AmeriHealth Administrators

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on X12 Implementation Guides, version 005010

October 2021

Preface

This Companion Guide (Companion Guide) refers to the v5010 X12 Implementation Guides (X12 IG) and associated errata adopted under HIPAA and clarifies and specifies the data content when exchanging electronically with AmeriHealth Administrators, Inc. (“AmeriHealth Administrators”). Transmissions based on this Companion Guide, used in tandem with the v5010 X12 IG, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the X12 IG adopted for use under HIPAA. This Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
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1. Introduction

1.1 Scope

The Provider EDI Companion Guide addresses how providers, or their business associates, conduct the following HIPAA standard electronic transactions:

Health Care Claim: Professional (837P)

Health Care Claim: Institutional (837I)

Health Care Eligibility/Benefit (270/271)

Health Care Claim Payment/Advice (835) with AmeriHealth Administrators through the Highmark Gateway.

Unsolicited 277 - Claim Acknowledgment Transaction (U277).*

This Companion Guide also applies to the above referenced transactions that are being transmitted to AmeriHealth Administrators through the Highmark Gateway by a health care clearinghouse.

An Electronic Data Interchange (EDI) trading partner is defined for this Companion Guide as any entity (provider, billing service, software vendor, employer group, or financial institution) that utilizes the Highmark Gateway to transmit to, or receive electronic data from, AmeriHealth Administrators.

The Highmark Gateway supports standard transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this Companion Guide.

Highmark EDI Operations supports transactions for multiple payers, including AmeriHealth Administrators.

**005010X AmeriHealth Administrators Unsolicited 277 Claim Acknowledgment Transaction (U277) is the AmeriHealth Administrators proprietary functional acknowledgment for ANSI 837 claims transactions. AmeriHealth Administrators, through the Highmark Gateway, supports all listed transactions in batch mode.*

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with AmeriHealth Administrators through the Highmark Gateway. This information is organized into the following sections:

- **Getting Started:** This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information about Trading Partner registration and authorization is also included in this section.
- **Testing with the Payer:** This section includes transaction testing information and other relevant information needed to complete transaction testing with AmeriHealth Administrators on the Highmark Gateway, if applicable.
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- **Contact Information:** This section includes telephone numbers and for support from Highmark EDI Operations.
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- **Payer-Specific Business Rules and Limitations:** This section contains information describing AmeriHealth Administrators business rules.
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- **Transaction-Specific Information:** This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that has additional information that might supplement the IGs.

1.3 References

Trading partners must use the X12 National Implementation Guides adopted under the HIPAA Administrative Simplification Electronic Transaction rule and this Companion Guide for development of the EDI transactions. This Companion Guide document is available at the EDI Trading Partner Business Center:

https://edi.highmark.com/edi-amerihealth/resources/index.shtml

Trading partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the following website:

External Code Lists | X12

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice [835])
- Claim Status Category Codes and Claim Status Codes (Health Care Claim Acknowledgement [U277])
- Provider Taxonomy Codes (ASC X12/005010X222A1Health Care Claim: Professional [837P] and ASC X12/005010X223A2 Health Care Claim: Institutional [837I])

1.4 Additional Information

There is no additional information currently.

2. Getting Started

2.1 Working with Highmark, Inc. (“Highmark”)

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

It is highly recommended that trading partners transmit any test data during the hours that Highmark EDI Operations is available, 8:00 a.m. through 5:00 p.m. ET, Monday through Friday.

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Highmark and/or AmeriHealth Administrators may require access to these records at any time.

The Trading Partner’s automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Trading Partner documents are acceptable. The Trading Partner, not the billing agent, is held accountable for accurate records.

The audit conducted by AmeriHealth Administrators consists of verifying a sample of automated claim input against medical records. Retention of records might also be checked. Compliance to reporting requirements is sample checked to ensure proper coding technique is employed. Signature(s) on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark may request for itself and AmeriHealth Administrators, and the Trading Partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, “string”, Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex Value
!	Exclamation Point	(21)
>	Greater than	(3E)
^	Caret	(5E)
|	Pipe	(7C)
~	Tilde	(7E)

These five characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing and therefore would cause problems if encountered in the transaction data.

As described in the X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters are left justified. Leading spaces, when they occur, are presumed to be significant characters. In the actual data stream, trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality/Security/Privacy

Trading Partners, including health care clearinghouses, must comply with the HIPAA Electronic Transaction and Code Set standards and HIPAA Privacy and Security standards for all EDI transactions and confidentiality requirements as outlined in the Trading Partner Agreement.

Authorized Release of Information

When contacting Highmark EDI Operations concerning any EDI transactions, you will be required to confirm your trading partner information.

2.2 Trading Partner Registration

An Electronic Data Interchange (EDI) trading partner is any entity (provider, billing service, software vendor, employer group, or financial institution, etc.) using the HighMark Gateway to transmit or receive electronic data standard transactions to or from AmeriHealth Administrators.

While Highmark EDI Operations accepts HIPAA compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure be established to secure access to data. As a result, Highmark has a process in place to establish a trading partner relationship. That process has 2 aspects:

- A Trading Partner Agreement must be submitted which establishes the legal relationship and requirements. This is separate from a participating provider agreement.
- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing Highmark’s EDI system for submission or retrieval of AmeriHealth Administrator transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner. Maintenance of the ID and password by the Trading Partner is detailed in section 4.5.

Authorization Process

New trading partners wishing to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application process includes review and acceptance of the appropriate EDI Trading Partner Agreement. Submission of the EDI Transaction Application indicates compliance with specifications set forth by Highmark for the submission of EDI transactions. This form must be completed by an authorized representative of the organization

Highmark can terminate this Agreement, without notice, if participant's account is inactive for a period of six (6) consecutive months.

