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 3.0

November 12, 2019

Change Log

Version	Release date	Changes
1.0	10/11/2010	Initial creation based on 5010 transaction changes
2.0	11/6/2017	Updated applicable UnitedHealthcareOnline references to UHCprovider.com and updated Optum contact information.
3.0	11/12/2019	Updated section 4.4 – website links for Optum EDI Client Center and UnitedHealthcare EDI Support

Preface

This companion guide (CG) to the Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare Health Plans (OHP). Transactions 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 X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the 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 theTR3.

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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 UnitedHealthcare Oxford Health Plans (OHP) has something additional, over and above, the information in the TR3. 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 OHP

In addition to the row for each segment, one or more additional rows are used to describe OHP'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 OHP has something additional, over and above, the information in the TR3's. The following is just an example of the type of information that would be spelled out or elaborated from Section 9 – Transaction Specific Information.

TR3 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 Technical Report Type 3 (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 (CG) is not intended to replace the TR3.

1.2. OVERVIEW

This CG will replace, in total, the previous OHP CG versions for Health Care Eligibility and Benefit Inquiry and Response and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing electronic Eligibility and Benefit transactions that meet OHP processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this CG occur periodically, available online and distributed to registered trading partners with reasonable notice, or a minimum of 30 days, prior to required implementation. CG documents are posted in the EDI section of our Resource Library on the Companion Guides page: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html.

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.

2. GETTING STARTED

2.1. EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE OXFORD

There are three methods to connect with OHP for submitting and receiving EDI transactions: through Post-n-Track, Optum or another clearinghouse.

Post-n-Track Connection

Eligibility and Benefit transactions for Oxford can be submitted via Post-n-Track. To register with Post-n-Track for OHP's Eligibility and Benefit transaction visit www.post-n- track.com or call 860-257-2030

CAQH CORE Connectivity or Clearinghouse Connection

Council for Affordable Health Care (CAQH) is seeking to simplify healthcare administration. CAQH through CORE, (Committee on Operating Rules for Information Exchange) a voluntary organization comprised of providers, health plans, vendors and clearinghouses, has developed industry rules. These rules seek to increase interoperability between health plans and providers to reduce administrative costs. The rules are being release in phases. CORE has defined methods for connecting to a health plan, details of the connectivity methods can be found on CAQH's website http://www.CAQH.org.

Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct. Optum partners with providers to deliver the tools that help drive administrative simplification at minimal cost and realize the benefits originally intended by HIPAA — standard, low-cost claim transactions. Please contact Optum Support at 800-341-6141 to get set up.

If interested in using Optum's online solution, Intelligent EDI (IEDI), contact the Optum sales team at 866-367-9778, option 3, send an email to IEDIsales@optum.com or visit https://www.optum.com/campaign/fp/free-edi.html.

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss their ability to support the Eligibility and Benefit transaction, as well as associated timeframe, costs, etc.

2.2. CERTIFICATION AND TESTING WITH OHP

The Eligibility and Benefit transaction is an inquiry and response transaction and does not result in any data changing upon completion therefore test transactions (ISA15 value of "T") with production data can be sent to our production environment without any negative impact. During testing the data being returned must not be acted on as a production response.

Post-n-Track:

Physicians and health care professionals should contact their current clearinghouse vendor to discuss testing.

Clearinghouse Connection:

Physicians and health care professionals should contact their current clearinghouse vendor to discuss testing or Optum.

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

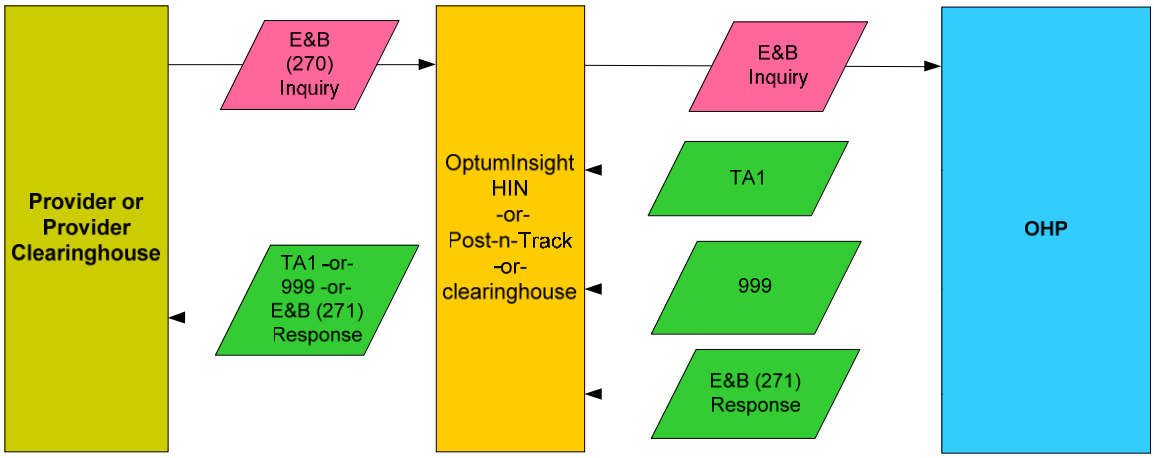
3.1. PROCESS FLOWS

Real-Time Eligibility Benefit Inquiry and Response:

The response to a real-time eligibility transaction will consist of:

1. First level response - TA1 will be generated when errors occur within the outer envelope.

2. Second level response – 999 will be generated when errors occur during 270 compliance validation.
3. 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 nature of the error. Transactions that pass compliance checks and have do not generate AAA segments will create a 271 using the information in our eligibility and benefit system.

