HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides
Based on ASC X12 Version 005010X279A1
270/271 Eligibility & Benefit Inquiry and Response (270/271)

Companion Guide Version Number: 2.3

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The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12’s copyrights and Fair Use statement.

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with ForwardHealth. Transmissions based on this companion guide, used in tandem with the TR3, also called the 270/271 Health Care Eligibility and Benefit Inquiry and Response (270/271) ASC X12N (version 005010X279A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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Table of Contents

INTRODUCTION

This section describes how TR3, also called 270/271 ASC X12N (version 005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that ForwardHealth has information additional to the TR3. That information can:

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

In addition to the row for each segment, one or more additional rows are used to describe ForwardHealth'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 Notes/Comments column to provide additional information from ForwardHealth for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 9: Transaction Specific Information.

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 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by ForwardHealth.
			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 three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 270/271 (referred to as Eligibility and Benefit in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate ForwardHealth-specific information required to successfully exchange transactions electronically with ForwardHealth interChange. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to ForwardHealth, which includes the following programs: BadgerCare Plus, Wisconsin Medicaid, SeniorCare, Wisconsin Chronic Disease Program (WCDP), the Wisconsin Well Woman Program (WWWP), and Medicaid managed care programs. All of these programs use ForwardHealth interChange for processing.

ForwardHealth interChange will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain ForwardHealth-specific information, though processed, may be denied. For example, a compliant 270 inquiry (270) created with an invalid ForwardHealth member ID number will be processed by ForwardHealth but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the ForwardHealth Online Handbook.

Refer to this companion guide first if there is a question about how ForwardHealth processes a HIPAA transaction. For further information, contact the ForwardHealth Electronic Data Interchange (EDI) Department at 866-416-4979. This guide is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with ForwardHealth interChange in successfully conducting EDI of administrative health care transactions. This document provides instructions for enrolling as a ForwardHealth interChange trading partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, ForwardHealth and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to ForwardHealth interChange. This guide supplements (but does not contradict) requirements in

the ASC X12N 270/271 (version 005010X279A1) implementation. This information should be given to the provider's business area to ensure that eligibility responses are interpreted correctly. This guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with ForwardHealth interChange.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 270/271 transactions that meet ForwardHealth interChange processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new documents will be posted on the Trading Partners area of the ForwardHealth Portal at www.forwardhealth.wi.gov/.

1.3 References

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

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's information technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with ForwardHealth interChange.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific ID numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only ID number that will be allowed on these transactions.

ForwardHealth has determined that all providers, except for personal care only providers, specialized medical vehicle providers, and blood banks, are health care providers (per the

definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. ForwardHealth requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. ForwardHealth accepts the extended character set. Uppercase characters are recommended.

Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the ForwardHealth Portal to determine the status of their files.

2 GETTING STARTED

2.1 Working with ForwardHealth

This section describes how to interact with ForwardHealth's EDI Department.

Before ForwardHealth can process transactions, the submitter is required to obtain a trading partner ID, create a Portal user account, and complete Production Authorization testing. Additional information is provided in the next section of this companion guide. Trading partners should exchange electronic health care transactions with ForwardHealth interChange via the Portal or Safe Harbor Connectivity (Council for Affordable Quality Healthcare [CAQH] Committee on Operating Rules for Information Exchange [CORE] Operating Rules 153 & 270). After establishing a transmission method, each trading partner must successfully complete testing. Upon successful completion of testing, production transactions may be exchanged.

2.2 Trading Partner Registration

This section describes how to register as a trading partner with ForwardHealth.

ForwardHealth maintains a profile for all trading partners. All ForwardHealth trading partners are required to:

- Complete a Trading Partner Profile — Go to https://www.forwardhealth.wi.gov/.
- Click the **Trading Partner Profile** link on the bottom right side of the screen.
- Download to your desktop the **Trading Partner Profile Testing Packet for ASC X12 transactions**.
- Click **Submit online** at the top of the screen.
- Enter the information requested and select the transaction types you will be exchanging.
- Agree to the Trading Partner Agreement at the end of the Trading Partner Profile process.
- You will be assigned a Trading Partner ID — please save this number.
- Create a Portal user account using the PIN that will be mailed to you and the trading partner ID.
- Complete Production Authorization testing (using the Trading Partner Profile **Testing Packet** above as your guide).

If you have already completed this process, you will not be required to complete it again. Contact the ForwardHealth EDI Helpdesk at 866-416-4979 or via email using the Contact link at the bottom of the Portal home page https://www.forwardhealth.wi.gov/ if you have any questions.

2.3 Certification and Testing Overview

This section provides a general overview of what to expect during any certification and testing phases.

ForwardHealth does not require certification of trading partners and their transactions but does require some minimal transaction testing. All trading partners will be “certified” through the completion of production authorization testing. All trading partners that exchange electronic transactions with ForwardHealth must complete production authorization testing. Completion of the testing process must occur prior to electronic submission of production transactions. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, ForwardHealth requests that trading partners send live transmission data. The 270/271 transaction is an inquiry and response transaction and does not result in any data changing upon completion; therefore, test transactions (ISA15 value of “T”) with production data can be sent to the production environment without any negative impact. More than one test transmission may be required depending on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the ForwardHealth interChange system. Also, changes to the ANSI formats may require additional testing.

Reminder: Testers are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains personal health information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.

3 TESTING WITH FORWARDHEALTH

This section contains a detailed description of the testing phase.

Before exchanging production transactions with ForwardHealth, each trading partner must complete production authorization testing. The 270/271 transaction is an inquiry and response transaction and does not result in any data changing upon completion; therefore, test transactions (ISA15 value of “T”) with production data can be sent to the production environment without any negative impact.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

ForwardHealth recommends that trading partners submit two successful and unique 270 submissions and receive the associated 999 (accepted) acknowledgement in response in order to obtain approval from ForwardHealth to promote to Production.

Production Authorization Testing is detailed in the Trading Partner Profile **Testing Packet** for ASC X12 transactions available on the ForwardHealth Portal (https://www.forwardhealth.wi.gov/) — click on the **Trading Partner Profile** link in the bottom right corner of the main landing page.

Questions may be directed to the ForwardHealth EDI Helpdesk at 866-416-4979 or via email using the Contact link at the bottom of the Portal home page at https://www.forwardhealth.wi.gov/.

4 CONNECTIVITY WITH FORWARDHEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 270 transactions, along with various submission methods, security requirements, and exception handling procedures.

4.1 Process Flows

This section contains process flow diagrams and appropriate text.

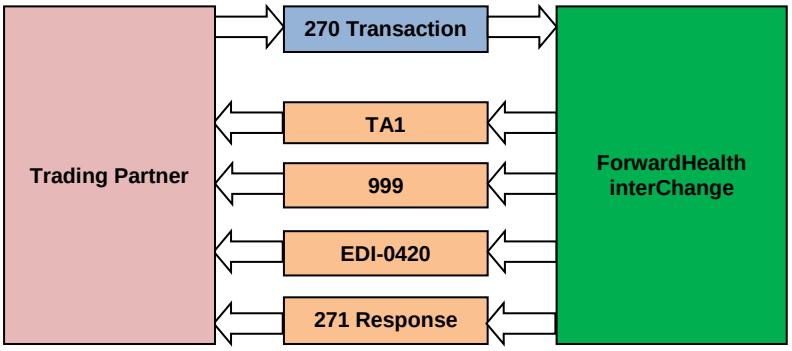
Batch Eligibility Benefit Inquiry and Response

The response to a batch eligibility transaction will consist of the following:

1. First-level response — TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
2. Second-level response — 999 will be generated — “Rejected” 999 when errors occur during 270 compliance validation (no 271 will be generated) or “Accepted” 999 if no errors are detected during the compliance validation).
3. Third-level response — The Batch Submit Balance Rpt (EDI_0420) will be generated with a count of the compliant transactions in the file submitted, the number of transactions that passed translation and the number of transactions that were rejected.
4. Fourth-level response — 271 will be generated indicating either the eligibility and benefits **or** AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3.

