An Independent Licensee of the Blue Cross Blue Shield Association

Blue Cross Blue Shield of Arizona
HIPAA Version 5010 Companion Guide

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Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires Blue Cross Blue Shield of Arizona (BCBSAZ) and all health insurance payers to comply with the Electronic Data Interchange (EDI) standards for health care as established by the Department of Health and Human Services.

The ASC X12N 5010 version of the National Electronic Data Interchange Transactions Set Technical Report Type 3 (TR3) have been established as the standards for compliance of health care transactions. The TR3's for each transaction are available electronically from the WPC website at http://www.wpc-edi.com/.

This Companion Guide is to be used with, not as a replacement for, the ASC X12N 5010 version of the HIPAA Transaction Technical Report Type 3 (TR3).

270/271 Transaction Set Business Use and Description

Health Care Eligibility Benefit Inquiry and Response

Transaction Set	*Business Use*
ASC X12N 270 Transaction	To inquire about the eligibility, coverage, or benefits associated with • a benefit plan • employer • plan sponsor • subscriber or a dependent under the subscriber's policy
ASC X12N 271 Transaction	To communicate information about or changes to • eligibility • coverage • benefits from information sources , insurers, sponsors, and health plans to information receivers, i.e., the following: • physicians • hospitals • third-party administrators • government agencies

Description

- Provides a method for the following sources to inquire about eligibility, coverage, and benefits associated with a subscriber's policy:
  - physicians
  - hospitals
  - third-party administrators
  - government agencies
- Does not provide a history of benefit use.

276/277 Transaction Set Business Use and Description

Health Care Claim Status Request and Response

Transaction Set	*Business Use*
ASC X12N 276 Transaction	Used by health care providers, recipients of health care products or services, or their authorized agents to request the status of a health care claim or encounter from a health care payer.
ASC X12N 277 Transaction	Used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent the status of a health care claim or encounter.

Description

- Provides a method for providers and recipients of health care products or services to request the status of a health care claim or encounter from a health plan or payer.
- The 276 request may occur at the summary or service level.
- The 277 response may be at a summary or service line detail level.
- The 276 transaction set is not intended to replace the Health Care Claim transaction set (837), but rather to occur after the receipt of a claim or encounter information.
- The 277 transaction set is not intended to replace the Health Care Claim Payment / Advice Transaction set (835), and therefore, should not be used for account payment posting.

278 Transaction Set Business Use and Description

Health Care Services Request for Review and Response

Transaction Set	*Business Use*
ASC X12N 278 Transaction	Used to transmit health care service information, i.e., subscriber, patient, demographic and diagnosis, or treatment data between the following referring sources • health care providers • health care providers furnishing services • utilization management organizations • payers • plan sponsors and • health plans for the purpose of request for review, certification, notification, or reporting the outcome of a health care services review.

Description

- Provides a method for health care providers to obtain certification for certain health care services based on the subscriber's contract.
- Used by both the provider (request) and the health plan (response).
- Can be used for certification appeal review requests and associated responses.
- Can be used for extended certification review requests and associated responses.

820 Transaction Set Business Use and Description

Payroll Deducted and Other Group Premium Payment for Insurance Products

Transaction Set	*Business Use*
ASC X12N 820 Transaction	Used to initiate: • an electronic premium payment that includes the remittance detail needed by the premium receiver to properly apply the payment, or • a payment without the remittance detail. The remittance detail is sent separately to the premium receiver.

Description

- Provides a method for employers, employees, unions, and associations to make and keep track of payments of health plan premiums to their health insurers.
- Can be used to make a payment, send a remittance advice, or make a payment and send a remittance advice.
- Contains payment data related to a group employer's billing for health care premiums.
- Can be an order to a financial institution to make payment to a payee.
- Can also be a remittance advice identifying the detail needed to post payment to the payee's accounts receivable system.
- The remittance advice can go directly from payer to payee, through a financial institution, or through a third-party agent.

834 Transaction Set Business Use and Description

Benefit Enrollment and Maintenance

Transaction Set	*Business Use*
ASC X12N 834 Transaction	Used to establish communication between the sponsor of a health benefit and the health plan or payer for the purpose of providing the following enrollment data: • subscriber and dependents information • employer information, and • healthcare provider information.

Description

- Provides a method for the exchange of enrollment data between health benefit sponsors and health plans or payers.
- The sponsor is the backer of the coverage, benefit or product. A sponsor can be an employer, union, government agency, association or insurance company.
- The health plan or payer refers to an entity that pays claims, administers the insurance product or benefit, or both.

835 Transaction Set Business Use and Description

Health Care Claim Payment Advice

Transaction Set	*Business Use*
ASC X12N 835 Transaction	Used by a health plan to: • make a payment to a financial institution for a health care provider (sending payment only) • send an Explanation of Benefits (EOB) remittance advice directly to a health care provider (sending data only).

Transaction Description

- Contains an explanation of payment and/or adjustment detail from the health plan.
- One 835 transaction set reflects a single payment device – one 835 corresponds to one check or one Electronic Funds Transfer (EFT) payment. Multiple claims can be referenced within one 835.
- Permits auto-posting of payments to the health care provider's practice management software or patient financial services accounts receivable system.

837 Transaction Set Business Use and Description

Health Care Claim Professional, Institutional, and Dental

Transaction Set	*Business Use*
ASC X12N 837 Transaction	Used to submit health care claim billing information and/or encounter information from health care providers to health plans or payers, either directly or via intermediary billing services or claims clearinghouses. The 837 transaction can also be used to transmit health care claims and billing payment information between the following: • health plans or payers with different payment responsibilities where coordination of benefits is required, or • health plans and regulatory agencies to monitor the rendering, billing and/or payment of health care services within a specific health care/insurance industry segment. Separate 837 transaction sets support the submission of institutional, professional, and dental claim and/or encounter data.
ASC X 12 Health Care Claim Acknowledgement (277CA)	Is a business application level acknowledgment for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage.

Getting Started

Becoming a Trading Partner	The first step in becoming an electronic submitter is to contact eSolutions at the phone number listed below. You may also contact eSolutions for additional information on enrollment procedures or electronic transaction questions. For HIPAA content information, visit BCBSAZ's public website at www.azblue.com.

Electronic Submission Options	**Important!** Providers have the option to connect to BCBSAZ either through • 1) a direct connection to BCBSAZ or • 2) connecting through a third party clearinghouse. Call eSolutions with questions concerning any method of connectivity at the phone numbers listed below.

eSolutions Contact Information

Address

Blue Cross Blue Shield of Arizona
eSolutions
2444 W Las Palmaritas Drive
Phoenix, AZ 85021-4883

Contact Numbers

If the Information You Need Is...	*The Phone Number Is...*
To become a trading partner, help with a connectivity questions, to set up electronic transactions or for customer support of existing connections	**(602) 864-4844 or** **(Out-of-state)** **(800) 232-2345 ext. 4844** **(In-state)** **(800) 650-5656**
FAX	**(602) 864-3117**

Getting Started, Continued

BCBSAZ Direct Connect Requirements	If your software vendor offers the ASC X12N, 5010- transactions and can connect directly to BCBSAZ, please call eSolutions at (602) 864-4844 or (800) 650-5656 to initiate the set up process to submit electronic transactions directly to BCBSAZ. • In some cases, BCBSAZ requires a signed and executed Trading Partner Agreement prior to testing any ASC X12N HIPAA Transaction.

Connecting Through a Third-Party Clearinghouse	If your software vendor cannot connect directly, the following information will assist you with connecting through a third-party clearinghouse. • Contact your software vendor to see if they are affiliated with a clearinghouse. Some software vendors will require that the provider/submitter connect through a designated clearinghouse. • The third-party clearinghouse is responsible for assisting the provider/submitter with the communication connection between the provider/submitter and clearinghouse.

Implementation Checklist

HIPAA ASC X12N Transactions Implementation Check List
☐ **Trading Partner Agreement** • Direct connect providers should complete a Trading Partner Agreement.
☐ **BCBSAZ Companion Guide** • The guide details situational data elements unique to BCBSAZ for processing each transaction. It should be used in conjunction with the Washington Publishing Company (*WPC) 5010 Version 5 Release 1Technical Report Type 3 (TR3).* A link is available on BCBSAZ's website at www.azblue.com.
☐ **Complete the required HIPAA testing with BCBSAZ** • BCBSAZ will have submitters test all transactions: o For HIPAA compliance and payer specific edits via BCBSAZ's HIPAA testing website. o With BCBSAZ translators, clearinghouse *payer specific edits. • Once testing is successfully completed, BCBSAZ will implement the HIPAA Transaction ASC X12N 5010

* ***The clearinghouse operated by BCBSAZ is not a clearinghouse as defined by HIPAA. The BCBSAZ clearinghouse will not translate electronic transactions sent from a non-standard format into a HIPAA standard format or from a HIPAA format into a non-standard format.***

Control Segments/Envelope Specifications

Acknowledgment Transactions	BCBSAZ will acknowledge all inbound HIPAA batch transactions with either a TA-1 Interchange Acknowledgment or a 999 Implementation Acknowledgment transaction.

TA-1 Interchange Acknowledgment	For either batch or real-time transactions, a TA-1 Interchange Acknowledgement will be sent for compliance failures at the X12 Interchange Envelope level [within the Interchange Control Header (ISA) and Trailer (IEA) segments], resulting in rejection of the entire Interchange.

Control Segments/Envelope Specifications, Continued

999 Implementation Acknowledgment	If a valid interchange is received, a 999 acknowledgement transaction will be sent which provides the results of the compliancy status of the electronic file. The acknowledgement results are one of the following: • A Transaction Set Acknowledgment Code (IK501) of 'A' indicates that the batch transaction passed compliance and was accepted. For this Transaction Set Acknowledgment Code (IK501) the Functional Group Acknowledgment Code (AK901) will have a value of 'A' – Accepted. • A Transaction Set Acknowledgment Code (IK501) of 'E' indicates that the batch transaction set was partially accepted; the claims or inquiries that passed compliance were accepted for processing. For this Transaction Set Acknowledgment Code (IK501) the Functional Group Acknowledgment Code (AK901) will have a value of either 'E' – Accepted, But Errors Were Noted or 'P' – Partially Accepted, At Least One Transaction Set Was Rejected. • A Transaction Set Acknowledgment Code (IK501) of 'R' indicates that the entire batch transaction set was rejected as non compliant. For this Transaction Set Acknowledgment Code (IK501) the Functional Group Acknowledgment Code (AK901) will have a value of 'P' – Partially Accepted, At Least One Transaction Set Was Rejected (Batch) or 'R' – Rejected (Real-Time or Batch). More information on the 999 Functional Acknowledgment transactions can be found in *HIPAA Transaction Technical Report Type 3s 5010 – Health Care Claim Acknowledgment 999.*
277CA Acknowledgment	The ASC X12 Health Care Claim Acknowledgment (277CA) is a business application level acknowledgment for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage. • Loop 2200D STC03 'U' = (Reject) represents significant submitter level errors in the entire claim transaction (ST – SE). • Loop 2200D STC03 'WQ' = (Accept) additional information will be provided for the following: o Total Accepted Quantity o Total Rejected Quantity o Total Accepted Amount o Total Rejected Amount • Additional information on the 277CA Health Care Claim Acknowledgment transactions can be found in the HIPAA Technical Report Type 3 (TR3) 5010 – Health Care Claim Acknowledgment 277CA.

