Standard Companion Guide

Refers to the Implementation Guide

Based on X12 Version 005010X279A1

Health Care Eligibility Benefit

Inquiry and Response

(270/271)

Companion Guide Version Number 6.0

May 8, 2020

CHANGE LOG

Version	Release Date	Changes
1.0	11/10/2008	Created 11/10/2008 for 5010 Implementation.
2.0	11/10/2008	Initial External Release – Changes to comply with MN 62J (Eligibility Transaction Requirements); This functionality is planned for December, 2008; Effective date will be communicated separately in a release notice.
2.1	06/23/2009	Added Disclaimer in section 6.2.
2.2	12/11/2009	Added Additional service type codes (2, 5, 7, 9, 12, 13, 53, 60) in section 6.2.1; Updated service type code "AL" in section 6.2.1; Added specialty medication message segment example to the 271 response in section 7.2.
2.3	02/05/2010	Changed coinsurance amounts in examples from a whole number to a percentage.
3.0	10/11/2010	Updated based on 5010 270/271 transactions changes.
3.1	04/13/2011	Specified the valid single date inquiry range.
3.2	11/18/2011	Modified the descriptions for the service type codes returned in the 271, Section 6.2 #2.
4.0	08/30/2017	Changed clearinghouse name from Ingenix to OptumInsight; Added contacts for Optum; Updated all sections with current hyperlinks; Changed references from UnitedHealthcareOnline to UHCprovider.com.
4.1	11/07/2017	Updated UnitedHealthcare and Optum contact information, including hyperlinks to online resources; Reviewed document in detail, updating as needed.
4.2	12/08/2017	Added Vision service type codes AM, AN, AO.
5.0	04/06/2018	Updated service type code list in section 6.2.
6.0	05/08/2020	Updated Section 2.2, Clearinghouse Connection; Section 3.8 Costs to Connect

PREFACE

This companion guide (CG) to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare.

Transmissions based on this companion guide, used in tandem with the TR3, also called 270/271 Health Care Eligibility and Benefit Inquiry and Response ASC X12N (005010X279A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 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 TR3.

The TR3, also known as X12N Implementation Guide (IG), adopted under HIPAA, here on in within this document will be known as IG or TR3.

Table of Contents

1. INTRODUCTION

This section describes how Technical Report Type 3 (TR3), also called 270/271 Health Care Eligibility and Benefit Inquiry and Response ASC X12N (005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has included, in addition to the information contained in the TR3s. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The table below specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the TR3s.

The following is an example (from Section 9 – Transaction Specific Information) of the type of information that may be included:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	**2100C**	**NM1**	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	**2100C**	**NM109**	Subscriber Primary Identifier		**15**	This type of row exists to limit the length of the specified data element.
196	**2100C**	**REF**	Subscriber Additional Identification			
197	**2100C**	**REF01**	**Reference Identification Qualifier**	18, 49, 6P, HJ, N6		These are the only codes transmitted by UnitedHealth Group.
			Plan Network Identification Number	**N6**		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
218	**2110C**	**EB**	Subscriber Eligibility or Benefit Information			
231	**2110C**	**EB13-1**	Product/Service ID Qualifier	**AD**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

This document is to be used for the implementation of the TR3 HIPAA 5010 270/271 Health Care Eligibility and Benefit Inquiry and Response (referred to as Eligibility and Benefit in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This companion guide is not intended to replace the TR3.

1.2 OVERVIEW

This CG will replace, in total, the previous UnitedHealthcare CG versions for Health Care Eligibility and Benefit Inquiry and Response and must be used in conjunction with the TR3 instructions.

This CG is intended to assist you in implementing electronic Eligibility and Benefit transactions that meet UnitedHealthcare processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library on the Companion Guides page: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html In addition, trading partners can sign up for the Network Bulletin and other online news: https://uhg.csharmony.epsilon.com/Account/Register..

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (005010X279A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company website: http://www.wpc-edi.com

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers. Please note that this is UnitedHealthcare's approach to the 270/271 eligibility and benefits transactions. After careful review of the existing IG for the Version 005010X279A1, we have compiled the UnitedHealthcare specific CG. We are not responsible for any changes and updates made to the IG.

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE

UnitedHealthcare exchanges transactions with clearinghouses and direct submitters, also referred to as Trading Partners. Most transactions go through the Optum clearinghouse, OptumInsight, the managed gateway for UnitedHealthcare EDI transactions.

2.2 CLEARINGHOUSE CONNECTION

Physicians, facilities and health professionals should contact their current clearinghouse vendor to discuss their ability to support the 270/271 005010X279A1 Health Care Eligibility and Benefit Inquiry and Response transaction, as well as associated timeframes, costs, etc. This includes protocols for testing the exchange of transactions with UnitedHealthcare through your clearinghouse.

Optum: Physicians, facilities and health professionals can submit and receive EDI transactions through their all payer clearinghouse or online solution, Intelligent EDI.