Transactions that fail this compliance check will generate a “Rejected” 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an “Accepted” 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a “Partial” 999 file back to the sender with an error message indicating the compliance error (all inquiries in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Transactions that pass compliance checks, but failed to process (e.g., due to member not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the requested dates) do not generate AAA segments but will create a 271 using the information in our eligibility and benefit system.



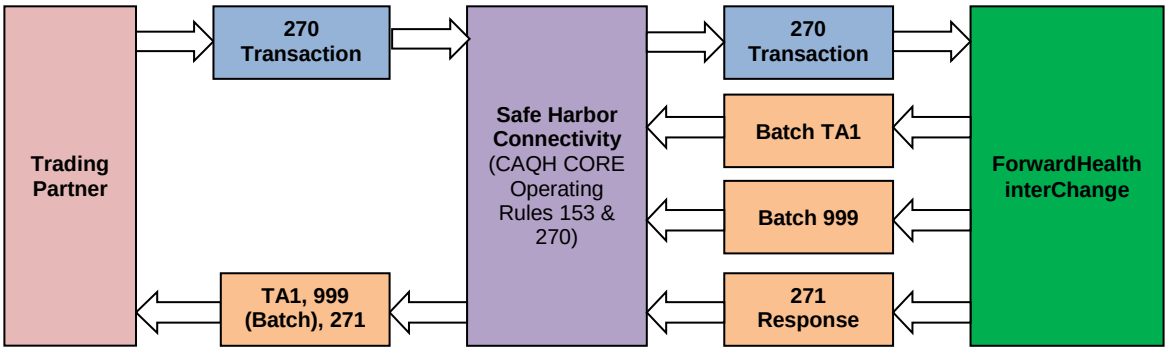
Real-time Eligibility Benefit Inquiry and Response

The response to a real-time eligibility transaction will consist of the 271 being generated to indicate the eligibility and benefits **or** AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3.

Transactions that pass compliance checks but fail to process (e.g., due to the member not being found) will generate a real-time 271 response transaction with the appropriate AAA segment(s) indicating the nature of the error. Transactions that pass compliance checks and have not failed

to process (e.g., the member was found with eligibility within the requested dates) will generate a real-time 271 using the information in our eligibility and benefit system without AAA segments.



Note: Wisconsin has not implemented the TA1 and 999 acknowledgement transactions for real-time submissions. Instead, trading partners will receive the following error messages:

- TA1 — Validate payload content is a valid X12 transaction with all required segments.
- 999 — System processing error.

4.2 Transmission Administrative Procedures

This section provides ForwardHealth's specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator. For details about available ForwardHealth Access Methods, refer to the Communication Protocol Specifications section of this guide.

ForwardHealth is available only to authorized users. Submitters must be ForwardHealth trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

4.3 Re-Transmission Procedure

This section provides ForwardHealth's specific procedures for re-transmissions.

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

In the event of an interrupted communications session, trading partners only have to reconnect and initiate the file transfer as they normally do.

If a file fails compliance, errors must be corrected before re-transmission. It is recommended that transmitted files that were rejected be assigned new Interchange, Group, and Transaction Control Numbers.

4.4 Communication Protocol Specifications

This section describes ForwardHealth's communication protocol(s).

The following communication methods are available to get a member's Eligibility and Benefits from ForwardHealth:

- Portal — Direct Data Entry (DDE).
- Portal — Batch.
- WICall.
- Real-time — value added network (VAN).

- Safe Harbor Connectivity (CAQH CORE Operating Rules 153 and 270).

Portal — DDE

This method utilizes a web Portal where providers enter their information in a DDE format. Providers can submit enrollment requests, prior authorization (PA) requests, all claims types, and claims status requests. Access is free; however, the user must have their own internet connection to access the web application and be an enrolled provider with ForwardHealth.

Portal — Batch

Trading partners can submit all batch transactions to ForwardHealth interChange and download acknowledgements and response files. Access is free; however, users must have their own internet connection to access the web application.

WICall

This method utilizes a provider's telephone where users enter their information using their telephone's touchpad. Providers can submit enrollment verification requests. Access is free; however, users must have a touchpad on their telephone to access this application and be a enrolled provider with ForwardHealth.

Real-Time — VAN

Providers can submit enrollment verification requests, prior approval requests, and claims status requests to ForwardHealth interChange through a VAN or Switch network.

Safe Harbor Connectivity (CAQH CORE Operating Rules 153 and 270)

Safe Harbor is a web-based access method used to exchange transaction files. This application complies with the CAQH CORE Phase I and II "Safe Harbor" rules. The ForwardHealth Safe Harbor Connectivity Companion Guide is available for download at https://www.forwardhealth.wi.gov/.

4.5 Passwords

This section describes ForwardHealth's use of passwords.

The Portal password must be reset every 60 days. The passwords are maintained by the external user. If general users need their password reset, they must contact the EDI Helpdesk at 866-416-4979.

Reminder: Strong security precautions should be taken with passwords. For example, password complexity should be used. Passwords must not be shared or written down where persons other than the authorized party can access them.

5 CONTACT INFORMATION

If the trading partner has questions beyond what is explained in this companion guide, refer to the contact information below to reach the appropriate ForwardHealth support area.

5.1 EDI Helpdesk

This section contains detailed information concerning EDI Helpdesk, especially contact numbers.

Most questions can be answered by referencing the materials posted at https://www.forwardhealth.wi.gov/. For questions related to ForwardHealth's Eligibility and Benefits Request and Response, contact the EDI Helpdesk at 866-416-4979.

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

EDI Customer Service can help with connectivity issues or transaction formatting issues at 866-416-4979 (Monday–Friday, 8:30 a.m.–4:30 p.m. CST) or via email using the Contact link at the bottom of the Portal at https://www.forwardhealth.wi.gov/.

Trading Partner ID

The assigned trading partner ID is ForwardHealth's key to accessing a provider's trading partner information. Have this number available each time the EDI Helpdesk is contacted.

5.3 Provider Services

This section contains detailed information concerning Provider Services, especially contact numbers.

Provider Services should be contacted instead of the EDI Helpdesk for questions regarding the details of a member's benefits, claim status information, credentialing and many other services. Provider Services is available at 800-947-9627 (Monday–Friday, 7:00 a.m.–6:00 p.m. CST) or via email using the Contact link at the bottom of the Portal home page at https://www.forwardhealth.wi.gov/.

Note: Have the applicable provider identifier, the NPI for health care providers or the Medicaid provider ID for atypical providers available for tracking and faster issue resolution.

The Provider Relations representative, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representative are available to assist providers with complex billing and claims processing questions. To find or contact the appropriate Provider Relations Representative, use the Contact link at the bottom of the Portal home page at https://www.forwardhealth.wi.gov/.

5.4 Applicable Websites

This section contains detailed information about useful websites and email addresses.

