



The Forum Companion Document

For use with ANSI ASC X12N
Health Care Eligibility Benefits Inquiry and Response
Implementation Guide

Health Care Eligibility Benefits Inquiry and Response (Batch) 270/271

ANSI ASC X12N 270/271 (004010X092A1)

“Developing, Posting From &
Troubleshooting the
Transactions”

*Version:
July 11, 2005*

Getting an Electronic Version of this Document

An electronic version of this document, and other 270-271 related documents, can be found at www.wahealthcareforum.org/hipaa/work_products.asp. From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

Participants in the 270-271 Companion Document Initiative

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and medical groups. For additional information about The Forum see www.wahealthcareforum.org.

Health plans & TPAs participating in this initiative include:

- *Asuris Northwest Health*
- *First Choice Health Administrators*
- *Group Health Cooperative and Option Healthcare*
- *Premera Blue Cross*
- *Regence BlueShield*
- *Washington Dental Service*

Professional provider organizations participating in this initiative include:

- *The Everett Clinic*
- *Children's Hospital & Regional Medical Center*
- *Group Health Cooperative*
- *Wenatchee Valley Medical Center*

Intended Use of the 270-271 Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Health Care Eligibility Benefits Inquiry and Response (Batch) Transactions.

A complete version on the Implementation Guide can be accessed at www.wpc-edi.com/hipaa/HIPAA_40.asp.

This Companion Document is designed to help provider organizations, e.g. medical practices, clinics, dentists and hospitals in their efforts to:

- *Become familiar with the HIPAA 270 transaction and how that transaction will be processed by participating health plans*
- *Become familiar with the HIPAA 271 transaction they will receive from participating health plans*
- *Develop software to implement & exchange the HIPAA 270 transaction with participating health plans and to automatically post relevant information into their accounts from the HIPAA 271 transaction.*
- *Develop specification materials for vendors who will implement the HIPAA 270 transaction and who may do any automatic posting from the HIPAA 271 transaction.*
- *Resolve possible issues that might arise in the process of HIPAA 270 transaction exchange and in the process of posting from the HIPAA 271 transaction.*

*This Companion Document should be a useful guide for provider organizations, and others that exchange the 270 & 271 transactions **directly** with participating health plans (previously listed).*

This Companion Document is likely to become one part of any trading partner agreement between a provider organization, or electronic receiver, and a health plan. The term, '*trading partner agreement*', is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

All conventions should be stated clearly in the *trading partner agreement* so that implementation and operations expectations are defined unambiguously. Conventions that are established in a *trading partner agreement* take precedence over any conventions that are contained in this document.

*This Companion Document may be less useful when a provider organization, or their electronic intermediary, is not exchanging transactions directly with participating health plans. Information contained in this document **may not** apply to exchanges between:*

- Provider Organizations and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Provider Organizations and Clearinghouses: Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this Companion Document. The clearinghouse may reformat the health plan's transaction before passing it along to the provider. This reformatting may add unforeseen complexity to the process of transaction exchange.

Scope of the 270-271 Transaction

Within Scope of this Companion Document:

It is expected that providers will use this transaction to request coverage information from health plans on patients for whom . . .

- Services are scheduled for today
- Services are scheduled for some date in the future

Note: Since future eligibility cannot be guaranteed, the information provided in this transaction will be for eligibility as of the date of the transaction. If there are questions about future eligibility, a 270 transaction should be sent closer to the scheduled service date.

- Services have already been delivered

Outside Scope of this Companion Document:

- This transaction set will exchange information about eligibility for a set of health care benefits. This information **DOES NOT** constitute a guarantee of payment
- Payer-to-payer exchange of the 270/271

Coverage Information Available from Participating Health Plans

The coverage information to be provided will vary by health plan. The following tables set expectations about the information that is available.

- Table I identifies the 270 data elements that will impact the scope of eligibility/benefits information to be contained in the 271 response.
- Table II identifies the eligibility/benefits information that will be contained in the 271 response.

Table I -- 270 Data Elements that will affect the 271 Response

The 270 contains a number of data elements that can be used to request different types of coverage information. Not all health plans have the capability to respond to the various types of possible requests. This table indicates how each health plan is able to respond to the different possible values of each data field in the 270.

In the table, *270 input values are in italics*. The health plans ability to respond in the 271 is in plain text.

IG Page#	Element	FCHA	GHC	Premera	Asuris & Regence	WDS
81-82 & 121-123	Provider Code	<i>Any value.</i> No difference in	<i>Any value.</i> No difference in	<i>Any value.</i> No difference in	<i>Any value.</i> No difference in	<i>Any value.</i> No difference in

IG Page#	Element	FCHA	GHC	Premera	Asuris & Regence	WDS
	(PRV01-PRV06)	response.	response.	response.	response.	response.
88, 106, 130 & 145	Date-Time Qualifier (DTP01)	<i>Any value.</i> No difference in response.	<i>307 expected.</i> No difference in response.	<i>307 expected.</i> No difference in response.	<i>307 expected.</i> No difference in response.	<i>Any value.</i> No difference in response.
88, 107, 130 & 146	Date-Time Period (DTP02-DTP03)	<i>D8 expected.</i> If range is entered, the first date in range will be used.	<i>D8 expected.</i> If range is entered, the first date in range will be used.	<i>D8 expected.</i> If range is entered, the first date in range will be used.	<i>D8 expected.</i> If range is entered, the first date in range will be used.	<i>D8 expected.</i> If range is entered, the first date in range will be used.
90 & 132	Service Type Code (EQ01)	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value</i> Response will vary depending upon value specified. Use 30 for a general answer.	<i>Any value.</i> No difference in response.
95-96 & 137-138	Composite Medical Procedure Identifier, Product/ Service (EQ02)	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.
97 & 139	Coverage Level Code (EQ03)	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.
97 & 139	Insurance Type Code (EQ04)	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.
99-105 & 140-143	AMT01-02, III01-02, REF01-02	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.	<i>Any value.</i> No difference in response.

Table II -- 271 Response Information by Health Plan

This table presents the scope of coverage information that can be provided within the 271 by each health plan.

Data Elements	FCHA	GHC	Premera	Asuris & Regence	WDS
Patient Information					
Patient Name	Yes	Yes	Yes	Yes	Yes
Patient Birth Date	Yes	Yes	Yes	Yes	Yes

Data Elements	FCHA	GHC	Premera	Asuris & Regence	WDS
Patient Number (Plan's unique identification of the member)	Yes	Yes	No	Yes ^{*A}	Yes ^{*4}
Relationship to Subscriber	Yes	Yes	Yes	Yes	Yes
Medicare HIC Number (when available)	N.A.	Yes	N.A.	N.A.	N.A.
Subscriber Information ^{*S}					
Subscriber Name	Yes	Yes	Yes	Yes	Yes
Subscriber Number	Yes	Yes	Yes	Yes	No
Subscriber Social Security Number	If available in database	Only if Subscriber is the patient	No	No	Yes
Medicare HIC Number (when available)	N.A.	Yes	N.A.	N.A.	N.A.
Provider Information (for Managed Care Products)					
Primary Care Provider Name	N.A.	Yes	N.A.	Yes	N.A.
PCP Office Phone	N.A.	Yes	N.A.	No	N.A.
PCP Effective Date	N.A.	Yes	N.A.	Yes	N.A.
PCP Termination Date	N.A.	No	N.A.	Yes	N.A.
Provider Group Name (Clinic/Practice Name)	N.A.	Yes	N.A.	No	N.A.
At Risk Group Name	N.A.	No	N.A.	Yes ^{*2}	N.A.
PCP Identification Number	N.A.	No	N.A.	TIN-Rider ^{*2}	N.A.
Coverage Information					
Program (HO, BHP, etc.)	Yes	Yes	Yes	Yes	Yes
Status (Active, Inactive)	Yes	Yes	Yes	Yes	Yes
Group Name (Employer Group)	Yes	Yes	No	No	Yes
Group Number	Yes	Yes	Yes	Yes	Yes
Effective Date on Group	Yes	Yes	Yes	Yes	No
Termination Date off Group	Yes	Yes	Yes	Yes	No
Deductible & Co-Pay Information					
Deductible	No	Yes	Yes	Yes	Yes
Emergency Room Co-Pay	Yes	Yes	Yes ^{*1}	Yes	N.A.
Inpatient Co-Pay	No	Yes	Yes	Yes	N.A.
Office Visit Co-Pay	Yes	Yes	Yes ^{*1}	Yes	N.A. except for Delta Care
Pharmacy Co-Pay	No	Yes	N.A.	Yes	N.A.

