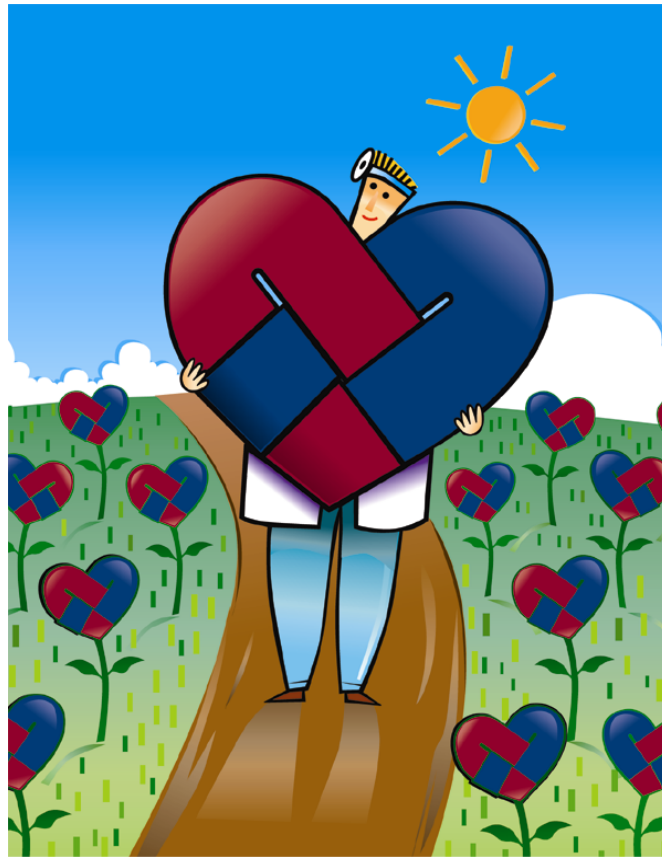


# Manual for HealthLink 27X Series Transactions



## Companion Guide for Payors

- ANSI X12N Implementation Guide 004010X092A1: 270 – Eligibility Request
- ANSI X12N Implementation Guide 004010X092A1: 271 – Eligibility Response
- ANSI X12N Implementation Guide 004010X093A1: 276 – Claim Status Request
- ANSI X12N Implementation Guide 004010X093A1: 277 – Claim Status Response

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## Introduction

### Scope of Companion Document

This Companion Document to the ASCX12N Implementation Guides is adopted under HIPAA. This document clarifies and specifies the data content when exchanging eligibility and claim status transactions electronically with HealthLink. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both the X12 syntax and those guidelines.

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 is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides. HealthLink, NCPPO and AHI eligibility and claim status requests/responses are sent in the following formats:

Transaction Type	Description of Transaction Type	HIPAA Format	Description of HIPAA Format
<b>270 Transactions</b> (Eligibility Request)	Payors Receive Electronic Eligibility Requests From HealthLink's Networks' Providers	ANSI 004010X092A1	Implementation Guide With Addenda
<b>271 Transactions</b> (Eligibility Response)	Payors Respond to Electronic Eligibility Requests From HealthLink's Networks' Providers	ANSI 004010X092A1	Implementation Guide With Addenda
<b>276 Transactions</b> (Claim Status Request)	Payors Receive Electronic Claim Status Requests From HealthLink's Networks' Providers	ANSI 004010X093A1	Implementation Guide With Addenda
<b>277 Transactions</b> (Claim Status Response)	Payors Respond to Electronic Claim Status Requests From HealthLink's Networks' Providers	ANSI 004010X093A1	Implementation Guide With Addenda

### Applicability of Companion Document

This Companion Guide is designed to assist Payors on implementing and understanding eligibility (270) and claim status (276) requests, as created by HealthLink within the web portal, from NCPPO and Affiliated Healthcare Inc. (AHI) PPO providers. This Guide is also designed to assist Payors on generating eligibility (271) and claim status (277) responses to those requests. This guide supplements information in and should be read in conjunction with the X12 Implementation Guides.

# 1 270 Transactions (Eligibility Request)

## 1.1 ISA Information

The following information is used in the primary EDI envelope structure.

### 1.1.1 Sender ID

This is HealthLink’s EDI identification number. HealthLink will use the same Sender ID for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....ISA06
- Sender ID: .....“900010001”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA06	Sender ID	“900010001”	PPO Sender ID

### 1.1.2 Sender ID Qualifier

This is a two-digit code that relays the type of identifier being sent. HealthLink will use the same Sender ID Qualifier for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....ISA05
- Sender ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA05	Sender ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

### 1.1.3 Receiver ID

This identifier represents the Payor in the transaction envelope. HealthLink will expect the Trading Partner ID to be one of the allowed HIPAA Identifier Types. This identifier must be established prior to EDI implementation.

- This information will be sent in: .....ISA08
- Receiver ID: .....<Payor’s ID> (Varies by Trading Partner)

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA08	Receiver ID	<Payor’s ID> (Varies by Trading Partner)	It is expected that Identifiers will adhere to the standard format applicable to the 837 ECMAP value.

**1.1.4 Receiver ID Qualifier**

This is a two-digit code that relays the type of identifier being sent. This qualifier must be established prior to EDI implementation.

- This information will be sent in: .....ISA07
- Receiver ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA07	Receiver ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

**1.1.5 Acknowledgement Requests**

HealthLink will not request Acknowledgement for Eligibility transactions, whether sent in real time or batch format.

- This information will be sent in: .....ISA14
- Acknowledgement Requests:.....“0”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA14	Acknowledgement Requests	“0”	A value of “0” (zero) will be sent in this field indicating that no acknowledgement is requested.

