

# **270/271 Health Care Eligibility Benefit Inquiry and Response**



ASC X12N 270/271 (005010X279A1)



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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 version **005010X279A1** Implementation Guide (hereinafter referred to as the 270/271). It should be used to process eligibility requests for AmeriHealth Administrators (hereinafter referred to as AHA).

The document is to be used to clarify the usage of specific data elements within the context of AHA's business practices, and to delineate specific data requirements where that option is available within the 5010A1 Implementation Guide.

This Companion Document does not add, delete or change the name or usage of any data element that is specified in the HIPAA 270/271 Implementation Guide.

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## 2.0 General Information

This 270 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 (AHA) and the **Information Receiver** is a Provider/Facility organization.

### Patient Identification

The maximum set of fields that an Information Source may require for look-up are defined in the HIPAA Implementation Guide.

AHA *prefers* to receive the Member's ID, Member's Date of Birth, Member's First Name, and the Member's Last Name. However, AHA will perform the best search possible using the data received in the 270. Please review section 1.4.8.2 and 1.4.8.3 in the HIPAA 5010 Implementation Guide for more information.

- The AHA Member ID consists of an 8-digit numerical ID followed by a "TPA" suffix (e.g. 12345678TPA). Inclusion of the "TPA" suffix is not required, but can be submitted at the option of the Provider.

### Dates of Service

For the 270 transaction, if a service date is not provided, AHA will use the current date to conduct the search. In addition, providers can submit a service date up to 2 years prior to the current date and up to 30 days after the current date.

### Transmission Size and Type

Real time as defined in the HIPAA Implementation Guide is a real time transaction that contains an inquiry for no more than **one** 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.

### **3.0 Provider Identification**

The Provider ID is not used by AHA to process 270 requests for our members. As such, the National Provider ID (NPI), Tax ID or AHA Provider ID will be accepted in the Information Receiver loop. Additional details are provided in section 5.0.

### **4.0 Contact Information**

The 271 response transaction will contain contact information within the PER segment should the Provider require additional eligibility or benefit information.

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## 5.0 270 Data Elements

### Segment: **GS** Functional Group Header

**Loop:** GS

**Level:** Header

**Usage:** Required – Provide control info.

**Notes:** AHA business practices require this information

#### Data Element Summary

Element ID	Element Name	Element Note
GS03	App Receiver Id Code	Enter value: <b>54763</b>

### Segment: **BHT** Beginning of Hierarchical Transaction

**Loop:** N/A

**Level:** Header

**Usage:** Required

**Notes:** AHA business practices require this information

#### Data Element Summary

Element ID	Element Name	Element Note
BHT02	Transaction Set Purpose Code	Enter Code value: <b>13</b> (Request)

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**Segment:** **NM1** Information Source Name  
**Loop:** 2100 A  
**Level:** Detail  
**Usage:** Required  
**Notes:** AHA business practices require this information

### Data Element Summary

<b>Element ID</b>	<b>Element Name</b>	<b>Element Note</b>
NM101	Entity Identifier Code	Enter code value: <b>PR</b> (Payer)
NM108	Identification Code Qualifier	Enter code value: <b>NI</b> (National Association of Insurance Commissioners (NAIC) Identification)
NM109	Identification Code	Enter code value: <b>54763</b>

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**Segment:** **NM1** Information Receiver Name  
**Loop:** 2100 B  
**Level:** Detail  
**Usage:** Required  
**Notes:** AHA business practices require this information

### Data Element Summary

<b>Element ID</b>	<b>Element Name</b>	<b>Element Note</b>
NM101	Entity Identifier Code	Facility Providers – <b>FA</b> Prof. Providers – <b>1P</b>
NM108	Identification Code Qualifier	Enter code value: <b>XX</b> – National Provider Identifier (NPI) <b>FI</b> – Federal Taxpayer Identification Number <b>SV</b> – AHA Service Provider Number
NM109	Identification Code	Enter the NPI, Tax ID or AHA Provider Number

**Segment:** **NM1** Subscriber Name  
**Loop:** 2100 C  
**Level:** Detail  
**Usage:** Required  
**Notes:** AHA business practices require this information

### Data Element Summary

Element ID	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: <b>MI</b> (Member Identification)
NM109	Identification Code	Enter value: Subscriber's Member Identification Number on the ID card Example: 12345678TPA Inclusion of "TPA" suffix is optional

**Segment:** **TRN** Trace Number  
**Loop:** 2000  
**Level:** Detail  
**Usage:** Situational  
**Notes:** AHA business practices require this information

### Data Element Summary

Element ID	Element Name	Element Note
TRN01	Trace Type Code	Enter code value: <b>1</b>
		Please reference the HIPAA Implementation guide for all other TRN segment data elements

**Segment:** EQ **Service Type Code**

**Loop:** 2110 C/D

**Level:** Detail

**Usage:** Required

**Notes:** AHA business practices can handle any service type value in use by the HIPAA 270. However, the list below represents those service types where AHA is able to provide specific benefit limitations and details. All other service types will be responded to with general benefit information.