Complete and accurate reporting of information will ensure that your authorization forms are processed in a timely manner. If you need assistance in completing the EDI Transaction Application, contact your company's technical support area, your software vendor, or Highmark EDI Operations.

Upon completion of the authorization process, a Logon ID and Password will be assigned to the Trading Partner. Highmark EDI Operations will authorize, in writing via email, the Trading Partner to submit production EDI transactions to AmeriHealth Administrators.

Where to Get Authorization Forms to Request a Trading Partner ID

To receive a Trading Partner ID, you must complete an online EDI Transaction Application and electronically agree to the terms of the Trading Partner Agreement. The EDI Transaction Applications and all other EDI request forms are available through the Trading Partner Business Center on our Internet website. You may access the online Application from the page accessed by the link below.

https://edi.highmark.com/edi-amerihealth/index.shtml

Receiving ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)

If you are not currently receiving Health Care Claim Payment/Advice (835) remittance transactions generated from the payment cycle in a batch process and wish to, you will need to request ERA (835) by completing the 'ERA Enrollment Form' on the Update Trading Partners section of the site.

https://edi.highmark.com/edi-amerihealth/exist/index.shtml

Adding a New Provider to an Existing Trading Partner

Trading partners currently using electronic claims submission who wish to add a new provider to their Trading Partner ID or add ERA (835) to an existing Provider should go to the Update Trading Partners page below, click on the "Provider Changes" Form and select the option to "Add Provider" or "add ERA (835)".

https://edi.highmark.com/edi-amerihealth/exist/index.shtml

Note: See Section 7.3 for information on enrolling in Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA).

Deleting Providers from an Existing Trading Partner

Trading partners currently using electronic claims submission who wish to remove a provider from their Trading Partner Number should go to the Update Trading Partners page on the website, click on the "Provider Changes" Form and select the option to "Delete Provider".

https://edi.highmark.com/edi-amerihealth/exist/index.shtml

Reporting Changes in Status

Trading Partners changing any other Trading Partner information must inform EDI Operations by completing the appropriate Trading Partner update form and including all information that is to be updated.

https://edi.highmark.com/edi-amerihealth/exist/index.shtml

2.3 Certification and Testing Overview

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

Testing Policy

Highmark does not currently require the testing or certification of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors ensure their software complies with all current transaction requirements.

Highmark Transactional Testing

Claims Transactions

Highmark does not allow Trading Partners to send test claim transaction files to our production environment. A TA1 will be generated for any transaction file that has “test” indicated in the ISA15 element.

3. Testing with the Payer

AmeriHealth Administrators does not currently require or provide for the testing of any electronic transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors test their software for HIPAA compliance on behalf of all their clients. Any questions about the requirements contained within this Guide may be directed to EDI Operations at 800-992-0246.

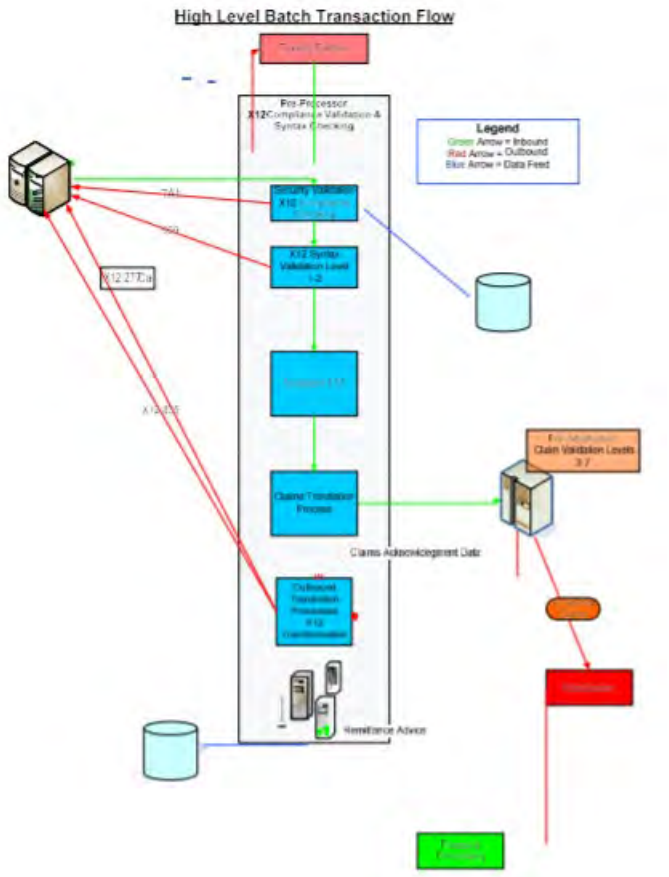
4. Connectivity with the Payer/Communications

Highmark offers AmeriHealth Administrators trading partners the following communication method for transferring data electronically: **Secure File Transfer Protocol (SFTP)** through a secure https Internet connection (Secure Transport) available for transactions in batch mode.

4.1 Process Flows

Trading partners submit claims (837s) and eligibility benefit inquiries (270s) to AmeriHealth Administrators through the Highmark Gateway. The response transactions: 1) 999 Implementation Acknowledgment for Health Care Insurance, 2) TA1 Acknowledgment, 3) U277 Health Care Claim Acknowledgment, 4) eligibility benefit response (271) and 5) 835 Health Care Payment/Advice are also returned to trading partners through the Highmark Gateway.

High Level Batch Transaction Flow



4.2 Transmission Administrative Procedures

This information will be communicated to the trading partner upon Highmark's receipt of the agreed-to Trading Partner Agreement.

