

270/271 Health Care Eligibility Benefit Inquiry and Response

For Independence Administrators

Version 4010A1

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270 Health Care Eligibility Benefit Inquiry

1.0 Overview of Document

This guide is to be used as a supplement to the 270/271 Health Care Eligibility Benefit Inquiry Implementation Guide, version 4010A1. It should be used to process eligibility requests for Independence Administrators (hereinafter referred to as IA).

The purpose of this document is to outline IA processes for handling the 270/271 Health Care Eligibility Benefit Implementation Guide (hereinafter referred to as the 270 or 271), and to delineate specific data requirements where that option is available within the 4010A1 Implementation Guide.

This Companion Document does not add, delete or change the name of any data element that is specified in the Implementation Guide. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements.

2.0 General Information

This transaction set is used to inquire about the eligibility/benefits associated with a Subscriber's (or Dependent's) health plan coverage.

The Information Source is a Health Plan (IA) and the Information Receiver is a Provider organization.

The 270 transaction will be used to request eligibility information for a specific patient. That patient may be identified in the 270 as a subscriber or as a dependent.

Per the HIPAA implementation guide, the maximum set of fields that an Information Source can require for look-up are:

If Subscriber - Member ID, Patient First name, Last name and Date of Birth
Dependent – Subscriber Member ID, Patient First name, Last name and Date of Birth

For the 270 transaction, if a service date is not provided, IA will use the current date to conduct the search. In addition, providers can submit a service date up to 1 year prior to the current date and up to 30 days after the current date.

3.0 Transmission Size and Type

Real time ANSI X12 270 Health Care Eligibility Benefit Inquiry - As defined in the HIPAA Implementation Guide, a real time transaction contains an inquiry for no more than 1 patient. The Information Receiver, or their electronic intermediary, will send the 270 transaction to the Information Source through some means of telecommunications and will remain connected while the Information Source processes the transaction and returns a response.

This document considers a real time transaction to be a single transaction that contains a single inquiry for a single patient in a single envelope. As such, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, IEA.

4.0 270 Data Elements

The following matrix identifies the recommended usage of the data elements when the trading partner submits 270 transactions to IA. Additional information about the data

elements or HIPAA requirements can be found within the ASC X12N Health Care Eligibility Benefits Inquiry and Response Implementation Guide:

Segment: **GS Functional Group Header**

Loop: GS

Level: Header

Usage: Required – Provide control info.

Notes: Due to IA business practices, this information is needed.

Data Element Summary

Ref Des	Element Name	Element Note
GS-02	App Sender Id Code	"R" or "B" appended to Trading Partner FTIN (Federal TAX ID Number)
GS-03	App Receiver Id Code	Enter value: TA720 (IA Number)

Segment: **NM1** Information Source Name
Loop: 2100 A
Level: Detail
Usage: Required
Notes: Due to IA business practices, this information is needed.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value: PR (Payer)
NM108	Identification Code Qualifier	Enter code value: NI (National Association of Insurance Commissioners (NAIC) Identification)
NM109	Identification Code	Enter code value: TA720

Segment: **NM1** Information Receiver Name
Loop: 2100 B
Level: Detail
Usage: Required
Notes: Due to IA business practices, this information is needed.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: FI (Federal Taxpayer's Identification Number)
NM109	Identification Code	Enter value: Federal Tax Identification Number

Segment: **NM1** Subscriber Name
Loop: 2100 C
Level: Detail
Usage: Required
Notes: Due to IA business practices, this information is needed.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: MI (Member Identification) or SV (Social Security Number)
NM109	Identification Code	Enter value: Subscriber's Member Identification Number on ID card including (YX_) alpha prefix

Segment: EQ Service Type Code

Loop: 2110 C
2110 D

Level: Detail

Usage: Required

Notes: IA expects 30,35 or AL. Other values may also be sent, but will be treated as 30. Only 1 EQ loop is allowed per 270.