**1.2 GS Information**

The following information is used in the EDI envelope sub-grouping structure

**1.2.1 Application Sender Code**

This code is used to identify the unit sending the transaction. HealthLink will use the same Application Sender Code for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....GS02
- Application Sender Code:.....<Same Value as Element ISA06>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS02	Application Sender Code	<Same Value as Element ISA06>	

### 1.2.2 Application Receiver Code

This information is usually used to define routing for sending the eligibility response to a department inside the receiver organization (For example, **GS03** would be used to send the eligibility response to the **Customer Service** department of **XYZ Organization**). Please provide HealthLink with the appropriate code prior to transaction implementation.

- This information will be sent in: .....GS03
- Application Receiver Code: .....<Same Value as Element **ISA08**>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS03	Application Receiver Code	<Same Value as Element <b>ISA08</b> >	

### 1.3 Information Receiver Level

The following information will identify the Entity requesting the Eligibility information, typically the provider. The specific location of the data within the transaction is indicated in parentheses.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM102	2100B	Entity Type Qualifier	Available Identifier types are: "1" Person "2" Non-Person	"1" when first name is used "2" for Facility
NM103	2100B	Organization or Last Name	<Provider Name>	Length is 1-35 characters.
NM104	2100B	First Name	<Provider First Name>	Length is 1-25 characters.
NM105	2100B	Middle Name	<Provider Middle Name>	Length is 1-25 characters.
NM101	2100B	Organization Type	"1P" = (Provider) "FA" = (Facility)	(Provider or Facility)
NM109	2100B	Entity Identifier	<Provider's TIN>	(Requesting Provider's Tax Identification Number)
NM108	2100B	Entity ID Qualifier	Available Identifier types are: "FI" = (Federal TaxPayor's Identification Number)	
REF01	2100B	Provider Identifier Qualifier	Additional Identifier types are: "N5" = (Provider Plan Network) (Identification Number)	Six-digit HealthLink Provider ID.

### 1.4 Information Source Level

The following information is required for the EDI transaction. This varies by Trading Partner and is the Payor's ID.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100A	Organization Name	<Payor's Name>	Provides the name of the Payor. Length is 1-35 characters.
NM101	2100A	Organization Type	Available types are: "PR"= (Payor)	Identifies the type of Trading Partner.
NM109	2100A	Entity Identifier	(Payor ID)	Identifies the receiving entity in the 270 transaction.
NM108	2100A	Entity ID Qualifier	"PI"= (Payor Identification)	Indicates the type of identifier being sent. Only one qualifier should be used, "PI".

### 1.5 Identifying the Patient

HealthLink supports the functionality recommended by the HIPAA Eligibility Implementation Guide for identifying the patient in the provider's request. The Guide states that the maximum data elements that can be required for the identification of a patient are:

Data Element
Patient's Member ID
Patient's First Name
Patient's Last Name
Patient's Date of Birth

### 1.6 Subscriber Information

The following information will always be sent for the subscriber. Please refer to the Implementation Guide, section 1.3.8, for more information on **Subscriber Information**.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100C	Subscriber First Name		Use this name if the subscriber is the patient and if utilizing the HIPAA search option. Format is 1/25 A/N characters.
NM103	2100C	Subscriber Last Name		Use this name if the subscriber is the patient and if utilizing the HIPAA search option. Format is 1/35 A/N characters.
NM105	2100C	Subscriber Middle Name		Format is 1/25 A/N characters.
NM109	2100C	Subscriber Identifier		The appropriate subscriber ID should be established between the provider and the receiving entity. Format is 2/80 A/N characters.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM108	2100C	Subscriber ID Qualifier	Available ID types are: "MI" = (Member Identification Number)	"MI" will be used here.
DMG02	2100C	Subscriber Date of Birth	Expected in format: "CCYYMMDD"	DMG01 = D8
REF01	2100C	Subscriber Reference ID Qualifier	Available ID types are: "SY" = Social Security Number "1L" = Group or Policy Number "18" = Plan Number	HealthLink may send up to three additional ID REF segments containing SSN, Health Plan, HealthLink ID (HIPAA Privacy Number)

## 1.7 Dependent Information

The following information will be sent when the dependent is the subject of the eligibility request.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100D	Dependent First Name		Format is 1/25 A/N characters.
NM103	2100D	Dependent Last Name		Format is 1/35 A/N characters.
NM105	2100D	Dependent Middle Name		Format is 1/25 A/N characters.
DMG02	2100D	Dependent Date of Birth	(CCYYMMDD)	DMG01 = D8

## 1.8 Trace Number

The Eligibility Request transaction will include unique identifier information at either the Subscriber level (2000C) or Dependent level (2000D), depending on which individual is the subject of the request. The following details the information that will be sent.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
TRN01	2000C/D	Trace Type	"1"	A value of "1" will be sent.
TRN02	2000C/D	Transaction Trace Number		This should be a unique identifier assigned by HealthLink. Format is 1/30 A/N characters.
TRN03	2000C/D	Originating Company Identifier	"1900010001"	This will be a "1" (one) followed by HealthLink's EIN "900010001" Number. (i.e. – 1900010001). Format is 10 A/N characters.
TRN04	2000C/D	Additional Trace Identifier	Not populated.	This field will not be populated.

## 1.9 Request Specific Information

The provider will have the ability to request detailed eligibility information. This information can be requested at either the subscriber or dependent loop level, depending on which is the subject of the request. All Eligibility Requests will contain, at a minimum, a generic request for eligibility that is made by submitting a service type code (EQ01) of '30'. HealthLink will send an additional EQ Loop with a Service Type Code (EQ01) = "60" (General Benefits).

