UnitedHealthcare

Standard Companion Guide

Refers to the Implementation Guide Based on X12 Version 005010X279A1 **Health Care Eligibility Benefit Inquiry and Response(270/271)**

Companion Guide Version Number 9.0

February 2, 2025

CHANGE LOG

Versio	Release Date	Changes
1.0	11/10/2008	Created 11/10/2008 for 5010 Implementation.
2.0	11/10/2008	Initial External Release – Changes to comply with MN 62J (Eligibility Transaction Requirements); This functionality is planned for December, 2008; Effective date will be communicated separately in a release notice.
2.1	06/23/2009	Added Disclaimer in section 6.2.
2.2	12/11/2009	Added Additional service type codes (2, 5, 7, 9, 12, 13, 53, 60) in section 6.2.1; Updated service type code “AL” in section 6.2.1; Added specialty medication message segment example to the 271 response in section 7.2.
2.3	02/05/2010	Changed coinsurance amounts in examples from a whole number to a
3.0	10/11/2010	Updated based on 5010 270/271 transactions changes.
3.1	04/13/2011	Specified the valid single date inquiry range.
3.2	11/18/2011	Modified the descriptions for the service type codes returned in the 271, Section 6.2
4.0	08/30/2017	Changed clearinghouse name from Ingenix to OptumInsight; Added contacts for Optum; Updated all sections with current hyperlinks; Changed references from UnitedHealthcareOnline to UHCprovider.com.
4.1	11/07/2017	Updated UnitedHealthcare and Optum contact information, including hyperlinks to online resources; Reviewed document in detail, updating as
4.2	12/08/2017	Added Vision service type codes AM, AN, AO.
5.0	04/06/2018	Updated service type code list in section 6.2.
6.0	05/08/2020	Updated Section 2.2, Clearinghouse Connection; Section 3.8 Costs to Connect
7.0	07/05/2022	Updated Sections 1.3 REFERENCE, 2.2, Clearinghouse Connection; 4,4 Applicable Websites/Email
8.0	**12/7/2023**	Updates Logo, Section 6 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS
9.0	**2/4/2025**	Updated Links

PREFACE

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

Transmissions based on this companion guide, used in tandem with the IMPLEMENTATION GUIDE, also called 270/271 Health Care Eligibility and Benefit Inquiry and Response ASC X12N (005010X279A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N IMPLEMENTATION GUIDE adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the IMPLEMENTATION GUIDE.

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

Table of Contents

1. INTRODUCTION

This section describes how X12 IMPLEMENTATION GUIDE, also called 270/271 Health Care Eligibility and Benefit Inquiry and Response ASC X12N (005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has included, in addition to the information contained in the IMPLEMENTATION GUIDEs. That information can:

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

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

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

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

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

231	**2110C**	**EB13-1**	Product/Service ID Qualifier	**AD**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

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

1.2 OVERVIEW

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

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

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

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (005010X279A1) and to purchase copies of the Implementation documents, consult the X12 website: Products | X12

1.3 ADDITIONAL INFORMATION

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

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE

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

2.2 CLEARINGHOUSE CONNECTION

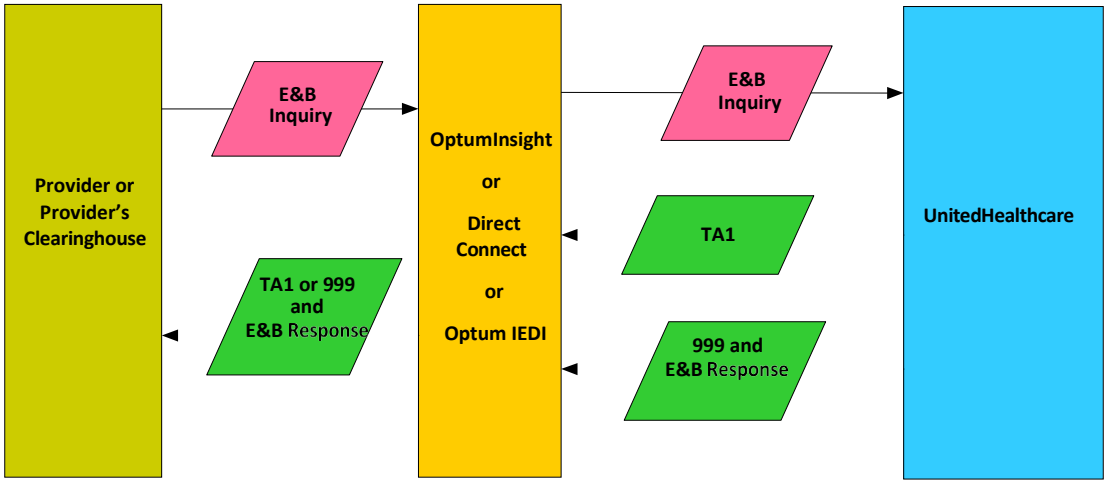
Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct through Optum. For more information, please contact your Optum account manager. If you do not have an account manager you can contact Optum at Medical Claims Management | Optum .

