



270-271 Health Care Eligibility Benefit Inquiry and Resource Companion Guide

For use with
ASC X12N 270-271 Health Care Eligibility Benefit Inquiry and Response
Transactions Set Implementation Guides and Addenda
(Version 4010A1)

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Chapter 1

Introduction

- 1.1 What is HIPAA?
- 1.2. Purpose
- 1.3. Intended Audience
- 1.4. Contact Information

1.1. What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the establishment of national standards for electronic transmission of health data and ensuring privacy protection. The Administrative Simplification provisions of HIPAA, Title II, require the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in health care.

Carelon Behavioral Health (Carelon), as a covered entity and health insurance payer, will be accepting X12 270 Health Care Eligibility Benefit Inquiry transactions and producing X12 271 Health Care Eligibility Benefit Response transactions as mandated by the administration simplification provisions of HIPAA.

1.2. Purpose

This document has been prepared as a Carelon-specific companion document to that implementation guide and to clarify when conditional data elements and segments must be used for Carelon reporting, and identify those codes and data elements that do not apply to Carelon. This companion guide document **supplements**, but does not contradict any requirements in the 270 version 2010a implementation guide. This companion is to be used in conjunction with the X12 implementation guide. The implementation guides for all HIPAA transactions are available from Washington Publishing Company and are available electronically to download at www.wpc-edi.com/HIPAA.

This document will be subject to revisions as new versions of the X12 270-271 Health Care Eligibility Benefit Inquiry and Response Transaction Set Implementation Guides are released.

1.3. Intended Audience

The intended audience for this document is the technical area which is responsible for submitting electronic eligibility transactions to Carelon. In addition, this information should be communicated and coordinated with the information receiver in order to ensure the required eligibility information is provided to the inquiry submitter.

1.4. Contact Information

The purpose of this section is to provide contact information for any questions regarding HIPAA, 2700 transactions, EDI, EDI Gateway, documentation, and testing.

For general HIPAA questions relating to Carelon, you can get answers in one of the following ways:

1. From Carelon website at www.carelonbehavioralhealth.com. Go to the provider sections and click on "resources" and then on "HIPAA."
2. By contacting any of the following staff listed here by responsibility.

TYPE OF CONTACT	CONTACT	TELEPHONE NUMBER	EMAIL ADDRESS
General TCS	EDI Operations	781.994.7500	BH_EDI.Operations@carelon.com
Companion Documents	EDI Operations	781.994.7500	BH_EDI.Operations@carelon.com
Trading Partner Setup	EDI Operations	781.994.7500	BH_EDI.Operations@carelon.com
EDI Gateway	EDI Operations	781.994.7500	BH_EDI.Operations@carelon.com
270 Transactions and Testing	EDI Operations	781.994.7500	BH_EDI.Operations@carelon.com

Transaction Submission Procedures

- 2.1. Submission Methods
- 2.2. Setup/Certification Procedures
- 2.3. Testing
- 2.4. Technical Requirements

2.1. Submission Methods

Providers/trading partners will be able to submit 270 inquiry transactions using Carelon's online secure EDI Gateway. To use this EDI Gateway, you will need an Internet connection, a browser that supports 128-bit encryption, such as Internet Explorer 5.5 or higher.

2.2. Setup/Certification Process

1. If providers/trading partners already have an established EDI account with Carelon, they need to call the EDI department or mail the setup form indicating their interest in utilizing 270-271 transactions.
2. Providers/trading partners interested in submitted electronic eligibility benefit inquiry transactions must complete the following forms supplied by Carelon.
 - a. EDI Transactions/Billing Intermediary Authorization Form (Appendix A)
 - b. Trading Partner/EDI Gateway Setup Form (Appendix B)
3. These forms can be downloaded from Carelon's website at www.carelonbehavioralhealth.com or can be requested by contacting EDI Operations at Carelon.
4. The EDI Transactions/Billing Intermediary Authorization Form has to be completed by every providers who will be conducting EDI transactions with Carelon. This form is also utilized to authorize a billing intermediary if the provider utilizes on.
5. The Trading Partner/EDI Gateway Setup Form has to be completed by the technical person of the health care providers or the billing intermediary if applicable. This form is utilized to gather some trading partner technical information and to setup a Submitted ID on Carelon's EDI Gateway.
6. Complete both the forms and mail it to:

EDI Operations
Carelon Behavioral
Health 500 Unicorn
Park Drive Woburn,
MA 01801
7. Upon receipt of the EDI Transactions/Billing Intermediary Authorization Form, you will receive an acknowledgement letter from Carelon which will also include the site identification numbers for the provider to be utilized when billing electronically in the service facility location segment.
8. Once the Trading Partner/EDI Gateway Setup Form is received, EDI Operations will establish a test submitter ID and a folder (mailbox) on our EDI Gateway and notify the technical contact via regular mail.
9. A submitter ID is assigned to each trading partners, provider, or billing intermediary. You will utilize the submitter ID to create a login ID and password on the EDI Gateway. To access your folder (mailbox) to upload or download files, you have to login using the login ID. If there are multiple people who do the upload and download, you can create a login ID for each person utilizing the same submitter ID. This way there is a history of who uploaded or downloaded specific files. If a person with a login ID is no longer with the organization, the trading partner should notify EDI Operations at Carelon so we can deactivate that login ID.