The following identifies the levels of detail which will and will not be supported.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Level of Detail Supported
EQ01	2110C/D	Service Type Requests	Service Type codes: "30" = (Health Benefit Plan Coverage) "60" = (General Benefits)	All requests will contain two EQ Loops, a Service Type code "30" (Health Benefit Coverage), and a Service Type code "60" (General Benefits).
DTP02	2110C/D	Date Specific Information	Values Indicated by DTP01.  Single Date Format: "CCYYMMDD"  Date Range Format: "CCYYMMDD-CCYYMMDD"	These dates will indicate the Eligibility dates as indicated by the Date Qualifier (2110C/D DTP01). The dates may be sent as either a single date (CCYYMMDD) or a range of dates (CCYYMMDD-CCYYMMDD).
DTP01	2110C/D	Date/Time Qualifier	"307" – (Eligibility)	
EQ02	2110C/D	Procedure Code Requests	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.
EQ03	2110C/D	Coverage Level Codes	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.
EQ04	2110C/D	Insurance Type Code	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.
AMT02	2110C/D	Spend Down Amounts	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.
III02	2110C/D	Diagnosis Code Specific Requests	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.
REF02	2110C/D	Prior Auth./Referral Numbers	N/A	This level of detail is <u>not</u> currently supported in the eligibility request.

## 1.10 Provider Information

The provider initiating the request through the HealthLink Portal will be identified in the 2100B Information Receiver loop. See section 1.4 for additional details.

## 1.11 Transmission Methods

- **FTP Push**

HealthLink can 'push' eligibility transactions to your organization via FTP. This may require the use of PGP encryption software.

- **FTP Pull**

Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pick up their eligibility transactions from their mailbox. HealthLink prefers that PGP encryption is used.

## 1.12 EDI Problems

If your organization encounters electronic issues, please contact:

- HealthLink's Information Technology Help Desk at (314) 989-6123 (all clients), or [helpdesk@healthlink.com](mailto:helpdesk@healthlink.com).

Payor Relations at (877) 284-0101, ext 6132 (for Payors), or [PayorRelations@HealthLink.com](mailto:PayorRelations@HealthLink.com), or the specific account manager's email address.

## 2 271 Transactions (Eligibility Response)

### 2.1 ISA Information

The following information is used in the primary EDI envelope structure.

#### 2.1.1 Sender ID

This identifier represents the Payor in the transaction envelope. HealthLink will expect the Trading Partner ID to be one of the allowed HIPAA Identifier Types. This identifier must be established prior to EDI implementation.

- This information will be sent in: .....ISA06
- Sender ID: .....<Payor's ID> (Varies by Trading Partner)

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA06	Sender ID	<Payor's ID>	Value varies by Trading Partner. It is expected that Identifiers will adhere to the standard format applicable to the 837 ECMAP Value.

#### 2.1.2 Sender ID Qualifier

This is a two-digit code that relays the type of identifier being sent. This qualifier must be established prior to EDI implementation.

- This information will be sent in: .....ISA05
- Sender ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA05	Sender ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

#### 2.1.3 Receiver ID

This is HealthLink’s EDI identification number. It is expected that the Payor will return HealthLink's Sender ID from the Eligibility Request in this field.

- This information will be sent in: .....ISA08
- Receiver ID: .....“900010001”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA08	Receiver ID	“900010001”	PPO ID

### 2.1.4 Receiver ID Qualifier

This is a two-digit code that relays the type of identifier being sent. It is expected that the Payor will return HealthLink's Sender ID Qualifier from the Eligibility Request in this field.

- This information will be sent in: .....*ISA07*
- Receiver ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA07	Receiver ID	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

### 2.1.5 Acknowledgement Requests

HealthLink does not anticipate sending Acknowledgement for Eligibility Response transactions, whether sent in real time or batch format.

- This information will be sent in: .....*ISA14*
- Acknowledgement Requests:.....“0”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA14	Acknowledgement Requests	“0”	A value of “0” (zero) should be sent in this field indicating that no acknowledgement is requested.

## 2.2 GS Information

The following information is used in the EDI envelope sub-grouping structure.

### 2.2.1 Application Sender Code

This code is used to identify the unit sending the transaction. Please provide HealthLink with the appropriate code prior to transaction implementation.

- This information will be sent in: .....*GS02*
- Application Sender Code:.....<Same Value as Element **ISA06**>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS02	Application Sender Code	<Same Value as Element <b>ISA06</b> >	

### 2.2.2 Application Receiver Code

This information is usually used to define routing for sending the eligibility response to a department inside the receiver organization (For example, **GS03** would be used to send the eligibility response to the **Customer Service** department of **XYZ Organization**). HealthLink will use the same Application Receiver Code for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....GS03
- Application Receiver Code: .....<Same as the **ISA08** Value>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS03	Application Receiver Code	<Same as the <b>ISA08</b> Value>	

### 2.3 Information Receiver Level

The following information will identify the Entity that will receive the Eligibility Response transaction, typically the provider. The specific location of the data within the transaction is indicated in parentheses.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100B	Organization Name	"<Provider Name>"	Length is 1-35 characters.
NM101	2100B	Organization Type	"1P" = (Provider)	Provider
NM109	2100B	Entity Identifier	<Provider's Tax Identification Number>	
NM108	2100B	Entity ID Qualifier	"F1" = Federal Taxpayer's Identification Number	
REF01	2100B	ID Qualifier	The additional ID types are: "N5" = (Provider Plan Network Identification Number)	Six-digit HealthLink Provider ID.
REF02	2100B	Reference ID	1/30 Length	Use this information for the Reference Number as qualified by REF01.

## 2.4 Information Source Level

The following information is expected in the Eligibility Response transaction. Required fields are indicated with an **(R)**.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100A	Organization Name		This is the name of the Payor <b>(R)</b> . Length is up to 30 characters.
NM101	2100A	Organization Type	Available values are: "PR" = (Payor) "36" = (Employer) "GP" = (Gateway Provider) "P5" = (Plan Sponsor) "2B" = (Third Party Administrator)	The type of Trading Partner <b>(R)</b> .
NM109	2100A	Entity Identifier	<5 Digit Code Sent by Payor>	Payor ID <b>(R)</b> .
NM108	2100A	Entity ID Qualifier	Available values are: "PI" = (Payor Identifier)	Indicates the type of identifier being sent. Recommend using Payor Identifier (PI) only <b>(R)</b> .