Data Elements	FCHA	GHC	Premera	Asuris & Regence	WDS
Managed Care Co-Insurance Levels	N.A.	No	N.A.	Yes ^{*3}	N.A.
Coinsurance Percentage	No	No	Yes	Yes	Yes

Legend:

- Yes – information will be returned
- No - the health plan offers a product for which this information is relevant, but the information is not available to be returned
- N.A. – the health plan does not offer a product for which this information is relevant

Notes:

^A – Alpha prefixes will be returned as part of the Patient Number

^S – Health Plans are beginning to use alternative identifiers. Social Security Numbers may not be available to the health plan

¹ – For Premera, Data availability dependent upon system platform

² – For Asuris & Regence, if member has coverage with an At-Risk Group, the PCP Identification with that At-Risk Group will be added to the PCP Identification Number.

³ – For Asuris & Regence, three tiers of co-insurance will be indicated using data fields 2110C EB05 & 2110C EB12

* EB05 = 'In Network', EB12 = 'Y' - Benefits are considered In-Plan Network.

* EB05 = 'EXT Network', EB12 = 'N' - benefits are considered Out-of-Plan Network

* EB05 = 'Out of Area', EB12 = 'U' - unknown whether the benefits identified are part of the Plan Network

⁴ – If patient is subscriber, the Subscribers's Member ID will be returned in NM109. If the patient is a dependent, no Member ID will be sent.

⁵ – Additional Information about providers for Managed Care Products

* EB05 = "Medicare Lock In"

* EB05 = "OON" Out of Network

Helpful Hints for Developing the 270 Transaction

This section of the 270-271 Companion Document provides hints that may be helpful in developing and submitting a 270 transaction. Following these hints should expedite turnaround time on the eligibility request.

These hints apply to the batch implementation of the 270 transaction. Batch implementation means that the submitting organization sends the 270 transaction to the health plan through some means of telecommunications and does not remain connected while the health plan processes the transaction.

1. Creating an electronic envelope (ISA-IEA) for the claim transaction

The X12N structure allows for either one or multiple transaction types to be transmitted in an ISA-IEA envelope. Participating health plans prefer that each different type of transaction is contained within its own ISA-IEA envelope. For example, if an electronic transmission between two trading partners contains eligibility inquiries and claim status inquiries, there will be two ISA-IEA sets; one for the eligibility inquiries (270) and one for the claims status inquiries (276).

This Companion document reflects conventions for *batch* implementation of the ANSI X12 270/271 Health Care Eligibility Benefit Inquiry and Information Response Transaction. As defined in the HIPAA Implementation Guide, a batch transaction contains requests for up to 999 patient. This maximum number of requests may be changed through the trading partner agreement.

2. Structuring the Transaction (GS-GE & ST-SE)

The 270-271 transactions will use the following HL structure: Information Source/ Information Receiver/ Subscriber/Dependent

3. Using Parent and Child Loops

Relevant information contained in a ‘parent’ loop or segment will apply to the ‘child’ loops or segments, unless specific information is contained in the child loop or segment. For example, the begin date of eligibility coverage with a specific Primary Care Provider will be the same begin date of eligibility for general coverage with the health plan, unless specifically indicated in the EB loop for the Primary Care Provider.

4. Formatting Data in the Transaction

- Any character used in a data element cannot be used as a delimiter, separator, or terminator. Ideally, the following characters should not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , # , : , ~).

- By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 should contain a '2' to indicate a non-person entity.

5. Staying Compliant With HIPAA Transaction Versions and Code Sets

- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, only the legally mandated version of the transaction. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.
- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, the medical data code sets that are valid at the time that the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submission date.) This means that health plans must be able to process versions of the code sets that precede the current version.
- Current versions of many of the code sets are available at www.wpc-edi.com/codes/

6. Filling in 'Information Source' and 'Information Receiver'

- The Information Source is a Health Plan and the Information Receiver is a Provider Organization
- In the 270, the NM109 field will contain a facility identification number agreed upon between the health plan and the provider (or intermediary)

The health plans will not use the PRV segment to associate a particular provider with the eligibility request.

7. Correctly Identifying the Member

- The 270-271 transaction will be used to request eligibility information for a specific member. That member may be identified in the 270 as a subscriber or as a dependent. The health plan will check for that member as both a subscriber and a dependent, regardless of how the member is submitted in the 270.

To minimize confusion, the subscriber should be the person that has the contract with the health plan.

- Per the HIPAA implementation guide, the minimum set of fields that need to be entered for an inquiry on a member are:
 - If Subscriber - Member ID, Patient Firstname, Lastname and Date of Birth

- If a Dependent – Subscriber Member ID, Patient Firstname, Lastname and Date of Birth

To be guaranteed a response by a health plan, all of these fields should be entered on the 270 inquiry. If fewer fields are entered, the health plan may not be able to determine if the inquiry pertains to a member in their production system.

- If the information contained in the 270 is not sufficient for a health plan to uniquely identify a single member (i.e. more than one member matches the entered information), the appropriate AAA segment in the 271 will indicate that the health plan will need to be contacted directly.

8. Correctly Identifying the Date(s) of Service

- The 270 transaction will be used to request eligibility information for **a specific single date of service, and not a date range**. If no date is entered in the 270, the transaction date will be assumed by the health plan. If a range of dates is entered in the 270, the first date in the range will be assumed.

Coverage information for the date of service will be returned. A beginning date of coverage will always be provided. An ending date of coverage will be provided if it is known.

9. Testing the Transaction

When testing the transaction, limit the number of inquiries in the batch to 50 or less. Once the testing process has been completed, the number of inquiries can be increased.

Testing your transaction with a validation tool/company is strongly recommended. This process will make it significantly easier to test the transaction with your dental plan/health plan or other intermediary. Examples of validation tools/companies include EDIFECS and ClarEDI. These companies are listed as examples. This listing is not intended as an endorsement.

Participating Dental Plans/Health Plan request that EDI batches that contain any test data be sent separate from EDI batches that contain production data. The values in ISA 15 and REF 02 of the BHT segment should correspond. Both should indicate either test data or production data.

Helpful Hints for Posting From the 271 Transaction

This section of the 270-271 Companion Document provides hints that may be helpful in posting from a 271 transaction.

1. The number of responses contained in a 271 may not match the number of inquiries contained in the 270

As described in the table below, some health plan process the 270 inquires as a batch and return all responses in a single, corresponding 271. Some health plans divide the 270 inquiries and return responses in different 271 batches.

