Health Care Eligibility Benefit Inquiry and Response

270/271 Companion Guide

Refers to the ASC X12N 270/271
Technical Report Type 3 Guide
(version 005010X279A1)

Companion Guide Version Number: 2.2

Preface

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Blue Cross Blue Shield of Massachusetts. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Technical Report Type 3 Guides.

TABLE OF CONTENTS

1. Introduction

1.1. Overview

The Health Insurance Portability and Accountability Act–Administration Simplification (HIPAA-AS) requires Blue Cross Blue Shield of Massachusetts ("Blue Cross" or "BCBSMA") and all other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

This guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Blue Cross. This guide supplements (but does not contradict) requirements in the ASC X12N 270/271 (version 005010X279A1) implementation. This information should be given to the provider's business area to ensure that eligibility responses are interpreted correctly.

1.2. References

- The ASC X12N 270/271 (version 005010X279A1) Technical Report Type 3 guide for Health Care Eligibility Benefit Inquiry and Response has been established as the standard for eligibility transactions and is available at http://www.wpc-edi.com/HIPAA.
- Our Provider Portal containing documentation on transactions for providers is located at http://www.bluecrossma.com/provider.

1.3. Technical Requirements

Blue Cross supports the 270/271 ASC X12N version 005010X279A1 for eligibility and benefit inquiries and responses. Providers wishing to receive the 271 must support this version. We support both Real Time and batch transactions.

Real Time 270s have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed). For trading partners using the NEHEN portal, the last character of the GS02 element is set to "R" on the 270. Typical turnaround time is under 10 seconds during which the portal connection is held open.

Batch 270s also have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed). Batch 270s can take up to 6 hours to process a response. A single 271 is created for each 270 submitted. For trading partners using the NEHEN portal, the last character of the GS02 is set to "B" on the 270.

Table of Contents

2. Testing

Blue Cross recommends that Trading Partners submit 25 successful and unique 270 submissions and receive the associated 271 responses in order to obtain our approval to promote to Production. Providers must coordinate with us for testing timeframes and to ensure that the necessary patient test data is available.

Table of Contents

3. Connecting and Communicating

The purpose of this section is to identify the process for establishing connectivity to transmit and receive electronic transactions with Blue Cross and Blue Shield of Massachusetts.

3.1. e-Channels

We provide multiple options for submission of 270 requests.

- Provider Central (our web portal): http://www.bluecrossma.com/provider.
- New England Healthcare Exchange Network (NEHEN) – http://www.nehen.org.
- Change Healthcare – http://www.changehealthcare.com/legacy/our-partners/providers or **1-877-363-3666**
- Direct channel for Real Time 270 transactions in accordance with CAQH CORE connectivity rules:
    - Communication Methods Supported:
        - The transport protocol is HTTPS over the Internet
        - The message (payload) protocol can be either SOAP or MIME
        - The content of the request and response is a standard X12N HIPAA transaction.
        - Production URL: https://authsso.bluecrossma.com/s44318/caqh2 SOAP connection
        - Production URL: https://authsso.bluecrossma.com/s44319/caqh2 MIME connection
    - Technical standards and versions for HTTPS/SOAP are:
        - HTTPS Version 1.1
        - SOAP Version 1.2
        - SSL Version 1.2
        - WS-Security Version 1.x
        - Health Care Eligibility and Benefit Inquiry and Response Version 005010X279A1
    - Technical standards and versions for HTTPS/MIME are:
        - HTTPS Version 1.1
        - MIME Version 1.0

    - SSL Version 1.2
    - Health Care Eligibility and Benefit Inquiry and Response Version 005010X279A1 Submissions & Response Pickups use MTOM to handle the file payloads.
- User ID and password for SOAP and CMIME are provided upon completion of enrollment process.
    - Health Care Eligibility and Benefit Inquiry and Response Version 005010X279A1
- User ID and password for SOAP and CMIME are provided upon completion of enrollment process.

For Blue Cross systems to effectively process 27x transactions, we request Submitters disperse their 27x transmissions throughout the day at a steady pace.

In addition, when sending transactions, **please use member/subscriber IDs** rather than names.

Table of Contents

3.2. Security

Blue Cross is dedicated to maintaining the confidentiality of personal health information. We have adopted a mindset to safeguard member information as if it were our own. Associates are required to safeguard member privacy by using reasonable measures during all phases of the information-handling process: from collection and storage, to disclosure and disposal. This policy applies to the personally identifiable health information of all applicants and past or present members. Information may be in the form of data in storage or in transit, on paper or in electronic format.

Due to its sensitivity, the use and disclosure of PHI is restricted, except in circumstances where permitted or required by law or where appropriate authorization for use or disclosure is obtained. Access to PHI is limited to those with a business need to know the information for treatment, payment, or health care operations, or as otherwise permitted or required by law. Associates with a business need to handle PHI must be identified and granted appropriate access in accordance with their department-level policies and procedures.

We maintain policies and procedures for the HIPAA compliant transfer of protected health information to external health care partners. These provisions include secure file transfer, encryption, password protection, secure fax, and other measures, as indicated based on the nature of the data being transferred.

NEHEN trading partners transmit transactions using private network frame relay connections, Virtual Private Networks (VPN) or X.509 digital certificates for Web Services connections.

Direct Submitter (CORE) Trading Partners exchange transactions using secure HTTP over the Internet. The HTTPS connection is secured by a certificate. Each request is authenticated by a User ID and Password.

Table of Contents

3.3. System availability

Blue Cross will be available to process Real Time and Batch transactions 24x6, Monday through Saturday from 1:00 AM ET – 12:59 AM ET. Maintenance may be performed by BCBS Plans on the following major holidays:

- New Year's Day (1/1)
- Memorial Day (Last Monday in May)
- Independence Day (7/4)
- Labor Day (1st Monday in September)
- Thanksgiving Day (4th Thursday in November)
- Christmas Day (12/25)

In addition, routine maintenance may be performed on Sundays. Trading partners may receive rejection messages indicating that Blue Cross is unable to respond to their transactions. It is recommended that transactions submitted during these maintenance windows be sent in Batch mode.

Table of Contents

4. Provider Support

If you cannot find the answers to your questions within this Companion Guide, please use the contact information below to reach the appropriate support area.

EDI Support

For technical questions or help related to 270 or 271 transactions, please contact:

Phone: 800-771-4097
Email: EDISupport@bcbsma.com

Provider Central (provider portal)

Provider Central provides information regarding our products, policies and procedures, as well as Companion Guides for various electronic transactions. Please refer to online documentation for the most up-to-date materials.

Website: http://www.bluecrossma.com/provider

Table of Contents

5. Eligibility (270/271)

We process 270 requests for Blue Cross Blue Shield of Massachusetts members, Federal Employee Program (FEP) members, and Out-of-State BCBS Plan (BlueCard) members.

If the member is enrolled with the Federal Employee Program (FEP) or an Out-of-State BCBS Plan (BlueCard), we coordinate with the member's Home Plan to return a 271 response. 271 responses for these members may vary based on the Home Plan's processing.