4.3 Re-Transmission Procedures

AmeriHealth Administrators does not have specific re-transmission procedures. Trading partners can re-transmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers two methods to utilize the Internet for conducting electronic business with AmeriHealth Administrators. The first is a Secured File Transfer Protocol (SFTP) through “Secure Transport”. “Secure Transport” is available for trading partners who submit or receive any HIPAA compliant EDI transactions in batch mode. The second Internet-based service offers “Real-Time” capability for the following real-time enabled transaction:

Health Care Eligibility Benefit Inquiry and Response (270/271)

Internet Secure File Transfer Protocol (SFTP) through “Secure Transport”

The Highmark Secure FTP Server (“Secure Transport”) provides an SFTP service over an encrypted data session providing “on-the-wire” privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple SFTP process in an encrypted and private manner.

Any state-of-the-art browser can be used to access the Highmark Secure FTP Server. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.
2. Connect to the SFTP server at https://mft.hmhs.com.
3. The server will prompt you for a logon ID and password. Use the logon ID/password that Highmark provided you for accessing this service. Enter the ID, tab to password field and enter the password, then hit enter or click on OK
4. The server will then place you in an individual file space on the FTP server. No one else can access your space and you cannot access the space of others. You will not be able to change out of your space.
5. You need to change into the directory for the type of file you are putting or getting from the server.
6. By default, the file transfer mode is binary, and this mode is acceptable for all data types. However, you may change between ASCII and binary file transfer modes by clicking the “Set ASCII”/ “Set Binary” toggle button.
7. Send Highmark a file. The following is an example of the submission of an electronic claim (837 P/I) transaction file:
    a. Click the “hipaa-in” folder to change into that directory.
    b. Click the **browse** button to select a file from your system to send to Highmark. This will pop open a file finder box listing the files available on your system.

c. Select the file you want to send to Highmark and click on **OK**.

d. This will return you to the browser with the file name you selected in the filename window. Now click on the **Upload File** button to transfer the file to Highmark. Once completed, the file appears in your file list.

8. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:

   a. Click the “hipaa-out” directory.

   b. Your browser lists all the files available to you.

   c. Click the “ack” directory.

   d. Click the file you wish to download. Your browser downloads the file. If your browser displays the file instead of downloading, click the **browser back** button and click the tools next to the file you want to receive. Select application/ octet-stream

   e. You may be prompted with a “**Save As”** file location window. Make the selection appropriate to your system and click on **Save** to download the file.

Internet/Real-Time (HTTPS – Hypertext Terminal Protocol Secure)

Highmark offers a Real-Time Web Service through a secure Internet Connection (HTTPS) for our real-time enabled transactions:

Real-Time Inquiry Transactions

- Health Care Eligibility Benefit Inquiry and Response (270/271)

Real-time inquiry transactions utilize a CORE-compliant Web Services Description Language (WSDL) Simple Object Access Protocol (SOAP). SOAP is a way for a program running in one kind of operating system to communicate with another operating system by using Extensible Markup Language (XML) for the exchange of information over the Internet. Since the Internet is being utilized to transport the data, encryption will be utilized to secure messages.

To take advantage of real-time transactions for AmeriHealth Administrators with Highmark, a Trading Partner will need to:

- Check with your EDI software vendor to ensure that the EDI transaction software is programmed for Highmark’s real-time CORE-compliant or proprietary SOAP transactions, as appropriate. For instructions on how to program for Highmark’s real-time transactions, refer to the “Real-Time Inquiry Connectivity Specifications” at the following site:

https://www.highmark.com/edi/resources/guides/index.shtml

- Complete an EDI Transaction Application (See link in Section 2.2)
  - Select the real-time inquiry transaction option (270/271)
  - Include your email address
  - Trading Partner must have a valid Internet enabled 'V' Logon ID.

- Download the Web Services Security Certificate as outlined in the appropriate Real-Time Connectivity Specification documents.

For typical inquiry requests, the average response time should be within 10 seconds. Actual response time will be dependent upon real-time transaction activity. Batched inquiries should not be submitted through the real-time process as it may impact the response time.

4.5 Passwords

Highmark EDI Operations will assign logon IDs and passwords to Trading Partners. EDI transactions submitted by unauthorized trading partners will not be accepted by Highmark.

Trading partners should protect password privacy by limiting knowledge of the password to key personnel. Passwords should be changed regularly; upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the trading partner office, or at any time the trading partner deems necessary.

Password requirements include:

- Password must be 8 characters in length.
- Password must contain a combination of both numeric and alpha characters.
- Password cannot contain the logon ID.
- Password must be changed periodically.

Trading Partners can refer to the terms of their Trading Partner Agreement for any additional obligations they may have concerning logon IDs and passwords

5. Contact Information

5.1 Highmark EDI Customer Service

Contact information for EDI Operations:

Telephone Number: (800) 992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for EDI Operations:

Telephone Number: (800) 992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

5.3 Provider Services

Non-EDI related inquiries should be handled through your existing channels of communication with AmeriHealth Administrators.

5.4 Applicable Websites/Email

EDI specifications, including this Companion Guide, will be accessible online in the *Resources* section of the EDI Trading Partner Business Center website:

https://edi.highmark.com/edi-amerihealth/resources/index.shtml

6. Control Segments/Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the national IGs. The AmeriHealth Administrators expectations for inbound/outbound ISAs are detailed in this chapter. Specific GS/GE instructions for each transaction are available in Section 10 of this Companion Guide.

Note: Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

For 5010 claim files, the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days, the file is considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the national IGs, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark EDI Operations (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that Line Feed, hex value “0A”, is not an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1E
!	21

Description	Hex value
“	22
%	25
&	26
„	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^	5E
{	7B
}	7D
~	7E

Note: "^" may be used as a Data Element Separator but will not be accepted as a Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark uses the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, "!", cannot be used in text data (type AN, String data element) within the transaction; refer to section 2.1 Valid Characters in Text Data in this document.