FCHA	GHC	Premera	Asuris & Regence	WDS
271 batch matches 270 batch	271 batch matches 270 batch	270 requests returned in different 271 batch	270 requests returned in different 271 batch	Only accept 1 270 and return 1 271.

2. Dual Eligibility

In the case of dual eligibility, i.e. when a patient has 2 or more policies in effect from the same health plan, more than one set of eligibility information may be returned for any specified date of service. See appendices for a description of how dual eligibility will be returned in the 271.

The following table indicates whether the health plan will use the SAME member ID or DIFFERENT member IDs to identify the multiple policies.

	FCHA	GHC	Premera	Asuris & Regence	WDS
Same member ID		X	For old systems		X
Different member ID	X		For new system	X	

3. Clarifying Coverage Information for the Date of Service

- The 271 transaction will provide eligibility information for **a specific single date of service, and not a date range**. If no date is entered in the 270, the transaction date will be assumed by the health plan. If a range of dates is entered in the 270, the first date in the range will be assumed.

Coverage information for the date of service will be returned. A beginning date of coverage will always be provided. An ending date of coverage will be provided if it is known.

- If the date of eligibility coverage is a future date . . .

FCHA: will check date to determine that it is a valid value.

GHC: will return current information if the date of service is not greater than 60 days. If date is greater than 60 days, will return an “AAA03 = 63” Date of Service is in the Future

Premiera: Currently looking into the changing the method of responding to future dates. When finalized, this information will be updated.

Asuris & Regence: will check the date to determine that it is a valid value. The health plan will reply with eligibility/benefits that are on file for the specified date. If the date is in the future AND it falls within a group effective date range, the health plan will reply with eligibility/benefits that are on file for that group coverage. Otherwise, they will reply with eligibility/coverage for the date the transaction was received. Future eligibility/benefits may be dependent upon payment of premiums.

WDS: Health plan will check date to determine that it is a valid value.

- If eligibility for the specified date of service is Pending, no end date will be provided
- Dates of eligibility coverage relating to general coverage or a benefit for a specified date of service for a patient will be handled as follows:
 - An ‘RD8’ type date range will not be returned in the DTP02 field of any DTP segment related to dates of eligibility coverage.
 - If the specified date of service did not/does not fall within a period of eligibility coverage, no dates will be returned. Eligibility coverage will be considered ‘Inactive’.
 - If the specified date of service did/does fall within a period of eligibility coverage
 - A beginning date of eligibility coverage associated with the specified date of service will be returned, as type ‘D8’, in the first occurrence of the DTP segment.
 - If the end date of eligibility coverage for the specified date of service is in the past, an ending date will be returned, as type ‘D8’, in the second occurrence of the DTP segment.
- Health plans will use the Insurance Type Code (EB04 in the EB segment) and the Plan Coverage Description (EB05 in the EB segment) as described in the following table:

	EB04 ‘Insurance Type Code’	EB05 ‘Plan Coverage Description’
FCHA	HM – Health Maintenance	• OON = Out of Network Benefits

	EB04 'Insurance Type Code'	EB05 'Plan Coverage Description'
	Organization	
GHC	<ul style="list-style-type: none"> • 12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan • MA - Medicare Part A • MB - Medicare Part B • MP - Medicare Primary 	<ul style="list-style-type: none"> • OON = Out of Network Benefits • Medicare –Lock-In • CPYEXC – Co-pay exclusion Please Call – for date of service in a previous year we may return this message asking Provider to call for Co-pay information. If you do not get this message on a previous year inquiry, the Co-pay data is valid
Premera	<ul style="list-style-type: none"> • IN – Indemnity • MA – Medicare Part A • PR - Standard 	Free form – There are too many responses to place in this document
Regence	<ul style="list-style-type: none"> • OT - Other • C1 – Coommercial • HM – Health Maintenance Organization • PR – Preferred Provider Organization • PS – Point of Service • SP – Supplemental Policy 	<ul style="list-style-type: none"> • OT – Basic Health, Healthy Options, Healthy Options for Kids, Individual Basic, PEBB • C1 – Dental, Benchmark Traditional • HM – HMO Washington, RegenceCare, RegenceCare PEBB • PR – PPO, Benchmark PPO, • PS – Selections, Selections Plus, Incentives • SP – Medicare Supplement, FEP Dental Blue Supplement
Asuris	<ul style="list-style-type: none"> • OT – Other • PR – Preferred Provider Organization • SP - Supplemental Policy 	<ul style="list-style-type: none"> • OT = Asuris Basic Health, Asuris BHP+, Asuris Traditional, Asuris Healthy Options, • PR – PPO • SP = Medicare Supplement
WDS	<ul style="list-style-type: none"> • HM - for employer groups using DeltaCare product • PR – for employer groups using DeltaPreferredOption (PPO) product: • GP, for DeltaPremier product (Fee-for-Service) 	<ul style="list-style-type: none"> • For PPO type products, this element is populated with 'In Network', 'Out of Network', 'Out of Service Area'. EB12 is populated with Y, N, N respectively. EB08 is populated with the Percentage that will be paid by WDS based on the provider's network affiliation. • If the employer's plan is not a PPO type product, EB05 and EB12 are not populated.

4. Health plan system information may take precedence over information submitted on the 270 . . .

If information contained in the 271 is different than the information submitted on the 270, the health plan updated that information with what was on file in their system.

Trouble Shooting Questions and Answers

This section of the 270-271 Companion Documents provides answers to commonly asked questions that may arise during the process of exchanging eligibility inquiries and responses.

1. What acknowledgment should we receive from health plans?

For those 270 transactions that are readable and HIPAA compliant, health plans will respond to the submitter as described in following table

Does the health plan . . .	FCHA	GHC	Premera	Asuris & Regence	WDS
Acknowledge receipt with a 997?	Only if there is an error in the 270	997 will only be returned if requested by Provider	Immediately upon receipt of the 270	Only if there is an error in the 270	No.
Respond with a 271?	Within 5 minutes	By close of the first business day following receipt of the 270.	By close of the first business day following receipt of the 270.	Within 5 minutes for RBS business. Out of state business may take up to 72 hours.	Within 1 minute

Per HIPAA regulations, if the information associated with any of the inquiries in the 270 ST-SE batch is not correctly formatted from a syntactical perspective, all inquiries between the ST-SE will be rejected. The health plan will notify the submitting organization of the file rejection via a 997 transaction, or other method agreed upon in the trading partner agreement. Providers should consider this possible response when determining how many inquiries they will submit in a single 270.

Note: Since Regence separates the batch of 270 inquires upon receipt, they will only reject the inquiries that are not correctly formatted. The entire 270 batch will not be rejected.

If a 997 shows a rejected batch or batches, the provider organization should fix the error and resend everything that was contained within the ST-SE of the rejected 270 transaction.

If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide and Addenda, AND there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction OR will contact the provider organization *via* phone/fax whenever possible. In this case, the batch is not processed.

2. What are some likely situations when a 271 response may be different than expected?

- a) **SITUATION:** There is a difference between information contained in the 270 and information the health plan has on file.

ACTION: The 271 response will always reflect the information that the health plan has on file

EXAMPLE: Member is identified in the 270 as a subscriber, but the health plan considers the member a dependent. The health plan will return a 271 response with the member identified as a dependent and the subscriber that they have on file identified as the subscriber.

- b) **SITUATION:** The health plan cannot reply to a 270 with a complete 271 because one or more of their systems are not operational.