The information contained in this document pertains to Blue Cross Blue Shield of Massachusetts members.

Table of Contents

5.1. Identification Number Requirements

Blue Cross Blue Shield of Massachusetts member IDs begin with a three character alpha or alpha-numeric prefix followed by nine (without suffix) or eleven (with suffix) numeric characters.

Out-of-State BCBS member IDs begin with a three character alpha or alpha-numeric prefix followed by four to fourteen alpha-numeric characters.

Federal Employee Program (FEP) member IDs begin with the letter "R" followed by eight numeric characters.

Note: Member IDs should not contain hyphens, spaces, or any special characters.

Table of Contents

5.2. Eligibility By Name Search

270 Eligibility Requests without an identification number (Alpha Name Search Eligibility Requests) can be submitted to us for Blue Cross Blue Shield of Massachusetts members. Members enrolled with the Federal Employee Program (FEP) and Out-of-State Blue Plans (BlueCard) are excluded because they are not enrolled in our membership files.

An exact match on the patient's **First Name, Last Name, and Date of Birth** is required in order to return eligibility and benefits for the patient.

If the Alpha Name Search is unsuccessful, we will return a 271 response containing a AAA segment and, in some cases, a MSG segment. Please refer to Appendix C for additional information and troubleshooting tips.

Table of Contents

5.2.1. Name Normalization

In accordance with CAQH CORE requirements and under the recommendation of the Massachusetts Administration Simplification Workgroup, Blue Cross normalizes the patient's last name and first name from the submitted 270 request and compares them to a normalized version of the patient information contained in our membership files. When making name comparisons:

- The match will not be case-sensitive
- All special characters within the basic character set are ignored:

"!", """, "&", "'", "(", ")", "*", "+", ",", "-", ".", "/", ":", ";", "?", "=" and space

- All of the following character strings are ignored when they are:
  - At the beginning of the data element and followed by a space, comma, or forward slash
  - At the end of the data element and preceded by a space, comma, or forward slash

JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

Table of Contents

5.3. INS Segment Usage

We return the patient information (Subscriber and Dependent) from our membership files. The INS segment is used to indicate that the patient data returned on the

271 response differs from the patient data submitted on the 270 request. An INS segment is returned when any of these data elements varies:

- Patient's Identification Number (2100C NM109)
  - Note: We also returns a REF segment with REF01="Q4" when the submitted Subscriber Identification Number varies.
- Subscriber/Dependent Date of Birth (2100C/D DMG02)
- Subscriber/Dependent Last Name (2100C/D NM103)
- Subscriber/Dependent Group Number (2100C/D REF01 = 6P)

Table of Contents

5.4. Patient Relationship

5.4.1. Subscriber Submitted as Dependent

If the patient is a *dependent* in our membership files, but was submitted in the Subscriber loop on the 270 request (2100C), the patient will be returned in the appropriate Dependent loop on the 271 response (2100D). We will also return the corrected Subscriber information in the 2100C loop.

5.4.2. Dependent Submitted as Subscriber

If the patient is a subscriber in our membership files, but was submitted in the Dependent loop on the 270 request (2100D), the patient will be returned in the appropriate Subscriber loop on the 271 response (2100C).

Table of Contents

5.5. HIPAA Service Types

Blue Cross supports the Service Types required by the HIPAA 5010 270/271 TR3 and CAQH CORE. In addition to the "Standard" Service Type (30), we support many other useful Service Types. Please see Appendix A for a complete list Blue Cross-supported Service Types.

- When we don't support a specific Service Type, we will return the "Standard" Service Type (30) response.

5.5.1. Blue Cross Blue Shield of Massachusetts Service Type Groupings

Some specific Service Types will return benefits for related Service Types as well as for the Service Type submitted on the 270 request. For example, if Service Type "2" (Surgical) is submitted on the 270 request, Blue Cross will return the following Service Types: 2, 7, 8, and 20. Please see Appendix B for a complete list of Service Type groupings.

5.5.2. Benefit Details

The data contained in Blue Cross' 271 response is intended to provide details regarding the service requested. Benefit information will be contained in the appropriate EB segment. Additional benefit information may be provided in HSD, REF, MSG, and III segments.

5.5.3. Plan Level Benefits

Blue Cross always returns Plan Level benefits (e.g. – deductible, out-of-pocket, etc.) with Service Type 30.

5.5.4. Benefit Accumulations

Benefit Accumulations (when applicable) will be returned on the 271 response when the Date of Service submitted on the 270 request is the current date. If the Date of Service is a past or future date, benefit accumulations will not be returned.

5.5.5. Deductible Dates

Deductible dates (when applicable) are returned on the 271 response with the corresponding Plan Level or Benefit Level deductible. Blue Cross will return the appropriate Service Year or Calendar Year for the benefits returned. If the deductible dates are the same as the member's eligibility dates, deductible dates will not be returned.

5.5.6. No Cost/No Cost After Deductible

Benefits which have no cost to the member can be identified with zero member cost share amounts (e.g. $0 copayment, $0 deductible, 0% coinsurance).

Benefits which have no cost to the member after the Plan-level deductible has been satisfied can be identified with zero member cost share amounts for copayment and coinsurance (e.g. $0 copayment and 0% coinsurance).

- If the member does not have a Plan-level deductible, the $0 deductible will be omitted.

5.5.7. Multiple EQ Segments/Repeating EQ01 Elements

Blue Cross does not support 270 requests submitted with multiple EQ segments or repeating of the EQ01 element. If submitted, Blue Cross will return a 271 response with the "Standard" Service Type (30) and a MSG segment indicating that a new 270 request should be resubmitted with only one Service Type.

5.5.8. Procedure Code/Diagnosis Code EQ Elements

Blue Cross does not support 270 requests submitted with Diagnosis codes or non-dental Procedure Codes in the EQ segment. If a Procedure or Diagnosis code is submitted, Blue Cross will return a 271 response with the "Standard" Service Type (30).

5.5.9. First Dollar Coverage

Blue Cross returns First Dollar Coverage information (when applicable), identified by EB01 = "F" (Limitation) in a 2110 loop. Information about remaining benefit amounts will be included in the response when the Date of Service submitted on the 270 request is the current date. If the Date of Service is a past or future date, accumulations will not be returned. "First Dollar Coverage" will be noted in the MSG segment.

Table of Contents

5.6. Additional Information

5.6.1. PCP Information

For managed care members, Blue Cross returns the Primary Care Physician's NPI, name, address, and phone number (when known) in the 2120 loop.

5.6.2. Coordination of Benefits (COB)

Blue Cross returns COB information, identified by EB01 = "R" (Other or Additional Payor) followed by a 2120 loop. We return (when known) the other carrier's name and address, the other carrier's subscriber name, identification number, and group number.

Note: If the other carrier is Blue Cross Blue Shield of Massachusetts, the address information is not returned.