Control Segments/Envelope Specifications - Inbound

ISA Interchange Control Header Segment

Technical Report Type 3 5010 WPC Version 5 Release 1				
Data Element	***Data Element ID***	***Size***	***Value***	***Notes/Comments***
Authorization Information Qualifier	ISA01	2/2	00	
Authorization Information	ISA02	10/10		Space filled.
Security Information Qualifier	ISA03	2/2	00	
Security Information/Password	ISA04	10/10		Space filled.
Interchange ID Qualifier/ Qualifier for Trading Partner ID	ISA05	2/2	ZZ	
Interchange Sender ID/Trading Partner ID	ISA06	15/15		BCBSAZ assigns 8-digit Sender ID code; left-justified, space filled.
Interchange ID Qualifier/Qualifier for BCBSAZ	ISA07	2/2	33	
Interchange Receiver ID/BCBSAZ	ISA08	15/15	53589	Left-justified, space filled
Interchange Date	ISA09	6/6		YYMMDD
Interchange Time	ISA10	4/4		HHMM
Repetition separator	ISA11	1/1		Sender determines the repetition separator. **Note**: BCBSAZ will accept any standard delimiter for inbound transactions as defined in Section B of the Technical Report Type 3s.
Interchange Control Version Number	ISA12	5/5	00501	
Interchange Control Number/Last Control Number	ISA13	9/9		Sender determines the control number; must match IEA02.
Acknowledgment Request	ISA14	1/1	0,1	0 = No 1 = Yes (TA1)
Usage Indicator	ISA15	1/1	P T	P=Production T=Test
Component Element Separator	ISA16	1/1		Sender determines the component element separator.

Control Segments/Envelope Specifications – Inbound, Continued

GS Functional Group Header Segment

Technical Report Type 3 5010 WPC Version 5 Release 1				
Data Element	***Data Element ID***	***Size***	***Value***	***Notes/Comments***
Functional Identifier Code	GS01	2/2		Code is defined in the Technical Report Type 3 of the specific transaction in question.
Application Sender's Code	GS02	2/15		BCBSAZ assigns the Sender ID Code that must be submitted within the transaction.
Application Receiver's Code	GS03	2/15	53589	
Date	GS04	8/8		CCYYMMDD
Time	GS05	4/8		HHMM
Group Control Number	GS06	1/9		Sender determines the control number; must match GE02.
Responsible Agency Code	GS07	1/2	X	
Version/Release/Industry Identifier Code	*GS08	1/12	00501 0X???	The question marks are defined in the Technical Report Type 3 of the specific transaction in question.

***GS08 '???' Please refer to the TR3 to obtain the correct release and version for the GS08 value.**

Control Segments/Envelope Specifications – Outbound

ISA Interchange Control Header Segment

Technical Report Type 3 5010 WPC Version 5 Release 1				
Data Element	***Data Element ID***	***Size***	***Value***	***Notes/Comments***
Authorization Information Qualifier	ISA01	2/2	00	
Authorization Information	ISA02	10/10		Space filled.
Security Information Qualifier	ISA03	2/2	00	
Security Information/Password	ISA04	10/10		Space filled.
Interchange ID Qualifier/Qualifier for BCBSAZ ID	ISA05	2/2	33	
Interchange Sender ID/ BCBSAZ ID	ISA06	15/15	53589	Left-justified, space filled.
Interchange ID Qualifier/ Qualifier for Trading Partner ID	ISA07	2/2	ZZ	
Interchange Receiver/ Trading Partner ID	ISA08	15/15		BCBSAZ-assigned Sender ID is used as Receiver ID on outbound transactions. Left justified, space filled.
Interchange Date	ISA09	6/6		YYMMDD
Interchange Time	ISA10	4/4		HHMM
Repetition Separator	ISA11	1/1		Sender determines the repetition separator. **Note**: BCBSAZ will send any standard delimiter for outbound transactions as defined in Section B of the Technical Report Type 3s
Interchange Control Version Number	ISA12	5/5	00501	
Interchange Control/ Last Control Number	ISA13	9/9		Sender (BCBSAZ) determines the control number; must match IEA02.
Acknowledgment Request	ISA14	1/1	0,1	BCBSAZ will always use '0' (No Acknowledgment Requested). 0 = No 1 = Yes (TA1)
Usage Indicator	ISA15	1/1	P T	P=Production T=Test
Component Element Separator	ISA16	1/1		Sender determines the component separator. **Note**: BCBSAZ will send any standard delimiter for outbound transactions as defined in Section B of the Technical Report Type 3s

Control Segments/Envelope Specifications – Outbound, Continued

GS Functional Group Header Segment

Technical Report Type 3 5010 WPC Version 5 Release 1				
Data Element	***Data Element ID***	***Size***	***Value***	***Notes/Comments***
Functional Identifier Code	GS01	2/2		Code is defined in the Technical Report Type 3 of the specific transaction in question.
Application Sender's Code	GS02	2/15	53589	
Application Receiver's Code	GS03	2/15		BCBSAZ-assigned Sender ID Code is used as Receiver's Code on outbound transactions.
Date	GS04	8/8		CCYYMMDD
Time	GS05	4/8		HHMM
Group Control Number	GS06	1/9		Sender (BCBSAZ) determines the control number; must match GE02.
Responsible Agency Code	GS07	1/2	X	
Version/Release/ Industry Identifier Code	*GS08	1/12	005010X ???	The question marks are defined in the Technical Report Type 3 of the specific transaction in question.

***GS08 '???' *GS08 '???' Please refer to the TR3 to obtain the correct release and version for the GS08 value.**

General Transaction Information

Introduction	eSolutions will issue an eight-digit sender ID to be used within the HIPAA transactions that the trading partner has elected to send/receive.

Transmission Guidelines	• Do not concatenate multiple ISA/IEA interchanges within a file. • Submit one GS/GE functional group within one ISA/IEA interchange envelope structure. • Transaction responses for batch transactions will be available for electronic pickup by the provider. • Submit data in uppercase. • For batch transactions, the file naming convention is, "0000SSSS.###" **Note: ''0000SSSS'' indicates the 8 digit sender ID number assigned by BCBSAZ. "###" defines the transaction number. i.e. 837,**

Outbound Delimiters	**Trading Partners must be able to accept any compliant delimiters as defined in Section B of the Technical Report Type 3s. BCBSAZ will send standard delimiters for outbound transactions.**

Delimiters Character	***Purpose (for illustration only)***
Asterisk (*)	Used to separate elements within a segment
Colon (:)	Used for composite elements
Tilde (~)	Represents the end of a segment
Carat (^)	Used as a Repetition Separator

Inbound Delimiters	**Important!** The use of (*), (:),(^) and (~) other than as a delimiter is expressly prohibited. Do not use these delimiters in any data elements of the file. Using these delimiters in any data elements will create syntax error that will cause your file to fail compliancy. BCBSAZ will accept any standard delimiter for inbound transactions as defined in Section B of the Technical Report Type 3s.

General Transaction Information, Continued

Decimals	The decimal element, represented as 'R' in the Technical Report Type 3s may contain explicit decimal points and is used for numeric values that have a varying number of decimal positions. The decimal point always appears in the character stream if it is at any place other than the right-end. Examples • If the monetary amount submitted is $30.00, the data will look like '30' with no decimal present in the character stream. • If the monetary amount submitted is $30.25, the data will look like '30.25' with the decimal present in the character stream.

HIPAA Guidelines on Monetary Decimals	For implementation under HIPAA Guidelines, decimal data elements containing monetary amounts will be limited to a maximum length of 10 characters, including reported or implied places for cents (implied value of '00' after the decimal point).

Triad Separators	**Important!** The use of triad separators, i.e., the commas in 1,000,000, is expressly prohibited and will result in compliance failure at the point of entry.

Leading Zeros	Leading zeros should be suppressed unless needed to satisfy a minimum length requirement.

Trailing Zeros	Trailing zeros following the decimal point should be suppressed unless needed to indicate precision.

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

Introduction

The 270/271 ASC X12N – Health Care Eligibility Benefit Inquiry and Response transactions defines a format to electronically transfer health care eligibility and benefit information.

These transactions are used by inquiry submitters to determine if an information source organization (i.e., payer, employer, HMO) has a particular subscriber's and/or dependent health care eligibility and benefit information on file. The data is used to verify an individual's eligibility and benefit information, but does not provide a benefit history.

Transaction Type	***Description***
ASC X12N 270 Transaction	Health Care Eligibility Benefit inquiry from a submitter (information receiver) to an information source organization. This transaction is used for requesting eligibility and benefit information.
ASC X12N 271 Transaction	Health Care Eligibility Benefit response from an information source organization to a submitter (information receiver). This transaction is used to respond to eligibility and benefit coverage inquiries.

The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 270/271- Health Care Eligibility Benefit Inquiry and Response transaction.

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

270/271 Guidelines	• The 270/271 eligibility inquiry and response transaction can be conducted for local BCBSAZ, FEP (Federal Employee Program) and BlueCard (Out-of-Area) members. • Subscriber ID requirements to submit BCBS claims are as follows: o Local members - Three-digit alpha prefix. o FEP members - Alpha prefix begins with 'R'. o Out-of-Area members - A minimum of three-digit alpha prefix. • The 271 response transaction will also return an INS segment that identifies a "change" for any of the following data fields: provider ID, subscriber ID, first, last name and date of birth. • The NPI is required on all electronic transactions, unless the provider of services cannot obtain an NPI or does not meet the definition of a health care provider. . • Batch transactions will be broken down and processed as individual inquiries by BCBSAZ. You will receive individual responses for each inquiry. • The 270/271 transaction is capable of responding to past, present and future inquiries. Future inquiries must be less than or equal to 14 days in the future. • For Corporate Health Service (CHS) plans eligibility and benefit inquiries, contact the CHS plan or applicable third-party administrator (TPA) located on the back of the member's card.
AAA Segments	Potential scenarios which result in failure of the request transaction and creation of the 271 AAA segment response are: • system time-out • future date of service greater than 14 days • membership validation • provider ID validation

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

270/271 Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Comments***
69	2100A	NM101 Information Source Name	Entity Identifier Code	PR	2/3	Insert 'PR' (Payer)
70		NM102 Information Source Name	Entity Type Qualifier	2	1/1	Insert '2' (Non-Person Entity)
71		NM108 Information Source Name	Identification Code Qualifier	NI	1/2	Insert 'NI' (NAIC)
		NM109 Identification Code	Information Source Identifier	53589	2/80	Insert '53589'
77	2100B	NM108 Identification Code Qualifier	Identification Code Qualifier	SV or XX	1/2	
78		NM109 Identification Code	Information Source Identifier		2/80	
93	2100C	NM103 Subscriber Name	Subscriber Last Name		1/60	Must be present, if the patient is the subscriber.
		NM104 Subscriber Name	Subscriber First Name		1/35	
95		NM108 Subscriber Name	Identification Code Qualifier	MI	1/2	
		NM109 Subscriber Name	Subscriber Primary Identifier		2/80	