ACTION: The health plan will reply with a 271 that contains a '42 – Unable to Respond at Current Time' in the AAA03 field and an 'R – Resubmission Allowed' in the AAA04 field of the first AAA segment at the Information Source Level.

- c) **SITUATION:** The health plan cannot uniquely match the person identified in the 270 to a person in their database because all of the required inquiry fields have not been completed.

ACTION: The health plan will reply with a 271 that contains a series of AAA segments right after the Subscriber Name Segment at the Subscriber Level. The first AAA segment will contain a '76 – Duplicate Subscriber/Insured ID Number' in the AAA03 field and a 'C – Please Correct and Resubmit' in the AAA04 field. Each subsequent AAA segment will identify the data field that is missing or incomplete using the AAA03 field. The associated AAA04 field will contain a 'C - Please Correct and Resubmit'

- d) **SITUATION:** The health plan will not be able to uniquely match the person identified in the 270 to a person in their database even if/when all of the required inquiry fields are completed.

ACTION: The health plan will reply with a 271 that contains an AAA segment right after the Subscriber Name Segment at the Subscriber Level. The AAA segment will contain a '76 – Duplicate Subscriber/Insured ID Number' in the AAA03 field and an 'N – Resubmission Not Allowed' in the AAA04 field. No subsequent AAA records will be provided. The end user should call the health plan on the phone to resolve this situation.

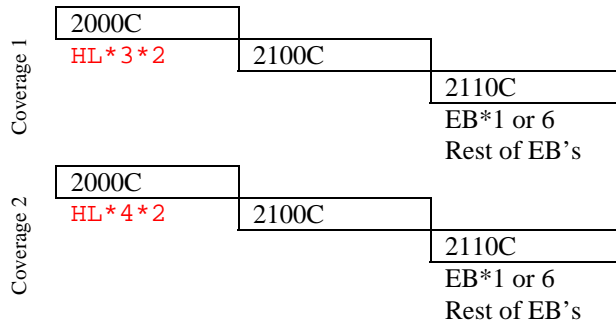
Appendices

- **Handling Dual Eligibility within the 271 Transaction**

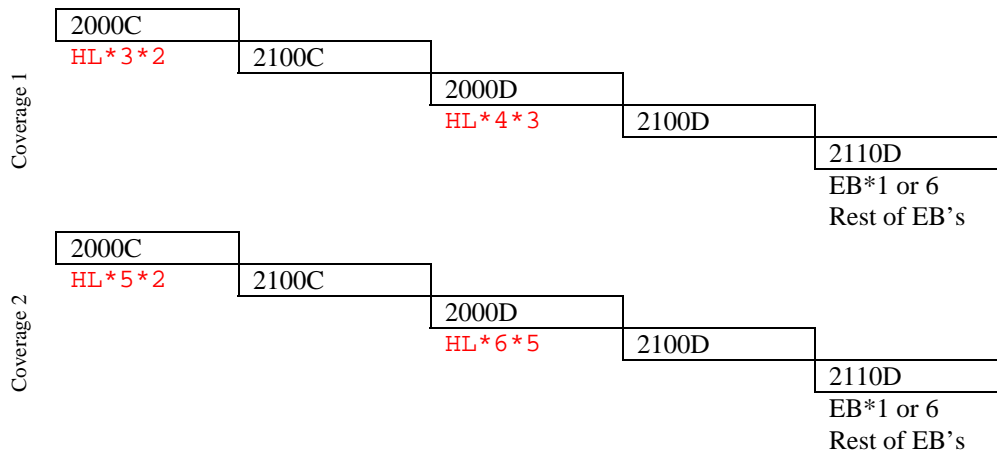
- **Scenarios**
 1. **Sample 270 - 271 Exchange Scenarios**
 - **Subscriber is the Patient – formatted in detail**
 2. **Sample 270 - 271 Exchange Scenarios**
 - ◆ **Subscriber is the patient**
 - ◆ **Dependent is the patient**
 3. **Sample 270 - 271 Exchange Scenarios**
 - ◆ **All 270s show subscriber as patient**
 - ◆ **271s show actual patient relationship - subscriber or dependent**

Note: These are intended as illustrations of how to code the transactions. They have not been tested as operational scenarios.

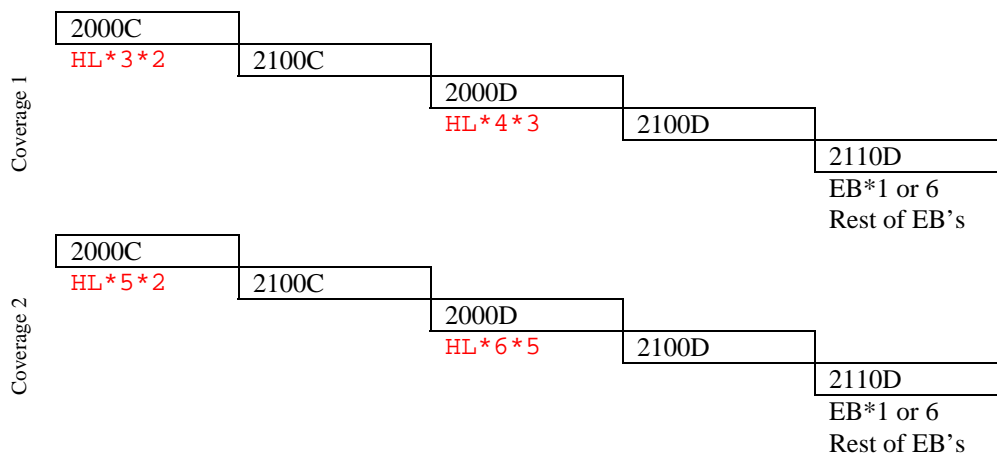
1) Dual Eligibility, patient is subscriber



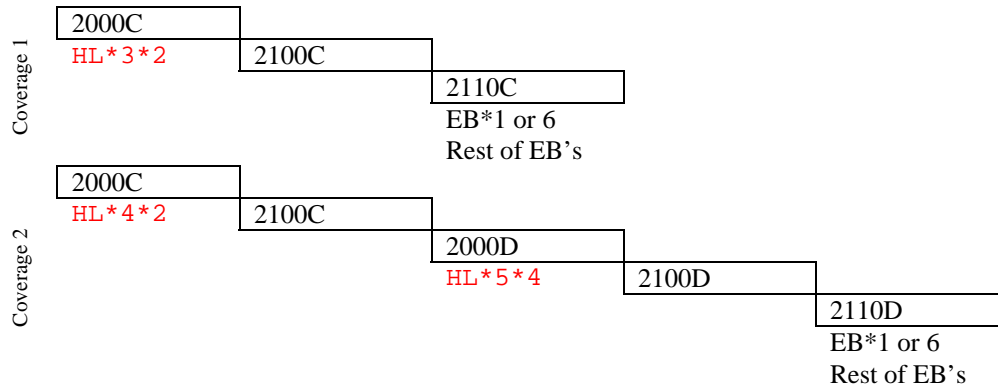
2) Dual Eligibility, patient is Dependent, 2 different Subscribers