3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

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

3.3. RE-TRANSMISSION PROCEDURE

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 in order for a successful response.

3.4. COMMUNICATION PROTOCOL SPECIFICATIONS

Post-n-Track:

Physicians and health care professionals should contact Post-n-Track for more information on the supported communication protocols.

Clearinghouse Connection:

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

3.5. PASSWORDS

Post-n-Track:

Physicians and Healthcare professionals should contact Post-n-Track for information regarding passwords.

Clearinghouse Connection:

Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss

password policies.

3.6. 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 Oxford 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.

3.7. COSTS TO CONNECT

Post-n-Track Connection:

Contact Post-n-Track for information on cost.

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
- Optum's online solution, Intelligent EDI (IEDI) –
  - Call 866-367-9778, option 3
  - Email IEDIsales@optum.com or
  - Visit https://www.optum.com/campaign/fp/free-edi.html

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 or
- calling us at 800-842-1109

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

4.2. CLEARINGHOUSE SUPPORT

When receiving the 278 from a clearinghouse, please contact the clearinghouse. If using OptumInsight, 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 / E-MAIL

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

Optum EDI Client Center – https://iedi.optum.com

UnitedHealthcare Administrative Guide: https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/UnitedHealthcare_Administrative_Guide_2017.pdf

UnitedHealthcare EDI Support: UHCprovider.com/edicontacts

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 are identified by interchange header segment (ISA) and trailer segments (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission and provides sender and receiver identification.

The below table represents only those fields that OHP 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	**06111**	OHP Payer ID -Right pad as needed with spaces to 15 characters.
C10	**None**	**IEA**	**IEA Interchange Control Trailer**		
C10		IEA01	Number of Included Functional Groups	**1**	Number of Functional Groups (GS-GE Loops) included in the Interchange.

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.
OHP supports only one Functional Group (GS-GE) per transmission.

The below table represents only those fields that OHP 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.7	**None**	**GS**	**Functional Group Header**		**Required Header**
C.7		GS03	Application Receiver's Code	**006111**	OHP Payer ID Code
C.8		GS08	Version/Release/Industry Identifier Code	**005010X279A1**	Version expected to be received by OHP.
C9	**None**	**GE**	**Functional Group Trailer**		
C9		GE01	Number of Transaction Sets Included	**1**	Number of Transaction Sets (ST-SE Loops) included in the Functional Group.

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 '1' ST and SE combination. A 270 file can only contain 270 transactions.

The below table represents only those fields that OHP 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
70	**None**	**ST**	**Transaction Set Header**		**Required Header**
		ST03	Implementation Convention Reference	**005010X279A1**	Version expected to be received by OHP.

5.4. CONTROL SEGMENT NOTES

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

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

5.5. 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 are 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 Name	First Name	Patient DOB
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.

1. OHP has unique ID numbers therefore only the 2100C subscriber loop will be used.

2. EB03 value of 30 will represent plan level information and will be returned in a positive 271 response. The EB04 and EB05 values will only be populated at the plan level and will not be sent at the benefit level to avoid redundant data in the response.

3. 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. OHP does not employ logic to search for the future or previous active timelines for the member.

4. The following HIPAA service type codes (2110C/D EB03) may be reported in the 271 response along with benefit co-pay, benefit co-insurance and/or benefit deductible information, the additional information column provides clarifying information about how the benefit was mapped:

HIPAA Code	Service Type Code	Additional Information
1	Medical Care	Office Visit
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	Ambulatory Surgery
18	Durable Medical Equipment Rental	
20	Second Surgical Opinion	Consultation
23	Diagnostic Dental	Specifies the name of the Dental Vendor
24	Periodontics	Specifies the name of the Dental Vendor
25	Restorative	
26	Endodontics	Specifies the name of the Dental Vendor
27	Maxillofacial Prosthetics	
28	Adjunctive Dental Services	
33	Chiropractic	
35	Dental Care	Specifies the name of the Dental Vendor
36	Dental Crowns	Specifies the name of the Dental Vendor
37	Dental Accident	
38	Orthodontics	Specifies the name of the Dental Vendor