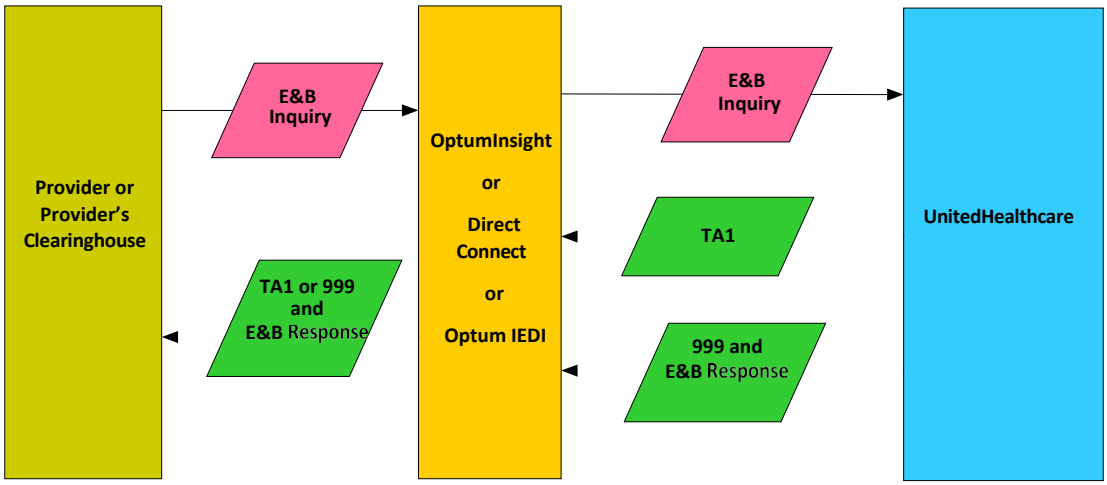
Go to UHCprovider.com/ediconnect for more information on clearinghouses and Optum solutions.

3. CONNECTIVITY AND COMMUNICATION PROTOCOLS

3.1 PROCESS FLOW: BATCH 270/271 ELIGIBILITY BENEFIT INQUIRY AND RESPONSE

The response to a batch of eligibility inquiry and response transactions will consist of:

1. First level response – TA1 will be generated when errors occur within the envelope.
2. Second level response – 999 Functional Acknowledgement may contain both positive and negative responses. Positive responses indicates conformance with TR3 guidelines; negative responses indicates non-compliance with TR3 guidelines.
3. Third level response – A single batch containing 271 responses for each 270 transaction that passes the compliance check in the second level response. This includes 271 responses with AAA errors.



When a batch of eligibility transactions is received, the individual transactions within the batch are first checked for format compliance. A 999 Functional Acknowledgement transaction is then created indicating number of transactions that passed and failed the initial edits. Data segment AK2 identifies the transaction set and data segment IK5 identifies if the transaction set in AK2 accepted or rejected. AK9 indicates the number of transaction sets received and accepted.

Transactions that pass envelope validation are then de-batched and processed individually. Each transaction is sent through another map to validate the individual eligibility transaction. Transactions that fail this compliance check will generate a 999 with an error message indicating that there was a compliance error.

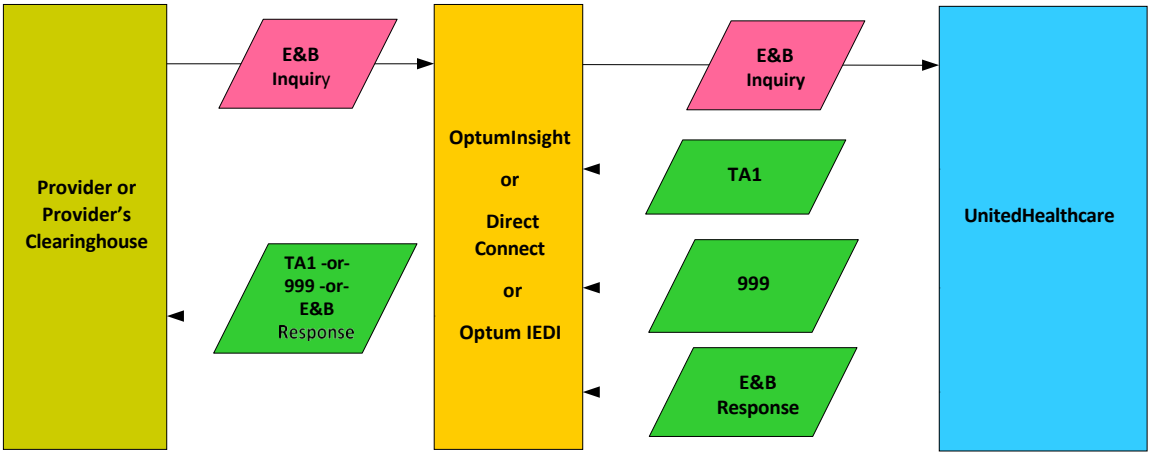
Transactions that pass the compliance check but fail further on in the processing (e.g. ineligible member) will result in an error message returned in a 271 AAA data segment.

Transactions that pass compliance checks and process successfully will return Eligibility and Benefit information in the 271 response.

All of the response transactions including those resulting from the initial edits (999s and 271) from each of the 270 requests are batched together and sent to the submitter.