3. CONNECTIVITY AND COMMUNICATION PROTOCOLS

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

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

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



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

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

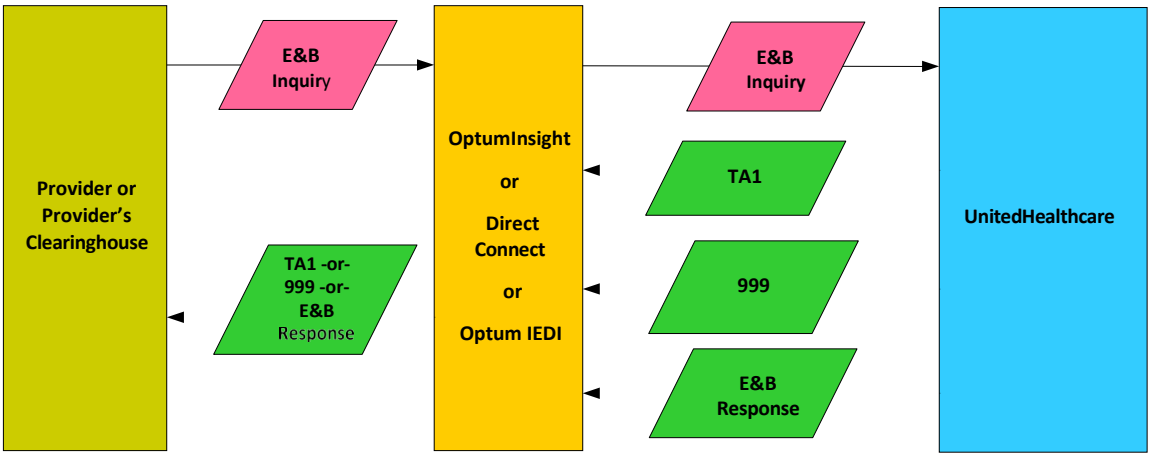
Transactions that pass the compliance check but fail further on in the processing (e.g. ineligible member) will result in an error message returned in a 271 AAA data segment.

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

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

3.2 PROCESS FLOW: REAL-TIME ELIGIBILITY INQUIRY AND RESPONSE

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



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

3.3 TRANSMISSION ADMININSTRATIVE PROCEDURES

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

3.4 RE-TRANSMISSION PROCEDURES

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

3.5 COMMUNICATION PROTOCOL SPECIFICATIONS

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

3.6 SYSTEM AVAILABILITY

UnitedHealthcare is generally up 24 hours, 7 days a week. However, there may be times when the main system or backend systems are down for general maintenance and upgrades. During these times, our ability to process incoming 270/271 EDI transactions may be impacted. The codes returned in the AAA segment of the 271 response will instruct the trading partner if any action is required.

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

3.7 COSTS TO CONNECT

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor or Optum to discuss costs.
Optum: For more information, please contact your Optum account manager. If you do not have an account manager you can contact Optum at Medical Claims Management | Optum

4. CONTACT INFORMATION

4.1 EDI SUPPORT

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

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

- Sending an email to supportedi@uhc.com or
  Completing EDI Transaction Support Form EDI Transaction Support Form (optum.com)

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

4.2 EDI TECHNICAL SUPPORT

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

4.3 PROVIDER SERVICES

For chat options and contact information, visit UHCprovider.com/contactus.