Delimiter Type	Character Used	(Hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to AmeriHealth Administrators

Segment: ISA Interchange Control Header (Incoming)

Note: Listed below are clarifications of AmeriHealth Administrators use of the ISA segment for outgoing interchanges.

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the national IGs, with the clarifications listed below:

Table 1: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	AmeriHealth Administrators can only support code 00 - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	AmeriHealth Administrators can only support code 00 - No Security Information present.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value “ZZ” Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the AmeriHealth Administrators assigned security logon ID. The ID must be left justified, and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value “33”. AmeriHealth Administrators only supports the NAIC code to identify the receiver.
	ISA08	Interchange Receiver ID	54704	
	ISA13	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days, the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA14	Acknowledge-ment Requested	1	A TA1 segment is always returned when the incoming interchange is rejected due to errors at the interchange or functional group envelope.
	ISA15	Usage Indicator		The value in this element is used to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from AmeriHealth Administrators

Segment: ISA Interchange Control Header (Outgoing)

Note: Listed below are clarifications of AmeriHealth Administrators use of the ISA segment for outgoing interchanges.

Table 2: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Code 00 is sent - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Code 00 is sent - no Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	33	Qualifier code value “33” is sent to designate that the NAIC code is used to identify the sender.
	ISA06	Interchange Sender ID	54704	
	ISA07	Interchange ID Qualifier	ZZ	Qualifier code value “ZZ” is sent. Mutually defined to designate that an AmeriHealth Administrators-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The assigned ID is the trading partner’s security logon ID. This ID is left-justified and space filled.
	ISA14	Acknowledgment Requested		AmeriHealth Administrators always uses a 0 (No Interchange Acknowledgment Requested).
	ISA15	Usage Indicator		AmeriHealth Administrators provides T or P as appropriate to identify the test or production nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in Section 7 (Payer-Specific Business Rules and Limitations) and Section 10 (Transaction Specific Information) of this Companion Guide.

6.3 ST-SE

AmeriHealth Administrators has no requirements outside the national transaction IGs

7. Payer-Specific Business Rules and Limitations (837P, 837I, 835, U277, 270/271, 999)

7.1 05010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 X12 005010X222 Implementation Guide, as modified by the June 2010, Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the Companion Guide for submitting Health Care Claim: Professional (837P) claims for patients with AmeriHealth Administrators benefits plans. Accurate reporting of AmeriHealth Administrator's NAIC code is critical for claims submitted to AmeriHealth Administrators through the Highmark EDI Gateway.

7.2 05010X223A2 Health Care Claim: Professional (837I)

The Health Care Claim: Professional (837I) transaction is used for Institutional claims. The May 2006 X12 005010X223 Implementation Guide, as modified by the August 2007 and the June 2010 Type 1 Errata Documents, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with the revisions in the errata; the transaction version must be identified as 05010X223A2.

This section and the corresponding transaction data detail make up the Companion Guide for submitting Health Care Claim: Institutional (837I) claims for patients with AmeriHealth Administrators benefits plans. Accurate reporting of AmeriHealth Administrator's NAIC code is critical for claims submitted to AmeriHealth Administrators through the Highmark EDI Gateway.

7.3 05010X221A1 Health Care Claim: Professional (835)

The 835 transaction is used to provide an explanation of claims payment. The April 2006 X12 005010X221 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Availability of Payment Cycle 835 Transactions (Batch)

Health Care Claim Payment/Advice (835) transactions are created on a weekly basis to correspond with AmeriHealth Administrator's weekly payment cycles. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete and remain available for seven days. If a Health Care Claim Payment/Advice (835) transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact Highmark EDI Operations for assistance.

Trading Partners interested in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) can visit: https://www.ahatpa.com/html/health-care-providers/index.html

Claim Overpayment Refunds

Reversal and Correction methodology is used to recoup immediate refunds for overpayments identified by the provider or by AmeriHealth Administrators. The change in payment details is reflected by a reversal claim (CLP02 = 22) and a corrected claim (CLP02 = 1, 2, 3, or 4). The payment amount of the check is reduced by the overpayment amount, after any outstanding provider offsets are applied from previous checks/EFTs.

If AmeriHealth Administrators is unable to recoup all or a portion of the refund money from the current check/EFT, the remaining refund amount to be offset on a future check will be shown as a negative amount in the Provider Adjustment PLB segment of the 835 using the Provider Adjustment Reason code of FB – Forward Balance. The negative PLB dollars allow the Health Care Claim Payment/Advice (835) payment to balance and essentially delay or move the refund balance forward to a future Health Care Claim Payment/Advice (835), when money is available to be offset from a check.

When the refund dollars are eventually offset in a subsequent check/EFT, the money is only reflected in the Health Care Claim Payment/Advice (835) PLB segment with the dollar amount being offset from that specific check/EFT. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835).

7.4 Health Care Claim: Professional (U277)

The 277 Claim Acknowledgment (U277) transaction is a business application level acknowledgment for the Health Care Claim (837) transaction(s). This transaction acknowledges the validity and acceptability of claims for adjudication.

Timeframe for Health Care Claim Acknowledgment (U277)

Generally, claim submitters should expect a Health Care Claim Acknowledgement (U277) within 24 hours after AmeriHealth Administrators receives the electronic claims[1], subject to processing cutoffs. The U277 files (ISA-IEA) will be grouped by the U277 transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837 transaction. Each U277 grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA – IEA) has two Functional Groups (GS-GE) and each Functional Group has two 837 transactions (ST-SE), there will be two U277 files (ISA-IEA) each with a Functional Group that contains two U277 transactions (ST-SE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

There is a one-to-one relationship between an 837 (ST-SE) and the corresponding U277 (ST-SE). In the event system issues are encountered and all claims from a single 837 transaction cannot be acknowledged in a single U277 transaction, it may be necessary to retrieve multiple U277 transactions related to an electronic claims transaction. See Section 4.4 Communication Protocol Specifications in this Companion Guide for information on retrieving the batch Health Care Claim Acknowledgment (U277).

