAX: **P0304** If either C02203 or C02204 is present, then the other is required. **E0809** Only one of C02208 or C02209 may be present. OD: **270B1_2100C_HI01_C022** **E codes are Not Used in HI01 except when defined by the claims processor. E codes may be put in any other HI element using BF as the qualifier.** **The diagnosis listed in this element is assumed to be the principal diagnosis.**	M 1
REQUIRED	HI01 - 1	1270	**Code List Qualifier Code** Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08. OD: **270B1_2100C_HI01_C02201_DiagnosisTypeCode** IMPLEMENTATION NAME: **Diagnosis Type Code**	M ID 1/3
			CODE: **ABK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) CODE: **BK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	
REQUIRED	HI01 - 2	1271	**Industry Code** Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. OD: **270B1_2100C_HI01_C02202_DiagnosisCode** IMPLEMENTATION NAME: **Diagnosis Code**	M AN 1/30
NOT USED	HI01 - 3	1250	**Date Time Period Format Qualifier**	X ID 2/3
NOT USED	HI01 - 4	1251	**Date Time Period**	X AN 1/35
NOT USED	HI01 - 5	782	**Monetary Amount**	O R 1/18
NOT USED	HI01 - 6	380	**Quantity**	O R 1/15
NOT USED	HI01 - 7	799	**Version Identifier**	O AN 1/30
NOT USED	HI01 - 8	1271	**Industry Code**	X AN 1/30
NOT USED	HI01 - 9	1073	**Yes/No Condition or Response Code**	X ID 1/1

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data element has been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI02_C022**

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI02_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI02 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI02_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI03_C022**

REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI03_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI03_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI04_C022**

REQUIRED **HI04 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI04_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI04 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI04_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI05_C022**

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI05_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI05_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI06_C022**

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI06_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI06 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI06_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI07_C022**

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI07_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI07_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100C_HI08_C022**

REQUIRED **HI08 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100C_HI08_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI08 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100C_HI08_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**	**1**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**	**1**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**	**1**
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**	**1**

SEGMENT DETAIL

DTP - SUBSCRIBER DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **2**

Usage: **SITUATIONAL**

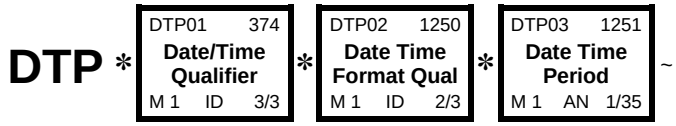
Situational Rule: **Required when the information receiver wishes to convey the plan date(s) for the subscriber in relation to the eligibility/benefit inquiry. If not required by this implementation guide, may be sent at the sender's discretion but cannot be required by the information source.**
OR
Required when utilizing a search option other than the Primary Search Option which requires the ID Card Issue Date. If not required by this implementation guide, may be sent at the sender's discretion but cannot be required by the information source.

TR3 Notes:

1. **Absence of a Plan date indicates the request is for the date the transaction is processed and the information source is to process the transaction in the same manner as if the processing date was sent.**
2. **Use this segment to convey the plan date(s) for the subscriber or for the issue date of the subscriber's identification card for the information source.**
3. **When using code "291" (Plan) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Inquiry (EQ) loops that follow. If there is a need to supply a different Plan date for a specific EQ loop, it must be provided in the DTP segment within the EQ loop and it will only apply to that EQ loop.**

TR3 Example: **DTP*291*D8*20051015~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M 1 ID 3/3
			OD: **270B1_2100C_DTP01__DateTimeQualifier**	
			IMPLEMENTATION NAME: **Date Time Qualifier**	
			CODE / DEFINITION	
			102 **Issue**	
			Used if utilizing a search option other than the Primary search option identified in section 1.4.8 and is present on the identification card and is available.	
			291 **Plan**	
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	M 1 ID 2/3
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			OD: **270B1_2100C_DTP02__DateTimePeriodFormatQualifier**	
			CODE / DEFINITION	
			D8 **Date Expressed in Format CCYYMMDD**	
			RD8 **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	
REQUIRED	DTP03	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	M 1 AN 1/35
			OD: **270B1_2100C_DTP03__DateTimePeriod**	
			Use this date for the date(s) as qualified by the preceding data elements.	

SEGMENT DETAIL

EQ - SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY

X12 Segment Name: Eligibility or Benefit Inquiry

X12 Purpose: To specify inquired eligibility or benefit information

X12 Syntax:
1. **R0102**
   At least one of EQ01 or EQ02 is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY Loop Repeat: 99**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the subscriber is the patient whose eligibility or benefits are being verified. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **When the subscriber is not the patient, the 2110C EQ segment must not be used. When the transaction is used in a batch environment, it is possible to have both 2110C and 2110D EQ segments when the subscriber and dependent(s) are patients whose eligibility or benefits are being verified. See Section 1.4.3 Batch and Real Time for additional information.**

2. **The 2110C EQ segment begins the 2110C loop.**

3. **If the EQ segment is used, either EQ01 - Service Type Code or EQ02 - Composite Medical Procedure Identifier must be used. Only EQ01 or EQ02 is to be sent, not both.**
   An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01. An information source may support the use of Service Type Codes other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion.
   An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes can be supplied in the 2100C HI segment and place of service in the 2110C III segment.

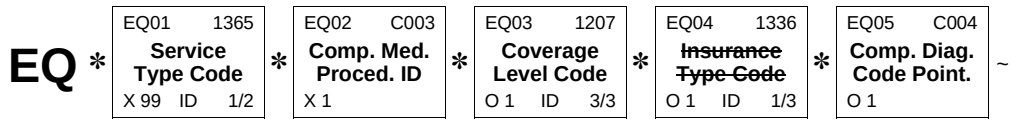
4. **If an information source receives a Service Type Code "30" submitted in the 270 EQ01 or a Service Type Code that they do not support, the 2110C EB03 values identified in Section 1.4.7.1 Item #8 must also be returned if they are a covered benefit category at a plan level. Refer to Section 1.4.7 for additional information.**

5. **EQ01 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110C loop is the same with the exception of the Service Type Code used in EQ01, it is more efficient to use the repetition function of EQ01 to send each of the Service Type Codes needed. If an Information Source supports more than Service Type Code "30", and can support requests for multiple Service Type Codes, the repetition use of EQ01 must be supported.**

TR3 Example: **EQ*30**FAM~**

TR3 Example: **EQ*98^34^44^81^A0^A3~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**EQ01**	**1365**	**Service Type Code**	**X ID 1/2 99**

Code identifying the classification of service

SYNTAX: R0102

SEMANTIC: Position of data in the repeating data element conveys no significance.

SITUATIONAL RULE: ***Required if utilizing a Service Type Code inquiry and EQ02 is not used. If not required by this implementation guide, do not send.***

OD: **270B1_2110C_EQ01__ServiceTypeCode**

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01.

An information source may support the use of Service Type Codes from the list other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion. If an information source supports codes in addition to "30", the information source may provide a list of the supported codes from the list below to the information receiver. If no list is provided, an information receiver may transmit the most appropriate code.

If an inquiry is submitted with a Service Type Code from the list other than "30" and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.4.7 for additional information.

EQ01 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110C loop is the same with the exception of the Service Type Code used in EQ01, it is more efficient to use the repetition function of EQ01 to send each of the Service Type Codes needed. If an Information Source supports more than Service Type Code "30", and can support requests for multiple Service Type Codes, the repetition use of EQ01 must be supported.

Not used if EQ02 is used.

CODE	DEFINITION
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
	If only a single category of inquiry can be supported, use this code.
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
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
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
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**
	Use for Routine Vision Exam only.
AO	**Lenses**
AQ	**Nonmedically Necessary Physical**
AR	**Experimental Drug Therapy**
B1	**Burn Care**
B2	**Brand Name Prescription Drug - Formulary**
B3	**Brand Name Prescription Drug - Non-Formulary**
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**
BT	**Gynecological**
BU	**Obstetrical**
BV	**Obstetrical/Gynecological**
BW	**Mail Order Prescription Drug: Brand Name**
BX	**Mail Order Prescription Drug: Generic**
BY	**Physician Visit - Office: Sick**
BZ	**Physician Visit - Office: Well**
C1	**Coronary Care**
CA	**Private Duty Nursing - Inpatient**
CB	**Private Duty Nursing - Home**
CC	**Surgical Benefits - Professional (Physician)**
CD	**Surgical Benefits - Facility**
CE	**Mental Health Provider - Inpatient**
CF	**Mental Health Provider - Outpatient**
CG	**Mental Health Facility - Inpatient**
CH	**Mental Health Facility - Outpatient**
CI	**Substance Abuse Facility - Inpatient**
CJ	**Substance Abuse Facility - Outpatient**

			CK	**Screening X-ray**
			CL	**Screening laboratory**
			CM	**Mammogram, High Risk Patient**
			CN	**Mammogram, Low Risk Patient**
			CO	**Flu Vaccination**
			CP	**Eyewear and Eyewear Accessories**
			CQ	**Case Management**
			DG	**Dermatology**
			DM	**Durable Medical Equipment**
			DS	**Diabetic Supplies**
			GF	**Generic Prescription Drug - Formulary**
			GN	**Generic Prescription Drug - Non-Formulary**
			GY	**Allergy**
			IC	**Intensive Care**
			MH	**Mental Health**
			NI	**Neonatal Intensive Care**
			ON	**Oncology**
			PT	**Physical Therapy**
			PU	**Pulmonary**
			RN	**Renal**
			RT	**Residential Psychiatric Treatment**
			TC	**Transitional Care**
			TN	**Transitional Nursery Care**
			UC	**Urgent Care**

SITUATIONAL	**EQ02**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**X 1**

SITUATIONAL RULE: ***Required if utilizing a Medical Procedure Code inquiry when the information receiver believes that the information source supports this high level of functionality and EQ01 is not used. If not required by this implementation guide, do not send.***

OD: **270B1_2110C_EQ02_C003**

An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes can be supplied in the 2100C HI segment and place of service can be supplied in the 2110C III segment.

If an inquiry is submitted with EQ02 and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.4.7 for additional information.

Not used if EQ01 is used.

REQUIRED **EQ02 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SEMANTIC:
C003-01 qualifies C003-02 and C003-08.

OD:
270B1_2110C_EQ02_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: Product or Service ID Qualifier

Use this code to qualify the type of specific Product/Service ID that will be used in EQ02-2.

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association
CJ	**Current Procedural Terminology (CPT) Codes** **CODE SOURCE 133:** Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **CODE SOURCE 130:** Healthcare Common Procedure Coding System
ID	**International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Procedure** **CODE SOURCE 131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **CODE SOURCE 513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	**National Drug Code in 5-4-2 Format** **CODE SOURCE 240:** National Drug Code by Format
ZZ	**Mutually Defined**
	Use this code only for International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). **CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)**

REQUIRED **EQ02 - 2** **234** **Product/Service ID** **M AN 1/48**

Identifying number for a product or service

SEMANTIC:
If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.

OD: 270B1_2110C_EQ02_C00302_ProcedureCode

IMPLEMENTATION NAME: Procedure Code

Use this number for the product/service ID as identified by the preceding data element (EQ02-1).

SITUATIONAL **EQ02 - 3** **1339** **Procedure Modifier** **O AN 2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-03 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.***

OD: 270B1_2110C_EQ02_C00303_ProcedureModifier

Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.

SITUATIONAL **EQ02 - 4** **1339** **Procedure Modifier** **O AN 2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-04 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a second modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.***

OD: 270B1_2110C_EQ02_C00304_ProcedureModifier

Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.

SITUATIONAL	**EQ02 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-05 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when a third modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.*** OD: **270B1_2110C_EQ02_C00305_ProcedureModifier** **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-06 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when a fourth modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.*** OD: **270B1_2110C_EQ02_C00306_ProcedureModifier** **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
NOT USED	**EQ02 - 7**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**EQ02 - 8**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**

SITUATIONAL	**EQ03**	**1207**	**Coverage Level Code**	**O 1**	**ID**	**3/3**

Code indicating the level of coverage being provided for this insured

SITUATIONAL RULE: ***Required when the information receiver desires coverage information for an entire family and believes that the information source supports this functionality. If not required by this implementation guide, do not send.***

OD: **270B1_2110C_EQ03__CoverageLevelCode**

It is at the sole discretion of the information source whether to support this functionality or not. If not supported, information source will process without this data element.

CODE	DEFINITION
FAM	**Family**

NOT USED	**EQ04**	**1336**	**Insurance Type Code**	**O 1**	**ID**	**1/3**
SITUATIONAL	**EQ05**	**C004**	**COMPOSITE DIAGNOSIS CODE POINTER**	**O 1**		

To identify one or more diagnosis code pointers

SITUATIONAL RULE: ***Required when a 2100C HI segment is used. If not required by this implementation guide, do not send.***

OD: **270B1_2110C_EQ05_C004**

REQUIRED	**EQ05 - 1**		**1328**	**Diagnosis Code Pointer**	**M**	**N0**	**1/2**

A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-01 identifies the primary diagnosis code for this service line.

OD: **270B1_2110C_EQ05_C00401_DiagnosisCodePointer**

This first pointer designates the primary diagnosis for this EQ segment. Remaining diagnosis pointers indicate declining level of importance to the EQ segment. Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL	**EQ05 - 2**		**1328**	**Diagnosis Code Pointer**	**O**	**N0**	**1/2**

A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-02 identifies the second diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a second diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: **270B1_2110C_EQ05_C00402_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL **EQ05 - 3** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-03 identifies the third diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a third diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: 270B1_2110C_EQ05_C00403_DiagnosisCodePointer

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL **EQ05 - 4** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-04 identifies the fourth diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a fourth diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: 270B1_2110C_EQ05_C00404_DiagnosisCodePointer

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SEGMENT DETAIL

AMT - SUBSCRIBER SPEND DOWN AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

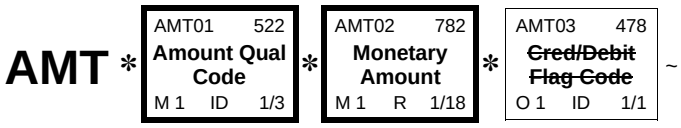
Situational Rule: **Required if Spend Down amount is being reported. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment only if it is 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. These programs require individuals to pay a certain amount towards their health care cost before Medicaid coverage starts.**

TR3 Example: **AMT*R*37.5~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M 1 ID 1/3**
			OD: **270B1_2110C_AMT01__AmountQualifierCode**	
			CODE / DEFINITION **R** **Spend Down**	
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M 1 R 1/18**
			OD: **270B1_2110C_AMT02__SpendDownAmount**	
			IMPLEMENTATION NAME: **Spend Down Amount**	
			Use this monetary amount to specify the dollar amount associated with this inquiry.	
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

AMT - SUBSCRIBER SPEND DOWN TOTAL BILLED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

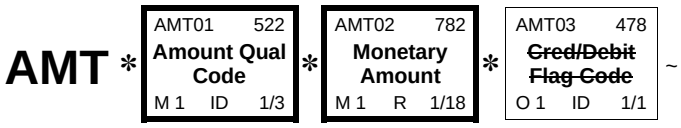
Situational Rule: **Required if Spend Down amount is being reported in a separate 2110C AMT segment and the information source also requires the Spend Down Total Billed Amount. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment only if it is necessary to report the Spend Down Total Billed Amount in addition to the Spend Down Amount. See 2110C Subscriber Spend Down Amount segment for more information about Spend Down.**

TR3 Example: **AMT*PB*37.5~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M 1 ID 1/3**
			OD: **270B1_2110C_AMT01__AmountQualifierCode**	
			CODE / DEFINITION **PB** **Billed Amount**	
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M 1 R 1/18**
			OD: **270B1_2110C_AMT02__SpendDownTotalBilledAmount**	
			IMPLEMENTATION NAME: **Spend Down Total Billed Amount**	
			Use this monetary amount to specify the dollar amount associated with this inquiry.	
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

III - SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION

X12 Segment Name: Information

X12 Purpose: To report information

X12 Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

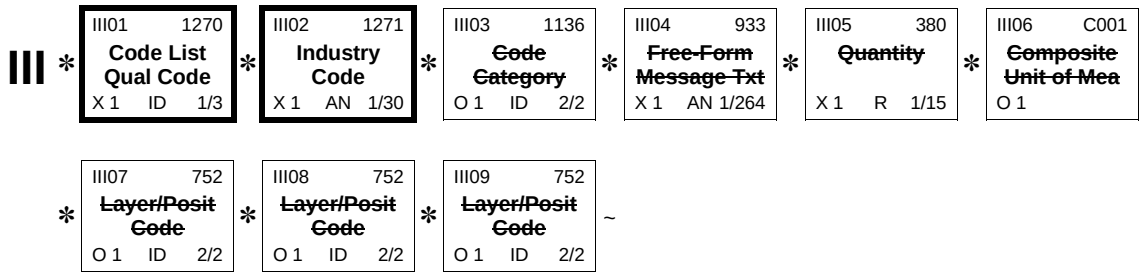
Situational Rule: **Required when the information receiver believes the Facility Type information is relevant to the inquiry and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use the III segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment.**

TR3 Example: **III*ZZ*21~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **OD: 270B1_2110C_III01__CodeListQualifierCode**	**X 1 ID 1/3**

Use this code to specify the code that is following in the III02 is a Facility Type Code.

CODE	DEFINITION
ZZ	**Mutually Defined**
	Use this code for Facility Type Code. See Appendix A for Code Source 237, Place of Service Codes for Professional Claims.

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102	**X 1**	**AN**	**1/30**

OD: **270B1_2110C_III02__IndustryCode**

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- **01 Pharmacy**
- **03 School**
- **04 Homeless Shelter**
- **05 Indian Health Service Free-standing Facility**
- **06 Indian Health Service Provider-based Facility**
- **07 Tribal 638 Free-standing Facility**
- **08 Tribal 638 Provider-based Facility**
- **11 Office**
- **12 Home**
- **13 Assisted Living Facility**
- **14 Group Home**
- **15 Mobile Unit**
- **20 Urgent Care Facility**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **23 Emergency Room - Hospital**
- **24 Ambulatory Surgical Center**
- **25 Birthing Center**
- **26 Military Treatment Facility**
- **31 Skilled Nursing Facility**
- **32 Nursing Facility**
- **33 Custodial Care Facility**
- **34 Hospice**
- **41 Ambulance - Land**
- **42 Ambulance - Air or Water**
- **49 Independent Clinic**
- **50 Federally Qualified Health Center**
- **51 Inpatient Psychiatric Facility**
- **52 Psychiatric Facility - Partial Hospitalization**
- **53 Community Mental Health Center**
- **54 Intermediate Care Facility/Mentally Retarded**
- **55 Residential Substance Abuse Treatment Facility**
- **56 Psychiatric Residential Treatment Center**
- **57 Non-residential Substance Abuse Treatment Facility**
- **60 Mass Immunization Center**
- **61 Comprehensive Inpatient Rehabilitation Facility**
- **62 Comprehensive Outpatient Rehabilitation Facility**
- **65 End-Stage Renal Disease Treatment Facility**
- **71 Public Health Clinic**
- **72 Rural Health Clinic**
- **81 Independent Laboratory**
- **99 Other Place of Service**

NOT USED	**III03**	**1136**	**Code Category**	**O 1**	**ID**	**2/2**

NOT USED	III04	933	Free-form Message Text	X 1	AN	1/264
NOT USED	III05	380	Quantity	X 1	R	1/15
NOT USED	III06	C001	COMPOSITE UNIT OF MEASURE	O 1		
NOT USED	III07	752	Surface/Layer/Position Code	O 1	ID	2/2
NOT USED	III08	752	Surface/Layer/Position Code	O 1	ID	2/2
NOT USED	III09	752	Surface/Layer/Position Code	O 1	ID	2/2

SEGMENT DETAIL

REF - SUBSCRIBER ADDITIONAL INFORMATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

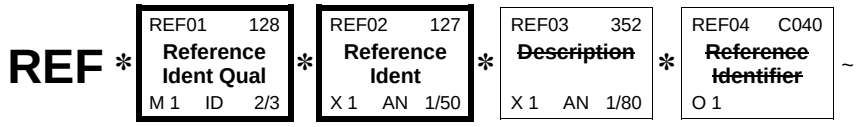
Usage: **SITUATIONAL**

Situational Rule: **Required when the subscriber has received a referral or prior authorization number and the information receiver believes the information is relevant to the inquiry (such as for a benefit or procedure that requires a referral or prior authorization) and the information is available. If not required by this implementation guide do not send.**

TR3 Notes: **1. Use this segment when it is necessary to provide a referral or prior authorization number for the benefit being inquired about.**

TR3 Example: **REF*9F*660415~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **270B1_2110C_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02.

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 270B1_2110C_REF02__PriorAuthorizationorReferralNumber** **IMPLEMENTATION NAME: Prior Authorization or Referral Number** **Use this reference number as qualified by the preceding data element (REF01).**	**X 1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

DTP - SUBSCRIBER ELIGIBILITY/BENEFIT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

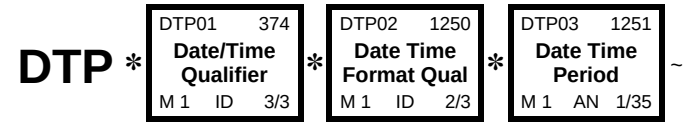
Situational Rule: **Required when the plan date(s) are different from the date(s) provided in the 2100C loop. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to convey plan dates associated with the information contained in the corresponding EQ segment.**
2. **This segment is only to be used to override dates provided in Loop 2100C when the date differs from the date provided in the DTP segment in Loop 2100C. Dates that apply to the entire request must be placed in the DTP segment in Loop 2100C. In order for a date to appear here, there must be a date or a date range in the corresponding 2100C loop.**

TR3 Example: **DTP*291*D8*20051031~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M 1 ID 3/3

OD: **270B1_2110C_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
291	Plan

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M 1 ID 2/3**

Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

OD: 270B1_2110C_DTP02__DateTimePeriodFormatQualifier

Use this code to specify the format of the date(s) or time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M 1 AN 1/35**

Expression of a date, a time, or range of dates, times or dates and times

OD: 270B1_2110C_DTP03__DateTimePeriod

Use this date for the date(s) as qualified by the preceding data elements.

SEGMENT DETAIL

HL - DEPENDENT LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000D — DEPENDENT LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the patient is a dependent of a member and cannot be uniquely identified to the information source without the member's information in the Subscriber Level 2000C loop. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **If a patient is a dependent of a member, but can be uniquely identified to the information source (such as by, but not limited to, a unique Member Identification Number) then the patient is considered the subscriber and is to be identified in the Subscriber Level.**
2. **Because the usage of this segment is "Situational", this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix B for further details on ASC X12 nomenclature.**
3. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

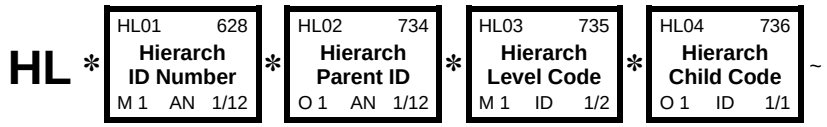
   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

4. An example of the overall structure of the transaction set when used in batch mode is:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry

TR3 Example: HL*4*3*23*0~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	**M 1 AN 1/12**

COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

OD: 270B1_2000D_HL01__HierarchicalIDNumber

Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction must begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).

An example of the use of the HL segment and this data element is:

HL*120*1~**
NM1*PR*2*ABC INSURANCE COMPANY***PI*842610001~**
HL*2*1*21*1~
NM1*1P*1*JONES*MARCUS*MD*SV*0202034~**
HL*3*2*22*1~
NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**
HL*4*3*23*0~
NM1*03*1*SMITH*MARY*LOU~
Eligibility/Benefit Data
HL*5*2*22*0~
NM1*IL*1*BROWN*JOHN*E*MI*22211333301~**
Eligibility/Benefit Data

REQUIRED **HL02** **734** **Hierarchical Parent ID Number** **O 1 AN 1/12**

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.

OD: **270B1_2000D_HL02__HierarchicalParentIDNumber**

Use this code to identify the specific Subscriber to which this level is subordinate.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: **270B1_2000D_HL03__HierarchicalLevelCode**

All data that follows this HL segment is associated with the Dependent identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
23	**Dependent**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **270B1_2000D_HL04__HierarchicalChildCode**

Because of the hierarchical structure, and because no HL level is subordinate to this level, the code value in the HL04 at the Loop 2000D level must always be “0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

SEGMENT DETAIL

TRN - DEPENDENT TRACE NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

X12 Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

Loop: **2000D — DEPENDENT LEVEL**

Segment Repeat: **2**

Usage: **SITUATIONAL**

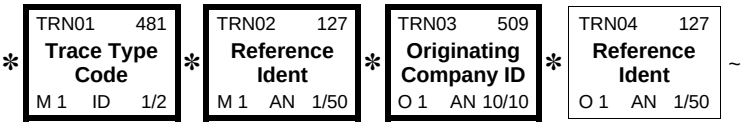
Situational Rule: **Required when information receiver or clearinghouse intends to use the TRN segment as a tracing mechanism for the eligibility transaction and the dependent is the patient. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Trace numbers assigned at the dependent level are intended to allow tracing of an eligibility/benefit transaction when the dependent is the patient.**
2. **The information receiver may assign one TRN segment in this loop if the dependent is the patient. A clearinghouse may assign one TRN segment in this loop if the dependent is the patient. See Section 1.4.6 Information Linkage.**

TR3 Example:
TRN*1*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M 1 ID 1/2**
			OD: **270B1_2000D_TRN01__TraceTypeCode**	
			CODE / DEFINITION	
			1 **Current Transaction Trace Numbers**	

REQUIRED **TRN02** **127** **Reference Identification** **M 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN02 provides unique identification for the transaction.

OD: 270B1_2000D_TRN02__TraceNumber

IMPLEMENTATION NAME: Trace Number

Use this number for the trace or reference number assigned by the information receiver or clearinghouse.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O 1 AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SEMANTIC: TRN03 identifies an organization.

OD: 270B1_2000D_TRN03__TraceAssigningEntityIdentifier

IMPLEMENTATION NAME: Trace Assigning Entity Identifier

Use this number for the identification number of the company that assigned the trace or reference number specified in the previous data element (TRN02).

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL **TRN04** **127** **Reference Identification** **O 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

SITUATIONAL RULE: ***Required when it is necessary to further identify a specific component of the company identified in the previous data element (TRN03). If not required by this implementation guide, do not send.***

OD: 270B1_2000D_TRN04__TraceAssigningEntityAdditionalIdentifier

IMPLEMENTATION NAME: Trace Assigning Entity Additional Identifier

This information allows the originating company to further identify a specific division or group within that organization that was responsible for assigning the trace or reference number.

SEGMENT DETAIL

NM1 - DEPENDENT NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100D — DEPENDENT NAME Loop Repeat: 1**

Segment Repeat: **1**

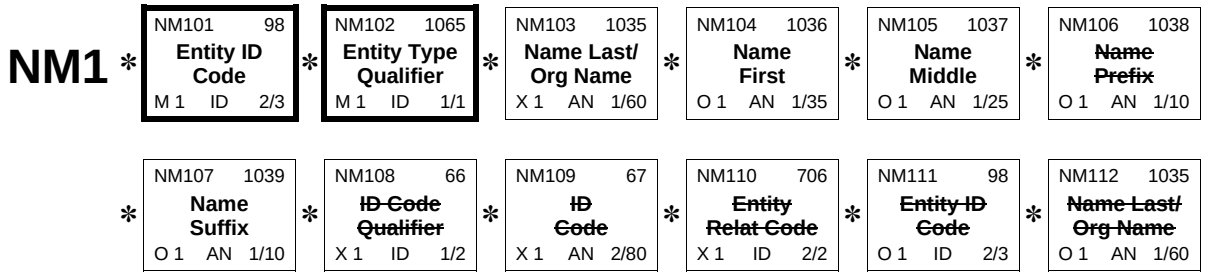
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name. This NM1 loop is used to identify the dependent of an insured or subscriber.**
2. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **NM1*03*1*SMITH*MARY LOU*R~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **270B1_2100D_NM101__EntityIdentifierCode**

CODE	DEFINITION
03	**Dependent**

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M 1** **ID** **1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

OD: 270B1_2100D_NM102__EntityTypeQualifier

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**

SITUATIONAL **NM103** **1035** **Name Last or Organization Name** **X 1** **AN** **1/60**
Individual last name or organizational name

SYNTAX: C1203

SITUATIONAL RULE: ***Required when the dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Last Name (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: 270B1_2100D_NM103__DependentLastName

IMPLEMENTATION NAME: Dependent Last Name

Use this name for the dependent's last name.

SITUATIONAL **NM104** **1036** **Name First** **O 1** **AN** **1/35**
Individual first name

SITUATIONAL RULE: ***Required when the dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's First Name (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: 270B1_2100D_NM104__DependentFirstName

IMPLEMENTATION NAME: Dependent First Name

Use this name for the dependent's first name.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1**	**AN**	**1/25**
			SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).*** ***If not required by this implementation guide, do not send.***			
			OD: **270B1_2100D_NM105__DependentMiddleName**			
			IMPLEMENTATION NAME: **Dependent Middle Name**			
			Use this name for the dependent's middle name or initial.			
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O 1**	**AN**	**1/10**
			SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).*** ***If not required by this implementation guide, do not send.***			
			OD: **270B1_2100D_NM107__DependentNameSuffix**			
			IMPLEMENTATION NAME: **Dependent Name Suffix**			
			Use this for the suffix to an individual's name; e.g., Sr., Jr. or III.			
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - DEPENDENT ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

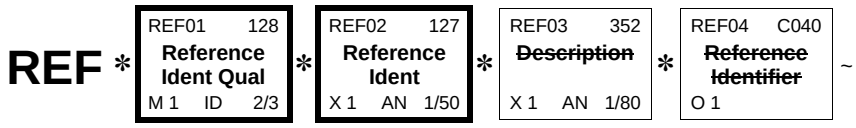
Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Notes:

1. **Use this segment when needed to convey identification numbers for the dependent. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100D loop.**
2. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **REF*1L*660415~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **270B1_2100D_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02.

Only one occurrence of each REF01 code value may be used in the 2100D loop.

CODE	DEFINITION
18	**Plan Number**

1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
6P	**Group Number**
CT	**Contract Number**
	This code is to be used only to identify the provider's contract number of the provider identified in the PRV segment of Loop 2100D. This code is only to be used once the CMS National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.
EA	**Medical Record Identification Number**
EJ	**Patient Account Number**
F6	**Health Insurance Claim (HIC) Number**
GH	**Identification Card Serial Number**
	Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.
HJ	**Identity Card Number**
	Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.
IF	**Issue Number**
IG	**Insurance Policy Number**
MRC	**Eligibility Category** CODE SOURCE **844:** Eligibility Category
N6	**Plan Network Identification Number**
SY	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
Y4	**Agency Claim Number**
	This code is to only be used when submitting an eligibility request to a Property and Casualty payer. Use this code to identify the Property and Casualty Claim Number associated with the dependent. This code is not a HIPAA requirement as of this writing.

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 270B1_2100D_REF02__DependentSupplementalIdentifier** **IMPLEMENTATION NAME: Dependent Supplemental Identifier** **Use this reference number as qualified by the preceding data element (REF01).**	**X 1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

N3 - DEPENDENT ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2100D — DEPENDENT NAME**

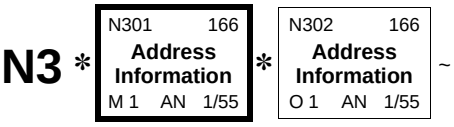
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Example: **N3*15197 BROADWAY AVENUE*APT 215~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **270B1_2100D_N301__DependentAddressLine**	
			IMPLEMENTATION NAME: **Dependent Address Line**	
			Use this information for the first line of the address information.	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).*** ***If not required by this implementation guide, do not send.***	
			OD: **270B1_2100D_N302__DependentAddressLine**	
			IMPLEMENTATION NAME: **Dependent Address Line**	
			Use this information for the second line of the address information.	
			Required if a second address line exists.	

SEGMENT DETAIL

N4 - DEPENDENT CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2100D — DEPENDENT NAME**

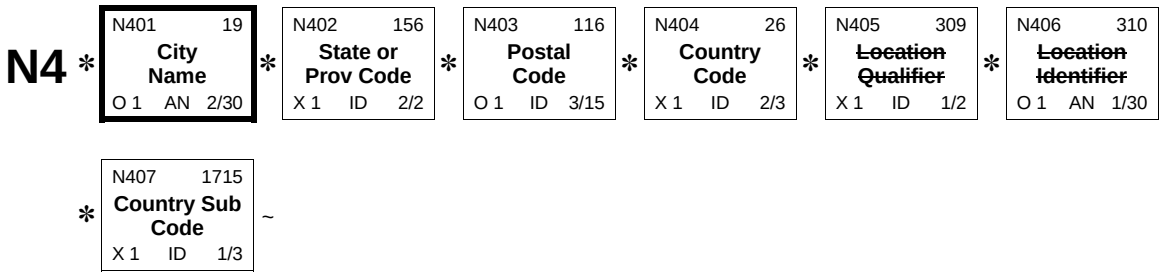
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).**
If not required by this implementation guide, do not send.

TR3 Example: **N4✻KANSAS CITY✻MO✻64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **OD: 270B1_2100D_N401__DependentCityName** **IMPLEMENTATION NAME: Dependent City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

SITUATIONAL RULE: ***Required when address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_N402__DependentStateCode**

IMPLEMENTATION NAME: **Dependent State Code**

CODE SOURCE **22:** States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_N403__DependentPostalZoneorZIPCode**

IMPLEMENTATION NAME: **Dependent Postal Zone or ZIP Code**

CODE SOURCE **51:** ZIP Code
CODE SOURCE **932:** Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_N404__CountryCode**

CODE SOURCE **5:** Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

NOT USED	**N405**	**309**	**Location Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1**	**AN**	**1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_N407__CountrySubdivisionCode**

CODE SOURCE **5:** Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

PRV - PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax:
1. **P0203**
   If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

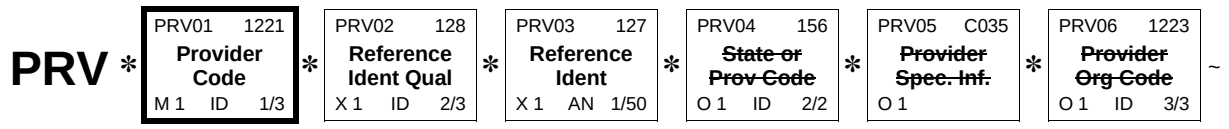
Usage: **SITUATIONAL**

Situational Rule: **Required when the information source is known to process this information in creating a 271 response and the information receiver feels it is necessary to identify a specific provider or to associate a specialty type related to the service identified in the 2110D loop. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.**

TR3 Notes:
1. **This segment must not be used to identify the information receiver or the information receiver's specialty type, unless the information is different from that sent in the 2100B loop.**
2. **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. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110D, use code PXC in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

TR3 Example:
PRV*RF*EI*9991234567~
PRV*RF*PXC*207Q00000X~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **270B1_2100D_PRV01__ProviderCode**

CODE	DEFINITION
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**
SK	**Skilled Nursing Facility**
SU	**Supervising**

SITUATIONAL **PRV02** **128** **Reference Identification Qualifier** **X 1** **ID** **2/3**
Code qualifying the Reference Identification

SYNTAX: P0203

SITUATIONAL RULE: ***Required when the information source is known to process this information in creating a 271 response and the information receiver feels it is necessary to identify a specific provider or to associate a specialty type related to the service identified in the 2110D loop. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **270B1_2100D_PRV02__ReferenceIdentificationQualifier**

If this segment is used to identify a specific provider and the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

If this segment is used to identify a type of specialty associated with the services identified in loop 2110D, use code PXC.

CODE	DEFINITION
9K	**Servicer**
	Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.
D3	**National Council for Prescription Drug Programs Pharmacy Number**
	CODE SOURCE **307:** National Council for Prescription Drug Programs Pharmacy Number
EI	**Employer's Identification Number**
HPI	**Centers for Medicare and Medicaid Services National Provider Identifier**
	Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
	CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier
PXC	**Health Care Provider Taxonomy Code**
	CODE SOURCE **682:** Health Care Provider Taxonomy
SY	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
TJ	**Federal Taxpayer's Identification Number**

SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** P0203 **SITUATIONAL RULE:** ***Required when PRV02 is used. If not required by this implementation guide, do not send.*** **OD: 270B1_2100D_PRV03__ProviderIdentifier** **IMPLEMENTATION NAME: Provider Identifier** **Use this reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

DMG - DEPENDENT DEMOGRAPHIC INFORMATION

X12 Segment Name: Demographic Information

X12 Purpose: To supply demographic information

X12 Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.
2. **P1011**
   If either DMG10 or DMG11 is present, then the other is required.
3. **C1105**
   If DMG11 is present, then DMG05 is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

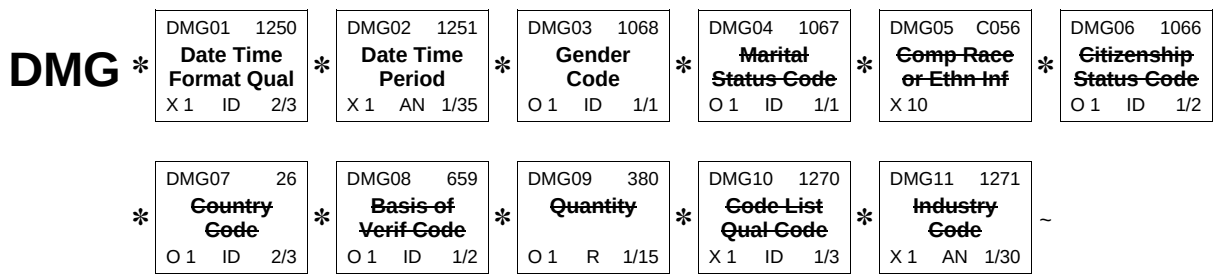
Situational Rule: **Required when the dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).**
OR
Required when the dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

TR3 Notes:

1. **Use this segment when needed to convey the birth date or gender demographic information for the dependent.**
2. **Please refer to Section 1.4.8 Search Options for specific information about how to identify an individual to an Information Source.**

TR3 Example: **DMG*D8*19430121*F~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X 1 ID 2/3**

SYNTAX: P0102

SITUATIONAL RULE: ***Required when the dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: **270B1_2100D_DMG01__DateTimePeriodFormatQualifier**

Use this code to indicate the format of the date of birth that follows in DMG02.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X 1 AN 1/35**

SYNTAX: P0102

SEMANTIC: DMG02 is the date of birth.

SITUATIONAL RULE: ***Required when the dependent is the patient and the information receiver is utilizing the Primary Search Option (See Section 1.4.8).***
OR
Required when the dependent is the patient and the information receiver is utilizing one of the Required Alternate Search Options that require the Patient's Date of Birth (See Section 1.4.8).
OR
Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).
If not required by this implementation guide, do not send.

OD: **270B1_2100D_DMG02__DependentBirthDate**

IMPLEMENTATION NAME: **Dependent Birth Date**

Use this date for the date of birth of the individual.

SITUATIONAL	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual	**O 1**	**ID**	**1/1**

SITUATIONAL RULE: ***Required when the information receiver believes this is needed for an Alternate Search Option supported by the Information Source (See Section 1.4.8).***
If not required by this implementation guide, do not send.

OD: **270B1_2100D_DMG03__DependentGenderCode**

IMPLEMENTATION NAME: **Dependent Gender Code**

Use this code to indicate the dependent's gender.

CODE	DEFINITION
F	**Female**
M	**Male**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X 10**		
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O 1**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O 1**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O 1**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O 1**	**R**	**1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X 1**	**ID**	**1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X 1**	**AN**	**1/30**

SEGMENT DETAIL

INS - DEPENDENT RELATIONSHIP

X12 Segment Name: Insured Benefit

X12 Purpose: To provide benefit information on insured entities

X12 Syntax:

1. **P1112**
   If either INS11 or INS12 is present, then the other is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the information receiver believes it is necessary to identify for an Alternate Search Option supported by the Information Source (See Section 1.4.8) the dependent's relationship to the insured and/or the birth sequence of the dependent in the case of multiple births with the same birth date. If not required by this implementation guide, do not send.**

TR3 Notes:

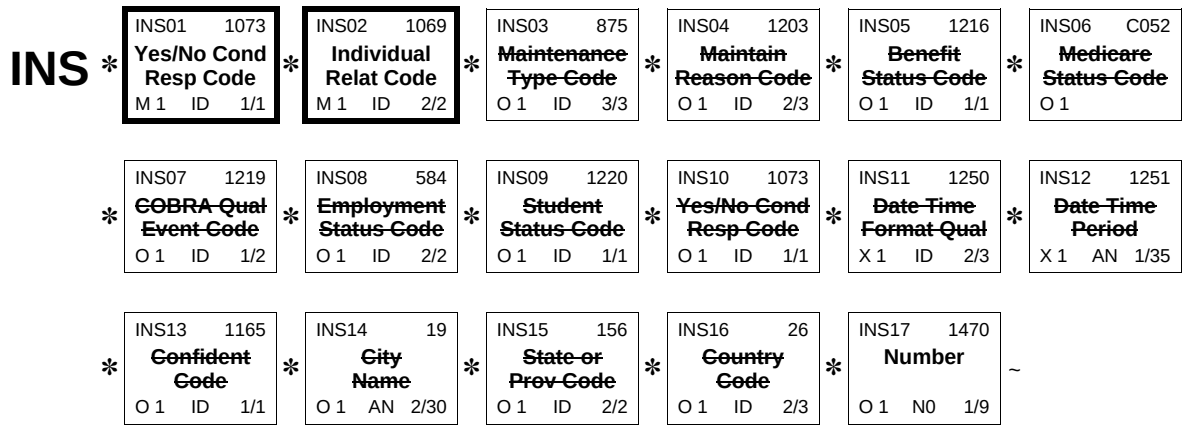
1. **Different types of health plans identify patients in different manners depending upon how their eligibility is structured. However, two approaches predominate.**

   The first approach is to assign each member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of whether he or she is a child, spouse, or the actual subscriber to the plan. The relationship of this individual to the actual subscriber or contract holder would be one of spouse, child, self, etc.

   The second approach is to assign the actual subscriber or contract holder a unique ID number that is entered into the eligibility system. Any related spouse, children, or dependents are identified through the subscriber's ID and have no unique identification number of their own. In this approach, the subscriber would be identified at the Loop 2100C subscriber or insured level and the actual patient (spouse, child, etc.) would be identified at the Loop 2100D dependent level under the subscriber.

TR3 Example: **INS*N*01~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SEMANTIC: INS01 indicates status of the insured. A “Y” value indicates the insured is a subscriber: an “N” value indicates the insured is a dependent. OD: **270B1_2100D_INS01__InsuredIndicator** IMPLEMENTATION NAME: **Insured Indicator**	**M 1 ID 1/1**
			CODE / DEFINITION **N** — **No**	
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities OD: **270B1_2100D_INS02__IndividualRelationshipCode**	**M 1 ID 2/2**
			CODE / DEFINITION **01** — **Spouse** **19** — **Child** **34** — **Other Adult**	
NOT USED	**INS03**	**875**	**Maintenance Type Code**	**O 1 ID 3/3**
NOT USED	**INS04**	**1203**	**Maintenance Reason Code**	**O 1 ID 2/3**
NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O 1 ID 1/1**
NOT USED	**INS06**	**C052**	**MEDICARE STATUS CODE**	**O 1**
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O 1 ID 1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O 1 ID 2/2**
NOT USED	**INS09**	**1220**	**Student Status Code**	**O 1 ID 1/1**
NOT USED	**INS10**	**1073**	**Yes/No Condition or Response Code**	**O 1 ID 1/1**
NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X 1 ID 2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X 1 AN 1/35**

NOT USED	INS13	1165	Confidentiality Code	O 1	ID	1/1
NOT USED	INS14	19	City Name	O 1	AN	2/30
NOT USED	INS15	156	State or Province Code	O 1	ID	2/2
NOT USED	INS16	26	Country Code	O 1	ID	2/3
SITUATIONAL	INS17	1470	Number A generic number	O 1	N0	1/9

SEMANTIC: INS17 is 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.).

SITUATIONAL RULE: ***Required when the information receiver believes it is necessary to identify the birth sequence of the dependent in the case of multiple births with the same birth date supplied in 2100 DMG02 for an Alternate Search Option supported by the Information Source (See Section 1.4.8). If not required by this implementation guide, do not send.***

OD: **270B1_2100D_INS17__BirthSequenceNumber**

IMPLEMENTATION NAME: **Birth Sequence Number**

SEGMENT DETAIL

HI - DEPENDENT HEALTH CARE DIAGNOSIS CODE

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

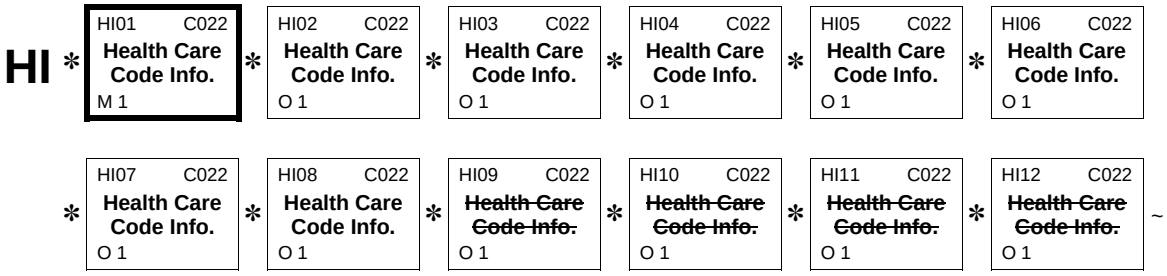
Situational Rule: **Required when the information receiver believes the Diagnosis information is relevant to the inquiry, the information is available and if the information source supports or is believed to support this level of functionality. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use the HI segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment. The information source must not use information in an HI segment of the 270 transaction in the determination of eligibility or benefits for the dependent if that information cannot be returned in the 271 response.**
2. **Use this segment to identify Diagnosis codes as they relate to the information provided in the EQ segments.**
3. **Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.**

TR3 Example: **HI*BK:8901*BF:87200*BF:5559~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities **SYNTAX:** **P0304** If either C02203 or C02204 is present, then the other is required. **E0809** Only one of C02208 or C02209 may be present. OD: **270B1_2100D_HI01_C022** **E codes are Not Used in HI01 except when defined by the claims processor. E codes may be put in any other HI element using BF as the qualifier.** **The diagnosis listed in this element is assumed to be the principal diagnosis.**	**M 1**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SEMANTIC:** C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08. OD: **270B1_2100D_HI01_C02201_DiagnosisTypeCode** IMPLEMENTATION NAME: **Diagnosis Type Code**	**M ID 1/3**
			CODE: **ABK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	
			CODE: **BK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. OD: **270B1_2100D_HI01_C02202_DiagnosisCode** IMPLEMENTATION NAME: **Diagnosis Code**	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data element has been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI02_C022**

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI02_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI02 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI02_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI03_C022**

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI03_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI03 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI03_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI04_C022**

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI04_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI04_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI05_C022**

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI05_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI05_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI06_C022**

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI06_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI06_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI07_C022**

REQUIRED **HI07 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI07_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI07 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI07_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **270B1_2100D_HI08_C022**

REQUIRED **HI08 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **270B1_2100D_HI08_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI08 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **270B1_2100D_HI08_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O 1**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O 1**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O 1**
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O 1**

SEGMENT DETAIL

DTP - DEPENDENT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **2**

Usage: **SITUATIONAL**

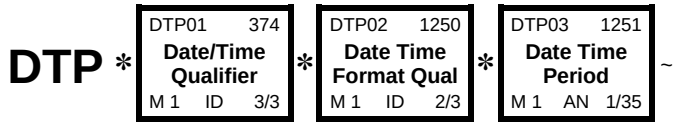
Situational Rule: **Required when the information receiver wishes to convey the plan date(s) for the dependent in relation to the eligibility/benefit inquiry. If not required by this implementation guide, may be sent at the sender's discretion but cannot be required by the information source.**
OR
Required when utilizing a search option other than the Primary Search Option which requires the ID Card Issue Date. If not required by this implementation guide, may be sent at the sender's discretion but cannot be required by the information source.

TR3 Notes:

1. **Absence of a Plan date indicates the request is for the date the transaction is processed and the information source is to process the transaction in the same manner as if the processing date was sent.**
2. **Use this segment to convey the plan date(s) for the dependent or for the issue date of the dependent's identification card for the information source.**
3. **When using code "291" (Plan) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Inquiry (EQ) loops that follow. If there is a need to supply a different Plan date for a specific EQ loop, it must be provided in the DTP segment within the EQ loop and it will only apply to that EQ loop.**

TR3 Example: **DTP*291*D8*20051015~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M 1 ID 3/3

OD: **270B1_2100D_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
102	Issue
	Used if utilizing a search option other than the Primary search option identified in section 1.4.8 and is present on the identification card and is available.
291	Plan

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	M 1 ID 2/3

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

OD: **270B1_2100D_DTP02__DateTimePeriodFormatQualifier**

Use this code to specify the format of the date(s) or time(s) that follow in the next data element.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP03	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	M 1 AN 1/35

OD: **270B1_2100D_DTP03__DateTimePeriod**

Use this date for the date(s) as qualified by the preceding data elements.

SEGMENT DETAIL

EQ - DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY

X12 Segment Name: Eligibility or Benefit Inquiry

X12 Purpose: To specify inquired eligibility or benefit information

X12 Syntax:
1. **R0102**
   At least one of EQ01 or EQ02 is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY Loop Repeat: 99**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to begin the eligibility/benefit inquiry looping structure.**

2. **If the EQ segment is used, either EQ01 - Service Type Code or EQ02 - Composite Medical Procedure Identifier must be used. Only EQ01 or EQ02 is to be sent, not both.**

   An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01. An information source may support the use of Service Type Codes other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion.

   An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes can be supplied in the 2100D HI segment and place of service in the 2110D III segment.

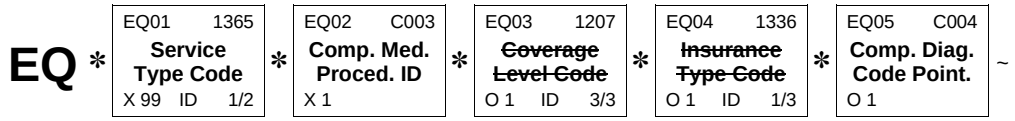
3. **If an information source receives a Service Type Code "30" submitted in the 270 EQ01 or a Service Type Code that they do not support, the 2110D EB03 values identified in Section 1.4.7.1 Item #8 must also be returned if they are a covered benefit category at a plan level. Refer to Section 1.4.7 for additional information.**

4. **EQ01 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110D loop is the same with the exception of the Service Type Code used in EQ01, it is more efficient to use the repetition function of EQ01 to send each of the Service Type Codes needed. If an Information Source supports more than Service Type Code "30", and can support requests for multiple Service Type Codes, the repetition use of EQ01 must be supported.**

TR3 Example: **EQ*98^34^44^81^A0^A3~**

TR3 Example: **EQ*30~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**EQ01**	**1365**	**Service Type Code**	**X 99 ID 1/2**

Code identifying the classification of service

SYNTAX: R0102

SEMANTIC: Position of data in the repeating data element conveys no significance.

SITUATIONAL RULE: ***Required if utilizing a Service Type Code inquiry and EQ02 is not used. If not required by this implementation guide, do not send.***

OD: 270B1_2110D_EQ01__ServiceTypeCode

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01.

