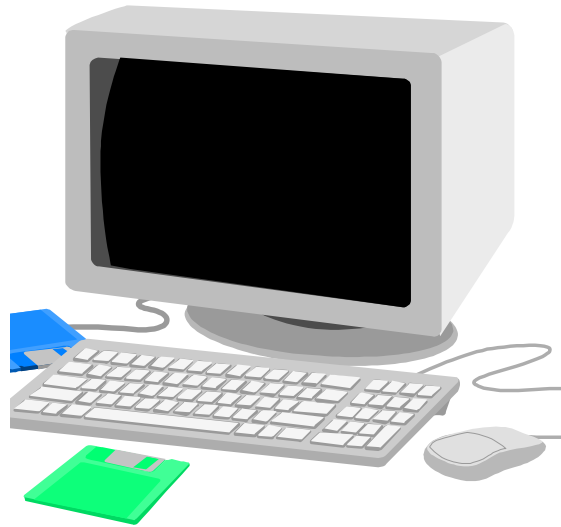


Claim Status Inquiry User Manual



Claim Status Detail and Beneficiary Eligibility Verification NHIC EDI

Revised March 2007

The enclosed information was current as of the revision date.
Please refer to our Web site, www.medicarenhic.com for recent updates.

NHIC

Claims Status Inquiry

All suppliers submitting claims electronically whether **participating** or **non-participating** can access CSI and beneficiary eligibility information. Suppliers can monitor the processing of all claims as they appear in the Medicare processing system for a specific Medicare supplier number, using a beneficiary's health insurance claim (HIC) number, through a specific date or dates of service. This will include paid, denied and pended claims for electronically transmitted claims, paper claims, assigned claims and non-assigned claims. Twenty-seven months of claim history is maintained and accessible through CSI.

**CSI is available from 7:00 AM to 9:00 PM (EST)
Monday through Friday**

The following network service vendors provide access to the CSI system. Address questions regarding ACCESS to CSI to the network service vendor chosen by your company:

IVANS Agency & Vendor Services
1-800-548-2675

VisionShare
1-612-460-4327

Address questions regarding **RESETTING NHIC PASSWORDS** to:

DME MAC A EDI Helpdesk
1-866-563-0049

9:00 AM – 5:00 PM (EST) (Monday through Friday)

The following pages are step by step instructions for CSI.

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LOGGING IN

For NHIC related problems, please call
EDI Helpdesk (Providers) 1-866-419-9458

```
.....>
  Userid=====>                               Password =====>
  New Password=====>                         VERIFY New Password =>
  TSO Procedure=====>                       TSO Region Size =====>
  RACF Group Ident=====>                   Take Session =====>

  PF1 = Help          PF2 = Time          PF3 = Logoff
  PF4 = Whoami        ENTER = Process     CLEAR = Refresh
```

Figure 1

1. Type your User I.D. at the "**Userid** = = = >" prompt. Do not press the "ENTER" key.
2. TAB to the "**Password** = = = >" prompt and type your password. You will not be able to see the characters typed at any of the password prompts. If this is the first time you have used CSI or if you must change your password, continue with Step 3. Otherwise, skip the following two steps and go directly to Step 5.
3. The cursor will be at the "**New Password** = = = >" prompt. Type a new password using the password rules below.

Password Rules:

- a. Passwords must be exactly 8 characters long.
- b. Passwords must contain at least one number, one letter and one of the three national characters (@, #, \$). Example: pas\$w0rd
- c. Passwords cannot contain repeating or sequential characters. Examples: 123, abc, 222, fff, etc.
- d. Passwords cannot contain any names or words.
- e. The system prompts you to change your password every 60 days.

A password will expire every 60 days if the customer does not access CSI. If you attempt to access CSI after 60 days, you will receive one of the following messages, "Unknown User ID" or "Login/Password Invalid". Contact the EDI Helpdesk to reset the password. To assign a new password, follow these steps again. The system will not allow you to reuse passwords within the last twelve months.

4. The cursor will move to the "**VERIFY New Password** = = = >" prompt. Type your new password again.
5. Press the "ENTER" key.

```
-----  
COMMANDS                ENVIRONMENT                HELP                EXIT  
-----  
  
MODEL : LU2 -2/2E                TELEVIEW 4.0                USERID: D1234  
LUNAME: V63A1111                ESCAPE: Attn  
  
COMMAND =====> ____  
  
Sesnum  SYSTEM Application Status Remarks / Description  
-----  
1  DME / VPIQ                Available                DME MAC A IN Prod  
  
99  USERMENU                Available                Alter MENU Facility  
  
-----  
PF1= HELP PF3= END PF7= PAGE UP PF8= PAGE DOWN PF9= NOTEPAD PF10= ERASE  
NOTES
```

Once the User ID and password is entered, the following screen will appear:

Figure 2

1. The cursor will be at the “**Command = = =>**” prompt. Type “1” for DME MAC A
2. If the cursor is not at the “**Command = = =>**” prompt. Press the “**TAB**” key until the cursor lands at the “**Command = = =>**” prompt. Then type the number that appears to the left of DME / VPIQ.
3. Press the “**ENTER**” key

PROVIDER CLAIMS DISPLAY SELECTION SCREEN

VMSPI 01

PROVIDER CLAIMS DISPLAY SELECTION SCREEN

CARRIER NO: 16003 (DME MAC A) PROVIDER NO:

RENDERING PROV: _____ TO _____

HICN: _____

SERVICE DATE: _____ TO _____
(MMDDYY)

PENDING CLAIMS: N (Y OR N)

BENEFICIARY ELIGIBILITY: N (Y OR N)

Figure 4

The “**Provider Claims Display Selection**” Screen gives you several options:

1. Detailed information on Claims in History (Instructions begin on Page 7)
2. Pending Claims Reports (Instructions begin on Page 9)
3. Beneficiary Eligibility Information for all Suppliers (Instructions begin on Page 18)

DETAILED INFORMATION ON CLAIMS IN HISTORY

VMSPI01

PROVIDER CLAIMS DISPLAY SELECTION SCREEN

CARRIER NO: 16003 PROVIDER NO: **0123456789** (DME MAC A)

RENDERING PROV: _____ TO _____

HICN: _____

SERVICE DATE: _____ TO _____
(MMDDYY)

PENDING CLAIMS: **N** (Y OR N)

BENEFICIARY ELIGIBILITY: **N** (Y OR N)

Figure 5

1. Enter your Medicare supplier number in the “PROVIDER NO:” field.
2. Two options are available
 - a. A list of all claims filed within the past 27 months that are pending, paid or denied for a specific Medicare supplier number.
Press the “ENTER” key.
 - b. To search for a specific claim(s) based on HIC number, date of service or service date range. Press the **TAB** key. Enter the specific information in appropriate fields.
Press the “ENTER” key.
3. Pending Claims: should be “N” for No.
4. Beneficiary Eligibility: should be “N” for No.

Explanation of fields on “Provider Claims Display Selection” Screen:

<u>FIELD NAME</u>	<u>DESCRIPTION</u>
PROVIDER NUMBER	Medicare Supplier Number (NSC Number)
RENDERING PROVIDER	NOT USED FOR DME MAC A
HICN	Beneficiary Health Insurance Claim Number
SERVICE DATE	Date of Service - MMDDYY. If both FROM and TO date is completed, all claims with beginning dates of service that fall within the range will be displayed.

Provider Claims Display Screen				VMSP102																
CARRIER NO: 00660		PROVIDER NO: 0123456001																		
HICN: A123456789	NAME: MOUSE	MINNIE	DOB: 12/14/1906	SEX: F																
CCN: 011111111111111	TOTAL SUBM. CHG: \$ 49.99	PD PROV: \$ 25.00																		
CAT: F1 FINALIZED	PAY TYPE: ACH	CHK/EFT DT:																		
10/06/2003																				
STAT DT: 10/06/2003	STAT: 65 CLAIM HAS BEEN PAID																			
<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">FROM</th> <th style="text-align: left;">TO</th> <th style="text-align: left;">PROC CODE</th> <th style="text-align: left;">SVC</th> <th style="text-align: left;">SUBMITTED</th> <th style="text-align: left;">REND PROV</th> <th style="text-align: left;">PAYTO PROV</th> <th style="text-align: left;">LN</th> </tr> </thead> <tbody> <tr> <td>06/26/01</td> <td>06/26/01</td> <td>E0570RRKH</td> <td>1</td> <td>\$ 9.99</td> <td>0123456001</td> <td>\$ 25.00</td> <td>1</td> </tr> </tbody> </table>					FROM	TO	PROC CODE	SVC	SUBMITTED	REND PROV	PAYTO PROV	LN	06/26/01	06/26/01	E0570RRKH	1	\$ 9.99	0123456001	\$ 25.00	1
FROM	TO	PROC CODE	SVC	SUBMITTED	REND PROV	PAYTO PROV	LN													
06/26/01	06/26/01	E0570RRKH	1	\$ 9.99	0123456001	\$ 25.00	1													
LN CTRL NBR: 000476																				
ENTER/PF8 = NEXT		PF7 = TOP	PF3 = MENU	CLEAR = QUIT																

The following **HISTORY** screen will appear:

Figure 6

<u>Field</u>	<u>Explanation</u>
CARRIER NO	Carrier Number (NHIC)
PROVIDER NO	Medicare Supplier Number (NSC Number)
HICN	Beneficiary Health Insurance Claim Number
NAME	Beneficiary Name
DOB	Beneficiary Date of Birth
SEX	Beneficiary Gender
CCN	Claim Control Number (Assigned by NHIC)
TOTAL SUBM CHG	Total Amount Submitted on this claim
PD PROVIDER	Amount paid to the provider only on an assigned claim. If the claim is still in process, the amount will be zero.
CAT*	277 Category Code and Verbiage
PAY TYPE	Payment Type
CHK/EFT DT	Check Date or EFT Effective Date
STAT DT	277 Claim Status Date
STAT*	277 Claim Status Code and Verbiage
FROM	Beginning date of service
TO	Ending date of service
PROC CODE	Procedure code (HCPCS/CPT code)
SVC	Number of services
SUBMITTED	Submitted amount
REND PROV	The Medicare supplier number that rendered the services

PAY TO PROV Line Paid to Provider Amount
LN CNTRL NBR Line Item Control Number

* The CAT and STAT codes are listed in the back of this manual.