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response, Continued

270/271 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Comments***
108	2100C	DMG01 Subscriber Demographic Information	Date Time Period Format Qualifier	D8	2/3	The DMG segment is situational but must be present if the patient is the subscriber; if it is used, this element is required.
		DMG02 Subscriber Demographic Information	Subscriber Date of Birth		1/35	Must be present if the patient is the subscriber, i.e., 2100C, DMG segment is created.
		DMG03 Subscriber Demographic Information	Gender Code	F, M	1/1	
123		DTP01 Subscriber Date	Date Time Qualifier	291	3/3	The DTP segment is situational. If it is used to specify a date of service, other than "today", this element is required. It is used only if the patient is the subscriber.
		DTP02 Subscriber Date	Date Time Period Format Qualifier	D8 RD8	2/3	
		DTP03 Subscriber Date	Date Time Period		1/35	
152	2100D	NM103 Dependent Name	Dependent Last Name		1/60	Must be present if the patient is a dependent.
		NM104 Dependent Name	Dependent First Name		1/35	

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response, Continued

270/271 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1

TR3 Page #	*Loop ID*	*Reference*	*Name*	*Codes*	*Length*	*Comments*
165	2100D	DMG01 Dependent Demographic Information	Date Time Period Format Qualifier	D8	2/3	The DMG segment is situational but must be present if the patient is a dependent; if used, this element is required.
		DMG02 Dependent Demographic Information	Dependent Date of Birth		1/35	Must be present if the patient is a dependent, i.e., 2100D, DMG01 is used.
179		DMG03 Dependent Demographic Information	Gender Code	F, M	1/1	Must be present if the patient is a dependent, i.e., 2100D, DMG segment is created.
		DTP01 Dependent Date	Date Time Qualifier	291	3/3	The DTP segment is situational. If it is used to specify a date of service other than “today”, this element is required. It is used only if the patient is a dependent.

270/271 Service Type Guidelines

Service Type	HIPAA Description	Included Service Types on Responses	Comments
1	Medical Care	1, 2, 42, 45, 69, 73, 76 ,83, AG, BT, BU, DM	
2	Surgical	2, 7, 8, 20	
3	Consultation	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	Please use service type 98
4	Diagnostic X-Ray	4	
5	Diagnostic Lab	5	Please do not use service type 66
6	Radiation Therapy	6	
7	Anesthesia	7	
8	Surgical Assistance	8	
9	Other Medical	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
10	Blood Charges	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
11	Used Durable Medical Equipment		Please use service type 12
12	DME Purchased	12	Please do not use service type 11, 75
13	Ambulatory Service Center Facility	13	
14	Renal Supplies in the Home		Please use service type 42
15	Alternate Method Dialysis	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
16	Chronic Renal Disease (CRD) Equipment	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
17	Pre-Admission Testing	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
18	DME Rental	18	
19	Pneumonia Vaccine		Please use service type 80
20	Second Surgical Opinion	20	
21	Third Surgical Opinion	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
22	Social Work	22	
23	Diagnostic Dental	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	
24	Periodontics	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
25	Restorative	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	
26	Endodontics	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	
27	Maxillofacial Prosthetics		
28	Adjunctive Dental Services	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	
30	Health Benefit Plan Coverage	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
32	Plan Waiting Period	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
33	Chiropractic	4, 33	
34	Chiropractic Office Visits		Please use service type 33
35	Dental Care	23, 24, 25, 26, 35, 36, 38, 39, 41	Service type 35 is Dental Baseline
36	Dental Crowns	23, 24, 25, 26, 35, 36, 38, 39, 41	
37	Dental Accident		Please use service type 30 for medical coverage. Please use 35 for dental coverage.
38	Orthodontics	23, 24, 25, 26, 35, 36, 38, 39, 41	
39	Prosthodontics	23, 24, 25, 26, 35, 36, 38, 39, 41	
40	Oral Surgery	40	
41	Routine (Preventive) Dental	23, 24, 25, 26, 35, 36, 38, 39, 41	
42	Home Health Care	42, 43, A3	
43	Home Health Prescription	42, 43, A3	
44	Home Health Visits	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
45	Hospice	45	
46	Respite Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
47	Hospital	47, 48, 50, 51, 52, 53	
48	Hospital – Inpatient	48, 49	
49	Hospital – Room and Board		Please use Service Type 48
50	Hospital – Outpatient	50, 51, 52, A0	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
51	Hospital – Emergency Accident	51	
52	Hospital – Emergency Medical	52	
53	Hospital – Ambulatory Surgical	53	
54	Long Term Care	54	
55	Major Medical	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
56	Medically Related Transportation		Please use service type 59
57	Air Transportation		Please use service type 59
58	Cabulance		Please use service type 59
59	Licensed Ambulance	59	
60	General Benefits	60	
61	In-Vitro Fertilization	61	
62	MRI/CAT Scan	62	
63	Donor Procedures	63	
64	Acupuncture	64	
65	Newborn Care	65	
66	Pathology		Please use service type 5
67	Smoking Cessation	67	
68	Well Baby	68, 80, BH	
69	Maternity	69	
70	Transplants	70	
71	Audiology Exam	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
72	Inhalation Therapy	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
73	Diagnostic Medical	4, 5, 62, 73	
74	Private Duty Nursing	74	
75	Prosthetic Device		Please use service type 12
76	Dialysis	76	
77	Otological Exam	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
78	Chemotherapy	78	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
79	Allergy Testing	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
80	Immunizations	80	
81	Routine Physical	81	
82	Family Planning	82	
83	Infertility	83	
84	Abortion	84	
85	AIDS	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
86	Emergency Services	51, 52, 86, 98	
87	Cancer	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
88	Pharmacy	88	Service Type 88 is the Pharmacy Baseline
89	Free Standing Prescription Drug		Please use service type 88
90	Mail Order Prescription Drug		Please use service type 88
91	Brand Name Prescription Drug		Please use service type 88
92	Generic Prescription Drug		Please use service type 88
93	Podiatry	91, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
94	Podiatry – Office Visit	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
95	Podiatry – Nursing Home Visits	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
96	Professional(Physician)	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
97	Anesthesiologist	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
98	Professional(Physician) Visit – Office	98, Specialist	
99	Professional(Physician) Visit – Inpatient	99	
A0	Professional(Physician) Visit – Outpatient	A0	
A1	Professional(Physician) Visit – Nursing Home	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
A2	Professional(Physician) Visit – Skilled Nursing Facility	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
A3	Professional(Physician) Visit – Home	A3	
A4	Psychiatric	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
A5	Psychiatric – Room and Board	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
A6	Psychotherapy	A6	
A7	Psychiatric – Inpatient	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
A8	Psychiatric – Outpatient	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
A9	Rehabilitation	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AA	Rehabilitation – Room and Board	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AB	Rehabilitation – Inpatient	AB	
AC	Rehabilitation – Outpatient	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AD	Occupational – Therapy	AD	
AE	Physical Medicine	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AF	Speech Therapy	AF	
AG	Skilled Nursing Care – Room and Board	AG	
AH	Skilled Nursing Care – Room and Board	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AI	Substance Abuse	AI	
AJ	Alcoholism		Please use service type AI
AK	Drug Addiction		Please use service type AI
AL	Vision (Optometry)	AL,AN,AO	Service Type AL is the Vision Baseline
AM	Frames	AM	
AN	Routine Exam		Please use Service Type AL
AO	Lenses		Please use Service Type AL
AQ	Non Medically Necessary Physical	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
AR	Experimental Drug Therapy	AR	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
BA	Independent Medical Evaluation	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BB	Partial Hospitalization (psychiatric)	BB	
BC	Day Care (psychiatric)	BC	
BD	Cognitive Therapy	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BE	Massage Therapy	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BF	Pulmonary Rehabilitation	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BG	Cardiac Rehabilitation	BG	
BH	Pulmonary Rehabilitation	BH	
BI	Nursery	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BJ	Skin	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BK	Orthopedic	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BL	Cardiac	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BM	Lymphatic	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BN	Gastrointestinal	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BP	Endocrine	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BQ	Neurology	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BR	Eye		Please use Service Type AL
BS	Invasive Procedures	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
BT	Gynecological	BT	
BU	Obstetrical		Please use Service Type 69
BV	Obstetrical/ Gynecological	BT, BU, BV	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
BW	Brand Name Prescription Drug Mail Order		Please use Service Type 88
BX	Generic Prescription Drug Mail Order		Please use Service Type 88
BY	Physician Visit – Office Sick	BY	
BZ	Physician Visit – Office Well	BZ	
B1	Burn Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
B2	Prescription Drug Formulary		Please use Service Type 88
B3	Prescription Drug Non Formulary		Please use Service Type 88
CA	Private Duty Nursing – Inpatient	CA	
CB	Private Duty Nursing – Home	CB	
CC	Surgical Benefits Professional	2, 7, 8, 20	
CD	Surgical Benefits Facility	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
CE	MH Professional – Inpatient	CE	
CF	MH Professional – Outpatient	CF	
CG	MH Facility – Inpatient	CE	
CH	MH Facility – Outpatient	CF	
CI	Substance Abuse Facility – Inpatient	CI	
CJ	Substance Abuse Facility – Outpatient	CJ	
CK	Screening X-Ray	CK	
CL	Screening Laboratory	CL	
CM	Screening Mammogram – HR Patient	CM	
CN	Screening Mammogram – LR Patient	CN	
CO	Flu Vaccination		Please use Service Type 80
CP	Eye Wear & Eye Wear Associates	AL, AN, AO	
CQ	Case Management	CQ	

270/271 Service Type Guidelines, Continued

Service Type	HIPAA Description	Included Service Types on Responses	Comments
C1	Coronary Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
DG	Dermatology	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
DM	DME	12, 18, DM	
DS	Diabetic Supply	DS	
GF	Prescription Drug Generic Formulary		Please use Service Type 88
GN	Prescription Drug Generic Non Formulary		Please use Service Type 88
GY	Allergy	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
IC	Intensive Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
MH	Mental Health	MH, CE, CF, CG, CH	
NI	Intensive Care Neonatal	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
ON	Oncology	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
PT	Physical Therapy	PT	
PU	Pulmonary	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
RN	Renal	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
RT	Residential Psychiatric TX	RT	
TC	Transitional Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
TN	Transitional Nursery Care	1, 86, 98, 47, MH, AL, 35, 88, UC, 33, 48, 50, 52, BY, BZ	
UC	Urgent Care	UC	

276/277-ASC X12N- Health Care Claim Status Request and Response

Introduction

The 276/277 ASC X12N - Health Care Claim Status Request and Response transactions defines a format to electronically transfer the subscriber's and/or dependent's health care claim status information. These transactions and their descriptions consist of the following :

Transaction Type	*Description*
ASC X12N 276 Transaction	This transaction is used for requesting information. The Claim Status inquiry is from a submitter (information receiver) to an information source organization.
ASC X12N 277 Transaction	This transaction is used to respond with claim status information. The Claim Status response is from an information source organization to a submitter (information receiver).