An information source may support the use of Service Type Codes from the list other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion. If an information source supports codes in addition to "30", the information source may provide a list of the supported codes from the list below to the information receiver. If no list is provided, an information receiver may transmit the most appropriate code.

If an inquiry is submitted with a Service Type Code from the list other than "30" and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.4.7 for additional information.

EQ01 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110D loop is the same with the exception of the Service Type Code used in EQ01, it is more efficient to use the repetition function of EQ01 to send each of the Service Type Codes needed. If an Information Source supports more than Service Type Code "30", and can support requests for multiple Service Type Codes, the repetition use of EQ01 must be supported.

Not used if EQ02 is used.

CODE	DEFINITION
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
	If only a single category of inquiry can be supported, use this code.
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
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
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**
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**
	Use for Routine Vision Exam only.
AO	**Lenses**
AQ	**Nonmedically Necessary Physical**
AR	**Experimental Drug Therapy**
B1	**Burn Care**
B2	**Brand Name Prescription Drug - Formulary**
B3	**Brand Name Prescription Drug - Non-Formulary**
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**
BT	**Gynecological**
BU	**Obstetrical**
BV	**Obstetrical/Gynecological**
BW	**Mail Order Prescription Drug: Brand Name**
BX	**Mail Order Prescription Drug: Generic**
BY	**Physician Visit - Office: Sick**
BZ	**Physician Visit - Office: Well**
C1	**Coronary Care**
CA	**Private Duty Nursing - Inpatient**
CB	**Private Duty Nursing - Home**
CC	**Surgical Benefits - Professional (Physician)**
CD	**Surgical Benefits - Facility**
CE	**Mental Health Provider - Inpatient**
CF	**Mental Health Provider - Outpatient**
CG	**Mental Health Facility - Inpatient**
CH	**Mental Health Facility - Outpatient**
CI	**Substance Abuse Facility - Inpatient**
CJ	**Substance Abuse Facility - Outpatient**
CK	**Screening X-ray**
CL	**Screening laboratory**
CM	**Mammogram, High Risk Patient**
CN	**Mammogram, Low Risk Patient**
CO	**Flu Vaccination**
CP	**Eyewear and Eyewear Accessories**
CQ	**Case Management**
DG	**Dermatology**
DM	**Durable Medical Equipment**
DS	**Diabetic Supplies**
GF	**Generic Prescription Drug - Formulary**
GN	**Generic Prescription Drug - Non-Formulary**

			GY	**Allergy**
			IC	**Intensive Care**
			MH	**Mental Health**
			NI	**Neonatal Intensive Care**
			ON	**Oncology**
			PT	**Physical Therapy**
			PU	**Pulmonary**
			RN	**Renal**
			RT	**Residential Psychiatric Treatment**
			TC	**Transitional Care**
			TN	**Transitional Nursery Care**
			UC	**Urgent Care**
SITUATIONAL	**EQ02**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**X 1**

To identify a medical procedure by its standardized codes and applicable modifiers

SITUATIONAL RULE: ***Required if utilizing a Medical Procedure Code inquiry when the information receiver believes that the information source supports this high level of functionality and EQ01 is not used. If not required by this implementation guide, do not send.***

OD: **270B1_2110D_EQ02_C003**

An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes can be supplied in the 2100D HI segment and place of service can be supplied in the 2110D III segment.

If an inquiry is submitted with EQ02 and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.4.7 for additional information.

Not used if EQ01 is used.

REQUIRED **EQ02 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SEMANTIC:
C003-01 qualifies C003-02 and C003-08.

OD:
270B1_2110D_EQ02_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: **Product or Service ID Qualifier**

Use this code to qualify the type of specific Product/Service ID that will be used in EQ02-2.

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association
CJ	**Current Procedural Terminology (CPT) Codes** **CODE SOURCE 133:** Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **CODE SOURCE 130:** Healthcare Common Procedure Coding System
ID	**International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Procedure** **CODE SOURCE 131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **CODE SOURCE 513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	**National Drug Code in 5-4-2 Format** **CODE SOURCE 240:** National Drug Code by Format
ZZ	**Mutually Defined**
	Use this code only for International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). **CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)**

REQUIRED **EQ02 - 2** **234** **Product/Service ID** **M AN 1/48**

Identifying number for a product or service

SEMANTIC:
If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.

OD: **270B1_2110D_EQ02_C00302_ProcedureCode**

IMPLEMENTATION NAME: **Procedure Code**

Use this number for the product/service ID as identified by the preceding data element (EQ02-1).

SITUATIONAL **EQ02 - 3** **1339** **Procedure Modifier** **O AN 2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-03 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.***

OD: 270B1_2110D_EQ02_C00303_ProcedureModifier

Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.

SITUATIONAL **EQ02 - 4** **1339** **Procedure Modifier** **O AN 2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-04 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a second modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.***

OD: 270B1_2110D_EQ02_C00304_ProcedureModifier

Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.

SITUATIONAL	**EQ02 - 5**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-05 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when a third modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.*** OD: **270B1_2110D_EQ02_C00305_ProcedureModifier** **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 6**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-06 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when a fourth modifier clarifies/improves the accuracy of the associated procedure code, the modifier is available and when the information receiver believes that the information source supports this high level of functionality. If not required by this implementation guide, do not send.*** OD: **270B1_2110D_EQ02_C00306_ProcedureModifier** **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
NOT USED	**EQ02 - 7**		**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**EQ02 - 8**		**234**	**Product/Service ID**	**O**	**AN**	**1/48**
NOT USED	**EQ03**	**1207**	**Coverage Level Code**		**O 1**	**ID**	**3/3**
NOT USED	**EQ04**	**1336**	**Insurance Type Code**		**O 1**	**ID**	**1/3**
SITUATIONAL	**EQ05**	**C004**	**COMPOSITE DIAGNOSIS CODE POINTER** To identify one or more diagnosis code pointers SITUATIONAL RULE: ***Required when a 2100D HI segment is used. If not required by this implementation guide, do not send.*** OD: **270B1_2110D_EQ05_C004**		**O 1**		

REQUIRED **EQ05 - 1** **1328** **Diagnosis Code Pointer** **M N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-01 identifies the primary diagnosis code for this service line.

OD: **270B1_2110D_EQ05_C00401_DiagnosisCodePointer**

This first pointer designates the primary diagnosis for this EQ segment. Remaining diagnosis pointers indicate declining level of importance to the EQ segment. Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EQ05 - 2** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-02 identifies the second diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a second diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: **270B1_2110D_EQ05_C00402_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EQ05 - 3** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-03 identifies the third diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a third diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: **270B1_2110D_EQ05_C00403_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EQ05 - 4** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-04 identifies the fourth diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a fourth diagnosis related to this EQ segment. If not required by this implementation guide, do not send.***

OD: **270B1_2110D_EQ05_C00404_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SEGMENT DETAIL

III - DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION

X12 Segment Name: Information

X12 Purpose: To report information

X12 Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

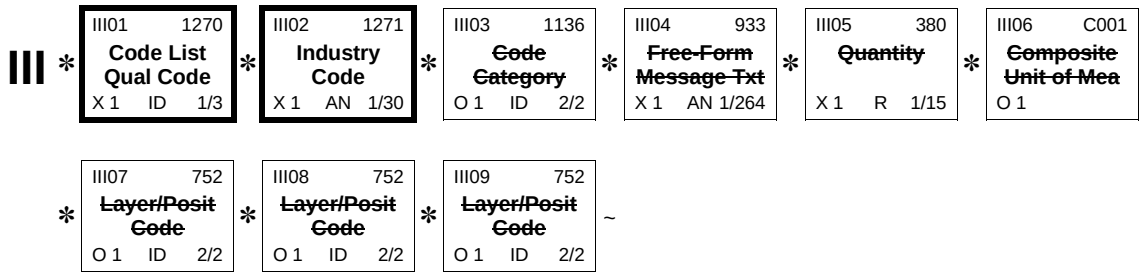
Situational Rule: **Required when the information receiver believes the Facility Type information is relevant to the inquiry and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use the III segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment.**

TR3 Example: **III*ZZ*21~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **OD: 270B1_2110D_III01__CodeListQualifierCode**	**X 1 ID 1/3**

Use this code to specify the code that is following in the III02 is a Facility Type Code.

CODE	DEFINITION
ZZ	**Mutually Defined**
	Use this code for Facility Type Code. See Appendix A for Code Source 237, Place of Service Codes for Professional Claims.

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102	**X 1**	**AN**	**1/30**

OD: **270B1_2110D_III02__IndustryCode**

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- **01 Pharmacy**
- **03 School**
- **04 Homeless Shelter**
- **05 Indian Health Service Free-standing Facility**
- **06 Indian Health Service Provider-based Facility**
- **07 Tribal 638 Free-standing Facility**
- **08 Tribal 638 Provider-based Facility**
- **11 Office**
- **12 Home**
- **13 Assisted Living Facility**
- **14 Group Home**
- **15 Mobile Unit**
- **20 Urgent Care Facility**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **23 Emergency Room - Hospital**
- **24 Ambulatory Surgical Center**
- **25 Birthing Center**
- **26 Military Treatment Facility**
- **31 Skilled Nursing Facility**
- **32 Nursing Facility**
- **33 Custodial Care Facility**
- **34 Hospice**
- **41 Ambulance - Land**
- **42 Ambulance - Air or Water**
- **49 Independent Clinic**
- **50 Federally Qualified Health Center**
- **51 Inpatient Psychiatric Facility**
- **52 Psychiatric Facility - Partial Hospitalization**
- **53 Community Mental Health Center**
- **54 Intermediate Care Facility/Mentally Retarded**
- **55 Residential Substance Abuse Treatment Facility**
- **56 Psychiatric Residential Treatment Center**
- **57 Non-residential Substance Abuse Treatment Facility**
- **60 Mass Immunization Center**
- **61 Comprehensive Inpatient Rehabilitation Facility**
- **62 Comprehensive Outpatient Rehabilitation Facility**
- **65 End-Stage Renal Disease Treatment Facility**
- **71 Public Health Clinic**
- **72 Rural Health Clinic**
- **81 Independent Laboratory**
- **99 Other Place of Service**

NOT USED	**III03**	**1136**	**Code Category**	**O 1**	**ID**	**2/2**

NOT USED	III04	933	Free-form Message Text	X 1	AN	1/264
NOT USED	III05	380	Quantity	X 1	R	1/15
NOT USED	III06	C001	COMPOSITE UNIT OF MEASURE	O 1		
NOT USED	III07	752	Surface/Layer/Position Code	O 1	ID	2/2
NOT USED	III08	752	Surface/Layer/Position Code	O 1	ID	2/2
NOT USED	III09	752	Surface/Layer/Position Code	O 1	ID	2/2

SEGMENT DETAIL

REF - DEPENDENT ADDITIONAL INFORMATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

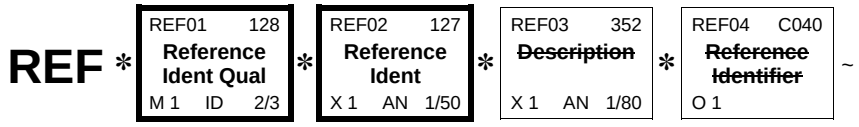
Usage: **SITUATIONAL**

Situational Rule: **Required when the dependent has received a referral or prior authorization number and the information receiver believes the information is relevant to the inquiry (such as for a benefit or procedure that requires a referral or prior authorization) and the information is available. If not required by this implementation guide do not send.**

TR3 Notes: **1. Use this segment when it is necessary to provide a referral or prior authorization number for the benefit being inquired about.**

TR3 Example: **REF*9F*660415~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **270B1_2110D_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02.

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 270B1_2110D_REF02__PriorAuthorizationorReferralNumber** **IMPLEMENTATION NAME: Prior Authorization or Referral Number** **Use this reference number as qualified by the preceding data element (REF01).**	**X 1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

DTP - DEPENDENT ELIGIBILITY/BENEFIT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY**

Segment Repeat: **1**

Usage: **SITUATIONAL**

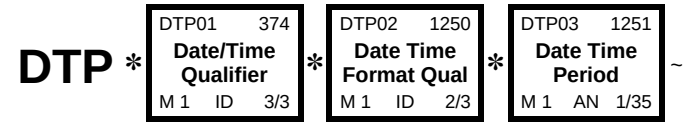
Situational Rule: **Required when the plan date(s) are different from the date(s) provided in the 2100C loop. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to convey plan dates associated with the information contained in the corresponding EQ segment.**
2. **This segment is only to be used to override dates provided in Loop 2100D when the date differs from the date provided in the DTP segment in Loop 2100D. Dates that apply to the entire request must be placed in the DTP segment in Loop 2100D. In order for a date to appear here, there must be a date or a date range in the corresponding 2100D loop.**

TR3 Example: **DTP*291*D8*20051031~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**

OD: **270B1_2110D_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
291	**Plan**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M 1 ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

OD: 270B1_2110D_DTP02__DateTimePeriodFormatQualifier

Use this code to specify the format of the date(s) or time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M 1 AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

OD: 270B1_2110D_DTP03__DateTimePeriod

Use this date for the date(s) as qualified by the preceding data elements.

SEGMENT DETAIL

SE - TRANSACTION SET TRAILER

X12 Segment Name: Transaction Set Trailer

X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

X12 Comments: **1.** SE is the last segment of each transaction set.

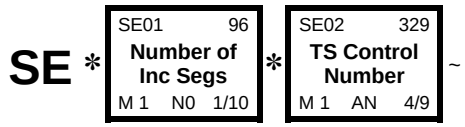
Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes: **1. Use this segment to mark the end of a transaction set and provide control information on the total number of segments included in the transaction set.**

TR3 Example: **SE*41*0001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M 1 N0 1/10**
			OD: **270B1__SE01__TransactionSegmentCount**	
			IMPLEMENTATION NAME: **Transaction Segment Count**	
			Use this number to indicate the total number of segments included in the transaction set inclusive of the ST and SE segments.	
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M 1 AN 4/9**
			OD: **270B1__SE02__TransactionSetControlNumber**	
			The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example "0001", and increment from there. This number must be unique within a specific functional group (segments GS through GE) and interchange, but can repeat in other groups and interchanges.	

2.5 Transaction Set Listing

2.5.1 Implementation

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail. Refer to section 2.1 Presentation Examples for detailed information on the components of the Implementation section.

IMPLEMENTATION

271 Health Care Eligibility Benefit Response

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
209	0100	ST	Transaction Set Header	R	1	
211	0200	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Information Source Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
213	0100	HL	Information Source Level	R	1	
215	0250	AAA	Request Validation	S	9	
			LOOP ID - 2100A INFORMATION SOURCE NAME			1
218	0300	NM1	Information Source Name	R	1	
221	0800	PER	Information Source Contact Information	S	3	
226	0850	AAA	Request Validation	S	9	

Table 2 - Information Receiver Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
229	0100	HL	Information Receiver Level	S	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
232	0300	NM1	Information Receiver Name	R	1	
236	0400	REF	Information Receiver Additional Identification	S	9	
238	0850	AAA	Information Receiver Request Validation	S	9	
241	0900	PRV	Information Receiver Provider Information	S	1	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SUBSCRIBER LEVEL			>1
243	0100	HL	Subscriber Level	S	1	
246	0200	TRN	Subscriber Trace Number	S	3	
			LOOP ID - 2100C SUBSCRIBER NAME			1
249	0300	NM1	Subscriber Name	R	1	
253	0400	REF	Subscriber Additional Identification	S	9	
257	0600	N3	Subscriber Address	S	1	
259	0700	N4	Subscriber City, State, ZIP Code	S	1	
262	0850	AAA	Subscriber Request Validation	S	9	
265	0900	PRV	Provider Information	S	1	

268	1000	DMG	Subscriber Demographic Information	S	1	
271	1100	INS	Subscriber Relationship	S	1	
274	1150	HI	Subscriber Health Care Diagnosis Code	S	1	
283	1200	DTP	Subscriber Date	S	9	
285	1275	MPI	Subscriber Military Personnel Information	S	1	
			LOOP ID - 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION			**>1**
289	1300	EB	Subscriber Eligibility or Benefit Information	S	1	
309	1350	HSD	Health Care Services Delivery	S	9	
314	1400	REF	Subscriber Additional Identification	S	9	
317	1500	DTP	Subscriber Eligibility/Benefit Date	S	20	
319	1600	AAA	Subscriber Request Validation	S	9	
322	2500	MSG	Message Text	S	10	
			LOOP ID - 2115C SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION			**10**
324	2600	III	Subscriber Eligibility or Benefit Additional Information	S	1	
328	3300	LS	Loop Header	S	1	
			LOOP ID - 2120C SUBSCRIBER BENEFIT RELATED ENTITY NAME			**23**
329	3400	NM1	Subscriber Benefit Related Entity Name	S	1	
335	3600	N3	Subscriber Benefit Related Entity Address	S	1	
336	3700	N4	Subscriber Benefit Related Entity City, State, ZIP Code	S	1	
339	3800	PER	Subscriber Benefit Related Entity Contact Information	S	3	
344	3900	PRV	Subscriber Benefit Related Provider Information	S	1	
346	4000	LE	Loop Trailer	S	1	

Table 2 - Dependent Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D DEPENDENT LEVEL			**>1**
347	0100	HL	Dependent Level	S	1	
351	0200	TRN	Dependent Trace Number	S	3	
			LOOP ID - 2100D DEPENDENT NAME			**1**
354	0300	NM1	Dependent Name	R	1	
357	0400	REF	Dependent Additional Identification	S	9	
361	0600	N3	Dependent Address	S	1	
363	0700	N4	Dependent City, State, ZIP Code	S	1	
366	0850	AAA	Dependent Request Validation	S	9	
369	0900	PRV	Provider Information	S	1	
372	1000	DMG	Dependent Demographic Information	S	1	
375	1100	INS	Dependent Relationship	S	1	
378	1150	HI	Dependent Health Care Diagnosis Code	S	1	
387	1200	DTP	Dependent Date	S	9	
389	1275	MPI	Dependent Military Personnel Information	S	1	
			LOOP ID - 2110D DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION			**>1**
393	1300	EB	Dependent Eligibility or Benefit Information	S	1	
412	1350	HSD	Health Care Services Delivery	S	9	
417	1400	REF	Dependent Additional Identification	S	9	
420	1500	DTP	Dependent Eligibility/Benefit Date	S	20	
422	1600	AAA	Dependent Request Validation	S	9	

425	2500	MSG	Message Text	S	10	
			LOOP ID - 2115D DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION			10
427	2600	III	Dependent Eligibility or Benefit Additional Information	S	1	
431	3300	LS	Loop Header	S	1	
			LOOP ID - 2120D DEPENDENT BENEFIT RELATED ENTITY NAME			23
432	3400	NM1	Dependent Benefit Related Entity Name	S	1	
438	3600	N3	Dependent Benefit Related Entity Address	S	1	
439	3700	N4	Dependent Benefit Related Entity City, State, ZIP Code	S	1	
442	3800	PER	Dependent Benefit Related Entity Contact Information	S	3	
447	3900	PRV	Dependent Benefit Related Provider Information	S	1	
449	4000	LE	Loop Trailer	S	1	
450	4100	SE	Transaction Set Trailer	R	1	

2.5.2 X12 Standard

This section is included as a reference. The implementation guide reference clarifies actual usage. Refer to section 2.1 Presentation Examples for detailed information on the components of the X12 Standard section.

STANDARD

271 Eligibility, Coverage or Benefit Information

Functional Group ID: HB

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.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BHT	Beginning of Hierarchical Transaction	M	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
0100	HL	Hierarchical Level	M	1	
0200	TRN	Trace	O	9	
0250	AAA	Request Validation	O	9	
		LOOP ID - 2100			>1
0300	NM1	Individual or Organizational Name	O	1	
0400	REF	Reference Information	O	9	
0500	N2	Additional Name Information	O	1	
0600	N3	Party Location	O	1	
0700	N4	Geographic Location	O	1	
0800	PER	Administrative Communications Contact	O	3	
0850	AAA	Request Validation	O	9	
0900	PRV	Provider Information	O	1	
1000	DMG	Demographic Information	O	1	
1100	INS	Insured Benefit	O	1	
1150	HI	Health Care Information Codes	O	1	
1200	DTP	Date or Time or Period	O	9	
1250	LUI	Language Use	O	9	
1275	MPI	Military Personnel Information	O	9	
		LOOP ID - 2110			>1
1300	EB	Eligibility or Benefit Information	O	1	
1350	HSD	Health Care Services Delivery	O	9	
1400	REF	Reference Information	O	9	
1500	DTP	Date or Time or Period	O	20	
1600	AAA	Request Validation	O	9	
1700	VEH	Vehicle Information	O	1	
1800	PID	Product/Item Description	O	1	
1900	PDR	Property Description - Real	O	1	

2000	PDP	Property Description - Personal	O	1	
2100	LIN	Item Identification	O	1	
2200	EM	Equipment Characteristics	O	1	
2300	SD1	Safety Data	O	1	
2400	PKD	Packaging Description	O	1	
2500	MSG	Message Text	O	10	
		LOOP ID - 2115			>1
2600	III	Information	O	1	
2700	DTP	Date or Time or Period	O	5	
2800	AMT	Monetary Amount Information	O	5	
2900	PCT	Percent Amounts	O	5	
		LOOP ID - 2117			>1
3000	LQ	Industry Code Identification	O	1	
3100	AMT	Monetary Amount Information	O	5	
3200	PCT	Percent Amounts	O	5	
3300	LS	Loop Header	O	1	
		LOOP ID - 2120			>1
3400	NM1	Individual or Organizational Name	O	1	
3500	N2	Additional Name Information	O	1	
3600	N3	Party Location	O	1	
3700	N4	Geographic Location	O	1	
3800	PER	Administrative Communications Contact	O	3	
3900	PRV	Provider Information	O	1	
4000	LE	Loop Trailer	O	1	
4100	SE	Transaction Set Trailer	M	1	

NOTE:

2/0200 If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

2.6 271 - Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Refer to section 2.1 Presentation Examples for detailed information on the components of the Segment Detail section.

SEGMENT DETAIL

ST - TRANSACTION SET HEADER

X12 Segment Name: Transaction Set Header

X12 Purpose: To indicate the start of a transaction set and to assign a control number

Segment Repeat: **1**

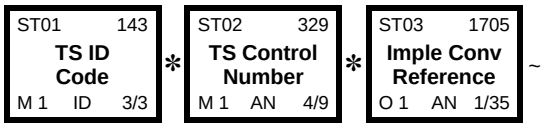
Usage: **REQUIRED**

TR3 Notes:

1. **Use this control segment to mark the start of a transaction set. One ST segment exists for every transaction set that occurs within a functional group.**

TR3 Example: **ST*271*0001*005010X279~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). OD: **271B1__ST01__TransactionSetIdentifierCode** **Use this code to identify the transaction set ID for the transaction set that will follow the ST segment. Each X12 standard has a transaction set identifier code that is unique to that transaction set.** CODE / DEFINITION **271** **Eligibility, Coverage or Benefit Information**	**M 1 ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: **271B1__ST02__TransactionSetControlNumber** **The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example "0001", and increment from there.**	**M 1 AN 4/9**

REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention	**O 1**	**AN**	**1/35**

SEMANTIC: The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.

OD: **271B1__ST03__ImplementationConventionReference**

This element must be populated with 005010X279.

This element contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST/SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.

SEGMENT DETAIL

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

X12 Segment Name: Beginning of Hierarchical Transaction

X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Segment Repeat: **1**

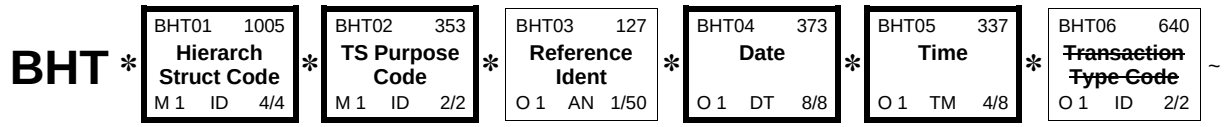
Usage: **REQUIRED**

TR3 Notes:

1. **Use this required segment to start the transaction set and indicate the sequence of the hierarchical levels of information that will follow in Table 2.**

TR3 Example: **BHT*0022*11*199800114000001*19980101*1401~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	**M 1 ID 4/4**
			OD: **271B1__BHT01__HierarchicalStructureCode**	
			Use this code to specify the sequence of hierarchical levels that may appear in the transaction set. This code only indicates the sequence of the levels, not the requirement that all levels be present. For example, if code "0022" is used, the dependent level may or may not be present for each subscriber.	
			CODE / DEFINITION **0022** — **Information Source, Information Receiver, Subscriber, Dependent**	
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set	**M 1 ID 2/2**
			OD: **271B1__BHT02__TransactionSetPurposeCode**	
			CODE / DEFINITION **06** — **Confirmation**	
			Use this code only to acknowledge the successful cancellation of a 270 transaction that was received with a BHT02 value of "01" Cancellation.	

11 Response

SITUATIONAL	**BHT03**	**127**	**Reference Identification**	**O 1**	**AN**	**1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

SITUATIONAL RULE: ***Required when the transaction is used in Real Time (See Section 1.4.3). If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1__BHT03__SubmitterTransactionIdentifier

IMPLEMENTATION NAME: Submitter Transaction Identifier

This information may be sent at the creator of the 271's discretion if using the transaction in a Batch mode and a Submitter Transaction Identifier was received in the 270 transaction BHT03, otherwise this is not used. Due to the nature of batch transaction processing, the receiver of the 270 transaction (whether it is a clearinghouse or information source) may or may not be able to return the 270 BHT03 value in the 271 BHT03. See Section 1.4.6 Information Linkage for additional information and requirements.

This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. This identifier is to be the identifier received in the BHT03 of the corresponding 270 transaction. This identifier is not to be passed through the complete life of the transaction, rather replaced with the identifier received in the 270.

REQUIRED	**BHT04**	**373**	**Date**	**O 1**	**DT**	**8/8**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

OD: 271B1__BHT04__TransactionSetCreationDate

IMPLEMENTATION NAME: Transaction Set Creation Date

Use this date for the date the transaction set was generated.

REQUIRED	**BHT05**	**337**	**Time**	**O 1**	**TM**	**4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

OD: 271B1__BHT05__TransactionSetCreationTime

IMPLEMENTATION NAME: Transaction Set Creation Time

Use this time for the time the transaction set was generated.

NOT USED	**BHT06**	**640**	**Transaction Type Code**	**O 1**	**ID**	**2/2**

SEGMENT DETAIL

HL - INFORMATION SOURCE LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000A — INFORMATION SOURCE LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

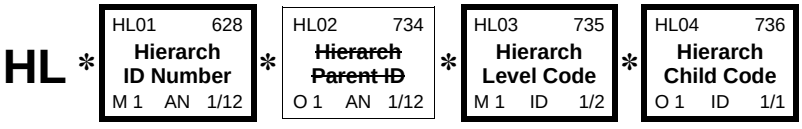
   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information

TR3 Example: **HL*1**20*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	**M 1 AN 1/12**

COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

OD: **271B1_2000A_HL01__HierarchicalIDNumber**

Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).

An example of the use of the HL segment and this data element is:

HL*120*1~**
NM1*PR*2*ABC INSURANCE COMPANY***PI*842610001~**

NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 1 AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure	**M 1 ID 1/2**

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: **271B1_2000A_HL03__HierarchicalLevelCode**

All data that follows this HL segment is associated with the Information Source identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
20	**Information Source**

REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described	**O 1 ID 1/1**

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **271B1_2000A_HL04__HierarchicalChildCode**

Use this code to indicate whether there are additional hierarchical levels subordinate to this Information Source.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

AAA - REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2000A — INFORMATION SOURCE LEVEL**

Segment Repeat: **9**

Usage: **SITUATIONAL**

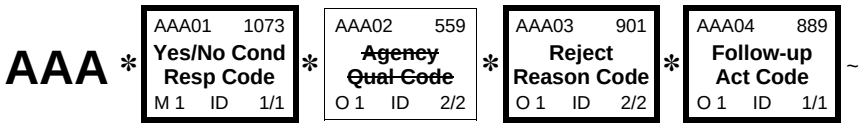
Situational Rule: **Required when the request could not be processed at a system or application level based on the entities identified in ISA06, ISA08, GS02 or GS03 and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use of this segment at this location in the HL is to identify reasons why a request cannot be processed based on the entities identified in ISA06, ISA08, GS02 or GS03.**

TR3 Example: **AAA*Y**42*Y~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid. OD: **271B1_2000A_AAA01__ValidRequestIndicator** IMPLEMENTATION NAME: **Valid Request Indicator**	**M 1 ID 1/1**
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O 1 ID 2/2**

CODE	DEFINITION
N	**No**
	Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.
Y	**Yes**
	Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.

REQUIRED **AAA03** **901** **Reject Reason Code** **O 1** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

OD: **271B1_2000A_AAA03__RejectReasonCode**

Use this code to indicate the reason why the transaction was unable to be processed successfully by the entity identified in either ISA08 or GS03.

CODE	DEFINITION
04	**Authorized Quantity Exceeded**
	Use this code to indicate that the transaction exceeds the number of patient requests allowed by the entity identified in either ISA08 or GS03. See section 1.4.3 Batch and Real Time for more information regarding the number of patient requests allowed in a transaction. This is not to be used to indicate that the number of patient requests exceeds the number allowed by the Information Source identified in Loop 2100A.
41	**Authorization/Access Restrictions**
	Use this code to indicate that the entity identified in GS02 is not authorized to submit 270 transactions to the entity identified in either ISA08 or GS03. This is not to be used to indicate Authorization/Access Restrictions as related to the Information Source Identified in Loop 2100A.
42	**Unable to Respond at Current Time**
	Use this code to indicate that the entity identified in either ISA08 or GS03 is unable to process the transaction at the current time. This indicates that there is a problem within the systems of the entity identified in either ISA08 or GS03 and is not related to any problem with the Information Source Identified in Loop 2100A.
79	**Invalid Participant Identification**
	Use this code to indicate that the value in either GS02 or GS03 is invalid.

REQUIRED **AAA04** **889** **Follow-up Action Code** **O 1** **ID** **1/1**
Code identifying follow-up actions allowed

OD: **271B1_2000A_AAA04__FollowupActionCode**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
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**

SEGMENT DETAIL

NM1 - INFORMATION SOURCE NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100A — INFORMATION SOURCE NAME Loop Repeat: 1**

Segment Repeat: **1**

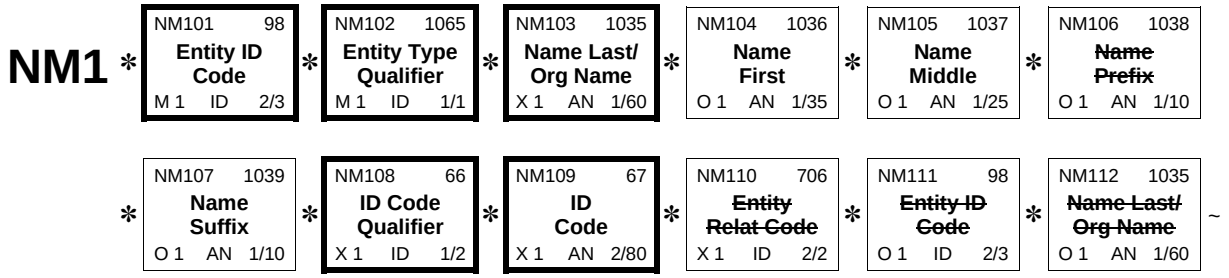
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name and identification number. This NM1 loop is used to identify the eligibility or benefit information source (e.g., insurance company, HMO, IPA, employer).**

TR3 Example: **NM1*PR*2*ACE INSURANCE COMPANY*****PI*87728~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **271B1_2100A_NM101__EntityIdentifierCode**

CODE	DEFINITION
2B	**Third-Party Administrator**
36	**Employer**
GP	**Gateway Provider**
P5	**Plan Sponsor**
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M 1**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

OD: 271B1_2100A_NM102__EntityTypeQualifier

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**X 1**	**AN**	**1/60**

SYNTAX: C1203

OD: 271B1_2100A_NM103__InformationSourceLastorOrganizationName

IMPLEMENTATION NAME: Information Source Last or Organization Name

Use this name for the organization name if NM102 is "2". Otherwise, this will be the individual's last name.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O 1**	**AN**	**1/35**

SITUATIONAL RULE: ***Required when NM102 is "1". If not required by this implementation guide, do not send.***

OD: 271B1_2100A_NM104__InformationSourceFirstName

IMPLEMENTATION NAME: Information Source First Name

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1**	**AN**	**1/25**

SITUATIONAL RULE: ***Required when NM102 is "1" and the identifier in 2100A NM109 and Last Name in 2100A NM103 and First Name in 2100A NM104 and Name Suffix in 2100A NM107 if sent, are not sufficient to identify the source of eligibility or benefit information. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: 271B1_2100A_NM105__InformationSourceMiddleName

IMPLEMENTATION NAME: Information Source Middle Name

NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**1**	**AN**	**1/10**

SITUATIONAL RULE: ***Required when NM102 is "1" and the identifier in 2100A NM109 and Last Name in 2100A NM103 and First Name in 2100A NM104 and Middle Name in 2100A NM105 if sent, are not sufficient to identify the source of eligibility or benefit information. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2100A_NM107__InformationSourceNameSuffix**

IMPLEMENTATION NAME: **Information Source Name Suffix**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**1**	**ID**	**1/2**

SYNTAX: P0809

OD: **271B1_2100A_NM108__IdentificationCodeQualifier**

Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Use code value "XX" if the information source is a provider and the CMS National Provider Identifier is mandated for use. Otherwise one of the other appropriate code values may be used.

CODE	DEFINITION
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	**Centers for Medicare and Medicaid Services PlanID** CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**1**	**AN**	**2/80**

SYNTAX: P0809

OD: **271B1_2100A_NM109__InformationSourcePrimaryIdentifier**

IMPLEMENTATION NAME: **Information Source Primary Identifier**

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**1**	**AN**	**1/60**

SEGMENT DETAIL

PER - INFORMATION SOURCE CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

X12 Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

Loop: **2100A — INFORMATION SOURCE NAME**

Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when the Information Source desires to advise the Information Receiver on how to contact the Information Source about this eligibility response. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.**

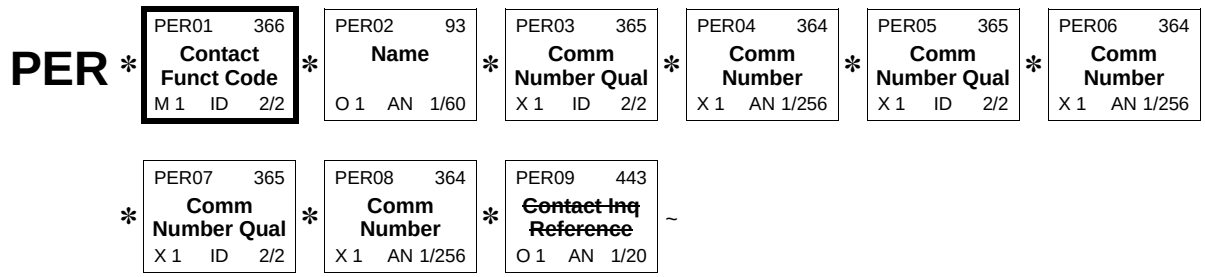
TR3 Notes:

1. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**
2. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

TR3 Example: **PER*IC*MEMBER SERVICES*TE*8005551654*FX*2128769304~**

TR3 Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**

OD: **271B1_2100A_PER01__ContactFunctionCode**

Use this code to specify the type of person or group to which the contact number applies.

CODE	DEFINITION
IC	**Information Contact**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**

SITUATIONAL RULE: ***Required when it is necessary to identify an individual or other contact point to discuss information related to this transaction. If not required by this implementation guide, do not send.***

OD: **271B1_2100A_PER02__InformationSourceContactName**

IMPLEMENTATION NAME: **Information Source Contact Name**

Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1 ID 2/2**

SYNTAX: P0304

SITUATIONAL RULE: ***Required when a contact communication number, e-mail or Web address is to be transmitted. If not required by this implementation guide, do not send.***

OD: **271B1_2100A_PER03__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**

			FX	**Facsimile**			
			TE	**Telephone**			
			UR	**Uniform Resource Locator (URL)**			
SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1**	**AN**	**1/256**

SYNTAX: P0304

SITUATIONAL RULE: ***Required when PER02 is not present or when a contact number, e-mail or Web address is to be sent in addition to the contact name. If not required by this implementation guide, do not send.***

OD:
271B1_2100A_PER04__InformationSourceCommunicationNumber

IMPLEMENTATION NAME: **Information Source Communication Number**

Use this for the communication number or URL as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1**	**ID**	**2/2**

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: **271B1_2100A_PER05__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**

SITUATIONAL **PER06** **364** **Communication Number** **X 1 AN 1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2100A_PER06__InformationSourceCommunicationNumber

IMPLEMENTATION NAME: **Information Source Communication Number**

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

SITUATIONAL **PER07** **365** **Communication Number Qualifier** **X 1 ID 2/2**
Code identifying the type of communication number

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: **271B1_2100A_PER07__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**1**	**AN** **1/256**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2100A_PER08__InformationSourceCommunicationNumber

IMPLEMENTATION NAME: **Information Source Communication Number**

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**1**	**AN** **1/20**

SEGMENT DETAIL

AAA - REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2100A — INFORMATION SOURCE NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

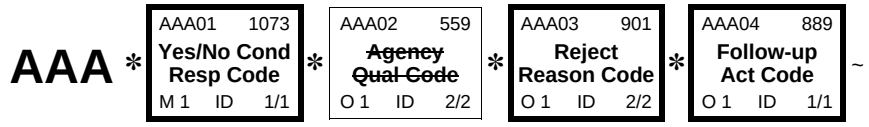
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to the information source data contained in the original 270 transaction's information source name loop (Loop 2100A) or to indicate that the information source itself is experiencing system problems and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to the information source data contained in the original 270 transaction's information source name loop (Loop 2100A) or to indicate that the information source itself is experiencing system problems.**

TR3 Example: **AAA*Y**42*Y~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1 ID 1/1**

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

OD: 271B1_2100A_AAA01__ValidRequestIndicator

IMPLEMENTATION NAME: Valid Request Indicator

CODE	DEFINITION
N	**No**
	Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.

			Y	**Yes**			
				Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.			
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**		**O 1**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection		**O 1**	**ID**	**2/2**
			OD: **271B1_2100A_AAA03__RejectReasonCode**				
			Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.				

CODE	DEFINITION
04	**Authorized Quantity Exceeded**
	Use this code to indicate that the transaction exceeds the number of patient requests allowed by the Information Source identified in Loop 2100A. See section 1.4.3 Batch and Real Time for more information regarding the number of patient requests allowed in a transaction.
41	**Authorization/Access Restrictions**
	Use this code to indicate that the entity identified in ISA06 or GS02 is not authorized to submit 270 transactions to the Information Source Identified in Loop 2100A.
42	**Unable to Respond at Current Time**
	Use this code to indicate that Information Source Identified in Loop 2100A is unable to process the transaction at the current time. This indicates that there is a problem within the Information Source's system.
79	**Invalid Participant Identification**
	Use this code to indicate that Information Source Identified in Loop 2100A is invalid. If the transaction is processed by a clearing house, VAN, etc., use this code to indicate that the Information Source Identified in Loop 2100A is not a valid identifier for Information Sources the clearing house, VAN, etc. have access to. If the transaction is sent directly to the Information Source, use this code to indicate that the Information Source Identified in Loop 2100A is not a valid identifier.
80	**No Response received - Transaction Terminated**
	Use this code only if the transaction is processed by a clearing house, VAN, etc. Use this code to indicate that the transaction was sent to the Information Source identified in Loop 2100A however no response was received in the expected time frame. **This code must not be used by the Information Source identified in Loop 2100A.**

			T4	**Payer Name or Identifier Missing**			
				Use this code to indicate that either the name or identifier for Information Source Identified in Loop 2100A is missing.			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2100A_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				

CODE	DEFINITION
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**

SEGMENT DETAIL

HL - INFORMATION RECEIVER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000B — INFORMATION RECEIVER LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required unless the 271 response contains an AAA segment in loop 2000A or 2100A. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

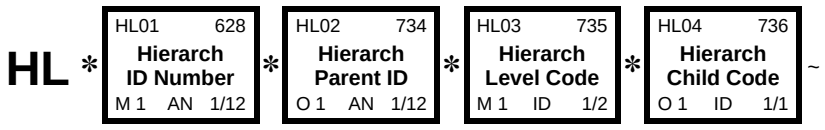
   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information

TR3 Example: **HL*2*1*21*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **OD: 271B1_2000B_HL01__HierarchicalIDNumber** **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~**	**M 1 AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. **OD: 271B1_2000B_HL02__HierarchicalParentIDNumber** **Use this ID number to identify the specific Information Source to which this Information Receiver is subordinate.**	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: 271B1_2000B_HL03__HierarchicalLevelCode

All data that follows this HL segment is associated with the Information Receiver identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: 271B1_2000B_HL04__HierarchicalChildCode

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - INFORMATION RECEIVER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100B — INFORMATION RECEIVER NAME Loop Repeat: 1**

Segment Repeat: **1**

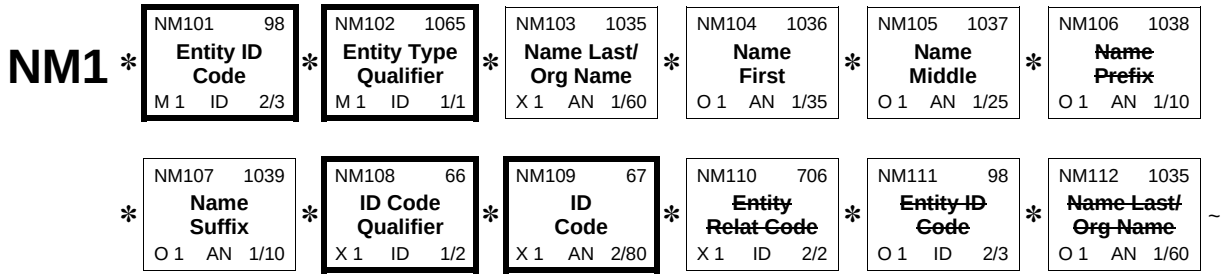
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility/benefit information receiver (e.g., provider, medical group, IPA, or hospital).**

TR3 Example: **NM1*1P*1*JONES*MARCUS***MD*34*111223333~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **271B1_2100B_NM101__EntityIdentifierCode**

CODE	DEFINITION
1P	**Provider**
2B	**Third-Party Administrator**
36	**Employer**
80	**Hospital**
FA	**Facility**

			GP	**Gateway Provider**			
			P5	**Plan Sponsor**			
			PR	**Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity		**M 1**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

OD: 271B1_2100B_NM102__EntityTypeQualifier

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name		**X 1**	**AN**	**1/60**

SYNTAX: C1203

SITUATIONAL RULE: ***Required when this information was used from the 270 transaction to identify the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD:
271B1_2100B_NM103__InformationReceiverLastorOrganizationName

IMPLEMENTATION NAME: Information Receiver Last or Organization Name

Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name		**O 1**	**AN**	**1/35**

SITUATIONAL RULE: ***Required when this information was used from the 270 transaction to identify the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1_2100B_NM104__InformationReceiverFirstName

IMPLEMENTATION NAME: Information Receiver First Name

Use this name only if NM102 is "1".

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**1**	**AN**	**1/25**

SITUATIONAL RULE: ***Required when this information was used from the 270 transaction to identify the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1_2100B_NM105__InformationReceiverMiddleName

IMPLEMENTATION NAME: Information Receiver Middle Name

Use this name only if NM102 is "1".

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**1**	**AN**	**1/10**

SITUATIONAL RULE: ***Required when this information was used from the 270 transaction to identify the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1_2100B_NM107__InformationReceiverNameSuffix

IMPLEMENTATION NAME: Information Receiver Name Suffix

Use name suffix only if NM102 is "1"; e.g., Sr., Jr., or III.

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**1**	**ID**	**1/2**

SYNTAX: P0809

OD: 271B1_2100B_NM108__IdentificationCodeQualifier

Use this element to qualify the identification number submitted in NM109. This is the number that the information source associates with the information receiver. Because only one number can be submitted in NM109, the following hierarchy must be used. Additional identifiers are to be placed in the REF segment. If the information receiver is a provider and the National Provider ID is mandated for use and the provider is a covered health care provider under the mandate, code value "XX" must be used. Otherwise, one of the following codes may be used with the following hierarchy applied: Use the first code that applies: "SV", "PP", "FI", "34". The code "SV" is recommended to be used prior to the mandated use of the National Provider ID. If the information receiver is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, use code value "PI". If the information receiver is an employer, use code value "24".

CODE	DEFINITION
24	**Employer's Identification Number** **Use this code only when the 270/271 transaction sets are used by an employer inquiring about eligibility and benefits of their employees.**

			34	**Social Security Number**			
				The social security number may not be used for any Federally administered programs such as Medicare.			
			FI	**Federal Taxpayer's Identification Number**			
			PI	**Payor Identification**			
				Use this code only when the information receiver is a payer.			
			PP	**Pharmacy Processor Number**			
			SV	**Service Provider Number**			
				Use this code for the identification number assigned by the information source.			
			XV	**Centers for Medicare and Medicaid Services PlanID** CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID			
			XX	**Centers for Medicare and Medicaid Services National Provider Identifier** CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 OD: **271B1_2100B_NM109__InformationReceiverIdentificationNumber** IMPLEMENTATION NAME: **Information Receiver Identification Number**		**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**		**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**		**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**		**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - INFORMATION RECEIVER ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2100B — INFORMATION RECEIVER NAME**

Segment Repeat: **9**

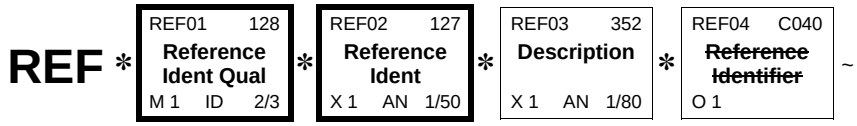
Usage: **SITUATIONAL**

Situational Rule: **Required when this information was used from the 270 transaction to identify the Information Receiver. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:
1. **Use this segment when needed to convey other or additional identification numbers for the information receiver. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100B loop.**

TR3 Example: **REF*EO*477563928~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **271B1_2100B_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Only one occurrence of each REF01 code value may be used in the 2100B loop.

CODE	DEFINITION
0B	**State License Number**
	The state assigning the license number must be identified in REF03.
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	**Centers for Medicare and Medicaid Services National Provider Identifier**			
				The Centers for Medicare and Medicaid Services National Provider Identifier may be used in this segment prior to being mandated for use.			
				CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier			
			JD	**User Identification**			
			N5	**Provider Plan Network Identification Number**			
			N7	**Facility Network Identification Number**			
			Q4	**Prior Identifier Number**			
			SY	**Social Security Number**			
				The social security number may not be used for any Federally administered programs such as Medicare.			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification**		**X**	**1**	**AN** **1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			SYNTAX: R0203				
			OD: **271B1_2100B_REF02__InformationReceiverAdditionalIdentifier**				
			IMPLEMENTATION NAME: **Information Receiver Additional Identifier**				
			Use this information for the reference number as qualified by the preceding data element (REF01).				
SITUATIONAL	**REF03**	**352**	**Description**		**X**	**1**	**AN** **1/80**
			A free-form description to clarify the related data elements and their content				
			SYNTAX: R0203				
			SITUATIONAL RULE: ***Required when REF01 = "0B". If not required by this implementation guide, do not send.***				
			OD: **271B1_2100B_REF03__InformationReceiverAdditionalIdentifierState**				
			IMPLEMENTATION NAME: **Information Receiver Additional Identifier State**				
			Use this element for the two character state code of the state assigning the identifier supplied in REF02. **See Code source 22: States and Outlying Areas of the U.S.**				
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**	**1**	

SEGMENT DETAIL

AAA - INFORMATION RECEIVER REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2100B — INFORMATION RECEIVER NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

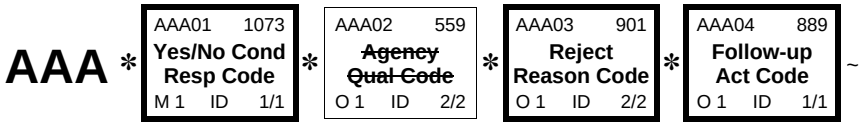
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to the information receiver data contained in the original 270 transaction's information receiver name loop (Loop 2100B) and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to the information receiver data contained in the original 270 transaction's information receiver name loop (Loop 2100B).**

TR3 Example: **AAA*N**43*C~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1 ID 1/1**

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

OD: 271B1_2100B_AAA01__ValidRequestIndicator

IMPLEMENTATION NAME: Valid Request Indicator

CODE	DEFINITION
N	**No**
	Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.

			Y	**Yes**			
				Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.			
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**		**O 1**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection		**O 1**	**ID**	**2/2**
			OD: **271B1_2100B_AAA03__RejectReasonCode**				
			Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.				

CODE	DEFINITION
15	**Required application data missing**
	Use this code only when the information receiver's additional identification is 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**
	Use this code only when the information receiver is not a provider or payer.
97	**Invalid or Missing Provider Address**
T4	**Payer Name or Identifier Missing**
	Use this code only when the information receiver is a payer.

REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2100B_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				

CODE	DEFINITION
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**

SEGMENT DETAIL

PRV - INFORMATION RECEIVER PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: **1. P0203**
If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100B — INFORMATION RECEIVER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

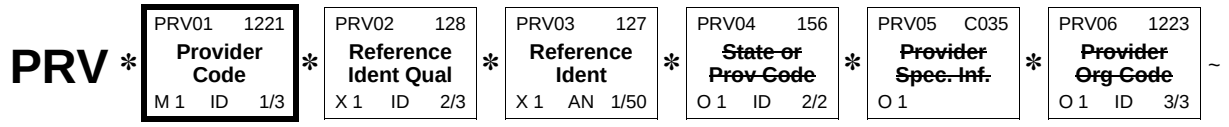
Situational Rule: **Required when the 270 request contained a 2100B PRV segment and the information contained in the PRV segment was used to determine the 271 response. If not required by this implementation guide, do not send.**

TR3 Notes: **1. This segment is used to convey additional information about a provider's role in the eligibility/benefit being inquired about and who is also the Information Receiver. For example, if the Information Receiver is also the Referring Provider, this PRV segment would be used to identify the provider's role. This PRV segment applies to all benefits returned for this Information Receiver unless overridden by a PRV segment in the 2100C, 2120C, 2100D or 2120D loops.**

2. PRV02 qualifies PRV03.

TR3 Example: **PRV*RF*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **271B1_2100B_PRV01__ProviderCode**

CODE	DEFINITION
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**			
SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 SITUATIONAL RULE: ***Required when the 270 request contained a 2100B PRV segment and the information contained in PRV02 and PRV03 was used to determine the 271 response. If not required by this implementation guide, do not send.*** OD: **271B1_2100B_PRV02__ReferenceIdentificationQualifier**	**X 1**	**ID**	**2/3**
			CODE / DEFINITION **PXC** — **Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy			
SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when the 270 request contained a 2100B PRV segment and the information contained in PRV02 and PRV03 was used to determine the 271 response. If not required by this implementation guide, do not send.*** OD: **271B1_2100B_PRV03__ReceiverProviderSpecialtyCode** IMPLEMENTATION NAME: **Receiver Provider Specialty Code** **Use this number for the reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

HL - SUBSCRIBER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000C — SUBSCRIBER LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required unless the 271 response contains an AAA segment in loop 2000A, 2100A or 2100B. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

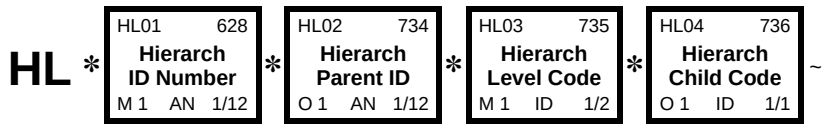
2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information

   The above example shows 2 different Subscribers. The first Subscriber is not the patient, only the dependent is the patient. The second Subscriber is a patient and the Dependent is also a patient.