3.2 PROCESS FLOW: REAL-TIME ELIGIBILITY INQUIRY AND RESPONSE

The response to a real-time eligibility transaction will consist of:
First level response – TA1 will be generated when errors occur within the outer envelope.
Second level response – 999 will be generated when errors occur during 270 compliance validation.
Third level response – 271 will be generated indicating the eligibility and benefits or indicating AAA errors within request validation.



Each transaction is validated to ensure that the 270 complies with the 005010X279A1. Transactions which fail this compliance check will generate a real-time 999 message back to the sender with an error message indicating that there was a compliance error. Transactions that pass compliance checks, but failed to process (e.g. due to member not being found) will generate a real-time 271 response transaction including an AAA segment indicating the reason for the error. Transactions that pass compliance checks and do not generate AAA segments will create a 271 using the information in our eligibility and benefit system.

3.3 TRANSMISSION ADMININSTRATIVE PROCEDURES

UnitedHealthcare supports both batch and real-time 270/271 transmissions. Contact your current clearinghouse vendor discuss transmission types and availability.

3.4 RE-TRANSMISSION PROCEDURES

Please follow the instructions within the 271 AAA data segment for information on whether resubmission is allowed or what data corrections need to be made for a successful response.

3.5 COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse for communication protocols with UnitedHealthcare.

3.6 PASSWORDS

1. Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss password policies.
2. CAQH CORE Connectivity: OptumInsight is acting as a CORE connectivity proxy for UnitedHealthcare Eligibility and Benefit transactions. For information regarding passwords, please contact Optum.

3.7 SYSTEM AVAILABILITY

Normal business hours: Monday - Friday, 5 am to 9 pm CST
Weekend hours: Saturday - Sunday, 5 am to 6 pm CST (exceptions may occur)

UnitedHealthcare systems may be down for general maintenance and upgrades. During these times, our ability to process incoming 270/271 EDI transactions may be impacted. The codes returned in the AAA segment of the 271 response will instruct the trading partner if any action is required.

In addition, unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming 270 transactions. UnitedHealthcare will send an email communication for scheduled and unplanned outages.

3.8 COSTS TO CONNECT

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor or Optum to discuss costs.

Optum:

- Optum Support – 800-341-6141

4. CONTACT INFORMATION

4.1 EDI SUPPORT

Most questions can be answered by referring to the EDI section of our resource library at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange (EDI): https://www.uhcprovider.com/en/resource-library/edi.html. View the EDI 270/271 page for information specific to Eligibility and Benefit Inquiry and Response transactions.

If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 270/271 or invalid data in the 271 response, please contact EDI Support by:

- Using our EDI Transaction Support Form
- Sending an email to supportedi@uhc.com
- Calling at 800-842-1109

For questions related to submitting transactions through a clearinghouse, please contact your clearinghouse or software vendor directly.

4.2 EDI TECHNICAL SUPPORT

When receiving the 271 response from a clearinghouse, please contact the clearinghouse. If using Optum, contact their technical support team at 800-225-8951, option 6.

4.3 PROVIDER SERVICES

Provider Services should be contacted at 877-842-3210 instead of EDI Support if you have questions regarding the details of a member's benefits. Provider Services is available Monday - Friday, 7 am - 7 pm in the provider's time zone.

4.4 APPLICABLE WEBSITES/EMAIL

CAQH CORE: http://www.caqh.org

Companion Guides: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html

Optum: https://www.optum.com/

OptumInsight/Optum EDI Client Center - https://www.enshealth.com

UnitedHealthcare Care Administrative Guides and Manuals: https://www.uhcprovider.com/en/admin-guides.html

UnitedHealthcare EDI Support: supportedi@uhc.com or EDI Transaction Support Form

UnitedHealthcare EDI Education website: https://www.uhcprovider.com/en/resource-library/edi.html

Washington Publishing Company: http://www.wpc-edi.com

5. CONTROL SEGMENTS/ENVELOPES

5.1 ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

The table below represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

TR3 Page #	LOOP ID	Reference	NAME	Codes	Notes/Comments
C.3	**None**	**ISA**	**ISA Interchange Control Header**		
C.5		ISA08	Interchange Receiver ID	**87726**	UnitedHealthcare Payer ID -Right pad as needed with spaces to 15 characters.
C.6		ISA15	Usage Identifier	**P**	Code indicating whether data enclosed is production or test.

5.2 GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in a transmission may vary.

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

Page #	LOOP ID	Reference	NAME	Codes	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**		**Required Header**
C.7		GS03	Application Receiver's Code	**87726**	UnitedHealthcare Payer ID Code
C.8		GS08	Version/Release/Industry Identifier Code	**005010X279**	Version expected to be received by UnitedHealthcare

5.3 ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. A 270 file can only contain 270 transactions.

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

Page #	LOOP ID	Reference	NAME	Codes	Notes/Comments
61	**None**	**ST**	**Transaction Set Header**		**Required Header**
62		ST03	Implementation Convention Reference	**010X279 A1**	

5.4 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header segment
First 278 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Second 278 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Third 278 Transaction
SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

5.5 CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record and all fields must be supplied. Fields not populated with actual data must be filled with space.