5.6.3. Medicare

Blue Cross returns Medicare information, identified by EB04 = "MA" or "MB". We return the Medicare effective date and an MSG segment indicating whether Blue Cross or Medicare is the primary coverage.

5.6.4. Tiered Options

When the member is enrolled in a Tiered Options product, Blue Cross returns EB01 = "N" (Service Restricted to Following Provider) with EB05 = "**TIERED OPTIONS**".

5.6.5. Hospital Choice Cost Sharing

When the member is enrolled in a Hospital Choice Cost Sharing product, Blue Cross returns EB01 = "N" (Service Restricted to Following Provider) with EB05 = "**HOSPITAL CHOICE COST SHARING**".

5.6.6. Financial Arrangements

Blue Cross returns the member's Plan Financial Arrangement, identified by EB01 = "CB" (Coverage Basis) and EB05 as "**FULLY INSURED**" or "**SELF INSURED**".

5.6.7. Benefits

5.6.7.1. Medical Telehealth

Blue Cross returns a member's network provider telehealth benefits and/or designated telehealth provider benefits as part of the 271.

To determine if a member has network provider telehealth benefits, submit a 270 request with the service type appropriate for the services being rendered. Telehealth benefit will

be communicated using an EB segment as well as an accompanying MSG segment containing "**IN-PERSON OR TELEHEALTH**" message text.

To determine if the member has telehealth benefits when rendered by a designated telehealth provider, submit a 270 request with Service Type "BY" (Physician Visit – Office: Sick) or "CF" (Mental Health Provider – Outpatient). If the member has the benefit, Blue Cross returns the telehealth cost share along with an MSG segment indicating "**TELEHEALTH**" or "**DESIGNATED TELEHEALTH**" Note: other applicable non-telehealth medical benefits will also be returned, but without the "**TELEHEALTH**" MSG segment.

5.6.7.2. Behavioral Health Telehealth

To determine if the member has standard benefits for Behavioral Health Telehealth services, submit a 270 Request with Service Type "**CF**" (Mental Health Provider – Outpatient). If the member has the benefit, Blue Cross returns the telehealth cost share along with an MSG segment indicating "**TELEHEALTH**".

Note: other applicable non-telehealth behavioral health benefits will also be returned, but without the "**TELEHEALTH**" MSG segment.

5.6.7.3. Lactation Counseling Telehealth

To determine if the member has standard benefits for **Lactation Counseling Telehealth services**, submit a 270 Request with Service Type **"BA" (Independent Medical Evaluation)**. If the member has the benefit, Blue Cross returns the telehealth cost share along with an MSG segment indicating **"TELEHEALTH".**

Note: other applicable non-telehealth medical benefits will also be returned, but without the **"TELEHEALTH"** MSG segment.

5.6.7.4. Routine Vision Benefits

To determine a member's next eligibility date for a **Routine Vision Exam**, submit a 270 request with Service Type **"AL" (Vision – Optometry)**. The member's next eligibility date for a routine vision exam will communicated using a DTP segment with a DTP01 value of "**307**" (Eligibility).

Example: DTP*307*D8*20210719~

Note: A default date may be returned if next eligibility date is unavailable.

5.6.7.5. Chiropractic Benefits

For plans where Chiropractic benefits do not have a predefined visit limitation other than medical necessity, the number of visits used in a benefit period will be communicated using

EB09 value of "99" (Quantity Used) and the number of visits in EB10. Additionally, an MSG segment indicating "**CHIROPRACTIC VISITS USED IN BENEFIT PERIOD**" will be sent in this scenario.

5.6.7.6. Value Care Visits

Employers can choose to offer their employees $0 cost share for a set number of outpatient visits (including telehealth) for any of the following services:

- Acupuncture
- Chiropractic care
- Mental health and substance use visits
- Non-preventive care visits with a PCP
- Physical therapy and occupational therapy

To determine a member's Value Care Visit benefit, submit a 270 with the service type appropriate for the services being rendered.

For most Value Care plans, Blue Cross will return a 271 containing an EB segment with EB01 equal to "**F**", EB09 equal to "**99**" and EB10 with **the number of Value Care Visits used** at the time response is created. Additionally, an EB segment containing the number of Value Care Visits **remaining** will be created. An MSG segment indicating the number of Value Care Visits allowed on the plan will also be returned.

To determine the remaining amount of Value Care Visits on a member's plan when a remaining visits EB segment is not present (for example an HMO Blue Essential plan) both the MSG segment (visits allowed) and the "benefit used" EB segment must be interrogated. In the example below the member would have "5" Value Care Visits remaining.

Example:
EB*F*IND*CF******99*1
MSG* VALUE CARE VISITS USED
EB*B*IND*CF***27*0****Y*Y
MSG*FOR 6 OVERALL VALUE CARE IN-PERSON OR TELEHEALTH VISITS PER MEMBER PER PLAN YEAR~

Table of Contents

5.7. Exceptions

5.7.1. Incorrect/Missing Information

If the Eligibility check is unsuccessful, Blue Cross will return a 271 response containing a AAA segment noting the reason a match could not be made. If indicated, correct and resubmit your request.

5.7.2. Inactive member

If the Eligibility check identifies a Blue Cross member who is inactive on the service date requested, Blue Cross will return a 271 response containing EB01 = "6". Membership data from the 270 request will be returned on the 271 response.

Table of Contents

6. 999 ACKNOWLEDGMENT FOR HEALTH CARE INSURANCE

270 Eligibility Requests submitted to Blue Cross must be HIPAA-compliant.

Blue Cross will issue a 999 Acknowledgment for Health Care Insurance (005010X231A1) when a 270 request (Batch or Real Time) fails validation of WEDI SNIP Type 1-5 HIPAA edits. Blue Cross does not return positive acknowledgments for successful 270 requests (the 271 acts as the acknowledgment).

The purpose of the 999 Acknowledgment (Reject) is to identify critical errors within the 270 request based on the ASC X12N 270 (version 005010X279A1) Technical Report Type 3 guide. The submitter should review the 999 to determine what errors occurred.

Table of Contents

7. 270 Data Specifications

Note: All data must be submitted in UPPER CASE. In addition, leading spaces must be omitted, and trailing spaces must be omitted unless necessary to fulfill a minimum field length.