From ForwardHealth's secure Portal at https://www.forwardhealth.wi.gov/, non-enrolled providers can begin the enrollment process and enrolled providers can do all of the following:

- Create dental, institutional, professional, and pharmacy claims for submission to interChange.
- Request claim reconsiderations.
- Check claim status and member enrollment.
- Submit authorizations, notifications, and referrals.
- View, download, and print explanation of benefits (EOBs), and Remittance Advices.

Trading Partners can do the following:

- Create a Trading Partner Profile and complete production authorization testing.
- Submit batch transactions (270, 276, 278, 837D, 837I, and 837P).
- Download batch transactions/acknowledgements (271, 277, 278, TA1, 999, and 835).
- View, download, and print companion guides.

A suite of other EDI and provider tools are also available on the Portal.

Additional information is available on the following websites:

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions: www.x12.org/.

- ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes: www.x12.org/.

- American Hospital Association (AHA) Central Office on *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) is a resource for the ICD-10-CM codes used in medical transcription and billing, and for Healthcare Common Procedure Coding System (HCPCS) procedure codes: www.ahacentraloffice.org/.

- American Medical Association (AMA) is a resource for the *Current Procedural Terminology* (CPT) procedure codes. The AMA copyrights the CPT codes: www.ama-assn.org/.

- Centers for Medicare & Medicaid Services (CMS) is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/.

- The CMS is the resource for information related to HCPCS procedure codes: www.cms.hhs.gov/HCPCSReleaseCodeSets/.

- The CMS is the resource for Medicaid HIPAA information related to the Administrative Simplification provision: www.cms.gov/medicaid/hipaa/adminsim/.

- The CORE is a multi-phase initiative of CAQH; CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care: www.caqh.org/CORE_overview.php/.

- The CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives — the CORE and Universal Provider Datasource (UPD); CAQH aims to reduce administrative burden for providers and health plans: www.caqh.org/.

- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org/.

- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards: www.hl7.org/.

- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org/.

- Medicaid HIPAA-Compliant Concept Model (MHCCM) presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit: www.mhccm.org/.

- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics, and national health information policy: www.ncvhs.hhs.gov/.

- National Council of Prescription Drug Programs (NCPDP) is the standards and codes development organization for pharmacy: www.ncpdp.org/.
- National Uniform Billing Committee (NUBC) is affiliated with the AHA and develops standards for institutional claims: www.nubc.org/.
- National Uniform Claim Committee (NUCC) is affiliated with the AMA. It develops and maintains a standardized data set for use by the non-institutional health care organizations to transmit claims and encounter information. The NUCC maintains the national provider taxonomy: www.nucc.org/.
- Office for Civil Rights (OCR) is the office within the HHS responsible for enforcing the Privacy Rule under HIPAA: www.hhs.gov/ocr/hipaa/.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA: www.aspe.hhs.gov/admnsimp/.
- WPC is a resource for HIPAA-required transaction implementation guides and code sets: http://www.wpc-edi.com/.
- Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org/.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Other resources pertaining to the NPI: www.cms.hhs.gov/NationalProvIdentStand/.
- Implementation guides and non-medical code sets: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS): www.cms.hhs.gov/HIPAAGenInfo/ or aspe.hhs.gov/datacncl/adminsim.shtml.
- Information from CMS about ICD-10 codes: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage or https://www.cms.gov/ICD10/.
- Quarterly updates to the HCPCS code set are available from CMS: www.cms.hhs.gov/HCPCSReleaseCodeSets/. (CPT-4, or Level 1 HCPCS, is maintained and licensed by the AMA and is available for purchase in various hardcopy and softcopy formats from of variety of vendors.)
- Information at the federal level about Medicaid can be found at www.cms.hhs.gov/home/medicaid.asp.
- The CMS online manuals system and internet-only manuals (IOM) system, including Transmittals and Program Memoranda, at www.cms.hhs.gov/Manuals/.
- Place of service codes are listed in the Medicare Claims Processing Manual and are maintained by the CMS at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.

6 CONTROL SEGMENTS / ENVELOPES

6.1 ISA-IEA

This section describes ForwardHealth's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following ForwardHealth specifications:

- Each trading partner is assigned a nine-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 99 inquiries per Transaction Set (ST-SE).
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted during a session or as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which ForwardHealth requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA03	Security Information Qualifier	0	Use "00" to indicate no Security Information Present.
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value "ZZ", which is mutually defined.
C.4		ISA06	Interchange Sender ID		Enter the nine-digit numeric trading partner ID number assigned by ForwardHealth interChange.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value "ZZ", which is mutually defined.
C.5		ISA08	Interchange Receiver ID	WISC_DHFS	Enter "WISC_DHFS".
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1).
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is production or test.
			Production Data	P	Enter value "P" to indicate that the file contains production data
			Test Data	T	Enter value "T" to indicate that the file contains test data.
C.6		ISA16	Component Element Separator	:	A colon ":" is recommended.

6.2 GS-GE

This section describes ForwardHealth's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

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

Note: Wisconsin accepts files with one GS/GE loop per file.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS02	Application Sender's Code		Enter the nine-digit numeric trading partner ID number assigned by ForwardHealth interChange.
C.7		GS03	Application Receiver's Code	WISC_TXIX WISC_WWWP WISC_WCDP	These are the only valid values for Wisconsin ForwardHealth.
			Wisconsin Medicaid, SeniorCare, and BadgerCare Plus	WISC_TXIX	
			Wisconsin Well Women Program (WWWP)	WISC_WWWP	
			Wisconsin Chronic Disease Program (WCDP)	WISC_WCDP	

6.3 ST-SE

This section describes ForwardHealth's use of transaction set control numbers.

ForwardHealth recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

6.4 Control Segment Notes

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

6.5 File Delimiters

ForwardHealth 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. Contact the EDI Helpdesk at 866-416-4979 if there is a need to use a delimiter other than the following.

Data Element

Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommended data element delimiter is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component-Element

ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Data Segment

Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

7 FORWARDHEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1 Trading Partner ID Number

Every entity that exchanges transactions with ForwardHealth must complete a Trading Partner Profile using the Portal (https://www.forwardhealth.wi.gov/). The trading partner ID of the trading partner sending the transaction is expected in the outside envelope data element ISA06 (Interchange Sender ID) and in data element GS02 (Application Sender's Code). These must always be the same. Additional information about the Trading Partner Profile is included in the Trading Partner Testing Packet, available in the Trading Partners area of the Portal at https://www.forwardhealth.wi.gov/.

7.2 Testing

ForwardHealth requires testing of the 270 transaction prior to accepting production 270 inquiries. Test inquiries will be processed to validate that the file structure and content meet HIPAA standards and ForwardHealth-specific data requirements. Once this validation is complete, the trading partner may submit production 270 inquiries to ForwardHealth interChange for eligibility and benefit responses. Follow the steps in the Trading Partner Testing Packet (available in the Trading Partner area of the Portal at https://www.forwardhealth.wi.gov/) to complete Production Authorization Testing.

7.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide. This term could refer to any one of the following programs for which the 270/271 transaction is being processed:

- BadgerCare Plus
- SeniorCare
- WCDP
- Wisconsin Medicaid
- WWWP

7.4 Number of Requests

The expected maximum number of eligibility requests allowed per submitter is 10,000 requests per batch file and 125,000 requests per day. If the total number of requests has been reached for the day, a submitter may resume submissions on the following day.

7.5 Member Limit

File Size is restricted to 99 member inquiries per 270 transaction set. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment. The 271 response will be in the same ST/SE structure as the original 270 transaction.