1. The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
2. The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
3. ISA16 defines the component element

5.6 FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Please contact UnitedHealthcare if there is a need to use a delimiter other than the following:

1. Data Segment: The recommended data segment delimiter is a tilde (~)
2. Data Element: The recommended data element delimiter is an asterisk (*)
3. Component Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a carrot (^)

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 270 REQUEST

1. If an explicit Service Type Code (STC) is not supported, the 271 response will be the same as if a generic service type code "30" (Health Benefit Plan Coverage) 270 request was received. Supported explicit (EQ01) values will result in only that explicit service type code being returned with the exception of category codes.
2. Eligibility requests containing multiple service type codes in 2110C/D EQ01 (up to 10) will be processed and returned. If more than 10 service type codes are returned, only the first 10 will be returned.
3. Eligibility requests for a date range will return all plans for the member that is identified by the search criteria sent in. Any plans that have coverage during the date range will be returned. Date range must have a start date no greater than 18 months in the past and the end date must be no greater than the end of the current month. A 271 AAA value of 62 or 63 will be returned if the date range validation fails.
4. Category service type codes supported are listed below. It is advised if a provider is looking for a specific category, that the category code is sent in the 270 2110C/D EQ01 (explicit) instead of sending a generic 30 inquiry. The below categories will return a list of service type codes unless the benefit is serviced by a vendor (e.g. Pharmacy Benefit Manager – Prescription Solutions) in which case the vendor information will be provided. The benefits that are recommended to be returned in the specific categories are defined in the TR3. UnitedHealthcare will return most of the recommended benefits. Benefits returned in a generic 30 request are:
    a. Medical Care
    b. Dental Care
    c. Hospital
    d. Pharmacy (potential vendor)
    e. Professional Office Visit
    f. Mental Health
5. If a specific service type code is desired, that explicit service type code should be submitted in the 270 EQ01. If the explicit service type code is not supported, a generic response will be returned.
6. The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). It is recommended that the maximum number of search data elements is used. This will result in the best chance of finding a member; however, all data elements aren't required. Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent indicating to the user what criteria needs to be supplied to find a match. If the policy number is sent in the request, it will be used as a tie breaker should there be multiple plans for the member.

The following table describes the data received for each search scenario that will be supported. If the necessary data elements are not sent to satisfy one of the scenarios noted below, a 271 AAA 75 error will be returned and a subsequent 270 request with the required additional data elements will need to be submitted.

SCENARIO	Patient/Member ID	Last	First	Patient
1	x	x	x	x
2	x	x		x
3	x		x	x
4	x			x
5	x	x	x	
6		x	x	x

6.2 271 RESPONSE

Disclaimer: Information provided in a 271 is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocol(s), date(s) of services rendered and benefit plan terms and conditions.

The 271 response may not be exclusively for the payer ID that was received in the 270 request.

1. When sending in single date inquiries, if an active plan is not found for the member, a subsequent request with a different date will need to be submitted. UnitedHealthcare does not employ logic to search for the future or previous active timeline for the member. Single date inquiries of 18 months in the past up to the end of the current month are acceptable.
2. The following HIPAA service type codes (2110C/D EB03) are supported as explicit or category requests in the 270. The 271 response will contain copay, coinsurance and benefit deductible information for the benefit requested or benefits within the category requested. The Additional Information column provides clarifying information about the benefit.

Service Type Code	Service Type Code Definition	Additional Information
1	Medical Care	
2	Surgical	
3	Consultation	
4	Diagnostic X-Ray	
5	Diagnostic Lab	
6	Radiation Therapy	
7	Anesthesia	
8	Surgical Assistance	
12	Durable Medical Equipment Purchase	
13	Ambulatory Service Center Facility	
18	Durable Medical Equipment Rental	
20	Second Surgical Opinion	
23	Diagnostic Dental	Dental Benefit or Vendor Name
24	Periodontics	Dental Benefit or Vendor Name
25	Restorative	Dental Benefit or Vendor Name
26	Endodontics	Dental Benefit or Vendor Name
27	Maxillofacial Prosthetics	Medical (Maxillofacial Prosthetics (TMJ Splints)) and/or Dental Benefit and/or
28	Adjunctive Dental Services	Dental Benefit or Vendor Name
30	Health Benefit Plan Coverage	Generic request for eligibility
33	Chiropractic	
35	Dental Care	Dental Benefit or Vendor Name
36	Dental Crowns	Dental Benefit or Vendor Name