To advance to the next screen, press the “**ENTER**” key or the “**F8**” key.

To return to the “**PROVIDER CLAIMS DISPLAY SELECTION SCREEN**”, press the “**F3**” key.

The following screen will appear:

```
VMSP101
PROVIDER CLAIMS DISPLAY SELECTION SCREEN
CARRIER NO: 16003 PROVIDER NO: 0123456789 (DME MAC A)
RENDERING PROV: _____ TO _____
HICN: _____
SERVICE DATE: _____ TO _____
(MMDDYY)
PENDING CLAIMS: Y (Y OR N)
BENEFICIARY ELIGIBILITY: N (Y OR N)
```

Figure 7

To receive Pending Claims Reports from the “**Provider Pending Inquiry System**” screen:

1. Enter the Medicare supplier number at the “**PROVIDER NO:**” field. **TAB** to Pending Claims.
2. Enter “**Y**” for Yes under Pending Claims.
3. Press the “**ENTER**” key.

The following “Provider Pending Inquiry System” screen will appear:

```
OPTION: ___ PROVIDER PENDING INQUIRY SYSTEM VMSPP10
CARRIER ID: 1 1- DME MAC A

PROVIDER NUMBER: _____

HICN: _____ (ENTER FOR OPTIONS A, C, R, OR O)

AVAILABLE FUNCTION

OPTIONS DESCRIPTION

A PROVIDER DETAIL PENDING - ALL
C PROVIDER DETAIL - COMPLETED HELD
R PROVIDER DETAIL - QUERY SUSPENSE
O PROVIDER DETAIL - OTHER SUSPENSE
S PROVIDER SUMMARY PENDING INQUIRY
Q QUIT

TYPE OPTION, PRESS ENTER

16003
```

Figure 8

PROVIDER PENDING INQUIRY SYSTEM

- A PROVIDER DETAIL PENDING-ALL:** Input option A, your Medicare supplier number if necessary and a specific HIC number. Press the “ENTER” key. This includes claims within "Held", "Query", and "Other Suspense" categories for the HIC number entered. *(Instructions start on page 12)*
- C PROVIDER DETAIL-COMPLETED HELD CLAIMS:** Input option C, your Medicare supplier number, if necessary and a specific HIC number to list claims on the payment floor. Press the “ENTER” key. *(Instructions start on page 14)*
- R PROVIDER DETAIL-QUERY SUSPENSE CLAIMS:** Input option R, your Medicare supplier number, if necessary and a specific HIC number to list claims waiting for a response regarding patient eligibility from the Common Working File. Press the “ENTER” key. *(Instructions start on page 15)*
- O PROVIDER DETAIL-OTHER SUSPENSE CLAIMS:** Input option O, your Medicare supplier number, if necessary and a specific HIC number to list claims suspended for manual review. Press the “ENTER” key. *(Instructions start on page 16)*

- S PROVIDER SUMMARY PENDING INQUIRY:** Input option S and your Medicare supplier number, if necessary. Press the “ENTER” key. This screen will list a summary of all claims separated into the following categories: Query Suspense, Other Suspense, Completed Held, and the total number of claims and submitted amounts. (*Instructions start on page 17*)
- Q QUIT:** Input option Q. Press the “ENTER” key. This option will return to the "Provider Pending Inquiry System" Screen.
- QQ QUIT:** Input option QQ. Press the “ENTER” key. This option will return to the Main Menu, the “Provider Claims Display Selection” Screen.

Note: The following pages show each screen and detail each field for the above options. The following screens will list specific claims that are currently pending adjudication in our processing system.

NOTES:

A - PROVIDER DETAIL PENDING INQUIRY

“Provider Detail Pending” includes claims within “Held”, “Query” and “Other Suspense” Categories.

```
OPTION: ___          PROVIDER DETAIL PENDING INQUIRY    VMSP50
                   ALL PENDED CLAIMS

PROVIDER: 01234567001
BENEFICIARY:
H: A123456789  NM: MOUSE          MINNIE          DOB: 12/14/1906    SEX: F

TOTALS: CLAIMS    1 SUB    35.00 PAID    .00

CLAIM NUMBER  SUBMITTED  PAYTO PROV  277 CD  STAT DATE  DESCRIPTION
0111111111111  35.00      9.99      F1/065  10/06/2003  CLAIM HAS BEEN PAID

277 CATEGORY LEGEND: AX – ACKNOWLEDGED  PX - PENDING  FX - FINALIZED
TYPE OPTION, PRESS ENTER KEY:
F-FORWARD          B-BACKWARD    P-ANOTHER PROVIDER
H-ANOTHER HICN     S-SUMMARY     Q-MAIN MENU      QQ-QUIT

A056-NO FOLLOWING RECORDS TO PAGE FORWARD          16003
```

Figure 9

Access instructions from the “Provider Pending Inquiry System” screen:

1. Enter “A” for Option; press the **TAB** key to move the cursor to the next field.
2. Enter a Medicare supplier number; press the **TAB** key to move the cursor to the next field.
3. Type a specific Beneficiary's Health Insurance Claim Number (HICN) for information about a claim in a pending status. Press the “**ENTER**” key.
4. Refer to page 13 for field descriptions.
5. To return to the Main Menu, ”Provider Pending Inquiry System” screen, key "Q" in the option field. Press the “**ENTER**” key.
6. To return to the “Provider Claims Display Selection” screen from the Main Menu, key “QQ” in the option field. Press the “**ENTER**” key.

FIELD DESCRIPTIONS

<u>Field</u>	<u>Explanation</u>
PROVIDER	Medicare Supplier Number
BENEFICIARY	Beneficiary's Health Insurance Claim Number (HICN)
NM	Beneficiary's Name
DOB	Beneficiary's Date of Birth
SEX	Beneficiary's Gender
CLAIMS	Total number of claims displayed
SUB	Total submitted amount of claims displayed
PAID	Total paid amount for claims displayed
CLAIM NUMBER	The Medicare system generated claim control number
SUBMITTED	Submitted amount for the claim
PAY TO PROV	Amount Paid to the Provider/Supplier
277/CD*	277 Category Code
STATUS DATE	277 Status Date
DESCRIPTION	277 Status Description

Note: For options at the bottom of the screen (F-FORWARD, B-BACKWARD, etc.) type the letter of the option you want in the space next to the "OPTION: _____" prompt and press the "ENTER" key.

*The Category Codes are listed in the back of this manual.

NOTES:

C - PROVIDER DETAIL COMPLETED HELD

“Completed Held Claims” displays information regarding claims being held on the payment floor, which is 13 days for electronic claims and 27 days for paper claims.

```
OPTION: __          PROVIDER DETAIL PENDING INQUIRY          VMSPP50
                   COMPLETED HELD CLAIMS

PROVIDER: 0123456001
BENEFICIARY:
H: A123456789      NM: MOUSE          MINNIE          DOB: 12/14/1906  SEX: F

TOTALS: CLAIMS    1  SUB    35.00  PAID    .00

CLAIM NUMBER  SUBMITTED  PAYTO PROV  277 CD    STAT DATE  DESCRIPTION
01111111111111  35.00      9.99      F1/065    10/06/2003  CLAIM HAS BEEN PAID

277 CATEGORY LEGEND: AX - ACKNOWLEDGED  PX - PENDING  FX - FINALIZED
TYPE OPTION, PRESS ENTER KEY:
F-FORWARD          B-BACKWARD          P-ANOTHER PROVIDER
H-ANOTHER HICN    S-SUMMARY          Q-MAIN MENU  QQ-QUIT

A056-NO FOLLOWING RECORDS TO PAGE FORWARD          16003
```

Figure 10

Access instructions from the “Provider Pending Inquiry System” screen:

1. Enter “C” for Option. Press the **TAB** key to move the cursor to the next field.
2. Enter the Medicare supplier number. Press the **TAB** key to move the cursor to the next field.
3. Enter a specific Beneficiary’s Medicare Health Insurance Claim Number (HICN) for information on a claim in this status. Press the “**ENTER**” key.
4. Refer to page 13 for field descriptions.
5. To return to the Main Menu, “Provider Pending Inquiry System” screen, enter “Q” in the option field. Press the “**ENTER**” key.
6. To return to the “Provider Claims Display Selection” screen from the Main Menu, enter “QQ” in the option field. Press the “**ENTER**” key.