10. Upon completion of successful testing, you will be notified of the same and you will be assigned a **new submitter ID for the production system** which should be used in all files submitted for production claims processing. The test Submitter ID should be used in all files submitted for testing.

2.3. Testing

Carelon requires testing for all providers/trading partners/submitters submitting the 270 transactions. Please follow the appropriate format specifications listed in the specific data requirements and submission directions. Test files have to be submitted utilizing the secure protocols and submission methodology selected.

Once a test Submitter ID is setup for a trading partners, the submitter can start sending inquiry transactions for testing. In order to test, it is imperative that a technical contact at the provider/submitter organization be established. This contact should have the ability to monitor, change, and submit the 270 transaction files to Carelon. This contact should be familiar with 270 transactions as well as possess a solid understanding of the technology used to create these files. During the testing process, Carelon will examine submitted transactions for required formats and elements and will get responses during the testing process. A Carelon EDI Operations staff will contact you via telephone with results of the most recent test, generally within a week of submission. This testing stage will continue until testing satisfaction is achieved in both sides.

Carelon's testing procedures will validate the test file in its entirety. The entire file will either pass or fail validation. Carelon does not allow partial file submissions. If the file fails validation, a failure report will be provided explaining the failure messages.

Upon the completion of successful testing, you will be notified of the same and you will be assigned a new submitter ID for the production system which should be used in all files submitted for production inquiry processing. The test Submitter ID should be used in all files submitted for testing.

2.4. Technical Requirements

During the testing of the 270 transactions, Carelon recommends that the files should contain a minimum of 10 inquiries and not exceed 100 inquiries in any one batch. File contents should simulate claims from normal business. Creating small files for testing provides for easier trouble shooting and recreation of the test file. Once your files have passed testing, you may send files of larger sizes.

Reports

The following sections list the reports that Carelon will provide and describes the process for retrieving these reports.

Providers/trading partners are responsible for downloading these reports from their mailbox when available. Providers/trading partners should have the capability of interpreting the 997 Acknowledgment Report and the 271 Response Transactions.

REPORT/FILE NUMBER	REPORT/FILE NAME	PURPOSE	SOURCE	TURNAROUND FROM TIME OF SUBMISSION
997	Functional Acknowledgement	This is a X12 file response report	Folder/ Mailbox	Day of submission
271	Eligibility Benefit Response Transaction	This is ASC X12N 271 report	Folder/ Mailbox	Within 24 hours of submission

FUNCTIONAL ACKNOWLEDGMENT REPORT (997)

File level summary indicating accepted and rejected transaction sets within a file. Please refer to the Implementation Guide for more details.

HEALTH CARE ELIGIBILITY BENEFIT RESPONSE TRANSACTIONS (271)

This is an inquiry level response to the 270 transaction submitted. The response file will contain Active, Inactive, or Not of File response for each inquiry. Information receives should have the capability to receive the 271 file. This guide lists elements that would be present in the 271 sent by Carelon. Please refer to the Implementation Guide for more details.

Note: Reports will be available to providers/trading partners via the EDI Gateway in the respective mailboxes. To access your mailbox, log in to the EDI Gateway and click on the “download files” link.

Considerations

- 4.1. Transactions Supported
- 4.2. Delimiters Supported
- 4.3. Search Options
- 4.4. Inquiry/Response Level Supported
- 4.5. Size/Maximum Limitations

4.1. Transactions Supported

INBOUND

Carelon will support and accept the following inbound transactions:

- 270 Health Care Eligibility Benefit Inquiry – ASC X12N 270 (004010X092A1)

OUTBOUND

Carelon will support and produce the following outbound transactions:

- 271 Health Care Eligibility Benefit Response – ASC X12N 271 (004010X092A1)
- 997 Functional Acknowledgment

4.2. Delimiters Supported

A delimiter is a character used to separate two data elements or sub elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separators is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transactions.

Carelon recommends utilizing the following default delimiters:

DESCRIPTION	DEFAULT DELIMITER
Data element separator	* (Asterisk)
Sub-element separator*	: (Colon)
Segment terminator	~ (Tilde)

Note: If the data contains any of the above delimiters, different delimiters can be utilized and specified in the ISA segment.