37	Dental Accident	Medical and/or Dental Benefit and/or Vendor
38	Orthodontics	Dental Benefit or Vendor Name
39	Prosthodontics	Dental Benefit or Vendor Name
40	Oral Surgery	Medical and/or Dental Benefit and/or Vendor Name
41	Routine (Preventive) Dental	Dental Benefit or Vendor Name
42	Home Health Care	
45	Hospice	Facility Charge
47	Hospital	See #3 below
48	Hospital - Inpatient	
49	Hospital - Room and Board	
50	Hospital - Outpatient	Outpatient Surgery
51	Hospital – Emergency Accident	
52	Hospital – Emergency Medical	
53	Hospital – Ambulatory Surgical	Outpatient Surgery and may also return Outpatient Hospital Services
62	MRI/CAT Scan	
65	Newborn Care	Inpatient Newborn Care and may also return Outpatient Newborn Care
68	Well Baby Care	
69	Maternity	Maternity Inpatient Facility Labor and Delivery may also return Office Visit/Outpatient Maternity Services
73	Diagnostic Medical	Diagnostic Medical Hospital Outpatient and may also return Diagnostic Medical Outpatient Services
76	Dialysis	
78	Chemotherapy	
80	Immunizations	
81	Routine Physical	
82	Family Planning	
83	Infertility	
86	Emergency	
88	Pharmacy	Specifies the Pharmacy Benefit Manager
89	Free Standing Prescription Drug	Specifies the Pharmacy Benefit Manager
90	Mail Order Prescription Drug	Specifies the Pharmacy Benefit Manager
91	Brand Name Prescription Drug	Specifies Pharmacy Benefit Manager
92	Generic Prescription Drug	Specifies the Pharmacy Benefit Manager
93	Podiatry	

96	Professional (Physician)	Specialist
98	Professional (Physician) Office	PCP Office Visit and may also return Specialist Office Visit
99	Professional (Physician) Visit - Inpatient	
A0	Professional (Physician) Visit – Outpatient	
A3	Professional (Physician) Visit - Home	
A4	Psychiatric	Individual Mental Health Office Visit and may also return Individual Mental Health Outpatient Visit
A5	Psychiatric - Room and Board	Facility Charge
A6	Psychotherapy	Individual Mental Health Office Visit and may also return Individual Mental Health Outpatient Visit
A7	Psychiatric - Inpatient	Facility Charge
A8	Psychiatric – Outpatient	Mental Health Individual Outpatient and may also return Mental Health Group Outpatient
AD	Occupational Therapy	
AE	Physical Medicine	
AF	Speech Therapy	
AG	Skilled Nursing	
AI	Substance Abuse	Outpatient Substance Abuse
AJ	Alcoholism	Outpatient Alcoholism
AK	Drug Addiction	Outpatient Drug Abuse
AL	Vision (Optometry)	All Benefits
AM	Vision Frames	
AN	Routine Exam - Vision	
AO	Vision Lens and Contact Lenses	
BG	Cardiac Rehabilitation	
BH	Pediatric	
BT	Gynecological	Preventative Care
BU	Obstetrical	Prenatal Office Visit
BW	Mail Order Prescription Drug: Brand Name	Specifies the Pharmacy Benefit Manager
BX	Mail Order Prescription Drug: Generic	Specifies the Pharmacy Benefit Manager

BY	Physician Visit - Office: Sick	
BZ	Physician Visit - Office: Well	
DM	Durable Medical Equipment	
GF	Generic Prescription Drug - Formulary	Specifies the Pharmacy Benefit Manager
GN	Generic Prescription Drug – Non-Formulary	Specifies the Pharmacy Benefit Manager
MH	Mental Health	Individual Mental Health Office Visit and may also return Individual Mental
PT	Physical Therapy	
UC	Urgent Care	

3. In the generic response (EB03=30) when benefit copay, coinsurance and deductible information for 48 (Hospital, Inpatient) and 50 (Hospital, Outpatient) are included in the response, then 47 (Hospital) will not include benefit copay, coinsurance and deductible information.
4. For explicit or category 271 responses, an eligibility benefit (EB) data segment indicating active (1), inactive (6) or non-covered (I) in loop 2110C/D EB01 will be returned for supported HIPAA service type codes.
    a. Active Benefit Example:
    EB*1**86~ = active coverage for individual emergency service benefits
    b. Inactive Benefit Example:
    EB*6**35~ = inactive dental coverage
    DTP*349*D8*20080630~ = coverage ended on of 6/30/2008
    c. Non-Covered Benefit Example:
    EB*I**96~ = Specialist is not covered
5. When applicable, an EB data segment in loop 2110C/D will be returned with benefit level co-payments, coinsurance and deductible amounts. Remaining benefit deductible will be returned if applicable.
    a. Base deductible example for a benefit:
    EB*C*IND*33****500*****Y~ = individual has a $500 base deductible for in-network chiropractic care
    b. Remaining deductible example for a benefit:
    EB*C*IND*33***29*183*****Y~ = individual has a $183 remaining deductible for in-network chiropractic care. When a benefit has multiple in-network copayments, coinsurance, deductibles, limitations or cost containment measures, a message segment will be sent distinguishing between multiple in-network benefits. The message segment will directly follow the EB data segment in loop 2110C/D that the message applies to.
    c. Highest in-network benefit coinsurance example:
    EB*A*IND*81***27**.20****Y~ = individual has a 20% coinsurance for in-network routine physical
    MSG* HIGHEST BENEFIT~ = highest benefit level for in-network benefits