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837P) and ASC X12/005010X223A2 Health Care Claim: Institutional (837I) unless otherwise noted.

7.5 05010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

The 270 transaction is used to request the health care eligibility and benefits for a subscriber or dependent. The 271 transaction is used to respond to that request. The May 2006 X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

NAIC (Payer ID) Codes

ISA-08 Segment – 54704

GS-03 Segment – 54763 (AmeriHealth Administrators)

Requests per Transaction Mode

The Eligibility Inquiry process for the payers in this Reference Guide is limited to one Information Source and Information Receiver per ST-SE transaction.

Real-time mode: If multiple requests are sent, the transaction is rejected.

Patient Search Criteria

In addition to the Required Primary and Required Alternate Search options mandated by the 270/271 implementation guide, AmeriHealth Administrators will search for the patient if only the following combinations of data elements are received on the 270 request:

- Subscriber ID, Patient First Name, and Patient Date of Birth
- Subscriber ID and Patient Date of Birth

7.6 05010X231A1 Implementation Acknowledgement for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is received. If multiple Functional Groups are received in an Interchange (ISA-IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Action on a Functional Group can be: Acceptance, Partial Acceptance, or Rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.) The location and reason for errors are identified in one or more of the following segments:

- IK3 – segment errors
- IK4 – data element errors
- IK5 – transaction errors
- AK9 – functional group errors

Rejection codes are contained in the X12 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA-IEA) and Functional Group (GS-GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be “005010X231A1”. Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment for Health Care Insurance (999) guide.

As part of your trading partner agreement, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values supplied in the trading partner agreement, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter

In the following example the IK404 value ‘TRADING PARTNER PROFILE’ indicates that one or more incorrect values were submitted. To process your submission, these values must be corrected and the transaction resubmitted.

ISA^00^ ^00^ ^33^54704 ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03

IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627

8. Acknowledgments and Reports

Report Inventory

AmeriHealth Administrators has no priority reports

ASC X12 Acknowledgements

TA1	Interchange Acknowledgement
999	Implementation Acknowledgement for Health Care Insurance
U277	Claim Acknowledgement to the Electronic Claim[1]

Outgoing Interchange Acknowledgment TA1 Segment

Highmark returns for AmeriHealth Administrators transactions a TA1 Interchange Acknowledgment segment in batch mode (Real-Time for 270/271) when the entire interchange (ISA - IEA) must be rejected.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the 999 Implementation Guide. Each TA1 will have an Interchange control envelope (ISA - IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns for AmeriHealth Administrators an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned. Transaction accepted/rejected status is indicated in IK501.

In real-time mode, a rejected Implementation Acknowledgment for Health Care Insurance (999) is returned only when the applicable real-time response transaction cannot be returned due to rejections at this level.

Outgoing Claim Acknowledgment (U277 Transaction)

The U277 Claim Acknowledgment Transaction is used to return a reply of “accepted” or “not accepted” for claims or encounters processed by AmeriHealth Administrators submitted via the electronic claim[1] transaction in batch mode.

Acceptance at this level is based on the electronic claim[1] Implementation Guides and front-end edits and will apply to individual claims within an electronic claim[1] transaction. For those claims not accepted, the Health Care Claim Acknowledgment (U277) will detail additional actions required of the submitter to correct and resubmit those claims. For details on this transaction, please refer to the Health Care Claim Acknowledgment (U277) in Section 7.4 and 10.3 of this Companion Guide

[1] Electronic claim includes both X12/005010X222A1 Health Care Claim: Professional (837P) and X12/005010X223A2 Health Care Claim: Institutional (837I) unless otherwise noted.

9. Trading Partner Agreements

Provider Trading Partner Agreement

For use by professionals and institutional providers.

Clearinghouse/Vendor Trading Partner Agreement

For use by software vendors, billing services, or clearinghouses.

Trading Partners

An EDI trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution, etc.) utilizing the Highmark Gateway to transmit or receive electronic data to or from AmeriHealth Administrators.

Payers have 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 with an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement might specify the roles and responsibilities of each party to the Agreement in conducting standard electronic transactions.

10. Transaction Specific Information

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that AmeriHealth Administrators has something additional, over and above the information in the IGs. 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 IGs 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 AmeriHealth Administrators.

In addition to the row for each segment, one or more additional rows are used to describe AmeriHealth Administrator'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 lists the X12 IG for which specific transaction instructions apply and which are included in Section 10 of this Companion Guide:

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X221A1	Health Care Claim Payment/Advice
	Health Care Claim Acknowledgement
005010X279A1	Health Care Eligibility Benefit Inquiry and Response*
005010X231A1	Implementation Acknowledgement for Health Care Insurance

AmeriHealth Administrators through the Highmark Gateway supports the transactions marked with an '*' in real-time only. All other listed transactions are supported in batch mode.