4.3. Search Options

The 270 transaction allows the receiver to provide whatever patient information they have on hand to identify them to an information source. The Implementation Guide defines a maximum data set that an information source may require, to identify the patient in the information source's system. Carelon requires the following elements to uniquely identify a member in their system.

REQUIRED SEARCH OPTIONS

If the patient is the subscriber, elements that are required to identify a patient in loop 2100C are:

- Patient's Member ID
- Patient's Date of Birth
- Patient's First Name

- Patient's Last Name

If the patient is a dependent of a subscriber, the data elements that are required to identify a patient in loop 2100C and 2100D are:

- Loop 2100C
Subscriber's Member ID
- Loop 2100D
Patient's First Name
Patient's Last Name
Patient's Date of Birth

Although not required, Patient's First Name and Last Name elements should be provided if available. They will assist in identifying the member, if a unique match is not found based on the Member ID and Date of Birth.

4.4. Inquiry/Response Level Supported

The 270/271 Health Care Eligibility Benefit Inquiry and Response transaction contains a super set of data segments, elements, and codes that represent its full functionality. Receivers of the 271 transactions need to design their systems to receive all of the data segments and data elements identified in the 271 transactions.

We support a generic request for eligibility and respond with either an acknowledgment that the individual has active or inactive coverage or that the individual was not found in their system. The response will be for the date the transaction is processed, unless a specific date is present in the DTP segment of the EQ loop. In the event that multiple matches are found in the database, Carelon will return the AAA segment used to indicate duplicates found.

4.5. Size/Maximum Limitations

Eligibility files submitted in "production" mode does not have any size limitations. Carelon will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope). Files will be processed in batch mode and the response file will be available within 24 hours of receipt.

The structure of the transaction is as follows:

Information Source

Information Receiver

Subscriber

Dependent (may be provided if the dependent does not have a unique identifier)

Eligibility Benefit (inquiry 270, or information 271)

Subscriber

Eligibility Benefit (inquiry 270, or information 271)

Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the Implementation Guide.

BATCH MODE

Carelon has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). Carelon requires that the Interchange Control structure is limited to one type of Functional Group, such as 270 Health Care Eligibility Benefit Inquiry Requests. Carelon will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope). Batch files will be processed and the response file will be available within 24 hours of receipt.

REAL-TIME MODE

At present, Carelon does not support real-time Eligibility Benefit Inquiry and Response transactions.

Specific Data Requirements

5.1. Health Care Eligibility Benefit Inquiry Transactions (270) Data Requirements

5.1. Health Care Eligibility Benefit Inquiry Transactions (270) Data Requirements

INTERCHANGE CONTROL AND FUNCTIONAL GROUP SPECIFICATIONS

General

This section outlines the specifications for the Interchange Control and Functional Group header and trailer information.

LOOP ID / SEGMENT	ELEMENT/DESCRIPTION	USAGE	REQ	COMMENTS	VALUES
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Headers

ISA	Interchange Control Header			Fixed record length segment	
	ISA01 – Authorization Info Qualifier		R	No Authorization Info Present	00
	ISA02 – Authorization Information		R	10 spaces	
	ISA03 – Security Information Qualifier		R		00
	ISA04 – Security Information		R	10 spaces	
	ISA05 – Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA06 – Interchange Sender ID		R	Submitter ID Provided by Carelton	
	ISA07 – Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA08 – Interchange Receiver ID		R	Use “BEACON963116116”	
	ISA09 – Interchange Date		R	Format YYMMDD	
	ISA10 – Interchange Time		R	Format HHMM	
	ISA11 – Interchange Control Standards ID		R		U
	ISA12 – Interchange Version Number		R		00401
	ISA13 – Interchange Control Number		R	Assigned by sender. Must equal IEA02	
	ISA14 – Acknowledgement Required		R		0

LOOP ID / SEGMENT	ELEMENT/DESCRIPTION	USAGE	REQ	COMMENTS	VALUES
	ISA15 – Usage Indicator		R	“T” for testing, “P” for production	
	ISA16 – Component Element Separator		R		:
GS	Functional Group Header		R		
	GS01 – Functional ID Code		R		HS
	GS02 – Application Sender's Code		R	Submitter ID Provided by Carelon	
	GS03 – Application Receiver's Code		R	Use “BEACON963116116”	
	GS04 – Date		R	Format CCYYMMDD	
	GS05 – Time		R	Format HHMM	
	GS06 – Group Control Number		R	Assigned by sender. Must equal GE02	
	GS07 – Responsible Agency Code		R		X
	GS08 – Version/Release		R	“004010X092A1”	

Trailers

GE	Functional Group Trailer		R		
	GE01 – Number of Transaction Sets		R		
	GE02 – Group Number Control		R	Same as GS06	
IEA	Interchange Group Trailer		R		
	IEA 01 – Number of Functional Groups		R		
	IEA 02 – Interchange Control Number		R	Same as ISA13	

ELIGIBILITY BENEFIT INQUIRY TRANSACTIONS

General

The purpose of this section is to clarify the data elements and segments that must be used for eligibility benefit inquiry transactions. The following information is designed to help you complete the 270 transaction.