3) Dual Eligibility, patient is Dependent, only 1 Subscriber



4) Dual Eligibility, patient is Subscriber first and Dependent second



270 Inquiry
Subscriber is the Patient – formatted in detail

TEXT DESCRIPTION OF SEGMENT	INPUT
Information Source Name- Entity ID Code	PR - Payer
Information Source Name- Entity Type Qualifier	2 - Non-Person
Information Source Name	Regence
Information Source Name- ID Code Qualifier	PI - Payor Identification
Information Source Name- ID Code	00932 - Primary Identifier
Information Receiver Name Entity ID Code	IP - Provider
Information Receiver Name Entity Type Qualifier	1 - Person
Information Receiver Name Last	Smith
Information Receiver Name First	John
Information Receiver Name ID Code Qualifier	FI - Federal Tax ID
Information Receiver Identification Code	911772233
Subscriber Trace Number Trace Type Code	Current - 1
Subscriber Trace Number Trace Number	00000014A
Subscriber Trace Number Orig Co. ID	9000000000
Entity Identifier Code	IL - Insured or Subscriber
Entity Type Qualifier	1 - Person
Subscriber Last Name	Jones
Subscriber First Name	Mary
Subscriber Middle Initial	A
Identification Code Qualifier	MI - Member Identification Code
Identification Code	123456789
Subscriber Demographic Info Date Format	D8 - CCYYMMDD
Subscriber Demographic Date of Birth	19680406
Subscriber Date Qualifier	307
Subscriber Date/Time Format Qualifier	D8 - CCYYMMDD
Subscriber Date/Time Period	20020930
Inquiry Info Service Type Code	1

ISA*00* *00* *ZZ*PRVDRSENDERID *ZZ*PAYERRCVRID
*010925*1647*U*00401*000000140*0*T*>~
GS*HS*PRVDRSENDERID*PAYERRCVRID*20021105*1647*1*X*004010X092~
ST*270*0001~
BHT*0022*13*00000014A*20021105*1128~
HL*1**20*1~
NM1*PR*2*REGENCE*****PI*00932~
HL*2*1*21*1~

NM1*1P*1*SMITH*JOHN****FI*911772233~
HL*3*2*22*0~
TRN*1*00000014A*9000000000~
NM1*IL*1*JONES*MARY*A***MI*123456789~
DMG*D8*19680406*F~
DTP*307*D8*20020930~
EQ*1~
SE*13*0001~
GE*1*1~
IEA*1*000000140~

271 Response
Subscriber is the Patient – formatted in detail

TEXT DESCRIPTION OF SEGMENT	OUTPUT
Information Source Name - Entity ID Code	PR = Payer
Information Source Name - Entity Type Qualifier	2 = Non-Person
Information Source Name	REGENCE BLUESHIELD
Information Source Name - ID Code Qualifier	PI = Payer ID
Information Source Name - ID Code	Primary Identifier = 00932
Information Source Contact Information	IC = Information Contact
Information Source Contact Name	Client Services
Communication Number Qualifier	ED = EDI
Communication number	206.464.3822
Communication Number Qualifier	TE = Telephone
Communication number	206.464.3823
Communication Number Qualifier	EM = Email
Communication Number	RBSTESTONLY.COM
Information Receiver Name Entity ID Code	1P = Provider
Information Reciever Name Entity Type Qlfr	1 = Person
Information Reciever Name Last	SMITH
Information Reciever Name First	JOHN
Information Reciever ID Code Qualifier	SV = Service Provider
Information Reciever Identification Code	911772233
Subscriber Trace Number Trace Type Code	1 = Current
Subscriber Trace Number Trace Number	00000014A
Subscriber Trace Number Orig Co. ID	9000000000
Subscriber Name Entity Identifier Code	IL = Insured or Subscriber
Subscriber Name Entity Type Qualifier	1 = Person
Subscriber Last Name	JONES
Subscriber First Name	MARY
Subscriber Midde Initial	A
Subscriber Name- Identification Code Qualifier	MI =Member Identification Code
Subscriber Name - Identification Code	123456789
Subscriber Additional Identification	
Subscriber Add'l Identification Reference Identification Qualifier	18 = Plan
Subscriber Name Reference Identification	932
Subscriber Name Reference Identification Qualifier	6P = Group Number
Subscriber Name Reference Identification	ABC123
Subscriber Name Reference Identification Description	SELECTIONS MEDICAL DRUG

TEXT DESCRIPTION OF SEGMENT	OUTPUT
	VISION
Subscriber Name Reference Identification Qualifier	IG = Insurance Policy Number
Subscriber NameReference Identification	222ABC
Subscriber Address Information- Address Line 1	4455 PLEASANT STREET
Subscriber Address Information- Address Line 2	APT 3B
City Name	SEATTLE
State	WA
Postal Code	980111234
Subscriber Name- Subscriber Demographic Information	
Subscriber Name -Date format	D8 = CCYYMMDD
Subscriber Name - Subscriber Date of Birth	19680406
Subscriber Name - Gender Code	F = Female
Subscriber Name - Subscriber Relationship Yes/NoResponse Code Insured Indicator	Y = Yes
Subscriber Name - Individual Relationship Code	18 = Self
Subscriber Eligibility or Benefit Information(EB01)	L = PCP
Subscriber - Service Type Code	1 = Medical Care
2100C Date Time Period Qualifier	295 = Primary Care Provider
2100C Date Time Period Qualifier Format	RD8
2100C Date Time Period	2002010120021231
2120C Subscriber Benefit Related Entity Name Identifier Code	P3 = Primary Care Physician
2120C Entity Type Qualifier	2 = Non-Person
2120C Last Name of Organization Name	SMITH JOHN
2120C Identification Code Qualifier	SV = Service Provider
2120C Identification Code	911772233SM111 POS
Eligibility or Benefit Information(EB01)	R = Other or Additional Payer
Subscriber Service Type Code	1 - Medical Care
2120C Subscriber Benefit Related Entity Name - Entity Identifier Code	PRP = Primary Payer
2120C Subscriber Entity Type Qualifier	2 = Non-Person
2120C Subscriber Last Name or Organizational Name	AETNA LIFE AND CSLTY COMP
2110C Message Text	For the Seattle plan, Current COB information shows that Regence is not primary
Subscriber Eligibility or Benefit Information (EB01)	1 = Active
Subscriber Eligibility or Benefit - Coverage Level	EM = Employee Only

TEXT DESCRIPTION OF SEGMENT	OUTPUT
Subscriber Service Type Code	1 = Medical Care
2110C Subscriber Eligibility Insurance Type	PS = Point of Service
2110C Subscriber Eligibility or Benefit Date Qualifier	307 = Eligibility
2110C Subscriber Eligibility or Benefit Date Format Qualifier	RD8 -CCYYMMDDCCYYMMDD
2110C Subscriber Eligibility or Benefit Date	2002010120021231
Subscriber Eligibility or Benefit Information (EB01)	B = CO-PAYMENT
Coverage Level Code	EMP = EMPLOYEE ONLY
Service Type Code	2 = SURGICAL
Plan Coverage Description	OUTPATIENT SURGERY COPAY
Time Period Qualifier	27 = VISIT
Monetary Amount	25.00
Subscriber Eligibility or Benefit Information (EB01)	B = CO-PAYMENT
Coverage Level Code	EMP = EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	MANAGED CARE
Time Period Qualifier	27 = VISIT
Monetary Amount	15.00
Subscriber Eligibility or Benefit Information(EB01)	B = CO-PAYMENT
Coverage Level Code	EMP = EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	COPAY - NON/MNGD
Time Period Qualifier	27 = VISIT
Monetary Amount	20.00
Subscriber Eligibility or Benefit Information (EB01)	C= DEDUCTIBLE
Coverage Level Code	EMP =EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	ANNUAL NON POINT OF SERVICE
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	100.00
Subscriber Eligibility or Benefit Information (EB01)	C= DEDUCTIBLE
Coverage Level Code	EMP =EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	ANNUAL NON POINT OF SERVICE
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	100.00
Quantity Qualifier	99 = Quantity Used
Quantity Qualifier	100.00