7.1. Header Data

Segment ID	Element ID	Data Element Name	Blue Cross Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"

	06	Interchange Sender ID	Value assigned by Blue Cross
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	Value assigned by Blue Cross
	14	Acknowledgment Requested	"0" (numeric)
	15	Interchange Usage Indicator	P – Production Requests T – Test Requests
GS		**Functional Group Header**	
	02	Application Sender's Code	Value assigned by Blue Cross
	03	Application Receiver's Code	Value assigned by Blue Cross
	08	Version/Release/ Industry Code	"005010X279A1"
BHT		**Beginning of Hierarchical Trans.**	
	02	Transaction Set Purpose Code	"13"

Table of Contents

7.2. Loop Specific Data

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2100A	**NM1**	**Information Source Name**	
	01	Entity Identifier Code	"PR"
	03	Name Last or Organization Name	"BLUE CROSS BLUE SHIELD OF MASSACHUSETTS"
	08	Identification Code Qualifier	"PI"
	09	Identification Code	"700"
2100C	**NM1**	**Subscriber Name**	

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	03	Subscriber Last Name	If the Subscriber ID # is not submitted in the NM109 field and the patient is the Subscriber, this field is Required.
	04	Subscriber First Name	If the Subscriber ID # is not submitted in the NM109 field and the patient is the Subscriber, this field is Required.
	08	Identification Code Qualifier	"MI"
	09	Identification Code	If used, this is the member's ID# as it appears on their BCBS ID card. It must include the alpha or alpha-numeric prefix (e.g. XXH, MTN). It is also helpful to include the member's suffix if it is present on the member's ID card.
2100C	**DMG**	**Subscriber Demographic Information**	
	02	Subscriber Birth Date	Required when the patient is the Subscriber.
2100C	**DTP**	**Subscriber Date**	
	01	Date Time Qualifier	"291"
	03	Date Time Period	Service Date. If a date range is submitted, only the first date is used to determine the member's eligibility and benefits. If no date is submitted, the current date will be used for processing.
2110C	**EQ**	**Subscriber Eligibility or Benefit Inquiry**	
	01	Service Type Code	Service Type associated with the benefits being requested (Please see section 5.5).

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	03	Coverage Level Code	If used, must be "IND". We do not support family-level requests.
2100D	**NM1**	**Dependent Name**	
	03	Dependent Last Name	If the Subscriber ID # is not submitted in the NM109 field and the patient is a Dependent, this field is Required.
	04	Dependent First Name	If the Subscriber ID # is not submitted in the NM109 field and the patient is a Dependent, this field is Required.
2100D	**DMG**	**Dependent Demographic Information**	
	02	Dependent Birth Date	Required when the patient is a Dependent.
2100D	**DTP**	**Dependent Date**	
	01	Date Time Qualifier	"291"
	03	Date Time Period	Service Date. If a date range is submitted, only the first date is used to determine the member's eligibility and benefits. If no date is submitted, the current date will be used for processing.
2110D	**EQ**	**Dependent Eligibility or Benefit Inquiry**	
	01	Service Type Code	Service Type associated with the benefits being requested (Please see section 5.5).
	03	Coverage Level Code	If used, must be "IND". We do not support family-level requests.

Table of Contents

8. 271 Data Specifications

8.1. Header Data

Segment ID	Element ID	Data Element Name	Blue Cross Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"
	06	Interchange Sender ID	ISA08 value from 270 request
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	ISA06 value from 270 request
	09	Interchange Date	Processed Date in GMT
	10	Interchange Time	Processed Time in GMT
GS		**Functional Group Header**	
	02	Application Sender's Code	GS03 value from 270 request
	03	Application Receiver's Code	GS02 value from 270 request
	04	Date	Processed Date in GMT
	05	Time	Processed Time in GMT
BHT		**Beginning of Hierarchical Transaction**	
	04	Date	Processed Date in GMT
	05	Time	Processed Time in GMT

Table of Contents

8.2. Loop Specific Data

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2100A	**NM1**	**Information Source Name**	

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01	Entity Identifier Code	"PR"
	03	Name Last or Organization Name	"BLUE CROSS BLUE SHIELD OF MASSACHUSETTS"
	08	Identification Code Qualifier	"PI"
	09	Identification Code	"700"
2100A	**PER**	**Information Source Contact Information**	
	02	Information Source Contact Name	If Utilization Management (UM) is required for High Tech Radiology and/or Chiropractic services, the appropriate UM vendor's name(s) will be returned. If UM is required for any other services, our Clinical Coordination dept. will be returned.
	04|06|08	Communication Numbers	The appropriate UM telephone/FAX number(s) and/or website(s) are returned here.
2100C	**NM1**	**Subscriber Name**	
	03	Subscriber Last Name	Subscriber's last name from our membership files.
	04	Subscriber First Name	Subscriber's first name from our membership files.
	05	Subscriber Middle Initial	Subscriber's middle initial from
	09	Subscriber Primary Identifier	Patient's ID# (including alpha or alpha-numeric prefix) from our membership files. Suffix is not included.
2100C	**REF**	**Subscriber Additional Information**	

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01	Reference Identification Qualifier	"6P" is the patient's Blue Cross Group Number. "Q4" is returned if the Subscriber ID # submitted on the 270 request differs from the Subscriber ID # in our membership files. "EJ" is returned if the patient's Patient Account Number was submitted on the 270 request.
	02	Subscriber Supplemental Identifier	If REF01 is "6P", this is the patient's Blue Cross Group Number. If REF01 is "Q4", this is the submitted Subscriber ID #. If REF01 is "EJ", this is the submitted Patient Account Number.
	03	Group Name	If REF01 is "6P", this is the patient's Blue Cross Group Name.
2100C	**DMG**	**Subscriber Demographic Information**	
	02	Subscriber Birth Date	If the patient is the Subscriber, the Subscriber's birth date from our membership files.
2100C	**INS**	**Subscriber Relationship**	
	01 - 04	Subscriber Relationship	If patient demographic information varies from the 270 request to the data in our membership files, this segment is returned: INS*Y*18*001*25
2100C	**DTP**	**Subscriber Date**	
	01	Date Time Qualifier	"291"
	03	Date Time Period	If the patient is the Subscriber, this is the Subscriber's Coverage Dates. A member with open coverage will have an end date of "99991231".

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2110C	**EB**	**Subscriber Eligibility or Benefit Information**	
	12	In Plan Network Indicator	If the patient is the Subscriber and In-Network and Out-of-Network benefits are the same, EB12 = "W". Otherwise, "Y" and "N" are used.
2100D	**NM1**	**Dependent Name**	
	03	Dependent Last Name	Dependent's last name from our membership files.
	04	Dependent First Name	Dependent's first name from our membership files.
	05	Dependent Middle Initial	Dependent's middle initial from our membership files.
2100D	**REF**	**Dependent Additional Identification**	
	01	Reference Identification Qualifier	"6P" is the patient's Blue Cross Group Number. "EJ" is returned if the patient's Patient Account Number was submitted on the 270 request.
	02	Dependent Supplemental Identifier	If REF01 is "6P", this is the patient's Blue Cross Group Number. If REF01 is "EJ", this is the submitted Patient Account Number.
	03	Group Name	If REF01 is "6P", this is the patient's Blue Cross Group Name.
2100D	**DMG**	**Dependent Demographic Information**	
	02	Dependent Birth Date	Dependent's birth date from our membership files.

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2100D	**INS**	**Dependent Relationship**	
	01 - 04	Dependent Relationship	If patient demographic information does not vary from the 270 request to the data in our membership files, this segment is returned: INS*N*?? If the patient demographic information varies from the 270 request to the data in our membership files, this segment is returned: INS*N*??*001*25- *Note: INS02 will vary based on the patient's relationship to the Subscriber.*
2100D	**DTP**	**Dependent Date**	
	01	Date Time Qualifier	"291"
	03	Date Time Period	The Dependent's Coverage Dates. A member with open coverage will have an end date of "99991231".
2110D	**EB**	**Dependent Eligibility or Benefit Information**	
	12	In Plan Network Indicator	If In-Network and Out-of-Network benefits are the same, EB12 = "W". Otherwise, "Y" and "N" are used.

