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# HIPAA EDI Companion Guide

For

## 270/271 Eligibility Inquiry & Response

Companion Guide Version: 3.0

ASCX12N National Electronic Data Interchange Transaction  
Set Implementation and Addenda Guides, Version 005010A1

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## Disclosure Statement

This document is intended to be a companion guide for use in conjunction with the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides. The information in this document is provided for Jefferson Health Plans and its associated Trading Partners.

This document contains clarifications as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard for Electronic Transactions. This document is not intended to convey information that exceeds the requirements or usages of data expressed in the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides defined by HIPAA.

**This document is not intended, and should not be regarded, as a substitute for the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides.**

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## **Preface**

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. This companion guide to the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides adopted under HIPAA will clarify and specify Jefferson Health Plans communication protocols, business rules, and information applicable to the 270/271 Eligibility Inquiry & Response transaction. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

## Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

| # | Version | Date      | Author                | Updates                                                                                                                                                             |
|---|---------|-----------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | 1.0     | 8/25/04   | HP Operations Support | <ul style="list-style-type: none"> <li>Initial version of 270/271 Companion Guide Document. This version was also posted to the plan's external website.</li> </ul> |
| 2 | 2.0     | 1/27/07   | HP Operations Support | <ul style="list-style-type: none"> <li>Added new company logo</li> <li>Updated ANSI fields tables to include NPI required data</li> </ul>                           |
| 3 | 3.0     | 10/17/13  | Claims Department     | <ul style="list-style-type: none"> <li>Added new plan name and logo.</li> </ul>                                                                                     |
| 4 | 4.0     | 10/9/2024 | Claims Department     | <ul style="list-style-type: none"> <li>Updated naming and contact information</li> </ul>                                                                            |

## **Introduction**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. The provisions for administrative simplification contained within HIPAA require the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions.

These transactions primarily occur between health care providers and health insurance plans or clearinghouses. HIPAA directs the Secretary of HHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

### **Scope**

This companion guide explains the procedures and requirements necessary for trading partners of Jefferson Health Plans to transmit the following HIPAA standard transactions:

- 270/271 Eligibility Inquiry & Response

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

### **References**

Additional information on the HIPAA Final Rule for Standards for Electronic Transmissions and the endorsed Implementation Guides can be found at:

- <http://www.cms.gov/hipaa/hipaa2> (HIPAA Administrative Simplification)
- <http://www.wpc-edi.com> (Washington Publishing Company)

## **Contact information**

### **EDI Customer Service and Technical Assistance**

Electronic Data Interchange (EDI) customer service and technical assistance requests focus solely on the generation, processing, and/or transmission of a HIPAA standard transaction. EDI customer service and technical assistance requests will not focus on transaction results, such as claim payment and remittance results.

Please contact Jefferson Health Plans EDI Department at [EDI@jeffersonhealthplans.com](mailto:EDI@jeffersonhealthplans.com) for technical assistance.

### **Non-EDI Customer Service and Assistance**

Non-EDI customer service and assistance requests focus solely on transaction results such as claim payment and remittance advice, member maintenance, or member eligibility. Non-EDI customer service and assistance requests will not focus on the generation, processing, and/or transmission of a HIPAA standard transaction.

Please contact Jefferson Health Plans Provider Services for non-EDI customer service and assistance.

## **Eligibility Benefit Inquiry and Response (270/271)**

### **Eligibility Status Request (270)**

The only data elements that are required by Jefferson Health Plans to identify the member are:

- Member ID
- Provider ID

The other fields on the Eligibility Request screen will be the Eligibility Start Date and Provider ID fields. If submitted, the eligibility date field will be used to determine if the member is/was eligible specifically on that date. If the eligibility start date is not submitted, the eligibility date will default to the transaction date. The provider ID identifies the provider making the inquiry.

### Data Necessary for Processing 270 Requests

| Loop      | Segment | Data Element | Field Description                  | Length | Mapping Comments                                                                   |
|-----------|---------|--------------|------------------------------------|--------|------------------------------------------------------------------------------------|
| IC Header | ISA     | 06           |                                    |        | Trading Partner ID                                                                 |
| Header    | BHT     | 02           | Transaction Set Purpose            | 2/2    | '13' = Request                                                                     |
| 2100B     | NM1     | 01           | Entity Identifier Code             | 2/3    | '1P' = Provider                                                                    |
| 2100B     | NM1     | 02           | Entity Type Qualifier              | 1/1    | '1' = Person, '2' = Non-person                                                     |
| 2100B     | NM1     | 08           | Identification Code Qualifier      | 1 / 2  | 'XX'                                                                               |
| 2100B     | NM1     | 09           | Identification Code                | 2/80   | Use appropriate NPI                                                                |
| 2100B     | REF     | 01           | Reference Identification Qualifier | 2/3    | N5                                                                                 |
| 2100B     | REF     | 02           | Reference Identification           | 1/30   | Jefferson Health Plans Provider Identification Number (Up to 14 Digits)            |
| 2100C     | NM1     | 03           | Last Name                          | 1/35   | Member Last Name                                                                   |
| 2100C     | NM1     | 04           | First Name                         | 1/25   | Member First Name                                                                  |
| 2100C     | NM1     | 08           | Identification Code Qualifier      | 1 / 2  | 'ZZ'                                                                               |
| 2100C     | NM1     | 09           | Identification Code                | 2/80   | Member ID                                                                          |
| 2100C     | DTP     | 01           | Date Time Qualifier                | 3/3    | '307' = Eligibility                                                                |
| 2100C     | DTP     | 02           | Date Time Period Format Qualifier  | 2/3    | 'D8' = Format CCYYMMDD                                                             |
| 2100C     | DTP     | 03           | Date Time Period                   | 1/35   | Date for Eligibility inquiry (if not sent, then the transaction date will be used) |
| 2110C     | EQ      | 01           | Eligibility or Benefit Inquiry     | 1/2    | '30' = Health Benefit Plan Coverage                                                |