7.6 271 Interpretation Guidelines

The following five types of eligibility and benefit information can be returned in a ForwardHealth interChange 271 eligibility response:

- Wisconsin health care program eligibility
- Medicare coverage
- Medicaid managed care program enrollment
- Lock-In status
- Private insurance coverage

It is important that all aspects of a subscriber's eligibility and benefits are considered when reading an eligibility response. The simple fact that a subscriber is eligible in a health program does not always indicate that the health program should be billed for services rendered. If a subscriber has coverage through private insurance, Medicare, or Medicaid managed care, services should be billed accordingly. For questions regarding appropriate billing procedures, providers should refer to the ForwardHealth Online Handbook.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the dates of service (DOS) submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber's coverage may vary at times throughout the range of service dates.

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, DOS rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

7.7 Notes on 270 Search Hierarchy

1. If the Patient Account Number (PAN) is present, a search of the database is made for the PAN. If no member is found, an AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned. When the PAN is not present;

2. If a Medicaid ID (MID) is present, a search of the database is made for the medical ID. If no member is found, an AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned. When the MID is not present;

3. If last name (first seven characters), first name (first five characters), and Social Security number (SSN) are present, a search of the database is made for the name and SSN match. If no member is found, an AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned. When last name, first name, and SSN are not present;

4. If last name (first seven characters), first name (first five characters), and date of birth (DOB) are present, a search is made for the name and DOB match. If no member is found, an AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned. When last name, first name, and DOB are not present;

5. If SSN and DOB are present, a search is made for a match on the SSN and DOB. If no member is found, a AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned. When SSN and DOB are not present;

6. If none of the above information is available to try any of the above searches, a AAA segment with a value of 15 (Required application data missing) in AAA03 is returned.

7. All ForwardHealth members of the programs listed in Section 7.5 of this guide are defined as “subscribers.” All requests should be submitted at the subscriber level. Any requests submitted at the dependent level that result in an error (Not Found) will be returned at the dependent level. If the member is a **subscriber** in ForwardHealth’s membership files but was submitted in the Dependent loop on the 270 request (2100D), the member will be returned in the Subscriber loop on the 271 response (2100C).

8. If the search for a subscriber is successful, the subscriber's identifying information contained in the 271 response will be taken from the applicable eligibility file.

   Note: The INS segment is not used by ForwardHealth.

9. If the search for a subscriber is unsuccessful, the subscriber's identifying information contained in the incoming 270 will be returned in the 271 response.

10. ForwardHealth does one search based on the hierarchy stated above and what information is available in the 270 — there is no cascading.

7.8 270 Request

No dependent level (Loop 2100D) data should be sent within a 270 Eligibility Inquiry file. All ForwardHealth members can be uniquely identified by their member ID number.

If no DOS is sent with the 270 Eligibility Inquiry file, the current date will be used for processing.

If an explicit service type code (EQ01) is not supported by ForwardHealth, the 271 response will be the same as if a generic service type code “30” (Health Benefit Plan Coverage) 270 request was received.

If an explicit service type code (EQ01) is supported by ForwardHealth, the 271 response will contain information for only that explicit service type code.

Eligibility requests containing multiple service type codes in 2110C EQ01 will be processed as if EQ01 value of “30” is submitted. Multiple explicit service type codes should be sent in individual requests or the category service type codes should be utilized.

ForwardHealth interChange does not support 270 requests submitted with multiple EQ segments or repeating of the EQ01 element. If submitted, ForwardHealth interChange will process as if EQ01 value of “30” was submitted.

ForwardHealth interChange does not support 270 requests submitted with procedure codes or diagnosis pointers (to the HI segment) in the EQ segment. If a procedure code or diagnosis pointer is submitted, ForwardHealth interChange will return a 271 response with the “Standard” Service Type (30).

Eligibility requests for a date range will return all plans for the member that are identified by the search criteria submitted. Any plans that had/have coverage during the date range will be returned.

Parameters for requesting past and future eligibility:

- A request can be for any date in the past.
- A date range can be for any 12-month (366-day) period in the past.
- If the eligibility request is received before the 20th of the month, then ForwardHealth allows you to inquire about eligibility up to and including the last day of the current month.

Example: If the eligibility is requested on November 15, you could request eligibility all the way up to and including November 30.

- If the eligibility request is received after the 19th (20th or greater) of the month, then ForwardHealth allows you to inquire about eligibility up to and including the last day of the following month.

  Example: If you requested eligibility on November 21, you could request eligibility all the way up to and including December 31).

- A 271 AAA value of 62 or 63 will be returned if the date range validation fails.

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.

7.9 271 Response

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, DOS rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

The 271 response may not be at the same level that was received in the 270 request. All eligibility and benefit responses will be at the subscriber 2100C level.

ForwardHealth interChange returns Medicare information, identified by EB01 = "R" (Other or Additional Payor) and EB04 = "MA" or "MB" or "OT". ForwardHealth interChange returns the Medicare effective date and the member's Medicare ID.

If the Eligibility check is unsuccessful, ForwardHealth interChange will return a 271 response containing a AAA segment noting the reason a match could not be made. If indicated (AAA04 = "C"), correct and resubmit your request.

If the Eligibility check identifies a ForwardHealth member who is inactive on the service date requested, ForwardHealth will return a 271 response containing EB01 = "6". The 271 response will contain data from the ForwardHealth's membership files.

ForwardHealth interChange returns COB information, identified by EB01 = U (Contact Following Entity for Eligibility or Benefit Information) followed by a 2120 loop. ForwardHealth returns (when known) the other carrier's name, address, and group number in the 2120C loop.

Additional payer example:

EB*U*IND**OT~	= Additional payer exists
REF*1L*0987654321~	= Group or policy number
REF*6P*1234567890~	= Policy number
DTP*307*RD8*20121128-20121128~	
LS*2120~	= Loop identifier start
NM1*PR*2* DELTA DENTAL PLAN OF WISCONSIN ~	= Non-person payer name is Delta Dental
N3*PO BOX 828~	= Delta Dental's address
N4*STEVENS POINT*WI*54481~	
PER*IC**TE*8001234567~	= Delta Dental's telephone number
NM1*IL*1*Last*First~	= Name of the policy holder
LE*2120~	= Loop identifier end

7.10 Scheduled Maintenance

ForwardHealth recycles the real-time servers every night between 00:00 a.m. and 01:00 a.m. CST. Real-time processing is not available during this period.

ForwardHealth schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST. Real-time processing is not available during this period.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

8.1 Acknowledgements

TA1 — Transaction Acknowledgement

ForwardHealth interChange will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then neither a 999 nor 271 response will be sent. The submitted 270 will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. ForwardHealth interChange will always respond with a 999 for a batch X12 file. If a “rejected” 999 is produced then the 271 response will not be sent. The submitted 270 will need to be corrected and resubmitted.

8.2 Report Inventory

There are no acknowledgement reports at this time.

9 TRADING PARTNER AGREEMENTS

Any entity intending to exchange electronic transactions with ForwardHealth must agree to the ForwardHealth Trading Partner Agreement at the end of the Trading Partner Profile process. A Trading Partner Profile can be completed using the Portal at https://www.forwardhealth.wi.gov/.

9.1 Trading Partners

An EDI trading partner is defined as any ForwardHealth customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from, ForwardHealth.

The EDI Trading Partner Agreements 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.

10 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that ForwardHealth has something additional, over and above, the information in the implementation guides. That information can do the following:

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 guides’ 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, composite, or simple data element pertinent to trading electronically with ForwardHealth.