4.4 APPLICABLE WEBSITES/EMAIL

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

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

OptumInsight/Optum EDI Client Center - Medical Claims Management | Optum

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

- UnitedHealthcare EDI Support: supportedi@uhc.com

UnitedHealthcare EDI Education website: https://www.uhcprovider.com/en/resource-library/edi.html X12 Reference | X12

5. CONTROL SEGMENTS/ENVELOPES

5.1 ISA-IEA

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

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

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

5.2 GS-GE

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

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

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

5.3 ST-SE

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

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

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

5.4 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header segment
First 270 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Second 270 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Third 270 Transaction
SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

5.5 CONTROL SEGMENT NOTES

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

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

5.6 FILE DELIMITERS

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

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

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

UnitedHealthcare is certified and in conformance with the CAQH Core Operating Rules for the Eligibility and Benefit Transaction

6.1 270 REQUEST

1. If an explicit Service Type Code (STC) is not supported, the 271 response will be the same as if a generic service type code “30” (Health Benefit Plan Coverage) 270 request was received. Supported explicit (EQ01) values will result in only that explicit service type code being returned with the exception of category codes.
2. Eligibility requests containing multiple service type codes in 2110C/D EQ01 (up to 10) will be processed and returned. If more than 10 service type codes are returned, only the first 10 will be returned.
3. Eligibility requests for a date range will return all plans for the member that is identified by the search criteria sent in. Any plans that have coverage during the date range will be returned. Date range must have a start date no greater than 18 months in the past and the end date must be no greater than the end of the current month. A 271 AAA value of 62 or 63 will be returned if the date range validation fails.
4. Category service type codes supported are listed below. It is advised if a provider is looking for a specific category, that the category code is sent in the 270 2110C/D EQ01 (explicit) instead of sending a generic 30 inquiry. The below categories will return a list of service type codes unless the benefit is serviced by a vendor (e.g. Pharmacy Benefit Manager – Prescription Solutions) in which case the vendor information will be provided. The benefits that are recommended to be returned in the specific categories are defined in the IMPLEMENTATION GUIDE. UnitedHealthcare will return most of the recommended benefits. Benefits returned in a generic 30 request are:
    a. Medical Care
    b. Dental Care
    c. Hospital
    d. Pharmacy (potential vendor)
    e. Professional Office Visit
    f. Mental Health
5. If a specific service type code is desired, that explicit service type code should be submitted in the 270 EQ01. If the explicit service type code is not supported, a generic response will be returned.
6. If a medical plan offers benefits with variable copay, the copay will be determined by either the practitioner seen, or the location where care is administered and can vary based on the type of service benefit requested.

Practitioner-Specific Searches

To retrieve practitioner-specific variable copay amounts, only the NPI value is required. This should be populated via NM108 (XX) and NM109 (NPI value) fields:

NM1*1P*1*LastName*FirstName****XX*NPI~

Location-Specific Searches

To retrieve location-specific variable copay amounts, the TIN value and address are both required. The TIN should be populated via NM108 (FI) and NM109 (TIN value) fields. The address associated with the TIN should also be passed in the N3 and N4 loops:

NM1*1P*1*LastName*FirstName****FI*TIN~

N3*AddressStreet~
N4*AddressCity*AddressState*AddressZip~

Practitioner and Location Searches

When the 270x12 submitter is looking to have support for both practitioner-specific and location-specific variable copays on a single 271x12 response, the NPI must be passed at the NM109 segment and the TIN will need to be passed using a REF loop where REF01 (TJ) and REF02 (TIN value) are populated. The address associated with the TIN should still be passed in the N3 and N4 loops:

NM1*1P*1*LastName*FirstName****XX*NPI~
REF*TJ*TIN~
N3*AddressStreet~
N4*AddressCity*AddressState*AddressZip~

7. The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). It is recommended that the maximum number of search data elements is used. This will result in the best chance of finding a member; however, all data elements aren't required. Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent indicating to the user what criteria needs to be supplied to find a match. If the policy number is sent in the request, it will be used as a tie breaker should there be multiple plans for the member.