### **Eligibility Status Response (271)**

The following are the Eligibility Response Values utilized by Jefferson Health Plans:

- Member is Eligible
- Member is Not Eligible
- Member is Not Found
- Member is Invalid

For valid, eligible members, Jefferson Health Plans will return the member's ID along with selected demographic information, including the member's name and date of birth, PCP information (provider ID, name, effective date), Ob/Gyn information (same information as PCP, as available), and the member's hospital affiliation.

In the event of a member who has been terminated (not eligible), Jefferson Health Plans will return the member's ID, the member's name, and the termination date.

In the event that the member is not found in Jefferson Health Plans' database, Jefferson Health Plans will return a 271 transaction set containing an AAA segment identifying that the member was not found.

If the member is found in Jefferson Health Plans' database but determined to either be an invalid member – either a “dummy member” (these are fictitious member numbers that are used for testing) or members who have been only partially entered, etc. – Jefferson Health Plans will return a 271 transaction set containing an AAA segment identifying that the member was invalid.

### Sample Eligibility Response Screen

The following is an example of what the Eligibility Response screen might look like:

|                                                                                                                                                                                           |                        |                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------|
| <b>Patient :</b><br>Member ID :<br>Plan Network ID :<br>Plan Network ID Description :<br>DOB :<br>Gender :                                                                                |                        | <b>Plan</b><br><br><a href="#">Coverages</a><br><u>Health Benefit Plan Coverage</u> |
| <b>Submitter Info</b><br>Submitter Type : Provider<br>Service Provider # :                                                                                                                |                        |                                                                                     |
| <b>Coverage : Health Benefit Plan Coverage</b>                                                                                                                                            |                        |                                                                                     |
| <b>Benefits</b><br><u>Coverage Level :</u><br>Active Coverage<br><u>Eligibility Begin :</u><br>Coverage Level :<br>Active Coverage<br><u>Eligibility Begin :</u><br>PCP Name :<br>PCP # : | <b>Additional Info</b> |                                                                                     |

### Data Necessary for Sending 271 Response

| Loop   | Segment | Data Element | Field Description                  | Length | Mapping Comments                                                                                    |
|--------|---------|--------------|------------------------------------|--------|-----------------------------------------------------------------------------------------------------|
| Header | BHT     | 02           | Hierarchical Structure Code        | 2/2    | '11' = Response                                                                                     |
| 2100C  | NM1     | 03           | Last Name                          | 1/35   | Member Last Name                                                                                    |
| 2100C  | NM1     | 04           | First Name                         | 1/25   | Member First Name                                                                                   |
| 2100C  | NM1     | 08           | Identification Code Qualifier      | 1 / 2  | 'ZZ'                                                                                                |
| 2100C  | NM1     | 09           | Identification Code                | 2/80   | Member ID                                                                                           |
| 2100C  | AAA     | 01           | Condition or Response Code         | 1/1    | 'N' = Request not valid                                                                             |
| 2100C  | AAA     | 03           | Reject Reason Code                 | 2/2    | '64' = Invalid Member ID<br>'67' = Member not found                                                 |
| 2100C  | DMG     | 01           | Date Time Period Format Qualifier  | 2/3    | 'D8' = Format CCYYMMDD                                                                              |
| 2100C  | DMG     | 02           | Date Time Period                   | 1/35   | Member's DOB                                                                                        |
| 2100C  | DMG     | 03           | Gender Code                        | 1/1    | 'F' = Female, 'M' = Male,<br>'U' = Unknown                                                          |
| 2110C  | EB      | 01           | Eligibility or Benefit Information | 1 / 2  | '1' = Active Coverage, '6' = Inactive,<br>'A' = Co-Insurance, 'B' = Co-Payment,<br>'C' = Deductible |
| 2110C  | EB      | 03           | Service Type Code                  | 1 / 2  | '30' = Health Plan Coverage                                                                         |
| 2110C  | DTP     | 01           | Date/Time Qualifier                | 3/3    | '356' = Eligibility Begin,<br>'357' = Eligibility End                                               |
| 2110C  | DTP     | 02           | Date Time Period Format Qualifier  | 2/3    | 'D8' = Format CCYYMMDD                                                                              |
| 2110C  | DTP     | 03           | Date Time Period                   | 1/35   | Eligibility Date (Effective or Termination Date)                                                    |
| 2120C  | NM1     | 01           | Entity Identifier Code             | 2/3    | 'P3' = PCP, '73' = Other Physician                                                                  |
| 2120C  | NM1     | 03           | Last Name                          | 1/35   | Provider Last Name                                                                                  |
| 2120C  | NM1     | 04           | First Name                         | 1/25   | Provider First Name                                                                                 |
| 2120C  | NM1     | 08           | Identification Code Qualifier      | 1 / 2  | 'XX'                                                                                                |
| 2120C  | NM1     | 09           | Identification Code                | 2/80   | Use appropriate NPI                                                                                 |