**Data Element Summary**

Element ID	Element Name	Element Note
EQ01	Service Type Code	Any valid value from HIPAA Guide

Service Type Requested	
1 Medical Care	88 Pharmacy (Active/Inactive Only)
2 Surgical	98 Professional (Physician) Visit - Office
4 Diagnostic X-Ray	99 Professional (Physician) Visit - Inpatient
5 Diagnostic Lab	A0 Professional (Physician) Visit - Outpatient
6 Radiation Therapy	A3 Professional (Physician) Visit - Home
7 Anesthesia	AD Occupational Therapy
8 Surgical Assistance	AF Speech Therapy
12 Durable Medical Equipment Purchase	AG Skilled Nursing Care
13 Ambulatory Service Center Facility	AI Substance Abuse
18 Durable Medical Equipment Rental	AL Vision (Optometry) - Active/inactive Only
20 Second Surgical Opinion	BG Cardiac Rehabilitation
30 Health Benefit Plan Coverage (General)	BH Pediatric
33 Chiropractic	BT Gynecological
35 Dental Care (Active/Inactive Only)	BU Obstetrical
40 Oral Surgery	BV Obstetrical/Gynecological
42 Home Health Care	BY Physician Visit - Office: Sick
45 Hospice	BZ Physician Visit - Office: Well
47 Hospital	CE MH Provider - Inpatient
48 Hospital - Inpatient	CF MH Provider - Outpatient
50 Hospital - Outpatient	CG MH Provider Facility - Inpatient
51 Hospital - Emergency Accident	CH MH Provider Facility - Outpatient
52 Hospital - Emergency Medical	CI Substance Abuse Facility - Inpatient
53 Hospital - Ambulatory Surgical	CJ Substance Abuse Facility - Outpatient
60 General Benefits (Active/Inactive Only)	CK Screening X-ray
61 In-vitro Fertilization	CL Screening Laboratory
62 MRI/CAT Scan	CM Mammogram, HR Patient
65 Newborn Care	CN Mammogram, LR Patient
68 Well Baby Care	CO Flu Vaccination
69 Maternity	DM Durable Medical Equipment
73 Diagnostic Medical	MH Mental Health
76 Dialysis	PT Physical Therapy

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Service Type Requested	
78 Chemotherapy	UC Urgent Care
80 Immunizations	
81 Routine Physical	
82 Family Planning	
83 Infertility	
84 Abortion	
86 Emergency Services	

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## 6.0 271 Data Elements

**Segment:**     **REF** Reference Information

**Loop:**        2100 C/D

**Level:**       Detail

**Usage:**       Situational

**Notes:**       AHA business practices require this information when the Member ID sent in the 270 was corrected in the 271 response

### Data Element Summary

Element ID	Element Name	Element Note
REF01	Ref. Identification Qualifier	Enter value: <b>Q4</b> (Prior Identification Number)  NOTE: This code is to be used when a corrected or Member identification number is returned in 271 2100C/D NM109
REF02	Ref. Identification	Expect value: Originally submitted Patient ID

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**Segment:**     **INS** Insured benefit  
**Loop:**        2100 C/D  
**Level:**       Detail  
**Usage:**       Situational  
**Notes:**       AHA business practices require this information when Patient Identifiers from the 270 were corrected in the 271 response

### Data Element Summary

Element ID	Element Name	Element Note
INS01	Yes/No Condition Or Response Code	See HIPAA Implementation Guide
INS02	Individual Relationship Code	See HIPAA Implementation Guide
INS03	Maintenance Type Code	Expect Value: <b>001</b>
INS04	Maintenance Reason Code	Expect Value: <b>25</b>

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**Segment:** **DTP** Subscriber Date

**Loop:** 2100 C  
2100 D

**Level:** Detail

**Usage:** Situational

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

### Data Element Summary

Element ID	Element Name	Element Note
DTP01	Date Time Qualifier	Expect value: <b>291</b> (Plan)
DTP02	Date Time Period Format Qualifier	Expect value: <b>D8</b> (Format: CCYYMMDD) <b>RD8</b> (Format: CCYYMMDD-CCYYMMDD)
DTP03	Date Time Period	Expect value: <b>Eligibility Begin Date - Eligibility End Date</b> <b>Or</b> <b>270 DTP Date (Inactive responses only)</b>