6. The eligibility response will populate loop 2100C/D – EB03 valued with 30 - DTP01 with '346' to represent the health plan coverage start and end dates. When only one date is sent in the response, the date represents the member's eligibility start date; DTP02 will be valued with 'D8'. When DTP02 value of 'RD8' is sent, then both a start date and end date will be returned indicating coverage has ended.
    a. Health plan coverage example:
       DTP*346*D8*20070501~ = Member eligibility started on 05/01/2007
7. The eligibility response will populate loop 2100C/D – EB03 valued with 30 - DTP01 with '346' to represent the health plan coverage start and end dates. When only one date is sent in the response, the date represents the member's eligibility start date; DTP02 will be valued with 'D8'. When DTP02 value of 'RD8' is sent, then both a start date and end date will be returned indicating coverage has ended.
    a. Health plan coverage example:
       DTP*346*D8*20070501~ = Member eligibility started on 05/01/2007
8. The remaining health plan deductible and out-of-pocket values will be returned in the 271(loop 2110C/D EB03=30).
    a. Remaining deductible example:
       EB*C*IND*30***29*266*****Y~ = Individual In-network health plan remaining deductible is $266
9. When UnitedHealthcare knows of additional payers and knows the name of the other payer, the other payer name will be sent in the 2110C/D loop with EB01 valued with 'R'. In the 2120C/D loop, a NM1 data segment will be included to identify the other payer name.
    a. Additional payer example: EB*R**30~ = Additional payer exists LS*2120~ = Loop identifier start
    b. NM1*PR*2*ABC PAYER~ = Non-person payer name is Medicare
    c. PER*IC**TE*8001234567*UR*www.ABCPayer.com~ = Phone number and URL LE*2120~ = loop identifier end
10. An EB data segment in loop 2110C/D will be included in the 271 for any limitations that apply to a benefit.
    a. Limitation dollar example:
       EB*F*IND*33***23*500*****Y~ = Individual in-network chiropractor benefits are limited to $500 per calendar year
    b. Limitation visit example:
       EB*F*IND*33***25***VS*5**Y~ = Individual in-network chiropractor benefits are limited to 5 visits per contract (policy) year
    c. Limitation visit example with Health Care Services Delivery (HSD) data segment:
       EB*F*IND*96*********Y~ = Limitation for individual in-network professional (physician)
       HSD*VS*5***34*6 = limitation period is 5 visits in 6 months
    d. Limitation dollar example with HSD segment:
       EB*F*IND*33****500*****Y~ = $500 limitation for individual in-network chiropractor benefits
       HSD*****34*6 = Limitation period is 6 months
    e. Additional covered dollar per occurrence/day limitation example:
       EB*F*IND*48****20*****Y~ = $20 limitation for individual in-network hospital-inpatient. MSG*Additional Covered per Occurrence = Additional covered dollars per occurrence/day which identifies the additional dollar allowance over the semi-private rate. Allow the semi-private room rate plus $20.00.
11. An EB data segment in loop 2110C/D will be included in the 271 for any cost containment measures that apply to a benefit. Cost containment is defined as a penalty that impacts a member's financial responsibility for member non-authorization.

a. Cost Containment example: EB*J*IND*A7*C1*******Y*Y~
b. MSG*Prior authorization is required otherwise member's financial responsibility will not be at the network level

12. An EB data segment in loop 2110C/D with the vendor's name will be included in the 271 when a benefit is administered by another vendor.
    a. Vendor name example:
    EB*U**35~ = Contact following vendor for dental benefits LS*2120~ = Loop identifier start
    NM1*VN*2*ABC Dental~ = Non-Person vendor name is ABC Dental LE*2120~ = Loop identifier end

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 REPORT INVENTORY

There are no known applicable reports.

8. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, billing service, software vendor, clearinghouse, employer group, financial institution, etc.) that transmits to or receives electronic data from UnitedHealth Group.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

9. TRANSACTION SPECIFIC INFORMATION

This section describes how TR3's adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has something additional, over and above, the information in the TR3's. That information can:

1. Limit the repeat of loops or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the TR3s.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments

193	**2100C**	**NM1**	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	**2100C**	**NM109**	Subscriber Primary Identifier		**15**	This type of row exists to limit the length of the specified data element.
196	**2100C**	**REF**	Subscriber Additional Identification			
197	**2100C**	**REF01**	**Reference Identification Qualifier**	18, 49, 6P, HJ, N6		These are the only codes transmitted by UnitedHealth Group.
			Plan Network Identification Number	**N6**		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
218	**2110C**	**EB**	Subscriber Eligibility or Benefit Information			
231	**2110C**	**EB13-1**	Product/Service ID Qualifier	**AD**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

9.1 ELIGIBILITY BENEFIT REQUEST: 270 (05010X279A1)

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction the TR3 should be reviewed for that information.

TR3 Page #	Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
Payer Information -> NM1*PR*2*UNITEDHEALTHCARE*****PI*87726~					
69	**2100A**	NM1	Information Source Name		
69		NM101	Entity Identifier Code	PR	Used to identify organizational entity (e.g. PR = Payer).
70		NM102	Entity Type Qualifier	2	Used to indicate entity or individual person (e.g. 2 = Non-Person Entity).
70		NM103	Name Last or Organization name		Used to specify subscribers last name or organization name (e.g. UNITEDHEALTHCARE).
71		NM108	Identification Code Qualifier	PI	Used to qualify the identification number submitted (e.g. PI = Payer Identification).
71		NM109	Identification Code		Used to specify primary source information identifier. The changes will apply to commercial and government business for UnitedHealthcare (e.g. 87726).