R - PROVIDER DETAIL QUERY SUSPENSE CLAIMS

“Query Suspense Claims” displays claims that are being checked against the Common Working File (CWF) and are waiting a reply regarding patient eligibility.

```
OPTION: __          PROVIDER DETAIL PENDING INQUIRY          VMSP50
                   QUERY SUSPENSE CLAIMS

PROVIDER: 0123456001
BENEFICIARY:
H: XXXXXXXX  NM: John   Smith  DOB: MM/DD/CCYY  SEX: M

TOTALS: CLAIMS    1 SUB    35.00 PAID    .00

CLAIM NUMBER  SUBMITTED  PAYTO PROV  277 CD  STAT DATE  DESCRIPTION
0111111111111  35.00      9.99       XX/XXX  MM/DD/CCYY  <----->

277 CATEGORY LEGEND:  AX - ACKNOWLEDGED          PX - PENDING          FX - FINALIZED
TYPE OPTION, PRESS ENTER KEY:
F-FORWARD              B-BACKWARD              P-ANOTHER PROVIDER
H-ANOTHER HICN         S-SUMMARY              Q-MAIN MENU          QQ-QUIT

A056-NO FOLLOWING RECORDS TO PAGE FORWARD          16003
```

Figure 11

Access instructions from the “Provider Pending Inquiry System” screen:

1. Enter “R” for Option. Press the **TAB** key to move the cursor to the next field.
2. Enter the Medicare supplier number. Press the **TAB** key to move the cursor to the next field.
3. Enter a specific Beneficiary’s Health Insurance Claim Number (HICN) for information on a claim in this status. Press the “**ENTER**” key.
4. Refer to page 13 for field descriptions.
5. To return to the Main Menu, “Provider Pending Inquiry System” screen, key “Q” in the option field. Press the “**ENTER**” key.
6. To return to the “Provider Claims Display Selection” screen from the Main Menu, key “QQ” in the option field. Press the “**ENTER**” key.

O - PROVIDER DETAIL OTHER SUSPENSE

“Other Suspense Claims” displays information about claims being examined other than those in the Common Working File (CWF). Claims suspended for manual review.

```
OPTION: ___          PROVIDER DETAIL PENDING INQUIRY          VMSPP50
                   OTHER SUSPENSE CLAIMS

PROVIDER: 0123456001
BENEFICIARY:
H: XXXXXX  NM: John      Smith      DOB: MM/DD/CCYY      SEX: M

TOTALS: CLAIMS    1 SUB    35.00 PAID    .00

CLAIM NUMBER  SUBMITTED  PAYTO PROV  277 CD  STAT DATE  DESCRIPTION
0211111111111  35.00      9.99      XX/XXX  MM/DD/CCYY  <----->

277 CATEGORY LEGEND: AX - ACKNOWLEDGED  PX - PENDING  FX - FINALIZED
TYPE OPTION, PRESS ENTER KEY:
F-FORWARD          B-BACKWARD          P-ANOTHER PROVIDER
H-ANOTHER HICN    S-SUMMARY          Q-MAIN MENU  QQ-QUIT

A056-NO FOLLOWING RECORDS TO PAGE FORWARD          16003
```

Figure 12

Access instructions from the “Provider Pending Inquiry System” screen:

1. Enter “O” for Option. Press the **TAB** key to move the cursor to the next field.
2. Enter the Medicare supplier number. Press the **TAB** key to move the cursor to the next field.
3. Enter a specific Beneficiary’s Health Insurance Claim Number (HICN) for information on a claim in this status. Press the “**ENTER**” key.
4. Refer to page 13 for field descriptions.
5. To return to the Main Menu, “Provider Pending Inquiry System” screen, key “Q” in the option field. Press the “**ENTER**” key.

6. To return to the “Provider Claims Display Selection” screen from the Main Menu, key “QQ” in the option field. Press the “ENTER” key.

S – PROVIDER SUMMARY PENDING INQUIRY

“Provider Summary Pending Inquiry” lists the number of claims and the total dollar amounts separated into the following categories: Query Suspense, Other Suspense, and Completed Held.

```
OPTION: __ PROVIDER SUMMARY PENDING INQUIRY VMSP40
PROVIDER: 1234567
HICN: _____ (ENTER FOR OPTIONS A, C, R, OR O)
          CLAIMS  SUBMITTED AMOUNT
QUERY SUSPENSE          58          1,110.00
OTHER SUSPENSE          15           535.33
COMPLETED HELD         14         94,055.31
TOTAL                   222         5,700.64

FOR CLAIMS DETAIL INFORMATION, TYPE OPTION, PRESS ENTER

OPTIONS  DESCRIPTION
A        PROVIDER DETAIL PENDING - ALL
C        PROVIDER DETAIL - COMPLETED HELD
R        PROVIDER DETAIL - QUERY SUSPENSE
O        PROVIDER DETAIL - OTHER SUSPENSE
Q        MAIN MENU
QQ       QUIT

16003
```

Figure 13

Access instructions from the “Provider Pending Inquiry System” screen:

1. Enter “S” for Option. Press the **TAB** key to move the cursor to the next field.
2. Enter the Medicare supplier number. Press the “**ENTER**” key.

All Provider Pending Claims Reports can be accessed from this screen by selecting the appropriate option.

3. To return to the Main Menu, “Provider Pending Inquiry System” screen, key “Q” in the option field. Press the “**ENTER**” key.
4. To return to the “Provider Claims Display Selection” screen from the Main Menu, key “QQ” in the option field. Press the “**ENTER**” key.

BENEFICIARY ELIGIBILITY INQUIRY

INFORMATION AVAILABLE

CMS is currently in the process of developing a new solution for the HIPAA compliant Eligibility Inquiry and Response. Please visit the CMS website or go to the following link for the latest information:

<http://www.cms.hhs.gov/AccessToDataApplication/Downloads/HETSCompanionGuide.pdf>

ELIGIBILITY RULES OF BEHAVIOR

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This document reiterates your responsibility in obtaining, disseminating, and using beneficiary's Medicare eligibility data. It also further explains the expectations for Clearinghouses and providers using this application. Violating these Medicare Health Benefit Eligibility Inquiry Rules of Behavior and other CMS data privacy and security rules could result in revoked access and other penalties.

For a more comprehensive and complete version of the Eligibility Rules of Behavior please refer to the following link:

<http://www.cms.hhs.gov/HETSHelp/Downloads/Eligibility%20Transaction%20System%20Inquiries%20Rules%20of%20Behavior.pdf>

CLEARINGHOUSES

The Medicare Electronic Data Interchange (EDI) Enrollment process provides for the collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and establishes the expectations for both parties for the exchange.

As a reminder, along with other EDI provisions, you agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security

regulations) to ensure that all transmissions of data are authorized and protect all beneficiary-specific data from improper access.

The Clearinghouse is responsible for the privacy and security of eligibility transactions with providers. You must be able to associate each inquiry with a provider.

The CMS instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate Medicare claim or determining eligibility for specific services. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom a claim is filed.

Per the EDI agreement, to receive access to eligibility data on behalf of providers, you must adhere to the following rules:

- Each clearinghouse must sign a Network Service Vendor Agreement directly with NHIC, Corp.;
- Each provider that contracts with a clearinghouse must sign a valid EDI Enrollment Form before eligibility data can be sent to the third party;
- The provider must explain the type of EDI services to be furnished by its clearinghouse in a signed statement authorizing the vendor's access to eligibility data;
- The clearinghouse must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a clearinghouse, that vendor must be able to identify the provider making the request for each beneficiary's information and be able to assure that eligibility responses are routed only to the provider that originated each request; and
- No access will be allowed if there is a record of prior violation of a clearinghouse agreement that would indicate that beneficiary data could be at risk of improper disclosure if access was approved for the clearinghouse.

The access of Medicare beneficiary eligibility data is to be used for the business of Medicare only. You, and the providers you serve, when accessing Medicare eligibility data must be fully aware of this requirement and all penalties related to the misuse of "individually-identifiable" health information accessed from the CMS database.

- You must not submit an eligibility inquiry except as an authorized agent of the health care provider and pursuant to a business associate contract, as required by 45 C.F.R. §§ 164.314(a) and 164.504(e), with the health care provider.

- If you submit a 270 that has been prepared by a provider/supplier utilizing your services, you are responsible for ensuring that the provider/supplier provides sufficient security measures, including user ID and password, to be able to associate the submitted 270 to the specific person/submitter from the provider/supplier.