The information below and on the following pages define situational data elements unique to BCBSAZ for processing the ASC X12N 276 - Health Care Claim Status Request and Response transaction.

276/277 Guidelines

- Subscriber ID requirements to submit BCBS claims are as Follows:
  - Local members – Three – digit alpha prefix.
  - FEP members – Alpha prefix begins with 'R'.
  - Out-of-Area members – A minimum of three – digit alpha prefix.
- If an incorrect subscriber alpha prefix is submitted on a local BCBSAZ request, the 277 response will contain the corrected alpha prefix.
- The NPI is required on all electronic transactions, unless the provider of services can not obtain an NPI or does not meet the definition of a health care provider.
- Batch transactions will be broken down and processed as individual inquiries by BCBSAZ. You will receive individual responses for each inquiry.
- If the claim was paid by Electronic Funds Transfer (EFT), the EFT trace number in the 277 response will be a BCBSAZ tracking number, not the EFT number used by the bank.
- Provider claim status inquiries for all services provided in Arizona on behalf of any BCBSAZ Plan must be submitted to BCBSAZ.
- For Corporate Health Services (CHS) Plans claim status inquiries, contact the CHS Plan or applicable third-party administrator (TPA) located on the back of the member's card.

276/277-ASC X12N- Health Care Claim Status Request and Response, Continued

276/277 Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
42	2100A	NM108 Payer Name	Identification Code Qualifier	PI	1/2	Insert 'PI' (Payer ID).
		NM109 Payer Name	Payer Identifier		2/0	Insert '53589'.
136	2100D	NM109 Subscriber Name	Subscriber Identifier		2/80	Must be complete ID number, including the alpha prefix.

278-ASC X12N- Health Care Services Review–Request for Review and Response

Introduction

The ASC X12N 278 Health Care Services Review-Request for Review and Response transaction defines a format to electronically transfer a subscriber's and/or dependent's health care referral, pre-certification and pre-authorization review, request, and response between providers and review entities.

It processes information from primary participants such as, providers and Utilization Management Organizations (UMOs), where the entity inquiring is the primary provider and the service provider.

Transaction Type	***Description***
ASC X12N 278-13 Transaction	This transaction is used to request information related to pre-certification and pre-authorization. This is a Health Care Services Review-Request from a submitter (information receiver) to an information source organization.
ASC X12N 278-11 Transaction	This transaction is used to respond to referral, pre-certification and pre-authorization inquiries. This is a Health Care Services response from an information source organization to a submitter (information receiver).

The information on the following pages details situational data elements unique to BCBSAZ for processing the HIPAA 278 Health Care Services Review–Request for Review and Response transaction.

278-ASC X12N- Health Care Services Review–Request for Review and Response, Continued

278 Guidelines	**Important!** When the 278-11 response is sent, the HCR02 Certification Number may or may not be present. This number only confirms the return response and does not confirm approval of the 278-13 request. Therefore, it is imperative to check each Service Line for the appropriate HCR01 Action Code (A1, A3, A4, A6, CT or NA). The following guidelines will assist you in processing the 278 transaction. **General Guidelines** • BCBSAZ will only accept batch 278 HIPAA transactions. • Batch inquiries will be broken down and processed as individual transactions by BCBSAZ. You will receive individual responses. **278-13 Request** • The NPI is required on all electronic transactions, unless the provider of services cannot obtain an NPI or does not meet the definition of a health care provider. • Urgent and Non-Urgent 278-13 requests should be submitted with separate Level of Service Codes, per patient event. • Subscriber ID requirements to submit BCBS claims are as follows: o Local members - Three-digit alpha prefix. o FEP members - Alpha prefix begins with 'R'. o Out-of-Area members - A minimum of three-digit alpha prefix. • BCBSAZ will accept default values of all 9's on TRN02 and TRN03. **278-11 Response** • 278 responses sent from other Plans may not be considered final and can be followed-up with a letter, phone call, etc. Please contact the appropriate BCBS Plan for status. • If the TRN is submitted at the subscriber level and BCBSAZ determines the patient is the dependent the response will be returned at the dependent level. • If the TRN is submitted at the dependent level and BCBSAZ determines the patient is the subscriber the response will be returned at the subscriber level. • If an incorrect subscriber alpha prefix is submitted on a local BCBSAZ request, the 278 response will contain the corrected alpha prefix.
AAA Segments	Potential Scenarios which result in failure of the request transaction and creation of the 278 AAA segment response are: • system time-out • membership validation • provider id validation

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

278 Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
71-73	2010A	NM108 Utilization Management Organization Name (UMO)	UMO ID Code	PI	1/2	Insert 'PI' (Payor Identification).
		NM109 Utilization Management Organization Name (UMO)			2/80	Insert '860004538' for UMO (BCBSAZ) ID Code.
85-71	2010B	PER02 Requester Contact Information	Requester Contact Name		1/60	This information must be submitted to identify the Contact Name.
		PER03 Requester Contact Information	Requester Communica-tion Number Qualifier	EM FX TE	2/2	At least one Qualifier and up to three associated communication numbers must be submitted.
84-85	2010B	PER04 Requester Contact Information	Requester Communicati on Number		1/256	This information must be submitted as the contact communication number. **Note:** If additional Contact Communication Numbers are available, please use elements PER05 through PER08.
87	2010B	PRV	Requestor Provider Info			To specify the identifying characteristics of a provider
92	2010C	NM103 Subscriber Name	Subscriber Last Name		1/60	This information is required if the subscriber is the patient.
92	2010C	NM104 Subscriber Name	Subscriber First Name		1/35	

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

278 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
106	2010D	NM103 Dependent Name	Dependent Last Name		1/60	This information is required when the dependent loop is used.
106	2010D	NM104 Dependent Name	Dependent First Name		1/35	
113	2010D	DMG02 Dependent Demographic Information	Dependent Date of Birth		1/35	
113	2010D	DMG03 Dependent Demo-graphic Information	Gender Code	F, M, U	1/1	
118	2000E	TRN	Patient Event Tracking Number			
239	2000F	UM02 Health Care Services Review Information	Certification Type Code		1/1	Insert the selected certification type code to indicate type of certification. **Note:** If '1' is selected, then UM06 must be submitted with value of '03' or 'U' to indicate the level of service as Urgent. Otherwise, the request will be treated as non-urgent.
239	2000F	UM03 Health Care Services Review Information	Service Type Code		1/2	Required by BCBSAZ to indicate classification of service.

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products

Introduction	The 820 ASC X12N Payroll Deducted and Other Group Premium Payment for Insurance Products is used to initiate group premium payment transactions with or without remittance detail. The information on the following pages details situational data elements unique to BCBSAZ for processing this type of transaction.

820 Guidelines	The following are guidelines for processing the 820 transaction: • Receiving Depository Financial Institution ID Number and Receiver Bank Account Number will be provided after execution of the Trading Partner Agreement. • ACH payment dollars must include remittance detail with group section number and will be processed through the ACH Network and financial institutions. • BCBSAZ expects premium payments to be made in the same currency as billed (United States Dollars); therefore, the Non-US Dollars Currency segment should not be used.

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products,

820
Data Element

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
37		BPR01 Financial Information	Transaction Handling Code	C	1/ 2	Insert 'C' (Payment Accompanies Remittance Advice) when format is X12N including ACH payment.
				I		Insert 'I' (Remittance Information Only), when submitting a check and separate remittance detail.
38		BPR03 Financial Information	Credit/ Debit Flag Code	C	1/1	Insert 'C' (Credit).
38		BPR04 Financial Information	Payment Method Code	ACH	3/3	Insert 'ACH' (Automated Clearing House) when format is X12N including ACH payment.
				CHK		Insert 'CHK' (Check) when submitting a check and separate remittance detail.
38		BPR05 Financial Information	Payment Format Code	CTX	1/10	Insert 'CTX' (Corporation Trade Exchange) when format is X12N including ACH payment.
39-42		BPR06 thru BPR16	Bank Information			Data Elements must be used when format is X12N including ACH payment (BPR04 = 'ACH').
42		BPR13 Financial Information	Receiving Depository Financial Institution ID Number		3/12	Number determined upon completion of Trading Partner Agreement.
		BPR14 Financial Information	Account Number Qualifier	DA	1/3	Insert 'DA' (Demand Deposit).
		BPR15 Financial Information	Receiver Bank Account Number		1/35	Number determined upon completion of Trading Partner Agreement.

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products, Continued

820
Data Elements,
Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
43		TRN01 Re-Association Trace Number	Trace Type Code	1	1/2	Insert '1' (Current Transaction Trace Numbers) when format is X12N including ACH payment.
				3		Insert '3' (Financial Re-association Trace Number) when submitting a check and separate remittance detail.
45		CUR Foreign Currency Information	Non-US Dollars Currency			Segment should not be used.
48		REF01 Premium Receiver's Identification Key	Reference Identification Qualifier	14	2/3	Insert '14' (Master Account Number).
49		REF02 Premium Receiver's Identification Key	Reference Identification		1/50	Insert BCBSAZ Group Section Number as the ID.
56	1000A	N102 Premium Receiver's Name	Name		1/60	Insert 'BCBSAZ'.
57		N103 Premium Receiver's Name	Identification Code Qualifier	FI	1/2	Insert 'FI' (Federal Taxpayer's Identification Number).
57		N104 Premium Receiver's Name	Identification Code		2/80	Insert BCBSAZ Tax ID '860004538'.
59		N301 Premium Receiver's Address	Address Information		1/55	Insert BCBSAZ Address 'PO BOX 81049'.

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products, Continued

820 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
60		N401 Premium Receiver's City, State, Zip	City Name		2/30	Insert BCBSAZ City 'PHOENIX'.
61		N402 Premium Receiver's City, State, Zip	State or Providence Code		2/2	Insert BCBSAZ State 'AZ'.
61		N403 Premium Receiver's City, State, Zip	Postal Code		3/15	Insert BCBSAZ Zip Code '850691049'.
65	1000B	N103 Premium Payers Name	Identification Code Qualifier	FI, 24	1/2	Insert 'FI' (Federal Taxpayer's ID Number) or '24 (Employer's ID Number)
87	2300A	RMR01 Organiza-tion Summary Remittance Detail	Reference Identification Qualifier	1L	2/3	Insert '1L' (Group or Policy Number).
88	2300A	RMR02 Organiza-tion Summary Remittance Detail	Reference Identification		1/50	Insert use BCBSAZ Group Section Number.
107	2100B	NM101 Individual Name	Entity Identifier Code	EY	2/3	Insert 'EY' (Employee Name).
109		NM108 Individual Name	Identification Code Qualifier	EI	1/2	Insert 'EI' (Employee ID Number).
112/113	2300B	RMR01 Individual Premium Remittance Detail	Reference Identification qualifier	AZ, IK	2/3	Insert 'AZ' (Health Insurance Policy Number) when invoice has not been received. Insert 'IK' (Invoice Number) when invoice has been received.