In addition to the row for each segment, one or more additional rows are used to describe ForwardHealth's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will 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 ForwardHealth has something additional, over and above, the information in the TR3s.

10.1 005010X279A1 — 270 Health Care Eligibility Benefit Inquiry

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
63	None	BHT	Beginning of Hierarchical Transaction		
64	None	BHT02	Transaction Set Purpose Code	13	ForwardHealth interChange validates only Code 13 (Request).
69	2100A	NM1	Information Source Name		
69	2100A	NM101	Entity Identifier Code	PR	Enter "PR" to indicate payer.
70	2100A	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
70	2100A	NM103	Information Source Last or Organization Name	FORWARDHEALTH	Enter "FORWARDHEALTH".
71	2100A	NM108	Identification Code Qualifier	PI	Enter "PI" to indicate payer identification.
71	2100A	NM109	Information Source Primary Identifier	WISC_TXIX WISC_WWWP WISC_WCDP	
			Wisconsin Medicaid, SeniorCare, and BadgerCare Plus	WISC_TXIX	
			Wisconsin Well Women Program (WWWP)	WISC_WWWP	
			Wisconsin Chronic Disease Program (WCDP)	WISC_WCDP	
75	2100B	NM1	Information Receiver Name		
77	2100B	NM108	Identification Code Qualifier	XX SV	
			National Provider Identifier (NPI)	XX	
			Service Provider Number	SV	
78	2100B	NM109	Information Receiver Identification Number		Enter the 10-digit NPI when "XX" was reported in NM108. Enter the eight or nine-digit provider number when "SV" is entered in NM108.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
79	2100B	REF	Information Receiver Additional ID		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
81	2100B	N3	Information Receiver Address		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
82	2100B	N4	Information Receiver Address		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
84	2100B	PRV	Information Receiver Provider Information		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
90	2100B	TRN	Subscriber Trace Number		This segment may be used to assign a trace number to a transaction. 271 responses will contain as many TRN segments as were present on the received 270 inquiry as well as an additional segment originated by the information source.
91	2000C	TRN02	Trace Number		Use this field to assign a unique trace or reference number for this transaction.
91	2000C	TRN03	Trace Assigning Entity Identifier		Use this field for an identification number of the entity that originated the reference identification in TRN02.
92	2100C	NM1	Subscriber Name		*Note:* See Section 7.6 for rules on search hierarchy.
93	2100C	NM103	Subscriber Last Name		Enter the subscriber's last name.
93	2100C	NM104	Subscriber First Name		Enter the subscriber's first name.
95	2100C	NM108	Identification Code Qualifier	MI	
			Member Identification Number	MI	*Note:* This can be either a new or an old member ID.
96	2100C	NM109	Subscriber Primary Identifier		Enter the subscriber's member ID.
97	2100C	REF	Subscriber Additional Information		*Note:* See Section 7.6 for rules on search hierarchy.
98	2100C	REF01	Reference Identification Qualifier	SY HJ	

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
			Social Security number (SSN)	SY	
			Patient Account Number (PAN)	HJ	
99	2100C	REF02	Subscriber Supplemental Identifier		Enter either the PAN or SSN as qualified by field REF01.
100	2100C	N3	Subscriber Address		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
101	2100C	N4	Subscriber City, State, ZIP Code		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
103	2100C	PRV	Provider Information		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
107	2100C	DMG	Subscriber Demographic Information		The DMG segment should only be used if the subscriber's date of birth (DOB) is to be provided. Note: See Section 7.6 for rules on search hierarchy.
110	2100C	INS	Multiple Birth Sequence Number		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
113	2100C	HI	Subscriber Health Care Diagnosis Code		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
122	2100C	DTP	Subscriber Date		The DTP segment can be used to specify a date or range of dates for which eligibility will be verified. If no DTP segment is present, the member's eligibility will be provided for the date the transaction is processed. *Note:* See Section 7.7 for rules on past and future date ranges.
123	2100C	DTP01	Date Time Qualifier	291	

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
			Eligibility	291	
123	2100C	DTP-2	Date Time Period Qualifier	D8 RD8	
			Single Date	D8	
			Range of Dates	RD8	
123	2100C	DTP03	Date Time Period		Enter the date(s) of inquiry for the subscriber's benefits in the format CCYYMMDD or CCYYMMDD-CCYYMMDD.
124	2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
124	2110C	EQ01	Service Type Code		When service type code is not supplied or unsupported, the default service type code "30" (Health Benefit Plan Coverage) is processed. If more than one service type code is supplied we default to service type code "30".
136	2110C	AMT	Subscriber Spend Down Amount		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
136	2110C	AMT	Subscriber Spend Down Total Billed Amount		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
138	2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
142	2110C	REF	Subscriber Additional Information		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.
144	2110C	DTP	Subscriber Eligibility / Benefit Date		It is not necessary to submit any data in this segment as it is irrelevant for ForwardHealth interChange purposes. Any data submitted in this segment will not be used in processing the inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
146	2000D		Dependent Level		Because each subscriber and each of his/her dependents is assigned a unique ID number, dependents are treated as subscribers in the ForwardHealth interChange system. Any data submitted at the dependent level will be processed as a subscriber.