PROVIDERS/SUPPLIERS

The EDI Enrollment process must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the Carrier with whom EDI transactions will be exchanged before any transaction is conducted.

As a reminder, along with other EDI provisions, you agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

Acting on behalf of the beneficiary, providers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information. This rule specifically defines the authorized uses and disclosures of "individually-identifiable" health information. The privacy regulations ensures privacy protections for patients by limiting the ways that physicians, qualified non-physician practitioners, suppliers, hospitals and other provider covered entities can use a patients' personal medical information.

AUTHENTICATION FOR HIPAA 270/271 ELIGIBILITY DATA

Authenticating elements that must be granted by the inquirer prior to the release of any beneficiary-specific eligibility information include:

- Beneficiary last name (must match the name on the Medicare card)
- Beneficiary first name or first initial (must match the information on the Medicare card)
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN)), including both alpha and numerical characters
- Date of birth

Note: The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determining who to bill for services rendered, but also give you the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encouraged them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

AUTHORIZED PURPOSES FOR REQUESTING MEDICARE BENEFICIARY ELIGIBILITY INFORMATION

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include to:

- Verify eligibility for Part A or Part B of Medicare
- Determine beneficiary payment responsibility with regard to deductible/co-insurance
- Determine eligibility for services such as preventive services
- Determine if Medicare is the primary or secondary payer
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage)
- Determine proper billing

UNAUTHORIZED PURPOSES FOR REQUESTING BENEFICIARY MEDICARE ELIGIBILITY INFORMATION

- To determine eligibility for Medicare
- To acquire the beneficiary's health insurance claim number

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a provider you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors in the event you identify misuse of "individually-identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as having aberrant behavior (e.g. high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

CRIMINAL PENALTIES

Trading Partner Agreement Violation

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person." Offenders shall "(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both."

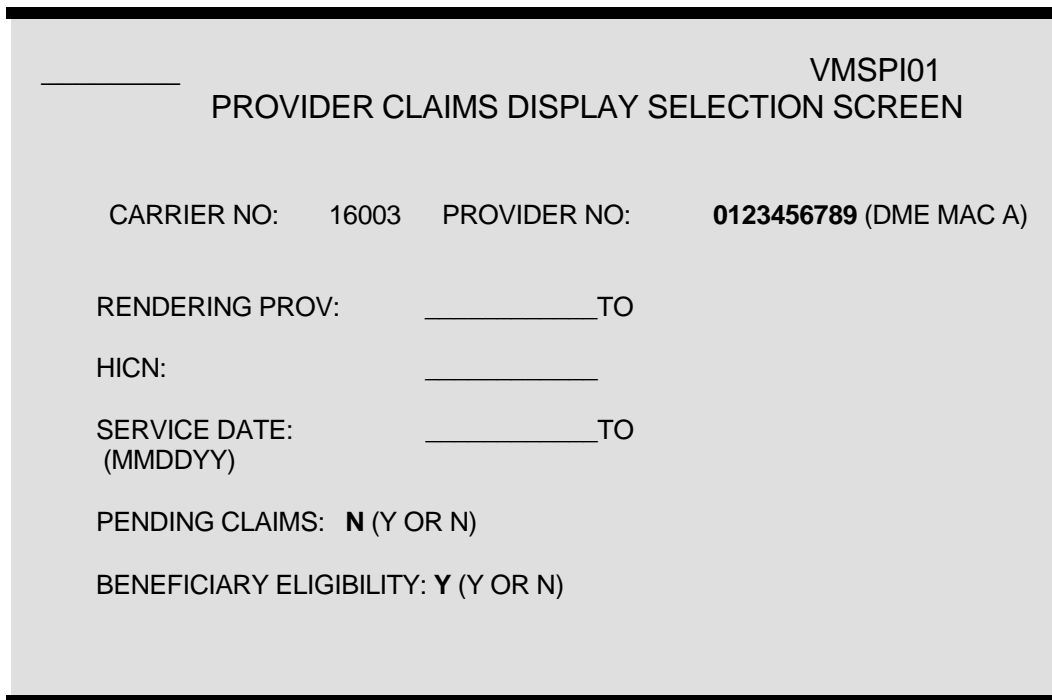
FALSE CLAIM ACT

Under the False Claims Act, [31 U.S.C. §§ 3729-3733](#), those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

The Beneficiary Eligibility option allows CSI-enrolled suppliers and their authorized billing agents to access beneficiary eligibility data. This is *confidential* information, subject to penalties and fines up to \$5,000 under the Privacy Act for illegal disclosure. Beneficiaries eligible for DME MAC A coverage must be entitled to Medicare Part B benefits.

The data is subject to change, and should be considered valid only at the time of inquiry. While information for Medicare Part B, Health Maintenance Organizations (HMOs), and Medicare Secondary Payer (MSP) is the most recent at our disposal, suppliers should always develop for the most up-to-date information.

Note: The fact that eligibility information is not found for a particular beneficiary does not necessarily mean that the person is ineligible for Medicare. Likewise, you may find data for a



```
VMSPi01
PROVIDER CLAIMS DISPLAY SELECTION SCREEN

CARRIER NO: 16003   PROVIDER NO: 0123456789 (DME MAC A)

RENDERING PROV: _____ TO
HICN: _____
SERVICE DATE: _____ TO
(MMDDYY)

PENDING CLAIMS: N (Y OR N)

BENEFICIARY ELIGIBILITY: Y (Y OR N)
```

beneficiary who currently is not eligible for Medicare. The **ultimate** determination of a beneficiary's Medicare eligibility can only be determined when submitting a claim for that person.

Figure 14

You can access the beneficiary eligibility information from the Provider Claims Display Selection Screen.

1. Enter your Medicare supplier number at the "PROVIDER NO:" field. **TAB** to Beneficiary Eligibility.
2. Enter a **"Y"** for Yes under Beneficiary Eligibility.
3. Press the **"ENTER"** key.

To use this inquiry function, you must enter the following six required fields: HIC Number, Surname, Initial, Date of Birth, Carrier Number, and Provider Number. Use the **TAB** key to move between fields.

```

ELGB_____ CWF PART B ELIGIBILITY SYSTEM ELGBSAT1
07/02/2003 09:33:06 INQUIRY BY PROVIDERS

ENTER THE FOLLOWING FIELDS:
HIC NUMBER      :
SURNAME         :
INITIAL         :
DATE OF BIRTH   : (MMDDCCYY)
SEX CODE        :
REQUESTOR ID    :
CARRIER NO     :
PROVIDER NO     :
HOST - ID       : GL, GW, KS, MA, PA, NE, SE, SO, SW
APP DATE        : (MMDDCCYY)
REASON CODE     :
RESPONSE CODE   :
  
```

Figure 15

Required Fields

HIC NUMBER: Enter the beneficiary’s Medicare number.
SURNAME: Enter the last name of the beneficiary, up to six characters.
INITIAL: Enter the first letter of the beneficiary’s first name.
DATE OF BIRTH: Enter the beneficiary’s date of birth in MMDDCCYY format.
CARRIER NO: Enter the number identifying the carrier processing the claim.
 16003 for Region B DME MAC A
PROVIDER NO: Enter the number assigned by the National Supplier
 Clearinghouse (NSC) of the supplier providing medical services
 to the beneficiary.

Optional Fields

SEX CODE: Enter the beneficiary’s sex. Valid values are:
 M = Male
 F = Female
HOST - ID: This field defaults to the local host against which the inquiry is
 processed. GL = DME MAC A (16003)
APP DATE: Enter the date that the beneficiary was admitted into the
 hospital in MMDDYYCC format.
REASON CODE: Enter the reason for the inquiry. The system defaults to “1.”
 Valid values include:
 1 = Status Inquiry (system default)

2 = Inquiry relating to an admission

RESPONSE CODE: Enter whether the inquiry is a test (actual test or CWF Test Inquiry) or production. The system defaults to "P." Valid values include:

P = Production (system default)
 T = Testing only
 X = CWF internal testing

After entering the required and/or optional information into the initial inquiry fields, press the "ENTER" key.

The Beneficiary Information screen will display:

ELGB 07/02/2003 09:44:47	CWF PART B ELIGIBILITY SYSTEM BENEFICIARY INFORMATION				ELGBCRO PAGE 01 OF 2
IP-REC CN PN	APP	NM MOUSE REAS 1	IT M	DB 07041926 SX REQ SMIT	CAR 16003 *
DISP CODE 01	MSG UNCONDITIONAL ACCEPT				
CORRECT CN	NM	IT	DB 07041924	SX F	
A-ENT 07011991 DOD 00000000	A-TRM 00000000 LRSV 60	B-ENT 07011986 LPSY	B-TRM 00000000		
DAYS LEFT CURRENT	FULL-HOSP	CO-HOSP	FULL-SNF	CO-SNF	IP-DED DOEBA DOLBA
PARTB YR 200301 01	DED-TBM 00000	PSYC	PHYS THER TBM 0159000	OCC THER TBM 0159000	
FULL-NAME ROSS.BETSY.G					
HMO: CURR ID ESRD: CODE 1 0	OPT EFF DATE 0000	ENTITL CODE-2 0	TERM EFF DATE 00000		
Highlighted Fields Do Not Match CMS Screens*					
PF1=INQ SCREEN		PF3/CLEAR=END		PF8=NEXT	

Figure 16

* The message on this line, "HIGHLIGHTED FIELDS DO NOT MATCH CMS FILE," will display when input data does not exactly match the CMS file. This referenced data will be highlighted on the Beneficiary Information Screen (note the DB field near the top of the screen in Figure 16).