834-ASC X12N- Benefit Enrollment and Maintenance

Introduction	The 834 ASC X12N-Benefit Enrollment and Maintenance transaction set is used to request and receive information and to transfer subscriber and/or dependent enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 834 – Benefit Enrollment and Maintenance transaction.

834 Guidelines	• Subscribers and dependents are sent as separate occurrences of Loop 2000 (Member Level Detail). The initial enrollment for the subscriber must be sent before sending the initial enrollment for any of the subscriber's dependents. The enrollment of a dependent may follow the subscriber's enrollment in the same transmission, or it may be sent separately in a later transmission. • It is required that Loop 2000 INS segment (Member Level detail) is sent with a termination Maintenance Type Code (024) when Health Coverage Maintenance Type Code 024 (2300-HD segment) is present. If the member being terminated is the subscriber, then all dependents linked to the subscriber will also be terminated. • It is recommended that Full File Audits (Verify), code value of '4', be used for regular weekly processing. A maintenance file contains "adds", "changes" or "terms" request for members. The maintenance file is identified in BGN08 by code value of '2', Change (Update). • No more than 10,000 INS segments can occur in a single 834 transaction **4010A1 version only**. Multiple transactions within a single interchange can be used to transfer information on larger numbers of members. • For submission with Member Communications Numbers in 2100A PER segment, PER03 and PER04 are required and should include the member's primary communication qualifier and the number where the member is likely to be reached. If additional communications numbers are available, use the remaining PER data elements to provide the next 'primary' communication numbers available.

834 ASC X12N- Benefit Enrollment and Maintenance

834 Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Comments***
36	Trans Set Policy Number	REF01 Trans Set Policy Number	Reference ID Qualifier	38	2/3	Must be submitted. Insert '38' (Master Policy Number).
36		REF02 Trans Set Policy Number	Master Policy Number		1/50	Must be submitted. Insert Group Policy Number supplied by BCBSAZ.
39	1000A	N102 Sponsor Name	Plan Sponsor Name		1/60	Insert group name.
40	1000A	N103	ID Code Qualifier		1/2	Insert 'FI' (Federal Taxpayer's ID Number).
40	1000A	N104	Sponsor ID Code		2/80	Insert Sponsor Federal Taxpayers ID Number
41-42	1000B	N102 Payer	Insurer Name		1/60	Insert 'BCBSAZ'.
		N103 Payer	ID Code Qualifier	FI	1/2	Insert 'FI' (Federal Taxpayer's ID Number).
		N104 Payer	Insurer ID Code		2/80	Insert '860004538' for BCBSAZ ID Code.
51	2000	INS05 Member Level Detail	Benefit Status Code	A,C	1/1	A= Active, C= COBRA. This element must be submitted if INS05 value is equal to C.
52	2000	INS07 Member Level Detail	COBRA Qualifying Reference ID	1-8	1/1	This element must be submitted if INS05 value is equal to C.

834 ASC X12N- Benefit Enrollment and Maintenance, Continued

834 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Comments***
55	2000	REF01 Subscriber Number	Reference ID Qualifier	0F	2/3	Insert '0F' (Member/Subscriber Number)
55	2000	REF02 Subscriber Number	Subscriber ID		1/50	Allowed examples of subscriber ID numbers are as follows: • SS Number • Employee ID Number • BCBSAZ Subscriber Number **Note**: Using Option 1 or 2 for new Members is temporary until the new member receives their ID card with the new Member ID.
57-58	2000	REF01 Member Supplemental ID	Reference ID Qualifier	DX, ZZ	2/3	DX=Group Division Qualifier(Location) ZZ=Employee Number Qualifier.
58	2000	REF02 Member Supplemental ID	Member Supplemental ID		1/50	For DX Qualifier Insert the Employee's billing location or department. For ZZ Qualifier Insert the Employee ID#
141	2300	HD03 Health Coverage	Insurance Line Code		2/3	*See BCBSAZ Health Coverage Codes and Descriptions below. **These are only examples. Coverage Codes may vary depending on your plan provisions.*
		HD04 Health Coverage	Plan Coverage Description		1/50	

834 ASC X12N- Benefit Enrollment and Maintenance, Continued

BCBSAZ Health Coverage Codes and Descriptions

BCBSAZ health coverage codes and descriptions are listed below to assist in selecting the proper HD03 and HD04 values. HD03 IG codes not listed are not used by BCBSAZ but will be accepted with an HD04 value of "UNK" but may cause delays in processing.

Note: If you do not see a product type here, please contact one of our analysts at (602)336-7444 or (800)232-2345 ext. 7444. E-mail elecenrl@azblue.com.

BCBSAZ Health Coverage Codes and Descriptions

BCBSAZ Code	=	*Description*	*HD03*	*HD04*
LIFE	=	Life	AG	LIFE
DPPO	=	Dental Preferred	DEN	DPPO
BC	=	BlueChoice	HMO	BC
BP	=	BluePreferred	PPO	BP
BS		BlueSelect	HMO	BS
BPS	=	BluePreferred Saver	PPO	NPS
NBP	=	EPO	PPO	NBP

835-ASC X12N- Health Care Claim Payment/Advice

Introduction	The purpose of the 835 ASC X12N-Health Care Claim Payment/Advice Transaction is to facilitate the electronic transfer of health care claim payment information through an electronic remittance advice.. The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 835 – Health Care Claim Payment/Advice transaction.

AMT Segment	**Loop 2100 – Claim Supplemental Information (Situational)** AMT segment is used to convey information only; it is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier is Non-zero.

CAS Segment	**Loop 2100 – Claim Adjustment (Situational)** Payers must use CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged.

PLB Segment

Provider Level Adjustments

Offset detail is reported in the PLB segment. The following information will be reported in the PLB03-2 Provider Adjustment Identifier data element for the type of offset specified.

Note: The Patient Account Number will be provided in the Offset Detail when available.

Offset Type	***Data Reported in PLB03-2***
IRS Backup Withholding (PLB03-1 Adjustment Reason Code = 'IR')	IRS Backup Withholding
Claim Overpayment Offset (PLB03-1 Adjustment Reason Code = 'WO')	11-digit Offset A/R Number, space, first 8 letters of the Subscriber's Last Name, space, first 9 digits of the Subscriber ID.

835-ASC X12N- Health Care Claim Payment/Advice

835 Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
79	Header	CUR	Foreign Currency Information			Will not be used.
82		REF	Receiver Identification			
84		REF02 Receiver Identification	Version Identification		1/30	
102	1000B	N102 Payee Identification	Payee Name		1/60	'Pay To' Provider Name will be reported.
103		N104 Payee Identification	Payee Identification Code		2/80	As of 05/23/08, 'Pay To' Provider NPI will be reported.
107		REF02 Payee Additional Identification	Additional Payee Identifier		1/50	As of 5/23/08, 'Pay To' provider Tax ID will be reported.
112	2000	TS3	Provider Summary Information			Will not be used.
117		TS2	Provider Supplemental Summary Information			
147	2100	NM103 Service Provider Name	Rendering Provider Last or Organization Name		1/60	Claim-level Rendering Provider Name will be reported if different from the 'Pay To' Provider
		NM104 Service Provider Name	Rendering Provider First Name		1/35	
148	2100	NM105 Service Provider Name	Rendering Provider Middle Name		1/25	

835-ASC X12N- Health Care Claim Payment/Advice, Continued

835 Data Elements, Continued

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
149	2100	NM109 Service Provider Name	Rendering Provider Identifier		2/80	As of 5/23/08, NPI will be reported.
150	2100	NM1	Crossover Carrier Name			Will not be used.
159	2100	MIA	In-patient Adjudication Information			
166	2100	MOA	Out-patient Adjudication Information			
208	2110	REF02 Rendering Provider Information	Rendering Provider Identifier		1/50	As of 5/23/08, NPI will be reported.
213	2110	QTY	Service Supplemental Quantity			Will not be used.
215		LQ	Health Care Remark Codes			

837-ASC X12N- Health Care Claim: Professional, Institutional, and Dental

Introduction	The 837 ASC X12N transactions are used to electronically transfer and exchange health care claim billing and encounter information for the following types of claims: • ASC X12N 837 P — (Professional Claims) • ASC X12N 837 I — (Institutional Claims) • ASC X12N 837 D — (Dental Claims) The information on the following pages details situational data elements unique to BCBSAZ for processing the HIPAA 837 Health Care Claim for Professional, Institutional, and Dental transactions.

837 ASC X12N- Health Care Claim: Professional

837 Professional Data Elements,

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
117	2000B	SBR03 Subscriber Information	Subscriber Group Number		1/50	For CHS claims, the appropriate Group Number must be submitted in this element.
122-123	2010BA	NM108 Subscriber Information	Identification Code Qualifier	MI	1/2	Insert 'MI' (Member ID Number).
		NM109 Subscriber Information	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for non-CHS and Commercial claims.
157-163	2300	CLM Claim Information	Claim Information		1/80	No more than 5000 CLM segments should be submitted within the ST/SE Functional Group.
352	2400	SV101-1 Professional Service	Product or Service ID Qualifier	HC	2/2	'HC' (HCPCS Codes) is the only value accepted for this element by BCBSAZ.

837 ASC X12N- Health Care Claim: Professional-Coordination of Benefits (COB)

837 Professional COB Data Elements

Note: 837 Professional COB billing is done at the line level (2430 loop)

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
160	2300	CLM07 Claim Information	Provider Accept Assignment Code		1/1	Required field for all payers, the Provider Accept Assignment Code must be present.
305	2400	AMT01/02 Coordination of Benefits (COB)	Amount Qualifier Code/ Payer Paid Amount	D	1/3 1/18	The payer total claim paid amount by the primary payer must be entered in a AMT02 with the Qualifier D in AMT01.
481	2430	SVD02 Line Adjudication Information	Service Line Paid Amount		1/18	The amount paid by the primary payer must be entered in SVD02.
485	2430	CAS01 Line Adjustments	Claim Adjustment Group Code	CO, CR, PR, OA, PI	1/2	CO=Contractual Obligation CR=Correction and Reversals OA=Other Adjustments PI=Payor Initiated Reductions PR=Patient Responsibility. Note: CAS01 Repeats per Adjustment Group Code.
486	2430	CAS02	Adjustment Reason Code		1/5	1' (deductible) and/or '2' (coinsurance) CAS05 if both are applicable
486	2430	CAS03	Adjustment Amount		1/18	CAS06 If both are applicable

837 ASC X12N- Health Care Claim: Professional-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Professional, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

837 Professional Data Elements, Adjustments

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
159	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required** Must be equal to 7 = Debit; or 8 = Credit
196	2300	REF01 Payer Claim Control Number	Reference Identifier Qualifier	F8	2/3	**Required** Insert “F8”
196	2300	REF02 Payer Claim Control Number	Payer Claim Control Number		1/50	**Required** For BlueCard Host ICN/DCN must be 15-17 numeric characters. For Local & FEP ICN/DCN must be 15 numeric characters.
209	2300	NTE01 Claim Information	Note Reference Code	ADD	3/3	**Required** Insert “ADD”
210	2300	NTE02 Claim Information	Claim Note Text		1/80	**Required** Must contain the adjustment reason and narrative explaining why the claim is being adjusted.