## 2.5 Required Subscriber Information

HealthLink expects a HIPAA compliant transaction back from the Payor.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100C	Subscriber First Name		Format is 1/25 characters.
NM103	2100C	Subscriber Last Name		Format is 1/35 characters.
NM105	2100C	Subscriber Middle Name		Format is 1/25 characters.
NM109	2100C	Subscriber Primary Identifier		The appropriate subscriber ID should be established between the provider and the receiving entity. Format is 2/80 characters.
NM108	2100C	Subscriber Primary ID Qualifier	Available ID types are: "MI" = (Member Identification Number) "ZZ" = (Mutually defined)	
DMG02	2100C	Subscriber Date of Birth	Expected in Format: "CCYYMMDD".	DMG01 = D8
PER segment	2100C	Subscriber Contact Information	See Segment Usage	Administrative Communications Contact.

## 2.6 Additional Subscriber Information

The following information may be sent at the Payor's discretion. HIPAA standard code sets and formats are expected.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
REF02	2100C	Additional Subscriber Identifiers		Sent if the Payor wishes to include additional codes used to identify the subscriber. Use this information for the Reference Number as qualified by REF01. Format is 1/30 characters.
REF01	2100C	Additional Subscriber Qualifiers	Available values are: "18" = (Plan Number) "1L" = (Group or Policy Number) "1W" = (Member Identification Number) "3H" = (Case Number) "49" = (Family Unit Number) "6P" = (Group Number) "A6" = (Employee Identification Number) "CT" = (Contract Number) "EA" = (Medical Record Identification Number) "EJ" = (Patient Account Number) "F6" = (Health Insurance Claim (HIC) Number) "GH" = (Identification Card Serial Number) "HJ" = (Identity Card Number) "IF" = (Issue Number) "IG" = (Insurance Policy Number) "ML" = (Military Rank/Civilian Pay Grade Number) "N6" = (Plan Network Identification Number) "NQ" = (Medicaid Recipient Identification Number) "Q4" = (Prior Identifier Number) "SY" = (Social Security Number)	Sent if the Payor wishes to include additional codes used to identify the subscriber.

## 2.7 Dependent Information

The following information must be sent when the dependent is the subject of the eligibility request.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100D	Dependent First Name		Format is 1/25 characters.
NM103	2100D	Dependent Last Name		Format is 1/35 characters.
NM105	2100D	Dependent Middle Name		Format is 1/25 characters.
DMG02	2100D	Dependent Date of Birth	(CCYYMMDD)	DMG01 = D8

## 2.8 Request Error Information

Any errors encountered in the processing of the Eligibility request should be returned in the appropriate AAA segment. It is expected that current and valid HIPAA codes will be used to identify any errors.

- ISA/GS Problems: .....Return errors in the 2100A AAA segment
- Requestor Problems:.....Return errors in the 2100B AAA segment
- Subscriber Problems: .....Return errors in the 2100C AAA segment
- Specific Eligibility Request Problems (Subscriber):.....Return errors in the 2110C AAA segment
- Dependent Problems:.....Return errors in the 2100D AAA segment
- Specific Eligibility Request Problems (Dependent): .....Return errors in the 2110D AAA segment

## 2.9 Trace Number

The Eligibility Response transaction should return the unique identifier information sent in the Eligibility Request at either the Subscriber level (2000C) or Dependent level (2000D), depending on which individual is the subject of the request. The following details the information expected by HealthLink.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
TRN01	2000C/D	Trace Type	"2"	A value of "2" is expected.
TRN02	2000C/D	Transaction Trace Number		This will be the value received in TRN02 in the Eligibility Request transaction. Reference the Trace Number that was originally sent in the 270 transaction. Format is 1/30 characters.
TRN03	2000C/D	Originating Company Identifier	"1900010001" (10 positions)	This will be a "1" (one) followed by HealthLink's EIN "900010001" Number. (i.e. – 1900010001). This will be the value received in TRN03 in the Eligibility Request transaction.
TRN04	2000C/D	Additional Trace Identifier	Not populated.	This field will not be populated.

## 2.10 Response Specific Information

Each Eligibility Response must include the eligibility information described below. Current and valid standard HIPAA codes are expected in all responses. The Payor, at their discretion, may include as much additional detail related to the subscriber's or dependents' eligibility status as is available and appropriate to the 271 transaction. HealthLink strongly encourages Payors to include as much detail in the response transactions as possible.