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

**Loop:** 2110 C/D

**Level:** Detail

**Usage:** Situational

**Notes:** Expect Multiple EB segments per 271

**Data Element Summary**

<b>Element ID</b>	<b>Element Name</b>	<b>Element Note</b>
EB01	Elig. or Benefit Info	<b>Expect Values:</b>  <b>1 (Active)</b> <b>6 (Inactive)</b> <b>U (Contact Following Entity)</b> <b>A (Coinsurance)</b> <b>B (Copayment)</b> <b>C (Deductible)</b> <b>F (Limitations)</b> <b>G (Out-of-Pocket)</b> <b>I (Non-Covered)</b> <b>P (Benefit Disclaimer)</b> <b>R (Other or Additional Payer)</b>
EB03	Service Type Code	<b>Expect Values:</b>  <b>30 (Health Benefit Plan Coverage)</b> <b>Additional Service Types based on 270 EQ01</b>

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EB05	Coverage Plan Description	Expect Value: <b>AmeriHealth Administrators</b>
EB06	Time Period Qualifier	Expect Values: <b>7 (Day)</b> <b>21 (Years)</b> <b>22 (Service Year)</b> <b>23 (Calendar Year)</b> <b>27 (Visit)</b> <b>29 (Remaining)</b> <b>36 (Admission)</b>
EB09	Quantity Qualifier	Expect Values: <b>S7 (Age, High Value)</b> <b>S8 (Age, Low Value)</b>
EB11	Authorization or Cert Ind.	Expect Code Values: <b>Y (Yes)</b> <b>U (Unknown)</b>
EB12	In Plan Network Indicator	Expect Code Values: <b>Y (Yes)</b> <b>N (No)</b> <b>W (Not Applicable)</b>

**Segment:** **DTP** **Subscriber Eligibility/Benefit Date**

**Loop:** 2110 C/D

**Level:** Detail

**Usage:** Situational

**Notes:** AHA will provide this segment when Vision, Dental & Prescription Drug benefits (if applicable) have a different coverage effective date than the medical coverage, or when there is a COB verification date.

**Data Element Summary**

<b>Element ID</b>	<b>Element Name</b>	<b>Element Note</b>
DTP01	Date Time Qualifier	Expect value: <b>348</b> (Benefit Begin) <b>290</b> (Coordination of Benefits)
DTP02	Date Time Period Format Qualifier	Expect value: <b>D8</b> (Format: CCYYMMDD) <b>RD8</b> (Format: CCYYMMDD-CCYYMMDD)
DTP03	Date Time Period	Expect value: <b>Benefit Begin Date – Benefit End Date (RD8)</b> <b>COB Verification Date (D8)</b>

**Segment:** **NM1** **Subscriber Benefit Entity Related Name**

**Loop:** 2120 C/D

**Level:** Detail

**Usage:** Situational

**Notes:** AHA will provide this segment when COB and/or Care Management Information is applicable

### Data Element Summary

Element ID	Element Name	Element Note
NM101	Identifier Code Qualifier	Expect Value: <b>IC</b> (Insured or Subscriber) - COB <b>PR</b> (Payer) - COB <b>PRP</b> (Primary Payer) - COB <b>SEP</b> (Secondary Payer) - COB <b>X3</b> (Utilization Management Organization)
NM102	Entity Type Qualifier	<b>1</b> (Person) <b>2</b> (Non-Person Entity)
NM103	Name Last or Org. Name	Expect: Other Insured Last Name (COB) Other Insurer Name (COB) Applicable Care Management Organization
NM104	Name First	Other Insured First Name (COB)
NM108	Identifier Code Qualifier	Expect Value: <b>MI</b> (COB)
NM109	Identification Code	Expect Value: <b>Other Insured Member ID Number</b> (COB)

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**Segment:** **PER** **Benefit Related Contact Information**

**Loop:** 2120 C/D

**Level:** Detail

**Usage:** Situational

**Notes:** AHA will provide this segment when COB and/or Care Management Information is applicable

### Data Element Summary

<b>Element ID</b>	<b>Element Name</b>	<b>Element Note</b>
PER01	Contact Function Code	Expect Value: <b>IC</b> – Information Contact
PER03	Comm. Number Qual.	Expect Value: <b>TE</b> – Telephone
PER04	Communication Number	Expect:  Other Insurer Contact Number  Care Management Org. Contact Number  Format: AAABBBCCCC AAA = Area Code BBBCCCC = Local Number