837 ASC X12N- Health Care Claim: Institutional

837 Institutional Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
113-114	2010 BA	NM108 Subscriber Name	Identification Code Qualifier	MI	1/2	Insert 'MI' (Member ID Number).
		NM109 Subscriber Name	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for Non-CHS claims.
143	2300	CLM Claim Information	Claim Information			No more than 5000 CLM segments should be submitted within the ST/SE Transaction Set Header.
184	2300	HI01-1/01-2	Health Care Code Information	BK (ICD-9)	1/3	Institutional 'BK' (ICD-9CM Principal Diagnosis) is the only value accepted in this element by BCBSAZ. (Please refer to the TR3 for additional qualifiers.
185-186	2300	HI0X-9	POA - Present on Admission Indicator	Y, U, N, W	1/1	Y=the diagnosis was present on admission. U=it is unknown if the diagnosis was present on admission. N=the diagnosis was not present on admission. W=it is clinically undetermined if the diagnosis was present on admission. **Excludes Admitting Diagnosis.**
239-241	2300	HI01-1/01-2 Principal Procedure Information	Principal Code List Qualifier Code	BR(ICD-9)	1/3	Inpatient institutional 'BR' (ICD-9-CM Procedure) is the only value accepted in the element by BCBSAZ.
242	2300	HI0X-1/0X-2 Other Procedure Information	Other Procedure Code List Qualifier Code	BQ (ICD-9)	1/3	Inpatient institutional 'BQ' (ICD-9-CM Other Procedure) is the only value accepted in this element by BCBSAZ. **Note:** The 'X' represents the value 1 – 12.

837 ASC X12N- Health Care Claim: Institutional-Coordination of Benefits (COB)

837 Institutional COB Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
109	2000B	SBR01	Payer Responsibility Sequence Number Code	"S" or "T"	1/1	If secondary or Tertiary payer is Blue Cross, the assignment code must be present. (Additional acceptable codes: A-H, P)
123	2010BB	NM103	Payer Last Name or Organization Name	BCBSAZ	1/60	The payer name must be entered in this field. Note: NM102 = 2 'Required'
146	2300	CLM07	Provider Accept Assignment Code		1/1	Required field for all Payers. The 'Provider Accept Assignment code must be present'.
364	2320	AMT01	Amount Qualifier Code – Payer Paid Amount	D	1/3	Code to Qualify Amount
364	2320	AMT02	Payer Paid Amount		1/18	Amount Paid by the Primary Payer. Used in COB situations
476	2430	SVD01 match NM109 Loop 2330B	Service Line Adjustment		2/80	Identification Code
477	2430	SVD02	Paid Amount	**Note:** 'Zero '0' is an acceptable value.	1/18	If 2320 AMT01=D and 2430 SVD are equal, no 2430 CAS segment is required, except if both are = 0. If they are not equal or both = 0, the 2430 CAS segment is required. If this isn't correct the claim will error for "Insufficient COB Data Submitted to Adjudicate Claim."

837 ASC X12N- Health Care Claim: Institutional-Coordination of Benefits (COB) Continued

Note: 837 Institutional COB billing is done at the claim level (2320)

837 Institutional COB Data Elements

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
481	2430	CAS01 Line Adjustments	Claim Adjustment Group Code	CO, CR, PR, OA, PI	1/2	CO=Contractual Obligation CR=Correction and Reversals OA=Other Adjustments PI=Payor Initiated Reductions PR=Patient Responsibility. **Note**: CAS01 Repeats per Adjustment Group Code.
482	2430	CAS02	Adjustment Reason Code		1/5	1' (deductible) and/or '2' (coinsurance) CAS05 if both are applicable
482	2430	CAS03	Adjustment Amount		1/18	CAS06 If both are applicable
482	2430	CAS05	Adjustment Reason Code		1/5	1' (deductible) and/or '2' (coinsurance) CAS05 if both are applicable
482	2430	CAS06	Adjustment Amount		1/18	CAS06 If both are applicable

837 ASC X12N- Health Care Claim: Institutional-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Institutional, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

837 Institutional Data Elements Adjustments

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
145	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	5 7 8	1/1	Required Insert 5 (Late Charges) 7 (Debit) or 8 (Credit)
166	2300	REF01 Payer Claim Control Number	Reference Identifier Qualifier	F8	2/3	**BCBSAZ Requires** Insert "F8" (Original Reference Number) **Not required** on CHS
187	2300	REF02 Payer Claim Control Number	Reference Identification Number		1/50	Required Insert ICN/DCN of 15-17 numeric characters for BlueCard Host; or Insert ICN/DCN of 15 numeric characters for Local or FEP. **Not required** on CHS
180	2300	NTE01 Billing Note	Billing Note	ADD	3/3	Required Insert "ADD"
204	2300	NTE02 Billing Note	Billing Note Text		1/80	**Required** Must contain the adjustment reason and narrative explaining why the claim is being adjusted.
294	2300	HI0X – 1 Condition Information	Condition Qualifier	BG	1/3	Required Insert "BG"
294	2300	HI0X – 2 Claim Information	Condition Code		1/30	Required Insert valid Condition Code (See page 6 for code values and descriptions).

837 ASC X12N- Health Care Claim: Dental

837 Dental Data Elements,

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
112	2000B	SBR03 Subscriber Information	Insured Group or Policy Number		1/50	Insert the appropriate group number. For CHS claims, the appropriate Group Number must be submitted in this element.
115-116	2010 BA	NM108 Subscriber Name	Identification Code Qualifier	MI	1/2	Insert 'MI' (Member ID Number).
116		NM109 Subscriber Name	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for Non-CHS claims.
145	2300	CLM	Claim Information			No more than 5000 CLM segments should be submitted within the ST/SE Functional Group.

837 ASC X12N- Health Care Claim: Dental-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Dental, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

837 Dental Data Elements, Adjustments

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***
167	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required** Must be equal to 7 = Debit; or 8 = Credit
175	2300	REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	**BCBSAZ Requires:** Insert “F8”
175	2300	REF02 Claim Identifier for Transmission Intermediaries	Reference Identification		1/50	**Required** For BlueCard Host ICN/DCN must be 15-17 numeric characters. For Local & FEP ICN/DCN must be 15 numeric characters.
232	2300	NTE01 Claim Note	Note Reference Code	ADD	3/3	**Required** Insert “ADD”
232	2300	NTE02 Claim Note	Claim Note Text		1/80	**Required** Must contain the adjustment reason and narrative explaining why the claim is being adjusted.

837 ASC X12N- Health Care Claim: Medicare Direct

(RESERVED FOR FUTURE USE)

837-Medicare Direct Data Elements,

Technical Report Type 3 5010 WPC Version 5 Release 1						
TR3 Page #	***Loop ID***	***Reference***	***Name***	***Codes***	***Length***	***Notes/Comments***

Frequently Asked Transaction Questions

General	***Q- "How do I begin the testing process for HIPAA transactions?"*** ***A-*** *Contact eSolutions at* ***(602)864-4844*** *or* ***(800)650-5656*** *to initiate the set up process.*
	Q- "What will happen during the testing process?" ***A-*** *BCBSAZ tests HIPAA standard transactions in phases. You will be given a a Sender ID number. In addition, you will receive instructions on accessing a web-based testing site contracted by BCBSAZ to ensure that transactions pass all HIPAA syntax and semantic requirements.* *In the second testing phase, the Trading Partner will receive set up information to enable the site to send test files to BCBSAZ. A test file is processed through BCBSAZ's system to ensure that the transactions meet pre system edits.* *Test results will be provided to the Trading Partner in an Acknowledgment Response and/or Reports similar to what you will receive in production.*
	Q- "How much time will testing require?" ***A-*** *The time line may vary depending on the support and coordination you Establish with your software vendor, clearinghouse, and health plans. The accuracy of the test file, based on the Technical Report Type 3 and the BCBSAZ Companion Guide requirements, will also help accelerate the testing process.*
	Q- "When can I begin to submit "live" transactions in production?" ***A-*** *After you successfully complete the second phase of HIPAA compliance testing as defined above.*
	Q- "Do I still have to submit a BCBSAZ specific sender ID number?" ***A-*** *Yes, the BCBSAZ specific sender ID must be sent in the Interchange Control Header ISA06 and the Functional Group Header GS02 Application Sender's Code.*
	Q- "Will BCBSAZ have special requirements for HIPAA transactions?" ***A-*** *There are situational data elements BCBSAZ needs in order to conduct business and process your transactions. BCBSAZ has developed the BCBSAZ Companion Guide to supplement the HIPAA 5010 Transactions Technical Report Type 3s, Version 5 Release 1. The BCBSAZ Companion Guide contains specific data elements required for transactions and Clarifies some of the standard uses of the transaction elements.*

Frequently Asked Transaction Questions, Continued

General, Continued	***Q- "If I am only sending an 837, can I start sending other HIPAA transactions?"*** ***A-*** *Yes. If you want to send additional types of HIPAA transactions, contact eSolutions at* ***(602)864-4844*** *or* ***(800)650-5656*** *to begin testing for these additional transactions.*
	Q- "What is the difference between real-time and batch transactions?" ***A-*** *Batch is 1 or more transactions sent with the expectation that a response will not be available immediately. BCBSAZ typically responses within 24 hours or the next business day.* *Real-time is a single transaction sent with the expectation that a response should be returned in the same session, typically within 60 seconds. The transactions available in real-time are the* ***270/271*** *and* ***276/277****.*
	Q- "Who is the contact for HIPAA transaction testing technical support?" ***A-*** *Contact eSolutions Customer Support at* ***(602)544-4994*** *or* ***(866)207-4011****.*

Frequently Asked Transaction Questions, Continued

270/271	***Q- "What is the 270/271 ASC X12N transaction?"*** ***A-*** *This transaction provides a member's eligibility and benefit information, but does not provide a history of benefit use.*
	Q- "What information will I receive from BCBSAZ in a 271 response?" ***A-*** *The BCBSAZ 271 response will provide detailed member information indicating active/inactive status on the date requested, health benefit plan coverage, and/or dental coverage.*
	Q- "Will I be able to send and receive 270/271 transactions in real-time?" ***A-*** *Yes, BCBSAZ accepts real-time transactions from vendors, clearinghouses, and providers. Real-time response transactions are typically sent within 60 seconds.*
	Q- "Can I send 270 batch inquiries?" ***A-*** *Yes, BCBSAZ accepts and processes batch 270 inquiries. Batch responses are typically provided within 24 hours or the next business day.*
	Q- "Can I submit BlueCard (Out-of-area) and FEP 270 requests to BCBSAZ?" ***A-*** *Yes, providers should submit BlueCard and FEP requests to BCBSAZ. BCBSAZ will forward your inquiry to the appropriate Home Plan or FEP for processing.*
	Q- "How long will it take to receive an answer for BlueCard (Out-of-area) and FEP request?" ***A-*** *Providers typically receive a real-time 271 response BlueCard and FEP request within a maximum of 60 seconds. Batch response for BlueCard and FEP request are typically received within a maximum of 48 hours.*
	Q- "Why are multiple service types returned in the same EB segment on the 271?" ***A-*** *5010 has provided new functionality to reduce the size of the 271 response. If all the data is the same for multiple service types, they will be returned in the same EB03 using the new EB03 separator.*