TR3 Example: **HL*3*2*22*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HL01	628	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. OD: **271B1_2000C_HL01__HierarchicalIDNumber** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~** **HL*3*2*22*1~** **NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~** **HL*4*3*23*0~** **NM1*03*1*SMITH*MARY*LOU~** **Eligibility/Benefit Data** **HL*5*2*22*0~** **NM1*IL*1*BROWN*JOHN*E***MI*22211333301~** **Eligibility/Benefit Data** **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).**	M 1 AN 1/12
REQUIRED	HL02	734	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. OD: **271B1_2000C_HL02__HierarchicalParentIDNumber** **Use this ID number to identify the specific Information Receiver to which this Subscriber is subordinate.**	O 1 AN 1/12

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: **271B1_2000C_HL03__HierarchicalLevelCode**

All data that follows this HL segment is associated with the Subscriber identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
22	**Subscriber**
	Use the subscriber level to identify the insured or subscriber of the health care coverage. This entity may or may not be the actual patient.

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **271B1_2000C_HL04__HierarchicalChildCode**

Because of the hierarchical structure, the code value in the HL04 at the Loop 2000C level should be “1" if a Loop 2000D level (dependent) is associated with this subscriber. If no Loop 2000D level exists for this subscriber, then the code value for HL04 should be ”0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

TRN - SUBSCRIBER TRACE NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

X12 Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

Loop: **2000C — SUBSCRIBER LEVEL**

Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when the 270 request contained one or two TRN segments and the subscriber is the patient (See Section 1.4.2.). One TRN segment for each TRN submitted in the 270 must be returned.**
OR
Required when the Information Source needs to return a unique trace number for the current transaction.
If not required by this implementation guide, do not send.

TR3 Notes:

1. **An information source may receive up to two TRN segments in each loop 2000C of a 270 transaction and must return each of them in loop 2000C of the 271 transaction unless the person submitted in loop 2000C is determined to be a dependent, then the TRN segments must be returned in loop 2000D. See Section 1.4.2. The returned TRN segments will have a value of “2” in TRN01. See Section 1.4.6 Information Linkage for additional information.**

2. **If the subscriber is the patient, an information source may add one TRN segment to loop 2000C with a value of “1" in TRN01 and must identify themselves in TRN03.**

3. **This segment must not be used if the subscriber is not the patient. See section 1.4.2. Basic Concepts.**

4. **If this transaction passes through a clearinghouse, the clearinghouse will receive from the information source the information receiver’s TRN segment and the clearinghouse’s TRN segment with a value of “2" in TRN01. Since the ultimate destination of the transaction is the information receiver, if the clearinghouse intends on passing their TRN segment to the information receiver, the clearinghouse must change the value in TRN01 to ”1" of their TRN segment. This must be done since the trace number in the clearinghouse’s TRN segment is not actually a referenced transaction trace number to the information receiver.**

5. **The trace number in the 271 transaction TRN02 must be returned exactly as submitted in the 270 transaction. For example, if the 270 transaction TRN02 was 012345678 it must be returned as 012345678 and not as 12345678.**

TR3 Example:

TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*2*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

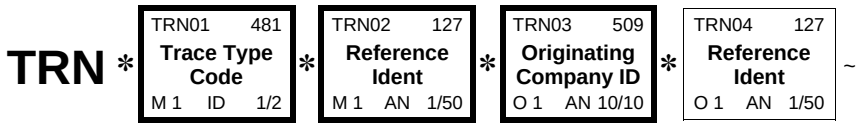
The above example represents how an information source would respond. The first TRN segment was initiated by the information receiver. The second TRN segment was initiated by the clearinghouse. The third TRN segment was initiated by the information source.

TR3 Example:

TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how a clearinghouse would respond to the same set of TRN segments if the clearinghouse intends to pass their TRN segment on to the information receiver. If the clearinghouse does not intend to pass their TRN segment on to the information receiver, only the first and third TRN segments in the example would be sent.

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M 1 ID 1/2**

OD: **271B1_2000C_TRN01__TraceTypeCode**

CODE	DEFINITION
1	**Current Transaction Trace Numbers**
	The term "Current Transaction Trace Numbers" refers to trace or reference numbers assigned by the creator of the 271 transaction (the information source). **If a clearinghouse has assigned a TRN segment and intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to "1" (since it will be returned by the information source as a "2").**

2 **Referenced Transaction Trace Numbers**

The term "Referenced Transaction Trace Numbers" refers to trace or reference numbers originally sent in the 270 transaction and now returned in the 271.

REQUIRED **TRN02** **127** **Reference Identification** **M 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN02 provides unique identification for the transaction.

OD: **271B1_2000C_TRN02__TraceNumber**

IMPLEMENTATION NAME: **Trace Number**

This element must contain the trace number submitted in TRN02 from the 270 transaction and must be returned exactly as submitted.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O 1 AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SEMANTIC: TRN03 identifies an organization.

OD: **271B1_2000C_TRN03__TraceAssigningEntityIdentifier**

IMPLEMENTATION NAME: **Trace Assigning Entity Identifier**

If TRN01 is "1", use this information to identify the organization that assigned this trace number.

If TRN01 is "2", this is the value received in the original 270 transaction.

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL **TRN04** **127** **Reference Identification** **O 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

SITUATIONAL RULE: ***Required when TRN01 = "2" and this element was used in the corresponding 270 TRN segment.***
OR
Required when TRN01 = "1" and the Information Source needs to further identify a specific component, such as a specific division or group of the entity identified in the previous data element (TRN03). If not required by this implementation guide, do not send.

OD: **271B1_2000C_TRN04__TraceAssigningEntityAdditionalIdentifier**

IMPLEMENTATION NAME: **Trace Assigning Entity Additional Identifier**

SEGMENT DETAIL

NM1 - SUBSCRIBER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100C — SUBSCRIBER NAME Loop Repeat: 1**

Segment Repeat: **1**

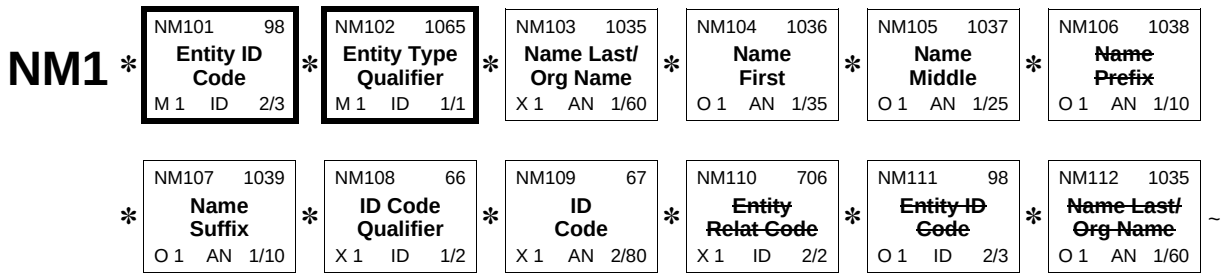
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the insured or subscriber.**

TR3 Example: **NM1*IL*1*SMITH*JOHN*L***MI*44411555501~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **271B1_2100C_NM101__EntityIdentifierCode**

CODE	DEFINITION
IL	**Insured or Subscriber**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. OD: **271B1_2100C_NM102__EntityTypeQualifier** CODE / DEFINITION **1** **Person**	**M 1**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_NM103__SubscriberLastName** IMPLEMENTATION NAME: **Subscriber Last Name** **Use this name for the subscriber's last name.**	**X 1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_NM104__SubscriberFirstName** IMPLEMENTATION NAME: **Subscriber First Name** **Use this name for the subscriber's first name.**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100C_NM105__SubscriberMiddleNameorInitial** IMPLEMENTATION NAME: **Subscriber Middle Name or Initial** **Use this name for the subscriber's middle name or initial.**	**O 1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**

SITUATIONAL **NM107** **1039** **Name Suffix** **O 1 AN 1/10**
Suffix to individual name

SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2100C_NM107__SubscriberNameSuffix**

IMPLEMENTATION NAME: **Subscriber Name Suffix**

Use this for the suffix to an individual's name; e.g., Sr., Jr., or III.

SITUATIONAL **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request.***
If not required by this implementation guide, do not send.

OD: **271B1_2100C_NM108__IdentificationCodeQualifier**

Use this element to qualify the identification number submitted in NM109. This is the primary number that the information source associates with the subscriber.

CODE	DEFINITION
II	**Standard Unique Health Identifier for each Individual in the United States**
	Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services may adopt a standard individual identifier for use in this transaction.
MI	**Member Identification Number**
	This code may only be used prior to the mandated use of code "II". This is the unique number the payer or information source uses to identify the insured (e.g., Health Insurance Claim Number, Medicaid Recipient ID Number, HMO Member ID, etc.).

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_NM109__SubscriberPrimaryIdentifier** IMPLEMENTATION NAME: **Subscriber Primary Identifier** **Use this code for the reference number as qualified by the preceding data element (NM108).**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - SUBSCRIBER ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **9**

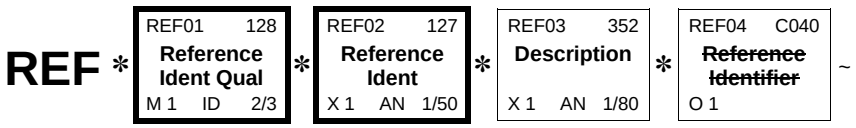
Usage: **SITUATIONAL**

Situational Rule: **Required when the Information Source requires additional identifiers necessary to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7);**
OR
Required when the 270 request contained a REF segment with a Patient Account Number in Loop 2100C/REF02 with REF01 equal EJ;
OR
Required when the 270 request contained a REF segment and the information provided in that REF segment was used to locate the individual in the information source's system (See Section 1.4.7).
If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.

TR3 Notes:
1. **If the 270 request contained a REF segment with a Patient Account Number in REF02 with REF01 equal EJ, then it must be returned in the 271 transaction using this segment if the patient is the Subscriber. The Patient Account Number in the 271 transaction must be returned exactly as submitted in the 270 transaction.**
2. **Use this segment to supply an identification number other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100C loop.**
3. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

TR3 Example: **REF*EJ*660415~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **271B1_2100C_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Only one occurrence of each REF01 code value may be used in the 2100C loop.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes IG or 6P when they can be determined.
1W	**Member Identification Number**
	Use only if Loop 2100C NM108 contains II, and is prior to the mandated use of the HIPAA Unique Patient Identifier.
3H	**Case Number**
49	**Family Unit Number**
	Required when the Information Source is a Pharmacy Benefit Manager (PBM) and the individual has a suffix to their member ID number that is required for use in the NCPDP Telecom Standard in the Insurance Segment in field 303-C3 Person Code. If not required by this implementation Guide, do not send. **NOTE: For all other uses, the Family Unit Number (suffix) is considered a part of the Member ID number and is used to uniquely identify the individual and must be returned at the end of the Member ID number in 2100C NM109 or in 2100C REF02 if REF01 is "1W".**
6P	**Group Number**

CT	**Contract Number**
	This code is to be used only to identify the provider's contract number of the provider identified in the PRV segment of Loop 2100C. This code is only to be used once the CMS National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.
EA	**Medical Record Identification Number**
EJ	**Patient Account Number**
F6	**Health Insurance Claim (HIC) Number**
	See segment note 3.
GH	**Identification Card Serial Number**
	Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.
HJ	**Identity Card Number**
	Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.
IF	**Issue Number**
IG	**Insurance Policy Number**
N6	**Plan Network Identification Number**
NQ	**Medicaid Recipient Identification Number**
	See segment note 3.
Q4	**Prior Identifier Number**
	This code is to be used when a corrected or new identification number is returned in NM109, the originally submitted identification number is to be returned in REF02. To be used in conjunction with code "001" in INS03 and code "25" in INS04.
SY	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
Y4	**Agency Claim Number**
	This code is to only to be used when the information source is a Property and Casualty payer. Use this code to identify the Property and Casualty Claim Number associated with the subscriber. This code is not a HIPAA requirement as of this writing.

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 271B1_2100C_REF02__SubscriberSupplementalIdentifier** **IMPLEMENTATION NAME: Subscriber Supplemental Identifier** **Use this information for the reference number as qualified by the preceding data element (REF01).** **If REF01 is "EJ", the Patient Account Number from the 270 transaction must be returned exactly as submitted.**	**X 1**	**AN**	**1/50**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content **SYNTAX:** R0203 **SITUATIONAL RULE:** ***Required when REF01 = "18", "6P" or "N6" and a name needs to be associated with the corresponding identifier. If not required by this implementation guide, do not send.*** **OD: 271B1_2100C_REF03__PlanGrouporPlanNetworkName** **IMPLEMENTATION NAME: Plan, Group or Plan Network Name**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

N3 - SUBSCRIBER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

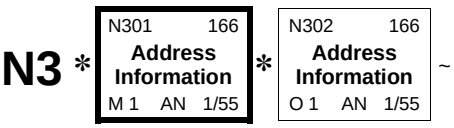
Situational Rule: **Required when the Subscriber is the patient or when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Do not return address information from the 270 request.**
2. **Use this segment to identify address information for a subscriber.**

TR3 Example: **N3*15197 BROADWAY AVENUE*APT 215~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **271B1_2100C_N301__SubscriberAddressLine**	
			IMPLEMENTATION NAME: **Subscriber Address Line**	
			Use this information for the first line of the address information.	

SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**1**	**AN**	**1/55**

SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2100C_N302__SubscriberAddressLine**

IMPLEMENTATION NAME: **Subscriber Address Line**

Use this information for the second line of the address information.

SEGMENT DETAIL

N4 - SUBSCRIBER CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

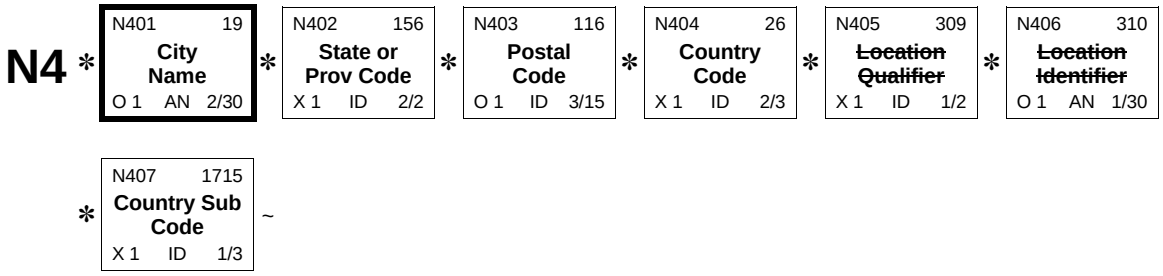
Situational Rule: **Required when the Subscriber is the patient or when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Do not return address information from the 270 request.**
2. **Use this segment to identify address information for a subscriber.**

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. OD: **271B1_2100C_N401__SubscriberCityName** IMPLEMENTATION NAME: **Subscriber City Name**	**O 1 AN 2/30**
SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_N402__SubscriberStateCode** IMPLEMENTATION NAME: **Subscriber State Code** CODE SOURCE **22:** States and Provinces	**X 1 ID 2/2**
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_N403__SubscriberPostalZoneorZIPCode** IMPLEMENTATION NAME: **Subscriber Postal Zone or ZIP Code** CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes	**O 1 ID 3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_N404__SubscriberCountryCode** IMPLEMENTATION NAME: **Subscriber Country Code** CODE SOURCE **5:** Countries, Currencies and Funds **Use the alpha-2 country codes from Part 1 of ISO 3166.**	**X 1 ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X 1 ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1 AN 1/30**

SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD: 271B1_2100C_N407__SubscriberCountrySubdivisionCode

IMPLEMENTATION NAME: Subscriber Country Subdivision Code

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

AAA - SUBSCRIBER REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

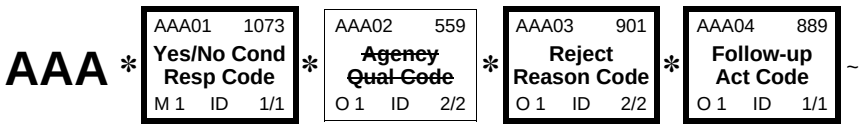
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to the data contained in the original 270 transaction's subscriber name loop (Loop 2100C) and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's subscriber name loop (Loop 2100C).**

TR3 Example: **AAA*N**72*C~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid. OD: **271B1_2100C_AAA01__ValidRequestIndicator** IMPLEMENTATION NAME: **Valid Request Indicator**	**M 1 ID 1/1**
			CODE / **DEFINITION** **N** — **No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.** **Y** — **Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**	
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O 1 ID 2/2**

REQUIRED **AAA03** **901** **Reject Reason Code** **O 1 ID 2/2**

Code assigned by issuer to identify reason for rejection

OD: **271B1_2100C_AAA03__RejectReasonCode**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

Use codes "43", "45", "47", "48", or "51" only in response to information that is in or should be in the PRV segment in the Subscriber Name loop (2100C).

See section 1.4.8 Search Options for data content criteria for the subscriber.

CODE	DEFINITION
15	Required application data missing
35	Out of Network
	Use this code to indicate that the subscriber is not in the Network of the provider identified in the 2100B NM1 segment, or the 2100B/2100CPRV segment if present in the 270 transaction.
42	Unable to Respond at Current Time
	Use this code in a batch environment where an information source returns all requests from the 270 in the 271 and identifies "Unable to Respond at Current Time" for each individual request (subscriber or dependent) within the transaction that they were unable to process for reasons other than data content (such as their system is down or timed out when generating a response).
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
	Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.
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

			71	**Patient Birth Date Does Not Match That for the Patient on the Database**			
				Code 71 must be returned when the transaction was rejected when the information source located an individual based other information submitted, but the Birth Date does not match.			
			72	**Invalid/Missing Subscriber/Insured ID**			
				Required when the transaction was rejected when the information source cannot find a match for the Subscriber/Insured ID number submitted or if the ID submitted was missing or formatted incorrectly.			
			73	**Invalid/Missing Subscriber/Insured Name**			
				Required when the transaction was rejected when the information source cannot find a match for the Subscriber Name submitted or if the Subscriber Name was missing.			
			74	**Invalid/Missing Subscriber/Insured Gender Code**			
			75	**Subscriber/Insured Not Found**			
				Code 75 may not be returned if the information receiver submitted all four pieces of the mandated search option.			
			76	**Duplicate Subscriber/Insured ID Number**			
			78	**Subscriber/Insured Not in Group/Plan Identified**			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2100C_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				

CODE	DEFINITION
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**
	Use only when AAA03 is “42".

SEGMENT DETAIL

PRV - PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax:

1. **P0203**
   If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

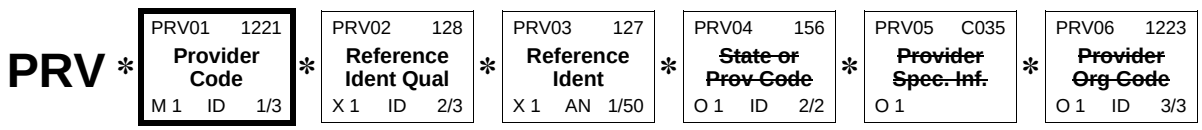
Situational Rule: **Required when the 270 request contained a 2100C PRV segment and the information contained in the PRV segment was used to determine the 271 response.;**
OR
Required when needed either to identify a specific provider or to associate a specialty type related to the service identified in the 2110C loops. This PRV segment applies to all benefits in this 2100C loop unless overridden by a PRV segment in the 2120C loop.
If not required by this implementation guide, do not send.

TR3 Notes:

1. **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. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
2. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
3. **If identifying a type of specialty associated with the services identified in loop 2110C, use code PXC in PRV02 and the appropriate code in PRV03.**
4. **PRV02 qualifies PRV03.**
5. **If there is a PRV segment in 2100B, this PRV overrides it for this occurrence of the 2100C loop.**

TR3 Example: **PRV*RF*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **271B1_2100C_PRV01__ProviderCode**

CODE	DEFINITION
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**
SK	**Skilled Nursing Facility**
SU	**Supervising**

SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X 1 ID 2/3**

SYNTAX: P0203

SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_PRV02__ReferenceIdentificationQualifier**

CODE	DEFINITION
PXC	**Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy

SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** P0203 **SITUATIONAL RULE:** ***Required when needed to identify a provider's specialty type. If not required by this implementation guide, do not send.*** **OD: 271B1_2100C_PRV03__ProviderIdentifier** **IMPLEMENTATION NAME: Provider Identifier** **Use this number for the reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

DMG - SUBSCRIBER DEMOGRAPHIC INFORMATION

X12 Segment Name: Demographic Information

X12 Purpose: To supply demographic information

X12 Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.
2. **P1011**
   If either DMG10 or DMG11 is present, then the other is required.
3. **C1105**
   If DMG11 is present, then DMG05 is required.

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

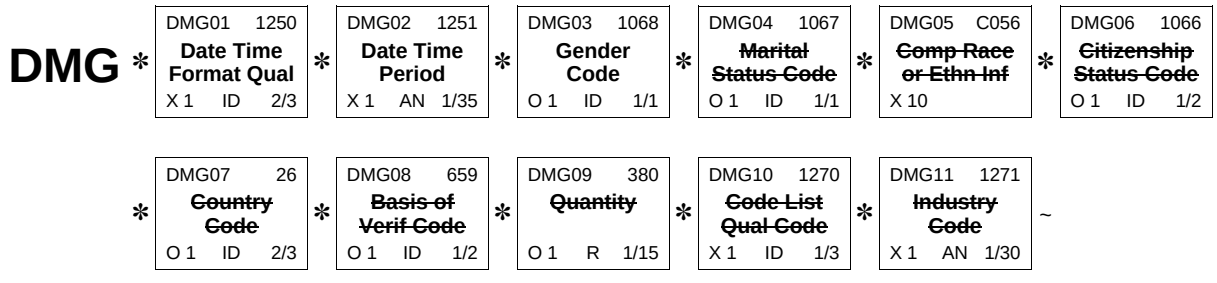
Situational Rule: **Required when the Subscriber is the patient or when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated with a 2100C or 2110C AAA segment and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Use this segment to convey the birth date or gender demographic information for the subscriber.**

TR3 Example: **DMG*D8*19430917*M~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 SITUATIONAL RULE: ***Required when Subscriber Birth Date is sent in DMG02. If not required by this implementation guide, do not send.*** OD: **271B1_2100C_DMG01__DateTimePeriodFormatQualifier** **Use this code to indicate the format of the date of birth that follows in DMG02.** CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**X 1 ID 2/3**
SITUATIONAL	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. SITUATIONAL RULE: ***Required when the Subscriber is the patient or when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated with a 2100C or 2110C AAA segment and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100C_DMG02__SubscriberBirthDate** IMPLEMENTATION NAME: **Subscriber Birth Date** **Use this date for the date of birth of the subscriber.**	**X 1 AN 1/35**
SITUATIONAL	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100C_DMG03__SubscriberGenderCode** IMPLEMENTATION NAME: **Subscriber Gender Code** CODE / DEFINITION **F** — **Female** **M** — **Male** **U** — **Unknown**	**O 1 ID 1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O 1 ID 1/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X 10**

NOT USED	DMG06	1066	Citizenship Status Code	O	1	ID	1/2
NOT USED	DMG07	26	Country Code	O	1	ID	2/3
NOT USED	DMG08	659	Basis of Verification Code	O	1	ID	1/2
NOT USED	DMG09	380	Quantity	O	1	R	1/15
NOT USED	DMG10	1270	Code List Qualifier Code	X	1	ID	1/3
NOT USED	DMG11	1271	Industry Code	X	1	AN	1/30

SEGMENT DETAIL

INS - SUBSCRIBER RELATIONSHIP

X12 Segment Name: Insured Benefit

X12 Purpose: To provide benefit information on insured entities

X12 Syntax: **1. P1112**
If either INS11 or INS12 is present, then the other is required.

Loop: **2100C — SUBSCRIBER NAME**

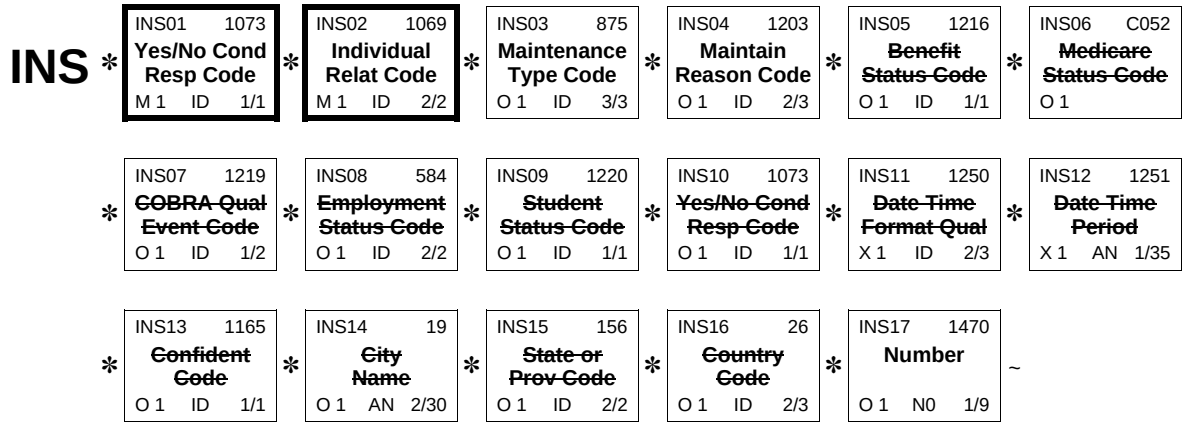
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when acknowledging a change in the identifying elements for the subscriber from those submitted in the 270 or the Birth Sequence Number submitted in INS17 of the 270 was used to locate the Subscriber. If not required by this implementation guide, do not send.**

TR3 Example: **INS*Y*18*001*25~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1 ID 1/1**

SEMANTIC: INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent.

OD: 271B1_2100C_INS01__InsuredIndicator

IMPLEMENTATION NAME: Insured Indicator

CODE	DEFINITION
Y	**Yes**

REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**M 1**	**ID**	**2/2**

OD: **271B1_2100C_INS02__IndividualRelationshipCode**

CODE	DEFINITION
18	**Self**

SITUATIONAL	**INS03**	**875**	**Maintenance Type Code** Code identifying the specific type of item maintenance	**O 1**	**ID**	**3/3**

SITUATIONAL RULE: ***Required along with INS04 when acknowledging a change in the identifying elements for the subscriber from those submitted in the 270. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_INS03__MaintenanceTypeCode**

CODE	DEFINITION
001	**Change**

SITUATIONAL	**INS04**	**1203**	**Maintenance Reason Code** Code identifying the reason for the maintenance change	**O 1**	**ID**	**2/3**

SITUATIONAL RULE: ***Required along with INS03 when acknowledging a change in the identifying elements for the subscriber from those submitted in the 270. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_INS04__MaintenanceReasonCode**

CODE	DEFINITION
25	**Change in Identifying Data Elements**
	Use this code to indicate that a change has been made to the primary elements that identify a specific person. Such elements are first name, last name, date of birth, identification numbers, and address.

NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS06**	**C052**	**MEDICARE STATUS CODE**	**O 1**		
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O 1**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS09**	**1220**	**Student Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS10**	**1073**	**Yes/No Condition or Response Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X 1**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X 1**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS14**	**19**	**City Name**	**O 1**	**AN**	**2/30**
NOT USED	**INS15**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS16**	**26**	**Country Code**	**O 1**	**ID**	**2/3**

SITUATIONAL	**INS17**	**1470**	**Number** A generic number	**O**	**1**	**N0**	**1/9**

SEMANTIC: INS17 is 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.).

SITUATIONAL RULE: ***Required when the Birth Sequence Number submitted in the 270 was used to locate the Subscriber. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1_2100C_INS17__BirthSequenceNumber

IMPLEMENTATION NAME: Birth Sequence Number

Use to indicate the birth order in the event of multiple birth's in association with the birth date supplied in DMG02.

SEGMENT DETAIL

HI - SUBSCRIBER HEALTH CARE DIAGNOSIS CODE

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

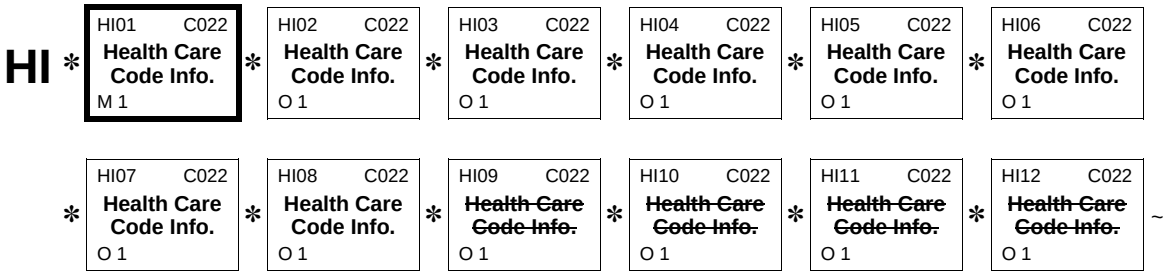
Situational Rule: **Required when an HI segment was received in the 270 and if the information source uses the information in the determination of the eligibility or benefit response for the subscriber. All information used from the HI segment of the 270 used in the determination of the eligibility or benefit response for the subscriber must be returned. If information was provided in an HI segment of 270 but was not used in the determination of the eligibility or benefits for the subscriber it must not be returned. The information source must not use information in an HI segment of the 270 transaction in the determination of eligibility or benefits for the subscriber if that information cannot be returned in the 271 response.**
OR
Required when needed to identify limitations in the benefits identified in the 2110C loops, such as if benefits are limited for a specific diagnosis code if the information source can support this high level functionality. If the information source cannot support this high level functionality, do not send.

TR3 Notes:

1. **Use the Diagnosis code pointers in 2110C EB14 to identify which diagnosis code or codes in this HI segment relates to the information provided in the EB segment.**
2. **Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.**

TR3 Example: **HI*BK:8901*BF:87200*BF:5559~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities **SYNTAX:** **P0304** If either C02203 or C02204 is present, then the other is required. **E0809** Only one of C02208 or C02209 may be present. OD: **271B1_2100C_HI01_C022** **E codes are Not Used in HI01 except when defined by the claims processor. E codes may be put in any other HI element using BF as the qualifier.** **The diagnosis listed in this element is assumed to be the principal diagnosis.**	**M 1**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SEMANTIC:** C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08. OD: **271B1_2100C_HI01_C02201_DiagnosisTypeCode** IMPLEMENTATION NAME: **Diagnosis Type Code**	**M ID 1/3**
			CODE: **ABK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	
			CODE: **BK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. OD: **271B1_2100C_HI01_C02202_DiagnosisCode** IMPLEMENTATION NAME: **Diagnosis Code**	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data element has been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI02_C022**

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI02_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI02 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI02_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI03_C022**

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI03_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI03 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI03_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI04_C022**

REQUIRED **HI04 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI04_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI04 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI04_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI05_C022**

REQUIRED **HI05 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI05_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI05 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI05_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI06_C022**

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI06_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI06_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI07_C022**

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI07_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI07_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_HI08_C022**

REQUIRED **HI08 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100C_HI08_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI08 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100C_HI08_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED **HI08 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**

NOT USED **HI08 - 4** **1251** **Date Time Period** **X** **AN** **1/35**

NOT USED **HI08 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI08 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI08 - 7** **799** **Version Identifier** **O** **AN** **1/30**

NOT USED **HI08 - 8** **1271** **Industry Code** **X** **AN** **1/30**

NOT USED **HI08 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**

NOT USED **HI09** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI10** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI11** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

SEGMENT DETAIL

DTP - SUBSCRIBER DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2100C — SUBSCRIBER NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

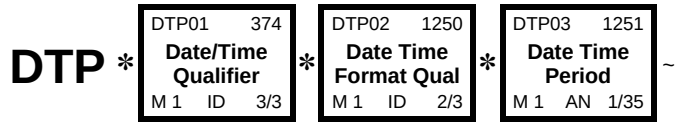
Situational Rule: **Required to identify the Plan (DTP01 = 291) or Plan Begin (DTP01 = 346) date when the individual has active coverage unless multiple plans apply to the individual or multiple plan periods apply, which must then be returned in the 2110C DTP (See Section 1.4.7);**
OR
Required when needed to identify other relevant dates that apply to the Subscriber.
If not required by this implementation guide, do not send.

TR3 Notes:

1. **The dates represented may be in the past, the current date, or a future date. The dates may also be a single date or a span of dates. Which date(s) to use is determined by the format qualifier in DTP02.**
2. **Dates supplied in the 2100C DTP apply to the Subscriber and all 2110C loops unless overridden by an occurrence of a 2110C DTP with the same value in DTP01.**

TR3 Example: **DTP*346*D8*19950818~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**

OD: **271B1_2100C_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
096	**Discharge**
102	**Issue**
152	**Effective Date of Change**
291	**Plan**

			307	**Eligibility**			
			318	**Added**			
				Information Sources are encouraged to return Added date in the case of retroactive eligibility.			
			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**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M 1**	**ID**	**2/3**

Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

OD: **271B1_2100C_DTP02__DateTimePeriodFormatQualifier**

Use this code to specify the format of the date(s)/time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M 1**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

OD: **271B1_2100C_DTP03__DateTimePeriod**

Use this date for the date(s) as qualified by the preceding data elements.

SEGMENT DETAIL

MPI - SUBSCRIBER MILITARY PERSONNEL INFORMATION

X12 Segment Name: Military Personnel Information

X12 Purpose: To report military service data

X12 Syntax: **1. P0607**
If either MPI06 or MPI07 is present, then the other is required.

Loop: **2100C — SUBSCRIBER NAME**

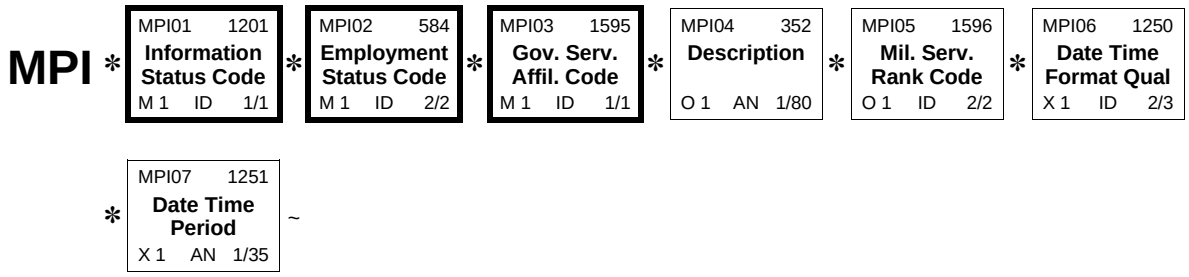
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when this transaction is processed by DOD or CHAMPUS/TRICARE and when necessary to convey the Subscriber's military service data If not required by this implementation guide, do not send.**

TR3 Example: **MPI*C*AO*A**L3~**
Current Active Military - Overseas Air Force Lieutenant Colonel

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**MPI01**	**1201**	**Information Status Code** A code to indicate the status of information	**M 1 ID 1/1**

OD: **271B1_2100C_MPI01__InformationStatusCode**

CODE	DEFINITION
A	**Partial**
C	**Current**
L	**Latest**
O	**Oldest**
P	**Prior**
S	**Second Most Current**
T	**Third Most Current**

REQUIRED **MPI02** **584** **Employment Status Code** **M 1** **ID** **2/2**
Code showing the general employment status of an employee/claimant

OD: **271B1_2100C_MPI02__EmploymentStatusCode**

CODE	DEFINITION
AE	Active Reserve
AO	Active Military - Overseas
AS	Academy Student
AT	Presidential Appointee
AU	Active Military - USA
CC	Contractor
DD	Dishonorably Discharged
HD	Honorably Discharged
IR	Inactive Reserves
LX	Leave of Absence: Military
PE	Plan to Enlist
RE	Recommissioned
RM	Retired Military - Overseas
RR	Retired Without Recall
RU	Retired Military - USA

REQUIRED **MPI03** **1595** **Government Service Affiliation Code** **M 1** **ID** **1/1**
Code specifying the government service affiliation

OD: **271B1_2100C_MPI03__GovernmentServiceAffiliationCode**

CODE	DEFINITION
A	Air Force
B	Air Force Reserves
C	Army
D	Army Reserves
E	Coast Guard
F	Marine Corps
G	Marine Corps Reserves
H	National Guard
I	Navy
J	Navy Reserves
K	Other
L	Peace Corp
M	Regular Armed Forces
N	Reserves
O	U.S. Public Health Service
Q	Foreign Military
R	American Red Cross
S	Department of Defense
U	United Services Organization
W	Military Sealift Command

SITUATIONAL **MPI04** **352** **Description** **O 1 AN 1/80**
A free-form description to clarify the related data elements and their content

SEMANTIC: MPI04 is the actual response to further identify the exact military unit.

SITUATIONAL RULE: ***Required when needed to further identify the exact military unit. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_MPI04__Description**

SITUATIONAL **MPI05** **1596** **Military Service Rank Code** **O 1 ID 2/2**
Code specifying the military service rank

SITUATIONAL RULE: ***Required when needed to indicate the current or most recent military service rank. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_MPI05__MilitaryServiceRankCode**

CODE	DEFINITION
A1	Admiral
A2	Airman
A3	Airman First Class
B1	Basic Airman
B2	Brigadier General
C1	Captain
C2	Chief Master Sergeant
C3	Chief Petty Officer
C4	Chief Warrant
C5	Colonel
C6	Commander
C7	Commodore
C8	Corporal
C9	Corporal Specialist 4
E1	Ensign
F1	First Lieutenant
F2	First Sergeant
F3	First Sergeant-Master Sergeant
F4	Fleet Admiral
G1	General
G4	Gunnery Sergeant
L1	Lance Corporal
L2	Lieutenant
L3	Lieutenant Colonel
L4	Lieutenant Commander
L5	Lieutenant General
L6	Lieutenant Junior Grade
M1	Major
M2	Major General
M3	Master Chief Petty Officer

			M4	**Master Gunnery Sergeant Major**
			M5	**Master Sergeant**
			M6	**Master Sergeant Specialist 8**
			P1	**Petty Officer First Class**
			P2	**Petty Officer Second Class**
			P3	**Petty Officer Third Class**
			P4	**Private**
			P5	**Private First Class**
			R1	**Rear Admiral**
			R2	**Recruit**
			S1	**Seaman**
			S2	**Seaman Apprentice**
			S3	**Seaman Recruit**
			S4	**Second Lieutenant**
			S5	**Senior Chief Petty Officer**
			S6	**Senior Master Sergeant**
			S7	**Sergeant**
			S8	**Sergeant First Class Specialist 7**
			S9	**Sergeant Major Specialist 9**
			SA	**Sergeant Specialist 5**
			SB	**Staff Sergeant**
			SC	**Staff Sergeant Specialist 6**
			T1	**Technical Sergeant**
			V1	**Vice Admiral**
			W1	**Warrant Officer**

SITUATIONAL **MPI06** **1250** **Date Time Period Format Qualifier** **X 1** **ID** **2/3**

Code indicating the date format, time format, or date and time format

SYNTAX: P0607

SITUATIONAL RULE: ***Required when needed to indicate the beginning date or date span of military service. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_MPI06__DateTimePeriodFormatQualifier**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

SITUATIONAL **MPI07** **1251** **Date Time Period** **X 1** **AN** **1/35**

Expression of a date, a time, or range of dates, times or dates and times

SYNTAX: P0607

SEMANTIC: MPI07 indicates the date span of military service.

SITUATIONAL RULE: ***Required when needed to indicate the beginning date or date span of military service. If not required by this implementation guide, do not send.***

OD: **271B1_2100C_MPI07__DateTimePeriod**

SEGMENT DETAIL

EB - SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

X12 Segment Name: Eligibility or Benefit Information

X12 Purpose: To supply eligibility or benefit information

X12 Syntax: 1. **P0910**
If either EB09 or EB10 is present, then the other is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the subscriber is the person whose eligibility or benefits are being described and the transaction is not rejected (see Section 1.4.10) or if the transaction needs to be rejected in this loop. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **See Section 1.4.7 Implementation-Compliant Use of the 270/271 Transaction Set for information about what information must be returned if the subscriber is the person whose eligibility or benefits are being sent.**
2. **Either EB03 or EB13 may be used in the same EB segment, not both.**
3. **EB03 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110C loop is the same with the exception of the Service Type Code used in EB03, it is more efficient to use the repetition function of EB03 to send each of the Service Type Codes needed. If an Information Source supports responses with multiple Service Type Codes, the repetition use of EB03 must be supported if all other elements in the 2110C loop are identical.**
4. **A limit to the number of repeats of EB loops has not been established. In a batch environment there is no practical reason to limit the number of EB loop repeats. In a real time environment, consideration should be given to how many EB loops are generated given the amount of time it takes to format the response and the amount of time it will take to transmit that response. Since these limitations will vary by information source, it would be completely arbitrary for the developers to set a limit. It is not the intent of the developers to limit the amount of information that is returned in a response, rather to alert information sources to consider the potential delays if the response contains too much information to be formatted and transmitted in real time.**
5. **Use this segment to begin the eligibility/benefit information looping structure. The EB segment is used to convey the specific eligibility or benefit information for the entity identified.**

TR3 Example: **EB*1*FAM*96*GP~**
Active Coverage for subscriber and family, for Professional (Physician) services, and coverage is through a Group Policy

TR3 Example: **EB*B**68***27*10~**
Co-payment for Well Baby Care is $10 per visit

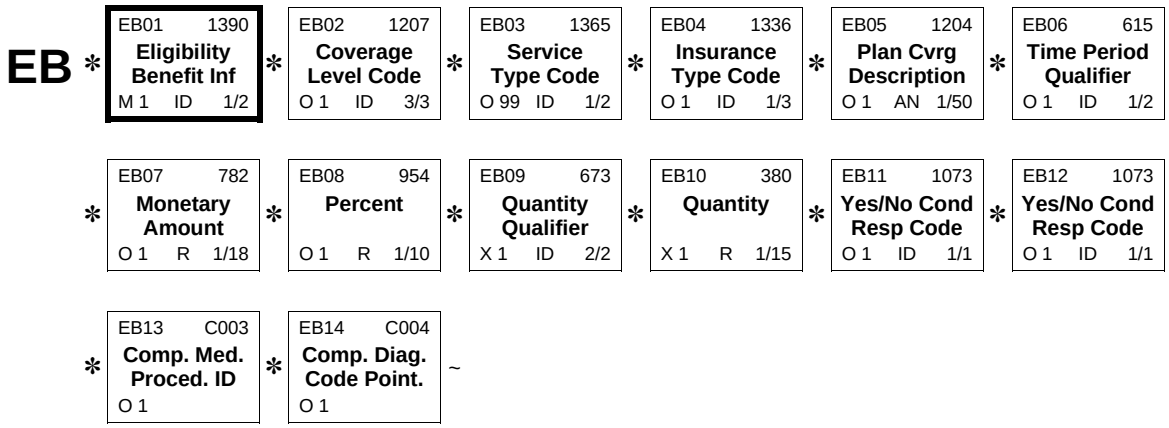
TR3 Example: **EB*C*FAM****23*600~**
Deductible for the family is $600 per calendar year

TR3 Example: **EB*L~**
Primary Care Provider (information about the Primary Care Provider will be located in the 2120 loop)

TR3 Example: **EB*A**A6*****.50~**
Co-Insurance is 50 percent for Psychotherapy

TR3 Example: **EB*B**98^34^44^81^A0^A3****10**VS*1~**
Co-payment for Professional (Physician) Visit - Office, Chiropractic Office Visits, Home Health Visits, Routine Physical, Professional (Physician) Visit - Outpatient, Professional (Physician) Visit - Home, is $10 for one visit

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**EB01**	**1390**	**Eligibility or Benefit Information Code** Code identifying eligibility or benefit information	**M 1 ID 1/2**

SEMANTIC: EB01 qualifies EB06 through EB10.

OD: 271B1_2110C_EB01__EligibilityorBenefitInformation

IMPLEMENTATION NAME: Eligibility or Benefit Information

Use this code to identify the eligibility or benefit information. This may be the eligibility status of the individual or the benefit related category that is being further described in the following data elements. This data element also qualifies the data in elements EB06 through EB10.

If codes A, B, C, G, J or Y are used, it is required that the patient's portion of responsibility is reflected in either EB07 or EB08. See Section 1.4.9 Patient Responsibility for detailed information and definitions.

CODE	DEFINITION
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
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
B	Co-Payment
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
C	Deductible
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
CB	Coverage Basis
D	Benefit Description
E	Exclusions
F	Limitations
G	Out of Pocket (Stop Loss)
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
H	Unlimited
I	Non-Covered

			J	**Cost Containment**
				See Section 1.4.9 Patient Responsibility for detailed information and definitions.
			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**
				Not recommended. See section 1.4.11 Disclaimers Within the Transaction.
			Q	**Second Surgical Opinion Required**
			R	**Other or Additional Payor**
			S	**Prior Year(s) History**
			T	**Card(s) Reported Lost/Stolen**
				Code "T" is typically used by Medicaids to indicate to a provider that the person who has presented the ID card is using a stolen ID card.
			U	**Contact Following Entity for Eligibility or Benefit Information**
			V	**Cannot Process**
			W	**Other Source of Data**
			X	**Health Care Facility**
			Y	**Spend Down**
				See Section 1.4.9 Patient Responsibility for detailed information and definitions.
SITUATIONAL	**EB02**	**1207**	**Coverage Level Code** **O 1 ID 3/3** Code indicating the level of coverage being provided for this insured	
			SITUATIONAL RULE: ***Required when needed to identify the types of individuals associated with the eligibility or benefits being identified in the 2110C loop. If not required by this implementation guide, do not send.***	
			OD: **271B1_2110C_EB02__BenefitCoverageLevelCode**	
			IMPLEMENTATION NAME: **Benefit Coverage Level Code**	
			This element is used in conjunction with EB01 codes (e.g. Active Family Coverage, Deductible Individual, etc.). This element can be used to identify types of individual's within the Subscriber's family that eligibility or benefits extends to (unless EB01 = E - Exclusions).	
			CODE	**DEFINITION**
			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**			
SITUATIONAL	**EB03**	**1365**	**Service Type Code**		**O** **99**	**ID**	**1/2**

Code identifying the classification of service

SEMANTIC: Position of data in the repeating data element conveys no significance.

SITUATIONAL RULE: ***Required when the subscriber is the patient and has been found in the Information Source's system to identify Active or Inactive Health Benefit Plan Coverage (See Section 1.4.7);***
OR
Required when one of the Service Type Codes identified in Section 1.4.7 must be returned;
OR
Required when responding to a corresponding Service Type code used from the 270 transaction;
OR
Required when the eligibility or benefits being identified in the 2110C loop need to be associated with a specific Service Type Code.
If not required by this implementation guide or if EB13 is used, do not send.

OD: **271B1_2110C_EB03__ServiceTypeCode**

See Section 1.4.7 Implementation-Compliant Use of the 270/271 Transaction Set for information about what service type codes must be returned.

EB03 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110C loop is the same with the exception of the Service Type Code used in EB03, it is more efficient to use the repetition function of EB03 to send each of the Service Type Codes needed. If an Information Source supports responses with multiple Service Type Codes, the repetition use of EB03 must be supported if all other elements in the 2110C loop are identical.

Not used if EB13 is present.

CODE	DEFINITION
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
	See Section 1.4.7.1
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
55	Major Medical
56	Medically Related Transportation

57	**Air Transportation**
58	**Cabulance**
59	**Licensed Ambulance**
60	**General Benefits**
61	**In-vitro Fertilization**
62	**MRI/CAT Scan**
63	**Donor Procedures**
64	**Acupuncture**
65	**Newborn Care**
66	**Pathology**
67	**Smoking Cessation**
68	**Well Baby Care**
69	**Maternity**
70	**Transplants**
71	**Audiology Exam**
72	**Inhalation Therapy**
73	**Diagnostic Medical**
74	**Private Duty Nursing**
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
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
	Use for Routine Vision Exam only.
AO	Lenses
AQ	Nonmedically Necessary Physical
AR	Experimental Drug Therapy
B1	Burn Care
B2	Brand Name Prescription Drug - Formulary
B3	Brand Name Prescription Drug - Non-Formulary
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**
BT	**Gynecological**
BU	**Obstetrical**
BV	**Obstetrical/Gynecological**
BW	**Mail Order Prescription Drug: Brand Name**
BX	**Mail Order Prescription Drug: Generic**
BY	**Physician Visit - Office: Sick**
BZ	**Physician Visit - Office: Well**
C1	**Coronary Care**
CA	**Private Duty Nursing - Inpatient**
CB	**Private Duty Nursing - Home**
CC	**Surgical Benefits - Professional (Physician)**
CD	**Surgical Benefits - Facility**
CE	**Mental Health Provider - Inpatient**
CF	**Mental Health Provider - Outpatient**
CG	**Mental Health Facility - Inpatient**
CH	**Mental Health Facility - Outpatient**
CI	**Substance Abuse Facility - Inpatient**
CJ	**Substance Abuse Facility - Outpatient**
CK	**Screening X-ray**
CL	**Screening laboratory**
CM	**Mammogram, High Risk Patient**
CN	**Mammogram, Low Risk Patient**
CO	**Flu Vaccination**
CP	**Eyewear and Eyewear Accessories**
CQ	**Case Management**
DG	**Dermatology**
DM	**Durable Medical Equipment**
DS	**Diabetic Supplies**
GF	**Generic Prescription Drug - Formulary**
GN	**Generic Prescription Drug - Non-Formulary**
GY	**Allergy**
IC	**Intensive Care**
MH	**Mental Health**
NI	**Neonatal Intensive Care**
ON	**Oncology**
PT	**Physical Therapy**
PU	**Pulmonary**
RN	**Renal**
RT	**Residential Psychiatric Treatment**

			TC	**Transitional Care**			
			TN	**Transitional Nursery Care**			
			UC	**Urgent Care**			
SITUATIONAL	**EB04**	**1336**	**Insurance Type Code**		**O 1**	**ID**	**1/3**

Code identifying the type of insurance policy within a specific insurance program

SITUATIONAL RULE: ***Required when the Information Source requires the Subscriber's Insurance Type Code for subsequent EDI transactions (see Section 1.4.7). If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2110C_EB04__InsuranceTypeCode**

CODE	DEFINITION
12	**Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan**
13	**Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated 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**
	When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D.
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**

SITUATIONAL **EB05** **1204** **Plan Coverage Description** **O 1** **AN** **1/50**
A description or number that identifies the plan or coverage

SITUATIONAL RULE: ***Required when a specific Plan Name exists for the plan which the individual has coverage in conjunction with the 2110C loop with EB01 Status = 1, 2, 3, 4, 5, 6, 7 or 8 and EB03 Service Type Code = 30 (See Section 1.4.7). If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2110C_EB05__PlanCoverageDescription**

This element is to be used only to convey the specific product name or special program name for an insurance plan. For example, if a plan has a brand name, such as "Gold 1-2-3", the name may be placed in this element. This element must not be used to give benefit details of a plan.