Additional information (e.g., Hospice, Screening, and MSP information; Home Health Benefit Periods; Home Health PPS Episodes) can be accessed by paging forward and backward through additional screens. Press F8 to page forward and F7 to page backward through the screens. When you have completed your inquiry, press F1 to return to the Inquiry by Providers screen

(see Figure 14). To exit ELGB, see “Exiting the Beneficiary Eligibility System (ELGB)” at the end of this section.

Explanation of the fields on the “**Beneficiary Eligibility Inquiry**” Screen:

Beneficiary Eligibility Inquiry Screen – Data from the Inquiry Request

- CN: The beneficiary’s Social Security, Health Insurance or Railroad Board Number
NM: The first six characters of the beneficiary’s last name
IT: First letter of the beneficiary’s first name
DB: The beneficiary’s date of birth
SX: The beneficiary’s sex
CAR: Identifies the carrier processing the claim
PN: The number assigned by Medicare to the provider rendering medical service to the beneficiary
AP: Used for spell determination (i.e., admission date, current date) in MMDDCCYY format
REAS: Indicates the reason for the inquiry. Values include:
 1 = Status inquiry
 2 = Inquiry relating to an admission
REQ: The Requestor ID, identifying the person submitting the inquiry

Beneficiary Eligibility Inquiry Screen – Returned Fields

- DISP-CODE: The Disposition Code, indicating a condition on cable response. Values include:
 01 = Part B inquiry approved; Beneficiary has never used Part A services
 02 = Part B inquiry approved; Beneficiary has had some prior part A util.
 03 = Part B inquiry rejected
 20 = Qualified approval, may require further invest.
 25 = Qualified approval; according to CMS’s records, this inquiry begins a new benefit period.
 50 = Not in file
 51 = Not in file on CMS batch system
 52 = Master record housed at another cable site
 55 = Does not match a master record
 60 = Input/output error on data base
 61 = Cross reference data base problem
MSG: Information pertaining to the disposition code.
CORRECT
CN: Provides the corrected claim number. This field is only used if the HIC Number is incorrect.

NM: Provides the corrected name. This field is only used if the name is not consistent with CMS's record.

IT: Provides the corrected first initial of the first name. This field is only used if the name is not consistent with CMS's record.

DB: Provides the corrected date of birth. This field indicates the date of birth as contained in CMS's beneficiary record in MMDDCCYY format.

SX: Provides the corrected sex code. This field indicates the beneficiary's sex as contained in CMS's beneficiary record.

A-ENT: Date of entitlement to Part A benefits in MMDDCCYY format. May be zeros.

A-TRM: Date of termination of Part A entitlement in MMDDCCYY format. May be zeros.

B-ENT: Date of entitlement to Part B benefits in MMDDCCYY format. May be zeros.

B-TRM: Date of termination of Part B entitlement in MMDDCCYY format. May be zeros.

DOD: Date of beneficiary's death in MMDDCCYY format. May be zeros if the actual day of death is unknown.

LRSV: Indicates the number of lifetime reserve days remaining.

LPSY: Indicates the number of lifetime psychiatric days remaining. This field displays if the provider number indicates that the requestor is a psych provider (there must be a "4" in the third digit of the provider number).

FULL-HOSP: Provides the number of inpatient days remaining to be paid at full benefit amount.

CO-HOSP: Provides the number of inpatient days remaining to be paid at the coinsurance benefit amount.

FULL-SNF: Indicates the number of Skilled Nursing Facility (SNF) days remaining to be paid at full benefit.

CO-SNF: Indicates the number of SNF days remaining to be paid at coinsurance benefit.

IP-DED: Indicates the amount of inpatient deductible remaining to be met.

BLOOD: Provides the number of blood pints deductible remaining to be met.

DOEBA: The date of the earliest billing action for the spell of illness.

DOLBA : The date of the latest billing action for the spell of illness.

PART B YR: Indicates the most recent Part B year from the applicable date input field.

DED-TBM: This is the amount of the Part B cash deductible remaining to be met.

PSYC: Indicates the amount of psychiatric deductible used for the year.

PHYS THER

TBM: Shows the physical therapy deductible used in the Part B year.

OCC THER

TBM: Shows the occupational therapy deductible used in the Part B year.

FULL-NAME: Relates to the Full Name on the master HI record.

HMO: PER: A code that indicates that the individual has had 1, 2, or 3 (more than 2) periods of enrollment in an HMO.

CURR ID: The HMO Identification code.

OPT: The HMO Option Code describes the beneficiary's relationship with the HMO.

ENTITL: The HMO entitlement date in MMDDCCYY format.

TERM: The HMO termination date in MMDDCCYY format.

ESRD: End Stage Renal Disease

CODE-1: A one-digit code that indicates whether End Stage Renal Disease (ESRD) covered services are reimbursed under method 1 or method 2.

EFF DATE: The date that ESRD benefits began in MMDDCCYY format.

CODE-2: The method of reimbursement for ESRD.

EFF DATE: The date that ESRD benefits began in MMDDCCYY format.

Error Messages

Note: Please remember that the information found through the inquiry function does not necessarily mean that a person is eligible for Medicare. The ultimate determination of a beneficiary’s Medicare eligibility can only be found when submitting a claim for that person.

The following error messages may display at the bottom of any of the beneficiary eligibility screens:

A00 2	INVALID HIC	You must enter the beneficiary’s Medicare number in the HIC Number field.
A00 4	INVALID SURNAMEM/I UNIT OF MEASURE	You must enter 6 characters of the beneficiary’s last name.
A00 5	INVALID INITIAL	You must enter the first letter of the beneficiary’s first name.
A00 6	INVALID DATE OF BIRTH	You must enter the beneficiary's date of birth in MMDDYYCC format.
A00 7	SEX CODE	You must enter the beneficiary's sex.
A00 8	INVALID CARRIER NO	Enter a valid carrier number.
A00 9	INVALID PROVIDER NUMBER	Enter a valid provider number
	BENE - ERROR, BNEDEFICIARY RECORD NOT FOUND,	The data entered in the HIC number and Name fields, and one additional characteristic (either the date of birth or the first initial) must match a CMS data file. Check your records and correct any invalid data.
	HIC#, NAME, & 1 CHARACTERISTIC MUST MATCH CMS FIELD	The data entered in the HIC number and Name fields, and one additional characteristic (either the date of birth or the first initial) must match a CMS data file. Check your records and correct any invalid data.
	Highlighted Fields do not match CMS file	You must enter the correct information for the field highlighted.

Exiting the Beneficiary Eligibility System (ELGB)

To exit the Beneficiary Eligibility System (ELGB), press the “F3” key. The system will return you to a blank screen from which you can access all CSI functions.

Type one of the following commands on the blank screen and press the “ENTER” key:

1. Type **“VPIQ”** — This will take you to the Provider Claims Display Selection screen for access to general and pending claim information and beneficiary eligibility.

Or

2. Type **“CESF LOGOFF”** — To exit CSI and then follow the steps on the next page to completely logoff the CSI system.

Logoff Procedures

To logoff of the system properly:

1. At the "Provider Claims Display Selection" screen, press the "F3" key to clear the screen.
2. Once the screen is clear, type "CESF LOGOFF" and press the "ENTER" key.
3. This should return you to the TELEVIEW Screen. At the COMMAND prompt
COMMAND= = = > , enter "LOGOFF ALL" and press the "ENTER" key.

You should be back to AT&T sign-on screen. You will see "NO CARRIER". At this point you must hang-up your communications to completely disconnect. Press "ALT" key and "H" keys simultaneously. This will send the hang-up command.

Health Care Claim Status Category Codes

Supplemental

X0 Supplemental Messages

Acknowledgements

- A0 Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity
- A1 Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication
- A2 Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system
- A3 Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system
- A4 Acknowledgement/Not Found-The claim/encounter can not be found in the adjudication system
- A5 Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system
- A6 Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.
- A7 Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.
- A8 Acknowledgement/Rejected for relational field in error.