Table of Contents

9. Appendices

9.1. Appendix A. Service Types Supported by Blue Cross Blue Shield of Massachusetts

Service Type	Service Type Definition	Blue Cross Business Rule
1	Medical Care	Please see Appendix B for Service Type Grouping
2	Surgical	Please see Appendix B for Service Type Grouping
4	Diagnostic X-ray	

Service Type	Service Type Definition	Blue Cross Business Rule
5	Diagnostic Lab	
6	Radiation Therapy	
7	Anesthesia	
8	Surgical Assistance	
12	Durable Medical Equipment Purchase	
13	Ambulatory Service Center Facility	
17	Pre-admission Testing	
18	Durable Medical Equipment Rental	
20	Second Surgical Opinion	
23	Diagnostic Dental	
24	Periodontics	
25	Restorative	
26	Endodontics	
30	Health Benefit Plan Coverage	"Standard" 30 Response Please see Appendix B for Service Type Grouping
33	Chiropractic	
35	Dental Care	Please see Appendix B for Service Type Grouping
36	Dental Crowns	
38	Orthodontics	
39	Prosthodontics	
40	Oral Surgery	
41	Routine (Preventive) Dental	
42	Home Health Care	
45	Hospice	
47	Hospital	Please see Appendix B for Service Type Grouping
48	Hospital - Inpatient	Please see Appendix B for Service Type Grouping
50	Hospital - Outpatient	Please see Appendix B for Service Type Grouping
51	Hospital - Emergency Accident	
52	Hospital - Emergency Medical	
53	Hospital - Ambulatory Surgical	
56	Medically Related Transportation	
61	In-Vitro Fertilization	
62	MRI/CAT Scan	Use for High Tech Radiology benefits
64	Acupuncture	
65	Newborn Care	
66	Pathology	
68	Well Baby Care	Please see Appendix B for Service Type Grouping
69	Maternity	
71	Audiology Exam	
72	Inhalation Therapy	

Service Type	Service Type Definition	Blue Cross Business Rule
73	Diagnostic Medical	Please see Appendix B for Service Type Grouping
75	Prosthetic Device	
76	Dialysis	
78	Chemotherapy	
80	Immunizations	
81	Routine Physical	
82	Family Planning	
83	Infertility	Please see Appendix B for Service Type Grouping
84	Abortion	
86	Emergency Services	Please see Appendix B for Service Type Grouping
88	Pharmacy	
93	Podiatry	
98	Professional (Physician) Visit - Office	Please see Appendix B for Service Type Grouping
99	Professional (Physician) Visit - Inpatient	
A0	Professional (Physician) Visit - Outpatient	
A3	Professional (Physician) Visit - Home	
A6	Psychotherapy	
A7	Psychiatric - Inpatient	
A8	Psychiatric - Outpatient	
A9	Rehabilitation	Please see Appendix B for Service Type Grouping
AD	Occupational Therapy	Early Intervention benefits are included
AE	Physical Medicine	Early Intervention benefits are included
AF	Speech Therapy	Early Intervention benefits are included
AG	Skilled Nursing Care	
AI	Substance Abuse	
AJ	Alcoholism	
AK	Drug Addiction	
AL	Vision (Optometry)	
BA	Independent Medical Evaluation	
BF	Pulmonary Rehabilitation	
BG	Cardiac Rehabilitation	
BH	Pediatric	
BT	Gynecological	
BU	Obstetrical	
BV	Obstetrical/Gynecological	Please see Appendix B for Service Type Grouping
BY	Physician Visit - Office: Sick	
BZ	Physician Visit - Office: Well	
CE	Mental Health Provider - Inpatient	
CF	Mental Health Provider - Outpatient	

Service Type	Service Type Definition	Blue Cross Business Rule
CG	Mental Health Facility- Inpatient	
CH	Mental Health Facility - Outpatient	
CI	Substance Abuse Facility - Inpatient	
CJ	Substance Abuse Facility - Outpatient	
CK	Screening X-ray	
CL	Screening laboratory	
CM	Mammogram, High Risk Patient	
CN	Mammogram, Low Risk Patient	
CO	Flu Vaccination	
DM	Durable Medical Equipment	Please see Appendix B for Service Type Grouping
MH	Mental Health	Use for Mental Health benefits
PT	Physical Therapy	Use for Physical Therapy benefits Early Intervention benefits are included
UC	Urgent Care	

9.2. Appendix B. Service Type Groupings

Service Type Requested: 30 – Health Benefit Plan Coverage (“Standard” 30 Response)		
Service Types Returned		**Blue Cross Business Rule**
1	Medical Care	Active Status ONLY (no benefits returned)
33	Chiropractic	Benefits returned
35	Dental Care	Active Status ONLY (no benefits returned) Omitted if patient does not have coverage for benefit
47	Hospital	Benefits returned
48	Hospital - Inpatient	Benefits returned
50	Hospital - Outpatient	Benefits returned
51	Hospital - Emergency Accident	Benefits returned
52	Hospital - Emergency Medical	Benefits returned
86	Emergency Services	Benefits returned
88	Pharmacy	Active Status ONLY (no benefits returned) Omitted if patient does not have coverage for benefit
98	Professional (Physician) Visit - Office	“Sick” Benefits returned
AL	Vision (Optometry)	Active Status ONLY (no benefits returned) Omitted if patient does not have coverage for benefit
BZ	Physician Visit - Office: Well	Benefits returned
MH	Mental Health	Active Status ONLY (no benefits returned)
UC	Urgent Care	Benefits returned
Service Type Requested: 1 – Medical Care		
Service Types Returned		**Blue Cross Business Rule**
1	Medical Care	Active Status ONLY (no benefits returned)