SITUATIONAL **EB06** **615** **Time Period Qualifier** **O 1** **ID** **1/2**
Code defining periods

SITUATIONAL RULE: ***Required when the availability of the eligibility or benefits being identified in the 2110C loop need to be qualified by a time period. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB06__TimePeriodQualifier**

CODE	DEFINITION
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**			
SITUATIONAL	**EB07**	**782**	**Monetary Amount** Monetary amount		**O 1**	**R**	**1/18**

SITUATIONAL RULE: ***Required when EB01 = B, C, G, J or Y. Do not use if EB01 = A. May be used at the sender's discretion for other EB01 values. May not be a negative number.***

OD: **271B1_2110C_EB07__BenefitAmount**

IMPLEMENTATION NAME: **Benefit Amount**

Use this monetary amount as qualified by EB01.

When EB01 = B, C, G, J or Y, the amount represents the Patient's portion of responsibility. See Section 1.4.9 Patient Responsibility.

Use if eligibility or benefit must be qualified by a monetary amount; e.g., deductible, co-payment.

SITUATIONAL **EB08** **954** **Percentage as Decimal** **O 1 R 1/10**
Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%)

SITUATIONAL RULE: ***Required when EB01 = A. Do not use if EB01 = B, C, G, J or Y. May be used at the sender's discretion for other EB01 values. May not be a negative number.***

OD: **271B1_2110C_EB08__BenefitPercent**

IMPLEMENTATION NAME: **Benefit Percent**

Use this percentage rate as qualified by EB01.

When EB01 = A, the amount represents the Patient's portion of responsibility. See Section 1.4.9 Patient Responsibility.

Use if eligibility or benefit must be qualified by a percentage; e.g., co-insurance.

SITUATIONAL **EB09** **673** **Quantity Qualifier** **X 1 ID 2/2**
Code specifying the type of quantity

SYNTAX: P0910

SITUATIONAL RULE: ***Required when needed to further qualify the eligibility or benefits being identified in the 2110C loop by quantity. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB09__QuantityQualifier**

Use this code to identify the type of units that are being conveyed in the following data element (EB10).

CODE	DEFINITION
8H	Minimum
99	Quantity Used
CA	Covered - Actual
CE	Covered - Estimated
D3	Number of Co-insurance Days
DB	Deductible Blood Units
DY	Days
HS	Hours
LA	Life-time Reserve - Actual
LE	Life-time Reserve - Estimated
M2	Maximum
MN	Month
P6	Number of Services or Procedures
QA	Quantity Approved
S7	Age, High Value
	Use this code when a benefit is based on a maximum age for the patient.
S8	Age, Low Value
	Use this code when a benefit is based on a minimum age for the patient.

			VS	**Visits**			
			YY	**Years**			
SITUATIONAL	**EB10**	**380**	**Quantity** Numeric value of quantity		**X 1**	**R**	**1/15**

SYNTAX: P0910

SITUATIONAL RULE: ***Required when needed to further qualify the eligibility or benefits being identified in the 2110C loop by quantity. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB10__BenefitQuantity**

IMPLEMENTATION NAME: **Benefit Quantity**

Use this number for the quantity value as qualified by the preceding data element (EB09).

SITUATIONAL	**EB11**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response		**O 1**	**ID**	**1/1**

SEMANTIC: EB11 is the authorization or certification indicator. A “Y” value indicates that an authorization or certification is required per plan provisions. An “N” value indicates that an authorization or certification is not required per plan provisions. A “U” value indicates it is unknown whether the plan provisions require an authorization or certification.

SITUATIONAL RULE: ***Required when needed to indicate if authorization or certification is required for the eligibility or benefits being identified in the 2110C loop. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB11__AuthorizationorCertificationIndicator**

IMPLEMENTATION NAME: **Authorization or Certification Indicator**

Use code “U” - Unknown, In the event that a payer typically responds Yes or No for some benefits, but the inquired benefit requirements are not accessible or the rules are more complex than can be determined using the data sent in the 270.

CODE	DEFINITION
N	**No**
U	**Unknown**
Y	**Yes**

SITUATIONAL **EB12** **1073** **Yes/No Condition or Response Code** **O 1** **ID** **1/1**
Code indicating a Yes or No condition or response

SEMANTIC: EB12 is the plan network indicator. A "Y" value indicates the benefits identified are considered In-Plan-Network. An "N" value indicates that the benefits identified are considered Out-Of-Plan-Network. A "U" value indicates it is unknown whether the benefits identified are part of the Plan Network.

SITUATIONAL RULE: ***Required when needed to indicate if benefits are considered In Plan Network or Out Of Plan Network for the eligibility or benefits being identified in the 2110C loop. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB12__InPlanNetworkIndicator**

IMPLEMENTATION NAME: **In Plan Network Indicator**

Use code "U" - Unknown, In the event that a payer typically responds Yes or No for some benefits, but the inquired benefit requirements are not accessible or the rules are more complex than can be determined using the data sent in the 270.

CODE	DEFINITION
N	**No**
U	**Unknown**
W	**Not Applicable**
	Use code "W" - Not Applicable when benefits are the same regardless of whether they are In Plan-Network or Out of Plan-Network or a Plan-Network does not apply to the benefit.
Y	**Yes**

SITUATIONAL **EB13** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **O 1**
To identify a medical procedure by its standardized codes and applicable modifiers

SITUATIONAL RULE: ***Required when a Medical Procedure Code was used from the 270 to determine the response being identified in the 2110C loop;***
OR
Required when the Information Source supports Medical Procedure Code based 271 transactions and a Medical Procedure Code is available and appropriate for the eligibility or benefits being identified in the 2110C loop.
If not required by this implementation guide or if EB03 is used, do not send.

OD: **271B1_2110C_EB13_C003**

Use this composite data element only if an information source can support this high level of functionality. The EB13 allows for a very specific response.

Not used if EB03 is present.

REQUIRED **EB13 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SEMANTIC:
C003-01 qualifies C003-02 and C003-08.

OD:
271B1_2110C_EB13_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: **Product or Service ID Qualifier**

Use this code to identify the external code list of the following procedure/service code.

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association
CJ	**Current Procedural Terminology (CPT) Codes** **CODE SOURCE 133:** Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **CODE SOURCE 130:** Healthcare Common Procedure Coding System
ID	**International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Procedure** **CODE SOURCE 131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.** **CODE SOURCE 513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	**National Drug Code in 5-4-2 Format** **CODE SOURCE 240:** National Drug Code by Format
ZZ	**Mutually Defined** **Use this code only for International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).** **CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)**

REQUIRED **EB13 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

SEMANTIC:
If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.

OD: **271B1_2110C_EB13_C00302_ProcedureCode**

IMPLEMENTATION NAME: **Procedure Code**

Use this ID number for the product/service code as qualified by the preceding data element.

SITUATIONAL **EB13 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-03 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110C loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110C_EB13_C00303_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-04 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110C loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110C_EB13_C00304_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-05 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110C loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110C_EB13_C00305_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-06 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110C loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110C_EB13_C00306_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

NOT USED **EB13 - 7** **352** **Description** **O AN 1/80**

SITUATIONAL **EB13 - 8** **234** **Product/Service ID** **O AN 1/48**
Identifying number for a product or service

SEMANTIC:
C003-08 represents the ending value in the range in which the code occurs.

SITUATIONAL RULE: ***Required when the Information Source desires to indicate a range of procedure codes. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_EB13_C00308_ProductorServiceID**

IMPLEMENTATION NAME: **Product or Service ID**

EB13-2 indicates the beginning of value of the range of procedure codes and EB13-8 represents the end of the range of procedure codes. All procedure codes in the range will apply.

SITUATIONAL **EB14** **C004** **COMPOSITE DIAGNOSIS CODE POINTER** **O 1**
To identify one or more diagnosis code pointers

SITUATIONAL RULE: ***Required when a 2100C HI segment is used and the information in this 2110C EB loop is related to a diagnosis code. If 2100C HI segment is not used or if the information in this 2110C EB loop is not related to a diagnosis code, do not send.***

OD: **271B1_2110C_EB14_C004**

See requirements for the use of the 2100C HI segment for additional information.

REQUIRED **EB14 - 1** **1328** **Diagnosis Code Pointer** **M N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-01 identifies the primary diagnosis code for this service line.

OD: **271B1_2110C_EB14_C00401_DiagnosisCodePointer**

This first pointer designates the primary diagnosis for this EB segment. Remaining diagnosis pointers indicate declining level of importance to the EB segment. Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL **EB14 - 2** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-02 identifies the second diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a second diagnosis related to this EB segment. If not required, do not send.***

OD: **271B1_2110C_EB14_C00402_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL **EB14 - 3** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-03 identifies the third diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a third diagnosis related to this EB segment. If not required, do not send.***

OD: **271B1_2110C_EB14_C00403_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SITUATIONAL **EB14 - 4** **1328** **Diagnosis Code Pointer** **O N0 1/2**

A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-04 identifies the fourth diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a fourth diagnosis related to this EB segment. If not required, do not send.***

OD: 271B1_2110C_EB14_C00404_DiagnosisCodePointer

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100C.

SEGMENT DETAIL

HSD - HEALTH CARE SERVICES DELIVERY

X12 Segment Name: Health Care Services Delivery

X12 Purpose: To specify the delivery pattern of health care services

X12 Syntax:

1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.
2. **C0605**
   If HSD06 is present, then HSD05 is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

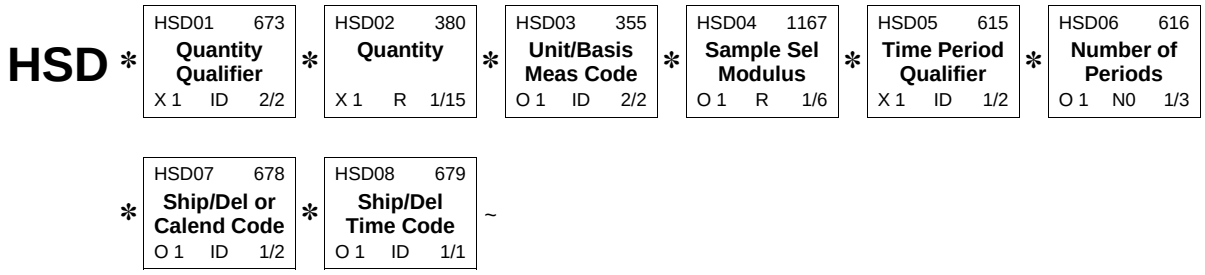
Usage: **SITUATIONAL**

Situational Rule: **Required when needed to identify a specific delivery or usage pattern associated with the benefits identified in either EB03 or EB13. If not required by this implementation guide, do not send.**

TR3 Example: **HSD*VS*30***22~**
Thirty visits per service year

TR3 Example: **HSD*VS*12*WK*3*34*1~**
Twelve visits, three visits per week, for 1 month.

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**HSD01**	**673**	**Quantity Qualifier** Code specifying the type of quantity SYNTAX: P0102 SITUATIONAL RULE: ***Required when identifying type and quantity benefits identified. If not required by this implementation guide, do not send.*** OD: **271B1_2110C_HSD01__QuantityQualifier** **Required if HSD02 is used.**	**X 1 ID 2/2**
SITUATIONAL	**HSD02**	**380**	**Quantity** Numeric value of quantity SYNTAX: P0102 SITUATIONAL RULE: ***Required when identifying type and quantity benefits identified. If not required by this implementation guide, do not send.*** OD: **271B1_2110C_HSD02__BenefitQuantity** IMPLEMENTATION NAME: **Benefit Quantity** **Required if HSD01 is used.**	**X 1 R 1/15**
SITUATIONAL	**HSD03**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.*** OD: **271B1_2110C_HSD03__UnitorBasisforMeasurementCode**	**O 1 ID 2/2**

CODE	DEFINITION
DY	**Days**
FL	**Units**
HS	**Hours**
MN	**Month**
VS	**Visits**

CODE	DEFINITION
DA	**Days**
MO	**Months**
VS	**Visit**
WK	**Week**
YR	**Years**

SITUATIONAL **HSD04** **1167** **Sample Selection Modulus** **O 1** **R** **1/6**
To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_HSD04__SampleSelectionModulus**

SITUATIONAL **HSD05** **615** **Time Period Qualifier** **X 1** **ID** **1/2**
Code defining periods

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_HSD05__TimePeriodQualifier**

CODE	DEFINITION
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**

SITUATIONAL **HSD06** **616** **Number of Periods** **O 1** **N0** **1/3**
Total number of periods

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_HSD06__PeriodCount**

IMPLEMENTATION NAME: **Period Count**

SITUATIONAL **HSD07** **678** **Ship/Delivery or Calendar Pattern Code** **O 1 ID 1/2**
Code which specifies the routine shipments, deliveries, or calendar pattern

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_HSD07__DeliveryFrequencyCode**

IMPLEMENTATION NAME: **Delivery Frequency Code**

CODE	DEFINITION
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)**			
SITUATIONAL	**HSD08**	**679**	**Ship/Delivery Pattern Time Code** Code which specifies the time for routine shipments or deliveries	**O 1**	**ID**	**1/1**	

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110C_HSD08__DeliveryPatternTimeCode**

IMPLEMENTATION NAME: **Delivery Pattern Time Code**

CODE	DEFINITION
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)**

SEGMENT DETAIL

REF - SUBSCRIBER ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

Usage: **SITUATIONAL**

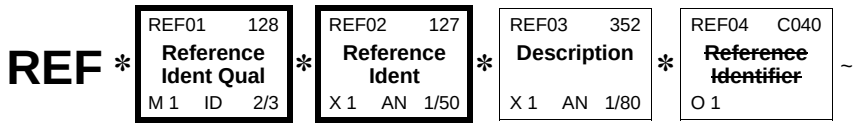
Situational Rule: **Required when the Information Source requires one or more of these additional identifiers for subsequent EDI transactions (see Section 1.4.7); OR**
Required when an additional identifier is associated with the eligibility or benefits being identified in the 2110C loop. If not required by this implementation guide, do not send.

TR3 Notes:

1. **Use this segment for reference identifiers related only to the 2110C loop that it is contained in (e.g. Other or Additional Payer's identifiers).**
2. **Use this segment to identify other or additional reference numbers for the entity identified. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2110C loop.**

TR3 Example: **REF*G1*653745725~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: 271B1_2110C_REF01__ReferenceIdentificationQualifier

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Use "1W", "49", "F6", and "NQ" only in a 2110C loop with EB01 = "R".

Only one occurrence of each REF01 code value may be used in the 2110C loop.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
1W	**Member Identification Number**
49	**Family Unit Number**
	Required when the Information Source is a Pharmacy Benefit Manager (PBM) and the individual has a suffix to their member ID number that is required for use in the NCPDP Telecom Standard in the Insurance Segment in field 303-C3 Person Code. If not required by this implementation Guide, do not send. **NOTE: For all other uses, the Family Unit Number (suffix) is considered a part of the Member ID number and is used to uniquely identify the individual and must be returned at the end of the Member ID number in 2110C REF02 if REF01 is "1W".**
6P	**Group Number**
9F	**Referral Number**
ALS	**Alternative List ID**
	Allows the source to identify the list identifier of a list of drugs and its alternative drugs with the associated formulary status for the patient.
CLI	**Coverage List ID**
	Allows the source to identify the list identifier of a list of drugs that have coverage limitations for the associated patient.
F6	**Health Insurance Claim (HIC) Number**
FO	**Drug Formulary Number**
G1	**Prior Authorization Number**
IG	**Insurance Policy Number**

			M7	**Medical Assistance Category**			
			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 OD: **271B1_2110C_REF02__SubscriberEligibilityorBenefitIdentifier** IMPLEMENTATION NAME: **Subscriber Eligibility or Benefit Identifier** **Use this information for the reference number as qualified by the preceding data element (REF01).**		**X 1**	**AN**	**1/50**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content SYNTAX: R0203 SITUATIONAL RULE: ***Required when REF01 = "18", "6P" or "N6" and a name needs to be associated with the corresponding identifier. If not required by this implementation guide, do not send.*** OD: **271B1_2110C_REF03__PlanGrouporPlanNetworkName** IMPLEMENTATION NAME: **Plan, Group or Plan Network Name**		**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O 1**		

SEGMENT DETAIL

DTP - SUBSCRIBER ELIGIBILITY/BENEFIT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **20**

Usage: **SITUATIONAL**

Situational Rule: **Required when the individual has active coverage with multiple plans or multiple plan periods apply (See 2100C DTP segment);**
OR
Required when needed to convey dates associated with the eligibility or benefits being identified in the 2110C loop.
If not required by this implementation guide, do not send.

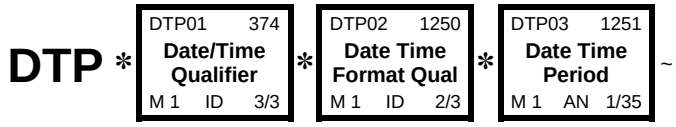
TR3 Notes:

1. **When using the DTP segment in the 2110C loop this date applies only to the 2110C Eligibility or Benefit Information (EB) loop in which it is located.**

   If a DTP segment with the same DTP01 value is present in the 2100C loop, the date is overridden for only this 2110C Eligibility or Benefit Information (EB) loop.

TR3 Example: **DTP*472*D8*19960624~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**

OD: **271B1_2110C_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
096	**Discharge**
193	**Period Start**
194	**Period End**
198	**Completion**
290	**Coordination of Benefits**

			291	**Plan**			
				Use code 291 only if multiple plans apply to the individual or multiple plan periods apply. Dates supplied in this DPT segment only apply to the 2110C loop in which it occurs.		
			292	**Benefit**			
			295	**Primary Care Provider**			
			304	**Latest Visit or Consultation**			
			307	**Eligibility**			
			318	**Added**			
			346	**Plan Begin**			
				Use code 346 only if multiple plans apply to the individual or multiple plan periods apply. Dates supplied in this DPT segment only apply to the 2110C loop in which it occurs.		
			348	**Benefit Begin**			
			349	**Benefit End**			
			356	**Eligibility Begin**			
			357	**Eligibility End**			
			435	**Admission**			
			472	**Service**			
			636	**Date of Last Update**			
			771	**Status**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M**	**1**	**ID** **2/3**
			Code indicating the date format, time format, or date and time format				
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.				
			OD: **271B1_2110C_DTP02__DateTimePeriodFormatQualifier**				
			Use this code to specify the format of the date(s)/time(s) that follow in the next data element.				
			CODE	**DEFINITION**			
			D8	**Date Expressed in Format CCYYMMDD**			
			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**			
REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M**	**1**	**AN** **1/35**
			Expression of a date, a time, or range of dates, times or dates and times				
			OD: **271B1_2110C_DTP03__EligibilityorBenefitDateTimePeriod**				
			IMPLEMENTATION NAME: **Eligibility or Benefit Date Time Period**				
			Use this date for the date(s) as qualified by the preceding data elements.				

SEGMENT DETAIL

AAA - SUBSCRIBER REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

Usage: **SITUATIONAL**

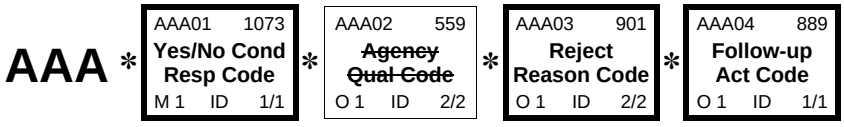
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's subscriber eligibility/benefit inquiry information loop (Loop 2110C) and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's subscriber eligibility/benefit inquiry information loop (Loop 2110C).**

TR3 Example: **AAA*N**70*C~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1 ID 1/1**

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

OD: 271B1_2110C_AAA01__ValidRequestIndicator

IMPLEMENTATION NAME: Valid Request Indicator

CODE	DEFINITION
N	**No**
	Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.

			Y	**Yes**			
				Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.			
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**		**O 1**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection		**O 1**	**ID**	**2/2**
			OD: **271B1_2110C_AAA03__RejectReasonCode**				
			Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.				

CODE	DEFINITION
15	**Required application data missing**
33	**Input Errors**
	Use this code only when data is present in this transaction and no other Reject Reason Code is valid for describing the error. Detail of the error must be supplied in the MSG segment of the 2110C loop containing this Reject Reason Code.
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**
98	**Experimental Service or Procedure**
AA	**Authorization Number Not Found**
	Use this code only when the Referral Number or Prior Authorization Number in 2110C REF02 is not found.
AE	**Requires Primary Care Physician Authorization**
AF	**Invalid/Missing Diagnosis Code(s)**
AG	**Invalid/Missing Procedure Code(s)**
	Use this code for errors with Procedure Codes in EQ02-2 or Procedure Code Modifiers in EQ02-3 through EQ02-6.

			AO	**Additional Patient Condition Information Required**			
				Use this code only if the Information Source supports responding to a detailed eligibility request and the information can be processed from a 270 transaction received by the Information Source but was not received and is needed to respond appropriately.		
			CI	**Certification Information Does Not Match Patient**			
				Use this code only when the Referral Number or Prior Authorization Number in 2110C REF02 is found but is not associated with the subscriber.		
			E8	**Requires Medical Review**			
			IA	**Invalid Authorization Number Format**			
				Use this code only when the Referral Number or Prior Authorization Number in 2110C REF02 is not formatted properly.		
			MA	**Missing Authorization Number**			
				Use this code only when the Referral Number or Prior Authorization Number has been issued and is missing in 2110C REF02 but is needed to respond appropriately.		
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2110C_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				
			CODE	**DEFINITION**			
			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**			

SEGMENT DETAIL

MSG - MESSAGE TEXT

X12 Segment Name: Message Text

X12 Purpose: To provide a free-form format that allows the transmission of text information

X12 Syntax:
1. **C0302**
   If MSG03 is present, then MSG02 is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **10**

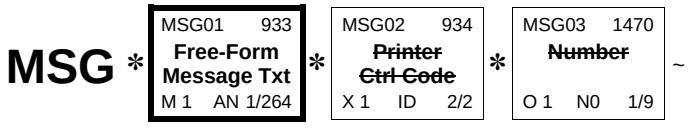
Usage: **SITUATIONAL**

Situational Rule: **Required when the eligibility or benefit information cannot be codified in existing data elements (including combinations of multiple data elements and segments);**
AND
Required when this information is pertinent to the eligibility or benefit response.
If not required by this implementation guide, do not send.

TR3 Notes:
1. **Free form text or description fields are not recommended because they require human interpretation.**
2. **Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements (including combinations of multiple data elements and segments). If the information cannot be codified, then cautionary use of the MSG segment is allowed as a short term solution. It is highly recommended that the entity needing to use the MSG segment approach X12N with data maintenance to solve the long term business need, so the use of the MSG segment can be avoided for that issue.**
3. **Benefit Disclaimers are strongly discouraged. See section 1.4.11 Disclaimers Within the Transaction. Under no circumstances are more than one MSG segment to be used for a Benefit Disclaimer per individual response.**

TR3 Example: **MSG*Free form text is discouraged~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**MSG01**	**933**	**Free-form Message Text** Free-form message text	**M 1**	**AN**	**1/264**
			OD: **271B1_2110C_MSG01__FreeFormMessageText**			
			IMPLEMENTATION NAME: **Free Form Message Text**			
NOT USED	**MSG02**	**934**	**Printer Carriage Control Code**	**X 1**	**ID**	**2/2**
NOT USED	**MSG03**	**1470**	**Number**	**O 1**	**N0**	**1/9**

SEGMENT DETAIL

III - SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

X12 Segment Name: Information

X12 Purpose: To report information

X12 Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

Loop: **2115C — SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION Loop Repeat: 10**

Segment Repeat: **1**

Usage: **SITUATIONAL**

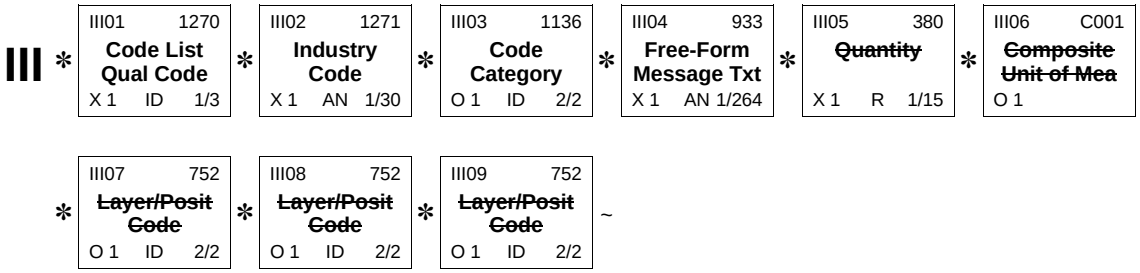
Situational Rule: **Required when III segments in Loop 2110C of the 270 Inquiry were used in the determination of the eligibility or benefit response;**
OR
Required when needed to identify limitations in the benefits explained in the corresponding Loop 2110C (such as if benefits are limited to a type of facility).
If not required by this implementation guide, do not send.

TR3 Notes:

1. **This segment has two purposes. Information that was received in III segments in Loop 2110C of the 270 Inquiry and was used in the determination of the eligibility or benefit response must be returned. If information was provided in III segments of Loop 2110C but was not used in the determination of the eligibility or benefits it must not be returned. This segment can also be used to identify limitations in the benefits explained in the corresponding Loop 2110C, such as if benefits are limited to a type of facility.**
2. **Use this segment to identify Nature of Injury Codes and/or Facility Type as they relate to the information provided in the EB segment.**
3. **Use the III segment only if an information source can support this high level functionality.**
4. **Use this segment only one time for the Facility Type Code.**

TR3 Example:
III*ZZ*21~
III*44*Broken bones and third degree burns~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **SITUATIONAL RULE:** ***Required when identifying a Nature of Injury Code or a Facility Type Code. If not required by this implementation guide, do not send.*** **OD: 271B1_2115C_III01__CodeListQualifierCode** **Use this code to specify if the code that is following in the III02 is a Nature of Injury Code or a Facility Type Code.**	**X 1 ID 1/3**
SITUATIONAL	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SYNTAX:** P0102 **SITUATIONAL RULE:** ***Required when identifying a Nature of Injury Code or a Facility Type Code. If not required by this implementation guide, do not send.*** **OD: 271B1_2115C_III02__IndustryCode** **If III01 is GR, use this element for NCCI Nature of Injury code from code source 284.**	**X 1 AN 1/30**

CODE	DEFINITION
GR	**National Council on Compensation Insurance (NCCI) Nature of Injury Code** **CODE SOURCE 284:** Nature of Injury Code
NI	**Nature of Injury Code** **Other code source as specified by the jurisdiction.** **CODE SOURCE 284:** Nature of Injury Code **CODE SOURCE 407:** Occupational Injury and Illness Classification Manual
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix A for Code Source 237, Place of Service Codes for Professional Claims.**

If III01 is NI, use this element for Nature of Injury code from code source 407.

If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility - Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

SITUATIONAL	**III03**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SYNTAX:** L030405 **SEMANTIC:** III03 is used to categorize III04. **SITUATIONAL RULE:** ***Required when III01 and III02 are not present or if additional information is needed (see III04). If not required by this implementation guide or if III01 is ZZ, do not send.*** **OD: 271B1_2115C_III03__CodeCategory** CODE / DEFINITION **44** / **Nature of Injury**	**O 1**	**ID**	**2/2**
SITUATIONAL	**III04**	**933**	**Free-form Message Text** Free-form message text **SYNTAX:** L030405 **SITUATIONAL RULE:** ***Required when III03 = "44". If not required by this implementation guide, do not send.*** **OD: 271B1_2115C_III04__InjuredBodyPartName** **IMPLEMENTATION NAME: Injured Body Part Name** **Use this element to describe the injured body part or parts.**	**X 1**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X 1**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**

SEGMENT DETAIL

LS - LOOP HEADER

X12 Segment Name: Loop Header

X12 Purpose: To indicate that the next segment begins a loop

X12 Semantic:
1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as mandatory, this segment in combination with "LE", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comments:
1. See Figures Appendix for an explanation of the use of the LS and LE segments.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **1**

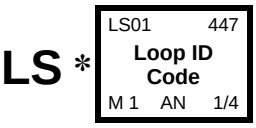
Usage: **SITUATIONAL**

Situational Rule: **Required when Loop 2120C is used. If not required by this implementation guide, do not send.**

TR3 Notes:
1. **Use this segment to identify the beginning of the Subscriber Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops.**

TR3 Example: **LS*2120~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LS01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	**M 1 AN 1/4**
			OD: **271B1_2110C_LS01__LoopIdentifierCode**	
			This data element must have the value of "2120".	

SEGMENT DETAIL

NM1 - SUBSCRIBER BENEFIT RELATED ENTITY NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME Loop Repeat: 23**

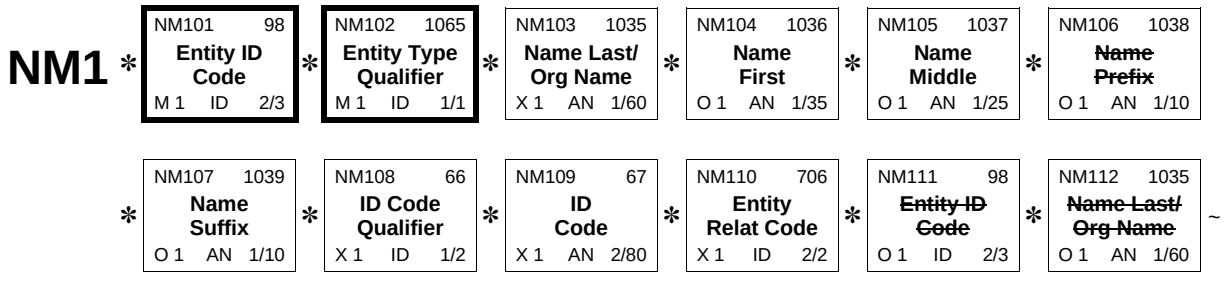
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when provider was identified in 2100C PRV02 and PRV03 by Identification Number (not Taxonomy Code) in the 270 Inquiry and was used in the determination of the eligibility or benefit response;**
OR
Required when needed to identify an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. primary care provider), an individual, an organization, another payer, or another information source;
If not required by this implementation guide, do not send.

TR3 Example: **NM1*P3*1*JONES*MARCUS***MD*SV*111223333~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3

OD: **271B1_2120C_NM101__EntityIdentifierCode**

CODE	DEFINITION
13	Contracted Service Provider
1I	Preferred Provider Organization (PPO)
	Use if identifying a Preferred Provider Organization (PPO) by name or identification number. May also be used if identifying the Network that benefits are restricted to when 2110C EB12 = "Y" (In-Network).
1P	Provider
2B	Third-Party Administrator
36	Employer
73	Other Physician
FA	Facility
GP	Gateway Provider
GW	Group
I3	Independent Physicians Association (IPA)
IL	Insured or Subscriber
	Use if identifying an insured or subscriber to a plan other than the information source (such as in a co-ordination of benefits situation).
LR	Legal Representative
OC	Origin Carrier
	Use if identifying an organization that added information relating to other insurance.
P3	Primary Care Provider
P4	Prior Insurance Carrier
P5	Plan Sponsor
PR	Payer
PRP	Primary Payer
SEP	Secondary Payer
TTP	Tertiary Payer
VN	Vendor
VY	Organization Completing Configuration Change
	Use if identifying an organization that changed information relating to other insurance.
X3	Utilization Management Organization

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M 1 ID 1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

OD: **271B1_2120C_NM102__EntityTypeQualifier**

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

SITUATIONAL **NM103** **1035** **Name Last or Organization Name** **X 1 AN 1/60**
Individual last name or organizational name

SYNTAX: C1203

SITUATIONAL RULE: ***Required when needed to identify by name an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source***
OR
Required when NM109 is not used.
If not required by this implementation guide, do not send.

OD:
271B1_2120C_NM103__BenefitRelatedEntityLastorOrganizationName

IMPLEMENTATION NAME: **Benefit Related Entity Last or Organization Name**

Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.

SITUATIONAL **NM104** **1036** **Name First** **O 1 AN 1/35**
Individual first name

SITUATIONAL RULE: ***Required when NM102 is "1" and NM103 is used. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_NM104__BenefitRelatedEntityFirstName**

IMPLEMENTATION NAME: **Benefit Related Entity First Name**

SITUATIONAL **NM105** **1037** **Name Middle** **O 1 AN 1/25**
Individual middle name or initial

SITUATIONAL RULE: ***Required when NM102 is "1" and the Last Name in NM103 and First Name in NM104 are not sufficient to identify the individual. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120C_NM105__BenefitRelatedEntityMiddleName**

IMPLEMENTATION NAME: **Benefit Related Entity Middle Name**

NOT USED **NM106** **1038** **Name Prefix** **O 1 AN 1/10**

SITUATIONAL **NM107** **1039** **Name Suffix** **O 1 AN 1/10**
Suffix to individual name

SITUATIONAL RULE: ***Required when NM102 is "1" and the Last Name in NM103 and First Name in NM104 and/or Middle Name in 2100A NM105 are not sufficient to identify the individual. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120C_NM107__BenefitRelatedEntityNameSuffix**

IMPLEMENTATION NAME: **Benefit Related Entity Name Suffix**

Use for name suffix only (e.g. Sr, Jr, II, III, etc.).

SITUATIONAL **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

SITUATIONAL RULE: ***Required when needed to identify by Identification Code an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source.***
OR
Required when NM103 is not used.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120C_NM108__IdentificationCodeQualifier**

If the entity being identified is a provider and the National Provider ID is mandated for use, code value "XX" must be used, otherwise, one of the other codes may be used. If the entity being identified is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used. If the entity being identified is an individual, the "HIPAA Individual Identifier" must be used once this identifier has been adopted, otherwise, one of the other codes may be used.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
46	**Electronic Transmitter Identification Number (ETIN)**
FA	**Facility Identification**
FI	**Federal Taxpayer's Identification Number**
II	**Standard Unique Health Identifier for each Individual in the United States**
	Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services may adopt a standard individual identifier for use in this transaction.

			MI	**Member Identification Number**			
				Use this code to identify the entity's Member Identification Number associated with a payer other than the information source in Loop 2100A. This code may only be used prior to the mandated use of code "II".			
			NI	**National Association of Insurance Commissioners (NAIC) Identification**			
			PI	**Payor Identification**			
			PP	**Pharmacy Processor Number**			
			SV	**Service Provider Number**			
			XV	**Centers for Medicare and Medicaid Services PlanID**			
				CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID			
			XX	**Centers for Medicare and Medicaid Services National Provider Identifier**			
				CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code		**X**	**1**	**AN**	**2/80**

SYNTAX: P0809

SITUATIONAL RULE: ***Required when needed to identify by Identification Code an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source.***
OR
Required when NM103 is not used.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120C_NM109__BenefitRelatedEntityIdentifier**

IMPLEMENTATION NAME: **Benefit Related Entity Identifier**

Use this code for the reference number as qualified by the preceding data element (NM108).

SITUATIONAL	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X 1**	**ID**	**2/2**

SYNTAX: C1110

COMMENT: NM110 and NM111 further define the type of entity in NM101.

SITUATIONAL RULE: ***Required when needed to indicate the Benefit Related Entity's relationship to the patient when EB01 = "R", the coverage is based on the Benefit Related Entity and the relationship is known. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120C_NM110__BenefitRelatedEntityRelationshipCode**

IMPLEMENTATION NAME: **Benefit Related Entity Relationship Code**

CODE	DEFINITION
01	**Parent**
02	**Child**
27	**Domestic Partner**
41	**Spouse**
48	**Employee**
65	**Other**
72	**Unknown**

NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

N3 - SUBSCRIBER BENEFIT RELATED ENTITY ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

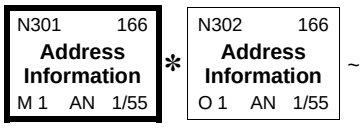
Situational Rule: **Required when needed to further identify the entity or individual in loop 2120C NM1 and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify address information for an entity.**

TR3 Example: **N3*201 PARK AVENUE*SUITE 300~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **271B1_2120C_N301__BenefitRelatedEntityAddressLine**	
			IMPLEMENTATION NAME: **Benefit Related Entity Address Line**	
			Use this information for the first line of the address information.	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when a second address line exists and is available. If not required by this implementation guide, do not send.***	
			OD: **271B1_2120C_N302__BenefitRelatedEntityAddressLine**	
			IMPLEMENTATION NAME: **Benefit Related Entity Address Line**	
			Use this information for the second line of the address information.	

SEGMENT DETAIL

N4 - SUBSCRIBER BENEFIT RELATED ENTITY CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

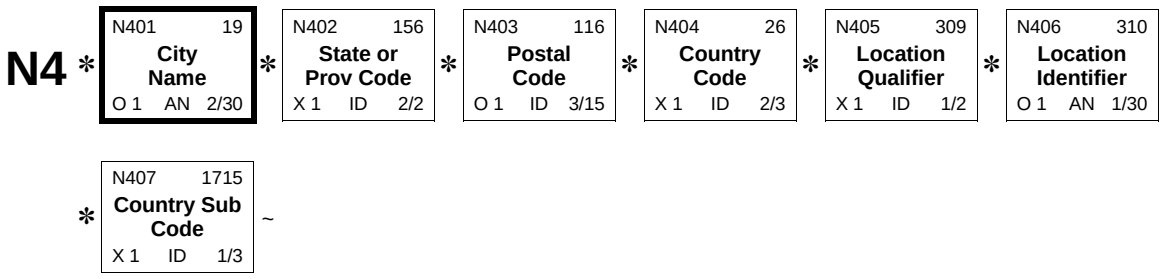
Situational Rule: **Required when needed to further identify the entity or individual in loop 2120C NM1 and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify address information for an entity.**

TR3 Example: **N4✻KANSAS CITY✻MO✻64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. OD: **271B1_2120C_N401__BenefitRelatedEntityCityName** IMPLEMENTATION NAME: **Benefit Related Entity City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_N402__BenefitRelatedEntityStateCode**

IMPLEMENTATION NAME: **Benefit Related Entity State Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_N403__BenefitRelatedEntityPostalZoneorZIPCode**

IMPLEMENTATION NAME: **Benefit Related Entity Postal Zone or ZIP Code**

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_N404__BenefitRelatedEntityCountryCode**

IMPLEMENTATION NAME: **Benefit Related Entity Country Code**

CODE SOURCE 5: Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

SITUATIONAL **N405** **309** **Location Qualifier** **X 1** **ID** **1/2**
Code identifying type of location

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed by CHAMPUS/TRICARE or CHAMPVA to communicate the DOD Health Service Region. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_N405__BenefitRelatedEntityLocationQualifier**

IMPLEMENTATION NAME: **Benefit Related Entity Location Qualifier**

CODE SOURCE **206:** Government Bill of Lading Office Code

Use this element only to communicate the Department of Defense Health Service Region.

CODE	DEFINITION
RJ	**Region**
	Use this code only to communicate the Department of Defense Health Service Region in N406.

SITUATIONAL **N406** **310** **Location Identifier** **O 1** **AN** **1/30**
Code which identifies a specific location

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed by CHAMPUS/TRICARE or CHAMPVA to communicate the DOD Health Service Region. If not required by this implementation guide, do not send.***

OD:
271B1_2120C_N406__BenefitRelatedEntityDODHealthServiceRegion

IMPLEMENTATION NAME: **Benefit Related Entity DOD Health Service Region**

Use this element only to communicate the Department of Defense Health Service Region.

CODE SOURCE DOD1: Military Health Systems Functional Area Manual - Data.

SITUATIONAL **N407** **1715** **Country Subdivision Code** **X 1** **ID** **1/3**
Code identifying the country subdivision

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD:
271B1_2120C_N407__BenefitRelatedEntityCountrySubdivisionCode

IMPLEMENTATION NAME: **Benefit Related Entity Country Subdivision Code**

CODE SOURCE **5:** Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

PER - SUBSCRIBER BENEFIT RELATED ENTITY CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

X12 Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when Contact Information exists and is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2120C NM1.**

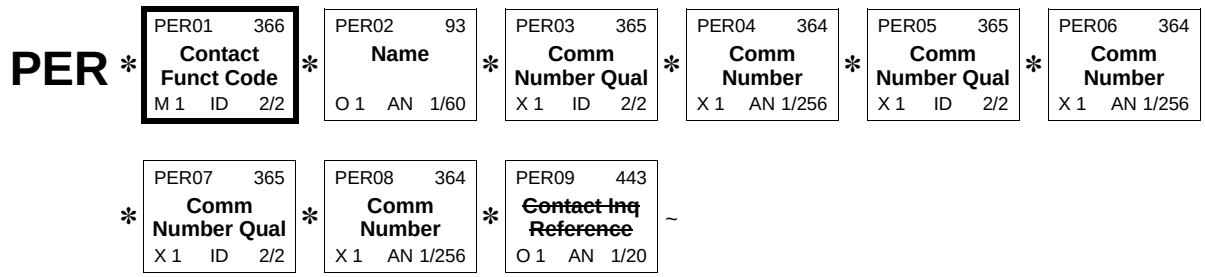
   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

TR3 Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**

OD: **271B1_2120C_PER01__ContactFunctionCode**

Use this code to specify the type of person or group to which the contact number applies.

CODE	DEFINITION
IC	**Information Contact**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**

SITUATIONAL RULE: ***Required when the name of the individual to contact is not already defined or is different than the name within 2120C NM1 segment and the name is available;***
OR
Required when PER03 and PER04 are not present.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120C_PER02__BenefitRelatedEntityContactName**

IMPLEMENTATION NAME: **Benefit Related Entity Contact Name**

Use this name for the individual's name or group's name to use when contacting the individual or organization.

SITUATIONAL **PER03** **365** **Communication Number Qualifier** **X 1** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0304

SITUATIONAL RULE: ***Required when PER02 is not present or when a communication number, e-mail or Web address is to be sent in addition to the contact name. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120C_PER03__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL **PER04** **364** **Communication Number** **X 1** **AN** **1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0304

SITUATIONAL RULE: ***Required when PER02 is not present or when a communication number, e-mail or Web address is to be sent in addition to the contact name. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD:
271B1_2120C_PER04__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: **Benefit Related Entity Communication Number**

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X 1** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: **271B1_2120C_PER05__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL **PER06** **364** **Communication Number** **X 1** **AN** **1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2120C_PER06__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: **Benefit Related Entity Communication Number**

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1**	**ID**	**2/2**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: 271B1_2120C_PER07__CommunicationNumberQualifier

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1**	**AN**	**1/256**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2120C_PER08__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: Benefit Related Entity Communication Number

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O 1**	**AN**	**1/20**

SEGMENT DETAIL

PRV - SUBSCRIBER BENEFIT RELATED PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: **1. P0203**
If either PRV02 or PRV03 is present, then the other is required.

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

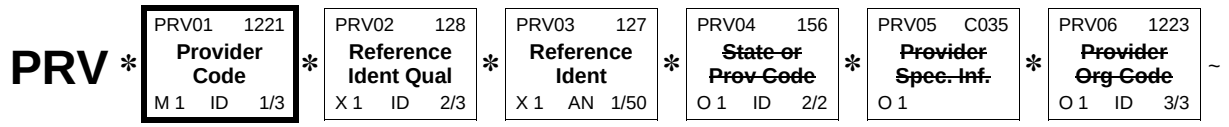
Situational Rule: **Required when needed either to identify a provider's role or associate a specialty type related to the service identified in the 2110C loop. If not required by this implementation guide, do not send.**

TR3 Notes: **1. If identifying a type of specialty associated with the services identified in loop 2110C, use code PXC in PRV02 and the appropriate code in PRV03.**

2. If there is a PRV segment in 2100B or 2100C, this PRV overrides it for this occurrence of the 2110C loop.

TR3 Example: **PRV*PE*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **271B1_2120C_PRV01__ProviderCode**

CODE	DEFINITION
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**			
SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type related to the service identified in the 2110C loop. If not required by this implementation guide, do not send.*** OD: **271B1_2120C_PRV02__ReferenceIdentificationQualifier**		**X 1**	**ID**	**2/3**
			CODE	**DEFINITION**			
			PXC	**Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy			
SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type related to the service identified in the 2110C loop. If not required by this implementation guide, do not send.*** OD: **271B1_2120C_PRV03__ProviderIdentifier** IMPLEMENTATION NAME: **Provider Identifier** **Use this reference number as qualified by the preceding data element (PRV02).**		**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**		**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**		**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**		**O 1**	**ID**	**3/3**

SEGMENT DETAIL

LE - LOOP TRAILER

X12 Segment Name: Loop Trailer

X12 Purpose: To indicate that the loop immediately preceding this segment is complete

X12 Semantic:
1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the other loop. When specified by the standards setting body as mandatory, this segment in combination with "LS", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop beginning segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comments:
1. See Figures Appendix for an explanation of the use of the LE and LS segments.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **1**

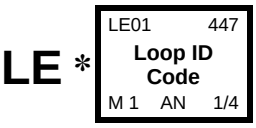
Usage: **SITUATIONAL**

Situational Rule: **Required when Loop 2120C is used. If not required by this implementation guide, do not send.**

TR3 Notes:
1. **Use this segment to identify the end of the Subscriber Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops.**

TR3 Example: **LE*2120~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LE01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	**M 1 AN 1/4**
			OD: **271B1_2110C_LE01__LoopIdentifierCode**	
			This data element must have the value of "2120".	

SEGMENT DETAIL

HL - DEPENDENT LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000D — DEPENDENT LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required if the patient is a dependent who does not have a unique Member Identification Number (See Section 1.4.2) unless the 271 response contains an AAA segment in loop 2000A, 2100A, 2100B, 2100C or 2110C. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **See Section 1.4.2 Basic Concepts for more information about dependents and patients.**
2. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source. See Section 1.3.2 for limitations on the number of occurrences of patients.

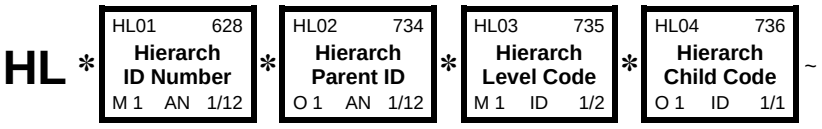
3. An example of the overall structure of the transaction set when used in batch mode is:

Information Source Loop 2000A
Information Receiver Loop 2000B
Subscriber Loop 2000C
Dependent Loop 2000D
Eligibility or Benefit Information
Subscriber Loop 2000C
Eligibility or Benefit Information
Dependent Loop 2000D
Eligibility or Benefit Information

The above example shows 2 different Subscribers. The first Subscriber is not the patient, only the dependent is the patient. The second Subscriber is a patient and the Dependent is also a patient.

TR3 Example: **HL*4*3*23*0~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	**M 1 AN 1/12**

COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

OD: 271B1_2000D_HL01__HierarchicalIDNumber

Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. The first HL segment in the transaction should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).

An example of the use of the HL segment and this data element is:

HL*120*1~**
NM1*PR*2*ABC INSURANCE COMPANY***PI*842610001~**
HL*2*1*21*1~
NM1*1P*1*JONES*MARCUS*MD*SV*0202034~**
HL*3*2*22*1~
NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**
HL*4*3*23*0~
NM1*03*1*SMITH*MARY*LOU~
Eligibility/Benefit Data
HL*5*2*22*0~
NM1*IL*1*BROWN*JOHN*E*MI*22211333301~**
Eligibility/Benefit Data

REQUIRED **HL02** **734** **Hierarchical Parent ID Number** **O 1 AN 1/12**
Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.

OD: **271B1_2000D_HL02__HierarchicalParentIDNumber**

Use this ID number to identify the specific Subscriber to which this Dependent is subordinate.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**
Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

OD: **271B1_2000D_HL03__HierarchicalLevelCode**

All data that follows this HL segment is associated with the Dependent identified by the level code. This association continues until the next occurrence of an HL segment.

CODE	DEFINITION
23	**Dependent**
	Use the dependent level to identify an individual(s) who may be a dependent of the subscriber/insured. This entity may or may not be the actual patient.

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

OD: **271B1_2000D_HL04__HierarchicalChildCode**

Because of the hierarchical structure, and because no subordinate HL levels exist, the code value in the HL04 at the Loop 2000D level must be “0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

SEGMENT DETAIL

TRN - DEPENDENT TRACE NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

X12 Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

Loop: **2000D — DEPENDENT LEVEL**

Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when the 270 request contained one or two TRN segments and the dependent is the patient (See Section 1.4.2.). One TRN segment for each TRN submitted in the 270 must be returned.;**
OR
Required when the Information Source needs to return a unique trace number for the current transaction.
If not required by this implementation guide, do not send.

TR3 Notes:

1. **An information source may receive up to two TRN segments in each loop 2000D of a 270 transaction and must return each of them in loop 2000D of the 271 transaction unless the person submitted in loop 2000D is determined to be a subscriber, then the TRN segments must be returned in loop 2000C (See Section 1.4.2). The returned TRN segments will have a value of "2" in TRN01. See Section 1.4.6 Information Linkage for additional information.**

2. **An information source may add one TRN segment to loop 2000D with a value of "1" in TRN01 and must identify themselves in TRN03.**

3. **If this transaction passes through a clearinghouse, the clearinghouse will receive from the information source the information receiver's TRN segment and the clearinghouse's TRN segment with a value of "2" in TRN01. Since the ultimate destination of the transaction is the information receiver, if the clearinghouse intends on passing their TRN segment to the information receiver, the clearinghouse must change the value in TRN01 to "1" of their TRN segment. This must be done since the trace number in the clearinghouse's TRN segment is not actually a referenced transaction trace number to the information receiver.**

4. **The trace number in the 271 transaction TRN02 must be returned exactly as submitted in the 270 transaction. For example, if the 270 transaction TRN02 was 012345678 it must be returned as 012345678 and not as 12345678.**

TR3 Example:

TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*2*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

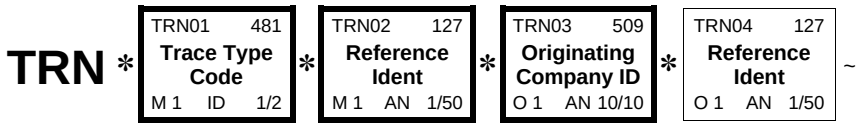
The above example represents how an information source would respond. The first TRN segment was initiated by the information receiver. The second TRN segment was initiated by the clearinghouse. The third TRN segment was initiated by the information source.

TR3 Example:

TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how a clearinghouse would respond to the same set of TRN segments if the clearinghouse intends to pass their TRN segment on to the information receiver. If the clearinghouse does not intend to pass their TRN segment on to the information receiver, only the first and third TRN segments in the example would be sent.

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	TRN01	481	**Trace Type Code** Code identifying which transaction is being referenced	M 1 ID 1/2

OD: **271B1_2000D_TRN01__TraceTypeCode**

CODE	DEFINITION
1	Current Transaction Trace Numbers
	The term “Current Transaction Trace Numbers” refers to trace or reference numbers assigned by the creator of the 271 transaction (the information source). If a clearinghouse has assigned a TRN segment and intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to “1" (since it will be returned by the information source as a "2").
2	Referenced Transaction Trace Numbers
	The term “Referenced Transaction Trace Numbers” refers to trace or reference numbers originally sent in the 270 transaction and now returned in the 271.

REQUIRED **TRN02** **127** **Reference Identification** **M 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN02 provides unique identification for the transaction.