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

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

6.2 271 RESPONSE

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

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

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

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
1	Medical Care	1	Medical Care	Medical services and supplies to diagnose and/or treat a medical condition, illness, or injury and provided by a physician or other healthcare provider
		2	Surgical	
		3	Consultation	
		42	Home Health Care	
		45	Hospice	
		69	Maternity	
		73	Diagnostic Medical	
		76	Dialysis	
		83	Infertility	
		A G	Skilled Nursing Care	
		BT	Gynecological	
		BU	Obstetrical	
		D M	Durable Medical Equipment	
2	Surgical	2	Surgical	Surgical services provided by a physician or other healthcare provider.
3	Consultation	3	Consultation	
4	Diagnostic X-ray	4	Diagnostic Xray	Diagnostic x-ray provided or ordered and billed by a physician or other healthcare provider.
5	Diagnostic lab	5	Diagnostic lab	Diagnostic lab provided or ordered and billed by a physician or other healthcare provider.
6	Radiation Therapy	6	Radiation Therapy	Radiation therapy or x-ray therapy provided or ordered and billed by a physician or other healthcare provider.
7	Anesthesia	7	Anesthesia	Anesthesia services related to inpatient or outpatient surgery provided or ordered and billed by

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				a physician or other healthcare provider
8	Surgical Assistance	8	Surgical Assistance	Assistant surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.
12	Durable Medical Equipment Purchase	12	Durable Medical Equipment Purchase	Purchase of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured , and can be used at home.
13	Ambulatory Service Center Facility	13	Ambulatory Service Center Facility	A facility that provides services on an outpatient basis, primarily for the purpose of performing medical, surgical or renal dialysis procedures.
18	Durable Medical Equipment Renal	18	Durable Medical Equipment Renal	Rental of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured , and can be used at home.
20	Second Surgical Opinion	20	Second Surgical Opinion	Additional professional opinion sought to verify or confirm the necessity for surgical procedures.
23	Diagnostic Dental	23	Diagnostic Dental	The translation of data gathered by clinical and radiographic examination into an organized, classified definition of conditions present.
24	Periodontics	24	Periodontics	The art and science of examination, diagnosis, and treatment of diseases affecting the periodontium; a study of the supporting structures of the teeth, normal anatomy and physiology and the deviations.
25	Restorative	25	Restorative	Broad term applied to any restorations to the tooth/teeth structure(s). Anterior teeth include up to five surface classifications - Mesial, Distal, Incisal, Lingual and Labial. Posterior teeth include up to five surface classifications:

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				Mesial, Distal, Occlusal, Lingual and Buccal.
26	Endodontics	26	Endodontics	The branch of dentistry that is concerned with the morphology, physiology and pathology of the dental pulp and periradicular (gum) tissues.
27	Maxillofacial Prosthetics	27	Maxillofacial Prosthetics	The branch of prosthetics is concerned with the restoration of stomatognathic and associated facial structure that have been affected by disease, injury, surgery, or congenital defect.
28	Adjunctive Dental Services	28	Adjunctive Dental Services	Services involve a drug such as anesthesia or other substances that serve as a supplemental purpose in dental therapy.
30	Health Benefit Plan Coverage	1	Medical Care	General high-level summary of the healthcare benefits of the member's policy or contract. **Additional STC codes returned under request for 30.**
		33	Chiropractic	
		35	Dental Care	
		47	Hospital	
		48	Hospital – Inpatient	
		50	Hospital – outpatient	
		86	Emergency Medical	
		88	Pharmacy	
		96	Office Visit – *MSG: Specialist	
		98	Office Visit	
		AL	Vision/Optometry	
		MH	Mental Health	
		UC	Urgent Care	
		PT	Physical Therapy	
33	Chiropractic	33	Chiropractic	Professional services which may include office visits, manipulations, and supplies
35	Dental Care	23	Diagnostic Dental	Benefits for services, supplies, or appliances for care of teeth.
		24	Periodontics	
		25	Restorative	
		26	Endodontics	
		27	Maxillofacial Prosthetics	
		28	Adjunctive Dental Services	
		36	Dental Crowns	
		37	Dental Accident	
		38	Orthodontics	
		39	Prosthodontics	
		40	Oral Surgery	
		41	Routine (Preventive) Dental	