Pending

- P0 Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid
- P1 Pending/In Process-The claim or encounter is in the adjudication system
- P2 Pending/In Review-The claim/encounter is suspended pending review
- P3 Pending/Requested Information-The claim or encounter is waiting for information that has already been requested
- P4 Pending/Patient Requested Information

Finalized

- F0 Finalized-The claim/encounter has completed the adjudication cycle and no more action will be taken
- F1 Finalized/Payment-The claim/line has been paid
- F2 Finalized/Denial-The claim/line has been denied
- F3 Finalized/Revised - Adjudication information has been changed

- F3F** Finalized/Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records
- F3N** Finalized/Not Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made. The claim/encounter has NOT been forwarded to any subsequent entity identified on the original claim
- F4** Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming
- F5** Finalized/Cannot Process

Requests for additional information

- R0** Requests for additional Information/General Requests-Requests that don't fall into other R-type categories
- R1** Requests for additional Information/Entity Requests-Requests for information about specific entities (subscribers, patients, various providers)
- R3** Requests for additional Information/Claim/Line-Requests for information that could normally be submitted on a claim
- R4** Requests for additional Information/Documentation-Requests for additional supporting documentation. Examples: certification, x-ray, notes
- R5** Request for additional information/more specific detail-Additional information as a follow up to a previous request is needed. The original information was received but is inadequate. More specific/detailed information is requested

General

- RQ** General Questions (Yes/No Responses)-Questions that may be answered by a simple 'yes' or 'no'

Error

- E0** Response not possible - error on submitted request data
- E1** Response not possible - System Status
- E2** Information Holder is not responding; resubmit at a later time.

Searches

- D0** Entity not found - change search criteria

Health Care Claim Status Codes

- 0 Cannot provide further status electronically
- 1 For more detailed information, see remittance advice
- 2 More detailed information in letter
- 3 Claim has been adjudicated and is awaiting payment cycle
- 4 This is a subsequent request for information from the original request
- 5 This is a final request for information
- 6 Balance due from the subscriber
- 7 Claim may be reconsidered at a future date
- 8 No payment due to contract/plan provisions
Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage
- 9 No payment will be made for this claim
- 10 All originally submitted procedure codes have been combined
Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage
- 11 Some originally submitted procedure codes have been combined
Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage
- 12 One or more originally submitted procedure codes have been combined
- 13 All originally submitted procedure codes have been modified
Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage
- 14 Some all originally submitted procedure codes have been modified
Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage
- 15 One or more originally submitted procedure code have been modified
- 16 Claim/encounter has been forwarded to entity
- 17 Claim/encounter has been forwarded by third party entity to entity
- 18 Entity received claim/encounter, but returned invalid status
- 19 Entity acknowledges receipt of claim/encounter
- 20 Accepted for processing
- 21 Missing or invalid information
- 22 ... before entering the adjudication system
- 23 Returned to Entity
- 24 Entity not approved as an electronic submitter
- 25 Entity not approved
- 26 Entity not found
- 27 Policy canceled
- 28 Claim submitted to wrong payer
- 29 Subscriber and policy number/contract number mismatched
- 30 Subscriber and subscriber id mismatched
- 31 Subscriber and policyholder name mismatched
- 32 Subscriber and policy number/contract number not found
- 33 Subscriber and subscriber id not found
- 34 Subscriber and policyholder name not found

- 35 Claim/encounter not found
- 37 Predetermination is on file, awaiting completion of services
- 38 Awaiting next periodic adjudication cycle
- 39 Charges for pregnancy deferred until delivery
- 40 Waiting for final approval
- 41 Special handling required at payer site
- 42 Awaiting related charges
- 44 Charges pending provider audit
- 45 Awaiting benefit determination
- 46 Internal review/audit
- 47 Internal review/audit - partial payment made
- 48 Referral/authorization
- 49 Pending provider accreditation review
- 50 Claim waiting for internal provider verification
- 51 Investigating occupational illness/accident
- 52 Investigating existence of other insurance coverage
- 53 Claim being researched for Insured ID/Group Policy Number error
- 54 Duplicate of a previously processed claim/line
- 55 Claim assigned to an approver/analyst
- 56 Awaiting eligibility determination
- 57 Pending COBRA information requested
- 59 Non-electronic request for information
- 60 Electronic request for information
- 61 Eligibility for extended benefits
- 64 Re-pricing information
- 65 Claim/line has been paid
- 66 Payment reflects usual and customary charges
- 67 Payment made in full
- 68 Partial payment made for this claim
- 69 Payment reflects plan provisions
- 70 Payment reflects contract provisions
- 71 Periodic installment released
- 72 Claim contains split payment
- 73 Payment made to entity, assignment of benefits not on file
- 78 Duplicate of an existing claim/line, awaiting processing
- 81 Contract/plan does not cover pre-existing conditions
- 83 No coverage for newborns
- 84 Service not authorized
- 85 Entity not primary
- 86 Diagnosis and patient gender mismatch
- 87 Denied: Entity not found
- 88 Entity not eligible for benefits for submitted dates of service
- 89 Entity not eligible for dental benefits for submitted dates of service

- 90 Entity not eligible for medical benefits for submitted dates of service
- 91 Entity not eligible/not approved for dates of service
- 92 Entity does not meet dependent or student qualification
- 93 Entity is not selected primary care provider
- 94 Entity not referred by selected primary care provider
- 95 Requested additional information not received
- 96 No agreement with entity
- 97 Patient eligibility not found with entity
- 98 Charges applied to deductible
- 99 Pre-treatment review
- 100 Pre-certification penalty taken
- 101 Claim was processed as adjustment to previous claim
- 102 Newborn's charges processed on mother's claim
- 103 Claim combined with other claim(s)
- 104 Processed according to plan provisions
- 105 Claim/line is capitated
- 106 This amount is not entity's responsibility
- 107 Processed according to contract/plan provisions
- 108 Coverage has been canceled for this entity
- 109 Entity not eligible
- 110 Claim requires pricing information
- 111 At the policyholder's request these claims cannot be submitted electronically
- 112 Policyholder processes their own claims
- 113 Cannot process individual insurance policy claims
- 114 Should be handled by entity
- 115 Cannot process HMO claims
- 116 Claim submitted to incorrect payer
- 117 Claim requires signature-on-file indicator
- 118 TPO rejected claim/line because payer name is missing
- 119 TPO rejected claim/line because certification information is missing
- 120 TPO rejected claim/line because claim does not contain enough information
- 121 Service line number greater than maximum allowable for payer
- 122 Missing/invalid data prevents payer from processing claim
- 123 Additional information requested from entity
- 124 Entity's name, address, phone and id number
- 125 Entity's name
- 126 Entity's address
- 127 Entity's phone number
- 128 Entity's tax id
- 129 Entity's Blue Cross provider id
- 130 Entity's Blue Shield provider id
- 131 Entity's Medicare provider id
- 132 Entity's Medicaid provider id

- 133 Entity's UPIN
- 134 Entity's CHAMPUS provider id
- 135 Entity's commercial provider id
- 136 Entity's health industry id number
- 137 Entity's plan network id
- 138 Entity's site id
- 139 Entity's health maintenance provider id (HMO)
- 140 Entity's preferred provider organization id (PPO)
- 141 Entity's administrative services organization id (ASO)
- 142 Entity's license/certification number
- 143 Entity's state license number
- 144 Entity's specialty license number
- 145 Entity's specialty code
- 146 Entity's anesthesia license number
- 147 Entity's qualification degree/designation (e.g. RN, PhD, MD)
- 148 Entity's social security number
- 149 Entity's employer id
- 150 Entity's drug enforcement agency (DEA) number
- 152 Pharmacy processor number
- 153 Entity's id number
- 154 Relationship of surgeon & assistant surgeon
- 155 Entity's relationship to patient
- 156 Patient relationship to subscriber
- 157 Entity's Gender
- 158 Entity's date of birth
- 159 Entity's date of death
- 160 Entity's marital status
- 161 Entity's employment status
- 162 Entity's health insurance claim number (HICN)
- 163 Entity's policy number
- 164 Entity's contract/member number
- 165 Entity's employer name, address and phone
- 166 Entity's employer name
- 167 Entity's employer address
- 168 Entity's employer phone number
- 169 Entity's employer id
- 170 Entity's employee id
- 171 Other insurance coverage information (health, liability, auto, etc.)
- 172 Other employer name, address and telephone number
- 173 Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber
- 174 Entity's student status
- 175 Entity's school name

- 176 Entity's school address
- 177 Transplant recipient's name, date of birth, gender, relationship to insured
- 178 Submitted charges
- 179 Outside lab charges
- 180 Hospital's semi-private room rate
- 181 Hospital's room rate
- 182 Allowable/paid from primary coverage
- 183 Amount entity has paid
- 184 Purchase price for the rented durable medical equipment
- 185 Rental price for durable medical equipment
- 186 Purchase and rental price of durable medical equipment
- 187 Date(s) of service
- 188 Statement from-through dates
- 189 Hospital admission date
- 190 Hospital discharge date
- 191 Date of Last Menstrual Period (LMP)
- 192 Date of first service for current series/symptom/illness
- 193 First consultation/evaluation date
- 194 Confinement dates
- 195 Unable to work dates
- 196 Return to work dates
- 197 Effective coverage date(s)
- 198 Medicare effective date
- 199 Date of conception and expected date of delivery
- 200 Date of equipment return
- 201 Date of dental appliance prior placement
- 202 Date of dental prior replacement/reason for replacement
- 203 Date of dental appliance placed
- 204 Date dental canal(s) opened and date service completed
- 205 Date(s) dental root canal therapy previously performed
- 206 Most recent date of curettage, root planing, or periodontal surgery
- 207 Dental impression and seating date
- 208 Most recent date pacemaker was implanted
- 209 Most recent pacemaker battery change date
- 210 Date of the last x-ray
- 211 Date(s) of dialysis training provided to patient
- 212 Date of last routine dialysis
- 213 Date of first routine dialysis
- 214 Original date of prescription/orders/referral
- 215 Date of tooth extraction/extraction
- 216 Drug information
- 217 Drug name, strength and dosage form
- 218 NDC number