9.2 ELIGIBILITY BENEFIT RESPONSE: 271 (005010X279A1)

The table below represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value sent in the response means. The table does not represent all of the fields that will be returned in a successful transaction the TR3 should be reviewed for that information.

TR3 Page #	Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
HRA Balance Information -> EB*F*FAM***HEALTH REIMBURSMENT ACCOUNT*29*500*****Y~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.
299/403		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan (e.g. Health Reimbursement Account).
299/403		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
300/404		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining (e.g. $500).
303/406		EB12	In Plan Network indicator	Y	Used to specify benefit are in-network (e.g. remaining family HRA balance is $500).
HRA Balance Message / Error Conditions -> EB*F*FAM***HEALTH REIMBURSMENT ACCOUNT*29*0*****Y~ MSG01* HRA FUNDS HAVE BEEN EXHAUSTED~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.
299/403		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan (e.g. Health Reimbursement Account).
299/403		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
300/404		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining (e.g. 0).
303/406		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network. ***Interpretation:*** Remaining family HRA balance is $0.
322/425		MSG	Free Form Message Text		A message segment is added to the 271 response when the HRA remaining balance being returned is zero. Ex. HRA FUNDS HAVE BEEN EXUASTED
322/425		MSG	Message Text		

323/426		MSG01	Free Form Message Text		A message segment is added to the 271 response when the HRA remaining balance being returned is zero (e.g. HRA FUNDS HAVE BEEN EXHAUSTED).
HRA Balance Message / Error Conditions -> EB*F*FAM***HEALTH REIMBURSMENT ACCOUNT*29******Y~ MSG*HRA BALANCE IS UNAVAILBLE AT THIS TIME. FOR BALANCE INFORMATION PLEASE CALL THE TOLL FREE NUMBER LOCATED ON THE PATIENT'S CARD.					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.
299/403		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan (e.g. Health Reimbursement Account).
299/403		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
300/404		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining.
303/406		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network. ***Interpretation:*** Remaining family HRA balance is unavailable at this time
322/425		MSG	Message Text		
323/426		MSG01	Free Form Message Text		This message is returned when HRA balance information is not available due to technology issues (e.g. HRA BALANCE IS UNAVAILBLE AT THIS TIME. FOR BALANCE INFORMATION PLEASE CALL THE TOLL FREE NUMBER LOCATED ON THE PATIENT'S CARD.)
Plan has benefit level limitation (Dollars) -> EB*F*IND*33***23*500*****Y~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation
292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. 33 = chiropractic).
300/404		EB07	Monetary Amount		Used to specify the monetary amount limitation for the member (e.g. 500). ***Interpretation:*** Individual in-network chiropractor benefits are limited to $500 per calendar year.
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
Plan has benefit level limitation (Visits) -> EB*F*IND*33***25***VS*5**Y~					

289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. 33 = chiropractic).
299/403		EB06	Time Period Qualifier		Used to qualify the time period category for the benefit (e.g. 25 = contract).
301/405		EB09	Visits		Used to specify the type of units/counts for the benefit (e.g. VS = visits).
302/405		EB10	Quantity		Used to specify the number of visits limitation for the member (e.g. 5) ***Interpretation:*** Individual in-network chiropractor benefits are limited to 5 visits per contract (policy) year.
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
Plan has benefit level limitation (Visits) with Health Care Services Delivery (HSD) data segment -> EB*F*IND*96*********Y~HSD*VS*5***34*6~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. 96 = professional / physician).
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
309/412		HSD	Health Care Services Delivery		
310/413		HSD01	Quantity Qualifier		Used to specify visits professional (physician) limitation (e.g. VS = visits).
310/413		HSD02	Quantity		Used to specify the number of visits allowed for professional (physician) limitation (e.g. 5).
311/414		HSD05	Time Period Qualifier		Used to specify the time period allowed for professional (physician) limitation (e.g. 34 = month).
311/414		HSD06	Number of periods		Used to specify length of period (e.g. 6). ***Interpretation:*** Limitation is 5 visits in 6 months.
Plan has benefit level limitation (Dollars) with Health Care Services Delivery (HSD) data segment -> EB*F*IND*96****500*****Y~HSD*****34*6~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		

291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. 33 = chiropractic). EB03 with visit limitation using Health Care Services Delivery (HSD) data segment.
300/404		EB07	Monetary Amount	IND	Used to specify the monetary amount limitation for the member (e.g. 500).
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
309/412		HSD	Health Care Services Delivery		
311/414		HSD05	Time Period Qualifier		Used to specify the time period allowed for professional (physician) limitation (e.g. 34 = month).
311/414		HSD06	Number of periods		Used to specify length of period (e.g. 6. ***Interpretation:*** Limitation is 5 visits in 6 months.
Plan has benefit level limitation – Additional covered dollar per occurrence/day -> EB*F*IND*48****20*****Y~MSG*ADDITIONAL COVERED PER OCCURRENCE~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit level limitation.
292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. 48 = hospital inpatient.
300/404		EB07	Monetary Amount	IND	Used to specify the monetary amount limitation for the member (e.g. 20).
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
322/425		MSG	Message Text		
323/426		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is highest benefit (e.g. MSG*ADDITIONAL COVERED PER OCCURRENCE). ***Interpretation:*** Additional covered dollars per occurrence/day which identifies the additional dollar allowance over the semi-private rate. Allow the semi-private room rate plus $20.
Plan has benefit level cost containment measures -> EB*J*IND*A7*C1******Y*Y~MSG*PRIOR AUTHORIZATION IS REQUIRED OTHERWISE MEMBER'S FINANCIAL RESPONSIBILITY WILL NOT BE AT THE NETWORK LEVEL~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has benefit cost containment.