2	Surgical	Benefits returned
42	Home Health Care	Benefits returned
45	Hospice	Benefits returned
69	Maternity	Benefits returned
76	Dialysis	Benefits returned
83	Infertility	Benefits returned
AG	Skilled Nursing Care	Benefits returned
BT	Gynecological	Benefits returned
BU	Obstetrical	Benefits returned
DM	Durable Medical Equipment	Active Status ONLY (no benefits returned)
Service Type Requested: 2 - Surgical		
Service Types Returned		**Blue Cross Business Rule**
2	Surgical	Benefits returned
7	Anesthesia	Benefits returned
8	Surgical Assistance	Benefits returned
20	Second Surgical Opinion	Benefits returned
Service Type Requested: 47 - Hospital		
Service Types Returned		**Blue Cross Business Rule**
47	Hospital	Benefits returned
51	Hospital - Emergency Accident	Benefits returned
52	Hospital - Emergency Medical	Benefits returned
53	Hospital - Ambulatory Surgical	Benefits returned
Service Type Requested: 48 – Hospital Inpatient		
Service Types Returned		Blue Cross Business Rule
48	Hospital - Inpatient	Benefits returned
99	Professional (Physician) Visit - Inpatient	Benefits returned
Service Type Requested: 50 – Hospital-Outpatient		
Service Types Returned		Blue Cross Business Rule
50	Hospital - Outpatient	Benefits returned
51	Hospital - Emergency Accident	Benefits returned
52	Hospital - Emergency Medical	Benefits returned
A0	Professional (Physician) Visit - Outpatient	Benefits returned
Service Type Requested: 68 – Well Baby Care		
Service Types Returned		Blue Cross Business Rule
68	Well Baby Care	Benefits returned
80	Immunizations	Benefits returned
BH	Pediatric	Benefits returned
Service Type Requested: 73 – Diagnostic Medical		
Service Types Returned		**Blue Cross Business Rule**
4	Diagnostic X-Ray	Benefits returned

5	Diagnostic Lab	Benefits returned
62	MRI/CAT Scan	Benefits returned
73	Diagnostic Medical	Active Status ONLY (no benefits returned)
Service Type Requested: 83 - Infertility		
Service Types Returned		**Blue Cross Business Rule**
61	In-Vitro Fertilization	Benefits returned
83	Infertility	Benefits returned
Service Type Requested: 86 – Emergency Services		
Service Types Returned		**Blue Cross Business Rule**
51	Hospital - Emergency Accident	Benefits returned
52	Hospital - Emergency Medical	Benefits returned
86	Emergency Services	Benefits returned
98	Professional (Physician) Visit - Office	"Sick" Benefits returned
Service Type Requested: 98 – Professional (Physician) Visit - Office		
Service Types Returned		**Blue Cross Business Rule**
98	Professional (Physician) Visit - Office	"Sick" Benefits returned
BZ	Physician Visit - Office: Well	Benefits returned
Service Type Requested: A9 - Rehabilitation		
Service Types Returned		**Blue Cross Business Rule**
A9	Rehabilitation	Active Status ONLY (no benefits returned)
12	Durable Medical Equipment Purchase	Benefits returned
18	Durable Medical Equipment Rental	Benefits returned
48	Hospital - Inpatient	Benefits returned
50	Hospital – Outpatient	Benefits returned
62	MRI/CAT Scan	Benefits returned
86	Emergency Services	Benefits returned
98	Professional (Physician Visit) - Office	"Sick" Benefits returned
A0	Professional (Physician) Visit - Outpatient	Benefits returned
A7	Psychiatric- Inpatient	Benefits returned
A8	Psychiatric- Outpatient	Benefits returned
AB	Rehabilitation – Inpatient	Benefits returned
AD	Occupational Therapy	Benefits returned
PT	Physical Therapy	Benefits returned
AF	Speech Therapy	Benefits returned
AG	Skilled Nursing Care	Benefits returned
BF	Pulmonary Rehabilitation	Benefits returned
BG	Cardiac Rehabilitation	Benefits returned
Service Type BV – Obstetrical/Gynecological		
Service Types Returned		**Blue Cross Business Rule**
BV	Obstetrical/Gynecological	Active Status ONLY (no benefits returned)

BT	Gynecological	Benefits returned
BU	Obstetrical	Benefits returned
Service Type Requested: DM – Durable Medical Equipment		
Service Types Returned		**Blue Cross Business Rule**
DM	Durable Medical Equipment	Active Status ONLY (no benefits returned)
12	Durable Medical Equipment Purchase	Benefits returned
18	Durable Medical Equipment Rental	Benefits returned
Service Type Requested: MH – Mental Health		
Service Types Returned		**Blue Cross Business Rule**
MH	Mental Health	Active Status ONLY (no benefits returned)
CE	Mental Health Provider - Inpatient	Benefits returned
CF	Mental Health Provider - Outpatient	Benefits returned
CG	Mental Health Provider Facility- Inpatient	Benefits returned
CH	Mental Health Provider Facility- Outpatient	Benefits returned
Service Type Requested: 35 – Dental Care		
Service Types Returned		**Blue Cross Business Rule**
23	Diagnostic Dental	Benefits returned
24	Periodontics	Benefits returned
25	Restorative	Benefits returned
26	Endodontics	Benefits returned
35	Dental Care	Active Status ONLY (no benefits returned)
36	Dental Crowns	Benefits returned
38	Orthodontics	Benefits returned
39	Prosthodontics	Benefits returned
40	Oral Surgery	Benefits returned
41	Routine Dental	Benefits returned

9.3. Appendix C. AAA Responses for Alpha Name Search Scenarios

Alpha Name Search submitted and...	Eligibility Response (271) returned with...	Action Needed...
Blue Cross identifies your patient (EXACT MATCH on the patient's First Name, Last Name, and Date of Birth)	Full eligibility and benefits including the patient's Blue Cross ID #	None

Alpha Name Search submitted and...	Eligibility Response (271) returned with...	Action Needed...
Your patient is enrolled with the Federal Employee Program (FEP) ***These members are not enrolled in Blue Cross's membership files.***	**AAA03 = 75** (Subscriber) or **AAA03 = 67** (Dependent) and a MSG segment "WE COULD NOT IDENTIFY YOUR PATIENT AS A BCBSMA MEMBER. PLEASE ASK THE PATIENT FOR HIS/HER BCBS IDENTIFICATION CARD OR CALL 800-676- BLUE FOR BCBS PATIENT ELIGIBILITY INFORMATION."	Ask the patient for his/her Blue Cross ID card and resubmit the request with the ID # (be sure to include the alpha prefix of "R"). Blue Cross will coordinate with FEP to return a 271 response.
Your patient is enrolled with another BCBS Plan *These members are not enrolled in our membership files.*	**AAA03 = 75** (Subscriber) or **AAA03 = 67** (Dependent) and a MSG segment "WE COULD NOT IDENTIFY YOUR PATIENT AS A BCBSMA MEMBER. PLEASE ASK THE PATIENT FOR HIS/HER BCBS IDENTIFICATION CARD OR CALL 800-676- BLUE FOR BCBS PATIENT ELIGIBILITY INFORMATION."	Ask the patient for his/her Blue Cross ID card and resubmit request with the ID # (be sure to include the alpha or alpha-numeric prefix). Blue Cross will coordinate with the member's BCBS plan to return a 271 response.
Blue Cross identifies more than one patient in our membership files with the same First Name, Last Name, and Date of Birth	**AAA03 = 76** (Subscriber) or **AAA03 = 68** (Dependent) and a MSG segment "WE COULD NOT IDENTIFY YOUR PATIENT AS A BCBSMA MEMBER. PLEASE ASK THE PATIENT FOR HIS/HER BCBS IDENTIFICATION CARD OR CALL 800-676-BLUE FOR BCBS PATIENT ELIGIBILITY INFORMATION."	Ask the patient for his/her Blue Cross ID card and resubmit request with the ID # (be sure to include the alpha or alpha-numeric prefix).
Blue Cross is unable to identify a Blue Cross patient with the submitted First Name, Last Name, and Date of Birth	**AAA03 = 75** (Subscriber) or **AAA03 = 67** (Dependent) and a MSG segment "WE COULD NOT IDENTIFY YOUR PATIENT AS A BCBSMA MEMBER. PLEASE ASK THE PATIENT FOR HIS/HER BCBS IDENTIFICATION CARD OR CALL 800-676-BLUE FOR BCBS PATIENT ELIGIBILITY INFORMATION."	Ask the patient for his/her Blue Cross ID card and resubmit request with the ID # (be sure to include the alpha or alpha-numeric prefix).
The Patient's First Name and/or Last Name is not submitted	**AAA03 = 73** (Subscriber) or **AAA03 = 65** (Dependent)	Resubmit your request with the Patient's First Name AND Last Name.
The Patient's Date of Birth is not submitted	**AAA03 = 58**	Resubmit your request with the Patient's Date of Birth.