10.1 005010X222A1 Health Care Claim: Professional (837P)

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark Assigned Trading Partner Number The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54763	AmeriHealth Administrators
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's assigned Trading Partner Number. The submitted value must not include leading zeros.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth Administrators
	NM109	Receiver Primary Identifier	54763	AmeriHealth Administrators
2010AA	NM1	Billing Provider Name		
2010AA	N3	Billing Provider Address		The provider's address on AmeriHealth Administrator's internal files will be used for mailing of a check or other documents related to the claim. If the NPI submitted in 2010AA/NM109 is tied to multiple locations, the physical office address where the patient was seen should be submitted in this loop.
	N301	Address Information		The Billing Provider Address must be a street address of a practice location. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID

Loop ID	Reference	Name	Codes	Notes/Comments
				2010AB), if necessary.
2010AA	N4	Billing Provider City, State, ZIP code		The provider's address on AmeriHealth Administrator's internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2010AA	REF	Billing Provider Tax Identification Number		
2010BB	NM1	Payer Name		
	NM109	Payer Identifier	54763	This value should match the value submitted in the GS03 segment (Application Receiver Code).
2010CA	NM1	Patient Name		
	NM102	Entity Type Code Qualifier	1	For AmeriHealth Administrators claims, the Patient must be a Person, code value "1"

10.2 005010X223A2 Health Care Claim: Institutional (837I)

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark Assigned Trading Partner Number The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54763	AmeriHealth Administrators
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's assigned Trading Partner Number. The submitted value must not include leading zeros.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		AmeriHealth Administrators
	NM109	Receiver Primary Identifier	54763	Identifies AmeriHealth Administrators as the receiver of the transaction and corresponds to the value in GS03 Application Receiver Code.
2010AA	NM1	Billing Provider Name		
	NM108	Identification Code Qualifier		
	NM109	Identification Code		When the organization is not a health care provider (is an “atypical” provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The “atypical” provider must submit their TIN in the REF segment and their assigned AmeriHealth Administrator’s Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment)
	N3	Billing Provider Address		The provider’s address on AmeriHealth Administrator’s internal files will be used for

Loop ID	Reference	Name	Codes	Notes/Comments
				mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on AmeriHealth Administrator's internal files will be used for mailing of a check or other documents related to the claim.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2010BB	NM1	Payer Name		
	NM103	Payer Name		AmeriHealth Administrators (based on values submitted in GS03)
	NM109	Payer Identifier	54763	This value should match the value submitted in the GS03 segment (Application Receiver Code).

10.3 005010X221A1 Health Care Claim Payment/Advice

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54763	AmeriHealth Administrators
	GS03	Application Receiver's Code		The receiver's assigned Trading Partner Number will be used The submitted value must not include leading zeros
	BPR	Financial Information		
	BPR01	Transaction Handling Code	I, H	The 835 contains the remittance details only. Payment is sent separately (EFT or Check)
	BPR04	Payment Method Code	CHK BOP NON	Non-EFT Payments EFT Payments Non-Payments
1000B	REF	Payee Additional Information		
	REF01	Payee Identification Qualifier	TJ	The Provider's Tax Identification Number will be sent when the Provider's NPI is sent in the 1000 Payee Identification in N104.
2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.
	LX01	Assigned Number	1	AmeriHealth Administrators uses this value for all claims
	PLB	Provider Adjustment		
	PLB01	Reference Identification		When the provider is a covered health care provider under HIPAA, the National Provider Identifier (NPI) assigned to the provider is required.

	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	FB WO CS	This value will be used to reflect balance forward refund amounts between weekly Health Care Claim Payment/Advice (835) transactions. This value will be used for recouping claim overpayments and reporting offset dollar amounts.

10.4 U277 Health Care Claim Acknowledgement

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code	54763	AmeriHealth Administrators. This matches the ID in the GS03 of the claim transaction.
	GS03	Application Receiver's Code		Receiver's Highmark Assigned Trading Partner Number
	BHT	Beginning of Hierarchical Transaction		
	BHT01	Hierarchical Structure Code		Constant Value "0010"
	BHT02	Transaction Set Purpose Code		Constant Value "06"
	BHT03	Reference Identification		From 837
	BHT04	Date		From 837
	BHT05	Time		From 837
	BHT06	Transaction Type Code		Constant Value "TH"
1000A	NM1	Submitter Name		
	NM108	Identification Code Qualifier		Constant Value "NI"
	NM109	Submitter's Identifier Code	54704	From the 837 Loop 1000B NM109
2100A	NM1	Payer Name		
	NM108	Identification Code Qualifier		Constant Value "NI"
	NM109	Submitter's Identifier Code	54763	From the 837 Loop 2010BB NM109
2100B	NM1	Information Receiver Name		
	NM108	Identification Code Qualifier		From the 837 Loop 1000A NM108
	NM109	Submitter's Identifier Code		From the 837 Loop 1000A NM109
2100D/E	NM1	Subscriber / Dependent Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM101	Entity Identifier Code	QC IL	If the value in 837 Loop 2000B SBR02 is “18” then Loop 2100D NM101 = “QC”; else if the value in 837 Loop 2000B SBR02 is empty, then 2100D NM101 will be set to “IL” and NM101 in Loop 2100E will be set to “QC”
2200D/E	TRN			
	TRN01	Trace Type Code	2	
	TRN02	Reference Identification		from 837 Loop 2300 CLM01
	TRN03	Originating Company Identifier		Not Used
	TRN04	Reference Identification		from 837 Loop 2000B SBR09
2200D/E	STC	Status Information		AmeriHealth Administrators will always return claim status in this loop
	STC01-1	Health Care Claim Status Category Code	A1, A2, A4	
	STC01-2	Health Care Claim Status Code	0 , 20, 33	
	STC01-3	Entity Identifier Code	QC	
	STC03	Action Code	NA or 15	NA - No Action 15 - Correct & Re-Submit
	STC04	Total Submitted Charges		
2200D/E	REF01	Reference Identification Qualifier	BLT	Type of Bill – Constant value “BLT”
	REF02	Reference Identification		Bill Type from 837 Loop 2300 CLM05-1 and CLM05-3
2200D/E	REF01	Reference Identification Qualifier	EA	Medical Record Number- Constant Value “EA”
	REF02	Reference Identification		Medical Record Number from 837 Loop 2300 REF02
2200D/E	DTP	Claim Service Date		

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP01	Date/Time Qualifier		Constant Value “472”
	DTP02	Date/Time Period Format Qualifier	D8 RD8	
	DTP03	Claim Service Period		The earliest and latest service line dates will be used