10.2 005010X279A1 — 271 Health Care Eligibility Benefit Response

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
211		BHT	Beginning of Hierarchical Transaction		
211		BHT03	Submitter Transaction Identifier		The value in this field will be identical to the unique transaction identifier received in the BHT03 field of the 270 inquiry.
215	2000A	AAA	Request Validation		This segment will be used in the response if the ForwardHealth interChange eligibility files are unavailable at the time of processing.
215	2000A	AAA03	Reject Reason Code	42	This field will contain “42” to indicate that ForwardHealth interChange is unable to respond at the current time.
215	2000A	AAA04	Follow-up Action Code	P	This field will contain a “P” to indicate that the inquiry must be resubmitted.
218	2100A	NM1	Information Source Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
221	2100A	PER	Information Source Additional Information		This segment will contain ForwardHealth helpdesk information.
226	2100A	AAA	Request Validation		This segment will be returned if an error was detected in the 2100A loop of the 270 inquiry.
226	2100A	AAA03	Reject Reason Code	79	This field will contain “79” to indicate that invalid participant identification has been entered in loop 2100A, field NM109 of the 270 inquiry.
226	2100A	AAA04	Follow-up Action Code	C	This field will contain “C” to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
232	2100B	NM1	Information Receiver Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
236	2100B	REF	Information Receiver Additional Identification		This segment will not be returned.
E-44	2100B	N3	Information Receiver Address		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
E-45	2100B	N4	Information Receiver City, State, ZIP Code		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
238	2100B	AAA	Information Receiver Request Validation		This segment will be returned if there was a problem with the 2100B loop, NM1 receiver name segment of the 270 inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
238	2100B	AAA03	Reject Reason Code	50 51	
			Provider Ineligible for Inquiries	50	
			Provider Not on File	51	
238	2100B	AAA04	Follow-up Action Code	C	This field will contain “C” to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
241	2100B	PRV	Information Receiver Provider Information		This segment will not be returned.
246	2000C	TRN	Subscriber Trace Number		This segment will be used to return the trace number received in the associated subscriber loop of the inquiry (TRN01 = 2).
246	2000C	TRN	Subscriber Trace Number		This segment will be used to assign a unique ForwardHealth interChange trace number (TRN01 = 1).
249	2100C	NM1	Subscriber Name		If the member is found the values returned to the receiver in this segment will be from our membership database. If the member is not found the data in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
253	2100C	REF	Subscriber Additional Identification		The member’s PAN will only be returned if it was present in the 270. The member’s SSN will be returned if the member was found in the ForwardHealth interChange database. *Note:* If the PAN was sent and the member was found two REF segments will be returned in the 271 — one for the PAN and one for the SSN.
253	2100C	REF01	Reference Identification Qualifier	HJ SY	
			Identity Card Number (PAN)	HJ	
			Social Security Number	SY	
253	2100C	REF02	Subscriber Supplemental Identifier		This field can contain either the subscriber's PAN or SSN as qualified by REF01.
257	2100C	N3	Subscriber Address		This segment will be used to indicate a subscriber's street address. The address will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
259	2100C	N4	Subscriber City, State, ZIP Code		This segment will be used to indicate a subscriber's additional address information. The information will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
262	2100C	AAA	Subscriber Request Validation		This segment will be used to report any errors detected in the associated 2100C loop of the inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
262	2100C	AAA03	Reject Reason Code	15 42 43 48 51 52 57 58 60 61 62 63 72 73 75	
			Required application data missing	15	
			Unable to respond at current time	42	
			Invalid/missing provider identification	43	
			Invalid/missing referring provider identification	48	
			Provider not on file	51	
			Service dates not within provider plan enrollment	52	
			Invalid/missing dates of service	57	
			Invalid date of birth	58	
			Date of birth follows date(s) of service	60	
			Date of death precedes date(s) of service	61	
			Date of service not within allowable inquiry period	62	
			Date of service in future	63	
			Invalid subscriber ID	72	
			Invalid/missing subscriber name	73	
			Subscriber not found	75	
262	2100C	AAA04	Follow-up Action Code	C	This field will contain “C” to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
265	2100C	PRV	Provider Information		This segment will not be returned.
268	2100C	DMG	Subscriber Demographic Information		This segment will be used to indicate a subscriber's DOB. If the member is found the DOB will appear as it is contained in the information source's files. If the member is not found and the DMG segment was in the inquiry this segment will contain the information as it was sent in the inquiry.
271	2100C	INS	Subscriber Relationship		This segment will not be returned.
274	2100C	HI	Subscriber Health Care Diagnosis Code		This segment will not be returned.
283	2100C	DTP	Subscriber Date		This segment will contain the requested eligibility date in the format CCYYMMDD.
285	2100C	MPI	Subscriber Military Personnel Information		This segment will not be returned.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information		Multiple EB segments may be used to communicate coverage information during the time period indicated in the related DTP segment. The following types of information will be communicated here: • Medicaid coverage. • Medicare coverage. • Private insurance. • Medicaid managed care program. • Lock-in information. See "270/271 Eligibility, Benefit, or Coverage Inquiry and Response Notes" in Appendix 2 — Business Scenarios of this guide for more information.
291	2110C	EB01	Eligibility or Benefit Information	1 6 B F I J N R U	ForwardHealth interChange returns these codes.
			Active Coverage	1	
			Inactive	6	
			Co-Insurance	A	
			Co-Payment	B	
			Deductible	C	
			Managed Care Coordinator	MC	
			Other or Additional Payor	R	
			Contact Following Entity for Eligibility or Benefit Information	U	
292	2110C	EB02	Benefit Coverage Level Code	IND	ForwardHealth interChange does not support family-level requests.
293	2110C	EB03	Service Type Code		If active coverage is indicated in EB01, this field will contain the applicable minimum benefit plan coverage codes from the list in Appendix 2 for generic request or the service type code from an explicit request. *Note:* The EB03 element will repeat up to 12 times to return the applicable coverage codes.
298	2110C	EB04	Insurance Type Code	HM MA MB MC OT	
			Health Maintenance Organization (HMO)	HM	Indicates HMO Coverage.
			Medicare Part A	MA	Indicates Medicare Part A Coverage.
			Medicare Part B	MB	Indicates Medicare Part B Coverage.
			Medicaid	MC	ForwardHealth is the coverage being referenced.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
			Other	OT	Indicates Medicare Part D (Prescription Drug) Coverage or Other Insurance Coverage.
299	2110C	EB05	Plan Coverage Description		This field will contain either the benefit plan name or the description of the managed care program or the lock-in type name (See Appendix 2).
300	2110C	EB07	Benefit Amount		When EB01 = B, the amount reported here is the copay amount. When EB01 = C, the amount reported here is the Annual Deductible.
300	2110C	EB08	Benefit Percent		When EB01 = A, the amount reported here is the coinsurance from the member's viewpoint.
309	2110C	HSD	Health Care Services Delivery		This segment will not be returned.
314	2110C	REF	Subscriber Additional Information		The REF segment will occur at this level of the response in association with Medicare coverage(EB01 = R) to provide the health insurance claim (HIC) number or in association with private insurance coverage (EB01 = U) to provide the policy number and group number. Each private insurance policy will have an associated policy number and may or may not have an associated group number. See Appendix 3 — Transmission Examples of this guide for examples.
317	2110C	DTP	Subscriber Eligibility/Benefit Date		
317	2110C	DTP01	Date Time Qualifier	307	This field will contain "307" to indicate eligibility.
317	2110C	DTP03	Eligibility or Benefit Date Time Period		This field will contain the date or dates related to the eligibility or benefit information in the 2110C loop.
319	2110C	AAA	Subscriber Request Validation		This segment will not be returned.
322	2110C	MSG	Message Text		This segment can contain a number of different messages that describe a subscriber's benefits/status: • If the subscriber's PAN shows a status of lost/stolen card, the MSG segment will contain a message indicating that status. • In conjunction with Medicaid eligibility, the MSG segment will contain a message if the subscriber has additional eligibility that has not been displayed. • If the subscriber resides in a Health Professional Shortage Area (HPSA), the MSG segment will indicate that information.
324	2110C	III	Subscriber Eligibility or Benefit Additional Information		This segment will not be returned.
328	2110C	LS	Loop Header		This segment will be used only when a 2120C loop will be generated.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will provide identifying information regarding any lock-in providers, private insurance companies, or managed care programs identified in the EB segment. See Appendix 3 — Transmission Examples of this guide for examples.
335	2120C	N3	Subscriber Benefit Related Entity Address		This segment will be used to indicate street address information for private insurance companies.
336	2120C	N4	Subscriber Benefit Related City, State, ZIP Code		This segment will be used to indicate city, state, and ZIP code address information for private insurance companies.
339	2120C	PER	Subscriber Benefit Related Contact Information		This segment will provide telephone numbers for managed care programs, lock-in providers, and private insurance companies.
344	2120C	PRV	Subscriber Benefit Related Provider Information		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will provide identifying information regarding the policy holder of any private insurance companies or managed care programs identified in the EB segment.
346	2120C	LE	Loop Trailer		

APPENDICES

1. Implementation Checklist

A complete implementation checklist is available on the Portal at https://www.forwardhealth.wi.gov/. Click the **Trading Partner Profile** link on the bottom right side of the screen. Download the Trading Partner Profile **Testing Packet** for ASC X12 transactions. Contact the EDI Helpdesk at 866-416-4979 or via email using the Contact link at the bottom of the Portal home page with any questions.

2. Business Scenarios

Terminology

The term “subscriber” will be used as a generic term throughout the Companion Guide. This term could refer to any one of the following programs for which the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) transaction is being processed:

- BadgerCare Plus
- SeniorCare
- WCDP
- Wisconsin Medicaid
- WWWP

Member Limit

File Size is restricted to 99 member inquiries per 270 transaction set. One transaction set includes all data between and including an ST segment and SE segment. The response system will attempt to provide one response transaction set per inquiry transaction set.