The information should be sent at either the subscriber or dependent level, depending on which individual is the subject of the request. The following information outlines the specific required and optional eligibility information that can be included in the Eligibility Response transaction.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
EB01	2110C/D	Basic Eligibility/ Benefit Information	(Select specific Eligibility or Benefit Information Code – Standard HIPAA codes)	This level of detail <u>must</u> be provided. Minimum response requires one of the following: 1 = (Active Coverage) 6 = (Inactive)  Minimum response also requires all of the following: A = (Co-Insurance) B = (Co-Pay) C = (Deductible) L = (Only if a PCP) If the individual was not found, respond in the 'AAA' segment with 75–Subscriber not found (Loop 2100C) and/or 67–Patient not found (Loop 2100D), do not use the EB segment.
EB02	2110C/D	Coverage Level Codes	(Standard HIPAA codes)	This level of detail must be provided. Minimum response requires all of the following: FAM = (Active Coverage) IND = (Inactive)
EB03	2110C/D	Service Type Requests	(Standard HIPAA codes)	This level of detail must be provided. Minimum response requires all of the following: 48 = (Hospital Inpatient) 50 = (Hospital Outpatient) 98 = (Physician's Office) 52 = (Emergency Room)
EB04	2110C/D	Insurance Type Code	(Standard HIPAA codes)	This level of detail may be provided at the Payor's discretion.
EB05	2110C/D	Plan Coverage Description	(Free Form – not to exceed 50 characters)	This level of detail may be provided at the Payor's discretion. Free-form field not to exceed 50 characters.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
EB06	2110C/D	Benefits Time Period	(Standard HIPAA codes)	This level of detail may be provided at the Payor's discretion.
EB07	2100C/D	Monetary Amounts	(Maximum length is 18 characters)	Populated as required by the EB01.
EB08	2110C/D	Benefit Percent	(Maximum length is 10 characters)	This level of detail may be provided at the Payor's discretion.
EB09	2110C/D	Quantity Qualifier	(Standard HIPAA codes)	This level of detail may be provided at the Payor's discretion.
EB10	2110C/D	Benefit Quantity	(Maximum length is 15 characters)	This level of detail may be provided at the Payor's discretion.
EB11	2110C/D	Auth/Cert Indicator	(Standard HIPAA codes)	This level of detail may be provided at the Payor's discretion.
EB12	2110C/D	Coverage Level Codes	(Standard HIPAA codes)	This level of detail must be provided. Minimum response requires one of the following: N = (Not in Network) Y = (In Network) U = (Unknown)
EB13	2110C/D	Procedure Code Requests	(Standard HIPAA codes)	This level of detail may be provided at the Payor's discretion. Standard HIPAA codes expected.
DTP02	2110C/D	Date Specific Information	Single Date Format: "CCYYMMDD"  Date Range Format: "CCYYMMDD-CCYYMMDD"	This level of detail may be provided at the Payor's discretion. The dates may be sent as either a single date (CCYYMMDD) or a range of dates (CCYYMMDD-CCYYMMDD).
ILL02	2110C/D	Diagnosis Code Specific Requests	"BF" or "BK"	This level of detail may be provided at the Payor's discretion.
MSG01	2110C/D	Free Form Message	(Maximum length is 264 characters)	Note: This field will be used to provide additional co-pay information. The MSG segment will be used 3 times. Each MSG will follow the EB segment that will provide the monetary amount associated with the MSG.  Positions 1-2 will be used. UC = Urgent care MI = Mental Health Inpatient MO = Mental Health Outpatient

### **2.11 Service Delivery Patterns and Amounts (Loop 2110C / HSD Segment)**

This information may be provided at the Payor's discretion. This information should be sent in the **2110C HSD** segment. HIPPA standard code sets and formats are expected for all applicable data elements.

### **2.12 Eligibility and Benefit Contact Information (Loop 2120C)**

This information may be provided at the Payor's discretion. This information should be sent in **Loop 2120C**. HIPPA standard code sets and formats are expected for all applicable data elements.

### **2.13 Provider Information (Loop 2100B)**

- The provider initiating the request through the HealthLink Portal will be identified in the **2100B Information Receiver** loop. See section 1.3 for additional details.
- Additional Provider information may be sent at the Payor's discretion in the **2120C/2120D PRV** segment.

### **2.14 Transmission Methods**

- **FTP Push**  
HealthLink can 'push' eligibility transactions to your organization via FTP. This may require the use of PGP encryption software.
- **FTP Pull**  
Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pick up their eligibility transactions from their mailbox. HealthLink prefers that PGP encryption is used.

### **2.15 EDI Problems**

If your organization encounters electronic issues, please contact:

- HealthLink's Information Technology Help Desk at (314) 989-6123 (all clients), or [helpdesk@healthlink.com](mailto:helpdesk@healthlink.com).
- Payor Relations at (877) 284-0101, ext 6132 (for Payors), or [PayorRelations@HealthLink.com](mailto:PayorRelations@HealthLink.com), or the specific account manager's email address.

### 3 276 Transactions (Claim Status Request)

#### 3.1 ISA Information

The following information is used in the primary EDI envelope structure.

##### 3.1.1 Sender ID

This is HealthLink’s EDI identification number. HealthLink will use the same Sender ID for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: ...../ISA06
- Sender ID: .....“900010001”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA06	Sender ID	“900010001”	PPO Sender ID

##### 3.1.2 Sender ID Qualifier

This is a two-digit code that relays the type of identifier being sent. HealthLink will use the same Sender ID Qualifier for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: ...../ISA05
- Sender ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA05	Sender ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the ‘ZZ’ Qualifier must be used.

##### 3.1.3 Receiver ID

This identifier represents the Payor in the transaction envelope. HealthLink will expect the Trading Partner ID to be one of the allowed HIPAA Identifier Types. This identifier must be established prior to EDI implementation.

- This information will be sent in: ...../ISA08
- Receiver ID: .....<Payor’s ID> (Varies by Trading Partner)

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA08	Receiver ID	<Payor’s ID> (Varies by Trading Partner)	It is expected that Identifiers will adhere to the standard format applicable to the 837 ECRMAP value.

### 3.1.4 Receiver ID Qualifier

This is a two-digit code that relays the type of identifier being sent. This qualifier must be established prior to EDI implementation.

- This information will be sent in: .....*ISA07*
- Receiver ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA07	Receiver ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

### 3.1.5 Acknowledgement Requests

HealthLink will not request Acknowledgement for Claim Status transactions, whether sent in real time or batch format.

- This information will be sent in: .....*ISA14*
- Acknowledgement Requests.....“0”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA14	Acknowledgement Requests	“0”	A value of “0” (zero) will be sent in this field indicating that no acknowledgement is requested.

## 3.2 GS Information

The following information is used in the EDI envelope sub-grouping structure.