10.5 005010X279A1 Health Care Eligibility Benefit Inquiry and Response

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		The receiver's assigned Trading Partner Number will be used, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54763	AmeriHealth Administrators
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use this code to indicate that AmeriHealth Administrators is a payer.
	NM103	Information Source Last or Organization Name		The information in this element will not be captured and used in the processing.
	NM108	Identification Code Qualifier	PI	Use this code to indicate the NAIC value is being sent in NM109. Use with AmeriHealth Administrators requests.
	NM109	Information Source Primary Identifier	54763	AmeriHealth Administrators
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	1P, 80, FA, GP, PR	Highmark business practice allows for eligibility inquiries from any of these 5 codes.
	NM108	Identification Code Qualifier	XX PI	Provider Request Payer Request
	NM109	Identification Code		
2100B	REF	Information Receiver Additional Identification		The information in this segment will not be captured and used in the processing.

2100B	N3	Information Receiver Address		The information in this segment will not be captured and used in the processing.
2100B	N4	Information Receiver City, State, ZIP Code		The information in this segment will not be captured and used in the processing.
2100C	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		Enter ID Number from the Patient's current ID card Example: 012345677, H123456789, 1234567800. Do not include "tpa" suffix, if present
2100C	N3	Subscriber Address		The information in this segment will not be captured and used in the processing.
2100C	N4	Subscriber City, State, ZIP Code		The information in this segment will not be captured and used in the processing.
2100C	HI	Subscriber Health Care Diagnosis Code		AmeriHealth Administrators does not process eligibility responses at the diagnosis level. Do not send.
2100C	DTP	Subscriber Date		
	DTP03	Date Time Period		If the date is more than 24 months in arrears or a future date within 30 days of the current date, AmeriHealth Administrators will return the current information. Requests greater than 30 days in the future are rejected. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth Administrators will use the first date of the date range for processing.
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		

	EQ01	Service Type Code		Enter code value: The service types where AmeriHealth Administrators provides specific benefit limitations and details.
	EQ01	Service Type Code	3,9,10,11,14,15,16,17,19,21,22,23,24,25,26,27,28,32,34,36,37,38,39,41,43,44,46,54,55,56,57,58,59,63,66,67,71,72,74,75,77,85,87,89,90,91,92,94,95,96,97,A1,A2,A4,A5,A9,AA,AB,AC,AH,AJ,AK,AM,AN,AO,AQ,AR,BA,BB,BC,BD,BE,BF,BI,BJ,BK,BL,BM,BN,BP,BQ,BR,BS,B1,B2,B3,BW,BX,C1,CA,CB,CC,CD,CP,CQ,DS,GF,GN,IC,NI,ON,PU,RN,RT,TC,TN	AmeriHealth Administrators does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code.
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, AmeriHealth Administrators will return eligibility for the following Service Type Codes: 33, 47, 48, 50, 51, 52, 86, 98, BY, BZ and UC.
	EQ02	Composite Medical Procedure Identifier		AmeriHealth Administrators does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01.
	EQ03	Coverage Level Code	FAM	AmeriHealth Administrators does not process inquiries at the contract, or family, level. The 271 responses will include only Subscriber or Dependent eligibility information
2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		AmeriHealth Administrators does not consider the information in the III segment for processing.

2110C	DTP	Subscriber Eligibility/ Benefit Date		
	DTP03	Date Time Period		If the date is more than 24 months in arrears or a future date within 30 days of the current date, AmeriHealth Administrators will return the current information. Requests greater than 30 days in the future are rejected. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth Administrators will use the first date of the date range for processing.
2100D	N3	Dependent Address		The information in this segment will not be captured and used in the processing.
2100D	N4	Dependent City, State, ZIP Code		The information in this segment will not be captured and used in the processing.
2100D	HI	Dependent Health Care Diagnosis Code		AmeriHealth Administrators does not process eligibility responses at the diagnosis level. Do not send.
2100D	DTP	Dependent Date		
	DTP03	Date Time Period		If the date is more than 24 months in arrears or a future date within 30 days of the current date, AmeriHealth Administrators will return the current information. Requests greater than 30 days in the future are rejected. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth Administrators will use the first date of the date range for processing.
2110D	EQ	Dependent Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Enter code value: The service types where AmeriHealth Administrators provides specific benefit limitations and details.

	EQ01	Service Type Code	3,9,10,11,14,15,16,17,19,21,22,23,24,25,26,27,28,32,34,36,37,38,39,41,43,44,46,54,55,56,57,58,59,63,66,67,71,72,74,75,77,85,87,89,90,91,92,94,95,96,97,A1,A2,A4,A5,A9,AA,AB,AC,AH,AJ,AK,AM,AN,AO,AQ,AR,BA,BB,BC,BD,BE,BF,BI,BJ,BK,BL,BM,BN,BP,BQ,BR,BS,B1,B2,B3,BW,BX,C1,CA,CB,CC,CD,CP,CQ,DS,GF,GN,IC,NI,ON,PU,RN,RT,TC,TN	AmeriHealth Administrators does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code.
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, AmeriHealth Administrators will return eligibility for the following Service Type Codes: 33, 47, 48, 50, 51, 52, 86, 98, BY, BZ and UC.
	EQ02	Composite Medical Procedure Identifier		AmeriHealth Administrators does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01.
2110D	III	Dependent Eligibility or Benefit Additional Inquiry Information		AmeriHealth Administrators does not consider the information in the III segment for processing.
	DTP	Dependent Eligibility/ Benefit Date		

	DTP03	Date Time Period		If the date is more than 24 months in arrears or a future date within 30 days of the current date, AmeriHealth Administrators will return the current information. Requests greater than 30 days in the future are rejected. When DTP02 = RD8 and a date range is submitted in DTP03, AmeriHealth Administrators will use the first date of the date range for processing.