Frequently Asked Transaction Questions, Continued

270/271 Continued	***Q- "How do I know which benefits apply to a specific network?"*** ***A-*** *5010 has provided new values for the EB12. A "W" will be returned when the Benefit information being conveyed in the EB segment is not specific to a network. A "Y" will be returned if the benefit applies to in-network only. An "N" will be returned if the benefit applies to out-of-network only.*
	Q- "What does an EB01 = R mean?" ***A-*** *BCBSAZ will return EB01 = R (other or additional payor) if we show any other Payer liability information in our records. The provider should contact the member to find out if this information is still applicable and get the other payor information.*
	Q- "Why did I receive a group number on my 271 response when I did not submit one?" ***A-*** *5010 now requires the group number on the 837P if published on the ID card. BCBSAZ prints the group number on the ID card and will now return the group number on the 271 response for the providers convenience.*

Frequently Asked Transaction Questions, Continued

276/277	***Q- "What is the purpose of the 276/277 ASC X12N Transaction?"*** ***A-*** *This transaction provides a member's claim status information.*
	Q- "What information will I receive from BCBSAZ in a 277 Response?" ***A-*** *The response typically includes the patient's name, date of service, billed amount, processed date, paid amount, claim and line status, and procedure and revenue codes.*
	Q- "Will I be able to send and receive a 276/277 in real-time?" ***A-*** *Yes, BCBSAZ accepts real-time transactions. Real-time response transactions are typically sent with in 60 seconds.*
	Q- "Can I send 276 batch inquiries?" ***A-*** *Yes, BCBSAZ accepts and processes batch 276 Inquiries. Batch responses are generally provided within 24 hours or the next business day.*
	Q- "Can I submit BlueCard (Out-of-area) and FEP 276 requests to BCBSAZ?" ***A-*** *Yes, providers should submit BlueCard and FEP requests to BCBSAZ.*
	Q- "How long will it take to receive an answer for BlueCard (Out-of-area) request?" ***A-*** *Providers will receive a 277 response for BlueCard requests for real-time inquiries typically within a maximum of 60 seconds. Batch response will be received generally within a maximum of 48 hours.*

Frequently Asked Transaction Questions, Continued

278	***Q- "What is the purpose of the 278 ASC X12N transactions?"*** ***A-*** *This transaction provides the ability to electronically request precertifications and appeals.*
	Q- "What information will I receive from BCBSAZ in a 278 response?" ***A-*** *The 278 response provides an approval or denial of the 278 request.*
	Q- "Will I be able to send and receive this information real-time or batch?" ***A-*** *BCBSAZ accepts 278 requests in batch transactions only. Any real-time transactions will be rejected with a TA1 Interchange Acknowledgment.*
	Q- "How long will it take to receive a response for a 278 request?" ***A-*** *BCBSAZ returns responses within Department of Labor standards.*
	Q- "Can I submit 278 requests for other BCBS Plans?" ***A-*** *Yes, providers should submit BlueCard (Out-of-area) requests to BCBSAZ.*
	Q- "How long will it take to receive an answer for BlueCard (Out-of-Area) request?" ***A-*** *BCBSAZ returns responses within Department of Labor standards.*
	Q- "How will I know if my 278 request has been received for processing?" ***A-*** *BCBSAZ acknowledges all inbound HIPAA transactions with either a TA1 Interchange Acknowledgment or a 999 Functional Acknowledgment transaction.*

Frequently Asked Transaction Questions, Continued

820	**Q- "What is the purpose of the 820 ASC X12N transactions?"** **A-** This transaction is used to initiate premium payment with or without remittance detail from employer groups to BCBSAZ.
	Q- "If I have questions or have interest in sending 820 premium payment transactions, who should I contact?" **A-** For information on electronic premium payment, please contact BCBSAZ eSolutions at **(602) 864-4844** or **(800) 650-5656**.

834	**Q- "What is the purpose of the 834 ASC X12N transactions?"** **A-** This transaction is used to transfer benefit enrollment and maintenance information from employer groups to BCBSAZ.
	Q- "If I cannot send an 834 ASC X12N, how else can I send enrollment and maintenance information to BCBSAZ?" **A-** An employer group can submit an 834 Flat File. For information regarding submission of a flat file, please contact Enrollment at **(602) 336-7444 or (800) 232-2345 X 7444**.

Frequently Asked Transaction Questions, Continued

835	***Q- "What is the purpose of the 835 ASC X12N transactions?"*** ***A-*** *This transaction provides an electronic remittance advice (ERA) in a HIPAA compliant format to health care providers*
	Q- "What information will I receive from BCBSAZ on an 835?" ***A****- The 835 contains information about the payee, the payer, the amount and any identifying information of the payment.*
	Q- "What version of the 835 are we going to be receiving?" **A-** You will be receiving the ASCX12N 835 5010 Version 5 Release 1.
	Q- "Will the 835 electronic remittance advice (ERA) work with all practice management software systems?" **A-** Check with your software vendor as this feature may not be available with all practice management systems.
	Q- "Must we participate in electronic funds transfer (EFT) in order to get the 835 ERA?" ***A-*** *No, EFT is not required to receive the ERA. Utilizing the EFT and the ERA generally makes your accounts receivable reconciliation more efficient but EFT is not required to receive the ERA.*
	Q- "Will I be able to associate the EFT to the 835 ERA?" ***A-*** *There will be an EFT trace number present on the 835 ERA file for ease in reconciliation.*
	Q- "Will the patient account number be present in the 835 ERA?" ***A-*** *Yes, if the patient account number is received on the claim it will populate on the Electronic Remittance Advice (ERA).*
	Q- "Will I be able to identify the accounting adjustments?" ***A-*** *Yes, there will be an Adjustment Reason Code to identify the type of offset.* *.*
	Q- "Can we print the 835?" ***A- No, it is an electronic file. Check with your software vendor for printing*** *capability through your Practice Management System.*
	Q- "Who do I call for 835 ERA support?" ***A-*** *Call eSolutions Customer Support at (602) 864-4844 or (800) 650-5656.*
	Q- "How do I get set up for ERA or EFT?" ***A-*** *Contact Finance at* ***(602) 864-5397.***

Frequently Asked Transaction Questions, Continued

837	***Q- "What is the purpose of the 837 ASC X12N transaction?"*** ***A-*** *This transaction provides an electronic transfer and exchange of information* on encounters and the following claim types: • *Professional* • *Institutional* • *Dental*
	Q- "Do I need to send the subscriber's group number?" ***A-*** *If the claim is for a member that belongs to a Corporate Health Services (CHS) group, the subscriber group number must be sent or the claim will reject back to the submitter.*
	Q- "Do I have to send the alpha prefix of the subscriber's ID Number?" ***A-*** *Yes, the alpha prefix is part of the BCBS subscriber ID number and is used for identification in routing internally, as well as externally.*
	Q- "How many claims can I submit within a transaction?" ***A-*** *Please limit the volume of claims within a transaction (ST/SE Functional Group) to no more than 5000.*
	Q- "With the implementation of NPI, how should the Tax ID be billed on an electronic claim?" ***A-*** *Claims submitted in a standard 837 format must have the Billing Tax ID in Loop 2010AA, Segment REF, Data Element REF02. The data element qualifier will be either EI (Tax ID) or SY (SS# 837P only). NPI sent in Loop 2310B (Rendering Provider) NM109 must not match the NPI in the Billing Provider Loop 2010AA NM109.*
837I	**Q- "What is a POA?"** **A-** The definition of a POA is – the condition was present at the time the inpatient admission occurs. This includes conditions that develop while the patient is in the emergency room, having outpatient testing, while the patient is in observation or during an outpatient surgery.
	Q- "Who is required to report POA's?" **A-** POA's are required for all inpatient claims for acute care hospitals.

Frequently Asked Transaction Questions, Continued

837I Continued	***Q- "How do I submit POA's?*** **A-** 1. *In a standard 837I format, excluding the Admitting Diagnosis, a Present on Admission Indicator (POA) is required on every diagnosis code except 'exempt' codes should be populated in Loop 2300, Segment HI0X-9. (Your vendor or clearinghouse should be able to assist you in creating and including this data in your file). Valid POA indicators are as follows:* *Y – diagnosis was present on admission* *N – diagnosis was not present on admission* *U – it is unknown if the diagnosis was present on admission* *W – it is clinically undetermined if the diagnosis was present on admission.* ***(See 837 – Institutional Data Elements above for Loop and Segment information.)*** *2. For claims submitted on a UB-04 claim form, the Present on Admission Indicator (POA) will be the 8th digit of the Principal Diagnosis Code (FL67) and the 8th digit of each of the Secondary Diagnosis Codes (FL67A-Q).*
	Q- "What is a Never Event?" ***A-*** *A Never event is identified by one of 3 hospital inpatient occurrences* *1.E876.5 – Performance of wrong operation on correct patient (wrong surgery).* *2.E876.6 – Performance of operation (procedure) intended for another patient (wrong patient).* *3.E876.7 – Performance of correct operation (procedure) on wrong body part/side/site (wrong body part).*
	Q- "What type of facility would report a Never Event?" ***A-*** *Reporting a Never Event is applicable to all hospital inpatient claims that have the occurrence at least one of the three diagnosis listed in the above question "What is a Never Even?".*
	Q- "How do I submit a claim that includes a Never Event?" ***A-*** 1. For claims submitted in a standard 837I format or on a UB-04 claim form, a surgical Never Event will be submitted with the following: a. Type of Bill "110" b. One of the three above diagnosis codes (E876.5, E876.6 and E876.7) present in the Principal Diagnosis Code or any occurrences of Other Diagnosis Codes excluding the Admitting Diagnosis. 2. Claims identified as bills for a surgical Never Event using TOB 110 are bills for the non-covered services associated with the Never Event.

Frequently Asked Questions – 837 Adjustments

The following FAQs are to assist you with understanding the electronic 837 adjustment request process and data element requirements.