OD: **271B1_2000D_TRN02__TraceNumber**

IMPLEMENTATION NAME: **Trace Number**

This element must contain the trace number submitted in TRN02 from the 270 transaction and must be returned exactly as submitted.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O 1 AN 10/10**
A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SEMANTIC: TRN03 identifies an organization.

OD: **271B1_2000D_TRN03__TraceAssigningEntityIdentifier**

IMPLEMENTATION NAME: **Trace Assigning Entity Identifier**

If TRN01 is "1", use this information to identify the organization that assigned this trace number.

If TRN01 is "2", this is the value received in the original 270 transaction.

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL **TRN04** **127** **Reference Identification** **O 1 AN 1/50**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

SITUATIONAL RULE: ***Required when TRN01 = "2" and this element was used in the corresponding 270 TRN segment.;***
OR
Required when TRN01 = "1" and the Information Source needs to further identify a specific component, such as a specific division or group of the entity identified in the previous data element (TRN03). If not required by this implementation guide, do not send.

OD: **271B1_2000D_TRN04__TraceAssigningEntityAdditionalIdentifier**

IMPLEMENTATION NAME: **Trace Assigning Entity Additional Identifier**

If TRN01 is "1", use this information if necessary to further identify a specific component, such as a specific division or group of the entity identified in the previous data element (TRN03).

If TRN01 is "2", this is the value received in the original 270 transaction.

SEGMENT DETAIL

NM1 - DEPENDENT NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100D — DEPENDENT NAME Loop Repeat: 1**

Segment Repeat: **1**

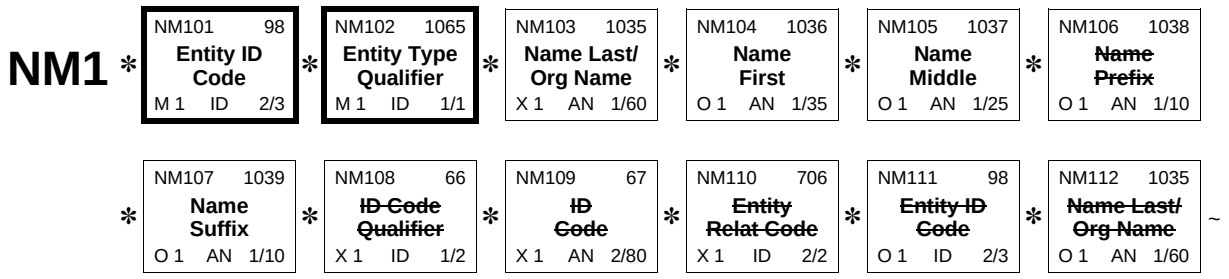
Usage: **REQUIRED**

TR3 Notes:

1. **Use this segment to identify an entity by name. This NM1 loop is used to identify the dependent of an insured or subscriber.**

TR3 Example: **NM1*03*1*SMITH*JOHN*L**JR~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **271B1_2100D_NM101__EntityIdentifierCode**

CODE	DEFINITION
03	**Dependent**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. OD: **271B1_2100D_NM102__EntityTypeQualifier** CODE / DEFINITION **1** **Person**	**M 1**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_NM103__DependentLastName** IMPLEMENTATION NAME: **Dependent Last Name** **Use this name for the dependent's last name.**	**X 1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name SITUATIONAL RULE: ***Required unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_NM104__DependentFirstName** IMPLEMENTATION NAME: **Dependent First Name** **Use this name for the dependent's first name.**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Dependent for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100D_NM105__DependentMiddleName** IMPLEMENTATION NAME: **Dependent Middle Name** **Use this name for the dependent's middle name or initial.**	**O 1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O 1**	**AN**	**1/10**
			SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Dependent for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated and this element was not valued in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***			
			OD: **271B1_2100D_NM107__DependentNameSuffix**			
			IMPLEMENTATION NAME: **Dependent Name Suffix**			
			Use this for the suffix to an individual's name; e.g., Sr., Jr., or III.			
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X 1**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

REF - DEPENDENT ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

Situational Rule: **Required when the Information Source requires additional identifiers necessary to identify the Dependent for subsequent EDI transactions (see Section 1.4.7);**
OR
Required when the 270 request contained a REF segment with a Patient Account Number in Loop 2100D/REF02 with REF01 equal EJ;
OR
Required when the 270 request contained a REF segment and the information provided in that REF segment was used to locate the individual in the information source's system (See Section 1.4.7).
If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.

TR3 Notes:
1. **If the 270 request contained a REF segment with a Patient Account Number in Loop 2100D/REF02 with REF01 equal EJ, then it must be returned in the 271 transaction using this segment if the patient is the Dependent. The Patient Account Number in the 271 transaction must be returned exactly as submitted in the 270 transaction.**

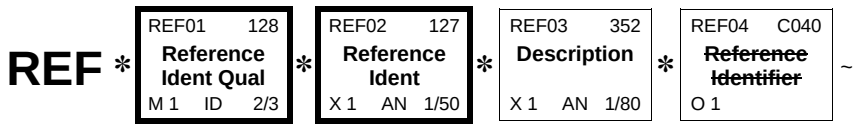
2. **Use this segment to supply an identification number other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2100D loop.**

3. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

TR3 Example: **REF*EJ*660415~**

TR3 Example: **REF*49*03~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: **271B1_2100D_REF01__ReferenceIdentificationQualifier**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Only one occurrence of each REF01 code value may be used in the 2100D loop.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
49	**Family Unit Number**
	Required when the Information Source is a Pharmacy Benefit Manager (PBM) and the individual has a suffix to their member ID number that is required for use in the NCPDP Telecom Standard in the Insurance Segment in field 303-C3 Person Code. If not required by this implementation Guide, do not send. **NOTE: For all other uses, the Family Unit Number (suffix) is considered a part of the Member ID number and is used to uniquely identify the individual and must be returned at the end of the Member ID number in 2100C NM109 or in 2100C REF02 if REF01 is "1W".**
6P	**Group Number**
CT	**Contract Number**
	This code is to be used only to identify the provider's contract number of the provider identified in the PRV segment of Loop 2100C. This code is only to be used once the CMS National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.
EA	**Medical Record Identification Number**

EJ	**Patient Account Number**
F6	**Health Insurance Claim (HIC) Number**
	See segment note 3.
GH	**Identification Card Serial Number**
	Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.
HJ	**Identity Card Number**
	Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.
IF	**Issue Number**
IG	**Insurance Policy Number**
MRC	**Eligibility Category** CODE SOURCE **844:** Eligibility Category
N6	**Plan Network Identification Number**
NQ	**Medicaid Recipient Identification Number**
	See segment note 3.
Q4	**Prior Identifier Number**
	This code is to be used when a corrected or new identification number is returned in NM109, the originally submitted identification number is to be returned in REF02. To be used in conjunction with code "001" in INS03 and code "25" in INS04.
SY	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
Y4	**Agency Claim Number**
	This code is to only to be used when the information source is a Property and Casualty payer. Use this code to identify the Property and Casualty Claim Number associated with the dependent. This code is not a HIPAA requirement as of this writing.

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 271B1_2100D_REF02__DependentSupplementalIdentifier** **IMPLEMENTATION NAME: Dependent Supplemental Identifier** **Use this information for the reference number as qualified by the preceding data element (REF01).** **If REF01 is "EJ", the Patient Account Number from the 270 transaction must be returned exactly as submitted.**	**X 1**	**AN**	**1/50**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content **SYNTAX:** R0203 **SITUATIONAL RULE:** ***Required when REF01 = "18", "6P" or "N6" and a name needs to be associated with the corresponding identifier. If not required by this implementation guide, do not send.*** **OD: 271B1_2100D_REF03__PlanGrouporPlanNetworkName** **IMPLEMENTATION NAME: Plan, Group or Plan Network Name**	**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**		

SEGMENT DETAIL

N3 - DEPENDENT ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

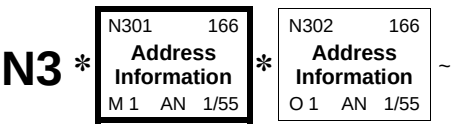
Situational Rule: **Required when the Information Source requires this information to identify the Dependent for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Do not return address information from the 270 request.**
2. **Use this segment to identify address information for a dependent.**

TR3 Example: **N3*15197 BROADWAY AVENUE*APT 215~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **271B1_2100D_N301__DependentAddressLine**	
			IMPLEMENTATION NAME: **Dependent Address Line**	
			Use this information for the first line of the address information.	

SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**1**	**AN**	**1/55**

SITUATIONAL RULE: ***Required when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7) unless a rejection response is generated. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2100D_N302__DependentAddressLine**

IMPLEMENTATION NAME: **Dependent Address Line**

Use this information for the second line of the address information.

SEGMENT DETAIL

N4 - DEPENDENT CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

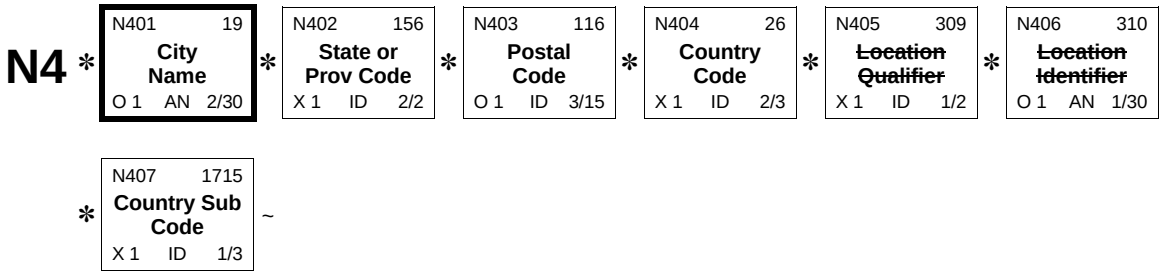
Situational Rule: **Required when the Information Source requires this information to identify the Dependent for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Do not return address information from the 270 request.**
2. **Use this segment to identify address information for a dependent.**

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. OD: **271B1_2100D_N401__DependentCityName** IMPLEMENTATION NAME: **Dependent City Name**	**O 1 AN 2/30**
SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_N402__DependentStateCode** IMPLEMENTATION NAME: **Dependent State Code** CODE SOURCE **22:** States and Provinces	**X 1 ID 2/2**
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_N403__DependentPostalZoneorZIPCode** IMPLEMENTATION NAME: **Dependent Postal Zone or ZIP Code** CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes	**O 1 ID 3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_N404__DependentCountryCode** IMPLEMENTATION NAME: **Dependent Country Code** CODE SOURCE **5:** Countries, Currencies and Funds **Use the alpha-2 country codes from Part 1 of ISO 3166.**	**X 1 ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X 1 ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O 1 AN 1/30**

SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_N407__DependentCountrySubdivisionCode**

IMPLEMENTATION NAME: **Dependent Country Subdivision Code**

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

AAA - DEPENDENT REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

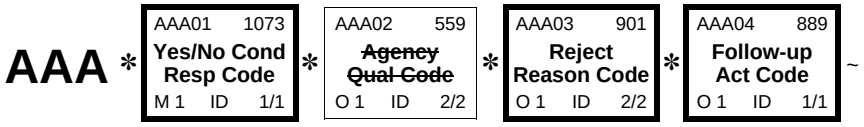
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to the data contained in the original 270 transaction's dependent name loop (Loop 2100D) and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's dependent name loop (Loop 2100D).**

TR3 Example: **AAA*N**58*C~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid. OD: **271B1_2100D_AAA01__ValidRequestIndicator** IMPLEMENTATION NAME: **Valid Request Indicator**	**M 1 ID 1/1**
			CODE / DEFINITION **N** — **No** **Y** — **Yes**	
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O 1 ID 2/2**

REQUIRED **AAA03** **901** **Reject Reason Code** **O 1 ID 2/2**

Code assigned by issuer to identify reason for rejection

OD: **271B1_2100D_AAA03__RejectReasonCode**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

Use codes "43", "45", "47", "48", or "51" only in response to information that is in or should be in the PRV segment in the Dependent Name loop (2100D).

CODE	DEFINITION
15	Required application data missing
35	Out of Network
	Use this code to indicate that the dependent is not in the Network of the provider identified in the 2100B NM1 segment, or the 2100B/2100D PRV segment if present, in the 270 transaction.
42	Unable to Respond at Current Time
	Use this code in a batch environment where an information source returns all requests from the 270 in the 271 and identifies "Unable to Respond at Current Time" for each individual request (subscriber or dependent) within the transaction that they were unable to process for reasons other than data content (such as their system is down or timed out in generating a response). Use only codes "R", "S", or "Y" for AAA04.
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
	Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.
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**			
				Required when the transaction was rejected when the information source cannot find a match for the Patient Name submitted or if the Patient Name was missing.			
			66	**Invalid/Missing Patient Gender Code**			
			67	**Patient Not Found**			
				Code 67 may not be returned if the information receiver submitted all four pieces of the mandated search option.			
			68	**Duplicate Patient ID Number**			
			71	**Patient Birth Date Does Not Match That for the Patient on the Database**			
				Code 71 must be returned when the transaction was rejected when the information source located an individual based other information submitted, but the Birth Date does not match.			
			77	**Subscriber Found, Patient Not Found**			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2100D_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				
			CODE	**DEFINITION**			
			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**			
				Use only when AAA03 is “42".			

SEGMENT DETAIL

PRV - PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax:
1. **P0203**
   If either PRV02 or PRV03 is present, then the other is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

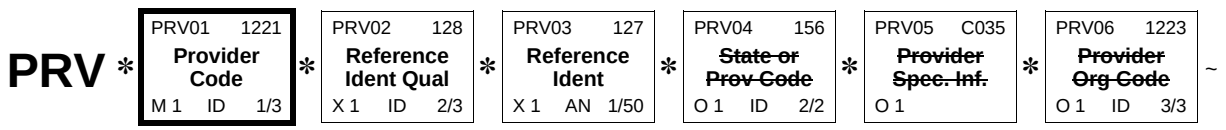
Usage: **SITUATIONAL**

Situational Rule: **Required when the 270 request contained a 2100D PRV segment and the information contained in the PRV segment was used to determine the 271 response.;**
OR
Required when needed either to identify a specific provider or to associate a specialty type related to the service identified in the 2110D loop. This PRV segment applies to all benefits in this 2100D loop unless overridden by a PRV segment in the 2120D loop.
If not required by this implementation guide, do not send.

TR3 Notes:
1. **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. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
2. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
3. **If identifying a type of specialty associated with the services identified in loop 2110D, use code PXC in PRV02 and the appropriate code in PRV03.**
4. **PRV02 qualifies PRV03.**
5. **If there is a PRV segment in 2100B, this PRV overrides it for this occurrence of the 2100D loop.**

TR3 Example: **PRV*RF*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **271B1_2100D_PRV01__ProviderCode**

CODE	DEFINITION
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**
SK	**Skilled Nursing Facility**
SU	**Supervising**

SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**X 1 ID 2/3**

SYNTAX: P0203

SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_PRV02__ReferenceIdentificationQualifier**

If this segment is used to identify a type of specialty associated with the services identified in loop 2110D, use code PXC.

CODE	DEFINITION
PXC	**Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy

SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_PRV03__ProviderIdentifier** IMPLEMENTATION NAME: **Provider Identifier** **Use this number for the reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

DMG - DEPENDENT DEMOGRAPHIC INFORMATION

X12 Segment Name: Demographic Information

X12 Purpose: To supply demographic information

X12 Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.
2. **P1011**
   If either DMG10 or DMG11 is present, then the other is required.
3. **C1105**
   If DMG11 is present, then DMG05 is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

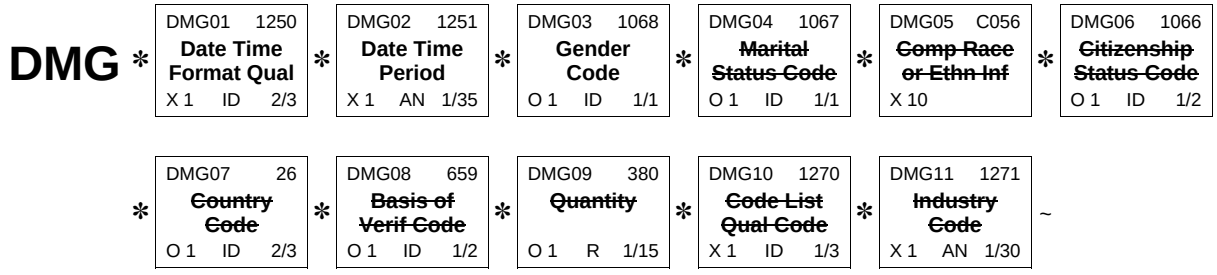
Situational Rule: **Required when the Dependent is the patient unless a rejection response is generated with a 2100D or 2110D AAA segment and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Use this segment to convey the birth date or gender demographic information for the dependent.**

TR3 Example: **DMG*D8*19750616*M~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 SITUATIONAL RULE: ***Required when Dependent Birth Date is sent in DMG02. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_DMG01__DateTimePeriodFormatQualifier** **Use this code to indicate the format of the date of birth that follows in DMG02.** CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**X 1 ID 2/3**
SITUATIONAL	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. SITUATIONAL RULE: ***Required when the Dependent is the patient unless a rejection response is generated with a 2100D or 2110D AAA segment and this element was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100D_DMG02__DependentBirthDate** IMPLEMENTATION NAME: **Dependent Birth Date** **Use this date for the date of birth of the dependent.**	**X 1 AN 1/35**
SITUATIONAL	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual SITUATIONAL RULE: ***Required when the Dependent is the patient unless a rejection response is generated with a 2100D or 2110D AAA segment and this element was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.*** OD: **271B1_2100D_DMG03__DependentGenderCode** IMPLEMENTATION NAME: **Dependent Gender Code** CODE / DEFINITION **F** — **Female** **M** — **Male** **U** — **Unknown**	**O 1 ID 1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O 1 ID 1/1**
NOT USED	**DMG05**	**C056**	**COMPOSITE RACE OR ETHNICITY INFORMATION**	**X 10**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O 1 ID 1/2**

NOT USED	DMG07	26	Country Code	O	1	ID	2/3
NOT USED	DMG08	659	Basis of Verification Code	O	1	ID	1/2
NOT USED	DMG09	380	Quantity	O	1	R	1/15
NOT USED	DMG10	1270	Code List Qualifier Code	X	1	ID	1/3
NOT USED	DMG11	1271	Industry Code	X	1	AN	1/30

SEGMENT DETAIL

INS - DEPENDENT RELATIONSHIP

X12 Segment Name: Insured Benefit

X12 Purpose: To provide benefit information on insured entities

X12 Syntax: **1. P1112**
If either INS11 or INS12 is present, then the other is required.

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

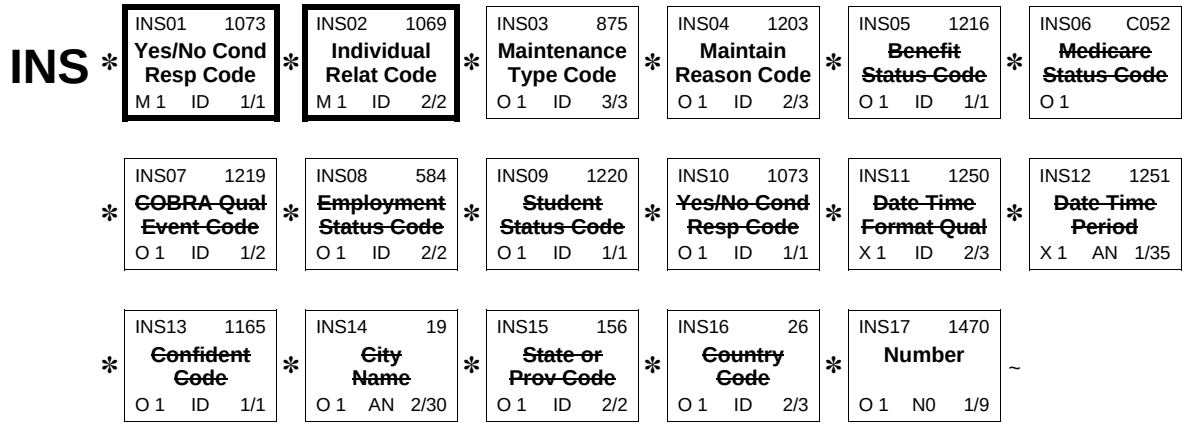
Usage: **SITUATIONAL**

Situational Rule: **Required when the Dependent is the patient unless a rejection response is generated with a 2100D or 2110D AAA segment and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.**

TR3 Notes: **1. This segment may also be used 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.**

TR3 Example: **INS*N*19**********3~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SEMANTIC: INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent. OD: **271B1_2100D_INS01__InsuredIndicator** IMPLEMENTATION NAME: **Insured Indicator** CODE / DEFINITION **N** — **No**	**M 1 ID 1/1**
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities OD: **271B1_2100D_INS02__IndividualRelationshipCode** CODE / DEFINITION **01** — **Spouse** **19** — **Child** **20** — **Employee** **21** — **Unknown** **Use this code only if relationship information is not available and there is a need to use data elements INS03, INS04, or INS17.** **39** — **Organ Donor** **40** — **Cadaver Donor** **53** — **Life Partner** **G8** — **Other Relationship**	**M 1 ID 2/2**
SITUATIONAL	**INS03**	**875**	**Maintenance Type Code** Code identifying the specific type of item maintenance SITUATIONAL RULE: ***Required along with INS04 when acknowledging a change in the identifying elements for the dependent from those submitted in the 270. If not required by this implementation guide, do not send.*** OD: **271B1_2100D_INS03__MaintenanceTypeCode** **Use this element (and code "25" in INS04) if any of the identifying elements for the dependent have been changed from those submitted in the 270.** CODE / DEFINITION **001** — **Change**	**O 1 ID 3/3**

SITUATIONAL	**INS04**	**1203**	**Maintenance Reason Code** Code identifying the reason for the maintenance change	**O 1**	**ID**	**2/3**

SITUATIONAL RULE: ***Required along with INS03 when acknowledging a change in the identifying elements for the dependent from those submitted in the 270. If not required by this implementation guide, do not send.***

OD: 271B1_2100D_INS04__MaintenanceReasonCode

Use this element (and code "001" in INS03) if any of the identifying elements for the dependent have been changed from those submitted in the 270.

CODE	DEFINITION
25	**Change in Identifying Data Elements**
	Use this code to indicate that a change has been made to the primary elements that identify a specific person. Such elements are first name, last name, date of birth, and identification numbers.

NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS06**	**C052**	**MEDICARE STATUS CODE**	**O 1**		
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O 1**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS09**	**1220**	**Student Status Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS10**	**1073**	**Yes/No Condition or Response Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X 1**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X 1**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O 1**	**ID**	**1/1**
NOT USED	**INS14**	**19**	**City Name**	**O 1**	**AN**	**2/30**
NOT USED	**INS15**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**INS16**	**26**	**Country Code**	**O 1**	**ID**	**2/3**
SITUATIONAL	**INS17**	**1470**	**Number** A generic number	**O 1**	**N0**	**1/9**

SEMANTIC: INS17 is 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.).

SITUATIONAL RULE: ***Required when the Birth Sequence Number submitted in the 270 was used to locate the Dependent. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: 271B1_2100D_INS17__BirthSequenceNumber

IMPLEMENTATION NAME: Birth Sequence Number

Use to indicate the birth order in the event of multiple births in association with the birth date supplied in DMG02.

SEGMENT DETAIL

HI - DEPENDENT HEALTH CARE DIAGNOSIS CODE

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

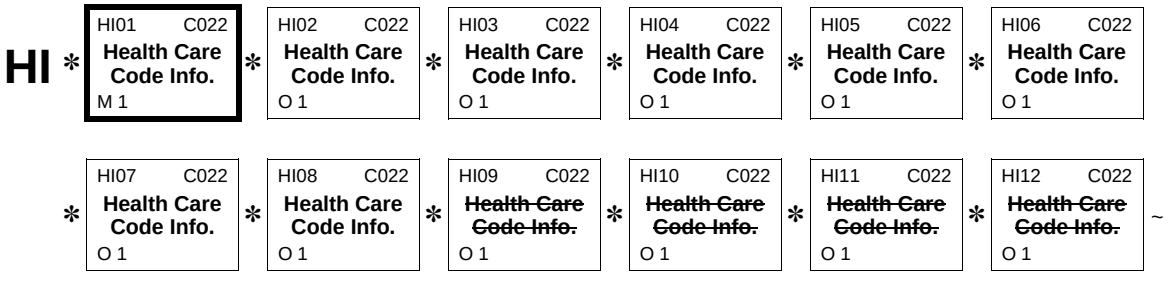
Situational Rule: **Required when an HI segment was received in the 270 and if the information source uses the information in the determination of the eligibility or benefit response for the dependent. All information used from the HI segment of the 270 used in the determination of the eligibility or benefit response for the dependent must be returned. If information was provided in an HI segment of 270 but was not used in the determination of the eligibility or benefits for the dependent it must not be returned. The information source must not use information in an HI segment of the 270 transaction in the determination of eligibility or benefits for the dependent if that information cannot be returned in the 271 response.**
OR
Required when needed to identify limitations in the benefits identified in the 2110D loops, such as if benefits are limited for a specific diagnosis code if the information source can support this high level functionality. If the information source cannot support this high level functionality, do not send.

TR3 Notes:

1. **Use the Diagnosis code pointers in 2110D EB14 to identify which diagnosis code or codes in this HI segment relates to the information provided in the EB segment.**
2. **Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.**

TR3 Example: **HI*BK:8901*BF:87200*BF:5559~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities **SYNTAX:** **P0304** If either C02203 or C02204 is present, then the other is required. **E0809** Only one of C02208 or C02209 may be present. OD: **271B1_2100D_HI01_C022** **E codes are Not Used in HI01 except when defined by the claims processor. E codes may be put in any other HI element using BF as the qualifier.** **The diagnosis listed in this element is assumed to be the principal diagnosis.**	**M 1**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SEMANTIC:** C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08. OD: **271B1_2100D_HI01_C02201_DiagnosisTypeCode** IMPLEMENTATION NAME: **Diagnosis Type Code**	**M ID 1/3**
			CODE: **ABK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	
			CODE: **BK** — DEFINITION: **International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. OD: **271B1_2100D_HI01_C02202_DiagnosisCode** IMPLEMENTATION NAME: **Diagnosis Code**	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data element has been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI02_C022**

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI02_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI02 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI02_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI03_C022**

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI03_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI03 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI03_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI04_C022**

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI04_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI04_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI05_C022**

REQUIRED **HI05 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI05_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI05 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI05_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI06_C022**

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI06_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI06_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI07_C022**

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI07_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI07_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_HI08_C022**

REQUIRED **HI08 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

OD: **271B1_2100D_HI08_C02201_DiagnosisTypeCode**

IMPLEMENTATION NAME: **Diagnosis Type Code**

CODE	DEFINITION
ABF	**International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis** CODE SOURCE **897:** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	**International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED **HI08 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

OD: **271B1_2100D_HI08_C02202_DiagnosisCode**

IMPLEMENTATION NAME: **Diagnosis Code**

NOT USED **HI08 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**

NOT USED **HI08 - 4** **1251** **Date Time Period** **X** **AN** **1/35**

NOT USED **HI08 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI08 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI08 - 7** **799** **Version Identifier** **O** **AN** **1/30**

NOT USED **HI08 - 8** **1271** **Industry Code** **X** **AN** **1/30**

NOT USED **HI08 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**

NOT USED **HI09** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI10** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI11** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

NOT USED **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O 1**

SEGMENT DETAIL

DTP - DEPENDENT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2100D — DEPENDENT NAME**

Segment Repeat: **9**

Usage: **SITUATIONAL**

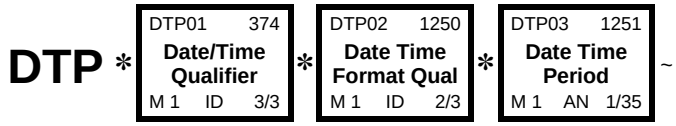
Situational Rule: **Required to identify the Plan (DTP01 = 291) or Plan Begin (DTP01 = 346) date when the individual has active coverage unless multiple plans apply to the individual or multiple plan periods apply, which must then be returned in the 2110D DTP (See Section 1.4.7);**
OR
Required when needed to identify other relevant dates that apply to the Dependent.
If not required by this implementation guide, do not send.

TR3 Notes:

1. **The dates represented may be in the past, the current date, or a future date. The dates may also be a single date or a span of dates. Which date(s) to use is determined by the format qualifier in DTP02.**
2. **Dates supplied in the 2100D DTP apply to the Dependent and all 2110D loops unless overridden by an occurrence of a 2110D DTP with the same value in DTP01.**

TR3 Example: **DTP*346*D8*19950818~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**

OD: 271B1_2100D_DTP01__DateTimeQualifier

IMPLEMENTATION NAME: Date Time Qualifier

CODE	DEFINITION
096	**Discharge**
102	**Issue**
152	**Effective Date of Change**
291	**Plan**

			307	**Eligibility**			
			318	**Added**			
				Information Sources are encouraged to return Added date in the case of retroactive eligibility.			
			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**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M 1**	**ID**	**2/3**

Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

OD: **271B1_2100D_DTP02__DateTimePeriodFormatQualifier**

Use this code to specify the format of the date(s)/time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M 1**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

OD: **271B1_2100D_DTP03__DateTimePeriod**

Use this date for the date(s) as qualified by the preceding data elements.

SEGMENT DETAIL

MPI - DEPENDENT MILITARY PERSONNEL INFORMATION

X12 Segment Name: Military Personnel Information

X12 Purpose: To report military service data

X12 Syntax: **1. P0607**
If either MPI06 or MPI07 is present, then the other is required.

Loop: **2100D — DEPENDENT NAME**

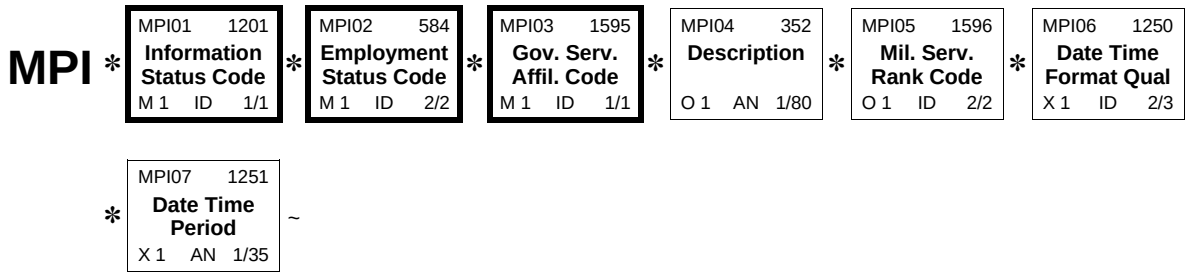
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when this transaction is processed by DOD or CHAMPUS/TRICARE and when necessary to convey the Dependent's military service data If not required by this implementation guide, do not send.**

TR3 Example: **MPI*C*AO*A**L3~**
Current Active Military - Overseas Air Force Lieutenant Colonel

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**MPI01**	**1201**	**Information Status Code** A code to indicate the status of information	**M 1 ID 1/1**

OD: **271B1_2100D_MPI01__InformationStatusCode**

CODE	DEFINITION
A	**Partial**
C	**Current**
L	**Latest**
O	**Oldest**
P	**Prior**
S	**Second Most Current**
T	**Third Most Current**

REQUIRED **MPI02** **584** **Employment Status Code** **M 1** **ID** **2/2**
Code showing the general employment status of an employee/claimant

OD: **271B1_2100D_MPI02__EmploymentStatusCode**

CODE	DEFINITION
AE	Active Reserve
AO	Active Military - Overseas
AS	Academy Student
AT	Presidential Appointee
AU	Active Military - USA
CC	Contractor
DD	Dishonorably Discharged
HD	Honorably Discharged
IR	Inactive Reserves
LX	Leave of Absence: Military
PE	Plan to Enlist
RE	Recommissioned
RM	Retired Military - Overseas
RR	Retired Without Recall
RU	Retired Military - USA

REQUIRED **MPI03** **1595** **Government Service Affiliation Code** **M 1** **ID** **1/1**
Code specifying the government service affiliation

OD: **271B1_2100D_MPI03__GovernmentServiceAffiliationCode**

CODE	DEFINITION
A	Air Force
B	Air Force Reserves
C	Army
D	Army Reserves
E	Coast Guard
F	Marine Corps
G	Marine Corps Reserves
H	National Guard
I	Navy
J	Navy Reserves
K	Other
L	Peace Corp
M	Regular Armed Forces
N	Reserves
O	U.S. Public Health Service
Q	Foreign Military
R	American Red Cross
S	Department of Defense
U	United Services Organization
W	Military Sealift Command

SITUATIONAL **MPI04** **352** **Description** **O 1** **AN** **1/80**
A free-form description to clarify the related data elements and their content

SEMANTIC: MPI04 is the actual response to further identify the exact military unit.

SITUATIONAL RULE: ***Required when needed to further identify the exact military unit. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_MPI04__Description**

SITUATIONAL **MPI05** **1596** **Military Service Rank Code** **O 1** **ID** **2/2**
Code specifying the military service rank

SITUATIONAL RULE: ***Required when needed to indicate the current or most recent military service rank. If not required by this implementation guide, do not send.***

OD: **271B1_2100D_MPI05__MilitaryServiceRankCode**

CODE	DEFINITION
A1	Admiral
A2	Airman
A3	Airman First Class
B1	Basic Airman
B2	Brigadier General
C1	Captain
C2	Chief Master Sergeant
C3	Chief Petty Officer
C4	Chief Warrant
C5	Colonel
C6	Commander
C7	Commodore
C8	Corporal
C9	Corporal Specialist 4
E1	Ensign
F1	First Lieutenant
F2	First Sergeant
F3	First Sergeant-Master Sergeant
F4	Fleet Admiral
G1	General
G4	Gunnery Sergeant
L1	Lance Corporal
L2	Lieutenant
L3	Lieutenant Colonel
L4	Lieutenant Commander
L5	Lieutenant General
L6	Lieutenant Junior Grade
M1	Major
M2	Major General
M3	Master Chief Petty Officer

			M4	**Master Gunnery Sergeant Major**			
			M5	**Master Sergeant**			
			M6	**Master Sergeant Specialist 8**			
			P1	**Petty Officer First Class**			
			P2	**Petty Officer Second Class**			
			P3	**Petty Officer Third Class**			
			P4	**Private**			
			P5	**Private First Class**			
			R1	**Rear Admiral**			
			R2	**Recruit**			
			S1	**Seaman**			
			S2	**Seaman Apprentice**			
			S3	**Seaman Recruit**			
			S4	**Second Lieutenant**			
			S5	**Senior Chief Petty Officer**			
			S6	**Senior Master Sergeant**			
			S7	**Sergeant**			
			S8	**Sergeant First Class Specialist 7**			
			S9	**Sergeant Major Specialist 9**			
			SA	**Sergeant Specialist 5**			
			SB	**Staff Sergeant**			
			SC	**Staff Sergeant Specialist 6**			
			T1	**Technical Sergeant**			
			V1	**Vice Admiral**			
			W1	**Warrant Officer**			
SITUATIONAL	**MPI06**	**1250**	**Date Time Period Format Qualifier**		**X 1**	**ID**	**2/3**

Code indicating the date format, time format, or date and time format

SYNTAX: P0607

SITUATIONAL RULE: ***Required when needed to indicate the beginning date or date span of military service. If not required by this implementation guide, do not send.***

OD: 271B1_2100D_MPI06__DateTimePeriodFormatQualifier

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

SITUATIONAL	**MPI07**	**1251**	**Date Time Period**		**X 1**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

SYNTAX: P0607

SEMANTIC: MPI07 indicates the date span of military service.

SITUATIONAL RULE: ***Required when needed to indicate the beginning date or date span of military service. If not required by this implementation guide, do not send.***

OD: 271B1_2100D_MPI07__DateTimePeriod

SEGMENT DETAIL

EB - DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION

X12 Segment Name: Eligibility or Benefit Information

X12 Purpose: To supply eligibility or benefit information

X12 Syntax: **1. P0910**
If either EB09 or EB10 is present, then the other is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the dependent is the person whose eligibility or benefits are being described and the transaction is not rejected (see Section 1.4.10) or if the transaction needs to be rejected in this loop. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **See Section 1.4.7 Implementation-Compliant Use of the 270/271 Transaction Set for information about what information must be returned if the subscriber is the person whose eligibility or benefits are being sent.**
2. **Either EB03 or EB13 may be used in the same EB segment, not both.**
3. **EB03 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110D loop is the same with the exception of the Service Type Code used in EB03, it is more efficient to use the repetition function of EB03 to send each of the Service Type Codes needed. If an Information Source supports responses with multiple Service Type Codes, the repetition use of EB03 must be supported if all other elements in the 2110D loop are identical.**
4. **A limit to the number of repeats of EB loops has not been established. In a batch environment there is no practical reason to limit the number of EB loop repeats. In a real time environment, consideration should be given to how many EB loops are generated given the amount of time it takes to format the response and the amount of time it will take to transmit that response. Since these limitations will vary by information source, it would be completely arbitrary for the developers to set a limit. It is not the intent of the developers to limit the amount of information that is returned in a response, rather to alert information sources to consider the potential delays if the response contains too much information to be formatted and transmitted in real time.**
5. **Use this segment to begin the eligibility/benefit information looping structure. The EB segment is used to convey the specific eligibility or benefit information for the entity identified.**

TR3 Example: **EB*1*FAM*96*GP~**
Active Coverage for subscriber and family, for Professional (Physician) services, and coverage is through a Group Policy

TR3 Example: **EB*B**68***27*10~**
Co-payment for Well Baby Care is $10 per visit

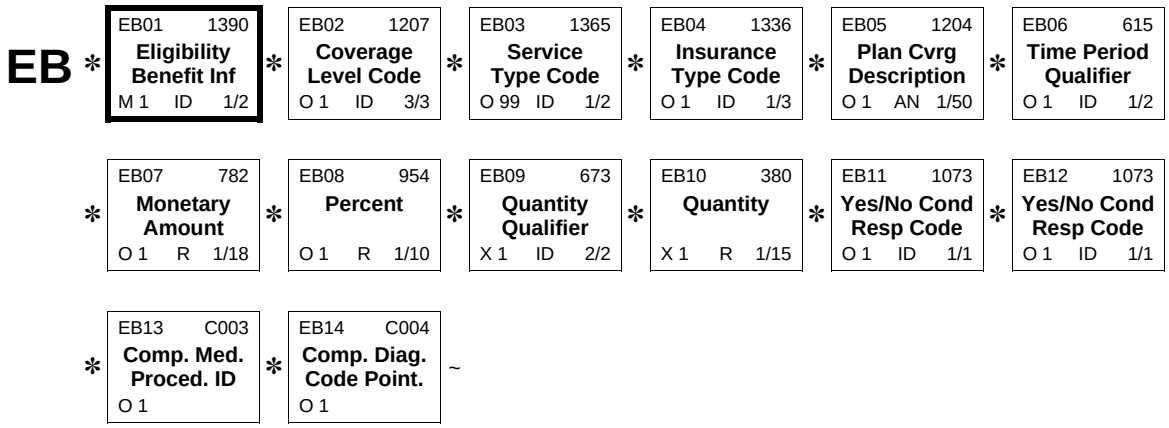
TR3 Example: **EB*C*FAM****23*600~**
Deductible for the family is $600 per calendar year

TR3 Example: **EB*L~**
Primary Care Provider (information about the Primary Care Provider will be located in the 2120 loop)

TR3 Example: **EB*A**A6*****.50~**
Co-Insurance is 50 percent for Psychotherapy

TR3 Example: **EB*B**98^34^44^81^A0^A3****10**VS*1~**
Co-payment for Professional (Physician) Visit - Office, Chiropractic Office Visits, Home Health Visits, Routine Physical, Professional (Physician) Visit - Outpatient, Professional (Physician) Visit - Home, is $10 for one visit

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**EB01**	**1390**	**Eligibility or Benefit Information Code** Code identifying eligibility or benefit information	**M 1 ID 1/2**

SEMANTIC: EB01 qualifies EB06 through EB10.

OD: 271B1_2110D_EB01__EligibilityorBenefitInformation

IMPLEMENTATION NAME: Eligibility or Benefit Information

Use this code to identify the eligibility or benefit information. This may be the eligibility status of the individual or the benefit related category that is being further described in the following data elements. This data element also qualifies the data in elements EB06 through EB10.

If codes A, B, C, G, J or Y are used, it is required that the patient's portion of responsibility is reflected in either EB07 or EB08. See Section 1.4.9 Patient Responsibility for detailed information and definitions.

CODE	DEFINITION
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
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
B	Co-Payment
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
C	Deductible
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
CB	Coverage Basis
D	Benefit Description
E	Exclusions
F	Limitations
G	Out of Pocket (Stop Loss)
	See Section 1.4.9 Patient Responsibility for detailed information and definitions.
H	Unlimited
I	Non-Covered

			J	**Cost Containment**
				See Section 1.4.9 Patient Responsibility for detailed information and definitions.
			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**
				Not recommended. See section 1.4.11 Disclaimers Within the Transaction.
			Q	**Second Surgical Opinion Required**
			R	**Other or Additional Payor**
			S	**Prior Year(s) History**
			T	**Card(s) Reported Lost/Stolen**
				Code "T" is typically used by Medicaids to indicate to a provider that the person who has presented the ID card is using a stolen ID card.
			U	**Contact Following Entity for Eligibility or Benefit Information**
			V	**Cannot Process**
			W	**Other Source of Data**
			X	**Health Care Facility**
			Y	**Spend Down**
				See Section 1.4.9 Patient Responsibility for detailed information and definitions.
SITUATIONAL	**EB02**	**1207**	**Coverage Level Code** **O 1 ID 3/3** Code indicating the level of coverage being provided for this insured	
			SITUATIONAL RULE: ***Required when needed to identify the types of individuals associated with the eligibility or benefits being identified in the 2110D loop. If not required by this implementation guide, do not send.***	
			OD: **271B1_2110D_EB02__BenefitCoverageLevelCode**	
			IMPLEMENTATION NAME: **Benefit Coverage Level Code**	
			This element is used in conjunction with EB01 codes (e.g. Active Family Coverage, Deductible Individual, etc.). This element can be used to identify types of individual's within the Subscriber's family that eligibility or benefits extends to (unless EB01 = E - Exclusions).	
			CODE	**DEFINITION**
			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**			
SITUATIONAL	**EB03**	**1365**	**Service Type Code**		**O** **99**	**ID**	**1/2**

Code identifying the classification of service

SEMANTIC: Position of data in the repeating data element conveys no significance.

SITUATIONAL RULE: ***Required when the dependent is the patient and has been found in the Information Source's system to identify Active or Inactive Health Benefit Plan Coverage (See Section 1.4.7);***
OR
Required when one of the Service Type Codes identified in Section 1.4.7 must be returned;
OR
Required when responding to a corresponding Service Type code used from the 270 transaction;
OR
Required when the eligibility or benefits being identified in the 2110D loop need to be associated with a specific Service Type Code.
If not required by this implementation guide or if EB13 is used, do not send.

OD: **271B1_2110D_EB03__ServiceTypeCode**

See Section 1.4.7 Implementation-Compliant Use of the 270/271 Transaction Set for information about what service type codes must be returned.

EB03 is a repeating data element that may be repeated up to 99 times. If all of the information that will be used in the 2110D loop is the same with the exception of the Service Type Code used in EB03, it is more efficient to use the repetition function of EB03 to send each of the Service Type Codes needed. If an Information Source supports responses with multiple Service Type Codes, the repetition use of EB03 must be supported if all other elements in the 2110D loop are identical.

Not used if EB13 is present.

CODE	DEFINITION
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
	See Section 1.4.7.1
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
55	Major Medical
56	Medically Related Transportation
57	Air Transportation

58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
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**
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**
	Use for Routine Vision Exam only.
AO	**Lenses**
AQ	**Nonmedically Necessary Physical**
AR	**Experimental Drug Therapy**
B1	**Burn Care**
B2	**Brand Name Prescription Drug - Formulary**
B3	**Brand Name Prescription Drug - Non-Formulary**
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**
BT	**Gynecological**
BU	**Obstetrical**
BV	**Obstetrical/Gynecological**
BW	**Mail Order Prescription Drug: Brand Name**
BX	**Mail Order Prescription Drug: Generic**
BY	**Physician Visit - Office: Sick**
BZ	**Physician Visit - Office: Well**
C1	**Coronary Care**
CA	**Private Duty Nursing - Inpatient**
CB	**Private Duty Nursing - Home**
CC	**Surgical Benefits - Professional (Physician)**
CD	**Surgical Benefits - Facility**
CE	**Mental Health Provider - Inpatient**
CF	**Mental Health Provider - Outpatient**
CG	**Mental Health Facility - Inpatient**
CH	**Mental Health Facility - Outpatient**
CI	**Substance Abuse Facility - Inpatient**
CJ	**Substance Abuse Facility - Outpatient**
CK	**Screening X-ray**
CL	**Screening laboratory**
CM	**Mammogram, High Risk Patient**
CN	**Mammogram, Low Risk Patient**
CO	**Flu Vaccination**
CP	**Eyewear and Eyewear Accessories**
CQ	**Case Management**
DG	**Dermatology**
DM	**Durable Medical Equipment**
DS	**Diabetic Supplies**
GF	**Generic Prescription Drug - Formulary**
GN	**Generic Prescription Drug - Non-Formulary**
GY	**Allergy**
IC	**Intensive Care**
MH	**Mental Health**
NI	**Neonatal Intensive Care**
ON	**Oncology**
PT	**Physical Therapy**
PU	**Pulmonary**
RN	**Renal**
RT	**Residential Psychiatric Treatment**
TC	**Transitional Care**

			TN	**Transitional Nursery Care**			
			UC	**Urgent Care**			
SITUATIONAL	**EB04**	**1336**	**Insurance Type Code**		**O 1**	**ID**	**1/3**

Code identifying the type of insurance policy within a specific insurance program

SITUATIONAL RULE: ***Required when the Information Source requires the Dependent's Insurance Type Code for subsequent EDI transactions (see Section 1.4.7). If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***

OD: **271B1_2110D_EB04__InsuranceTypeCode**

CODE	DEFINITION
12	**Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan**
13	**Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated 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**			
				When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D.			
			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**			
SITUATIONAL	**EB05**	**1204**	**Plan Coverage Description** A description or number that identifies the plan or coverage		**O 1**	**AN**	**1/50**
			SITUATIONAL RULE: ***Required when a specific Plan Name exists for the plan which the individual has coverage in conjunction with the 2110D loop with EB01 Status = 1, 2, 3, 4, 5, 6, 7 or 8 and EB03 Service Type Code = 30 (See Section 1.4.7). If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.***				
			OD: **271B1_2110D_EB05__PlanCoverageDescription**				
			This element is to be used only to convey the specific product name for an insurance plan. For example, if a plan has a brand name, such as "Gold 1-2-3", the name may be placed in this element. This element must not to be used to give benefit details of a plan.				
SITUATIONAL	**EB06**	**615**	**Time Period Qualifier** Code defining periods		**O 1**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required when the availability of the eligibility or benefits being identified in the 2110D loop need to be qualified by a time period. If not required by this implementation guide, do not send.***				
			OD: **271B1_2110D_EB06__TimePeriodQualifier**				
			CODE	**DEFINITION**			
			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**			
SITUATIONAL	**EB07**	**782**	**Monetary Amount** Monetary amount		**O 1**	**R**	**1/18**

SITUATIONAL RULE: ***Required when EB01 = B, C, G, J or Y. Do not use if EB01 = A. May be used at the sender's discretion for other EB01 values. May not be a negative number.***

OD: **271B1_2110D_EB07__BenefitAmount**

IMPLEMENTATION NAME: **Benefit Amount**

Use this monetary amount as qualified by EB01.

When EB01 = B, C, G, J or Y, the amount represents the Patient's portion of responsibility. See Section 1.4.9 Patient Responsibility.

Use if eligibility or benefit must be qualified by a monetary amount; e.g., deductible, co-payment.

SITUATIONAL	**EB08**	**954**	**Percentage as Decimal** Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%)		**O 1**	**R**	**1/10**

SITUATIONAL RULE: ***Required when EB01 = A. Do not use if EB01 = B, C, G, J or Y. May be used at the sender's discretion for other EB01 values. May not be a negative number.***

OD: **271B1_2110D_EB08__BenefitPercent**

IMPLEMENTATION NAME: **Benefit Percent**

Use this percentage rate as qualified by EB01.

When EB01 = A, the amount represents the Patient's portion of responsibility. See Section 1.4.9 Patient Responsibility.

Use if eligibility or benefit must be qualified by a percentage; e.g., co-insurance.

SITUATIONAL **EB09** **673** **Quantity Qualifier** **X 1** **ID** **2/2**
Code specifying the type of quantity

SYNTAX: P0910

SITUATIONAL RULE: ***Required when needed to further qualify the eligibility or benefits being identified in the 2110D loop by quantity. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_EB09__QuantityQualifier**

Use this code to identify the type of units that are being conveyed in the following data element (EB10).

CODE	DEFINITION
8H	Minimum
99	Quantity Used
CA	Covered - Actual
CE	Covered - Estimated
D3	Number of Co-insurance Days
DB	Deductible Blood Units
DY	Days
HS	Hours
LA	Life-time Reserve - Actual
LE	Life-time Reserve - Estimated
M2	Maximum
MN	Month
P6	Number of Services or Procedures
QA	Quantity Approved
S7	Age, High Value
	Use this code when a benefit is based on a maximum age for the patient.
S8	Age, Low Value
	Use this code when a benefit is based on a minimum age for the patient.
VS	Visits
YY	Years

SITUATIONAL **EB10** **380** **Quantity** **X 1** **R** **1/15**
Numeric value of quantity

SYNTAX: P0910

SITUATIONAL RULE: ***Required when needed to further qualify the eligibility or benefits being identified in the 2110D loop by quantity. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_EB10__BenefitQuantity**

IMPLEMENTATION NAME: **Benefit Quantity**

Use this number for the quantity value as qualified by the preceding data element (EB09).

SITUATIONAL **EB11** **1073** **Yes/No Condition or Response Code** **O 1** **ID** **1/1**
Code indicating a Yes or No condition or response

SEMANTIC: EB11 is the authorization or certification indicator. A "Y" value indicates that an authorization or certification is required per plan provisions. An "N" value indicates that an authorization or certification is not required per plan provisions. A "U" value indicates it is unknown whether the plan provisions require an authorization or certification.

SITUATIONAL RULE: ***Required when needed to indicate if authorization or certification is required for the eligibility or benefits being identified in the 2110D loop. If not required by this implementation guide, do not send.***

OD: 271B1_2110D_EB11__AuthorizationorCertificationIndicator

IMPLEMENTATION NAME: Authorization or Certification Indicator

Use code "U" - Unknown, In the event that a payer typically responds Yes or No for some benefits, but the inquired benefit requirements are not accessible or the rules are more complex than can be determined using the data sent in the 270.

CODE	DEFINITION
N	**No**
U	**Unknown**
Y	**Yes**

SITUATIONAL **EB12** **1073** **Yes/No Condition or Response Code** **O 1** **ID** **1/1**
Code indicating a Yes or No condition or response

SEMANTIC: EB12 is the plan network indicator. A "Y" value indicates the benefits identified are considered In-Plan-Network. An "N" value indicates that the benefits identified are considered Out-Of-Plan-Network. A "U" value indicates it is unknown whether the benefits identified are part of the Plan Network.