- 219 Prescription number
- 220 Drug product id number
- 221 Drug days supply and dosage
- 222 Drug dispensing units and average wholesale price (AWP)
- 223 Route of drug/myelogram administration
- 224 Anatomical location for joint injection
- 225 Anatomical location
- 226 Joint injection site
- 227 Hospital information
- 228 Type of bill for UB-92 claim
- 229 Hospital admission source
- 230 Hospital admission hour
- 231 Hospital admission type
- 232 Admitting diagnosis
- 233 Hospital discharge hour
- 234 Patient discharge status
- 235 Units of blood furnished
- 236 Units of blood replaced
- 237 Units of deductible blood
- 238 Separate claim for mother/baby charges
- 239 Dental information
- 240 Tooth surface(s) involved
- 241 List of all missing teeth (upper and lower)
- 242 Tooth numbers, surfaces, and/or quadrants involved
- 243 Months of dental treatment remaining
- 244 Tooth number or letter
- 245 Dental quadrant/arch
- 246 Total orthodontic service fee, initial appliance fee, monthly fee, length of service
- 247 Line information
- 248 Accident date, state, description and cause
- 249 Place of service
- 250 Type of service
- 251 Total anesthesia minutes
- 252 Authorization/certification number
- 253 Procedure/revenue code for service(s) rendered. Please use codes 454 or 455
- 254 Primary diagnosis code
- 255 Diagnosis code
- 256 DRG code(s)
- 257 ADSM-III-R code for services rendered
- 258 Days/units for procedure/revenue code
- 259 Frequency of service
- 260 Length of medical necessity, including begin date
- 261 Obesity measurements

- 262 Type of surgery/service for which anesthesia was administered
- 263 Length of time for services rendered
- 264 Number of liters/minute & total hours/day for respiratory support
- 265 Number of lesions excised
- 266 Facility point of origin and destination - ambulance
- 267 Number of miles patient was transported
- 268 Location of durable medical equipment use
- 269 Length/size of laceration/tumor
- 270 Subluxation location
- 271 Number of spine segments
- 272 Oxygen contents for oxygen system rental
- 273 Weight
- 274 Height
- 275 Claim
- 276 UB-92/CMS-1450/CMS-1500 claim form
- 277 Paper claim
- 278 Signed claim form
- 279 Itemized claim
- 280 Itemized claim by provider
- 281 Related confinement claim
- 282 Copy of prescription
- 283 Medicare worksheet
- 284 Copy of Medicare ID card
- 285 Vouchers/explanation of benefits (EOB)
- 286 Other payer's Explanation of Benefits/payment information
- 287 Medical necessity for service
- 288 Reason for late hospital charges
- 289 Reason for late discharge
- 290 Pre-existing information
- 291 Reason for termination of pregnancy
- 292 Purpose of family conference/therapy
- 293 Reason for physical therapy
- 294 Supporting documentation
- 295 Attending physician report
- 296 Nurse's notes
- 297 Medical notes/report
- 298 Operative report
- 299 Emergency room notes/report
- 300 Lab/test report/notes/results
- 301 MRI report
- 302 Refer to codes 300 for lab notes and 311 for pathology notes
- 303 Physical therapy notes. Please use code 297:6O (6 'OH' - not zero)
- 304 Reports for service

- 305 X-ray reports/interpretation
- 306 Detailed description of service
- 307 Narrative with pocket depth chart
- 308 Discharge summary
- 309 Code was duplicate of code 299
- 310 Progress notes for the six months prior to statement date
- 311 Pathology notes/report
- 312 Dental charting
- 313 Bridgework information
- 314 Dental records for this service
- 315 Past period treatment history
- 316 Complete medical history
- 317 Patient's medical records
- 318 X-rays
- 319 Pre/post-operative x-rays/photographs
- 320 Study models
- 321 Radiographs or models
- 322 Recent fm x-rays
- 323 Study models, x-rays, and/or narrative
- 324 Recent x-ray of treatment area and/or narrative
- 325 Recent fm x-rays and/or narrative
- 326 Copy of transplant acquisition invoice
- 327 Periodontal case type diagnosis and recent pocket depth chart with narrative
- 328 Speech therapy notes. Please use code 297:6R
- 329 Exercise notes
- 330 Occupational notes
- 331 History and physical
- 332 Authorization/certification (include period covered)
- 333 Patient release of information authorization
- 334 Oxygen certification
- 335 Durable medical equipment certification
- 336 Chiropractic certification
- 337 Ambulance certification/documentation
- 338 Home health certification
- 339 Enteral/parenteral certification
- 340 Pacemaker certification
- 341 Private duty nursing certification
- 342 Podiatric certification
- 343 Documentation that facility is state licensed and Medicare approved as a surgical facility
- 344 Documentation that provider of physical therapy is Medicare Part B approved
- 345 Treatment plan for service/diagnosis
- 346 Proposed treatment plan for next 6 months
- 347 Refer to code 345 for treatment plan and code 282 for prescription

- 348 Chiropractic treatment plan
- 349 Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P
- 350 Speech pathology treatment plan
- 351 Physical/occupational therapy treatment plan
- 352 Duration of treatment plan
- 353 Orthodontics treatment plan
- 354 Treatment plan for replacement of remaining missing teeth
- 355 Has claim been paid?
- 356 Was blood furnished?
- 357 Has or will blood be replaced?
- 358 Does provider accept assignment of benefits?
- 359 Is there a release of information signature on file?
- 360 Is there an assignment of benefits signature on file?
- 361 Is there other insurance?
- 362 Is the dental patient covered by medical insurance?
- 363 Will worker's compensation cover submitted charges?
- 364 Is accident/illness/condition employment related?
- 365 Is service the result of an accident?
- 366 Is injury due to auto accident?
- 367 Is service performed for a recurring condition or new condition?
- 368 Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?
- 369 Does patient condition preclude use of ordinary bed?
- 370 Can patient operate controls of bed?
- 371 Is patient confined to room?
- 372 Is patient confined to bed?
- 373 Is patient an insulin diabetic?
- 374 Is prescribed lenses a result of cataract surgery?
- 375 Was refraction performed?
- 376 Was charge for ambulance for a round-trip?
- 377 Was durable medical equipment purchased new or used?
- 378 Is pacemaker temporary or permanent?
- 379 Were services performed supervised by a physician?
- 380 Were services performed by a CRNA under appropriate medical direction?
- 381 Is drug generic?
- 382 Did provider authorize generic or brand name dispensing?
- 383 Was nerve block used for surgical procedure or pain management?
- 384 Is prosthesis/crown/inlay placement an initial placement or a replacement?
- 385 Is appliance upper or lower arch & is appliance fixed or removable?
- 386 Is service for orthodontic purposes?
- 387 Date patient last examined by entity
- 388 Date post-operative care assumed
- 389 Date post-operative care relinquished

- 390 Date of most recent medical event necessitating service(s)
- 391 Date(s) dialysis conducted
- 392 Date(s) of blood transfusion(s)
- 393 Date of previous pacemaker check
- 394 Date(s) of most recent hospitalization related to service
- 395 Date entity signed certification/recertification
- 396 Date home dialysis began
- 397 Date of onset/exacerbation of illness/condition
- 398 Visual field test results
- 399 Report of prior testing related to this service, including dates
- 400 Claim is out of balance
- 401 Source of payment is not valid
- 402 Amount must be greater than zero
- 403 Entity referral notes/orders/prescription
- 404 Specific findings, complaints, or symptoms necessitating service
- 405 Summary of services
- 406 Brief medical history as related to service(s)
- 407 Complications/mitigating circumstances
- 408 Initial certification
- 409 Medication logs/records (including medication therapy)
- 410 Explain differences between treatment plan and patient's condition
- 411 Medical necessity for non-routine service(s)
- 412 Medical records to substantiate decision of non-coverage
- 413 Explain/justify differences between treatment plan and services rendered
- 414 Need for more than one physician to treat patient
- 415 Justify services outside composite rate
- 416 Verification of patient's ability to retain and use information
- 417 Prior testing, including result(s) and date(s) as related to service(s)
- 418 Indicating why medications cannot be taken orally
- 419 Individual test(s) comprising the panel and the charges for each test
- 420 Name, dosage and medical justification of contrast material used for radiology procedure
- 421 Medical review attachment/information for service(s)
- 422 Homebound status
- 423 Prognosis
- 424 Statement of non-coverage including itemized bill
- 425 Itemize non-covered services
- 426 All current diagnoses
- 427 Emergency care provided during transport
- 428 Reason for transport by ambulance
- 429 Loaded miles and charges for transport to nearest facility with appropriate services

- 430 Nearest appropriate facility
- 431 Provide condition/functional status at time of service