39	Prosthodontics	Specifies the name of the Dental Vendor
40	Oral Surgery	
41	Routine (Preventive) Dental	Specifies the name of the Dental Vendor
42	Home Health Care	
45	Hospice	Facility Charge
47	Hospital	
48	Hospital - Inpatient	Inpatient Hospital Room and Board
49	Hospital - Room and Board	Inpatient Hospital Room and Board
50	Hospital - Outpatient	
51	Hospital - Emergency Accident	ER
52	Hospital - Emergency Medical	ER
53	Hospital - Ambulatory Surgical	Outpatient Hospital Services
62	MRI/CAT Scan	
65	Newborn Care	
68	Well Baby Care	
69	Maternity	
73	Diagnostic Medical	
76	Dialysis	
78	Chemotherapy	
80	Immunizations	
81	Routine Physical	
82	Family Planning	Office Visit
83	Infertility	Non Routine Office Visit
86	Emergency Services	ER
88	Pharmacy	Specifies the name of the Pharmacy Benefit Manager
89	Free Standing Prescription Drug	Specifies the name of the Pharmacy Benefit Manager
90	Mail Order Prescription Drug	Specifies the name of the Pharmacy Benefit Manager
91	Brand Name Prescription Drug	Specifies the name of the Pharmacy Benefit Manager

	92	Generic Prescription Drug	Specifies the name of the Pharmacy Benefit Manager
	93	Podiatry	
	98	Professional (Physician) Visit/Office	
	99	Professional (Physician) Visit - Inpatient	
	A0	Professional (Physician) Visit - Outpatient	
	A3	Professional (Physician) Visit - home	
	A4	Psychiatric	Mental Health Outpatient Visit
	A5	Psychiatric - Room and Board	Facility Charge
	A6	Psychotherapy	Mental Health Outpatient Visit
	A7	Psychiatric - Inpatient	Facility Charge
	A8	Psychiatric - Outpatient	Mental Health Outpatient Visit
	AD	Occupational Therapy	
	AE	Physical Medicine	
	AF	Speech Therapy	
	AG	Skilled Nursing Care	
	AI	Substance Abuse	Outpatient Rehabilitation
	AJ	Alcoholism	Outpatient Alcoholism Rehabilitation
	AK	Drug Addiction	Inpatient Detoxification
	AL	Vision (Optometry)	
	BG	Cardiac Rehabilitation	
	BH	Pediatric	
	BT	Gynecological	
	BU	Obstetrical	
	BV	Obstetrical/Gynecological	
	BW	Mail Order Prescription Drug: Brand Name	Specifies the name of the Pharmacy Benefit Manager
	BX	Mail Order Prescription	Specifies the name of the Pharmacy Benefit
		Drug: Generic	Manager
	BY	Physician Visit - Office: Sick	
	BZ	Physician Visit - Office: Well	
	DM	Durable Medical Equipment	
	GF	Generic Prescription Drug - Formulary	Specifies the name of the Pharmacy Benefit Manager

GN	Generic Prescription Drug - Non-Formulary	Specifies the name of the Pharmacy Benefit Manager
MH	Mental Health	Individual Mental Health Outpatient Visit
UC	Urgent Care	

5. In the generic response (EB03=30) when benefit co-pay/co-insurance/deductible information for 48 - Hospital – Inpatient and 50 -Hospital – Outpatient are included in the response then 47 – Hospital will not include benefit co-pay/co-insurance/deductible information.

6. When the deductible that applies to the benefit is separate and distinct from the plan level deductible (EB03=30) an EB data segment in loop 2110C will be returned with benefit level deductible amounts. Remaining deductible will also be returned.

   Base deductible example for a benefit:
   EB*C*IND*33****500*****Y = individual has a $500 base deductible for in-network chiropractic care

   Remaining deductible example for a benefit:
   EB*C*IND*33***29*183*****Y = individual has a $183 remaining deductible for in- network chiropractic care

7. When OHP knows of additional payers and knows the name of the other payer, the other payer name will be sent in the 2110C loop with EB01 valued with 'R'. In the 2120C loop a NM1 data segment will be included to identify the other payer name. OHP will identify if the other payer is primary, secondary or tertiary. Medical, worker's compensation and motor vehicle accidents are the types of other payers that will be returned. Worker's compensation and motor vehicle accidents will be identified with a payer type of PR (payer).

   Additional payer example: EB*R**30~ = Additional payer exists LS*2120~ = Loop identifier start
   NM1*PRP*2*MEDICARE~ = Non-person primary payer name is Medicare LE*2120 = Loop identifier end

8. An EB data segment in loop 2110C with the vendor's name will be included in the 271 response when a benefit is administered by another vendor.

   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

9. The most recent PCP that is associated to the member's plan will be returned. If multiple plans are being returned the most recent PCP for each plan in effect during the plan time frame will be returned.

7. ACKNOWLEDGEMENTS AND OR 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 OHP

In addition to the row for each segment, one or more additional rows are used to describe OHP 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 OHP has included, in addition to the information contained in the TR3s.

TR3 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. APPENDICES

10.1. IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection. However, 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. **Does this Companion Guide apply to all OH payers?**
   Yes. The changes will apply to commercial and government business for OHP using payer ID 06111.
2. **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.
3. **If a 270 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?**
   No. OHP will always send a response. Even if OHP systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.