TEXT DESCRIPTION OF SEGMENT	OUTPUT
Subscriber Eligibility or Benefit Information(EB01)	C = DEDUCTIBLE
Coverage Level Code	FAM = FAMILY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	ANNUAL NON POINT OF SERVICE
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	300.00
Subscriber Eligibility or Benefit Information(EB01)	B = CO-PAYMENT
Coverage Level Code	EMP = EMPLOYEE ONLY
Service Type Code	52 = HOSPITAL EMERGENCY MEDICAL
Plan Coverage Description	EMERGENCY ROOM
Time Period Qualifier	27 = VISIT
Monetary Amount	75.00
Subscriber Eligibility or Benefit Information (EB01)	A= CO-INSURANCE
Coverage Level Code	EMP =EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	IN NETWORK
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	100%
In Plan Indicator	Y = Yes In Plan
Subscriber Eligibility or Benefit Information(EB01)	A = CO-INSURANCE
Coverage Level Code	FAM = FAMILY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	EXT NETWORK
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	300.00
Subscriber Eligibility or Benefit Information (EB01)	A= CO-INSURANCE
Coverage Level Code	EMP =EMPLOYEE ONLY
Service Type Code	1 = MEDICAL CARE
Plan Coverage Description	OUT OF AREA
Time Period Qualifier	23 = CALENDAR YEAR
Monetary Amount	100%
In Plan Indicator	U = UNKNOWN IF PART OF NETWORK

ISA*00* *00* *ZZ*PAYERSENDERID *ZZ*PRVDRRCVRID
 *021119*1114*U*00401*000000159*0*T*>~

GS*HB*PAYERSENDERID*PRVDRRCVVID*20021119*1114*159*X*004010X092~
 ST*271*0001~
 BHT*0022*11*200211191151540781*20021119*11515511~
 HL*1**20*1~
 NM1*PR*2*REGENCE BLUE SHIELD*****PI*00932~
 PER*IC*CLIENT
 SERVICES*ED*206.464.3822*TE*206.464.3823*EM*RBSTESTONLY.COM~
 HL*2*1*21*1~
 NM1*1P*1*SMITH*JOHN****SV*91172233~
 HL*3*2*22*0~
 TRN*1*00000014A*9000000000~
 NM1*IL*1*JONES*MARY*A***MI*123456789~
 REF*18*932~
 REF*6P*ABC123*SELECTIONS Medical Drug Vision~
 REF*IG*222ABC~
 N3*4455 PLEASANT STREET*APT 3B~
 N4*SEATTLE*WA*980111234~
 DMG*D8*19680406*F~
 INS*Y*18~
 EB*L**1~
 DTP*295*RD8*2002010120021231~
 LS*2120~
 NM1*P3*2*SMITH JOHN*****SV*911772233SM111 POS~
 LE*2120~
 EB*R**1~
 NM1*PRP*2*AETNA LIFE AND CSLTY COMP~
 MSG*For the Seattle plan, Current COB information shows that Regence is not primary~
 EB*1*EMP*1*PS~
 DTP*307*RD8*2002100120021230~
 EB*B*EMP*2**OUTPATIENT SURGERY COPAY*27*25~
 EB*B*EMP*1**COPAY MANAGED CARE*27*15~
 EB*B*EMP*1**COPAY-NON/MNGD*27*20~
 EB*C*EMP*1**ANNUAL NON POINT OF SERVI*23*100*****N~
 EB*C*EMP*1**ANNUAL NON POINT OF SERVI*23*100**99*100**N~
 EB*C*FAM*1**ANNUAL NON POINT OF SERVI*23*300*****N~
 EB*B*EMP*52**EMERGENCY ROOM*27*75~
 EB*A*FAM*1**IN NETWORK**100*****Y~
 EB*A*FAM*1**EXT NETWORK**60*****N~
 EB*A*FAM*1**OUT OF AREA**80*****U~
 SE*52*0001~
 GE*1*159~
 IEA*1*000000159~

270 Inquiry
Subscriber is the Patient & Dependent in the Patient

```

ISA*00*                *00*                *ZZ*910214500          *ZZ*910511770
*050413*0629*U*00401*000103001*1*T*::~~
GS*HS*910214500*910511770*20050413*0629*103001*X*004010X092A1~
ST*270*000103001~
BHT*0022*13*000103001*20050413*0629~

HL*1**20*1~
NM1*PR*2*GHC REFERRAL SECOND*****PI*91051~
HL*2*1*21*1~
NM1*1P*2*THE EVERETT CLINIC*****FI*910214500~
REF*N5*018277~
PER*IC*THE EVERETT CLINIC*TE*4253173930~

HL*3*2*22*0~
TRN*1*H00014566871D20050413T00001040*9000000000~
NM1*IL*1*Doe*John*T***MI*166591~
N3*3213 WETMORE AVE APT 10~
N4*EVERETT*WA*98201~
DMG*D8*19241016*M~
DTP*307*D8*20050413~
EQ*1~

HL*4*2*22*1~
NM1*IL*1*BUNNY*DARLIN*L***MI*00294285~
N3*112 SKYLINE DR~
N4*EVERETT*WA*98201~
DMG*D8*19360923*F~
HL*5*4*23*0~
TRN*1*H00010350445D20050413T00001530*9000000000~
NM1*03*1*BUNNY*BUGS*H~
REF*N6*00294285~
N3*112 SKYLINE DR~
N4*EVERETT*WA*98201~
DMG*D8*19330713*M~
DTP*307*D8*20050413~
EQ*1~

```

Information Source

Information Receiver
ID Number

Information Contact

Subscriber is Patient

Subscriber

Subscriber Birth date
Eligibility Date
Service Type: Medical Care

Dependent is the patient
Subscriber

Subscriber Birth date

Dependent
Plan Network Ident Number

Dependent Birth date
Eligibility Date
Service Type: Medical Care

SE*31*000103001~

GE*1*103001~
IEA*1*000103001~

271 Response
Subscriber is the Patient & Dependent in the Patient

```

ISA*00*                *00*                *ZZ*910511770          *ZZ*910214500
*050415*1026*U*00401*000000001*0*T*::~~
GS*HB*910511770*910214500*20050415*102603*1*X*004010X092A1~
ST*271*00000003~
BHT*0022*11*000103001*20050415*102603~
                                     Subscriber is the Patient

HL*1**20*1~
NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~   Information Source
HL*2*1*21*1~
NM1*1P*2*THE EVERETT CLINIC*****FI*910214500~         Information Receiver

HL*3*2*22*0~
TRN*2*H00014566871D20050413T00001040*9000000000~
NM1*IL*1*DOE*JOHN*T***MI*00166591~                      Subscriber
REF*SY*539205722~                                        Patient SSN
REF*F6*539205722A~                                       Insurance Claim(HIC) Number
REF*6P*0056200*FEDERAL ANNUIT HIGH OPT~                 Group Number & Name
REF*18*NA*GHC MEDICARE COB~                              Plan Number & Name
N3*5120 COLBY AVE*APT 14~
N4*EVERETT*WA*98203~
PER*IC**WP*4253880700~                                  Contact Information Work Phone
DMG*D8*19241016*M~                                      Subscriber Birth Date
INS*Y*18~                                                Insured Indicator & Relationship
Self
DTP*472*D8*20050413~                                    Service Date
EB*1**30*MP~                                             Coverage - Medicare Primary
DTP*356*D8*20010101~                                    Eligibility Coverage Begin Date
EB*L~                                                    Primary Care Provider
DTP*295*D8*20001003~                                    Primary Care Provider Begin Date
LS*2120~                                                Subscriber Related Information
NM1*1P*1*MCELHANEY*SEAN*K~                              Primary Care Physician
N3*EVERETT MEDICAL CENTER~                              Provider Medical Center Name
PER*IC**TE*4252611773~                                  Information Contact, Telephone,
LE*2120~
EB*C*****0~                                           Deductible
EB*B**98****0~                                         Co-Pay Office Visit
EB*B**48****0~                                         Co-Pay Inpatient
EB*B**86****0~                                         Co-Pay Emergency Room
EB*B**88****50~                                        Co-Pay Prescription Drug
EB*B**92****15~                                        Co-Pay Generic Prescription Drug
EB*B**91****25~                                        Co-Pay Brand Name Presc. Drug
SE*36*00000003~

ST*271*00000022~
BHT*0022*11*000103001*20050415*102603~
                                     Dependent is the Patient
HL*1**20*1~
NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~   Information Source
HL*2*1*21*1~
NM1*1P*2*THE EVERETT CLINIC*****FI*910214500~         Information Receiver
HL*3*2*22*1~
NM1*IL*1*BUNNY*DARLIN*****MI*00294286~                Subscriber