292/396		EB02	Coverage Level Code	IND	Used to specify limitation applies to an individual.
293/395		EB03	Service Type Code		Used to specify limitation applies to service type (e.g. A7 = psychiatric inpatient).
298/402		EB04	Insurance Type Code		Used to specify insurance type code applies to member (e.g. C1 = commercial).
302/406		EB11	Authorization or Certification Indicator	Y	Used to specify member needs authorization or certification per plan provisions.
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
322/425		MSG	Message Text		
323/426		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is highest benefit (e.g. MSG*PRIOR AUTHORIZATION IS REQUIRED OTHERWISE MEMBER'S FINANCIAL RESPONSIBILITY WILL NOT BE AT THE NETWORK LEVEL). ***Interpretation:*** Prior authorization is required otherwise member's financial responsibility will not be at the network level.
Highest in-network benefit coinsurance -> EB*A*IND*52***27**.20****Y~MSG*HIGHEST BENEFIT~					
289/393	**2110C/D**	EB	Subscriber/Dependent Eligibility or Benefit Information		
291/395		EB01	Eligibility or Benefit Information Code	F	Used to specify that member has coinsurance.
292/396		EB02	Coverage Level Code	IND	Used to specify coinsurance applies to an individual.
293/395		EB03	Service Type Code		Used to specify coinsurance applies to service type (e.g. 52 = hospital emergency -medical).
299/403		EB06	Time Period Qualifier		Used to specify the time period for the benefit (e.g. 27 = visit).
301/404		EB08	Percent	Y	Used to specify percent of coinsurance that applies to the member (e.g. 20%).
303/406		EB12	In Plan Network Indicator	Y	Used to specify benefit is in-network.
322/425		MSG	Message Text		
323/426		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is highest benefit (e.g. MSG*HIGHEST BENEFIT). ***Interpretation:*** Coinsurance of 20% applies to member's financial responsibility at the network level.

10. APPENDECIES

10.1 IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection: Clearinghouse or CAQH CORE Connectivity. A basic check list would be to:

1. Register with trading partner
2. Create and sign contract with trading partner
3. Establish connectivity
4. Send test transactions
5. If testing succeeds, proceed to send production transactions

10.2 FREQUENTLY ASKED QUESTIONS

1. **What is MN 62J?**
   Minnesota regulations now require specific capabilities in the 270/271 transactions within Minnesota. These requirements are HIPAA-compliant and provide additional functionality to the eligibility inquiry. The MN Uniform Companion Guide for the 270/271 transaction is available at the Minnesota Department of Health website.
2. **Does this Companion Guide apply to only MN providers?**
   While the legislation was passed by Minnesota, this applies to all UnitedHealthcare business, not just business in Minnesota.
3. **Does this Companion Guide apply to all UnitedHealthcare payers and payer IDs?**
   No. It's applicable to UnitedHealthcare Commercial (87726), UnitedHealthcare Community Plan (87726), UnitedHealthcare Medicare and Retirement (87726), UnitedHealthcare Dental (52133), UnitedHealthcare Vision (00773), UnitedHealthcare West (87726) and Medica (94265).
4. **Are there recommendations for getting successful results with 270/271 transactions?** Yes. To help ensure we are returning eligibility and benefits information for all our members, UnitedHealthcare is recommending that you include the following information in the 270 inquiry transaction:
   - Member ID
   - Last Name
   - First Name
   - Patient Date of Birth
   - Group Number
5. **How does UnitedHealthcare support, monitor and communicate expected and unexpected connectivity outages?**
   Our systems do have planned outages. We will send an email communication for scheduled and unplanned outages.
6. **If a 270 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?**
   No. UnitedHealthcare will always send a response. Even if UnitedHealthcare's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.3 FILE NAMING CONVENTIONS

Node	Description	Value
ZipUnzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES		
ZipUnzip	Responses will be sent as either zipped or unzipped depending on how UnitedHealthcare received the inbound batch file	**N - Unzipped Z - Zipped**
ResponseType	Identifies the file response type	**TA1 – Interchange Acknowledgement 999 – Implementation Acknowledgement**
Batch ID	Response file will include the batch number from the inbound batch file specified in ISA13	**ISA13 Value from Inbound File**
Submitter ID	The submitter ID on the inbound transaction must be equal to ISA06 value in the Interchange Control Header within the file	**ISA08 Value from Inbound File**
DateTimeStamp	Date and time format is in the next column (time is expressed in military format as CDT/CST)	**MMDDYYYYHHMMSS**