Alpha Name Search submitted and...	Eligibility Response (271) returned with...	Action Needed...
Blue Cross is not able to process the Alpha Name Search 270 request	**AAA03 = 42** and a MSG segment "WE COULD NOT IDENTIFY YOUR PATIENT AS A BCBSMA MEMBER. PLEASE ASK THE PATIENT FOR HIS/HER BCBS IDENTIFICATION CARD OR CALL 800-676-BLUE FOR BCBS PATIENT ELIGIBILITY INFORMATION."	Ask the patient for his/her Blue Cross ID card and resubmit request with the ID # (be sure to include the alpha or alpha-numeric prefix).

9.4. Appendix D. Sample 270 Request

```
ISA*00*   *00*          *ZZ*NEHEN999       *ZZ*NEHEN004
*120203*0738*^*00501*799213902*0*P*>~
GS*HS*RITSA*RBTSA*20120203*0738*799213902*X*005010X279A1
~
ST*270*1234*005010X279A1~
BHT*0022*13*799213902*20120203*0738~
```

```
HL*1**20*1~
NM1*PR*2*BLUE       CROSS       BLUE       SHIELD       OF
MASSACHUSETTS*****PI*700~
HL*2*1*21*1~
NM1*1P*1*PROVIDER*NAME****XX*9999999999~
HL*3*2*22*0~
TRN*1*799213902*9RECVR999~
NM1*IL*1******MI*XXP999999999~
DMG*D8*19010101*M~
DTP*291*D8*20120203~
EQ*30~
SE*13*1234~
GE*1*799213902~
IEA*1*799213902~
```

9.5. Appendix E. Sample 271 Response

```
ISA*00*             *00*     *ZZ*NEHEN004          *ZZ*NEHEN999
*121127*2049*^*00501*000001176*0*P*:~
GS*HB*NEHEN004*0000000XX*20121127*2049509*1119*X*005010X279A1~
ST*271*2175*005010X279A1~
BHT*0022*11*E6BF480B-9456-49C3-BA02-595EAAFACEBC*20121127*2049509~
```

```
HL*1**20*1~
NM1*PR*2*BLUE CROSS BLUE SHIELD OF MASSACHUSETTS*****PI*700~
PER*IC*BCBSMA CLINICAL COORDINATION*TE*8003276716*FX*8882821321~
HL*2*1*21*1~
NM1*1P*2*PROVIDER*NAME****XX*9999999999~
N3*999 STREET NAME~
N4*CITY*MA*99999~
HL*3*2*22*0~
TRN*2*E6BF480B-9456-49C3-BA02-595EAAFACEBC*90000000XX~
NM1*IL*1*LAST*FIRST*M***MI*XXP999999999~
REF*6P*999999999*GROUP NAME~
N3*999 STREET NAME~
N4*CITY*MA*99999~
DMG*D8*19010101*F~
INS*Y*18*001*25~
DTP*291*RD8*20100901-99991231~
EB*1*FAM*30*PR*PPO - BLUE CARE ELECT PREFERRED~
EB*CB**30**SELF INSURED~
EB*N**30*********Y~
MSG*PPO PROVIDER NETWORK~
EB*N**30*********N~
MSG*ANY LICENSED HEALTH CARE PROVIDER IN A COVERED PROVIDER CATEGORY~
EB*C*IND*30***23*100*****N~
DTP*291*RD8*20120101-20121231~
MSG*(INCLUDES 4TH QUARTER CARRY-OVER PROVISION; DOES NOT APPLY TO
SERVICES
WITH A COPAYMENT)~
EB*C*IND*30***29*100*****N~
EB*C*FAM*30***23*300*****N~
DTP*291*RD8*20120101-20121231~
MSG*(INCLUDES 4TH QUARTER CARRY-OVER PROVISION; DOES NOT APPLY TO
SERVICES
WITH A COPAYMENT)~
EB*C*FAM*30***29*300*****N~
EB*G*IND*30***23*500*****N~
MSG*(INCLUDES DEDUCTIBLE AND COINSURANCE)~
EB*G*IND*30***29*500*****N~
EB*G*FAM*30***23*1000*****N~
MSG*(INCLUDES DEDUCTIBLE AND COINSURANCE)~
EB*G*FAM*30***29*1000*****N~
EB*1**1^33^88^AL^MH^UC~
EB*C**33****0****N*Y~
MSG*DIAGNOSTIC LAB, DIAGNOSTIC X-RAY~
EB*A*IND*33*****0***N*Y~
MSG*DIAGNOSTIC LAB, DIAGNOSTIC X-RAY~
EB*B*IND*33^98***27*20****N*Y~
MSG*MEDICAL CARE~
EB*B**33****0****N*Y~
MSG*DIAGNOSTIC LAB, DIAGNOSTIC X-RAY~
EB*A*IND*33*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*DIAGNOSTIC LAB, DIAGNOSTIC X-RAY~
EB*A*IND*33^98*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
```

```
MSG*MEDICAL CARE~
EB*F*IND*47*********W~
MSG*SELF-INJECTABLE AND SPECIALTY DRUG EXCLUSION – OUTPATIENT~
MSG*REFER TO PRESCRIPTION DRUGS~
EB*B*IND*47^48***36*250****Y*Y~
MSG*GENERAL HOSPITAL~
EB*B*IND*47^48***36*250****Y*Y~
MSG*CHRONIC DISEASE HOSPITAL~
EB*B*IND*47***27*20****N*Y~
MSG*OUTPATIENT MEDICAL CARE~
III*ZZ*22~
EB*A*IND*47^48*****.2***Y*N~
MSG*AFTER DEDUCTIBLE~
MSG*GENERAL HOSPITAL~
EB*A*IND*47^48*****.2***Y*N~
MSG*AFTER DEDUCTIBLE~
MSG*CHRONIC DISEASE HOSPITAL~
EB*A*IND*47*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*OUTPATIENT MEDICAL CARE~
III*ZZ*22~
EB*F*IND*50^98*********W~
MSG*SELF-INJECTABLE AND SPECIALTY DRUG EXCLUSION APPLIES~
MSG*REFER TO PRESCRIPTION DRUGS~
EB*B*IND*50***27*20****N*Y~
MSG*MEDICAL CARE~
III*ZZ*22~
EB*A*IND*50*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*MEDICAL CARE~
III*ZZ*22~
EB*B*IND*51^52^86^UC***27*100****N*Y~
MSG*EMERGENCY ROOM SERVICES~
III*ZZ*23~
EB*B*IND*51^52^86^UC***27*20****N*Y~
MSG*OFFICE, HEALTH CENTER AND HOSPITAL SERVICES~
III*ZZ*22~
EB*A*IND*51^52^86^UC*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*OFFICE, HEALTH CENTER AND HOSPITAL SERVICES~
III*ZZ*22~
EB*B*IND*51^52^86^UC***27*100****N*N~
MSG*DEDUCTIBLE DOES NOT APPLY~
MSG*EMERGENCY ROOM SERVICES~
III*ZZ*23~
EB*C**BZ****0****N*W~
MSG*ROUTINE PEDIATRIC~
EB*A*IND*BZ*****0***N*W~
MSG*ROUTINE PEDIATRIC~
EB*B**BZ****0****N*W~
MSG*ROUTINE PEDIATRIC~
EB*F*IND*BZ******S7*18**W~
MSG*ROUTINE PEDIATRIC~
```

```
MSG*ACCORDING TO AGE-BASED SCHEDULE THROUGH AGE 18~
EB*F*IND*BZ***23***VS*1**W~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*F*IND*BZ***29***VS*1**W~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*F*IND*BZ*********W~ MSG*ROUTINE
COLONOSCOPY~ MSG*ACCORDING TO AGE-
BASED SCHEDULE~
EB*C**BZ****0****N*Y~
MSG*ROUTINE PEDIATRIC~
EB*C**BZ****0****N*Y~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*C**BZ****0****N*Y~
MSG*ROUTINE COLONOSCOPY~
EB*A*IND*BZ*****0***N*Y~
MSG*ROUTINE PEDIATRIC~
EB*A*IND*BZ*****0***N*Y~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*A*IND*BZ*****0***N*Y~
MSG*ROUTINE COLONOSCOPY~
EB*B**BZ****0****N*Y~
MSG*ROUTINE PEDIATRIC~
EB*B**BZ****0****N*Y~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*B**BZ****0****N*Y~
MSG*ROUTINE COLONOSCOPY~
EB*A*IND*BZ*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*ROUTINE PEDIATRIC~
EB*A*IND*BZ*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*ROUTINE ADULT, RELATED ROUTINE TESTS~
EB*A*IND*BZ*****.2***N*N~
MSG*AFTER DEDUCTIBLE~
MSG*ROUTINE COLONOSCOPY~
EB*P~
MSG*UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A
GUARANTEE
OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE
MEMBER'S
STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE
MAY
CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.~
SE*143*2175~
GE*1*1119~
IEA*1*000001176~
```