```

HL*4*3*23*0~
 TRN*2*H00010350445D20050413T00001530*9000000000~
 NM1*03*1*BUNNY*BUGS*H***MI*00294285~ *Dependent*
 REF*SY*539301685~ *Patient SSN*
 REF*F6*539301685A~ *Health Ins. Claim(HIC) Number*
 REF*6P*0100300*PEBB RETIREES WEST~ *Group Number & Name*
 REF*18*NA*GROUP HEALTH COOPERATIVE~ *Plan Number & Name*
 N3*112 SKYLINE DR~
 N4*EVERETT*WA*98201~
 PER*IC**WP*4252591505~ *Contact Information Work Phone*

DMG*D8*19330713*M~ *Dependent Birth date*
 INS*N*01~ *Insured Relationship - Spouse*
 DTP*472*D8*20050413~ *Service Date*
 EB*1**30**MEDICARE LOCK-IN~ *Plan Coverage - Medicare Lock In*
 DTP*356*D8*20020901~ *Eligibility Coverage Begin Date*
 EB*L~ *Primary Care Provider*
 DTP*295*D8*20001003~ *Primary Care Provider Begin Date*
 LS*2120~
 NM1*1P*1*MCELHANEY*SEAN*K~ *Primary Care Physician*
 N3*EVERETT MEDICAL CENTER~ *Provider Medical Center Name*
 PER*IC**TE*4252611773~ *Information Contact, Telephone*
 LE*2120~
 EB*C*****0~ *Deductible*
 EB*B**98****10~ *Co-Pay Office Visit*
 EB*B**48****0~ *Co-Pay Inpatient*
 EB*B**86****50~ *Co-Pay Emergency Room*
 EB*B**92****10~ *Co-Pay Generic Prescription Drug*
 EB*B**91****30~ *Co-Pay Brand Name Presc. Drug*
 SE*37*00000022~
 GE*2*1~
 IEA*1*000000001~

EB*B**98****5~
 EB*B**48****0~
 EB*B**86****50~
 EB*B**88****5~
 SE*26*0000020~

Co-Pay Office Visit
Co-Pay Inpatient
Co-Pay Emergency Room
Co-Pay Pharmacy

ST*271*00000037~
 BHT*0022*11*0001*20050505*152340~
 HL*1**20*1~
 NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~
 HL*2*1*21*1~
 NM1*1P*2*MARY LOU TEST*****FI*911111111~
 HL*3*2*22*1~
 NM1*IL*1*HENSRUD*BONNIE*K***MI*01944376~
 HL*4*3*23*0~
 NM1*03*1*HENSRUD*PATRICK*L***MI*01944392~
 REF*SY*534365926~

Dependant is Patient – Spouse has two Plans

Information Source
Information Receiver
Subscriber
Dependent
SSN

REF*6P*0345100*FACTORY MUTUAL~
 REF*18*NA*GROUP HEALTH COOPERATIVE~
 N3*10510 TIETON DR~
 N4*YAKIMA*WA*98908~
 PER*IC**WP*5099661269~
 DMG*D8*19390412*M~
 INS*N*01~
 DTP*472*D8*20050504~
 EB*1**30~
 DTP*356*D8*20041001~
 EB*C*****0~
 EB*B**98****0~
 EB*B**48****0~
 EB*B**86****0~
 EB*B**88****0~
 HL*5*2*22*1~
 NM1*IL*1*HENSRUD*BONNIE*K***MI*01944376~
 HL*6*5*23*0~
 NM1*03*1*HENSRUD*PATRICK*L***MI*01944392~
 REF*SY*534365926~
 REF*6P*6801100*WASHINGTON ASSOCIATION OF~

Primary Coverage
Group Number Group Name
Plan Number Plan Name

Information Contact, Work Phone Number
Patient Birth Date
Insured Indicator & Relationship Spouse
Service Date
Active Coverage, Plan Coverage
Eligibility Coverage Begin Date
Deductible
Co-Pay Office Visit
Co-Pay Inpatient
Co-Pay Emergency Room
Co-Pay Pharmacy

Subscriber

Dependent
SSN
Group Number Group Name

REF*18*NA*OPTIONS~
 N3*10510 TIETON DR~
 N4*YAKIMA*WA*98908~
 PER*IC**WP*5099661269~
 DMG*D8*19390412*M~
 INS*N*01~
 DTP*472*D8*20050504~
 EB*1**30**OON~
Network Benefits
 DTP*356*D8*19991201~
 EB*C*****500~
 EB*B**98****0~
 EB*B**48****0~
 EB*B**86****0~
 EB*B**88****0~
 SE*47*00000037~

Secondary Coverage
Plan Number Plan Name

Information Contact, Work Phone Number
Patient Birthdate
Insured Indicator & Relationship Spouse
Service Date
Active Coverage, Plan Coverage & Out of

Eligibility Coverage Begin Date
Deductible
Co-Pay Office Visit
Co-Pay Inpatient
Co-Pay Emergency Room
Co-Pay Pharmacy

ST*271*00000057~ **Dependent is Patient - Parents have two separate plans**
 BHT*0022*11*0001*20050505*152340~
 HL*1**20*1~
 NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~ *Information Source*
 HL*2*1*21*1~
 NM1*1P*2*MARY LOU TEST*****FI*911111111~ *Information Receiver*
 HL*3*2*22*1~
 NM1*IL*1*DEPENDENT*GHCSIX*****MI*02312680~ *Subscriber*
 HL*4*3*23*0~
 NM1*03*1*TEST*FIFTEENCOB*****MI*02321806~ *Dependent*
 REF*SY*320105660~ *SSN*

Primary Coverage
 REF*6P*0024400*7-ELEVEN FRANCHISE~ *Group Number Group Name*
 REF*18*NA*GROUP HEALTH COOPERATIVE~ *Plan Number Plan Name*
 N3*12401 E MARGINAL WAY~
 N4*SEATTLE*WA*98168~
 DMG*D8*20030102*F~ *Patient Birthdate*
 INS*N*19~ *Insured Indicator & Relationship - Child*
 DTP*472*D8*20050504~ *Service Date*
 EB*1**30~ *Active Coverage, Plan Coverage*
 DTP*356*D8*20041001~ *Eligibility Coverage Begin Date*
 EB*C*****0~ *Deductible*
 EB*B**98****0~ *Co-Pay Office Visit*
 EB*B**48****0~ *Co-Pay Inpatient*
 EB*B**86****0~ *Co-Pay Emergency Room*
 EB*B**88****0~ *Co-Pay Pharmacy*
 HL*5*2*22*1~
 NM1*IL*1*LARGE*SUB*****MI*02260061~ *Subscriber*
 HL*6*5*23*0~
 NM1*03*1*TEST*FIFTEENCOB*****MI*02321806~ *Dependent*
 REF*SY*320105660~ *SSN*
 REF*6P*6000500*STUDIO 36~ *Group Number Group Name*