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
36	Dental Crowns	36	Dental Crowns	An artificial replacement for the natural crown of the tooth covering all five surfaces (Anterior teeth surface classifications - Mesial, Distal, Incisal, Lingual and Labial. Posterior teeth surface classifications: Mesial, Distal, Occlusal, Lingual and Buccal.
37	Dental Accident	37	Dental Accident	Supplies or appliances for care of teeth due to accidental injury provided by healthcare provider
38	Orthodontics	38	Orthodontics	The area of dentistry concerned with the supervision, guidance, and correction of the growing and mature orofacial structures. This includes conditions that require movement of the teeth or correction of the malrelationships and malformations of related structures by the adjustment of relationships between and among teeth and facial bones by the application of forces or the stimulation and redirection of functional forces within the craniofacial complex.
39	Prosthodontics	39	Prosthodontics	The part of dentistry pertaining to the restoration and maintenance of oral function, comfort, appearance and health of the patient by replacement of missing teeth and contiguous tissues with artificial substitutes. It has three main branches: removable prosthodontics, fixed prosthodontics and maxillofacial prosthetics.
40	Oral Surgery	40	Oral Surgery	Medical coverage for oral surgical procedures that involve diagnosis and treatment of disorders of the mouth, teeth, jaws and facial structure, including surgical correction of facial deformity and fractures
41	Preventive Dental	41	Preventive Dental	The dental procedures in dental practice and health programs that prevent the occurrence of oral diseases.
42	Home Health Care	42	Home Health Care	Healthcare services prescribed by a physician and rendered in the

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				home by a qualified healthcare provider including nursing services; speech, physical, occupational and rehabilitation therapy; social services and home infusion therapy.
45	Hospice	45	Hospice	Prescribed by a physician, an integrated set of services and supplies to provide palliative and supportive care to terminally ill patients.
47	Hospital	48	Hospital - Inpatient	Hospital Inpatient and Outpatient services and supplies for a patient who may or may not have been admitted to a hospital, for the purpose of receiving medical care or other health services.
		49	Hospital - Room and Board	
		50	Hospital - Outpatient	
		51	Hospital -Emergency Accident	
		52	Hospital -Emergency Medical	
		53	Hospital – Ambulatory Surgical	
48	Hospital - Inpatient	48	Hospital - Inpatient	Hospital services and supplies for a patient who has been admitted to the hospital for the purpose of receiving medical care or other health services.
50	Hospital – Outpatient	50	Hospital - Outpatient	Hospital services and supplies for a patient who has not been admitted to a hospital, for the purpose of receiving medical care or other health services.
51	Hospital -Emergency Accident	51	Hospital -Emergency Accident	Hospital services and supplies for the treatment of a sudden and unexpected medical injury caused by an external force or element which requires immediate medical attention.
52	Hospital -Emergency Medical	52	Hospital -Emergency Medical	Hospital services and supplies for the treatment of a sudden and unexpected medical or psychiatric condition which requires immediate medical attention.
53	Hospital – Ambulatory Surgical	53	Hospital – Ambulatory Surgical	Outpatient surgery and related services performed and billed for by a hospital
62	MRI/CAT Scan	62	MRI/CAT Scan	Diagnostic MRI (Magnetic Resonance Imaging) and/or CAT(Computed Axial Tomography) Scan services provided or ordered and billed by a physician or other healthcare

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				provider.
65	Well Baby Care	65	Well Baby Care	Medical services and physician visits which are recommended by the American Pediatric Association as appropriated and routine care for a child to a specific age limit
69	Maternity	69	Maternity	Complete maternity (obstetrical) care conditions resulting in childbirth or miscarriage when provided or ordered and billed by a physician or midwife.
73	Diagnostic Medicine	73	Diagnostic Medical	Services required to determine the diagnose to treat a medical condition, illness, or injury
76	Dialysis	76	Dialysis	Outpatient dialysis services furnished by a Hospital, Community Health Center, free-standing dialysis facility or physician. This coverage may also include dialysis service rendered on an inpatient basis or in a patient's home.
78	Chemotherapy	78	Chemotherapy	The treatment of disease by means of chemicals that have a specific toxic effect upon the disease-producing microorganisms or that selectively destroy cancerous tissue.
80	Immunizations	80	Immunizations	Services and supplies provided by physicians, hospitals, and other healthcare providers form the administration of preventative vaccines.
81	Routine Physical	81	Routine Physical	Routine medical exams provided by physicians, hospitals, and other healthcare providers.
82	Family Planning	82	Family Planning	Consultations related to the use of contraceptive methods that have been approved by the U.S. Food and Drug Administration,
83	Infertility	83	Infertility	Inpatient and outpatient services to diagnose and/or treat infertility. Covered services may include assisted reproductive technology procedures.
86	Emergency Services	86	Emergency Services	Medical services and supplies provided by physicians, hospitals, and other healthcare providers for the treatment of a sudden and