### 3.2.1 Application Sender Code

This code is used to identify the unit sending the transaction. HealthLink will use the same **Application Sender Code** for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....*GS02*
- Application Sender Code:.....<Same as Element **ISA06**>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS02	Application Sender Code	<Same as Element <b>ISA06</b> >	

### 3.2.2 Application Receiver Code

This information is usually used to define routing for sending the eligibility response to a department inside the receiver organization (For example, **GS03** would be used to send the eligibility response to the **Customer Service** department of **XYZ Organization**). Please provide HealthLink with the appropriate code prior to transaction implementation.

- This information will be sent in: .....GS03

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS03	Application Receiver Code	<Same as Element <b>ISA08</b> >	

### 3.3 Information Receiver Level

The following information will identify the Entity requesting the Claim Status information, typically the provider. The specific location of the data within the transaction is indicated in parentheses.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM102	2100B	Entity ID Type	Available Identifier types are: "1" = (Person) "2" = (Non-Person)	"1" when First Name is used, "2" for Facility.
NM103	2100B	Organization or Last Name	"<Provider Last Name>"	Format is 1/35 A/N characters.
NM104	2100B	First Name	"<Provider First Name>"	Format is 1/25 A/N characters.
NM105	2100B	Middle Name	"<Provider Middle Name>"	Format is 1/25 A/N characters.
NM101	2100B	Organization Type	"41"	
NM109	2100B	Entity Identifier	<Provider's TIN>	This will be the provider's Tax Identification Number.
NM108	2100B	Entity ID Qualifier	Available Identifier types are: "FI" = (Federal Taxpayer's Identification Number)	

### 3.4 Information Source Level

The following information is required for the EDI transaction and will need to be obtained from the Payor prior to implementation of the transaction.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100A	Organization Last Name		Provides the name of the Payor. Format is 1/35 A/N characters.
NM101	2100A	Organization Type	Available types are: "PR" = (Payor)	Identifies the type of Trading Partner.
NM109	2100A	Entity Identifier	(Payor ID)	Identifies the receiving entity in the 276 transaction.
NM108	2100A	Entity ID Qualifier	"PI" = (Payor Identification)	Indicates the type of identifier being sent.

### 3.5 Service Provider Information

The Service Provider loop identifies the billing provider from the original claim. This will usually, but not always, be the same as the provider requesting the claim status. The following information will be sent in this loop.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100C	Provider Last Name	"Provider XX"	Format is 1/35 A/N characters.
NM104	2100C	Provider First Name	Sent when NM102 contains: "1" = (Person)	Sent when NM102 contains the value "1" (Person).
NM105	2100C	Provider Middle Name		Format is 1/25 A/N characters.
NM101	2100C	Provider Type	"1P"	
NM109	2100C	Entity Identifier	<HealthLink Provider ID>	Six-digit HealthLink Provider ID.
NM108	2100C	Entity ID Qualifier	Identifier type: "SV"	Indicates the type of identifier being sent.

### 3.6 Subscriber Information

The following information will be sent for the subscriber.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100D	Subscriber First Name		Format is 1/25 A/N characters.
NM103	2100D	Subscriber Last Name		Format is 1/35 A/N characters.
NM105	2100D	Subscriber Middle Name		Format is 1/25 A/N characters.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM109	2100D	Subscriber Identifier		The appropriate Subscriber ID should be established between the Provider and the Receiving Entity. Format is 2/80 characters.
NM108	2100D	Subscriber ID Qualifier	The available ID types are: "MI" = (Member Identification Number)	Only "MI" will be used.
DMG02	2100D	Subscriber Date of Birth	Format: "CCYYMMDD"	DMG01 = D8
DMG03	2100D	Subscriber Gender Code		Gender code is required on the 276 transaction.

### 3.7 Dependent Information

The following information will be sent when the dependent is the patient in the original claim.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100E	Dependent First Name		Format is 1/25 A/N characters.
NM103	2100E	Dependent Last Name		Format is 1/35 A/N characters.
NM105	2100E	Dependent Middle Name		Format is 1/25 A/N characters.
NM109	2100E	Dependent Identifier		The appropriate Subscriber ID should be established between the Provider and the Receiving Entity. Format is 2/80 A/N characters.
NM108	2100E	Dependent ID Qualifier	The available ID types are: "MI" = (Member Identification Number)	Only "MI" should be used.
DMG02	2000E	Dependent Date of Birth	Format: "CCYYMMDD"	DMG01 = D8
DMG03	2000E	Subscriber Gender Code		Gender code is required on the 276 transaction.

### 3.8 Trace Number

The Claim Status request transaction will include a unique identifier at either the Subscriber level (2000C) or Dependent level (2000D), depending on which individual is the subject of the request. This identifier will allow HealthLink to reconcile the 277 response back the appropriate request.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
TRN01	2200D/E	Trace Type	"1"	A value of "1" will be sent.
TRN02	2200D/E	Transaction Trace Number		This will be a unique identifier generated by HealthLink. Format is 1/30 A/N characters.

### 3.9 Identifying the Claim

The Claim Status Request supports several identifiers as well as specific claim information that can be used by the receiving entity (Payor) to identify the claim in question. The following list identifies the data that will be sent in claim status requests generated with the HealthLink portal.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
AMT02	2200D/E	Total Claim Amount Charged		<u>Always</u> sent. This element has 18 maximum positions.
DTP01	2200D/E	Date Time Qualifier	"232" = (Claim statement period start and end)	
DTP02	2200D/E	Date Time Format Qualifier	"RD8"	
DTP03	2200D/E	Claim Dates of Service		<u>Always</u> sent. This will be sent as date range ("CCYYMMDD-CCYYMMDD"). If the date is a single date of service, then the begin date equals the end date.
REF02 Qualifier "1K"	2200D/E	Payor's Claim Number		Sent if the Payor's claim number is known. Not sent on initial request. Format is 1/30 A/N characters.
REF02 Qualifier "EA"	2200D/E	Medical Record Number		Sent when available. This is the Medical Record number submitted on the original claim. Format is 1/30 A/N characters.
REF02 Qualifier "BLT"	2200D/E	Institutional Bill Type		Sent when available. This is the institutional bill type submitted on the original claim. Format is 1/30 A/N characters.