SITUATIONAL RULE: ***Required when needed to indicate if benefits are considered In Plan Network or Out Of Plan Network for the eligibility or benefits being identified in the 2110D loop. If not required by this implementation guide, do not send.***

OD: 271B1_2110D_EB12__InPlanNetworkIndicator

IMPLEMENTATION NAME: In Plan Network Indicator

Use code "U" - Unknown, In the event that a payer typically responds Yes or No for some benefits, but the inquired benefit requirements are not accessible or the rules are more complex than can be determined using the data sent in the 270.

CODE	DEFINITION
N	**No**
U	**Unknown**
W	**Not Applicable**
	Use code "W" - Not Applicable when benefits are the same regardless of whether they are In Plan-Network or Out of Plan-Network or a Plan-Network does not apply to the benefit.
Y	**Yes**

SITUATIONAL **EB13** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **O 1**

To identify a medical procedure by its standardized codes and applicable modifiers

SITUATIONAL RULE: ***Required when a Medical Procedure Code was used from the 270 to determine the response being identified in the 2110D loop;***
OR
Required when the Information Source supports Medical Procedure Code based 271 transactions and a Medical Procedure Code is available and appropriate for the eligibility or benefits being identified in the 2110D loop.
If not required by this implementation guide or if EB03 is used, do not send.

OD: **271B1_2110D_EB13_C003**

Use this composite data element only if an information source can support this high level of functionality. The EB13 allows for a very specific response.

Not used if EB03 is present.

REQUIRED **EB13 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SEMANTIC:
C003-01 qualifies C003-02 and C003-08.

OD:
271B1_2110D_EB13_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: **Product or Service ID Qualifier**

Use this code to identify the external code list of the following procedure/service code.

CODE	DEFINITION
AD	**American Dental Association Codes** CODE SOURCE **135:** American Dental Association
CJ	**Current Procedural Terminology (CPT) Codes** CODE SOURCE **133:** Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** CODE SOURCE **130:** Healthcare Common Procedure Coding System
ID	**International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Procedure** CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

		IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** **This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.** CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List				
		N4	**National Drug Code in 5-4-2 Format** CODE SOURCE **240:** National Drug Code by Format				
		ZZ	**Mutually Defined** **Use this code only for International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).** **CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)**				
REQUIRED	**EB13 - 2**	**234**	**Product/Service ID** Identifying number for a product or service SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs. OD: **271B1_2110D_EB13_C00302_ProcedureCode** IMPLEMENTATION NAME: **Procedure Code** **Use this ID number for the product/service code as qualified by the preceding data element.**	**M**	**AN**	**1/48**	
SITUATIONAL	**EB13 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-03 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110D loop;*** ***OR*** ***Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.*** OD: **271B1_2110D_EB13_C00303_ProcedureModifier** **Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.**	**O**	**AN**	**2/2**	

SITUATIONAL **EB13 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-04 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110D loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110D_EB13_C00304_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-05 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110D loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110D_EB13_C00305_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-06 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required when a modifier was used from the 270 to determine the response being identified in the 2110D loop;***
OR
Required when a modifier clarifies/improves the accuracy of the associated procedure code and the modifier is available. If not required by this implementation guide, do not send.

OD: **271B1_2110D_EB13_C00306_ProcedureModifier**

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

NOT USED **EB13 - 7** **352** **Description** **O AN 1/80**

SITUATIONAL **EB13 - 8** **234** **Product/Service ID** **O AN 1/48**
Identifying number for a product or service

SEMANTIC:
C003-08 represents the ending value in the range in which the code occurs.

SITUATIONAL RULE: ***Required when the Information Source desires to indicate a range of procedure codes. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_EB13_C00308_ProductorServiceID**

IMPLEMENTATION NAME: **Product or Service ID**

EB13-2 indicates the beginning of value of the range of procedure codes and EB13-8 represents the end of the range of procedure codes. All procedure codes in the range will apply.

SITUATIONAL **EB14** **C004** **COMPOSITE DIAGNOSIS CODE POINTER** **O 1**
To identify one or more diagnosis code pointers

SITUATIONAL RULE: ***Required when a 2100D HI segment is used and the information in this 2110D EB loop is related to a diagnosis code. If 2100D HI segment is not used or if the information in this 2110D EB loop is not related to a diagnosis code, do not send.***

OD: **271B1_2110D_EB14_C004**

See requirements for the use of the 2100D HI segment for additional information.

REQUIRED **EB14 - 1** **1328** **Diagnosis Code Pointer** **M N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-01 identifies the primary diagnosis code for this service line.

OD: **271B1_2110D_EB14_C00401_DiagnosisCodePointer**

This first pointer designates the primary diagnosis for this EB segment. Remaining diagnosis pointers indicate declining level of importance to the EB segment. Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EB14 - 2** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-02 identifies the second diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a second diagnosis related to this EB segment. If not required, do not send.***

OD: **271B1_2110D_EB14_C00402_DiagnosisCodePointer**

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EB14 - 3** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-03 identifies the third diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a third diagnosis related to this EB segment. If not required, do not send.***

OD: 271B1_2110D_EB14_C00403_DiagnosisCodePointer

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SITUATIONAL **EB14 - 4** **1328** **Diagnosis Code Pointer** **O N0 1/2**
A pointer to the diagnosis code in the order of importance to this service

SEMANTIC:
C004-04 identifies the fourth diagnosis code for this service line.

SITUATIONAL RULE: ***Required when it is necessary to designate a fourth diagnosis related to this EB segment. If not required, do not send.***

OD: 271B1_2110D_EB14_C00404_DiagnosisCodePointer

Acceptable values are 1 through 8, and correspond to Composite Data Elements 01 through 08 in the Health Care Diagnosis Code HI segment in loop 2100D.

SEGMENT DETAIL

HSD - HEALTH CARE SERVICES DELIVERY

X12 Segment Name: Health Care Services Delivery

X12 Purpose: To specify the delivery pattern of health care services

X12 Syntax:

1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.
2. **C0605**
   If HSD06 is present, then HSD05 is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

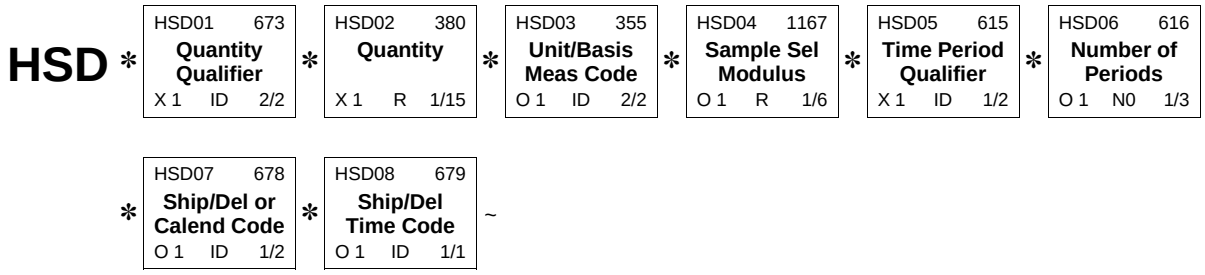
Usage: **SITUATIONAL**

Situational Rule: **Required when needed to identify a specific delivery or usage pattern associated with the benefits identified in either EB03 or EB13. If not required by this implementation guide, do not send.**

TR3 Example: **HSD*VS*30***22~**
Thirty visits per service year

TR3 Example: **HSD*VS*12*WK*3*34*1~**
Twelve visits, three visits per week, for 1 month.

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**HSD01**	**673**	**Quantity Qualifier** Code specifying the type of quantity SYNTAX: P0102 SITUATIONAL RULE: ***Required when identifying type and quantity benefits identified. If not required by this implementation guide, do not send.*** OD: **271B1_2110D_HSD01__QuantityQualifier** **Required if HSD02 is used.**	**X 1 ID 2/2**
SITUATIONAL	**HSD02**	**380**	**Quantity** Numeric value of quantity SYNTAX: P0102 SITUATIONAL RULE: ***Required when identifying type and quantity benefits identified. If not required by this implementation guide, do not send.*** OD: **271B1_2110D_HSD02__BenefitQuantity** IMPLEMENTATION NAME: **Benefit Quantity** **Required if HSD01 is used.**	**X 1 R 1/15**
SITUATIONAL	**HSD03**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.*** OD: **271B1_2110D_HSD03__UnitorBasisforMeasurementCode**	**O 1 ID 2/2**

CODE	DEFINITION
DY	**Days**
FL	**Units**
HS	**Hours**
MN	**Month**
VS	**Visits**

CODE	DEFINITION
DA	**Days**
MO	**Months**
VS	**Visit**
WK	**Week**
YR	**Years**

SITUATIONAL **HSD04** **1167** **Sample Selection Modulus** **O 1** **R** **1/6**
To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_HSD04__SampleSelectionModulus**

SITUATIONAL **HSD05** **615** **Time Period Qualifier** **X 1** **ID** **1/2**
Code defining periods

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_HSD05__TimePeriodQualifier**

CODE	DEFINITION
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**

SITUATIONAL **HSD06** **616** **Number of Periods** **O 1** **N0** **1/3**
Total number of periods

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_HSD06__PeriodCount**

IMPLEMENTATION NAME: **Period Count**

SITUATIONAL **HSD07** **678** **Ship/Delivery or Calendar Pattern Code** **O 1 ID 1/2**
Code which specifies the routine shipments, deliveries, or calendar pattern

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_HSD07__DeliveryFrequencyCode**

IMPLEMENTATION NAME: **Delivery Frequency Code**

CODE	DEFINITION
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)**			
SITUATIONAL	**HSD08**	**679**	**Ship/Delivery Pattern Time Code** Code which specifies the time for routine shipments or deliveries	**O 1**	**ID**	**1/1**	

SITUATIONAL RULE: ***Required when needed to provide further information about the number and frequency of benefits. If not required by this implementation guide, do not send.***

OD: **271B1_2110D_HSD08__DeliveryPatternTimeCode**

IMPLEMENTATION NAME: **Delivery Pattern Time Code**

CODE	DEFINITION
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)**

SEGMENT DETAIL

REF - DEPENDENT ADDITIONAL IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

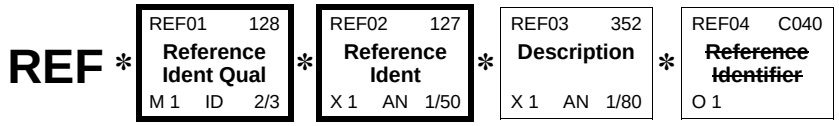
Usage: **SITUATIONAL**

Situational Rule: **Required when the Information Source requires one or more of these additional identifiers for subsequent EDI transactions (see Section 1.4.7);**
OR
Required when an additional identifier is associated with the eligibility or benefits being identified in the 2110D loop.
If not required by this implementation guide, do not send.

TR3 Notes:
1. **Use this segment for reference identifiers related only to the 2110D loop that it is contained in (e.g. Other or Additional Payer's identifiers).**
2. **Use this segment to identify other or additional reference numbers for the entity identified. The type of reference number is determined by the qualifier in REF01. Only one occurrence of each REF01 code value may be used in the 2110D loop.**

TR3 Example: **REF*G1*653745725~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**

OD: 271B1_2110D_REF01__ReferenceIdentificationQualifier

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Use "1W", "49", "F6", and "NQ" only in a 2110D loop with EB01 = "R".

Only one occurrence of each REF01 code value may be used in the 2110D loop.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**
	Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
1W	**Member Identification Number**
49	**Family Unit Number**
	Required when the Information Source is a Pharmacy Benefit Manager (PBM) and the individual has a suffix to their member ID number that is required for use in the NCPDP Telecom Standard in the Insurance Segment in field 303-C3 Person Code. If not required by this implementation Guide, do not send. **NOTE: For all other uses, the Family Unit Number (suffix) is considered a part of the Member ID number and is used to uniquely identify the individual and must be returned at the end of the Member ID number in 2110D REF02 if REF01 is "1W".**
6P	**Group Number**
9F	**Referral Number**
ALS	**Alternative List ID**
	Allows the source to identify the list identifier of a list of drugs and its alternative drugs with the associated formulary status for the patient.
CLI	**Coverage List ID**
	Allows the source to identify the list identifier of a list of drugs that have coverage limitations for the associated patient.
F6	**Health Insurance Claim (HIC) Number**
FO	**Drug Formulary Number**
G1	**Prior Authorization Number**
IG	**Insurance Policy Number**

			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **OD: 271B1_2110D_REF02__DependentEligibilityorBenefitIdentifier** **IMPLEMENTATION NAME: Dependent Eligibility or Benefit Identifier** **Use this information for the reference number as qualified by the preceding data element (REF01).**		**X 1**	**AN**	**1/50**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content **SYNTAX:** R0203 **SITUATIONAL RULE:** ***Required when REF01 = "18", "6P" or "N6" and a name needs to be associated with the corresponding identifier. If not required by this implementation guide, do not send.*** **OD: 271B1_2110D_REF03__PlanGrouporPlanNetworkName** **IMPLEMENTATION NAME: Plan, Group or Plan Network Name**		**X 1**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O 1**		

SEGMENT DETAIL

DTP - DEPENDENT ELIGIBILITY/BENEFIT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **20**

Usage: **SITUATIONAL**

Situational Rule: **Required when the individual has active coverage with multiple plans or multiple plan periods apply (See 2100D DTP segment);**
OR
Required when needed to convey dates associated with the eligibility or benefits being identified in the 2110D loop.
If not required by this implementation guide, do not send.

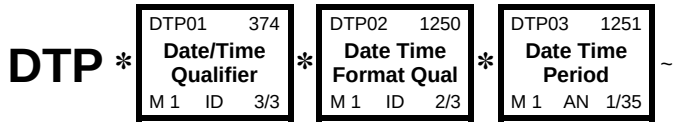
TR3 Notes:

1. **When using the DTP segment in the 2110D loop this date applies only to the 2110D Eligibility or Benefit Information (EB) loop in which it is located.**

   If a DTP segment with the same DTP01 value is present in the 2100D loop, the date is overridden for only this 2110D Eligibility or Benefit Information (EB) loop.

TR3 Example: **DTP*472*D8*19960624~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**

OD: **271B1_2110D_DTP01__DateTimeQualifier**

IMPLEMENTATION NAME: **Date Time Qualifier**

CODE	DEFINITION
096	**Discharge**
193	**Period Start**
194	**Period End**
198	**Completion**
290	**Coordination of Benefits**

			291	**Plan**			
				Use code 291 only if multiple plans apply to the individual or multiple plan periods apply. Dates supplied in this DPT segment only apply to the 2110D loop in which it occurs.			
			292	**Benefit**			
			295	**Primary Care Provider**			
			304	**Latest Visit or Consultation**			
			307	**Eligibility**			
			318	**Added**			
			346	**Plan Begin**			
				Use code 346 only if multiple plans apply to the individual or multiple plan periods apply. Dates supplied in this DPT segment only apply to the 2110D loop in which it occurs.			
			348	**Benefit Begin**			
			349	**Benefit End**			
			356	**Eligibility Begin**			
			357	**Eligibility End**			
			435	**Admission**			
			472	**Service**			
			636	**Date of Last Update**			
			771	**Status**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M 1**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format				
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.				
			OD: **271B1_2110D_DTP02__DateTimePeriodFormatQualifier**				
			Use this code to specify the format of the date(s)/time(s) that follow in the next data element.				
			CODE	**DEFINITION**			
			D8	**Date Expressed in Format CCYYMMDD**			
			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**			
REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M 1**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times				
			OD: **271B1_2110D_DTP03__EligibilityorBenefitDateTimePeriod**				
			IMPLEMENTATION NAME: **Eligibility or Benefit Date Time Period**				
			Use this date for the date(s) as qualified by the preceding data elements.				

SEGMENT DETAIL

AAA - DEPENDENT REQUEST VALIDATION

X12 Segment Name: Request Validation

X12 Purpose: To specify the validity of the request and indicate follow-up action authorized

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **9**

Usage: **SITUATIONAL**

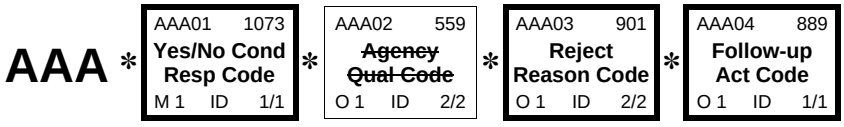
Situational Rule: **Required when the request could not be processed at a system or application level when specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's dependent eligibility/benefit inquiry information loop (Loop 2110D) and to indicate what action the originator of the request transaction should take. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to indicate problems in processing the transaction specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's dependent eligibility/benefit inquiry information loop (Loop 2110D).**

TR3 Example: **AAA*N**70*C~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M 1 ID 1/1**

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

OD: 271B1_2110D_AAA01__ValidRequestIndicator

IMPLEMENTATION NAME: Valid Request Indicator

CODE	DEFINITION
N	**No**
	Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.

			Y	**Yes**			
				Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.			
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**		**O 1**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection		**O 1**	**ID**	**2/2**
			OD: **271B1_2110D_AAA03__RejectReasonCode**				
			Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.				

CODE	DEFINITION
15	**Required application data missing**
33	**Input Errors**
	Use this code only when data is present in this transaction and no other Reject Reason Code is valid for describing the error. Detail of the error must be supplied in the MSG segment of the 2110D loop containing this Reject Reason Code.
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**
98	**Experimental Service or Procedure**
AA	**Authorization Number Not Found**
	Use this code only when the Referral Number or Prior Authorization Number in 2110D REF02 is not found.
AE	**Requires Primary Care Physician Authorization**
AF	**Invalid/Missing Diagnosis Code(s)**
AG	**Invalid/Missing Procedure Code(s)**
	Use this code for errors with Procedure Codes in EQ02-2 or Procedure Code Modifiers in EQ02-3 through EQ02-6.

			AO	**Additional Patient Condition Information Required**			
				Use this code only if the Information Source supports responding to a detailed eligibility request and the information can be processed from a 270 transaction received by the Information Source but was not received and is needed to respond appropriately.		
			CI	**Certification Information Does Not Match Patient**			
				Use this code only when the Referral Number or Prior Authorization Number in 2110D REF02 is found but is not associated with the subscriber.		
			E8	**Requires Medical Review**			
			IA	**Invalid Authorization Number Format**			
				Use this code only when the Referral Number or Prior Authorization Number in 2110D REF02 is not formatted properly.		
			MA	**Missing Authorization Number**			
				Use this code only when the Referral Number or Prior Authorization Number has been issued and is missing in 2110D REF02 but is needed to respond appropriately.		
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O 1**	**ID**	**1/1**
			OD: **271B1_2110D_AAA04__FollowupActionCode**				
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).				
			CODE	**DEFINITION**			
			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**			

SEGMENT DETAIL

MSG - MESSAGE TEXT

X12 Segment Name: Message Text

X12 Purpose: To provide a free-form format that allows the transmission of text information

X12 Syntax:
1. **C0302**
   If MSG03 is present, then MSG02 is required.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **10**

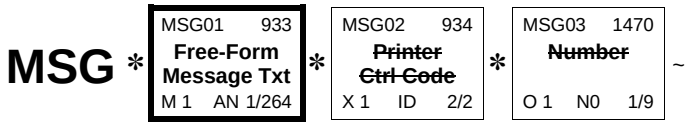
Usage: **SITUATIONAL**

Situational Rule: **Required when the eligibility or benefit information cannot be codified in existing data elements (including combinations of multiple data elements and segments);**
AND
Required when this information is pertinent to the eligibility or benefit response.
If not required by this implementation guide, do not send.

TR3 Notes:
1. **Free form text or description fields are not recommended because they require human interpretation.**
2. **Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements (including combinations of multiple data elements and segments). If the information cannot be codified, then cautionary use of the MSG segment is allowed as a short term solution. It is highly recommended that the entity needing to use the MSG segment approach X12N with data maintenance to solve the long term business need, so the use of the MSG segment can be avoided for that issue.**
3. **Benefit Disclaimers are strongly discouraged. See section 1.4.11 Disclaimers Within the Transaction. Under no circumstances are more than one MSG segment to be used for a Benefit Disclaimer per individual response.**

TR3 Example: **MSG*Free form text is discouraged~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	MSG01	933	**Free-form Message Text** Free-form message text	M 1	AN	1/264
			OD: **271B1_2110D_MSG01__FreeFormMessageText**			
			IMPLEMENTATION NAME: **Free Form Message Text**			
NOT USED	MSG02	934	**Printer Carriage Control Code**	X 1	ID	2/2
NOT USED	MSG03	1470	**Number**	O 1	N0	1/9

SEGMENT DETAIL

III - DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

X12 Segment Name: Information

X12 Purpose: To report information

X12 Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

Loop: **2115D — DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION Loop Repeat: 10**

Segment Repeat: **1**

Usage: **SITUATIONAL**

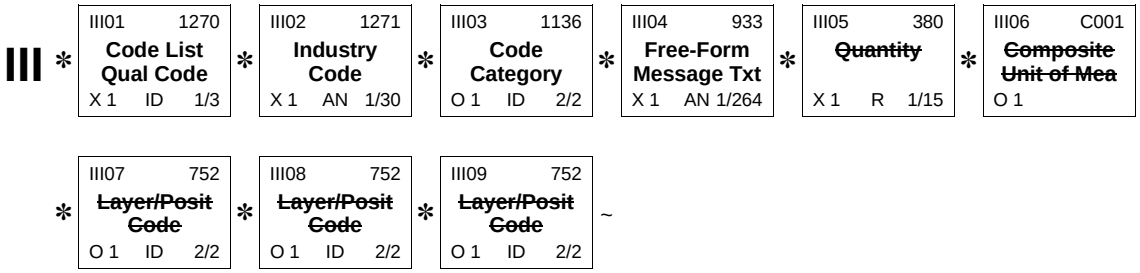
Situational Rule: **Required when III segments in Loop 2110D of the 270 Inquiry were used in the determination of the eligibility or benefit response;**
OR
Required when needed to identify limitations in the benefits explained in the corresponding Loop 2110D (such as if benefits are limited to a type of facility).
If not required by this implementation guide, do not send.

TR3 Notes:

1. **This segment has two purposes. Information that was received in III segments in Loop 2110D of the 270 Inquiry and was used in the determination of the eligibility or benefit response must be returned. If information was provided in III segments of Loop 2110D but was not used in the determination of the eligibility or benefits it must not be returned. This segment can also be used to identify limitations in the benefits explained in the corresponding Loop 2110D, such as if benefits are limited to a type of facility.**
2. **Use this segment to identify Nature of Injury Codes and/or Facility Type as they relate to the information provided in the EB segment.**
3. **Use the III segment only if an information source can support this high level functionality.**
4. **Use this segment only one time for the Facility Type Code.**

TR3 Example:
III*ZZ*21~
III*44*Broken bones and third degree burns~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **SITUATIONAL RULE:** ***Required when identifying a Nature of Injury Code or a Facility Type Code. If not required by this implementation guide, do not send.*** **OD: 271B1_2115D_III01__CodeListQualifierCode** **Use this code to specify if the code that is following in the III02 is a Nature of Injury Code or a Facility Type Code.**	**X 1 ID 1/3**

CODE	DEFINITION
GR	**National Council on Compensation Insurance (NCCI) Nature of Injury Code** **CODE SOURCE 284:** Nature of Injury Code
NI	**Nature of Injury Code** **Other code source as specified by the jurisdiction.** **CODE SOURCE 284:** Nature of Injury Code **CODE SOURCE 407:** Occupational Injury and Illness Classification Manual
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix A for Code Source 237, Place of Service Codes for Professional Claims.**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SYNTAX:** P0102 **SITUATIONAL RULE:** ***Required when identifying a Nature of Injury Code or a Facility Type Code. If not required by this implementation guide, do not send.*** **OD: 271B1_2115D_III02__IndustryCode** **If III01 is GR, use this element for NCCI Nature of Injury code from code source 284.**	**X 1 AN 1/30**

If III01 is NI, use this element for Nature of Injury code from code source 407.

If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility - Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

SITUATIONAL	**III03**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SYNTAX:** L030405 **SEMANTIC:** III03 is used to categorize III04. **SITUATIONAL RULE:** ***Required when III01 and III02 are not present or if additional information is needed (see III04). If not required by this implementation guide or if III01 is ZZ, do not send.*** **OD: 271B1_2115D_III03__CodeCategory**	**O 1**	**ID**	**2/2**

CODE	DEFINITION
44	**Nature of Injury**

SITUATIONAL	**III04**	**933**	**Free-form Message Text** Free-form message text **SYNTAX:** L030405 **SITUATIONAL RULE:** ***Required when III03 = "44". If not required by this implementation guide, do not send.*** **OD: 271B1_2115D_III04__InjuredBodyPartName** **IMPLEMENTATION NAME: Injured Body Part Name**	**X 1**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X 1**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O 1**	**ID**	**2/2**

SEGMENT DETAIL

LS - LOOP HEADER

X12 Segment Name: Loop Header

X12 Purpose: To indicate that the next segment begins a loop

X12 Semantic:

1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as mandatory, this segment in combination with "LE", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comments:

1. See Figures Appendix for an explanation of the use of the LS and LE segments.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **1**

Usage: **SITUATIONAL**

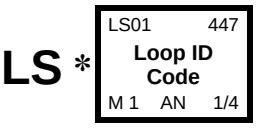
Situational Rule: **Required when Loop 2120D is used. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify the beginning of the Dependent Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops.**

TR3 Example: **LS*2120~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LS01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	**M 1 AN 1/4**
			OD: **271B1_2110D_LS01__LoopIdentifierCode**	
			This data element must have the value of "2120".	

SEGMENT DETAIL

NM1 - DEPENDENT BENEFIT RELATED ENTITY NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME Loop Repeat: 23**

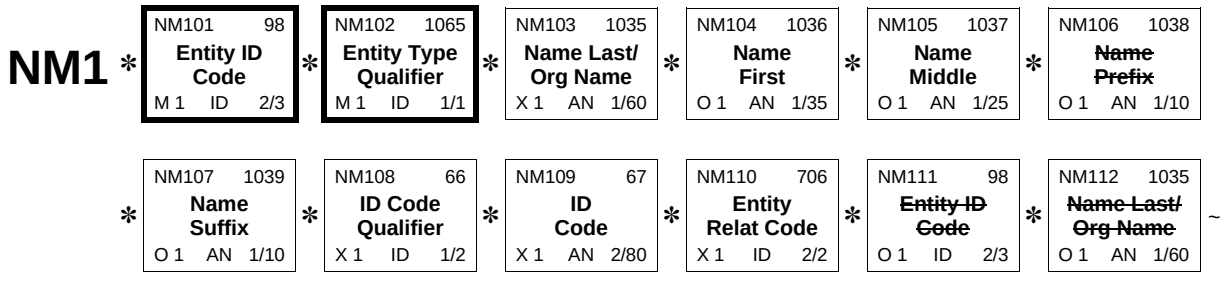
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when provider was identified in 2100D PRV02 and PRV03 by Identification Number (not Taxonomy Code) in the 270 Inquiry and was used in the determination of the eligibility or benefit response;**
OR
Required when needed to identify an entity associated with the eligibility or benefits being identified in the 2110D loop such as a provider (e.g. primary care provider), an individual, an organization, another payer, or another information source;
If not required by this implementation guide, do not send.

TR3 Example: **NM1*P3*1*JONES*MARCUS***MD*SV*111223333~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

OD: **271B1_2120D_NM101__EntityIdentifierCode**

CODE	DEFINITION
13	**Contracted Service Provider**
1I	**Preferred Provider Organization (PPO)**
	Use if identifying a Preferred Provider Organization (PPO) by name or identification number. May also be used if identifying the Network that benefits are restricted to when 2110D EB12 = "Y" (In-Network).
1P	**Provider**
2B	**Third-Party Administrator**
36	**Employer**
73	**Other Physician**
FA	**Facility**
GP	**Gateway Provider**
GW	**Group**
I3	**Independent Physicians Association (IPA)**
IL	**Insured or Subscriber**
	Use if identifying an insured or subscriber to a plan other than the information source (such as in a co-ordination of benefits situation).
LR	**Legal Representative**
OC	**Origin Carrier**
	Use if identifying an organization that added information relating to other insurance.
P3	**Primary Care Provider**
P4	**Prior Insurance Carrier**
P5	**Plan Sponsor**
PR	**Payer**
PRP	**Primary Payer**
SEP	**Secondary Payer**
TTP	**Tertiary Payer**
VN	**Vendor**
VY	**Organization Completing Configuration Change**
	Use if identifying an organization that changed information relating to other insurance.
X3	**Utilization Management Organization**

REQUIRED **NM102** **1065** **Entity Type Qualifier** **M 1 ID 1/1**
Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

OD: **271B1_2120D_NM102__EntityTypeQualifier**

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

SITUATIONAL **NM103** **1035** **Name Last or Organization Name** **X 1 AN 1/60**
Individual last name or organizational name

SYNTAX: C1203

SITUATIONAL RULE: ***Required when needed to identify by name an entity associated with the eligibility or benefits being identified in the 2110D loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source.***
OR
Required when NM109 is not used.
If not required by this implementation guide, do not send.

OD:
271B1_2120D_NM103__BenefitRelatedEntityLastorOrganizationName

IMPLEMENTATION NAME: **Benefit Related Entity Last or Organization Name**

Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.

SITUATIONAL **NM104** **1036** **Name First** **O 1 AN 1/35**
Individual first name

SITUATIONAL RULE: ***Required when NM102 is "1" and NM103 is used. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_NM104__BenefitRelatedEntityFirstName**

IMPLEMENTATION NAME: **Benefit Related Entity First Name**

SITUATIONAL **NM105** **1037** **Name Middle** **O 1 AN 1/25**
Individual middle name or initial

SITUATIONAL RULE: ***Required when NM102 is "1" and the Last Name in NM103 and First Name in NM104 are not sufficient to identify the individual. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120D_NM105__BenefitRelatedEntityMiddleName**

IMPLEMENTATION NAME: **Benefit Related Entity Middle Name**

NOT USED **NM106** **1038** **Name Prefix** **O 1 AN 1/10**

SITUATIONAL **NM107** **1039** **Name Suffix** **O 1 AN 1/10**
Suffix to individual name

SITUATIONAL RULE: ***Required when NM102 is "1" and the Last Name in NM103 and First Name in NM104 and/or Middle Name in 2100A NM105 are not sufficient to identify the individual. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120D_NM107__BenefitRelatedEntityNameSuffix**

IMPLEMENTATION NAME: **Benefit Related Entity Name Suffix**

Use for name suffix only (e.g. Sr, Jr, II, III, etc.).

SITUATIONAL **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

SITUATIONAL RULE: ***Required when needed to identify by Identification Code an entity associated with the eligibility or benefits being identified in the 2110D loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source.***
OR
Required when NM103 is not used.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120D_NM108__IdentificationCodeQualifier**

If the entity being identified is a provider and the National Provider ID is mandated for use, code value "XX" must be used, otherwise, one of the other codes may be used. If the entity being identified is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used. If the entity being identified is an individual, the "HIPAA Individual Identifier" must be used once this identifier has been adopted, otherwise, one of the other codes may be used.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
	The social security number may not be used for any Federally administered programs such as Medicare.
46	**Electronic Transmitter Identification Number (ETIN)**
FA	**Facility Identification**
FI	**Federal Taxpayer's Identification Number**
II	**Standard Unique Health Identifier for each Individual in the United States**
	Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services may adopt a standard individual identifier for use in this transaction.

			MI	**Member Identification Number**			
				Use this code to identify the entity's Member Identification Number associated with a payer other than the information source in Loop 2100A. This code may only be used prior to the mandated use of code "II".			
			NI	**National Association of Insurance Commissioners (NAIC) Identification**			
			PI	**Payor Identification**			
			PP	**Pharmacy Processor Number**			
			SV	**Service Provider Number**			
			XV	**Centers for Medicare and Medicaid Services PlanID**			
				CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID			
			XX	**Centers for Medicare and Medicaid Services National Provider Identifier**			
				CODE SOURCE **537:** Centers for Medicare & Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code		**X 1**	**AN**	**2/80**

SYNTAX: P0809

SITUATIONAL RULE: ***Required when needed to identify by Identification Code an entity associated with the eligibility or benefits being identified in the 2110D loop such as a provider (e.g. Primary Care Provider), an individual, an organization, another payer, or another information source.***
OR
Required when NM103 is not used.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120D_NM109__BenefitRelatedEntityIdentifier**

IMPLEMENTATION NAME: **Benefit Related Entity Identifier**

Use this code for the reference number as qualified by the preceding data element (NM108).

SITUATIONAL	**NM110**	**706**	**Entity Relationship Code** Code describing entity relationship	**X 1**	**ID**	**2/2**

SYNTAX: C1110

COMMENT: NM110 and NM111 further define the type of entity in NM101.

SITUATIONAL RULE: ***Required when needed to indicate the Benefit Related Entity's relationship to the patient when EB01 = "R", the coverage is based on the Benefit Related Entity and the relationship is known. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: **271B1_2120D_NM110__BenefitRelatedEntityRelationshipCode**

IMPLEMENTATION NAME: **Benefit Related Entity Relationship Code**

CODE	DEFINITION
01	**Parent**
02	**Child**
27	**Domestic Partner**
41	**Spouse**
48	**Employee**
65	**Other**
72	**Unknown**

NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

N3 - DEPENDENT BENEFIT RELATED ENTITY ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

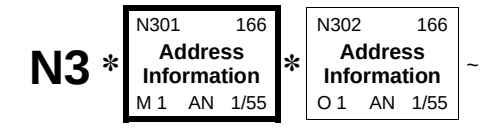
Situational Rule: **Required when needed to further identify the entity or individual in loop 2120D NM1 and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify address information for an entity.**

TR3 Example: **N3*201 PARK AVENUE*SUITE 300~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information	**M 1 AN 1/55**
			OD: **271B1_2120D_N301__BenefitRelatedEntityAddressLine**	
			IMPLEMENTATION NAME: **Benefit Related Entity Address Line**	
			Use this information for the first line of the address information.	
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O 1 AN 1/55**
			SITUATIONAL RULE: ***Required when a second address line exists and is available. If not required by this implementation guide, do not send.***	
			OD: **271B1_2120D_N302__BenefitRelatedEntityAddressLine**	
			IMPLEMENTATION NAME: **Benefit Related Entity Address Line**	
			Use this information for the second line of the address information.	

SEGMENT DETAIL

N4 - DEPENDENT BENEFIT RELATED ENTITY CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax:

1. **E0207**
   Only one of N402 or N407 may be present.
2. **C0605**
   If N406 is present, then N405 is required.
3. **C0704**
   If N407 is present, then N404 is required.

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

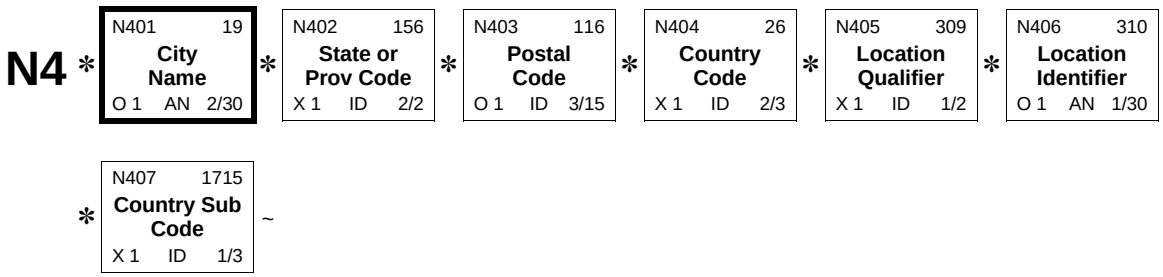
Situational Rule: **Required when needed to further identify the entity or individual in loop 2120D NM1 and the information is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify address information for an entity.**

TR3 Example: **N4*KANSAS CITY*MO*64108~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. OD: **271B1_2120D_N401__BenefitRelatedEntityCityName** IMPLEMENTATION NAME: **Benefit Related Entity City Name**	**O 1 AN 2/30**

SITUATIONAL **N402** **156** **State or Province Code** **X 1 ID 2/2**
Code (Standard State/Province) as defined by appropriate government agency

SYNTAX: E0207

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_N402__BenefitRelatedEntityStateCode**

IMPLEMENTATION NAME: **Benefit Related Entity State Code**

CODE SOURCE **22:** States and Provinces

SITUATIONAL **N403** **116** **Postal Code** **O 1 ID 3/15**
Code defining international postal zone code excluding punctuation and blanks (zip code for United States)

SITUATIONAL RULE: ***Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_N403__BenefitRelatedEntityPostalZoneorZIPCode**

IMPLEMENTATION NAME: **Benefit Related Entity Postal Zone or ZIP Code**

CODE SOURCE **51:** ZIP Code
CODE SOURCE **932:** Universal Postal Codes

SITUATIONAL **N404** **26** **Country Code** **X 1 ID 2/3**
Code identifying the country

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_N404__BenefitRelatedEntityCountryCode**

IMPLEMENTATION NAME: **Benefit Related Entity Country Code**

CODE SOURCE **5:** Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

SITUATIONAL **N405** **309** **Location Qualifier** **X 1** **ID** **1/2**
Code identifying type of location

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed by CHAMPUS/TRICARE or CHAMPVA to communicate the DOD Health Service Region. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_N405__BenefitRelatedEntityLocationQualifier**

IMPLEMENTATION NAME: **Benefit Related Entity Location Qualifier**

CODE SOURCE **206:** Government Bill of Lading Office Code

Use this element only to communicate the Department of Defense Health Service Region.

CODE	DEFINITION
RJ	**Region**
	Use this code only to communicate the Department of Defense Health Service Region in N406.

SITUATIONAL **N406** **310** **Location Identifier** **O 1** **AN** **1/30**
Code which identifies a specific location

SYNTAX: C0605

SITUATIONAL RULE: ***Required when needed by CHAMPUS/TRICARE or CHAMPVA to communicate the DOD Health Service Region. If not required by this implementation guide, do not send.***

OD:
271B1_2120D_N406__BenefitRelatedEntityDODHealthServiceRegion

IMPLEMENTATION NAME: **Benefit Related Entity DOD Health Service Region**

Use this element only to communicate the Department of Defense Health Service Region.

CODE SOURCE DOD1: Military Health Systems Functional Area Manual - Data.

SITUATIONAL **N407** **1715** **Country Subdivision Code** **X 1** **ID** **1/3**
Code identifying the country subdivision

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.***

OD:
271B1_2120D_N407__BenefitRelatedEntityCountrySubdivisionCode

IMPLEMENTATION NAME: **Benefit Related Entity Country Subdivision Code**

CODE SOURCE **5:** Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

PER - DEPENDENT BENEFIT RELATED ENTITY CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

X12 Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when Contact Information exists and is available. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2120D NM1.**

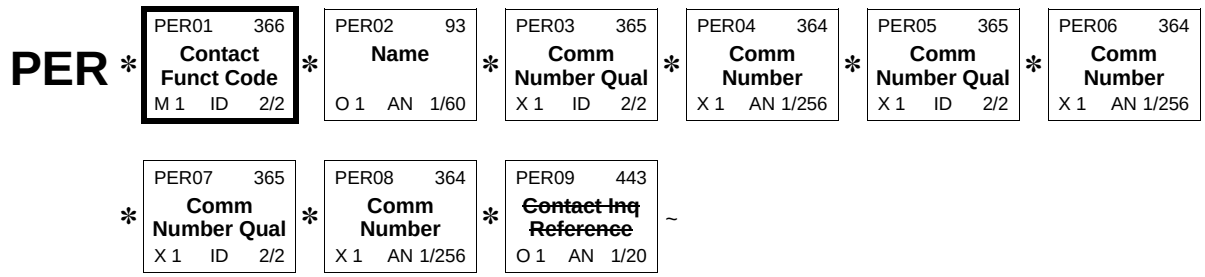
   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

TR3 Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**

OD: **271B1_2120D_PER01__ContactFunctionCode**

Use this code to specify the type of person or group to which the contact number applies.

CODE	DEFINITION
IC	**Information Contact**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**

SITUATIONAL RULE: ***Required when the name of the individual to contact is not already defined or is different than the name within 2120D NM1 segment and the name is available;***
OR
Required when PER03 and PER04 are not present.
If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

OD: **271B1_2120D_PER02__BenefitRelatedEntityContactName**

IMPLEMENTATION NAME: **Benefit Related Entity Contact Name**

Use this name for the individual's name or group's name to use when contacting the individual or organization.

SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1**	**ID**	**2/2**

SYNTAX: P0304

SITUATIONAL RULE: ***Required when PER02 is not present or when a communication number, e-mail or Web address is to be sent in addition to the contact name. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD: 271B1_2120D_PER03__CommunicationNumberQualifier

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1**	**AN**	**1/256**

SYNTAX: P0304

SITUATIONAL RULE: ***Required when PER02 is not present or when a communication number, e-mail or Web address is to be sent in addition to the contact name. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.***

OD:
271B1_2120D_PER04__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: Benefit Related Entity Communication Number

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X 1** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: **271B1_2120D_PER05__CommunicationNumberQualifier**

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL **PER06** **364** **Communication Number** **X 1** **AN** **1/256**
Complete communications number including country or area code when applicable

SYNTAX: P0506

SITUATIONAL RULE: ***Required when a second communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2120D_PER06__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: **Benefit Related Entity Communication Number**

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1**	**ID**	**2/2**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD: 271B1_2120D_PER07__CommunicationNumberQualifier

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
UR	**Uniform Resource Locator (URL)**
WP	**Work Phone Number**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1**	**AN**	**1/256**

SYNTAX: P0708

SITUATIONAL RULE: ***Required when a third communication contact number, e-mail or Web address is needed. If not required by this implementation guide, do not send.***

OD:
271B1_2120D_PER08__BenefitRelatedEntityCommunicationNumber

IMPLEMENTATION NAME: Benefit Related Entity Communication Number

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

Use this for the communication number or URL as qualified by the preceding data element.

NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O 1**	**AN**	**1/20**

SEGMENT DETAIL

PRV - DEPENDENT BENEFIT RELATED PROVIDER INFORMATION

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: **1. P0203**
If either PRV02 or PRV03 is present, then the other is required.

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Segment Repeat: **1**

Usage: **SITUATIONAL**

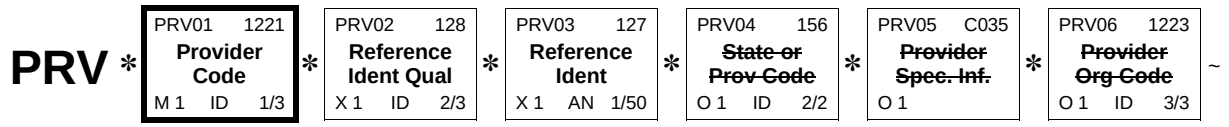
Situational Rule: **Required when needed either to identify a provider's role or associate a specialty type related to the service identified in the 2110D loop. If not required by this implementation guide, do not send.**

TR3 Notes: **1. If identifying a type of specialty associated with the services identified in loop 2110D, use code PXC in PRV02 and the appropriate code in PRV03.**

2. If there is a PRV segment in 2100B or 2100D, this PRV overrides it for this occurrence of the 2110D loop.

TR3 Example: **PRV*PE*PXC*207Q00000X~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code identifying the type of provider	**M 1 ID 1/3**

OD: **271B1_2120D_PRV01__ProviderCode**

CODE	DEFINITION
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**			
SITUATIONAL	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type related to the service identified in the 2110D loop. If not required by this implementation guide, do not send.*** OD: **271B1_2120D_PRV02__ReferenceIdentificationQualifier**	**X 1**	**ID**	**2/3**

CODE	DEFINITION
PXC	**Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy

SITUATIONAL	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 SITUATIONAL RULE: ***Required when needed to identify a provider's specialty type related to the service identified in the 2110D loop. If not required by this implementation guide, do not send.*** OD: **271B1_2120D_PRV03__ProviderIdentifier** IMPLEMENTATION NAME: **Provider Identifier** **Use this reference number as qualified by the preceding data element (PRV02).**	**X 1**	**AN**	**1/50**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O 1**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O 1**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O 1**	**ID**	**3/3**

SEGMENT DETAIL

LE - LOOP TRAILER

X12 Segment Name: Loop Trailer

X12 Purpose: To indicate that the loop immediately preceding this segment is complete

X12 Semantic:

1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the other loop. When specified by the standards setting body as mandatory, this segment in combination with "LS", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop beginning segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comments:

1. See Figures Appendix for an explanation of the use of the LE and LS segments.

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Segment Repeat: **1**

Usage: **SITUATIONAL**

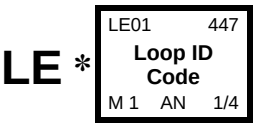
Situational Rule: **Required when Loop 2120D is used. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Use this segment to identify the end of the Dependent Benefit Related Entity Name loop. Because both the dependent's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops.**

TR3 Example: **LE*2120~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LE01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	**M 1 AN 1/4**
			OD: **271B1_2110D_LE01__LoopIdentifierCode**	
			This data element must have the value of "2120".	

SEGMENT DETAIL

SE - TRANSACTION SET TRAILER

X12 Segment Name: Transaction Set Trailer

X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

X12 Comments: **1.** SE is the last segment of each transaction set.

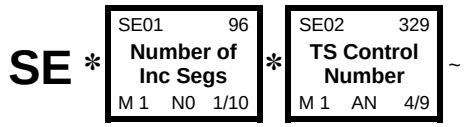
Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes: **1. Use this segment to mark the end of a transaction set and provide control information on the total number of segments included in the transaction set.**

TR3 Example: **SE*52*0001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments OD: **271B1__SE01__TransactionSegmentCount** IMPLEMENTATION NAME: **Transaction Segment Count**	**M 1 N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: **271B1__SE02__TransactionSetControlNumber** **The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example "0001", and increment from there. This number must be unique within a specific functional group (segments GS through GE) and interchange, but can repeat in other groups and interchanges.**	**M 1 AN 4/9**

3 Examples

The following information is associated with the information source, information receiver, subscriber, and dependent used in the following examples in this section:

Payer (Information Source)	ABC Company Payer Identification Number 842610001
Provider (Information Receiver) Clinic	Bone and Joint Clinic Service Provider Number 2000035 Facility Network Identification Number 234899 55 High Street Seattle, WA, 98123 Communication Contact Name Billing Department Phone Number 206-555-1212 Extension 2805 FAX 206-555-1213
Provider (Information Receiver) Individual Physician	Marcus Jones Service Provider Number 0202034 Provider Plan Network Identification Number 129 Communication Contact Name M. Murphy Phone Number 206-555-1212 Extension 3694 FAX 206-555-1214
Subscriber	Robert B. Smith Subscriber (Subscriber/Patient) Member Identification Number 11122333301 Date of Birth 19430519 Male Group or Policy Number 599119 29 Fremont St, Apt # 1, Peace, NY, 10023

Dependent	Mary Smith Dependent (Patient) Social Security Number 003221234 Date of Birth 19781014 Female Relationship to Subscriber Child

3.1 Example 1

Example 1 is for a subscriber who is also the patient. There are two responses in this section. The first response is a positive response where the subscriber was found. The second response is a rejection for a provider not authorized to access the payer's eligibility system.

3.1.1 Request

Generic request by a clinic for the patient's (subscriber) eligibility.
This is an example of an eligibility request from a clinic to a payer processed in Real Time (see Section 1.4.3 - *Batch and Real Time*). The clinic is inquiring if the patient (the subscriber) has coverage. The request is from Bone and Joint Clinic to the ABC Company. This example uses the Primary Search Option (see Section 1.4.8 - *Search Options*) for a subscriber who is the patient and is for a generic request for Eligibility (see Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set*).

ST*270*1234*005010X279~	Transaction Set ID Code = 270 (Eligibility, Coverage or Benefit Inquiry) Transaction Set Control Number = 1234 Implementation Convention Reference = 005010X279
BHT*0022*13*10001234*20060501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Identification Reference Identification = 10001234 Date = 20060501 (May 1, 2006) Time = 1:19 PM
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1

NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC***SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-Person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035
HL*3*2*22*0~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 0
TRN*1*93175-012547*9877281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*IL*1*SMITH*ROBERT**MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type Qualifier = 1 (Person) Last Name = Smith First Name = Robert Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301

DMG*D8*19430519~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519
DTP*291*D8*20060501~	Date/Time Qualifier = 291 (Plan) Date Time Period Format Qualifier D8 (Dates Expressed in Format CCYYMMDD) Date Time Period = 20060501 (May 1, 2006)
EQ*30~	Service Type Code = 30 (Health Benefit Plan Coverage
SE*13*1234~	Number of Included Segments = 13 Transaction Set Control Number = 1234

3.1.2 Response

Response to a generic request by a clinic for the patient's (subscriber) eligibility. This is an example of an eligibility response from a payer to a clinic based on the request in Section 3.1.1 - *Request*. The request is from Bone and Joint Clinic to the ABC Company. This response illustrates the required components outlined in Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set*. The payer has indicated the patient (the subscriber) has active coverage for the health plan, the beginning date for their coverage with the plan, active coverage for all the benefits outlined in Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set* and they have a Primary Care Physician.

ST*271*4321*005010X279~	Transaction Set ID Code = 271 (Eligibility, Coverage or Benefit Information) Transaction Set Control Number = 4321 Implementation Convention Reference = 005010X279
BHT*0022*11*10001234*20060501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Identification Reference Identification = 10001234 Date = 20060501 (May 1, 2006) Time = 1:19 PM

HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-Person Entity) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 (Information Receiver) Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC***SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-Person Entity) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV (Service Provider Number) Identification Code = 2000035
HL*3*2*22*0~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 (Subscriber) Hierarchical Child Code = 0
TRN*2*93175-012547*9877281234~	Trace Type Code = 2 (Referenced Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used

NM1*IL*1*SMITH*JOHN**MI*123456789~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type Qualifier = 1 (Person) Last Name = Smith First Name = John Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification) Identification Code = 123456789
N3*15197 BROADWAY AVENUE*APT 215~	Address Information = 15197 BROADWAY AVENUE Address Information = APT 215
N4*KANSAS CITY*MO*64108~	City = KANSAS CITY State or Prov Code = MO Postal Code = 64108
DMG*D8*19630519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19630519 Gender Code = M (Male)
DTP*346*D8*20060101~	Date/Time Qualifier = 346 (Plan Begin) Date Time Period Format Qualifier D8 (Dates Expressed in Format CCYYMMDD) Date Time Period = 20060101 (January 1, 2006)
EB*130**GOLD 123 PLAN~**	Eligibility or Benefit Information Code = 1 (Active Coverage) Coverage Level Code = * not used Service Type Code = 30 (Health Benefit Plan Coverage) Insurance Type Code = * not used Plan Coverage Description = Gold 123 Plan
EB*L~	Eligibility or Benefit Information Code = L (Primary Care Provider)
LS*2120~	Loop Identifier Code = 2120

NM1*P3*1*JONES*MARCUS**SV*0202034~**	Entity Identifier Code = P3 (Primary Care Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
LE*2120~	Loop Identifier Code = 2120
EB*11^33^35^47^86^88^98^AL^MH^UC~**	Eligibility or Benefit Information Code = 1 (Active Coverage) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care)

EB*B1^33^35^47^86^88^98^AL^MH^** **UC*HM*GOLD 123 PLAN*27*10*****Y~**	Eligibility or Benefit Information Code = B (Co-Payment) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care) Insurance Type Code =HM (Health Management Organization (HMO)) Plan Coverage Description = GOLD 123 PLAN Time Period Qualifier = 27 (Visit) Monetary Value = 10 (Dollar) Percent = * not used Quantity Qualifier = * not used Quantity = * not used Yes/No Condition Or Response Code (Certification/Authorization Indicator) = * not used Yes/No Condition Or Response Code (In Plan Network Indicator) = Y (Yes – In Network)

EB*B1^33^35^47^86^88^98^AL^MH^** **UC*HM*GOLD 123 PLAN*27*30*****N~**	Eligibility or Benefit Information Code = B (Co-Payment) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care) Insurance Type Code =HM (Health Management Organization (HMO)) Plan Coverage Description = GOLD 123 PLAN Time Period Qualifier = 27 (Visit) Monetary Value = 30 (Dollar) Percent = * not used Quantity Qualifier = * not used Quantity = * not used Yes/No Condition Or Response Code (Certification/Authorization Indicator) = * not used Yes/No Condition Or Response Code (In Plan Network Indicator) = N (No – Out of Network)
SE*22*4321~	Number of Included Segments = 22 Transaction Set Control Number = 4321

3.1.3 Response

Error response from the payer to a clinic that is not eligible for inquiries with the payer.