Data Element Summary

Ref Des	Element Name	Element Note
EQ04	Insurance Type Code	Enter code value: 30 (Health Benefit Plan Coverage) 35 (Dental Care) AL (Vision)

271 Health Care Eligibility Benefit Response

1.0 Overview of Document

This guide is to be used as a supplement to the 271 Health Care Eligibility Benefit Response Implementation Guide, version 4010A1. It should be used to process eligibility responses for Independence Administrators. (hereinafter referred to as IA).

The purpose of this document is to outline IA processes for handling the 270/271 Health Care Eligibility Response Implementation Guide (hereinafter referred to as the 271), and to delineate specific data requirements where that option is available within the 4010A1 Implementation Guide.

This Companion Document does not add, delete or change the name of any data element that is specified in the Implementation Guide. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements.

2.0 General Information

This transaction set is used to respond to eligibility/benefits inquiries (270's) associated with a Subscriber's (or Dependent's) health plan coverage.

The Information Source is a Health Plan (IA) and the Information Receiver is a Provider organization.

This 271 eligibility response will include Eligibility Status, Eligibility Begin/End Dates, and Coverage description.

3.0 Transmission Size and Type

Real time ANSI X12 271 Health Care Eligibility Response – IA's real-time response transaction will contain information for only one patient. As such, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, IEA.

4.0 271 Data Elements

The following matrix identifies the recommended usage of the data elements when the 271 transaction is being returned by IA to the submitter. Additional information about the data elements or HIPAA requirements can be found within the ASC X12N Health Care Eligibility Benefits Inquiry and Response Implementation Guide:

Segment: **NM1** Information Source Name

Loop: 2100 A

Level: Detail

Usage: Required

Notes: Due to IA business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identification Code HL-1	Enter code value: PR (Payer)
NM102	Entity Type Qualifier	Expect Code value: 2 (Non Person Entity)
NM103	Last Name or Organization Name	Expect value: Independence Administrators
NM108	Identification Code Qualifier	Expect value: NI (National Association of Insurance (NAIC) Commissioners)
NM109	Primary Identification	Expect value: TA720

Segment: **NM1** Information Receiver Name

Loop: 2100 B

Level: Detail

Usage: Required

Notes: Due to IA business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identifier Code	Expect code value: 1P (Provider)
NM102	Entity Type Qualifier	Expect value: 2 (Non Person Entity)
NM108	Identification Code Qualifier	Expect value: SV (Service Provider Number)
NM109	Identification Code	Expect value: Service Provider Number

Segment: **NM1** **Subscriber Name**

Loop: 2100 C

Level: Detail

Usage: Required

Notes: Due to IA business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identification Code	Expect value: IL (Insured or Subscriber)
NM102	Entity Type Qualifier	Expect value: 1 (Person)
NM108	Identification Code Qualifier	Expect value: MI (Member Identification Qualifier)
NM109	Identification Code	Expect value: Member Identification Number

Segment: **DTP** Subscriber Date

Loop: 2100 C
 2100 D

Level: Detail

Usage: Required

Notes: Due to IA business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
DTP01	Date Time Qualifier	Expect value(s): 356 (Eligibility Begin) 357 (Eligibility End) 472 (Date of Service)
DTP02	Date Time Period Format Qualifier	Expect value: D8 CCYYMMDD RD8 CCYYMMDD-CCYYMMDD
DTP03	Date Time Period	Expect value: Eligibility Begin Date Eligibility End Date Date of Service

Segment: **NM1** **Dependent Name**
Loop: 2100 D
Level: Detail
Usage: Required
Notes: Due to IA business practices, this information is provided

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Dependent Identification Code Qualifier	Expect Value: MI (Member Identification Qualifier)
NM109	Identification Code	Expect Value: Member Identification Number

Segment: **EB** Subscriber Eligibility or Benefit Information

Loop: 2110 C
 2110 D

Level: Detail

Usage: Required

Notes: Only 1 EB loop is allowed per 271.

Data Element Summary

Ref Des	Element Name	Element Note
EB01	Eligibility or Benefit Information	Expect code value: 1 (Active) 6 (Inactive) U (Contact Following Entity)
EB03	Service Type Code	Expect code value: 30 (Health Benefit Plan Coverage) 35 (Dental Care) AL (Vision)
EB05	Plan Coverage Description	Expect Value: Contact Number