9.6. Revision History

Revision Number	Date	Section	Notes
1.1	02/03/12	Cover	Replaced “HIPAA Transaction” with “Health Care Eligibility Benefit Inquiry and Response”
		Footer	Updated to February 2012
		5.2	Changed Title of section from “Alpha Search” to “Eligibility By Name Search”
		5.5.3	Added new section 5.5.3 – Plan Level Benefits
		5.6.2	Added description for EB01 = “R” (Other or Additional Payor)
		5.6.4	Added new section 5.6.4 – Tiered Options
		5.6.5	Added new section 5.6.5 – Financial Arrangements
		5.7	Added new section 5.7 – Exceptions
		5.7.1	Added new section 5.7.1 – Incorrect/Missing Information
		5.7.2	Added new section 5.7.2 – Inactive Member
		6	Updated language of initial paragraph to include: “270 Eligibility Requests submitted to Blue Cross must be HIPAA compliant”
		7	Note added to section heading: “All data must be submitted in UPPER CASE. In addition, leading spaces must be omitted and trailing spaces must be omitted unless necessary to fulfill a minimum field length.”
		8.1	New fields added to Header Data grid relating to Date/Time formatting: ISA09, 10 GS04, 05 BHT04, 05
		App. D	Replaced 270 Example
		App. E	Replaced 271 Example
1.2	12/01/12	Footer	Updated to December 2012
		3.3	Changed Section Heading and Contents to accommodate new core hours of operation.
		5.3	Added Group Number
		5.5	Added reference to CAQH CORE requirements
		5.5.5	Added new section 5.5.5 – Deductible Dates
		5.6.5	Added new section 5.6.5 – Hospital Choice Cost Sharing
		5.7.1	Removed reference to “AAA04”
		App. A	Updates to Supported Service Types: Service Type (action) 51 (add Service Type) AI (add Service Type)

Revision Number	Date	Section	Notes
		App. B	Updates to Service Type Groupings: Service Type Group : Service Type(s) (action) 30 : 47, 86 (Benefits returned) 30 : 98 (“Sick” Benefits returned) 30 : 51 (add Service Type to group) 30 : BY (remove Service Type from group) 1 : 73 (remove Service Type from group) 47 : 48, 50 (remove Service Types from group) 47 : 47 (Benefits returned) 68 : 80 (add Service Type to group) 86 : 62 (remove Service Type from group) 86 : 98 (“Sick” Benefits returned) 98 : BY (remove Service Type from group) 98 : 98 (“Sick” Benefits returned) A9 : 98 (“Sick” Benefits returned)
		App. E	New example provided
1.3	06/05/13	1.3	Revised Batch response time from 24 hours to 6 hours.
		2	Removed reference to Ramp Management and specific testing windows.
		3.1	Added Direct Channel.
		3.2	Added Direct Submitter information.
1.4	04/10/14	3.1	Revised Direct Channel.
1.5	12/10/15	3.1	Revised website name
		4	Revised phone prompt
		5.6.7	Added Telehealth Benefits section
1.6	11/08/16	3.3	Corrected duplicate data
1.7	5/22/17		Reviewed with no content changes necessary. Updated document template.
1.8	5/15/18	5.1	Revised prefix content
	5/15/18	7.2	Revised prefix content
	5/15/18	8.2	Revised prefix content
	5/15/18	9.3	Revised prefix content
	5/15/18	3.1	Revised e-Channels
1.9	1/1/20	5.5.9	Added section on First Dollar Coverage
	1/1/20	5.6.7	Added section on Lactation Counseling Telehealth
	1/1/20	App. A	Updated Supported Service Type to include BA and 64.
2.0	7/21/21	5.6.7	Divided section into sub-sections. Added information about Routine Vision Exams and Chiropractic visits.
2.1	12/23/21	5.6.7.1	Replaced information regarding medical telehealth visits
		5.6.7.5	Added section on Value Care Visits
2.2	2/9/23	3.1	Adding submission instructions to the end of the section on e-Channels

MPC_040417-2C (rev. 2/23)