This is an example of an eligibility response from a payer to a clinic based on the request in example Section 3.1.1 - *Request*. The request validation segment is used in this example to indicate that the provider is not eligible for inquiries.

ST*271*4323*005010X279~	Transaction Set ID Code = 271 (Eligibility, Coverage or Benefit Information) Transaction Set Control Number = 4323 Implementation Convention Reference = 005010X279

BHT*0022*11*10001234*20060501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Identification Reference Identification = 10001234 Date = 20060501 (May 1, 2006) Time = 1:19 PM
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC***SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-Person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035
AAA*Y50*N~**	Validity Code = Y (Yes) Agency Qualifier Code = * not used Reject Reason Code = 50 (Provider Ineligible For Inquiries) Follow-Up Action Code = N (Resubmission Not Allowed)

SE*8*4323~	Number of Included Segments = 8 Transaction Set Control Number = 4323

3.2 Example 2

Example 2 is for a patient who is the dependent of a subscriber. There are two responses in this section. The first response is a positive response where the dependent was found. The second response is a rejection for a provider not authorized to access the payer's eligibility system.

3.2.1 Request

Generic request by a physician for the patient's (dependent) eligibility.
This is an example of an eligibility request from an individual provider to a payer. The physician is inquiring if the patient (the dependent) has coverage. The request is from Marcus Jones to the ABC Company. This example uses the Primary Search Option (see Section 1.4.8 - *Search Options*) for a dependent who is the patient and is for a generic request for Eligibility (see Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set*).

ST*270*1235*005010X279~	Transaction Set ID Code = 270 (Eligibility, Coverage or Benefit Inquiry) Transaction Set Control Number = 1235 Implementation Convention Reference = 005010X279
BHT*0022*13*10001235*20060501*1320~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Identification Reference Identification = 10001235 Date = 20060501 (May 1, 2006) Time = 1:20 PM
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1

NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*1*JONES*MARCUS**SV*0202034~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*IL*1****MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type Qualifier = 1 (Person) Last Name = * not used First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
HL*4*3*23*0~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 Hierarchical Child Code = 0

TRN*1*93175-012547*9877281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*03*1*SMITH*MARY~	Entity Identifier Code = 03 (Dependent) Entity Type Qualifier = 1 (Person) Last Name = Smith First Name = Mary Middle Name = * not used Name Prefix = * not used Name Suffix = * not used * not used Identification Code = * not used
DMG*D8*19781014~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19781014
DTP*291*D8*20060501~	Date/Time Qualifier = 291 (Plan) Date Time Period Format Qualifier D8 (Dates Expressed in Format CCYYMMDD) Date Time Period = 20060501(May 1, 2006)
EQ*30~	Service Type Code = 30 (Health Benefit Plan Coverage
SE*15*1234~	Number of Included Segments = 15 Transaction Set Control Number = 1234

3.2.2 Response

Response to a generic request by a physician for the patient's (dependent) eligibility.

This is an example of an eligibility response from a payer to an individual provider based on the request in Section 3.2.1 - *Request*. The request is from Bone and Joint Clinic to the ABC Company. This response illustrates the required components outlined in Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set*. The payer has indicated the patient (the dependent) has active coverage for the health plan, the beginning date for their coverage with the plan, active coverage for all the benefits outlined in Section 1.4.7 - *Implementation-Compliant Use of the 270/271 Transaction Set* and they have a Primary Care Physician.

ST*271*4322*005010X279~	Transaction Set ID Code = 271 (Eligibility, Coverage or Benefit Information) Transaction Set Control Number = 4322 Implementation Convention Reference = 005010X279
BHT*0022*11*10001235*20060501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Identification Reference Identification = 10001235 Date = 20060501 (May 1, 2006) Time = 1:19 PM
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-Person Entity) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 (Information Receiver) Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC***SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-Person Entity) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV (Service Provider Number) Identification Code = 2000035

HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 21 (Subscriber) Hierarchical Child Code = 1
NM1*IL*1*SMITH*JOHN**MI*123456789~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type Qualifier = 1 (Person) Last Name = Smith First Name = John Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification) Identification Code = 123456789
N3*15197 BROADWAY AVENUE*APT 215~	Address Information = 15197 BROADWAY AVENUE Address Information = APT 215
N4*KANSAS CITY*MO*64108~	City = KANSAS CITY State or Prov Code = MO Postal Code = 64108
DMG*D8*19630519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19630519 Gender Code = M (Male)
HL*4*3*23*1~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 (Dependent) Hierarchical Child Code = 0
TRN*2*93175-012547*9877281234~	Trace Type Code = 2 (Referenced Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*03*1*SMITH*MARY~	Entity Identifier Code = 03 (Dependent) Entity Type Qualifier = 1 (Person) Last Name = Smith First Name = Mary Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = * not used Identification Code = * not used

N3*15197 BROADWAY AVENUE*APT 215~	Address Information = 15197 BROADWAY AVENUE Address Information = APT 215
N4*KANSAS CITY*MO*64108~	City = KANSAS CITY State or Prov Code = MO Postal Code = 64108
DMG*D8*19981014*F~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19981014 Gender Code = F (Female)
INS*N*19~	Yes/No Condition Or Response Code (Insured Indicator) = N (No) Individual Relationship Code = 19 (Child)
DTP*346*D8*20060101~	Date/Time Qualifier = 346 (Plan Begin) Date Time Period Format Qualifier D8 (Dates Expressed in Format CCYYMMDD) Date Time Period = 20060101 (January 1, 2006)
EB*130**GOLD 123 PLAN~**	Eligibility or Benefit Information Code = 1 (Active Coverage) Coverage Level Code = * not used Service Type Code = 30 (Health Benefit Plan Coverage) Insurance Type Code = * not used Plan Coverage Description = Gold 123 Plan
EB*L~	Eligibility or Benefit Information Code = L (Primary Care Provider)
LS*2120~	Loop Identifier Code = 2120
NM1*P3*1*JONES*MARCUS** SV*0202034~**	Entity Identifier Code = P3 (Primary Care Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
LE*2120~	Loop Identifier Code = 2120

EB*11^33^35^47^86^88^98^AL^MH^UC~**	Eligibility or Benefit Information Code = 1 (Active Coverage) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care)
EB*B1^33^35^47^86^88^98^AL^MH^UC*HM*GOLD 123 PLAN*27*10*****Y~**	Eligibility or Benefit Information Code = B (Co-Payment) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care) Insurance Type Code = HM (Health Management Organization (HMO)) Plan Coverage Description = GOLD 123 PLAN Time Period Qualifier = 27 (Visit) Monetary Value = 10 (Dollar) Percent = * not used Quantity Qualifier = * not used Quantity = * not used Yes/No Condition Or Response Code (Certification/Authorization Indicator) = * not used Yes/No Condition Or Response Code (In Plan Network Indicator) = Y (Yes – In Network)

EB*B1^33^35^47^86^88^98^AL^MH^UC *HM*GOLD 123 PLAN*27*30*****N~**	Eligibility or Benefit Information Code = B (Co-Payment) Coverage Level Code = * not used Service Type Code = 1 (Medical Care) Service Type Code = 33 (Chiropractic) Service Type Code = 35 (Dental Care) Service Type Code = 47 (Hospital) Service Type Code = 86 (Emergency Services) Service Type Code = 88 (Pharmacy) Service Type Code = 98 (Professional (Physician) Visit - Office) Service Type Code = AL (Vision (Optometry)) Service Type Code = MH (Mental Health) Service Type Code = UC (Urgent Care) Insurance Type Code = HM (Health Management Organization (HMO)) Plan Coverage Description = GOLD 123 PLAN Time Period Qualifier = 27 (Visit) Monetary Value = 30 (Dollar) Percent = * not used Quantity Qualifier = * not used Quantity = * not used Yes/No Condition Or Response Code (Certification/Authorization Indicator) = * not used Yes/No Condition Or Response Code (In Plan Network Indicator) = N (No – Out of Network)
SE*28*4322~	Number of Included Segments = 28 Transaction Set Control Number = 4322

A External Code Sources

A.1 External Code Sources

This Implementation Guide uses Code Sources belonging to the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Finance Administration (HCFA). Several of these code source's name and/or address information has been revised since the publication of the underlying X12 Standard. The entries in this appendix reflect the current Code Source name and/or address. The affected Code Sources are:

130 Health Care Financing Administration Common Procedural Coding System
237 Place of Service from Health Care Financing Administration Claim Form
537 Health Care Financing Administration National Provider Identifier
540 Health Care Financing Administration PlanID

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES
26, 100, 1715, 66/38, 235/CH, 955/SP

SOURCE
Codes for Representation of Names of Countries, ISO 3166-(Latest Release)

Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM
American National Standards Institute
25 West 43rd Street, 4th Floor
New York, NY 10036

ABSTRACT
Part 1 (Country codes) of the ISO 3166 international standard establishes codes that represent the current names of countries, dependencies, and other areas of special geopolitical interest, on the basis of lists of country names obtained from the United Nations. Part 2 (Country subdivision codes) establishes a code that represents the names of the principal administrative divisions, or similar areas, of the countries, etc. included in Part 1. Part 3 (Codes for formerly used names of countries) establishes a code that represents non-current country names, i.e., the country names deleted from ISO 3166 since its first publication in 1974. Most currencies are those of the geopolitical

entities that are listed in ISO 3166 Part 1, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166 Part 1, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166 Part 1. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166 Part 1.

22 States and Provinces

SIMPLE DATA ELEMENT/CODE REFERENCES
156, 66/SJ, 235/A5, 771/009

SOURCE
U.S. Postal Service or

Canada Post or
Bureau of Transportation Statistics

AVAILABLE FROM
The U.S. state codes may be obtained from:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013
www.usps.gov
The Canadian province codes may be obtained from:
http://www.canadapost.ca
The Mexican state codes may be obtained from:
www.bts.gov/ntda/tbscd/mex-states.html

ABSTRACT
Provides names, abbreviations, and two character codes for the states, provinces and sub-country divisions as defined by the appropriate government agency of the United States, Canada, and Mexico.

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES
116, 66/16, 309/PQ, 309/PR, 309/PS, 771/010

SOURCE
National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM
U.S Postal Service
Washington, DC 20260
New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT
The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes. The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

130 Healthcare Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES
235/HC, 1270/BO, 1270/BP

SOURCE
Healthcare Common Procedural Coding System

AVAILABLE FROM
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT
HCPCS is Centers for Medicare & Medicaid Service's (CMS) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

SIMPLE DATA ELEMENT/CODE REFERENCES
128/ICD, 235/DX, 235/ID, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/DD, 1270/PR, 1270/SD, 1270/TD, 1270/AAU, 1270/AAV, 1270/AAX

SOURCE
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II and III

AVAILABLE FROM
Superintendent of Documents
U.S. Government Printing Office
P.O. Box 371954
Pittsburgh, PA 15250

ABSTRACT
The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II (diagnoses) and III (procedures) describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases and procedures.

133 Current Procedural Terminology (CPT) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
128/CPT, 235/CJ, 1270/BS, 1270/AAW

SOURCE
Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT
A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

135 American Dental Association

SIMPLE DATA ELEMENT/CODE REFERENCES
1361, 235/AD, 1270/JO, 1270/JP, 1270/TQ, 1270/AAY

SOURCE
Current Dental Terminology (CDT) Manual

AVAILABLE FROM
Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT
The CDT manual contains the American Dental Association's codes for dental procedures and nomenclature and is the accepted set of numeric codes and descriptive terms for reporting dental treatments and descriptors.

206 Government Bill of Lading Office Code

SIMPLE DATA ELEMENT/CODE REFERENCES
309

SOURCE
Defense Traffic Management Regulation (DTMR), Appendix I - Government Bill of Lading Codes

AVAILABLE FROM
Military Traffic Management Command (MTMC)

Attn: Programs and Systems Support (MTIN-P)
5611 Columbia Pike
Falls Church, VA 22041-5050

ABSTRACT
Defines the regulations for managing the transportation of goods owned or purchased by the Department of Defense.

237 Place of Service Codes for Professional Claims

SIMPLE DATA ELEMENT/CODE REFERENCES
1332/B

SOURCE
Place of Service Codes for Professional Claims

AVAILABLE FROM
Centers for Medicare and Medicaid Services
CMSO, Mail Stop S2-01-16
7500 Security Blvd
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare and Medicaid Services develops place of service codes to identify the location where health care services are performed.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES
235/N1, 235/N2, 235/N3, 235/N4, 235/N5, 235/N6, 1270/NDC

SOURCE
Drug Establishment Registration and Listing Instruction Booklet

AVAILABLE FROM
Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

ABSTRACT
Publication includes manufacturing and labeling information as well as drug packaging sizes.

284 Nature of Injury Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1270/GR, 1270/NI

SOURCE
TABLE 8, DCI 25

AVAILABLE FROM
National Council on Compensation Insurance
E-Commerce
750 Park of Commerce Drive
Boca Raton, FL 33487

ABSTRACT
This publication describes nature of injury. The nature of injury or illness classification identifies the injury or illness in terms of its principal physical characteristics.

307 National Council for Prescription Drug Programs Pharmacy Number

SIMPLE DATA ELEMENT/CODE REFERENCES
128/D3

SOURCE
National Council for Prescription Drug Programs (NCPDP) Provider Number Database and Listing

AVAILABLE FROM
National Council for Prescription Drug Programs (NCPDP)
9240 East Raintree Drive
Scottsdale, AZ 85260

ABSTRACT
A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy and dispensing physician locations that conduct

business by billing third-party and dispensing physician locations that conduct business by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database. The NCPDP Provider Number is a seven-digit number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=sequential numbering scheme assigned to pharmacy locations, and C=check digit caluculate by algorithm from previous six digits.

407 Occupational Injury and Illness Classification Manual

SIMPLE DATA ELEMENT/CODE REFERENCES
559/LB, 1270/BT, 1270/BU, 1270/EK, 1270/GS, 1270/GU, 1270/GW, 1270/NI, 1270/PB, 1270/SJ, 1270/SL

SOURCE
U.S. Department of Labor

AVAILABLE FROM
Bureau of Labor Statistics
Office of Safety, Health, and Working Conditions
Room 3180
Postal Square Building
2 Massachusetts Ave., N.E.
Washington, DC 20212

ABSTRACT
The Occupational Injury and Illness Classification Manual (OI&ICM) provides a classification system for use in coding the case characteristics of injuries and illnesses in the Occupational Safety and Health (OSH) program and the Census of Fatal Occupational Injuries (CFOI) program. This manual contains the rules of selection, code descriptions, code titles, and indices, for the following code structures: Nature of Injury or Illness, Part of Body Affected, Source of Injury or Illness, Event or Exposure, and Secondary Source of Injury or Illness.

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES
235/IV, 1270/HO

SOURCE
Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM
HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018

ABSTRACT
This list contains codes identifying home infusion therapy products/services.

537 Centers for Medicare and Medicaid Services National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XX, 128/HPI

SOURCE
National Provider System

AVAILABLE FROM
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Provider/Supplier Enrollment
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare and Medicaid Services is developing the National Provider Identifier (NPI), which has been proposed as the standard unique identifier for each

health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Centers for Medicare and Medicaid Services PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XV, 128/ABY

SOURCE
PlanID Database

AVAILABLE FROM
Centers for Medicare and Medicaid Services
Center of Beneficiary Services, Membership Operations Group
Division of Benefit Coordination
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT
The Centers for Medicare and Medicaid Services has joined with other payers to develop a unique national payer identification number. The Centers for Medicare and Medicaid Services is the authorizing agent for enumerating payers through the services of a PlanID Registrar. It may also be used by other payers on a voluntary basis.

682 Health Care Provider Taxonomy

SIMPLE DATA ELEMENT/CODE REFERENCES
128/PXC, 1270/68

SOURCE
The National Uniform Claim Committee

AVAILABLE FROM
The National Uniform Claim Committee
c/o American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT
Codes defining the health care service provider type, classification, and area of specialization.

844 Eligibility Category

SIMPLE DATA ELEMENT/CODE REFERENCES
128/MRC

SOURCE
Department of Defense Instruction (DoDI) 1000.13

Dependent Information - Block 35 Relationship

AVAILABLE FROM
Office of the Deputy Undersecretary of Defense for Program Integration
Department of Defense
4000 Defense Pentagon
Washington, DC 20301-4000

ABSTRACT
The Department of Defense Eligibility Category expresses the eligibility category of the member to properly administer health benefits and coverage.

896 International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

SIMPLE DATA ELEMENT/CODE REFERENCES
235/IP, 1270/BBQ, 1270/BBR

SOURCE
International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

AVAILABLE FROM
CMM, HAPG, Division of Acute Care
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), describes the classification of inpatient procedures for statistical purposes and for the indexing of healthcare records by procedures.

897 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

SIMPLE DATA ELEMENT/CODE REFERENCES

235/DC, 1270/ABF, 1270/ABJ, 1270/ABK, 1270/ABN, 1270/ABU, 1270/ABV, 1270/ADD, 1270/APR, 1270/ASD, 1270/ATD

SOURCE

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

AVAILABLE FROM

OCD/Classifications and Public Health Data Standards
National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782

ABSTRACT

The International Classicication of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases.

932 Universal Postal Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

116

SOURCE

Universal Postal Union website

AVAILABLE FROM

International Bureau of the Universal Postal Union
POST*CODE
Case postale 13
3000 BERNE 15 Switzerland

ABSTRACT

The postcode is the fundamental, essential element of an address. A unique, universal identifier, it unambiguously identifies the addressee's locality and assists in the transmission and sorting of mail items. At present, 105 UPU member countries use postcodes as part of their addressing systems.

DOD1 Military Rank and Health Care Service Region

SIMPLE DATA ELEMENT/CODE REFERENCES

309/RJ

SOURCE

Military Health Systems Functional Area Manual - Data

AVAILABLE FROM

Health Affairs Functional Data Administrator
TRICARE Management Activity
Information Management Technology and Reengineering, FI and DA
5111 Leesburg Pike Suite 810
Falls Church, VA 22041-3206

ABSTRACT

(region): The Department of Defense Health Care Service Region code indicates the specific domestic or foreign regions that administer health benefits for military personnel.

DOD2 Paygrade

SIMPLE DATA ELEMENT/CODE REFERENCES

1038

SOURCE

Department of Defense Instruction (DODI) 1000.13
Sponsor Information - Block 7
Rank / Paygrade

AVAILABLE FROM

Office of the Deputy Undersecretary of Defense for Program Integration
Department of Defense
4000 Defense Pentagon
Washington, DC 20301-4000

ABSTRACT

The Department of Defense Rank and Paygrade expresses the rank and pay-grade code for military personnel.

B Nomenclature

B.1 ASC X12 Nomenclature

B.1.1 Interchange and Application Control Structures

Appendix B is provided as a reference to the X12 syntax, usage, and related information. It is not a full statement of Interchange and Control Structure rules. The full X12 Interchange and Control Structures and other rules (X12.5, X12.6, X12.59, X12 dictionaries, other X12 standards and official documents) apply unless specifically modified in the detailed instructions of this implementation guide (see Section B.1.1.3.1.2 - *Decimal* for an example of such a modification).

B.1.1.1 Interchange Control Structure

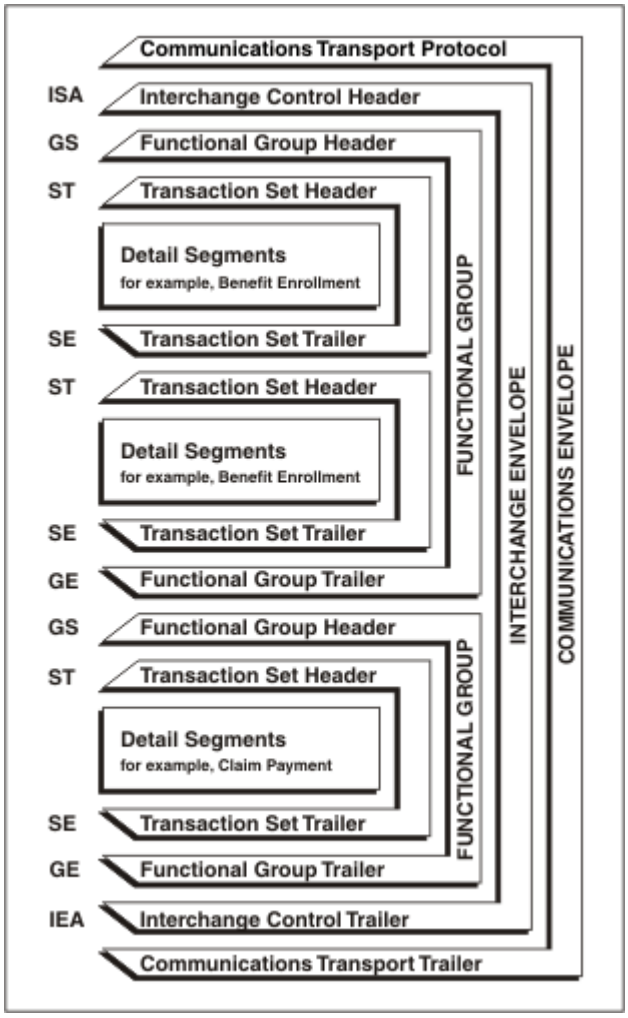
The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer.
Figure B.1 - *Transmission Control Schematic*, illustrates this interchange control.

Figure B.1 - Transmission Control Schematic



The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

B.1.1.2 Application Control Structure Definitions and Concepts

B.1.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. A data segment corresponds to a record in data processing terminology. The data segment

begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

B.1.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in Table B.1 - *Basic Character Set*, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

Table B.1 - Basic Character Set

A...Z	0...9	!		&		(	)	+	*
,	-	.	/	:	;	?	=	□ (space)	

B.1.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in Table B.2 - *Extended Character Set*.

Table B.2 - Extended Character Set

a...z	%	~	@	[	]	_	{
}	\	|	<	>	#	$	

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

For implementations compliant with this guide, either the entire extended character set must be acceptable, or the entire extended character set must not be used. In the absence of a specific trading partner agreement to the contrary, trading partners will assume that the extended character set is acceptable. Use of the extended character set allows the use of the "@" character in email addresses within the PER segment. Users should note that characters in the extended character set, as well as the basic character set, may be used as delimiters only when they do not occur in the data as stated in Section B.1.1.2.4.1 - *Base Control Set*.

B.1.1.2.4 Control Characters

Two control character groups are specified; they have restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In Table B.3 - *Base Control Set*, the column IA5 represents CCITT V.3 International Alphabet 5.

B.1.1.2.4.1 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

Table B.3 - Base Control Set

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

B.1.1.2.4.2 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in Table B.4 - *Extended Control Set*.

Table B.4 - Extended Control Set

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

B.1.1.2.5 Delimiters

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide (see Appendix C, ISA Segment Note 1) to be a 105 byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number

83; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in Table B.5 - *Delimiters*, in all examples of EDI transmissions.

Table B.5 - Delimiters

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

B.1.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called "transaction sets." A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

B.1.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The

distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

A simple data element within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated data element occurs.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in Table B.6 - *Data Element Types*, appear in this implementation guide.

Table B.6 - Data Element Types

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

The data element minimum and maximum lengths may be restricted in this implementation guide for a compliant implementation. Such restrictions may occur by virtue of the allowed qualifier for the data element or by specific instructions regarding length or format as stated in this implementation guide.

B.1.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is "Nn" where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

EXAMPLE

A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

B.1.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as "R."

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point must be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point must be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE

A transmitted value of 12.34 represents a decimal value of 12.34.

While the ASC X12 standard supports usage of exponential notation, this guide prohibits that usage.

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

EXAMPLE
For implementations mandated under HIPAA rules:

- The following transmitted value represents the largest positive dollar amount that can be sent: 99999999.99
- The following transmitted value is the longest string of characters that can be sent representing whole dollars: 99999999
- The following transmitted value is the longest string of characters that can be sent representing negative dollars and cents: -99999999.99
- The following transmitted value is the longest string of characters that can be sent representing negative whole dollars: -99999999

B.1.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces must be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is "ID."

B.1.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The string data element must contain at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces must be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is "AN."

B.1.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the

month (01 to 31). The representation for this data element type is "DT." Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment and the TA1 segment where the century is easily determined because of the nature of an interchange header.

B.1.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is "TM." The length of the data element determines the format of the transmitted time.

EXAMPLE

Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

B.1.1.3.1.7 Binary

The binary data element is any sequence of octets ranging in value from binary 00000000 to binary 11111111. This data element type has no defined maximum length. Actual length is specified by the immediately preceding data element. Within the body of a transaction set (from ST to SE) implemented according to this technical report, the binary data element type is only used in the segments Binary Data Segment BIN, and Binary Data Structure BDS. Within those segments, Data Element 785 Binary Data is a string of octets which can assume any binary pattern from hexadecimal 00 to FF, and can be used to send text as well as coded data, including data from another application in its native format. The binary data type is also used in some control and security structures.

Not all transaction sets use the Binary Data Segment BIN or Binary Data Structure BDS.

B.1.1.3.2 Repeating Data Elements

Simple or composite data elements within a segment can be designated as repeating data elements. Repeating data elements are adjacent data elements that occur up to a number of times specified in the standard as number of repeats. The implementation guide may also specify the number of repeats of a repeating data element in a specific location in the transaction that are permitted in a compliant implementation. Adjacent occurrences of the same repeating simple data element or composite data structure in a segment shall be separated by a repetition separator.

B.1.1.3.3 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described in Section B.1.1.3.8 - *Reference Designator* and Section B.1.1.3.9 - *Condition Designator*.

A composite data structure within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated composite data structure occurs.

B.1.1.3.4 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

B.1.1.3.5 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See Section B.1.1.3.9 - *Condition Designator*.

B.1.1.3.6 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

B.1.1.3.7 Comments

A segment comment provides additional information regarding the intended use of the segment.

B.1.1.3.8 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is prefixed with a hyphen and defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

B.1.1.3.9 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 2.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

Table B.7 - Condition Designator

DESIGNATOR	DESCRIPTION	
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.	
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.	
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition.	
	The definitions for each of the condition codes used within syntax notes are detailed below:	
	CONDITION CODE	DEFINITION
	P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
	R- Required	At least one of the elements specified in the condition must be present.
	E- Exclusion	Not more than one of the elements specified in the condition may be present.

DESIGNATOR	DESCRIPTION	
	C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
	L- List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

B.1.1.3.10 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed must be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

If a segment has no data in any data element within the segment (an "empty" segment), that segment must not be sent.

B.1.1.3.11 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

B.1.1.3.11.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

B.1.1.3.11.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

B.1.1.3.11.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header 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.

B.1.1.3.11.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

ST Transaction Set Header, starts a transaction set.

LS Loop Header, starts a bounded loop of data segments but is not part of the loop.

LS Loop Header, starts an inner, nested, bounded loop.

LE Loop Trailer, ends an inner, nested bounded loop.

LE Loop Trailer, ends a bounded loop of data segments but is not part of the loop.

SE Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

B.1.1.3.12 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See Figure B.1 - *Transmission Control Schematic*.

B.1.1.3.12.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

B.1.1.3.12.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

B.1.1.3.12.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1."

B.1.1.3.12.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of

repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is ">1."

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last consecutive occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

B.1.1.3.12.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

B.1.1.3.12.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

Table B.8 - Data Segment Requirement Designators

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

B.1.1.3.12.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

B.1.1.3.12.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

B.1.1.3.13 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See Figure B.1 - *Transmission Control Schematic*.

B.1.1.4 Envelopes and Control Structures

B.1.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two elements are identical. In most translation software products, if these elements are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. GS08 indicates the version of the transaction sets contained within the ISA/IEA envelope. The versions are not required to be the same. An Interchange

Acknowledgment can be requested through data element ISA14. The interchange acknowledgment is the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrepancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See Appendix C, EDI Control Directory, for a complete detailing of the inter-change control header and trailer. The authors recommend that when two transactions with different X12 versions numbers are sent in one interchange control structure (multiple functional groups within one ISA/IEA envelope), the Interchange Control version used should be that of the most recent transaction version included in the envelope. For the transmission of HIPAA transactions with mixed versions, this would be a compliant enveloping structure.

B.1.1.4.2 Functional Groups

Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, and GS06) can be used for debugging purposes. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate

count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See Appendix C, EDI Control Directory, for a complete detailing of the functional group header and trailer.

B.1.1.4.3 HL Structures

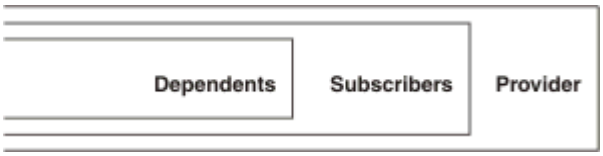
The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide.

For example, each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims.

Each guide states what levels are available, the level's usage, number of repeats, and whether that level has subordinate levels within a transaction set.

For implementations compliant with this guide, the repeats of the loops identified by the HL structure shall appear in the hierarchical order specified in BHT01, when those particular hierarchical levels exist. That is, an HL parent loop must be followed by the subordinate child loops, if any, prior to commencing a new HL parent loop at the same hierarchical level.

The following diagram, from transaction set 837, illustrates a typical hierarchy.



The two examples below illustrate this requirement:

Example 1 based on Implementation Guide 811X201:
INSURER
  First STATE in transaction (child of INSURER)
    First POLICY in transaction (child of first STATE)
      First VEHICLE in transaction (child of first POLICY)
    Second POLICY in transaction (child of first STATE)
      Second VEHICLE in transaction (child of second POLICY)
      Third VEHICLE in transaction (child of second POLICY)

Second STATE in transaction (child of INSURER)
Third POLICY in transaction (child of second STATE)
Fourth VEHICLE in transaction (child of third POLICY)

Example 2 based on Implementation Guide 837X141
First PROVIDER in transaction
First SUBSCRIBER in transaction (child of first PROVIDER)
Second PROVIDER in transaction
Second SUBSCRIBER in transaction (child of second PROVIDER)
First DEPENDENT in transaction (child of second SUBSCRIBER)
Second DEPENDENT in transaction (child of second SUBSCRIBER)
Third SUBSCRIBER in transaction (child of second PROVIDER)
Third PROVIDER in transaction
Fourth SUBSCRIBER in transaction (child of third PROVIDER)
Fifth SUBSCRIBER in transaction (child of third PROVIDER)
Third DEPENDENT in transaction (child of fifth SUBSCRIBER)

B.1.1.5 Acknowledgments

B.1.1.5.1 Interchange Acknowledgment, TA1

The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See Section B.1.1.5.2 - *Functional Acknowledgment, 997*, for more details. The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

B.1.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. The 997 is used as a functional acknowledgment to a previously transmitted functional group.

The 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

B.2 Object Descriptors

Object Descriptors (OD) provide a method to uniquely identify specific locations within an implementation guide. There is an OD assigned at every level of the X12N implementation:

1. Transaction Set
2. Loop
3. Segment
4. Composite Data Element
5. Component Data Element
6. Simple Data Element

ODs at the first four levels are coded using X12 identifiers separated by underbars:

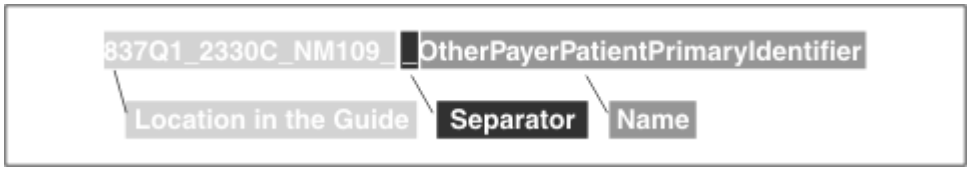
Entity	Example
1. Transaction Set Identifier plus a unique 2 character value	837Q1
2. Above plus under bar plus Loop Identifier as assigned within an implementation guide	837Q1_2330C
3. Above plus under bar plus Segment Identifier	837Q1_2330C_NM1

Entity	Example
4. Above plus Reference Designator plus under bar plus Composite Identifier	837Q1_2400_SV101_C003

The fifth and sixth levels add a name derived from the "Industry Term" defined in the X12N Data Dictionary. The name is derived by removing the spaces.

Entity	Example
5. Number 4 above plus composite sequence plus under bar plus name	837Q1_2400_SV101_C00302_ProcedureCode
6. Number 3 above plus Reference Designator plus two under bars plus name	837Q1_2330C_NM109__OtherPayerPatientPrimaryIdentifier

Said in another way, ODs contain a coded component specifying a location in an implementation guide, a separator, and a name portion. For example:



Since ODs are unique across all X12N implementation guides, they can be used for a variety of purposes. For example, as a cross reference to older data transmission systems, like the National Standard Format for health care claims, or to form XML tags for newer data transmission systems.

C EDI Control Directory

C.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **IEA**
  Interchange Control Trailer Segment

SEGMENT DETAIL

ISA - INTERCHANGE CONTROL HEADER

X12 Segment Name: Interchange Control Header

X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Segment Repeat: **1**

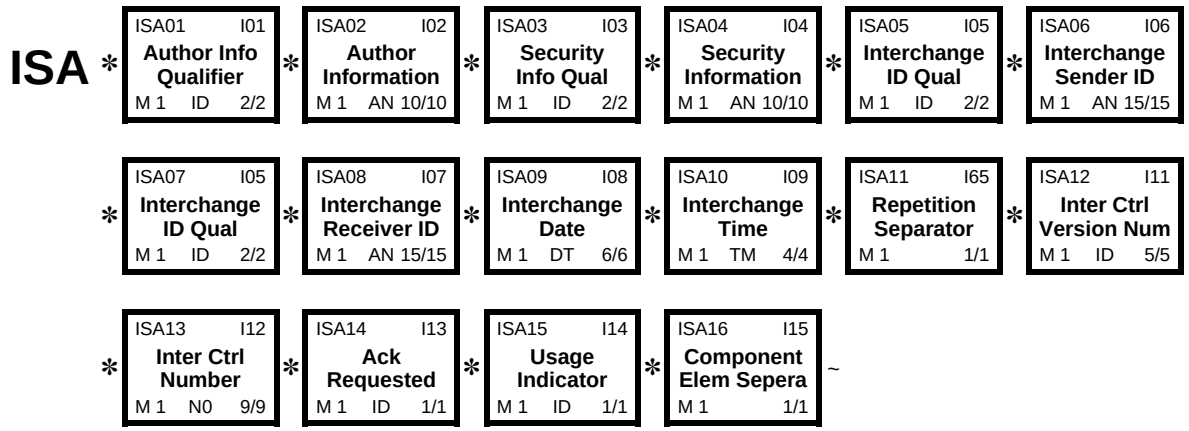
Usage: **REQUIRED**

TR3 Notes:

1. **All positions within each of the data elements must be filled.**
2. **For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.**
3. **The first element separator defines the element separator to be used through the entire interchange.**
4. **The ISA segment terminator defines the segment terminator used throughout the entire interchange.**
5. **Spaces in the example interchanges are represented by "." for clarity.**

TR3 Example: **ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*030101*1253*^*00501*000000905*1*T*:~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ISA01	I01	**Authorization Information Qualifier** Code identifying the type of information in the Authorization Information	M 1 ID 2/2
			CODE: **00** — DEFINITION: **No Authorization Information Present (No Meaningful Information in I02)**	
			CODE: **03** — DEFINITION: **Additional Data Identification**	
REQUIRED	ISA02	I02	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	M 1 AN 10/10
REQUIRED	ISA03	I03	**Security Information Qualifier** Code identifying the type of information in the Security Information	M 1 ID 2/2
			CODE: **00** — DEFINITION: **No Security Information Present (No Meaningful Information in I04)**	
			CODE: **01** — DEFINITION: **Password**	
REQUIRED	ISA04	I04	**Security Information** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)	M 1 AN 10/10
REQUIRED	ISA05	I05	**Interchange ID Qualifier** Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified	M 1 ID 2/2
			This ID qualifies the Sender in ISA06.	
			CODE: **01** — DEFINITION: **Duns (Dun & Bradstreet)**	
			CODE: **14** — DEFINITION: **Duns Plus Suffix**	
			CODE: **20** — DEFINITION: **Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number	
			CODE: **27** — DEFINITION: **Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**	
			CODE: **28** — DEFINITION: **Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**	
			CODE: **29** — DEFINITION: **Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**	
			CODE: **30** — DEFINITION: **U.S. Federal Tax Identification Number**	
			CODE: **33** — DEFINITION: **National Association of Insurance Commissioners Company Code (NAIC)**	
			CODE: **ZZ** — DEFINITION: **Mutually Defined**	
REQUIRED	ISA06	I06	**Interchange Sender ID** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element	M 1 AN 15/15

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M 1 ID 2/2**
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA08** **I07** **Interchange Receiver ID** **M 1 AN 15/15**
Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them

REQUIRED **ISA09** **I08** **Interchange Date** **M 1 DT 6/6**
Date of the interchange

The date format is YYMMDD.

REQUIRED **ISA10** **I09** **Interchange Time** **M 1 TM 4/4**
Time of the interchange

The time format is HHMM.

REQUIRED **ISA11** **I65** **Repetition Separator** **M 1 1/1**
Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator

REQUIRED **ISA12** **I11** **Interchange Control Version Number** **M 1 ID 5/5**
Code specifying the version number of the interchange control segments

CODE	DEFINITION
00501	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003**

REQUIRED **ISA13** **I12** **Interchange Control Number** **M 1 N0 9/9**
A control number assigned by the interchange sender

The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.

Must be a positive unsigned number and must be identical to the value in IEA02.

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M 1** **ID** **1/1**
Code indicating sender's request for an interchange acknowledgment

See Section B.1.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Interchange Acknowledgment Requested**
1	**Interchange Acknowledgment Requested (TA1)**

REQUIRED **ISA15** **I14** **Interchange Usage Indicator** **M 1** **ID** **1/1**
Code indicating whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M 1** **1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

SEGMENT DETAIL

GS - FUNCTIONAL GROUP HEADER

X12 Segment Name: Functional Group Header

X12 Purpose: To indicate the beginning of a functional group and to provide control information

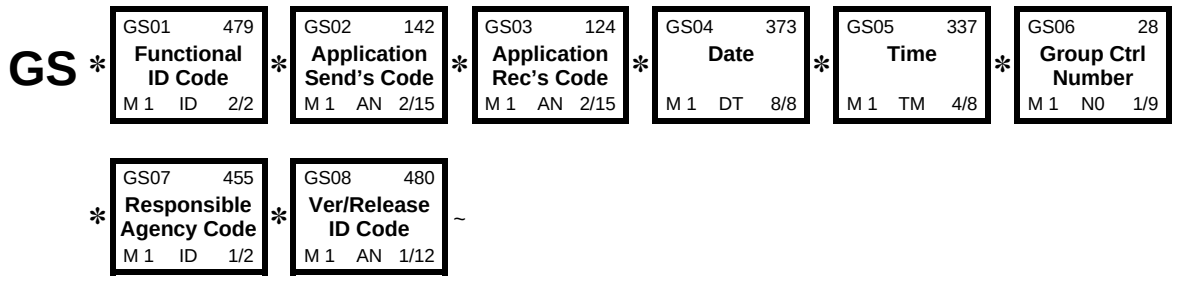
X12 Comments: **1.** A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **GS*XX*SENDER CODE*RECEIVER CODE*19991231*0802*1*X*005010X279~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **This is the 2-character Functional Identifier Code assigned to each transaction set by X12. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information.**	**M 1 ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M 1 AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M 1 AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M 1 DT 8/8**

REQUIRED **GS05** **337** **Time** **M 1 TM 4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: GS05 is the group time.

Use this time for the creation time. The recommended format is HHMM.

REQUIRED **GS06** **28** **Group Control Number** **M 1 N0 1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.

REQUIRED **GS07** **455** **Responsible Agency Code** **M 1 ID 1/2**

Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M 1 AN 1/12**

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE SOURCE 881: Version / Release / Industry Identifier Code

This is the unique Version/Release/Industry Identifier Code assigned to an implementation by X12N. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information.

CODE	DEFINITION
005010X279	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003**

SEGMENT DETAIL

GE - FUNCTIONAL GROUP TRAILER

X12 Segment Name: Functional Group Trailer

X12 Purpose: To indicate the end of a functional group and to provide control information

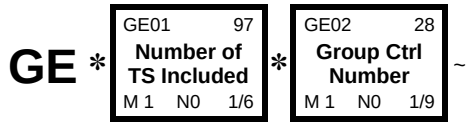
X12 Comments:
1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **GE*1*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M 1 N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M 1 N0 1/9**

SEGMENT DETAIL

IEA - INTERCHANGE CONTROL TRAILER

X12 Segment Name: Interchange Control Trailer

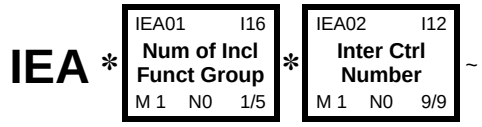
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **IEA*1*000000905~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M 1**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M 1**	**N0**	**9/9**

D Change Summary

This is the ASC X12N implementation guide for the 270/271 Health Care Eligibility Benefit Inquiry and Response. The following substantive changes have occurred since the previous Implementation Guide 004050X138, the 270/271 Health Care Eligibility Benefit Inquiry and Response.

D.1 Entire Document

1. All previous references to HCFA have been changed to CMS
2. Many segments and elements have TR3 segment notes, or notes added in addition to situational notes added to each segment/element that's usage is "situational"

D.2 Changes to Section 1

3. Sections have been added, re-ordered and combined. New section 1 encompasses old sections 1 and 2. New section 2 encompassed old section 3. Section cross references updated to reflect new section and subsection numbers and names
4. Section 1.4.1 - Additional notes added to clarify definitions of Subscriber and Dependent as it relates to Coordination of Benefits.
5. Section 1.4.2 - Updated definition of "Subscriber" and "Dependent" to sync up with 837 Implementation Guide
6. Section 1.4.2 - Updated/Clarified Payer expectations on 271. Payer must return subscriber/dependent information in 271 as it is needed in subsequent transactions.
7. Section 1.4.7 - New requirements regarding what MUST be returned on EVERY 271, such as plan begin date (346) or plan range of dates (291). If benefit dates for a specific EB03 value differ from plan begin or plan range, a value of 348 or 292 must be returned in the 2110 C/D. Also required is the service type code with associated EB01value (1-8), other payers/plans if known, Primary Care Provider if applicable.
8. Section 1.4.7 - Added note #6 which further clarifies what information sent on the 270 should be returned on the 271.
9. Section 1.4.7 - New requirements/clarification regarding service type codes that must be returned on 271.
10. Section 1.4.7 - Guidance regarding how specific service type codes fit into the more generic categories.
11. Section 1.4.7 - New paragraphs added to provide guidance on Person Specific benefits.
12. Section 1.4.8 - New Required Alternate and Optional Name/Date of Birth, Member ID/Date of Birth Search Options added.
13. Section 1.4.12 - Message Segments section added.

14. Section 1.6.1 - 997 is no longer required as a response to a batch or real time transaction.

15. Section 1.6.2 - 999 Implementation Acknowledgement outlines the requirements as a response to batch or real time transactions.

D.3 Changes to Section 2

16. Section 3 is now Section 2

270 and 271 Loops and Segments

17. All segments have an X12 Segment Name, X12 Segment Purpose and X12 Syntax area in the “implementation” (now known as “segment detail”) section. As well, the notes and examples as now referred to as “TR3 Notes” and “TR3 Example”.

270 and 271 Elements

18. All elements have an “implementation name” formerly referred to as the “industry” name.

270 Changes

19. ST03 - Usage changed from Not Used to Required

20. BHT/BHT02 - Removed code value 36

21. BHT/BHT06 - Removed code value RU - Medical Service Reservation

22. 2100A/NM1/NM103 - Usage changed from Situational to Required

23. 2100B/NM1/NM103 - Usage changed from Situational to Required

24. 2100B/N4/N407 -Usage changed from Not Used to Situational

25. 2100B/PRV/PRV02 - Usage changed from Required to Situational. Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

26. 2100B/PRV/PRV03 - Usage changed from Required to Situational

27. 2100B/PER - Segment Removed

28. 2100C/NM1/NM108 - Code Value ZZ removed and replaced with Code Value II (Standard Unique Health Identifier for each Individual in the United States)

29. 2100C/REF/REF01 - Code Value 49 (Family Unit Number) removed

30. 2100C/REF/REF01 - Code value Y4 added with usage note

31. 2100C/N4/N401 - Usage changed from Situational to required

32. 2100C/PRV/PRV02 - Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

33. 2100C/DTP/DTP01 - Added code 291 (Plan) standardizing all requests to one code. Removed code values 307, 435 and 472.

34. 2110C/EQ/EQ02-8 - Product/Service ID added - Usage “Not Used”

35. 2110C/EQ/EQ03 - Code values IND, DEP, ECH, ESP, EMP, SPC and SPO removed

36. 2110C/EQ/EQ04 - Usage changed from Situational to Not Used

37. 2110C/III - Diagnosis code functionality moved to 2100C HI segment. Codes 01, 03, 04, 05, 06, 07, 08, 13, 14, 15, 20, 49 and 57 added to III02

38. 2100D/REF/REF01 - Code value Y4 added with usage note

39. 2100D/N4/N401 - Usage changed from Situational to required

40. 2100D/PRV/PRV02 - Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

41. 2100D/DTP/DTP01 - Removed code value 307; added code value 291

42. 2110D/EQ/EQ02-8 - Product/Service ID added - Usage “Not Used”

43. 2110D/EQ/EQ03 - Usage changed from Situational to Not Used

44. 2110D/EQ/EQ04 - Usage changed from Situational to Not Used

45. 2110D/III - Diagnosis code functionality moved to 2100D HI segment. Codes 01, 03, 04, 05, 06, 07, 08, 13, 14, 15, 20, 49 and 57 added to III02

271

46. ST03 - Usage changed from Not Used to Required

47. 2100A/NM1/NM108 - XV note removed, XX note removed

48. 2100A/REF - Delete 2100A REF segment in it’s entirety

49. 2100A/PER03, PER05 and PER07 - Add code UR-Uniform Resource Locator (URL)

50. 2100A/AAA/AAA03 - Updated note on code value 04

51. 2100B/NM1/NM108 - XV note removed, XX note removed

52. 2100B/PRV/PRV02 - Usage changed from Required to Situational. Erroneous note referring to National Provider ID removed. Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code).

53. 2100B/PRV/PRV03 - Usage changed from Required to Situational

54. 2100C/NM1/NM106 - Changed usage from Situational to Not Used

55. 2100C/NM1/NM108 - Code Value ZZ removed and replaced with Code Value II (Standard Unique Health Identifier for each Individual in the United States)

56. 2100C/REF/REF01 - Updated Note on Code Value 49 to reference PBM’s.

57. 2100C/REF/REF01 - Add Code Value -Y4 Agency Claim Number

58. 2100C/N4 - Added Segment Notes

59. 2100C/N4/N405 - Change usage from Situational to Not Used

60. 2100C/N4/N406 - Change usage from Situational to Not Used

61. 2100C/N4/N407 - Change usage from Not Used to Situational

62. 2100C/PER - Delete PER segment in it’s entirety

63. 2100C/AAA/AAA03 - Add note to Code Value 58-Invalid/Missing Date-of-Birth, 71-Patient Date of Birth does not match that for the Patient on the Da-

tabase, 72-Invalid/Missing Subscriber/Insured ID, 73-Invalid/Missing Subscriber/Insured Name, 75-Subscriber/Insured Not Found

64. 2100C/AAA/AAA03 - Remove code values 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, 77-Subscriber Found, Patient Not Found

65. 2100C/PRV/PRV02 - Changed usage from Required to Situational. Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

66. 2100C/PRV/PRV03 - Changed usage from Required to Situational

67. 2100C/DMG - Added to Situational Note 1, and added additional Situational notes.

68. 2100C/DMG/DMG02 - “Added by copying Situational Note 1 from segment note to element note. Moved current note ”use this date for the date of birth..." to a note, not a Situational note.

69. 2100C/INS/INS09 - Changed usage from Situational to Not Used

70. 2100C/INS/INS10 - Changed usage from Situational to Not Used

71. 2100C HI - Added HI segment and elements

72. 2100C/DTP - Changed and added TR3 segment notes

73. 2100C/MPI - Added MPI segment and elements

74. 2110C/EB - Updated Situational Rule.

75. 2110C/EB/EB02 - Added clarifying note regarding relationship to EB01 value

76. 2110C/EB/EB03 - Added Code Values: CQ-Case Management, DS-Diabetic Supplies, ON-Oncology, PT-Physical Therapy, PU-Pulmonary, RN-Renal, RT-Residential Psychiatric Treatment

77. 2110C/EB/EB03 - Revised note on Code Value 30

78. 2110C/EB/EB04 - Add note to Code Value OT: When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D

79. 2110C/EB/EB07 - Added clarifying note re: Patient portion of responsibility and usage related to EB01 value

80. 2110C/EB/EB08 - Added clarifying note re: Patient portion of responsibility and usage related to EB01 value

81. 2110C/EB/EB09 - Added Code Values: 8H-Minimum, M2-Maximum, D3-Number of Co-insurance Days

82. 2110C/EB/EB12 - Added Code Value: W-Not applicable

83. 2110C/EB/EB13-8 - Added EB13-8 as Situational

84. 2110C/REF/REF01 - Updated Note on Code Value 49 to reference PBM’s.

85. 2110C/REF/REF01 - Added Code Values and Definitions: ALS-Alternative List ID, CLI-Coverage List ID

86. 2110C/MSG - Added TR3 segment notes

87. 2110C/DTP/DTP01 Added Code Values 291 and 346

88. 2115C/III - Removed references to Principle Diagnosis and Diagnosis Codes in the TR3 segment notes

89. 2115C/III/III01 - Removed code values BF and BK, added code values GR and NI

90. 2115C/III/III02 - Added Code Values: 01-Pharmacy, 03-School, 04-Homeless Shelter, 05-Indian Health Service Free-standing Facility, 06-Indian Health Service Provider-based Facility, 07-Tribal 638 Free-standing Facility, 08-Tribal 638 Provider-based Facility, 13-Assisted Living, 14-Group Home, 15-Mobile Unit, 20 Urgent Care Facility, 49-Independent Clinic, 57-Non-Residential Substance Abuse Treatment Facility

91. 2110C/LS - Added TR3 segment notes

92. 2120C/NM1/NM101 - Added Code Value: 1I-Preferred Provider Organization and Situational note for usage.