005010X279A1 Health Care Eligibility Benefit Response				
	GS	Functional Group Header		
	GS02	Application Sender's Code	54763	AmeriHealth Administrators. This will match the payer ID in the GS03 of the 270 transaction.
	GS03	Application Receiver's Code		The receiver's assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
2100C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		AmeriHealth Administrators will accept up to 60 characters on the 270 Inquiry.
	NM104	Subscriber First Name		AmeriHealth Administrators will accept up to 35 characters on the 270 Inquiry.
	NM108	Identification Code Qualifier	MI	This is the only qualifier AmeriHealth Administrators will return on the 271 Response.
	NM109	Subscriber Primary Identifier		
2110C	EB	Subscriber Eligibility or Benefit Information		AmeriHealth Administrators will populate this segment with Eligibility info and benefit info as applicable to 270 Service Type. AmeriHealth Administrators will also return EB01 = R when there is other coverage information available.
	EB03	Service Type Code		AmeriHealth Administrators will return this as a repeating element when applicable.
2110C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	6P	AmeriHealth Administrators returns this code if there is a Group Number available for another coverage
	REF02	Subscriber Supplemental Identifier		Group Number for the other coverage

2110C	DTP	Subscriber Eligibility/ Benefit Date		
	DTP01	Date Time Qualifier		AmeriHealth Administrators will return value “290” (Coordination of Benefits) when there is an effective date for another coverage on file
2110C	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".
2110C	LS	Subscriber Eligibility or Benefit Information		
	LS01	Loop Identifier Code	2120	This segment is sent when there is a need to identify a Utilization Management Organization and/or when there is a need to specify details regarding other coverage (COB)
2120C	NM1	Subscriber Benefit Related Entity Name		
	NM101	Entity Identifier Code	X3 IL, PR	AmeriHealth Administrators will return X3 when providing a Utilization Management Organization For COB, AmeriHealth Administrators will return IL when providing the Subscriber for the other coverage and PR when providing the other Payer
	NM103	Benefit Related Entity Last or Organization Name		AmeriHealth Administrators will supply the name of the Utilization Management Organization AmeriHealth Administrators will provide the Subscriber Last Name and the Payer Name for the other coverage
	NM104	Benefit Related Entity First Name		AmeriHealth Administrators will provide the Subscriber First Name for the other coverage
	NM108	Identification Code Qualifier	MI	This is the only code AmeriHealth Administrators will return on the 271 Response

	NM109	Benefit Related Entity Identifier		AmeriHealth Administrators will return the Member ID Number associated with the other coverage
2100D	NM1	Dependent Name		
	NM103	Dependent Last Name		AmeriHealth Administrators will accept up to 60 characters on the 270 Inquiry.
	NM104	Dependent First Name		AmeriHealth Administrators will accept up to 35 characters on the 270 Inquiry.
2110D	EB	Dependent Eligibility or Benefit Information		AmeriHealth Administrators will populate this segment with Eligibility info and benefit info as applicable to 270 Service Type. AmeriHealth Administrators will also return EB01 = R when there is other coverage information available.
	EB03	Service Type Code		AmeriHealth Administrators will return this as a repeating element when applicable.
2110D	REF	Dependent Additional Identification		
	REF01	Reference Identification Qualifier	6P	AmeriHealth Administrators returns this code if there is a Group Number available for another coverage
	REF02	Dependent Supplemental Identifier		Group Number for the other coverage
2110D	DTP	Dependent Eligibility/ Benefit Date		
	DTP01	Date Time Qualifier		AmeriHealth Administrators will return value “290” (Coordination of Benefits) when there is an effective date for another coverage on file
2110D	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".
2110D	LS	Dependent Eligibility or Benefit Information		

	LS01	Loop Identifier Code	2120	This segment is sent when there is a need to identify a Utilization Management Organization and/or when there is a need to specify details regarding other coverage (COB)
2120D	NM1	Dependent Benefit Related Entity Name		
	NM101	Entity Identifier Code	X3 IL, PR	AmeriHealth Administrators will return X3 when providing a Utilization Management Organization For COB, AmeriHealth Administrators will return IL when providing the Subscriber for the other coverage and PR when providing the other Payer
	NM103	Benefit Related Entity Last or Organization Name		AmeriHealth Administrators will supply the name of the Utilization Management Organization AmeriHealth Administrators will provide the Subscriber Last Name and the Payer Name for the other coverage
	NM104	Benefit Related Entity First Name		AmeriHealth Administrators will provide the Subscriber First Name for the other coverage
	NM108	Identification Code Qualifier	MI	This is the only code AmeriHealth Administrators will return on the 271 Response
	NM109	Benefit Related Entity Identifier		AmeriHealth Administrators will return the Member ID Number associated with the other coverage

10.6 Implementation Acknowledgement for Health Care Insurance (999)

005010X231A1 Implementation Acknowledgement for Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		For AmeriHealth Administrators, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		For AmeriHealth Administrators, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment; therefore, when there are errors in the submitted GS, “TRADING PARTNER PROFILE” will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		For AmeriHealth Administrators, Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.

Appendices

1. Implementation Checklist

AmeriHealth Administrators does not have an Implementation Checklist.

2. Business Scenarios

No business scenarios at this time.

3. Transmission Examples

No examples at this time.

4. Frequently Asked Questions

No FAQs at this time.

5. Change Summary

The items listed in the chart below were revised from the December 2013 version to this October 2021 version of the Companion Guide.

Page(s)	Section	Description
7,10,11,13,14,16	Various	Updated HighMark hyperlinks
26 & 39	7.5 & 10.5	Added 270/271 to this guide; previously there was a separate guide
25 & 36-38	7.4 & 10.4	Expanded U277 content