- 432 Date benefits exhausted
- 433 Copy of patient revocation of hospice benefits
- 434 Reasons for more than one transfer per entitlement period
- 435 Notice of Admission
- 436 Short term goals
- 437 Long term goals
- 438 Number of patients attending session
- 439 Size, depth, amount, and type of drainage wounds
- 440 why non-skilled caregiver has not been taught procedure
- 441 Entity professional qualification for service(s)
- 442 Modalities of service
- 443 Initial evaluation report
- 444 Method used to obtain test sample
- 445 Explain why hearing loss not correctable by hearing aid
- 446 Documentation from prior claim(s) related to service(s)
- 447 Plan of teaching
- 448 Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used
- 449 Projected date to discontinue service(s)
- 450 Awaiting spend down determination
- 451 Preoperative and post-operative diagnosis
- 452 Total visits in total number of hours/day and total number of hours/week
- 453 Procedure Code Modifier(s) for Service(s) Rendered
- 454 Procedure code for services rendered
- 455 Revenue code for services rendered
- 456 Covered Day(s)
- 457 Non-Covered Day(s)
- 458 Coinsurance Day(s)
- 459 Lifetime Reserve Day(s)
- 460 NUBC Condition Code(s)
- 461 NUBC Occurrence Code(s) and Date(s)
- 462 NUBC Occurrence Span Code(s) and Date(s)
- 463 NUBC Value Code(s) and/or Amount(s)
- 464 Payer Assigned Control Number
- 465 Principal Procedure Code for Service(s) Rendered
- 466 Entities Original Signature
- 467 Entity Signature Date
- 468 Patient Signature Source
- 469 Purchase Service Charge
- 470 Was service purchased from another entity?
- 471 Were services related to an emergency?
- 472 Ambulance Run Sheet

- 473 Missing or invalid lab indicator
- 474 Procedure code and patient gender mismatch
- 475 Procedure code not valid for patient age
- 476 Missing or invalid units of service
- 477 Diagnosis code pointer is missing or invalid
- 478 Claim submitter's identifier (patient account number) is missing
- 479 Other Carrier payer ID is missing or invalid
- 480 Other Carrier Claim filing indicator is missing or invalid
- 481 Claim/submission format is invalid
- 482 Date Error, Century Missing
- 483 Maximum coverage amount met or exceeded for benefit period
- 484 Business Application Currently Not Available
- 485 More information available than can be returned in real time mode. Narrow your current search criteria
- 486 Principle Procedure Date
- 487 Claim not found, claim should have been submitted to/through 'entity'
- 488 Diagnosis code(s) for the services rendered.
- 489 Attachment Control Number
- 490 Other Procedure Code for Service(s) Rendered
- 491 Entity not eligible for encounter submission
- 492 Other Procedure Date
- 493 Version/Release/Industry ID code not currently supported by information holder
- 494 Real-Time requests not supported by the information holder, resubmit as batch request
- 495 Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.
- 496 Submitter not approved for electronic claim submissions on behalf of this entity.
- 497 Sales tax not paid
- 498 Maximum leave days exhausted
- 499 No rate on file with the payer for this service for this entity
- 500 Entity's Postal/Zip Code
- 501 Entity's State/Province
- 502 Entity's City
- 503 Entity's Street Address
- 504 Entity's Last Name
- 505 Entity's First Name
- 506 Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse
- 507 HCPCS
- 508 ICD9
- 509 E-code
- 510 Future Date
- 511 Invalid character

512 Length invalid for receiver's application system
513 HIPPS Rate Code for services rendered
514 Entities Middle Name
515 Managed Care review
516 Adjudication or Payment Date
517 Adjusted Repriced Claim Reference Number
518 Adjusted Repriced Line item reference number
519 Adjustment Amount
520 Adjustment Quantity
521 Adjustment Reason Code
522 Anesthesia Modifying Unites
523 Anesthesia Unit Count
524 Arterial Blood Gas Quantity
525 Begin Therapy Date
526 Bundled or Unbundled Line
527 Certification Condition Indicator
528 Certification Period Projected Visit Count
529 Certification Revision Date
530 Claim Adjustment Indicator
531 Claim Disproportionate Share Amount
532 Claim DRG Amount
533 Claim DRG Outlier Amount
534 Claim ESRD Payment Amount
535 Claim Frequency Code
536 Claim Indirect Teaching Amount
537 Claim MSP Pass-through Amount
538 Claim or Encounter Identifier
539 Claim PPS Capital Amount
540 Claim PPS Capital Outlier Amount
541 Claim Submission Reason Code
542 Claim Total Denied Charge Amount
543 Clearinghouse or Value Added Network Trace
544 Clinical Laboratory Improvement Amendment
545 Contract Amount
546 Contract Code
547 Contract Percentage
548 Contract Type Code
549 Contract Version Identifier
550 Coordination of Benefits Code
551 Coordination of Benefits Total Submitted Charge
552 Cost Report Day Count
553 Covered Amount
554 Date Claim Paid

555 Delay Reason Code
556 Demonstration Project Identifier
557 Diagnosis Date
558 Discount Amount
559 Document Control Identifier
560 Entity's Additional/Secondary Identifier
561 Entity's Contract Name
562 Entity's National Provider Identifier (NPI)
563 Entity's Tax Amount
564 EPSDT Indicator
565 Estimated Claim Due Amount
566 Exception Code
567 Facility Code Qualifier
568 Family Planning Indicator
569 Fixed Format Information
570 Free Form Message Text
571 Frequency Count
572 Frequency Period
573 Functional Limitation Code
574 HCPCS Payable Amount Home Health
575 Homebound Indicator
576 Immunization Batch Number
577 Industry Code
578 Insurance Type Code
579 Investigational Device Exemption
580 Last Certification Date
581 Last Worked Date
582 Lifetime Psychiatric Days Count
583 Line Item Charge Amount
584 Line Item Control Number
585 Line Item Denied Charge or Non-covered Charge
586 Line Note Text
587 Measurement Reference Identification Code
588 Medical Record Number
589 Medicare Assignment Code
590 Medicare Coverage Indicator
591 Medicare Paid at 100% Amount
592 Medicare Paid at 80% Amount
593 Medicare Section 4081 Indicator
594 Mental Status Code
595 Monthly Treatment Count
596 Non-covered Charge Amount
597 Non-payable Professional Component Amount

598 Non-payable Professional Component Billed Amount
599 Note Reference Code
600 Oxygen Saturation Quantity
601 Oxygen Test Condition Code
602 Oxygen Test Date
603 Old Capital Amount
604 Originator Application Transaction Identifier
605 Orthodontic Treatment Months Count
606 Paid From Part A Medicare Trust Fund Amount
607 Paid From Part B Medicare Trust Fund Amount
608 Paid Service Unit Count
609 Participation Agreement
610 Patient Discharge Facility Type Code
611 Peer Review Authorization Number
612 Per Day Limit Amount
613 Physician Contact Date
614 Physician Order Date
615 Policy Compliance Code
616 Policy Name
617 Postage Claimed Amount
618 PPS-Capital DSH DRG Amount
619 PPS-Capital Exception Amount
620 PPS-Capital FSP DRG Amount
621 PPS-Capital HSP DRG Amount
622 PPS-Capital IME Amount
623 PPS-Operating Federal Specific DRG Amount
624 PPS-Operating Hospital Specific DRG Amount
625 Predetermination of Benefits Identifier
626 Pregnancy Indicator
627 Pre-Tax Claim Amount
628 Pricing Methodology
629 Property Casualty Claim Number
630 Referring CLIA Number
631 Reimbursement Rate
632 Reject Reason Code
633 Related Causes Code
634 Remark Code
635 Repriced Approved Ambulatory Patient Group
636 Repriced Line Item Reference Number
637 Repriced Saving Amount
638 Repriced Per Diem or Flat Rate Amount
639 Responsibility Amount
640 Sales Tax Amount

- 641 Service Adjudication or Payment Date
- 642 Service Authorization Exception Code
- 643 Service Line Paid Amount
- 644 Service Line Rate
- 645 Service Tax Amount
- 646 Ship, Delivery or Calendar Pattern Code
- 647 Shipped Date
- 648 Similar Illness or Symptom Date
- 649 Skilled Nursing Facility Indicator
- 650 Special Program Indicator
- 651 State Industrial Accident Provider Number
- 652 Terms Discount Percentage
- 653 Test Performed Date
- 654 Total Denied Charge Amount
- 655 Total Medicare Paid Amount
- 656 Total Visits Projected This Certification Count
- 657 Total Visits Rendered Count
- 658 Treatment Code
- 659 Unit or Basis for Measurement Code
- 660 Universal Product Number
- 661 Visits Prior to Recertification Date Count CR702
- 662 X-ray Availability Indicator
- 663 Entity's Group Name
- 664 Orthodontic Banding Date
- 665 Surgery Date
- 666 Surgical Procedure Code
- 667 Real-Time requests not supported by the information holder, do not resubmit
- 668 Missing Endodontics treatment history and prognosis
- 669 Dental service narrative needed