### **3.10 Service Line Specific Requests**

HealthLink can provide 'Service Line Specific' requests.

### **3.11 Transmission Methods**

- **FTP Push**

HealthLink can 'push' eligibility transactions to your organization via FTP. This may require the use of PGP encryption software.

- **FTP Pull**

Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pick up their eligibility transactions from their mailbox. HealthLink prefers that PGP encryption is used.

### **3.12 EDI Problems**

If your organization encounters electronic issues, please contact:

- HealthLink's Information Technology Help Desk at (314) 989-6123 (all clients), or [helpdesk@healthlink.com](mailto:helpdesk@healthlink.com).
- Payor Relations at (877) 284-0101, ext 6132 (for Payors), or [PayorRelations@HealthLink.com](mailto:PayorRelations@HealthLink.com), or the specific account manager's email address.

## 4 277 Transactions (Claim Status Response)

### 4.1 ISA Information

The following information is used in the primary EDI envelope structure.

#### 4.1.1 Sender ID

This identifier represents the Payor in the transaction envelope. HealthLink will expect the Trading Partner ID to be one of the allowed HIPAA Identifier Types. This identifier must be established prior to EDI implementation.

- This information will be sent in: ...../ISA06
- Sender ID: .....<Payor's ID> (Varies by Trading Partner)

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA06	Sender ID	<Payor's ID> (Varies by Trading Partner)	It is expected that Identifiers will adhere to the standard format applicable to the 837 ECMAP value.

#### 4.1.2 Sender ID Qualifier

This is a two-digit code that relays the type of identifier being sent. This qualifier must be established prior to EDI implementation.

- This information will be sent in: ...../ISA05
- Sender ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA05	Sender ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the ‘ZZ’ Qualifier must be used.

#### 4.1.3 Receiver ID

This is HealthLink’s EDI identification number. It is expected that the Payor will return HealthLink's Sender ID from the Claim Status Request in this field.

- This information will be sent in: ...../ISA08
- Receiver ID: .....“900010001”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA08	Receiver ID	“900010001”	PPO ID

**4.1.4 Receiver ID Qualifier**

This is a two-digit code that relays the type of identifier being sent. It is expected that the Payor will return HealthLink's Sender ID Qualifier from the Claim Status Request in this field.

- This information will be sent in: .....ISA07
- Receiver ID Qualifier: .....“ZZ”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA07	Receiver ID Qualifier	“ZZ”	If a mutually defined Identifier is used, then the “ZZ” Qualifier must be used.

**4.1.5 Acknowledgement Requests**

HealthLink does not anticipate sending Acknowledgement for Claim Status Response transactions, whether sent in real time or batch format.

- This information will be sent in: .....ISA14
- Acknowledgement Requests:.....“0”

ANSI Data Element	Data Element Name	Data Element Value	Notes
ISA14	Acknowledgement Requests	“0”	A value of “0” (zero) should be sent in this field indicating that no acknowledgement is requested.

**4.2 GS Information**

The following information is used in the EDI envelope sub-grouping structure.

**4.2.1 Application Sender Code**

This code is used to identify the unit sending the transaction. Please provide HealthLink with the appropriate code prior to transaction implementation.

- This information will be sent in: .....GS02

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS02	Application Sender Code	<Same Value as Element ISA06>	

### 4.2.2 Application Receiver Code

This information is usually used to define routing for sending the eligibility response to a department inside the receiver organization (For example, **GS03** would be used to send the eligibility response to the **Customer Service** department of **XYZ Organization**). HealthLink will use the same Application Receiver Code for both the 270 Eligibility and 276 Claim Status transactions.

- This information will be sent in: .....GS03
- Application Receiver Code: .....<Same Value as **ISA08**>

ANSI Data Element	Data Element Name	Data Element Value	Notes
GS03	Application Receiver Code	<Same Value as <b>ISA08</b> >	

### 4.3 Information Receiver Level

The following information will identify the Entity that will receive the Claim Status Response transaction, typically the provider. It is expected that the data sent in this loop in the response will mirror the information sent in the 2100B loop in the claim status request. The specific location of the data within the transaction is indicated in parentheses.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100B	Organization Name	<Provider' Last Name>	Format is 1/35 A/N characters.
NM101	2100B	Organization Type	"41"	Submitter.
NM109	2100B	Entity Identifier	<Provider's Tax ID Number>	The provider's Tax ID Number is expected.
NM108	2100B	Entity ID Qualifier	Expected Identifier type: "FI" = (Federal Taxpayer's Identification Number)	The Identifier type expected in this loop is "FI" (Federal Taxpayer's Identification Number).

### 4.4 Information Source Level

The following information is expected in the Claim Status Response transaction. Required fields are indicated with an **(R)**.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100A	Organization Name		This is the name of the Payor <b>(R)</b> . <b>Format is 1/35 A/N characters.</b>
NM101	2100A	Organization Type	Available values are: "PR" = (Payor)	The type of Trading Partner <b>(R)</b> .
NM109	2100A	Entity Identifier		Identifies the receiving entity in the 277 transaction <b>(R)</b> . Format is 2/80 A/N characters.
NM108	2100A	Entity ID Qualifier	"PI" = Payor Identifier	Indicates the type of identifier being sent. Recommend using Payor Identifier (PI) only <b>(R)</b> .