Secondary Coverage
 REF*18*NA*OPTIONS~ *Plan Number Plan Name*
 N3*12401 E MARGINAL WAY~
 N4*SEATTLE*WA*98168~
 DMG*D8*20030102*F~ *Patient Birthdate*
 INS*N*19~ *Insured Indicator & Relationship Child*
 DTP*472*D8*20050504~ *Service Date*
 EB*1**30**OON~ *Active Coverage, Plan Coverage & Out of*
Network Coverage
 DTP*356*D8*20041001~ *Eligibility Coverage Begin Date*
 EB*C*****0~ *Deductible*
 EB*B**98****0~ *Co-Pay Office Visit*
 EB*B**48****0~ *Co-Pay Inpatient*
 EB*B**86****0~ *Co-Pay Emergency Room*
 EB*B**88****0~ *Co-Pay Pharmacy*
 SE*45*00000057~

ST*271*00000077~
 BHT*0022*11*0001*20050505*152340~
 HL*1**20*1~
 NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~ *Information Source*
 HL*2*1*21*1~
 NM1*1P*2*MARY LOU TEST*****FI*911111111~ *Information Receiver*
 HL*3*2*22*1~
 NM1*IL*1*LARGE*SUB*****MI*02260061~ *Subscriber*
 HL*4*3*23*0~
 NM1*03*1*LARGE*CHILDONE*****MI*02260063~ *Dependent*

Primary Coverage

REF*6P*0481400*GROUP HEALTH COOPERATIVE~ *Group Number Group Nam*
 REF*18*NA*GROUP HEALTH COOPERATIVE~ *Plan Number Plan Name*
 N3*1730 MINOR~
 N4*SEATTLE*WA*98101~
 DMG*D8*19900319*M~ *Patient Birthdate*
 INS*N*19~ *Insured Indicator & Relationship – Child*
 DTP*472*D8*20050504~ *Service Date*
 EB*1**30~ *Active Coverage, Plan Coverage*
 DTP*356*D8*20050401~ *Eligibility Coverage Begin Date*
 EB*C*****0~ *Deductible*
 EB*B**98****0~ *Co-Pay Office Visit*
 EB*B**48****0~ *Co-Pay Inpatient*
 EB*B**86****0~ *Co-Pay Emergency Room*
 EB*B**88****0~ *Co-Pay Pharmacy*
 HL*5*2*22*1~
 NM1*IL*1*LARGE*SUB*****MI*02260061~ *Subscriber*
 HL*6*5*23*0~
 NM1*03*1*LARGE*CHILDONE*****MI*02260063~ *Dependent*
 REF*6P*6000500*STUDIO 36~ *Group Number Group Name*

Secondary Coverage

REF*18*NA*OPTIONS~ *Plan Number Plan Name*
 N3*1730 MINOR~
 N4*SEATTLE*WA*98101~
 DMG*D8*19900319*M~
 INS*N*19~ *Patient Birthdate*
 DTP*472*D8*20050504~ *Insured Indicator & Relationship Child*
 EB*1**30**OON~ *Service Date*
 Network Coverage *Active Coverage, Plan Coverage & Out of*
 DTP*356*D8*20010601~ *Eligibility Coverage Begin Date*
 EB*C*****0~ *Deductible*
 EB*B**98****0~ *Co-Pay Office Visit*
 EB*B**48****0~ *Co-Pay Inpatient*
 EB*B**86****0~ *Co-Pay Emergency Room*
 EB*B**88****0~ *Co-Pay Pharmacy*
 SE*43*00000077~

ST*271*00000097~
 BHT*0022*11*0001*20050505*152340~
 HL*1**20*1~
 NM1*PR*2*GROUP HEALTH COOPERATIVE*****PI*910511770~
 HL*2*1*21*1~
 NM1*1P*2*MARY LOU TEST*****FI*911111111~
 HL*3*2*22*0~
 NM1*IL*1*PETERSON*REBECCA*Y***MI*02316643~
 REF*SY*002366872~
 REF*6P*5162800*AMICABLE HEALTHCARE INC~

Subscriber is Patient on 1st Plan & Dependent on 2nd Plan

Information Source

Information Receiver

Subscriber

SSN

Group Number Group Name

Primary Coverage

Plan Number Plan Name

REF*18*NA*ALLIANT SELECT~
 N3*4213 SANDPOINT WAY~
 N4*SEATTLE*WA*98101~
 DMG*D8*19430101*F~
 INS*Y*18~
 DTP*472*D8*20050504~
 EB*1**30~
 DTP*356*D8*20050101~
 EB*L~
 DTP*295*D8*20030429~
 LS*2120~
 NM1*1P*1*CERVENKA*FRANK*J~
 N3*RENTON MEDICAL CENTER~
 PER*IC**TE*4252352833~
 LE*2120~

Patient Birthdate

Insured Indicator & Relationship – Self

Service Date

Active Coverage, Plan Coverage

Eligibility Coverage Begin Date

Primary Care Physician

Physician selected date

Beginning Subscriber Information Loop

Provider Name

Provider Medical Center Name

Address

EB*C*****0~
 EB*B**98****0~
 EB*B**48****0~
 EB*B**86****0~
 EB*B**88****0~

Deductible

Co-Pay Office Visit

Co-Pay Inpatient

Co-Pay Emergency Room

Co-Pay Pharmacy

HL*4*2*22*1~
 NM1*IL*1*PARKER*BOB****MI*02322845~
 HL*5*4*23*0~
 NM1*03*1*PETERSON*REBECCA*Y***MI*02316643~
 REF*SY*002366872~
 REF*6P*0481400*GROUP HEALTH COOPERATIVE~

Subscriber

Dependent

SSN

Group Number Group Name

Secondary Coverage

Plan Number Plan Name

REF*18*NA*GROUP HEALTH COOPERATIVE~
 N3*4213 SANDPOINT WAY~
 N4*SEATTLE*WA*98101~
 DMG*D8*19430101*F~
 INS*N*01~
 DTP*472*D8*20050504~
 EB*1**30~
 DTP*356*D8*20050401~
 EB*L~
 DTP*295*D8*20030429~
 LS*2120~
Loop
 NM1*1P*1*CERVENKA*FRANK*J~
 N3*RENTON MEDICAL CENTER~
 PER*IC**TE*4252352833~
 LE*2120~
 EB*C*****0~
 EB*B**98****0~

Patient Birthdate

Insured Indicator & Relationship Spouse

Service Date

Active Coverage, Plan Coverage

Eligibility Coverage Begin Date

Primary Care Physician

Physician selected date

Beginning Subscriber Related Information

Primary Care Physician

Provider Medical Center Name

Information Contact, Telephone, Phone #

Deductible

Co-Pay Office Visit

EB*B**48***0~
EB*B**86***0~
EB*B**88***0~
SE*57*00000097~

Co-Pay Inpatient
Co-Pay Emergency Room
Co-Pay Pharmacy

GE*6*1~
IEA*1*000000001~