<table>
<tr><td>837-
Adjustments</td><td>Q- “Can I submit requests for claim adjustments electronically?”
A- Yes. Effective October 1, 2008 all providers who currently send electronic 837 claims can submit 837 adjustment request.</td></tr>
<tr><td></td><td>Q- “What kind of adjustments can I send?”
A- Providers can submit adjustments NOT requiring Medical Records. Lines of Business (LOBs) and Claim Types included are:

Included:
Local — Professional, Institutional & Dental
FEP — Professional, Institutional & Dental
BlueCard Host — Professional & Institutional
CHS — Institutional

Excluded:
BlueCard Host — Dental
CHS — Professional & Dental</td></tr>
<tr><td></td><td>Q- “What kinds of adjustments require Medical Records?”
A- Medical Record adjustments include but are not limited to:

• Change in Diagnosis or Procedure Codes
• Active Rehab (exhausted benefits/requiring extension)
• Services denied as not medically necessary
• Multiple surgical procedures
• Second request for deductible, coinsurance and co-payments issues. (Claims Department has previously issued uphold letter)
• Second request on Timely Filing issues (Claims Department has previously issued Timely Filing letter)
• Second request on claims that denied for “Inclusive Services” (Claims Department has previously issued uphold letter)
• Second request on DME: Exhausted Rental has met Purchase Price. (Claims Department has previously issued uphold letter)
• Claims that denied for Medical Records and provider is asking for a review but Medical Records are <u>not</u> attached to correspondence</td></tr>
<tr><td></td><td>Q- “How are the adjustments sent / submitted?”
A- The provider will follow the same process they currently follow to submit electronic claims.</td></tr>
<tr><td></td><td>Q- “If I have questions about the submission of electronic adjustment, whom should I contact?”
A- For information on electronic claim solutions, contact BCBSAZ eSolutions at (602) 864-4844 or (800) 650-5656.</td></tr>
</table>

Frequently Asked 837 Adjustments Questions, Continued

<table>
<tr><td>837-
Adjustments,
Continued</td><td>Q- “How do I indicate the electronic claim is an adjustment?”
A- The provider will indicate the following:

<u>For Institutional Claims</u>
The 3rd position of the Type of Bill (Values 5, 7 or 8) indicates the claim is an adjustment.

<u>For Professional and Dental Claims</u>
The Frequency Code (Values 7 or 8) associated with the Place of Service on Professional and Dental claims. This indicates the claim is an adjustment.</td></tr>
<tr><td></td><td>Q- “How do I communicate what I want to have adjusted?”
A- BCBSAZ will require the following information be submitted within the electronic 837 adjustment request.

• Frequency Code – Must be present. Indicates the claim is an adjustment.
• Claim Note – Must be present in Professional and Dental adjustment requests. Must contain the adjustment reason and narrative explaining why the claim is being adjusted (i.e. Adjustment Reason could be “Number of units”, and additional narrative could be stated as “Units billed incorrectly, changed units from 001 to 010”.)
• Billing Note – Must be present in Institutional adjustment requests. Must contain the adjustment reason and narrative explaining why the claim is being adjusted (i.e. Adjustment Reason could be “Subscriber ID corrections” and additional narrative could be stated as “Transposed Sub ID Correct ID is 850123654 for Jane Doe, DOB 10-20-1975”.)
• Original Reference Number – Must be present. Claim number of the originally adjudicated claim found on your remittance advice (the (ICN/DCN) of the claim you want adjusted.)
• Condition Codes – Must be present in Institutional adjustment requests.</td></tr>
<tr><td></td><td>Q- “What are Conditions Codes?”
A- Condition Codes are Claim Change Reasons used in Institutional claims only.
The following are the values that BCBSAZ will accept:

<table>
<tr><td>D0</td><td>Changes to Service Date (Statement Dates)</td></tr>
<tr><td>D1</td><td>Changes to Charges</td></tr>
<tr><td>D3</td><td>Second or Subsequent Interim PPS Bill</td></tr>
<tr><td>D7</td><td>Changes to Make Medicare the Secondary Payer</td></tr>
<tr><td>D8</td><td>Changes to Make Medicare the Primary Payer</td></tr>
<tr><td>D9</td><td>Any other Change (including changes to service level dates</td></tr>
<tr><td>E0</td><td>Change in Patient Status</td></tr>
</table></td></tr>
<tr><td></td><td>Q- “What elements will be affected in my billing system and what do I tell my vendor regarding any required changes?”
A- The portion of the BCBSAZ Companion Guide for elements required on an 837 adjustment request (Professional, Dental and Institutional) can be found on pages 52, 56 and 58. Please use these requirements when working with your vendor to make the necessary changes to your billing systems.</td></tr>
</table>

Frequently Asked 837Adjustments Questions, Continued

837-Adjustments, Continued	***Q- "How will I know the adjustment was received by BCBSAZ?"*** ***A-*** *Submitters will receive a positive 999 for compliant 837claim files. Then they will receive the clearinghouse report also refer to as Custom Claims Acknowledgement report (CCAR). This report includes the following:* • *A list of received claims including adjustment claim information**.*** • *Error number and descriptions of failed claims.*
	Q- "Can I submit my daily electronic claims with my electronic adjustment requests in the same file?" ***A-*** *Yes.*
	Q- "Are Medicare Cross-over electronic 837 adjustments included in this process?" ***A-*** *Yes. The Medicare contractor will send adjustment 837s to BCBSAZ for Local, FEP and Senior Product Lines of Business.*
	Q- "How should I submit Medicare cross-over adjustments"? ***A-*** *Adjustments where Medicare is primary **MUST** be sent directly to Medicare. The adjustment, once processed by Medicare, will be electronically crossed over to BCBSAZ. The provider **MUST NOT** send these adjustments directly to BCBSAZ.*
	Q- "How do I submit a Medicare Advantage claim?" ***A-*** *Although BCBSAZ does not have a Medicare Advantage Product at this time, we do accept Medicare Advantage claims for our contracted providers on behalf of other Blue Plans. Please refer to the Provider Operating Guide for more information.*
	Q- "Can I continue to submit adjustment requests on paper"? ***A-*** *Yes. Adjustment requests for corrected claims or adjustment claims that require Medical Records or other documentation **MUST** be submitted on paper. However, electronic claims are handled more quickly and it reduces paper handling.*

BCBSAZ HIPAA Glossary

Note: The following glossary section is to assist with defining frequently used words and phrases encountered with HIPAA Transactions.

ASC X12N:	*The subcommittee chartered to develop electronic standards specific to the health insurance industry.*
BlueCard: (Out-of-area)	*The BlueCard Program enables members who are traveling or living in another Plan's service area to receive all the same benefits of their contracting BCBS Plan and access to BlueCard providers and savings. It links participating healthcare providers and the independent BCBS Plans across the country through a single electronic network for claims processing and reimbursement.*
Business Associate:	*A person who, or entity which, performs a function on behalf of a covered entity involving the use or disclosure of protected health information.*
CCAR:	*CCAR stands for Custom Claims Acknowledgment Report. This is replacing the All Payer Network Report (APN).*
Code Sets:	*A set of codes used for encoding data elements, such as, tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes including the codes and descriptors of the codes.*
Corporate Health Services (CHS):	*Provides large, self-insured groups access to the BCBSAZ provider networks. Most groups have selected a third party administrator (TPA) as their claims administrator for claims processing and verification of eligibility and benefits. BCBSAZ does not provide group health coverage for CHS accounts. Benefits for these groups may vary from BCBSAZ standard benefits.*
Covered Entities:	*A health plan, health care clearinghouse that, or health care provider who, transmits health information electronically.*
Data Condition:	*The rule that describes the circumstances a covered entity must use for a particular data element or segment.*
Data Content:	*All the data elements and code sets inherent in, but not related to the format of the transaction. Data elements related to the format are not considered data content.*
Data Element:	*The smallest named unit of information in a transaction.*
Data Set:	*A semantically meaningful unit of information exchanged between two parties, in relation to a transaction.*
Dependent:	*A person who is identifiable by an information source in association with a subscriber; not uniquely identifiable to an information source.*
Descriptor:	*The text defining a code.*
Format:	*Data elements that either provide or control the enveloping or hierarchical structure, or assist in identifying data content of a transaction.*

BCBSAZ HIPAA Glossary, Continued

Health Care Clearinghouse	*A public or private entity that either processes or facilitates the processing of health information in a non-standard format or containing non-standard data content into standard data elements or a standard transaction (or vice versa). Such an entity currently receives health care transactions from health care providers and other entities, translates the data from a given format into one acceptable to the intended recipient, then forwards the processed transaction to appropriate health plans and other health care clearinghouses, as necessary, for further action.* *HIPAA regulations considers the following entities to be health care clearinghouses if they conduct the foregoing activities: billing services, repricing companies, community health management information systems or community health information systems, value-added networks, and switches performing these functions.*
Health Care Provider:	*A provider of medical or other health services and other persons furnishing health care services or supplies; limited to entities who furnish or bill, and are paid for, health care services during the normal course of business.*
Health Information:	*Information, whether oral or recorded, in any form or medium, that:* a. *is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse* ***and*** b. *is related to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.*
Health Plan:	*An individual or group plan providing or paying medical care costs, including self-funded plans, Medicare, Medicaid, HMOs, long-term care insurers, programs for active military personnel, Indian Health Services, FEP, Medicare Choice, and Medicare supplemental policies.*
Implementation Acknowledgment – 999:	*The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the compliancy status of the electronic file sent.*
Information Receiver:	*The entity asking questions in relation to a 270 Eligibility or Benefit transaction, 276 Claim Status Inquiry transactions and the 278 Health Care Services Review Request.*
Interchange Acknowledgment TA-1:	*The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA-1 verifies the interchange envelope is compliant. A negative TA1 will occur when the envelope is setup incorrectly or information in the envelope does not match the information that has been agreed upon between the Trading Partners.*
Local Business:	*Services for Blue Cross Blue Shield of Arizona members. This excludes FEP, CHS and BlueCard programs.*

BCBSAZ HIPAA Glossary, Continued

Privacy:	*Standards that define who may use and disclose "protected health information" and circumstances requiring patient authorization or consent.*
Protected Health Information (PHI):	*Individually identifiable health information including demographic information, obtained from an individual, whether oral or recorded, in any form or medium.*
Security:	*Safeguards that encompass all information systems, including hardware, software, personnel policies, information practice policies, disaster preparedness, and the oversight of all these areas.* *The purpose of security is to protect the system and the information it contains from unauthorized external access and internal misuse.*
Segment:	*A group of related data elements in a transaction.*
Standard:	*A set of rules for a set of codes, data elements, transactions, or identifiers promulgated either by an organization accredited by ANSI or the HHS for the electronic transmission of health information.*
Standard Transaction:	*A transaction that complies with the applicable standard adopted under HIPAA.*
Subscriber:	*A person uniquely identifiable, to an information source, referred to as a member. The subscriber may or may not be the patient.*
Trading Partner:	*A sending or receiving party involved in the electronic exchange of business information.*
Trading Partner Agreement:	*An agreement between parties, whether distinct or part of a larger agreement, in relation to the electronic exchange of information transactions. For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.*
Transaction:	*A single business activity for health care EDI purposes. Transactions include claim submission, remittance advice, claim payment, claim status, eligibility and enrollment.*
Transaction Sets:	*Logical groupings of data used to convey a specific type of business information.*
277CA Acknowledgement:	*Health Care Claim Acknowledgment (277CA) technical report type 3 is a business application level acknowledgment for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage.*

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