#### 4.5 Service Provider Information

The Service Provider loop identifies the billing provider from the original claim. The following information is expected in this loop of the Claim Status response.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM103	2100C	Provider Name	<Provider Name>	Format is 1/35 A/N characters.
NM104	2100C	Provider First Name	Expected when NM102 contains: "1" = (Person)	Expected when NM102 contains the value "1" (Person).
NM101	2100C	Provider Type	"1P"	
NM109	2100C	Entity Identifier	<Provider's TIN>	This will be the Provider's Tax Identification Number.
NM108	2100C	Entity ID Qualifier	Expected Identifier type: "FI" = (Federal Taxpayer's Identification Number)	

#### 4.6 Trace Number

The Claim Status response transaction must include the unique identifier that was sent in this field in the Claim Status request at either the Subscriber level (2000C) or Dependent level (2000D).

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
TRN01	2000D/E	Trace Type	"2"	A value of "2" will be sent.
TRN02	2000D/E	Transaction Trace Number	<Identifier sent in 2000D/E TRN02 of the Claim Status <u>Request</u> >	This should be the identifier sent in this loop and segment in the corresponding Claim Status <u>Request</u> .

#### 4.7 Identifying the Claim

Claim identifiers that were sent in the claim status request are expected to be returned in the corresponding claim status response.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
AMT02	2200D/E	Total Claim Amount Charged		Must be returned. This element has 18 maximum positions.
DTP03	2200D/E	Claim Dates of Service	Date Range: "CCYYMMDD- CCYYMMDD"	Must be returned. Should be sent as a date range (CCYYMMDD-CCYYMMDD). If the date is a single date of service, then the begin date equals the end date.
REF02 Qualifier "1K"	2200D/E	Payor's Claim Number		Sent if the Payor's claim number is known. Not sent on initial request. Format is 1/30 A/N characters.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
REF02 Qualifier "EA"	2200D/E	Medical Record Number		Return if sent in the request. This is the Medical Record Number submitted on the original claim. Format is 1/30 A/N characters.
REF02 Qualifier "BLT"	2200D/E	Institutional Bill Type		Return if sent in the request. This is the institutional bill type submitted on the original claim. Format is 1/30 A/N characters.

#### 4.8 Required Subscriber Information

The following information should always be sent for the subscriber.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100D	Subscriber First Name		Format is 1/25 A/N characters.
NM103	2100D	Subscriber Last Name		Format is 1/35 A/N characters.
NM105	2100D	Subscriber Middle Name		Format is 1/25 A/N characters.
NM109	2100D	Subscriber Identifier		The appropriate subscriber ID should be established between the provider and the receiving entity. Format is 2/80 A/N characters.
NM108	2100D	Subscriber ID Qualifier	Available ID types are: "24" = (Employer's Identification Number) "MI" = (Member Identification Number) "ZZ" = (Mutually defined)	

#### 4.9 Dependent Information

The following information should be sent when the dependent is the patient in the claim status request.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
NM104	2100E	Dependent First Name		Format is 1/25 A/N characters.
NM103	2100E	Dependent Last Name		Format is 1/30 A/N characters.
NM105	2100E	Dependent Middle Name		Format is 1/25 A/N characters.
DMG02	2000E	Dependent Date of Birth	Format: "CCYYMMDD"	DMG01 = D8

#### 4.10 Response Specific Information

Information specific to a particular claims' status is carried in the STC segment in either the 2000D (Subscriber claim) or 2000E (Dependent claim) loops. This segment consists primarily of three iterations of the Health Care Claim composite. These composites are located at STC01, STC10 and STC11. In accordance with HIPAA guidelines, only the first of these three is required. The specifics of the STC segment, and the values expected are detailed below.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
STC01:01	2200D/E	Claim Status Category Code	Valid HIPAA codes expected.	Must be returned. This code provides basic information related to the claims' status.
STC01:02	2200D/E	Claim Status Code	Valid HIPAA codes expected.	Must be returned. This code provides additional detail on the claims' status. Minimum response requires one of the following: 0 = (Cannot Provide Further Status Electronically) 1 = (For More Detailed Information, See Remittance Advice) 2 = (More Detailed Information in Letter)
STC01:03	2200D/E	Claim Entity Identifier	Valid HIPAA codes expected.	Returned if needed. This code provides the identity of an entity referred to in the Status code in STC01:02.
STC02	2200D/E	Status Effective Date	Expected format: "CCYYMMDD"	Must be returned. Effective date of the status information.
STC04	2200D/E	Total Claim Charged Amount		Must be returned. Total amount of submitted charges for the claim. This element has a maximum length of 18 characters.
STC05	2200D/E	Claim Payment Amount		Must be returned. Total amount paid on the claim. This amount should be zero if the adjudication process is not complete. This element has a maximum length of 18 characters.
STC06	2200D/E	Adjudication or Payment Date	Format: "CCYYMMDD"	Return if applicable. This is the date of denial or payment. Use this date if the payment determination is complete.
STC07	2200D/E	Payment Method Code		Return if applicable.
STC08	2200D/E	Check Issue or EFT Date	Format: "CCYYMMDD"	Return if applicable.
STC09	2200D/E	Check or EFT Trace Number		Return if applicable. Format is 1/16 A/N characters.

ANSI Data Element	ANSI Loop	Data Element Name	Data Element Value	Notes
STC10:1-3	2200D/E	Claim Status Composite		Return if needed. This trio of claim status codes should be sent only when additional information needs to be sent regarding the claims' status. See elements <b>STC01:1 – STC01:3</b> for code definitions.
STC11:1-3	2200D/E	Claim Status Composite		Return if needed. This trio of claim status codes should be sent only when additional information needs to be sent regarding the claims' status. See elements <b>STC01:1 – STC01:3</b> for code definitions.

#### 4.11 Transmission Methods

- **FTP Pull**

Trading Partners can use FTP to connect to HealthLink's FTP server over the Internet to pick up their claim status transactions from their mailbox. HealthLink prefers that PGP encryption is used.

- **FTP Push**

HealthLink can 'push' claim status transactions to your organization via FTP. This may require the use of PGP encryption software.

#### 4.12 EDI Problems

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