93. 2120C/NM1/NM108 - XV note removed, XX note removed, Code Value ZZ removed and replaced with Code Value II (Standard Unique Health Identifier for each Individual in the United States)

94. 2120C/NM1/NM110 - Added Code Values: 27-Domestic Partner, 48-Employee

95. 2120C/N4/N406 - Added usage note for Department of Defense

96. 2120C/N4/N407 - Change usage from Not Used to Situational

97. 2120C/PER - Added TR3 segment notes

98. 2120C/PER/PER03 - Added Code Value UR-Universal Resource Locator (URL)

99. 2120C/PER/PER05 - Added Code Value UR-Universal Resource Locator (URL)

100. 2120C/PER/PER07 - Added Code Value UR-Universal Resource Locator (URL)

101. 2120C/PRV/PRV02 - Usage changed from Required to Situational, Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

102. 2120C/PRV/PRV03 - Usage changed from Required to Situational

103. 2120C/LE - Added TR3 segment notes

104. 2100D/NM1/NM106 - Changed usage from Situational to Not Used

105. 2100D/NM1/NM108 - Changed usage from Situational to Not Used

106. 2100D/NM1/NM109 - Changed usage from Situational to Not Used

107. 2100D/REF/REF01 - Updated Note on Code Value 49 to reference PBM's. Update note too to address Family Unit Number usage

108. 2100D/REF/REF01 - Remove Code Value: 1W-Member Identification Number

109. 2100D/REF/REF01 - Add Code Value -Y4 Agency Claim Number

110. 2100D/N4 - Added Segment Notes

111. 2100D/N4/N407 - Change usage from Not Used to Situational

112. 2100D/PER - Delete PER segment in it's entirety

113. 2100D/AAA/AAA03 - Add usage notes to code values: 58-Invalid/Missing Date of Birth, 71-Patient Birthdate Does Not Match That for the Patient on the Database.

114. 2100D/PRV/PRV02 - Changed usage from Required to Situational, Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

115. 2100D/PRV/PRV03 - Changed usage from Required to Situational

116. 2100D/DMG - Added to Situational Note 1, and added additional Situational notes.

117. 2100D/DMG/DMG02 - Added by copying Situational Note 1 from segment note to element note. Moved current note "use this date for the date of birth..." to a note, not a Situational note.

118. 2100D/INS/INS02 - Add Code Values: 20-Employee, 39-Organ Donor, 40-Cadaver Donor, 53-Life Partner, G8-Other Relationship.

119. 2100D/INS/INS09 - Changed usage from Situational to Not Used

120. 2100D/INS/INS10 - Changed usage from Situational to Not Used

121. 2100D HI - Added HI segment and elements

122. 2100D/DTP - Changed and added TR3 segment notes

123. 2100D/MPI - Added MPI segment and elements

124. 2110D/EB - Updated Situational Rule.

125. 2110D/EB/EB02 - Added clarifying note regarding relationship to EB01 value

126. 2110D/EB/EB03 - Added Code Values: CQ-Case Management, DS-Diabetic Supplies, ON-Oncology, PT-Physical Therapy, PU-Pulmonary, RN-Renal, RT-Residential Psychiatric Treatment

127. 2110D/EB/EB03 - Revised note on Code Value 30

128. 2110D/EB/EB04 - Add note to Code Value OT: When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D

129. 2110D/EB/EB07 - Added clarifying note re: Patient portion of responsibility and usage related to EB01 value

130. 2110D/EB/EB08 - Added clarifying note re: Patient portion of responsibility and usage related to EB01 value

131. 2110D/EB/EB09 - Added Code Values: 8H-Minimum, M2-Maximum, D3-Number of Co-insurance Days

132. 2110D/EB/EB12 - Added Code Value: W-Not applicable

133. 2110D/EB/EB13-8 - Added EB13-8 as Situational

134. 2110D/REF/REF01 - Updated Note on Code Value 49 to reference PBM's. Update note too to address Family Unit Number usage

135. 2110D/REF/REF01 - Added Code Values and Definitions: ALS-Alternative List ID, CLI-Coverage List ID

136. 2110D/DTP - Added TR3 segment notes

137. 2110D/DTP/DTP01 Added Code Values 291 and 346

138. 2110D/MSG - Added TR3 segment notes

139. 2115D/III - Removed references to Principle Diagnosis and Diagnosis Codes in the TR3 segment notes

140. 2115D/III/III01 - Removed code values BF and BK, added code values GR and NI

141. 2115D/III/III02 - Added Code Values: 01-Pharmacy, 03-School , 04-Homeless Shelter, 05-Indian Health Service Free-standing Facility, 06-Indian Health Service Provider-based Facility, 07-Tribal 638 Free-standing Facility, 08-Tribal 638 Provider-based Facility, 13-Assisted Living, 14-Group Home, 15-Mobile Unit, 20 Urgent Care Facility, 49-Independent Clinic, 57-Non-Residential Substance Abuse Treatment Facility

142. 2110D/LS - Added TR3 segment notes

143. 2120D/NM1/NM101 - Added Code Value: 1I-Preferred Provider Organization and Situational note for usage.

144. 2120D/NM1/NM108 - XV note removed, XX note removed, Code Value ZZ removed and replaced with Code Value II (Standard Unique Health Identifier for each Individual in the United States)

145. 2120D/NM1/NM110 - Added Code Values: 27-Domestic Partner, 48-Employee

146. 2120D/N4/N406 - Added usage note for Department of Defense

147. 2120D/N4/N407 - Change usage from Not Used to Situational

148. 2120D/PER - Added TR3 segment notes

149. 2120D/PER/PER03 - Added Code Value UR-Universal Resource Locator (URL)

150. 2120D/PER/PER05 - Added Code Value UR-Universal Resource Locator (URL)

151. 2120D/PER/PER07 - Added Code Value UR-Universal Resource Locator (URL)

152. 2120D/PRV/PRV02 - Usage changed from Required to Situational, Code Value ZZ removed and replaced with Code Value PXC (Provider Health Care Taxonomy Code)

153. 2120D/PRV/PRV03 - Usage changed from Required to Situational

154. 2110D/LE - Added TR3 segment notes

Section 3

155. Examples updated to reflect new requirements

Appendix A

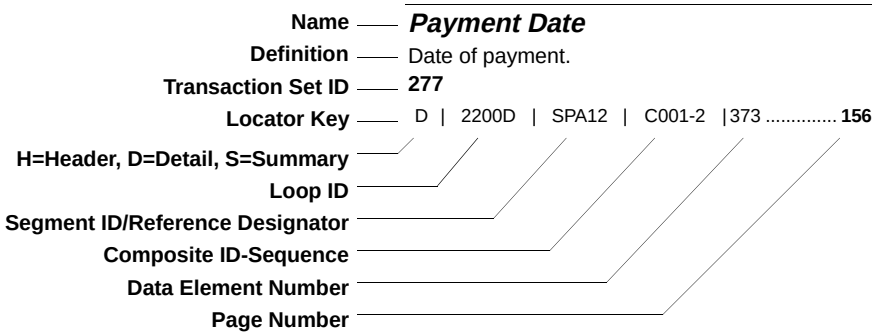
156. Added Code Sources: 896 - International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), 897 - International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM); 932 - Universal Postal Codes; DOD1 - Military Rank and Health Care Service Region; DOD2 - Paygrade

157. Deleted Code Sources: 43 - FIPS-55 (Named Populated Places); 77 - X12 Directories; 121 - Health Industry Number; 134 - National Drug Code; 411 - Centers for Medicare and Medicaid Services (CMS) Claim Payment Remark Codes; 507 - Health Care Claim Status Category Code; 508 - Health Care Claim Status Code; 530 - National Council for Prescription Drug Programs Reject/Payment Codes

E Data Element Glossary

E.1 Data Element Name Index

This section contains an alphabetic listing of data elements used in this implementation guide. Consult the X12N Data Element Dictionary for a complete list of all X12N Data Elements. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Amount Qualifier Code

Code to qualify amount.

270 - Eligibility Benefit Inquiry

D	2110C	AMT01		-	522	**136**
D	2110C	AMT01		-	522	**137**

Authorization or Certification Indicator

A yes/no indicator that identifies whether an authorization or certification is required per plan provisions.

271 - Eligibility Benefit Response

D	2110C	EB11		-	1073	**302**
D	2110D	EB11		-	1073	**406**

Benefit Amount

Benefit amount as qualifed by the eligibility or benefit information and service type code

271 - Eligibility Benefit Response

D	2110C	EB07		-	782	**300**
D	2110D	EB07		-	782	**404**

Benefit Coverage Level Code

Code indicating which family members are provided coverge for this insured.

271 - Eligibility Benefit Response

D	2110C	EB02		-	1207	**292**
D	2110D	EB02		-	1207	**396**

Benefit Percent

Benefit percentage as qualifed by the eligibility or benefit information and service type code

271 - Eligibility Benefit Response

D	2110C	EB08		-	954	**301**
D	2110D	EB08		-	954	**404**

Benefit Quantity

Benefit quantity as qualified by preceeding qualifier.

271 - Eligibility Benefit Response

D	2110C	EB10		-	380	**302**
D	2110C	HSD02		-	380	**310**
D	2110D	EB10		-	380	**405**
D	2110D	HSD02		-	380	**413**

Benefit Related Entity Address Line

Street Address of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D	2120C	N301		-	166	**335**
D	2120C	N302		-	166	**335**
D	2120D	N301		-	166	**438**
D	2120D	N302		-	166	**438**

Benefit Related Entity City Name

The city name of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D	2120C	N401		-	19	**336**

D | 2120D | N401 | - | 19 ..... **439**

Benefit Related Entity Communication Number

Communications number to contact the person, group or organization identified as the associated benefit related entity contact name.

271 - Eligibility Benefit Response

D | 2120C | PER04 | - | 364 ..... **341**
D | 2120C | PER06 | - | 364 ..... **342**
D | 2120C | PER08 | - | 364 ..... **343**
D | 2120D | PER04 | - | 364 ..... **444**
D | 2120D | PER06 | - | 364 ..... **445**
D | 2120D | PER08 | - | 364 ..... **446**

Benefit Related Entity Contact Name

The name at the benefit related entity to whom inquiries about the transaction may be directed.

271 - Eligibility Benefit Response

D | 2120C | PER02 | - | 93 ..... **340**
D | 2120D | PER02 | - | 93 ..... **443**

Benefit Related Entity Country Code

The country code of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D | 2120C | N404 | - | 26 ..... **337**
D | 2120D | N404 | - | 26 ..... **440**

Benefit Related Entity Country Subdivision Code

The country subdivision code of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D | 2120C | N407 | - | 1715 ..... **338**
D | 2120D | N407 | - | 1715 ..... **441**

Benefit Related Entity DOD Health Service Region

The Department of Defence (DOD) Health Service Region of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D | 2120C | N406 | - | 310 ..... **338**
D | 2120D | N406 | - | 310 ..... **441**

Benefit Related Entity First Name

The first name of the person identified as the benefit related entity, ofr an individual subscriber or dependent.

271 - Eligibility Benefit Response

D | 2120C | NM104 | - | 1036 ..... **331**
D | 2120D | NM104 | - | 1036 ..... **434**

Benefit Related Entity Identifier

Unique identifier for a benefit related entity or another information source associated with an individual subscriber or dependent.

271 - Eligibility Benefit Response

D | 2120C | NM109 | - | 67 ..... **333**
D | 2120D | NM109 | - | 67 ..... **436**

Benefit Related Entity Last or Organization Name

Lat name or organization name of the benefit related entity associated with an individual subscriber or dependent.

271 - Eligibility Benefit Response

D | 2120C | NM103 | - | 1035 ..... **331**
D | 2120D | NM103 | - | 1035 ..... **434**

Benefit Related Entity Location Qualifier

The code to qualify the location of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D | 2120C | N405 | - | 309 ..... **338**
D | 2120D | N405 | - | 309 ..... **441**

Benefit Related Entity Middle Name

Middle name of the benefit related entity associated with an individual subscriber or dependent.

271 - Eligibility Benefit Response

D | 2120C | NM105 | - | 1037 ..... **331**
D | 2120D | NM105 | - | 1037 ..... **434**

Benefit Related Entity Name Suffix

Suffix for the name of the benefit related entity associated with an individual subscriber or dependent.

271 - Eligibility Benefit Response

D | 2120C | NM107 | - | 1039 ..... **332**
D | 2120D | NM107 | - | 1039 ..... **435**

Benefit Related Entity Postal Zone or ZIP Code

The postal zone or ZIP Code of the entity associated with benefits described in the transaction.

271 - Eligibility Benefit Response

D | 2120C | N403 | - | 116..... **337**
D | 2120D | N403 | - | 116..... **440**

Benefit Related Entity Relationship Code

Code indicating Benefit Related Entity's relationship to the patient.

271 - Eligibility Benefit Response

D	2120C	NM110	-	706		**334**
D	2120D	NM110	-	706		**437**

Benefit Related Entity State Code

The state postal code of the entity related to benefits described in the transaction.

271 - Eligibility Benefit Response

D	2120C	N402	-	156		**337**
D	2120D	N402	-	156		**440**

Birth Sequence Number

A number indicating the order of birth for the identified person in relationship to family members with the same date of birth.

270 - Eligibility Benefit Inquiry

D	2100C	INS17	-	1470		**112**
D	2100D	INS17	-	1470		**169**

271 - Eligibility Benefit Response

D	2100C	INS17	-	1470		**273**
D	2100D	INS17	-	1470		**377**

Code Category

Specifies the situation or category to which the code applies.

271 - Eligibility Benefit Response

D	2115C	III03	-	1136		**327**
D	2115D	III03	-	1136		**430**

Code List Qualifier Code

Code identifying a specific industry code list.

270 - Eligibility Benefit Inquiry

D	2110C	III01	-	1270		**139**
D	2110D	III01	-	1270		**193**

271 - Eligibility Benefit Response

D	2115C	III01	-	1270		**325**
D	2115D	III01	-	1270		**428**

Communication Number Qualifier

Code identifying the type of communication number.

271 - Eligibility Benefit Response

D	2100A	PER03	-	365		**222**
D	2100A	PER05	-	365		**223**
D	2100A	PER07	-	365		**224**
D	2120C	PER03	-	365		**341**
D	2120C	PER05	-	365		**342**
D	2120C	PER07	-	365		**343**
D	2120D	PER03	-	365		**444**
D	2120D	PER05	-	365		**445**
D	2120D	PER07	-	365		**446**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

271 - Eligibility Benefit Response

D	2100A	PER01	-	366		**222**
D	2120C	PER01	-	366		**340**
D	2120D	PER01	-	366		**443**

Country Code

Code indicating the geographic location.

270 - Eligibility Benefit Inquiry

D	2100B	N404	-	26		**83**
D	2100C	N404	-	26		**102**
D	2100D	N404	-	26		**159**

Country Subdivision Code

Code identifying the country subdivision.

270 - Eligibility Benefit Inquiry

D	2100B	N407	-	1715		**83**
D	2100C	N407	-	1715		**102**
D	2100D	N407	-	1715		**159**

Coverage Level Code

Code indicating the level of coverage being provided for this insured

270 - Eligibility Benefit Inquiry

D	2110C	EQ03	-	1207		**134**

Date Time Period

Expression of a date, a time, or a range of dates, times, or dates and times.

270 - Eligibility Benefit Inquiry

D	2100C	DTP03	-	1251		**123**
D	2110C	DTP03	-	1251		**145**
D	2100D	DTP03	-	1251		**180**
D	2110D	DTP03	-	1251		**199**

271 - Eligibility Benefit Response

D	2100C	DTP03	-	1251		**284**
D	2100C	MPI07	-	1251		**288**
D	2100D	DTP03	-	1251		**388**
D	2100D	MPI07	-	1251		**392**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format.

270 - Eligibility Benefit Inquiry

D	2100C	DMG01	-	1250		**108**
D	2100C	DTP02	-	1250		**123**
D	2110C	DTP02	-	1250		**145**
D	2100D	DMG01	-	1250		**165**
D	2100D	DTP02	-	1250		**180**
D	2110D	DTP02	-	1250		**199**

271 - Eligibility Benefit Response

D	2100C	DMG01	-	1250		**269**
D	2100C	DTP02	-	1250		**284**
D	2100C	MPI06	-	1250		**288**
D	2110C	DTP02	-	1250		**318**
D	2100D	DMG01	-	1250		**373**
D	2100D	DTP02	-	1250		**388**
D	2100D	MPI06	-	1250		**392**

D | 2110D | DTP02 | - | 1250 ..... **421**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

270 - Eligibility Benefit Inquiry

D | 2100C | DTP01 | - | 374 ..... **123**
D | 2110C | DTP01 | - | 374 ..... **144**
D | 2100D | DTP01 | - | 374 ..... **180**
D | 2110D | DTP01 | - | 374 ..... **198**

271 - Eligibility Benefit Response

D | 2100C | DTP01 | - | 374 ..... **283**
D | 2110C | DTP01 | - | 374 ..... **317**
D | 2100D | DTP01 | - | 374 ..... **387**
D | 2110D | DTP01 | - | 374 ..... **420**

Delivery Frequency Code

Codw which specifies frequency by which services can be performed.

271 - Eligibility Benefit Response

D | 2110C | HSD07 | - | 678 ..... **312**
D | 2110D | HSD07 | - | 678 ..... **415**

Delivery Pattern Time Code

Code which specifies the time delivery pattern of the services.

271 - Eligibility Benefit Response

D | 2110C | HSD08 | - | 679 ..... **313**
D | 2110D | HSD08 | - | 679 ..... **416**

Dependent Address Line

The street address of the patient.

270 - Eligibility Benefit Inquiry

D | 2100D | N301 | - | 166 ..... **157**
D | 2100D | N302 | - | 166 ..... **157**

271 - Eligibility Benefit Response

D | 2100D | N301 | - | 166 ..... **361**
D | 2100D | N302 | - | 166 ..... **362**

Dependent Birth Date

The date of birth of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | DMG02 | - | 1251 ..... **165**

271 - Eligibility Benefit Response

D | 2100D | DMG02 | - | 1251 ..... **373**

Dependent City Name

The city name of the patient.

270 - Eligibility Benefit Inquiry

D | 2100D | N401 | - | 19 ..... **158**

271 - Eligibility Benefit Response

D | 2100D | N401 | - | 19 ..... **364**

Dependent Country Code

Country code of the dependent.

271 - Eligibility Benefit Response

D | 2100D | N404 | - | 26 ..... **364**

Dependent Country Subdivision Code

The country subdivision code of the dependent.

271 - Eligibility Benefit Response

D | 2100D | N407 | - | 1715 ..... **365**

Dependent Eligibility or Benefit Identifier

Number associated with the dependent for the eligibility or benefit being described.

271 - Eligibility Benefit Response

D | 2110D | REF02 | - | 127 ..... **419**

Dependent First Name

The first name of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | NM104 | - | 1036 ..... **152**

271 - Eligibility Benefit Response

D | 2100D | NM104 | - | 1036 ..... **355**

Dependent Gender Code

A code indicating the gender of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | DMG03 | - | 1068 ..... **166**

271 - Eligibility Benefit Response

D | 2100D | DMG03 | - | 1068 ..... **373**

Dependent Last Name

The last name of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | NM103 | - | 1035 ..... **152**

271 - Eligibility Benefit Response

D | 2100D | NM103 | - | 1035 ..... **355**

Dependent Middle Name

The middle name of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | NM105 | - | 1037 ..... **153**

271 - Eligibility Benefit Response

D | 2100D | NM105 | - | 1037 ..... **355**

Dependent Name Suffix

A suffix following the name, including the generation of the patient, such as I, II, III, Jr, Sr.

270 - Eligibility Benefit Inquiry

D | 2100D | NM107 | - | 1039 ..... **153**

271 - Eligibility Benefit Response

D | 2100D | NM107 | - | 1039 ..... **356**

Dependent Postal Zone or ZIP Code

The zip code of the dependent.

270 - Eligibility Benefit Inquiry

D | 2100D | N403 | - | 116..... **159**

271 - Eligibility Benefit Response

D	2100D	N403	-	116		**364**

Dependent State Code

The state postal code of the dependent.

270 - Eligibility Benefit Inquiry

D	2100D	N402	-	156		**159**

271 - Eligibility Benefit Response

D	2100D	N402	-	156		**364**

Dependent Supplemental Identifier

Identifies another or additional distinguishing code number associated with the dependent.

270 - Eligibility Benefit Inquiry

D	2100D	REF02	-	127		**156**

271 - Eligibility Benefit Response

D	2100D	REF02	-	127		**360**

Description

A free-form description to clarify the related data elements and their content.

271 - Eligibility Benefit Response

D	2100C	MPI04	-	352		**287**
D	2100D	MPI04	-	352		**391**

Diagnosis Code

An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition.

270 - Eligibility Benefit Inquiry

D	2100C	HI01	C022-2	1271		**114**
D	2100C	HI02	C022-2	1271		**115**
D	2100C	HI03	C022-2	1271		**116**
D	2100C	HI04	C022-2	1271		**117**
D	2100C	HI05	C022-2	1271		**118**
D	2100C	HI06	C022-2	1271		**119**
D	2100C	HI07	C022-2	1271		**120**
D	2100C	HI08	C022-2	1271		**121**
D	2100D	HI01	C022-2	1271		**171**
D	2100D	HI02	C022-2	1271		**172**
D	2100D	HI03	C022-2	1271		**173**
D	2100D	HI04	C022-2	1271		**174**
D	2100D	HI05	C022-2	1271		**175**
D	2100D	HI06	C022-2	1271		**176**
D	2100D	HI07	C022-2	1271		**177**
D	2100D	HI08	C022-2	1271		**178**

271 - Eligibility Benefit Response

D	2100C	HI01	C022-2	1271		**275**
D	2100C	HI02	C022-2	1271		**276**
D	2100C	HI03	C022-2	1271		**277**
D	2100C	HI04	C022-2	1271		**278**
D	2100C	HI05	C022-2	1271		**279**
D	2100C	HI06	C022-2	1271		**280**
D	2100C	HI07	C022-2	1271		**281**
D	2100C	HI08	C022-2	1271		**282**
D	2100D	HI01	C022-2	1271		**379**
D	2100D	HI02	C022-2	1271		**380**
D	2100D	HI03	C022-2	1271		**381**
D	2100D	HI04	C022-2	1271		**382**
D	2100D	HI05	C022-2	1271		**383**
D	2100D	HI06	C022-2	1271		**384**
D	2100D	HI07	C022-2	1271		**385**
D	2100D	HI08	C022-2	1271		**386**

Diagnosis Code Pointer

A pointer to the claim diagnosis code in the order of importance to this service.

270 - Eligibility Benefit Inquiry

D	2110C	EQ05	C004-1	1328		**134**
D	2110C	EQ05	C004-2	1328		**134**
D	2110C	EQ05	C004-3	1328		**135**
D	2110C	EQ05	C004-4	1328		**135**
D	2110D	EQ05	C004-1	1328		**191**
D	2110D	EQ05	C004-2	1328		**191**
D	2110D	EQ05	C004-3	1328		**191**
D	2110D	EQ05	C004-4	1328		**191**

271 - Eligibility Benefit Response

D	2110C	EB14	C004-1	1328		**307**
D	2110C	EB14	C004-2	1328		**307**
D	2110C	EB14	C004-3	1328		**307**
D	2110C	EB14	C004-4	1328		**308**
D	2110D	EB14	C004-1	1328		**410**
D	2110D	EB14	C004-2	1328		**410**
D	2110D	EB14	C004-3	1328		**411**
D	2110D	EB14	C004-4	1328		**411**

Diagnosis Type Code

Code identifying the type of diagnosis.

270 - Eligibility Benefit Inquiry

D	2100C	HI01	C022-1	1270		**114**
D	2100C	HI02	C022-1	1270		**115**
D	2100C	HI03	C022-1	1270		**116**
D	2100C	HI04	C022-1	1270		**117**
D	2100C	HI05	C022-1	1270		**118**
D	2100C	HI06	C022-1	1270		**119**
D	2100C	HI07	C022-1	1270		**120**
D	2100C	HI08	C022-1	1270		**121**
D	2100D	HI01	C022-1	1270		**171**
D	2100D	HI02	C022-1	1270		**172**
D	2100D	HI03	C022-1	1270		**173**
D	2100D	HI04	C022-1	1270		**174**
D	2100D	HI05	C022-1	1270		**175**
D	2100D	HI06	C022-1	1270		**176**
D	2100D	HI07	C022-1	1270		**177**
D	2100D	HI08	C022-1	1270		**178**

271 - Eligibility Benefit Response

D	2100C	HI01	C022-1	1270		**275**
D	2100C	HI02	C022-1	1270		**276**
D	2100C	HI03	C022-1	1270		**277**
D	2100C	HI04	C022-1	1270		**278**
D	2100C	HI05	C022-1	1270		**279**
D	2100C	HI06	C022-1	1270		**280**
D	2100C	HI07	C022-1	1270		**281**
D	2100C	HI08	C022-1	1270		**282**
D	2100D	HI01	C022-1	1270		**379**
D	2100D	HI02	C022-1	1270		**380**
D	2100D	HI03	C022-1	1270		**381**
D	2100D	HI04	C022-1	1270		**382**
D	2100D	HI05	C022-1	1270		**383**
D	2100D	HI06	C022-1	1270		**384**
D	2100D	HI07	C022-1	1270		**385**
D	2100D	HI08	C022-1	1270		**386**

Eligibility or Benefit Date Time Period

Date or period associated with the eligibility or benefit being described.

271 - Eligibility Benefit Response

D	2110C	DTP03	-	1251		**318**
D	2110D	DTP03	-	1251		**421**

Eligibility or Benefit Information

Benefit status of the individual or benefit related category to be further described in the transaction.

271 - Eligibility Benefit Response

D	2110C	EB01	-	1390	.....	**291**
D	2110D	EB01	-	1390	.....	**395**

Employment Status Code

A code used to define the employment status of the individual covered by this insurance payer.

271 - Eligibility Benefit Response

D	2100C	MPI02	-	584	.....	**286**
D	2100D	MPI02	-	584	.....	**390**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual.

270 - Eligibility Benefit Inquiry

D	2100A	NM101	-	98	.....	**69**
D	2100B	NM101	-	98	.....	**75**
D	2100C	NM101	-	98	.....	**92**
D	2100D	NM101	-	98	.....	**151**

271 - Eligibility Benefit Response

D	2100A	NM101	-	98	.....	**218**
D	2100B	NM101	-	98	.....	**232**
D	2100C	NM101	-	98	.....	**249**
D	2120C	NM101	-	98	.....	**330**
D	2100D	NM101	-	98	.....	**354**
D	2120D	NM101	-	98	.....	**433**

Entity Type Qualifier

Code qualifying the type of entity.

270 - Eligibility Benefit Inquiry

D	2100A	NM102	-	1065	.....	**70**
D	2100B	NM102	-	1065	.....	**76**
D	2100C	NM102	-	1065	.....	**93**
D	2100D	NM102	-	1065	.....	**152**

271 - Eligibility Benefit Response

D	2100A	NM102	-	1065	.....	**219**
D	2100B	NM102	-	1065	.....	**233**
D	2100C	NM102	-	1065	.....	**250**
D	2120C	NM102	-	1065	.....	**331**
D	2100D	NM102	-	1065	.....	**355**
D	2120D	NM102	-	1065	.....	**434**

Follow-up Action Code

Code identifying follow-up actions allowed.

271 - Eligibility Benefit Response

D	2000A	AAA04	-	889	.....	**216**
D	2100A	AAA04	-	889	.....	**228**
D	2100B	AAA04	-	889	.....	**239**
D	2100C	AAA04	-	889	.....	**264**
D	2110C	AAA04	-	889	.....	**321**
D	2100D	AAA04	-	889	.....	**368**
D	2110D	AAA04	-	889	.....	**424**

Free Form Message Text

Text used to convey information related to the transaction.

271 - Eligibility Benefit Response

D	2110C	MSG01	-	933	.....	**323**
D	2110D	MSG01	-	933	.....	**426**

Government Service Affiliation Code

Code specifying the government service affiliation.

271 - Eligibility Benefit Response

D	2100C	MPI03	-	1595	.....	**286**
D	2100D	MPI03	-	1595	.....	**390**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

270 - Eligibility Benefit Inquiry

D	2000A	HL04	-	736	.....	**68**
D	2000B	HL04	-	736	.....	**74**
D	2000C	HL04	-	736	.....	**89**
D	2000D	HL04	-	736	.....	**148**

271 - Eligibility Benefit Response

D	2000A	HL04	-	736	.....	**214**
D	2000B	HL04	-	736	.....	**231**
D	2000C	HL04	-	736	.....	**245**
D	2000D	HL04	-	736	.....	**350**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

270 - Eligibility Benefit Inquiry

D	2000A	HL01	-	628	.....	**67**
D	2000B	HL01	-	628	.....	**73**
D	2000C	HL01	-	628	.....	**88**
D	2000D	HL01	-	628	.....	**147**

271 - Eligibility Benefit Response

D	2000A	HL01	-	628	.....	**214**
D	2000B	HL01	-	628	.....	**230**
D	2000C	HL01	-	628	.....	**244**
D	2000D	HL01	-	628	.....	**348**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

270 - Eligibility Benefit Inquiry

D	2000A	HL03	-	735	.....	**67**
D	2000B	HL03	-	735	.....	**74**
D	2000C	HL03	-	735	.....	**89**
D	2000D	HL03	-	735	.....	**148**

271 - Eligibility Benefit Response

D	2000A	HL03	-	735	.....	**214**
D	2000B	HL03	-	735	.....	**231**
D	2000C	HL03	-	735	.....	**245**
D	2000D	HL03	-	735	.....	**349**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

270 - Eligibility Benefit Inquiry

D	2000B	HL02	-	734	.....	**73**
D	2000C	HL02	-	734	.....	**88**
D	2000D	HL02	-	734	.....	**148**

271 - Eligibility Benefit Response

D	2000B	HL02	-	734	.....	**230**
D	2000C	HL02	-	734	.....	**244**
D	2000D	HL02	-	734	.....	**349**

Hierarchical Structure Code

Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

270 - Eligibility Benefit Inquiry

H		BHT01	-	1005	.....	**63**

271 - Eligibility Benefit Response

H		BHT01	-	1005	.....	**211**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67).

270 - Eligibility Benefit Inquiry

D	2100A	NM108	-	66	.....	**71**
D	2100B	NM108	-	66	.....	**77**
D	2100C	NM108	-	66	.....	**95**

271 - Eligibility Benefit Response

D	2100A	NM108	-	66	.....	**220**
D	2100B	NM108	-	66	.....	**234**
D	2100C	NM108	-	66	.....	**251**
D	2120C	NM108	-	66	.....	**332**
D	2120D	NM108	-	66	.....	**435**

Implementation Convention Reference

Reference assigned to identify Implementation Convention.

270 - Eligibility Benefit Inquiry

H		ST03	-	1705	.....	**62**

271 - Eligibility Benefit Response

H		ST03	-	1705	.....	**210**

In Plan Network Indicator

A yes/no indicator that specifies whether or not services from the requested provider were provided within the health plan network or not.

271 - Eligibility Benefit Response

D	2110C	EB12	-	1073	.....	**303**
D	2110D	EB12	-	1073	.....	**406**

Individual Relationship Code

Code indicating the relationship between two individuals or entities.

270 - Eligibility Benefit Inquiry

D	2100C	INS02	-	1069	.....	**111**
D	2100D	INS02	-	1069	.....	**168**

271 - Eligibility Benefit Response

D	2100C	INS02	-	1069	.....	**272**
D	2100D	INS02	-	1069	.....	**376**

Industry Code

Code indicating a code from a specific industry code list.

270 - Eligibility Benefit Inquiry

D	2110C	III02	-	1271	.....	**140**
D	2110D	III02	-	1271	.....	**194**

271 - Eligibility Benefit Response

D	2115C	III02	-	1271	.....	**325**
D	2115D	III02	-	1271	.....	**428**

Information Receiver Additional Address Line

The Information Receiver's additional address information.

270 - Eligibility Benefit Inquiry

D	2100B	N302	-	166	.....	**81**

Information Receiver Additional Identifier

Identifies another or additional distinguishing code number associated with the receiver of information.

270 - Eligibility Benefit Inquiry

D	2100B	REF02	-	127	.....	**80**

271 - Eligibility Benefit Response

D	2100B	REF02	-	127	.....	**237**

Information Receiver Additional Identifier State

Code indicating which state issued the identifier.

270 - Eligibility Benefit Inquiry

D	2100B	REF03	-	352	.....	**80**

271 - Eligibility Benefit Response

D	2100B	REF03	-	352	.....	**237**

Information Receiver Address Line

The Information Receiver's address.

270 - Eligibility Benefit Inquiry

D	2100B	N301	-	166	.....	**81**

Information Receiver City Name

The City Name of the Information Receiver's address.

270 - Eligibility Benefit Inquiry

D	2100B	N401	-	19	.....	**82**

Information Receiver First Name

The first name of the individual or organization who expects to receive information in response to a query.

270 - Eligibility Benefit Inquiry
D | 2100B | NM104 | - | 1036 ..... **76**

271 - Eligibility Benefit Response
D | 2100B | NM104 | - | 1036 ..... **233**

Information Receiver Identification Number

The identification number of the individual or organization who expects to receive information in response to a query.

270 - Eligibility Benefit Inquiry
D | 2100B | NM109 | - | 67 ..... **78**

271 - Eligibility Benefit Response
D | 2100B | NM109 | - | 67 ..... **235**

Information Receiver Last or Organization Name

The name of the organization or last name of the individual that expects to receive information or is receiving information.

270 - Eligibility Benefit Inquiry
D | 2100B | NM103 | - | 1035 ..... **76**

271 - Eligibility Benefit Response
D | 2100B | NM103 | - | 1035 ..... **233**

Information Receiver Middle Name

The middle name of the individual or organization who expects to receive information in response to a query.

270 - Eligibility Benefit Inquiry
D | 2100B | NM105 | - | 1037 ..... **76**

271 - Eligibility Benefit Response
D | 2100B | NM105 | - | 1037 ..... **234**

Information Receiver Name Suffix

The suffix to the name of the individual or organization who expects to receive information in response to a query.

270 - Eligibility Benefit Inquiry
D | 2100B | NM107 | - | 1039 ..... **77**

271 - Eligibility Benefit Response
D | 2100B | NM107 | - | 1039 ..... **234**

Information Receiver Postal Zone or ZIP Code

The Zip Code of the Information Receiver's address.

270 - Eligibility Benefit Inquiry
D | 2100B | N403 | - | 116..... **83**

Information Receiver State Code

The State Postal Code of the Information Receiver's address.

270 - Eligibility Benefit Inquiry
D | 2100B | N402 | - | 156 ..... **83**

Information Source Communication Number

Contact number for the designated person or entity for the information source.

271 - Eligibility Benefit Response
D | 2100A | PER04 | - | 364 ..... **223**
D | 2100A | PER06 | - | 364 ..... **224**
D | 2100A | PER08 | - | 364 ..... **225**

Information Source Contact Name

Information source contact name to whom inquiries about this transaction should be directed.

271 - Eligibility Benefit Response
D | 2100A | PER02 | - | 93 ..... **222**

Information Source First Name

First name of an individual who is the source of the information.

270 - Eligibility Benefit Inquiry
D | 2100A | NM104 | - | 1036 ..... **70**

271 - Eligibility Benefit Response
D | 2100A | NM104 | - | 1036 ..... **219**

Information Source Last or Organization Name

The organization name or the last name of an individual who is the source of the information.

270 - Eligibility Benefit Inquiry
D | 2100A | NM103 | - | 1035 ..... **70**

271 - Eligibility Benefit Response
D | 2100A | NM103 | - | 1035 ..... **219**

Information Source Middle Name

Middle name of an individual who is the source of the information.

270 - Eligibility Benefit Inquiry
D | 2100A | NM105 | - | 1037 ..... **70**

271 - Eligibility Benefit Response
D | 2100A | NM105 | - | 1037 ..... **219**

Information Source Name Suffix

Suffix to the name of the individual who is the source of the information.

270 - Eligibility Benefit Inquiry
D | 2100A | NM107 | - | 1039 ..... **71**

271 - Eligibility Benefit Response

D	2100A	NM107		-	1039	**220**

Information Source Primary Identifier

Identifies the number by which the information source is known to the information receiver.

270 - Eligibility Benefit Inquiry

D	2100A	NM109		-	67	**71**

271 - Eligibility Benefit Response

D	2100A	NM109		-	67	**220**

Information Status Code

A code to indicate the status of information.

271 - Eligibility Benefit Response

D	2100C	MPI01		-	1201	**285**
D	2100D	MPI01		-	1201	**389**

Injured Body Part Name

Part of body affected by injury or illness

271 - Eligibility Benefit Response

D	2115C	III04		-	933	**327**
D	2115D	III04		-	933	**430**

Insurance Type Code

Code identifying the type of insurance.

271 - Eligibility Benefit Response

D	2110C	EB04		-	1336	**298**
D	2110D	EB04		-	1336	**402**

Insured Indicator

Indicates whether the insured is the subscriber or a dependent.

270 - Eligibility Benefit Inquiry

D	2100C	INS01		-	1073	**111**
D	2100D	INS01		-	1073	**168**

271 - Eligibility Benefit Response

D	2100C	INS01		-	1073	**271**
D	2100D	INS01		-	1073	**376**

Loop Identifier Code

The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE.

271 - Eligibility Benefit Response

D	2110C	LS01		-	447	**328**
D	2110C	LE01		-	447	**346**
D	2110D	LS01		-	447	**431**
D	2110D	LE01		-	447	**449**

Maintenance Reason Code

Code identifying reason for the maintenance change

271 - Eligibility Benefit Response

D	2100C	INS04		-	1203	**272**
D	2100D	INS04		-	1203	**377**

Maintenance Type Code

Code identifying a specific type of item maintenance

271 - Eligibility Benefit Response

D	2100C	INS03		-	875	**272**
D	2100D	INS03		-	875	**376**

Military Service Rank Code

Code specifying the military service rank.

271 - Eligibility Benefit Response

D	2100C	MPI05		-	1596	**287**
D	2100D	MPI05		-	1596	**391**

Period Count

Total number of periods.

271 - Eligibility Benefit Response

D	2110C	HSD06		-	616	**311**
D	2110D	HSD06		-	616	**414**

Plan Coverage Description

A description or number that identifies the plan or coverage

271 - Eligibility Benefit Response

D	2110C	EB05		-	1204	**299**
D	2110D	EB05		-	1204	**403**

Plan, Group or Plan Network Name

Identifies the Plan, Group or Plan Network Name in association with the Subscriber/Dependent Supplemental Identifier.

271 - Eligibility Benefit Response

D	2100C	REF03		-	352	**256**
D	2110C	REF03		-	352	**316**
D	2100D	REF03		-	352	**360**
D	2110D	REF03		-	352	**419**

Prior Authorization or Referral Number

A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved.

270 - Eligibility Benefit Inquiry

D	2110C	REF02		-	127	**143**
D	2110D	REF02		-	127	**197**

Procedure Code

Code identifying the procedure, product or service.

270 - Eligibility Benefit Inquiry

D	2110C	EQ02		C003-2	234	**131**
D	2110D	EQ02		C003-2	234	**188**

271 - Eligibility Benefit Response

D	2110C	EB13		C003-2	234	**305**
D	2110D	EB13		C003-2	234	**408**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

270 - Eligibility Benefit Inquiry

D	2110C	EQ02	C003-3	1339	.....	**132**
D	2110C	EQ02	C003-4	1339	.....	**132**
D	2110C	EQ02	C003-5	1339	.....	**133**
D	2110C	EQ02	C003-6	1339	.....	**133**
D	2110D	EQ02	C003-3	1339	.....	**189**
D	2110D	EQ02	C003-4	1339	.....	**189**
D	2110D	EQ02	C003-5	1339	.....	**190**
D	2110D	EQ02	C003-6	1339	.....	**190**

271 - Eligibility Benefit Response

D	2110C	EB13	C003-3	1339	.....	**305**
D	2110C	EB13	C003-4	1339	.....	**305**
D	2110C	EB13	C003-5	1339	.....	**306**
D	2110C	EB13	C003-6	1339	.....	**306**
D	2110D	EB13	C003-3	1339	.....	**408**
D	2110D	EB13	C003-4	1339	.....	**409**
D	2110D	EB13	C003-5	1339	.....	**409**
D	2110D	EB13	C003-6	1339	.....	**409**

Product or Service ID

Identifying number for a product or service.

271 - Eligibility Benefit Response

D	2110C	EB13	C003-8	234	.....	**306**
D	2110D	EB13	C003-8	234	.....	**410**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

270 - Eligibility Benefit Inquiry

D	2110C	EQ02	C003-1	235	.....	**131**
D	2110D	EQ02	C003-1	235	.....	**188**

271 - Eligibility Benefit Response

D	2110C	EB13	C003-1	235	.....	**304**
D	2110D	EB13	C003-1	235	.....	**407**

Provider Code

Code identifying the type of provider.

270 - Eligibility Benefit Inquiry

D	2100B	PRV01	-	1221	.....	**84**
D	2100C	PRV01	-	1221	.....	**104**
D	2100D	PRV01	-	1221	.....	**161**

271 - Eligibility Benefit Response

D	2100B	PRV01	-	1221	.....	**241**
D	2100C	PRV01	-	1221	.....	**266**
D	2120C	PRV01	-	1221	.....	**344**
D	2100D	PRV01	-	1221	.....	**370**
D	2120D	PRV01	-	1221	.....	**447**

Provider Identifier

Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider.

270 - Eligibility Benefit Inquiry

D	2100C	PRV03	-	127	.....	**106**
D	2100D	PRV03	-	127	.....	**163**

271 - Eligibility Benefit Response

D	2100C	PRV03	-	127	.....	**267**
D	2120C	PRV03	-	127	.....	**345**
D	2100D	PRV03	-	127	.....	**371**
D	2120D	PRV03	-	127	.....	**448**

Quantity Qualifier

Code specifying the type of quantity.

271 - Eligibility Benefit Response

D	2110C	EB09	-	673	.....	**301**
D	2110C	HSD01	-	673	.....	**310**
D	2110D	EB09	-	673	.....	**405**
D	2110D	HSD01	-	673	.....	**413**

Receiver Provider Specialty Code

Identifies another or distinguishing number for a provider.

271 - Eligibility Benefit Response

D	2100B	PRV03	-	127	.....	**242**

Receiver Provider Taxonomy Code

Code designating the provider type, classification, and specialization.

270 - Eligibility Benefit Inquiry

D	2100B	PRV03	-	127	.....	**85**

Reference Identification Qualifier

Code qualifying the reference identification.

270 - Eligibility Benefit Inquiry

D	2100B	REF01	-	128	.....	**79**
D	2100B	PRV02	-	128	.....	**85**
D	2100C	REF01	-	128	.....	**98**
D	2100C	PRV02	-	128	.....	**105**
D	2110C	REF01	-	128	.....	**142**
D	2100D	REF01	-	128	.....	**154**
D	2100D	PRV02	-	128	.....	**162**
D	2110D	REF01	-	128	.....	**196**

271 - Eligibility Benefit Response

D	2100B	REF01	-	128	.....	**236**
D	2100B	PRV02	-	128	.....	**242**
D	2100C	REF01	-	128	.....	**254**
D	2100C	PRV02	-	128	.....	**266**
D	2110C	REF01	-	128	.....	**315**
D	2120C	PRV02	-	128	.....	**345**
D	2100D	REF01	-	128	.....	**358**
D	2100D	PRV02	-	128	.....	**370**
D	2110D	REF01	-	128	.....	**418**
D	2120D	PRV02	-	128	.....	**448**

Reject Reason Code

Code assigned by issuer to identify reason for rejection.

271 - Eligibility Benefit Response

D	2000A	AAA03	-	901	.....	**216**
D	2100A	AAA03	-	901	.....	**227**
D	2100B	AAA03	-	901	.....	**239**
D	2100C	AAA03	-	901	.....	**263**
D	2110C	AAA03	-	901	.....	**320**
D	2100D	AAA03	-	901	.....	**367**
D	2110D	AAA03	-	901	.....	**423**

Sample Selection Modulus

To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes.

271 - Eligibility Benefit Response

D	2110C	HSD04	-	1167	.....	**311**
D	2110D	HSD04	-	1167	.....	**414**

Service Type Code

Code identifying the classification of service.

270 - Eligibility Benefit Inquiry

D	2110C	EQ01	-	1365	.....	**125**
D	2110D	EQ01	-	1365	.....	**182**

271 - Eligibility Benefit Response

D	2110C	EB03	-	1365	.....	**293**
D	2110D	EB03	-	1365	.....	**397**

Spend Down Amount

Dollar amount subscriber must pay or has paid toward cost of health care before benefits are effective.

270 - Eligibility Benefit Inquiry

D	2110C	AMT02	-	782	.....	**136**

Spend Down Total Billed Amount

The sum of all original charges that will be billed, or have been billed, for services related to the Spend Down Amount.

270 - Eligibility Benefit Inquiry

D	2110C	AMT02	-	782	.....	**137**

Submitter Transaction Identifier

Trace or control number assigned by the originator of the transaction.

270 - Eligibility Benefit Inquiry

H		BHT03	-	127	.....	**64**

271 - Eligibility Benefit Response

H		BHT03	-	127	.....	**212**

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	N301	-	166	.....	**100**
D	2100C	N302	-	166	.....	**100**

271 - Eligibility Benefit Response

D	2100C	N301	-	166	.....	**257**
D	2100C	N302	-	166	.....	**258**

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

270 - Eligibility Benefit Inquiry

D	2100C	DMG02	-	1251	.....	**108**

271 - Eligibility Benefit Response

D	2100C	DMG02	-	1251	.....	**269**

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	N401	-	19	.....	**101**

271 - Eligibility Benefit Response

D	2100C	N401	-	19	.....	**260**

Subscriber Country Code

The code identifying the country of the insured or subscriber address.

271 - Eligibility Benefit Response

D	2100C	N404	-	26	.....	**260**

Subscriber Country Subdivision Code

The country subdivision code of the insured or subscriber address.

271 - Eligibility Benefit Response

D	2100C	N407	-	1715	.....	**261**

Subscriber Eligibility or Benefit Identifier

Number associated with the subscriber for the eligibility or benefit being described.

271 - Eligibility Benefit Response

D	2110C	REF02	-	127	.....	**316**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	NM104	-	1036	.....	**93**

271 - Eligibility Benefit Response

D	2100C	NM104	-	1036	.....	**250**

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

270 - Eligibility Benefit Inquiry

D	2100C	DMG03	-	1068	.....	**109**

271 - Eligibility Benefit Response

D	2100C	DMG03	-	1068	.....	**269**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	NM103	-	1035	.....	**93**

271 - Eligibility Benefit Response

D	2100C	NM103	-	1035	.....	**250**

Subscriber Middle Name or Initial

The middle name or initial of the subscriber to the indicated coverage or policy.

270 - Eligibility Benefit Inquiry

D	2100C	NM105	-	1037	.....	**94**

271 - Eligibility Benefit Response

D	2100C	NM105	-	1037	.....	**250**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	NM107	-	1039	.....	**94**

271 - Eligibility Benefit Response

D	2100C	NM107	-	1039	.....	**251**

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	N403	-	116	.....	**102**

271 - Eligibility Benefit Response

D	2100C	N403	-	116	.....	**260**

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	NM109	-	67	.....	**96**

271 - Eligibility Benefit Response

D	2100C	NM109	-	67	.....	**252**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage.

270 - Eligibility Benefit Inquiry

D	2100C	N402	-	156	.....	**102**

271 - Eligibility Benefit Response

D	2100C	N402	-	156	.....	**260**

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

270 - Eligibility Benefit Inquiry

D	2100C	REF02	-	127	.....	**99**

271 - Eligibility Benefit Response

D	2100C	REF02	-	127	.....	**256**

Time Period Qualifier

Code defining the type of time period.

271 - Eligibility Benefit Response

D	2110C	EB06	-	615	.....	**299**
D	2110C	HSD05	-	615	.....	**311**
D	2110D	EB06	-	615	.....	**403**
D	2110D	HSD05	-	615	.....	**414**

Trace Assigning Entity Additional Identifier

Additional identifier for the entity assigning the trace number.

270 - Eligibility Benefit Inquiry

D	2000C	TRN04	-	127	.....	**91**
D	2000D	TRN04	-	127	.....	**150**

271 - Eligibility Benefit Response

D	2000C	TRN04	-	127	.....	**248**
D	2000D	TRN04	-	127	.....	**353**

Trace Assigning Entity Identifier

Identifies the organization assigning the trace number.

270 - Eligibility Benefit Inquiry

D	2000C	TRN03	-	509	.....	**91**
D	2000D	TRN03	-	509	.....	**150**

271 - Eligibility Benefit Response

D	2000C	TRN03	-	509	.....	**248**
D	2000D	TRN03	-	509	.....	**353**

Trace Number

Identification number used by originator of the transaction.

270 - Eligibility Benefit Inquiry

D	2000C	TRN02	-	127	.....	**91**
D	2000D	TRN02	-	127	.....	**150**

271 - Eligibility Benefit Response

D	2000C	TRN02	-	127	.....	**248**
D	2000D	TRN02	-	127	.....	**353**

Trace Type Code

Code identifying the type of re-association which needs to be performed.

270 - Eligibility Benefit Inquiry

D	2000C	TRN01	-	481	.....	**90**
D	2000D	TRN01	-	481	.....	**149**

271 - Eligibility Benefit Response

D	2000C	TRN01	-	481	.....	**247**
D	2000D	TRN01	-	481	.....	**352**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

270 - Eligibility Benefit Inquiry

D		SE01	-	96	.....	**200**

271 - Eligibility Benefit Response

D		SE01	-	96	.....	**450**

Transaction Set Control Number

The unique identification number within a transaction set.

270 - Eligibility Benefit Inquiry

H		ST02	-	329	**61**
D		SE02	-	329	**200**

271 - Eligibility Benefit Response

H		ST02	-	329	**209**
D		SE02	-	329	**450**

Transaction Set Creation Date

Identifies the date the submitter created the transaction.

270 - Eligibility Benefit Inquiry

H		BHT04	-	373	**64**

271 - Eligibility Benefit Response

H		BHT04	-	373	**212**

Transaction Set Creation Time

Time file is created for transmission.

270 - Eligibility Benefit Inquiry

H		BHT05	-	337	**65**

271 - Eligibility Benefit Response

H		BHT05	-	337	**212**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

270 - Eligibility Benefit Inquiry

H		ST01	-	143	**61**

271 - Eligibility Benefit Response

H		ST01	-	143	**209**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

270 - Eligibility Benefit Inquiry

H		BHT02	-	353	**64**

271 - Eligibility Benefit Response

H		BHT02	-	353	**211**

Transaction Type Code

Code specifying the type of transaction.

270 - Eligibility Benefit Inquiry

H		BHT06	-	640	**65**

Unit or Basis for Measurement Code

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.

271 - Eligibility Benefit Response

D	2110C	HSD03	-	355	**310**
D	2110D	HSD03	-	355	**413**

Valid Request Indicator

Code indicating if the information request or portion of the request is valid or invalid.

271 - Eligibility Benefit Response

D	2000A	AAA01	-	1073	**215**
D	2100A	AAA01	-	1073	**226**
D	2100B	AAA01	-	1073	**238**
D	2100C	AAA01	-	1073	**262**
D	2110C	AAA01	-	1073	**319**
D	2100D	AAA01	-	1073	**366**
D	2110D	AAA01	-	1073	**422**