271 Interpretation Guidelines

The following five types of eligibility and benefit information can be returned in a ForwardHealth interChange 271 eligibility response:

- Wisconsin health care program eligibility
- Medicare coverage
- Medicaid managed care program enrollment
- Lock-In status
- Private insurance coverage

It is important that all aspects of a subscriber’s eligibility and benefits are considered when reading an eligibility response. The simple fact that a subscriber is eligible in a health program does not always indicate that the health program should be billed for services rendered. If a subscriber has coverage through private insurance, Medicare, or Medicaid managed care, services should be billed accordingly. For questions regarding appropriate billing procedures, providers should refer to the ForwardHealth Online Handbook.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the DOS submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber’s coverage may vary at times throughout the range of service dates.

270/271 Eligibility, Benefit, or Coverage Inquiry and Response Notes

The EB segment of the 2110C loop in the 271 eligibility response can contain many different types of information relating to the subscriber and can repeat several times. The following grids show the different types of information that can be returned in the EB segment.

ForwardHealth Eligibility

Medicaid eligibility must be considered in conjunction with all other indicated benefits for appropriate billing.

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain one of the following values: • "1" — Indicates active coverage. • "6" — Indicates inactive coverage. • "T" — Indicates card reported lost or stolen. If this value is returned in EB01, the EB segment will be immediately terminated and EB02-EB04 will not be present.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.
2110C	EB03	Service Type Code	If active coverage is indicated in EB01, this field will contain the applicable minimum benefit plan coverage codes from the list below. *Note:* The EB03 element will repeat up to 12 times to return the applicable coverage codes. New minimum requirements: • "1" — Medical Care • "33" — Chiropractic • "35" — Dental Care • "47" — Hospital • "48" — Hospital Inpatient • "50" — Hospital Outpatient • "86" — Emergency Services • "88" — Pharmacy • "98" — Professional (Physician) Visit — Office • "AL" — Vision (Optometry) • "MH" — Mental Health • "UC" — Urgent Care
2110C	EB04	Insurance Type Code	This field will contain the value "MC" to indicate that ForwardHealth is the coverage being referenced.
2110C	EB05	Plan Coverage Description	This field will contain the benefit plan name.*

***** Medicaid EB05 Values:

- Alien Emergency Services Only
- BadgerCare Plus
- CRS Waiver
- Dental Ortho/Dentures Only
- Family Care Non-MA
- Family Planning Services Only
- Medicaid
- Medicaid Purchase Plan
- Medicaid Purchase Plan Waiver
- Medicaid Waiver
- Medicaid for Foster Care
- Medicaid for SSI
- Qualified Disabled Working Individuals
- Qualified Medicare Beneficiary
- SeniorCare 2 — Over 200 percent FPL
- Senior Care Level 1 — 0 to 200 percent FPL
- Specified Low-income Medicare Beneficiary
- Specified Low-income Medicare Beneficiary Plus
- Tuberculosis Services Only
- Wisconsin Well Woman Medicaid

Medicare

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value “R” to indicate other or additional payer.
2110C	EB02	Coverage Level Code	This field will contain the value “IND” to indicate individual.
2110C	EB03	Service Type Code	This field will not be populated as ForwardHealth is not the true information source.
2110C	EB04	Insurance Type Code	This field will contain one of the following values: • “MA” — Indicates that Medicare Part A is the coverage being referenced. • “MB” — Indicates that Medicare Part B is the coverage being referenced. • “OT” — Indicates Medicare Part D (Prescription Drug) coverage.

Medicaid Managed Care Program

This structure will be used for Family Care, Medicaid-contracted HMOs, and special managed care programs.

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value “MC” to indicate managed care coordinator.
2110C	EB02	Coverage Level Code	This field will contain the value “IND” to indicate individual.
2110C	EB03	Service Type Code	This field will not be populated as benefit details are returned in the ForwardHealth EB repetition.
2110C	EB04	Insurance Type Code	This field will contain the value “HM” to indicate HMO.
2110C	EB05	Plan Coverage Description	This field will contain the description of the managed care program.*

***** Managed Care EB05 Values:

- Children Come First
- Core — HMO — Medical
- Family Care
- HMO — Medical
- HMO —- Medical/Chiro
- HMO — Medical/Chiro/Dental
- HMO - Medical/Dental
- PACE/Partnership
- SSI — Dane — Medical
- SSI — Dane — Medical/Chiro
- SSI — Dane — Medical/Chiro/Dental
- SSI — Dane — Medical/Dental
- SSI — Milw — Medical/Dental
- SSI — Milw — Medical
- SSI — Milw — Medical/Chiro
- SSI — Milw — Medical/Chiro/Dental
- Wraparound Milwaukee

Lock-In

Loop	Element	Name	Instruction
2110C	EB01	Eligibility or Benefit Information	This field will contain the value “N” to indicate service restricted to the following provider.
2110C	EB02	Coverage Level Code	This field will contain the value “IND” to indicate individual.
2110C	EB03	Service Type Code	Each lock-in instance will return the one benefit code from the minimum requirements that best represents the lock-in. New minimum requirements: • “1” — Medical Care • “33” — Chiropractic • “35” — Dental Care • “47” — Hospital • “48” — Hospital Inpatient • “50” — Hospital Outpatient • “86” — Emergency Services • “88” — Pharmacy • “98” — Professional (Physician) Visit — Office • “AL” — Vision (Optometry) • “MH” — Mental Health • “UC” — Urgent Care
2110C	EB04	Insurance Type Code	This field will contain the value “OT” to indicate other.
2110C	EB05	Plan Coverage Description	This will contain the lock-in type name (for example, Lockin Controlled Substances).

Private Insurance

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value “U” to indicate other or additional payer.
2110C	EB02	Coverage Level Code	This field will contain the value “IND” to indicate individual.
2110C	EB03	Service Type Code	This field will not be populated as ForwardHealth is not the true information source.
2110C	EB04	Insurance Type Code	This field will contain the value “OT” to indicate other.