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				unexpected medical condition or injury which requires immediate medical attention.
88	Pharmacy	88	Pharmacy	Drugs and supplies dispensed by a licensed pharmacist, which may include mail order or internet dispensary.
90	Mail Order Prescription Drug	90	Mail Order Prescription Drug	A mail order pharmacy delivers medications directly to patients through the mail.
91	Brand Name Prescription Drug	91	Brand Name Prescription Drug	The original formulation of a prescription drug, approved by the FDA for distribution.
92	Generic Prescription Drug	92	Generic Prescription Drug	Generic drugs are copies of brand-name drugs that have the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original drug. In other words, their pharmacological effects are the same as those of their brand-name counterparts.
93	Podiatry	93	Podiatry	Professional services of a physician or other healthcare provider for the care or treatment of conditions of the foot.
96	Professional (Physician)	96	Professional (Physician) * msg Specialist	
98	Professional (Physician) visit – office)	BY	Physician visit – office: SICK	Professional services of a physician or other health care provider for routine/preventative care or for a non- routine visit related to an illness.
		BZ	Physician visit – office: WELL	
99	Professional (physician) Visit – Inpatient	99	Professional (physician) Visit – Inpatient	Professional services of a physician or other healthcare provider during an inpatient hospital admission
A0	Professional Visit (physician) – Outpatient	A0	Professional Visit (physician) – Outpatient	Professional services of a physician or other healthcare provider performed in the outpatient department of a hospital or other covered facility.
A3	Professional (physician) Visit – Home	A3	Professional (physician) Visit – Home	Professional services of a physician or other healthcare provider performed in the patient's home.
A4	Psychiatric	A4	Psychiatric	Services related to the diagnosis or treatment of mental health.
A5	Psychiatric - Room and Board	A5	Psychiatric - Room and Board	
A6	Psychotherapy	A6	Psychotherapy	Professional services, including individual or group therapy by

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses.
A7	Psychiatric - Inpatient	A7	Psychiatric - Inpatient	
A8	Psychiatric – Outpatient	A8	Psychiatric – Outpatient	
AD	Occupational Therapy	AD	Occupational Therapy	Professional and facility occupational therapy services performed by an occupational therapist, physician or other healthcare provider at a hospital, office or other covered facility.
AE	Physical Medicine	AE	Physical Medicine	Services related to the diagnosis, evaluation, and management of persons of all ages with physical and/or cognitive impairment and disability.
AF	Speech Therapy	AF	Speech Therapy	Professional and facility speech therapy services performed by a speech therapist, physician or other healthcare provider at a hospital, office or other covered facility.
AG	Skilled Nursing Care	AG	Skilled Nursing Care	Services and supplies for a patient who has been admitted to a skilled nursing facility for the purpose of receiving medical care or other health services.
AI	Substance Abuse	AI	Substance Abuse	Professional services provided at a hospital, office or other covered facility as they related to the diagnosis and treatment of Substance Abuse.
AJ	Alcoholism	AJ	Alcoholism	Services related to the management of Alcohol dependencies or addiction
AK	Drug Addiction	AK	Drug Addiction	Services related to the management of Drug dependencies or addiction, excluding Alcohol
AL	Vision (Optometry)	AL	Vision (Optometry)	Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.
AM	Vision - Frames	AM	Vision - Frames	The framework for a pair of eyeglasses
AN	Routine Exam - Vision	AN	Routine Exam - Vision	Routine Vision Exam only