3. Transmission Examples

Sample 5010 Generic 271 Member Loop

NM1*IL*1*MEMBERLAST*FIRST*M***MI*1234567890~	**Medicaid Name and Number**
REF*SY*123456789~	**SSN**
REF*HJ*1234567890123~	**PAN Number (sent if included in 270)**
N3*4321 OCEAN BLVD*APT 2~	**Member Address**
N4*MENASHA*WI*53714~	
DMG*D8*19451003*M~	**DOB, Gender**
DTP*307*RD8*20100101-20101231~	**270 Range of Coverage Queried**
DTP*102*D8*20101117~	**Date PAN Number Assigned**
EB*1*IND*1^33^35^47^48^50^86^88^98^AL^MH^UC*MC*Medicaid~	**Medicaid Coverage**
DTP*307*RD8*20101201-20101231~	
MSG*PARTIAL~	
EB*B*IND*1^33^35^47^48^50^86^88^98^AL^MH^UC*MC*Medicaid**0~	**COPAY = $0**
EB*C*IND*1^33^35^47^48^50^86^88^98^AL^MH^UC*MC*Medicaid**0~	**DEDUCTIBLE = $0**
EB*1*IND*1*MC*Wisconsin Well Woman Medicaid~	
DTP*307*RD8*20131117-20131117~	
MSG*HPSA RECIPIENT, COPAY EXEMPT~	
EB*B*IND*1*MC*Wisconsin Well Woman Medicaid**0~	**COPAY = $0**
EB*C*IND*1*MC*Wisconsin Well Woman Medicaid**0~	**DEDUCTIBLE = $0**
EB*R*IND**MA~	**Medicare Part A Coverage**
REF*F6*3333333333~	**Medicare Beneficiary Identifier (MBI)**
DTP*307*RD8*20100901-20100930~	
EB*U*IND**OT~	**Commercial Insurance Coverage**
REF*1L*232323*~	**Group or Policy Number**
REF*6P*454545~	**Group Number**
DTP*307*RD8*20101001-20101031~	
LS*2120~	
NM1*PR*2*AMERICAN FAMILY INSURANCE GRP~	**Name of Commercial Insurance Entity**
N3*600 AMERICAN PARKWAY~	**Address of Commercial Insurance Entity**
N4*MADISON*WI*53783~	
PER*IC**TE*6082492111~	**Commercial Insurance Phone Number**
NM1*IL*1*POLICYHOLDERLAST*FIRST~	**Name of Policy Holder**
LE*2120~	
EB*N*IND*35*OT*Lockin Dental~	**Lock-in**
DTP*307*RD8*20101101-20101130~	
LS*2120~	
NM1*1P*1*DEAN*LAURA****XX*123456789~	**Provider Name**
PER*IC**TE*6514391234~	**Provider's Telephone Number**
LE*2120~	
EB*MC*IND**HM*Family Care~	**Managed Care**
DTP*307*RD8*20101101-20101231~	
LS*2120~	
NM1*PRP*2*FOND DU LAC COUNTY CMO*****SV*69008888~	**Managed Care Name**
PER*IC**TE*9209065100~	**Managed Care Telephone Number**
LE*2120~	
EB*A*IND******0~	**COINSURANCE = 0%**
EB*P~	**Copay, Coinsurance, and Deductible Disclaimer**

MSG* PAYMENT OF BENEFITS AND PATIENT LIABILITY REMAINS SUBJECT TO ALL BENEFIT PLAN TERMS, LIMITS, CONDITIONS, EXCLUSIONS AND THE MEMBER'S ELIGIBILITY AT THE TIME SERVICES ARE RENDERED.~

Sample 5010 Explicit (Pharmacy) 271 Member Loop

NM1*IL*1*MEMBERLAST*FIRST*M***MI*1234567890~	**Medicaid Name and Number**
REF*SY*123456789~	**SSN**
REF*HJ*1234567890123~	**PAN Number (sent if included in 270)**
N3*4321 OCEAN BLVD*APT 2~	**Member Address**
N4*MENASHA*WI*53714~	
DMG*D8*19451003*M~	**DOB, Gender**
DTP*307*RD8*20100101-20101231~	**270 Range of Coverage Queried**
DTP*102*D8*20101117~	**Date PAN Number Assigned**
EB*1*IND*UC*MC*Medicaid~	**Medicaid Coverage**
DTP*307*RD8*20101201-20101231~	
MSG*PARTIAL~	
EB*B*IND*UC*MC*Medicaid**0~	**COPAY = $0**
EB*C*IND*UC*MC*Medicaid**0~	**DEDUCTIBLE = $0**
EB*6*IND*UC*MC*Wisconsin Well Woman Medicaid~	
EB*R*IND**MA~	**Medicare Part A Coverage**
REF*F6*3333333333~	**MBI**
DTP*307*RD8*20100901-20100930~	
EB*U*IND**OT~	**Commercial Insurance Coverage**
REF*1L*232323*~	**Group or Policy Number**
REF*6P*454545~	**Group Number**
DTP*307*RD8*20101001-20101031~	
LS*2120~	
NM1*PR*2*AMERICAN FAMILY INSURANCE GRP~	**Name of Commercial Insurance Entity**
N3*600 AMERICAN PARKWAY~	**Address of Commercial Insurance entity**
N4*MADISON*WI*53783~	
PER*IC**TE*6082492111~	**Commercial Insurance Telephone Number**
NM1*IL*1*POLICYHOLDERLAST*FIRST~	**Name of Policy Holder**
LE*2120~	
EB*N*IND*35*OT*Lockin Dental~	**Lock-in**
DTP*307*RD8*20101101-20101130~	
LS*2120~	
NM1*1P*1*DEAN*LAURA****XX*123456789~	**Provider Name**
PER*IC**TE*6514391234~	**Provider's Telephone Number**
LE*2120~	
EB*MC*IND**HM*Family Care~	**Managed Care**
DTP*307*RD8*20101101-20101231~	
LS*2120~	
NM1*PRP*2*FOND DU LAC COUNTY CMO*****SV*69008888~	**Managed Care Name**
PER*IC**TE*9209065100~	**Managed Care Telephone Number**
LE*2120	
EB*A*IND******0~	**COINSURANCE = 0%**
EB*P~	**Copay, Coinsurance, and Deductible Disclaimer**

MSG* PAYMENT OF BENEFITS AND PATIENT LIABILITY REMAINS SUBJECT TO ALL BENEFIT PLAN TERMS, LIMITS, CONDITIONS, EXCLUSIONS AND THE MEMBER'S ELIGIBILITY AT THE TIME SERVICES ARE RENDERED.~

4. FAQs

This appendix contains a compilation of questions and answers relative to ForwardHealth and its providers.

Q: What are the main differences between the Portal, batch, and Real-Time submission methods?
A:

- Portal — This option is best for those providers who have a low volume of ForwardHealth members, want to check for specific members, or other limited review of ForwardHealth member data. Portal access also allows you to check the history of an earlier eligibility response you received.
- Batch — This option is best for providers who have large volumes of ForwardHealth members and need an automated way to check eligibility. Typically, software vendors, billing intermediaries, clearinghouses, and providers with a technical team benefit from this option.
- Real-Time — This option is best for those providers who have a large volume of ForwardHealth members and see them on a regular basis, but do not have the resources or expertise to use the batch method. This option must be used for single queries.

Q: What are the main differences between a 271 and a 999?
A: 271 is the response to a 270 and contains eligibility information. 999 is an acknowledgement transaction that indicates if a 270 file was accepted or rejected. 999 does not contain any eligibility information.

Q: Is there a limit to the number of inquiries I can submit at once?
A: We recommend you follow HIPAA requirements for a maximum of 99 inquiries per ST/SE segment. Real-time transactions are limited to one inquiry per interchange. Also, only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Q: What information is returned on the 271?
A: All available information about the member will be returned. This may include:

- Member address
- Member ID, SSN, and/or other agency ID
- ForwardHealth benefit plan
- Other insurance information
- Managed care information
- Member payment responsibility information
- Long-term care information
- Behavioral health information
- Restrictive messages

Q: Will I get back different information if I check by member ID vs. name?
A: The information sent is specific to the member and the complete details are sent, regardless of inquiry by member ID or name.

Q: Are any fields case sensitive?
A: ForwardHealth accepts the extended character set. Uppercase characters are recommended.

5. Change Summary

Version 2.1 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 11/2013
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	ALL PAGES				Modified for CAQH CORE Phase I & II Data Content and Safe Harbor Connectivity Rules.

Version 2.2 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 5/2013
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	13, 14				Remove all text regarding Real-Time TA1 and 999 transactions being returned.

Version 2.3 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 01/2018
Modified by: BX

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	20				Added Section 7.4 Number of Requests to establish daily file submission limitations per trading partner for the 270/271 file.