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
AO	Vision Lens and Contact Lenses	AO	Vision Lens and Contact Lenses	A piece of transparent substance having two opposite surfaces either both curved or one curved and one plane, used in an optical device in correcting defects of vision.
BG	Cardiac Rehabilitation	BG	Cardiac Rehabilitation	Cardiac Rehabilitation services rendered by a physician or other healthcare provider in a hospital or other covered facility.
BH	Pediatric	BH	Pediatric	Routine medical exams and related routine services rendered to a child. Restrictions may apply due to age schedule and/or visit limits
BT	Gynecological	BT	Gynecological	Medical care related to care and management of the female reproductive system and associated disorders provided by a physician or other healthcare provider
BU	Obstetrical	BU	Obstetrical	Medical care related to care of women during pregnancy, parturition, and puerperium provided by a physician or other healthcare provider.
BW	Mail Order Prescription Drug: Brand Name	BW	Mail Order Prescription Drug: Brand Name	
BX	Mail Order Prescription Drug: Generic	BX	Mail Order Prescription Drug: Generic	
BY	Physician Visit – office: Sick	BY	Physician Visit – office: Sick	Professional services of a physician or other healthcare provider during a non-routine visit related to an illness.
BZ	Physician Visit - office: Well	BZ	Physician Visit -office: Well	Professional services of a physician or other health care provider during a routine or preventative care visit.
DM		DM	Durable Medical Equipment	Equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, that are for a patient's use in the home and that are usable for an extended period of time.
		12	Durable Medical Equipment Purchase	
		18	Durable Medical Equipment Rental	
GF	Generic Prescription Drug - Formulary	GF	Generic Prescription Drug - Formulary	Lists of generic drugs covered and published by the health plan/payer/processor/PBM to help physicians reach clinically and

EQ01 Service Type Code Request		EB03 Service Type(s) Response		Definition/Comments
				economically appropriate prescribing decisions for patients.
GN	Generic Prescription Drug – Non-Formulary	GN	Generic Prescription Drug – Non-Formulary	A generic drug that is not listed on the covered and published list of the health plan/payer/processor/PBM.
MH	Mental Health	A4	Psychiatric	Mental Health Services provided by a physician or other healthcare provider who is trained and educated to perform services related to mental health diagnoses and treatment and may be licensed or practice within the scope or licensure or training.
		A5	Psychiatric - Room and Board	
		A6	Psychotherapy	
		A7	Psychiatric - Inpatient	
		A8	Psychiatric - Outpatient	
		AI	Substance Abuse	
		AJ	Alcoholism	
		AK	Drug Addiction	
PT	Physical Therapy	PT	Physical Therapy	Services and care related to evaluation and treatment of injury or disorders
UC	Urgent Care	UC	Urgent Care	Medical services and supplies provided by physicians or other healthcare providers for the treatment of an urgent medical condition or injury which requires medical attention.

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

copayments, coinsurance, deductibles, limitations or cost containment measures, a message segment will be sent distinguishing between multiple in-network benefits. The message segment will directly follow the EB data segment in loop 2110C/D that the message applies to.

c. Highest in-network benefit coinsurance example:
EB*A*IND*81***27**.20****Y~ = individual has a 20% coinsurance for in-network routine physical
MSG* HIGHEST BENEFIT~ = highest benefit level for in-network benefits

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

11. An EB data segment in loop 2110C/D will be included in the 271 for any Variable

Copay that apply to a benefit when an exact practitioner/location match is found. To identify this copay as a variable one, the MSG segment will be populated with 1 of two messages: “AMOUNT VARIES BY LOCATION” or “AMOUNT VARIES BY PRACTITIONER”:

EB*B*IND*50***27*125*****Y~
MSG*AMOUNT VARIES BY LOCATION~

12. An EB data segment in loop 2110C/D will be included in the 271 for any Variable Range Copay that apply to a benefit when an exact practitioner/location match cannot be found. The first EB loop will set EB09 segment as 8H (Minimum) and the second EB loop will set EB09 segment of M2 (Maximum). The amount will be present within both the EB07 and EB10 segments:

    EB*B*IND*BY***27*5**8H*5**Y~
    MSG*AMOUNT VARIES BY PRACTITIONER~
    EB*B*IND*BY***27*90**M2*90**Y~
    MSG*AMOUNT VARIES BY PRACTITIONER~

13. An EB data segment in loop 2110C/D will be included in the 271 for any cost containment measures that apply to a benefit. Cost containment is defined as a penalty that impacts a member’s financial responsibility for member non-authorization.

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

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

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 REPORT INVENTORY

There are no known applicable reports.

8. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

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

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

9. TRANSACTION SPECIFIC INFORMATION

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

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

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

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

IMPLEMENTATION GUIDEs.

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

9.1 ELIGIBILITY BENEFIT REQUEST: 270 (05010X279A1)

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

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

9.2 ELIGIBILITY BENEFIT RESPONSE: 271 (005010X279A1)

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

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

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

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

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

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

10. APPENDECIES

10.1 IMPLEMENTATION CHECKLIST

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

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

10.2 FREQUENTLY ASKED QUESTIONS

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

10.3 FILE NAMING CONVENTIONS

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