Detail Data

ST	Transaction Set Header	1	R		
	ST01 - Transaction set ID code		R	This element should be hard coded when submitting the inquiry.	270
	ST02 - Transaction set control number		R	Assigned by sender. Must equal SE02	
BHT	Beginning of HL Transaction	1	R		
	BHT01 - Hierarchical Structure Code		R	0022 – Information Source, Information Receiver, Subscriber, dependent	0022
	BHT02 - Transaction Set Purpose Code		R	“01” – Cancellation “13” – Request “36” – Authority to deduct	0
	BHT03 - Reference ID		R	This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. Assigned by Sender.	X
	BHT04 - Date		R	File creation date. Format CCYYMMDD	
	BHT05 - Time		R	File creation time. Format HHMM	
LOOP 2100A	Information Source Level	1	R		
NM1	Information Source Name		R		
	NM101 – Entity Identifier Code		R	Allowed Values – “2B” Third-Party Administrator “36” Employer “GP” Gateway Provider “P5” Plan Sponsor “PR” Payer	PR
	NM102 – Entity Type Qualifier		R	Allowed Values - “1” for person, “2” for non-	2

				person	
	NM103 – Last Name/Org Name		R	Use “Carelton”	Carelton
	NM108 – ID Code Qualifier		R	Allowed Values - “24” Employers’ Identification Number “46” Electronic Transmitter Identification Number “FI” Federal Taxpayer’s ID Number “NI” National Association of Insurance Commissioners (NAIC) Identification “PI” Payer Identification “PP” Pharmacy Processor Number “XV” Health Care Financing Administration National Plan ID (Required if mandated) “XX” Health Care Financing Administration National Provider ID (Required if mandated)	PI
	NM109 – ID Code		R	Use “BEACON963116116”	“BHS-963116116”
LOOP 2100B	Information Receiver Level	>1			
	NM101 – Entity ID Code		R	Allowed Values – 1P – Provider 2B – Third-Party Administer 36 – Employer 80 – Hospital FA – Facility GP – Gateway provider P5 – Plan Sponsor PR – Payer	1P
	NM102 – Entity Type Qualifier		R	Allowed Values – “1” for person, “2” for non-person	
	NM103 – Last Name/Org Name		R	Last Name of Provider or Organization Name	

	NM104 – Name First		S	Required if NM102 is 1	
	NM105 – Name Middle		S	Required if NM102 is 1	
	NM107 – Name Suffix		S	Required if NM102 is 1	
	NM108 – ID Code Qualifier		R	Allowed Values - 24 – Employer’s Identification Number 34 – Social Security Number FI – Federal Taxpayer’s Identification Number PI – Payer Identification Number PP – Pharmacy Process Number SV – Service Provider Number XV – Health Care Financing Admin Nat’l Plan ID (required if Nat’l Plan ID is mandated for use) XX – Health Care Financing Admin. Nat’l Provider Identifier (requires value if Nat’l Provider is mandated for use)	SV
	NM109 – ID Code		R	Carelon Provider ID	
LOOP 2100C	Subscriber Level	>1			
NM1	Subscriber Name		R		
	NM103 – Subscriber Last Name		S	Use this name if the subscriber is the patient	
	NM104 – Subscriber First Name		S	Use this name if the subscriber is the patient	
	NM108 – ID Code Identifier		R	Allowed Values - “MI” Member Identification Number “ZZ” Mutually Defined	MI
	NM109 – ID Code		R	Use Member ID from membership card	
DMG	Subscriber Demographic Information		S		

	DMG01 – Date Time Period Format Qualifier		R	Date Express “CCYYMMDD” – D8	D8
	DMG02 – Date Time Period		R	Subscriber’s Date of Birth	
	DMG03 – Gender Code		S	Subscriber’s Gender M-Male F-Female	
DTP	Subscriber Date		S	Use this segment to convey the eligibility date(s) for the subscriber. If sent, Carelon will use this to verify eligibility	
	DTP01 – Date Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 472 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD” RD8	
	DTP03 – Date Time Period		R	Date/Date Range in Inquiry	
LOOP 2110C	Subscriber Eligibility Benefit Inquiry Information	>1	S		
EQ	Eligibility Benefit Inquiry Information		S	Use the EQ loop/segment when the subscriber is the patient whose eligibility or benefits are being verified. When the subscriber is not the patient, this loop must not be used.	
	EQ01 – Service Type Code		S	“30” – Health Benefit Plan Coverage Carelon treats all inquiries as Service Type Code	30
DTP	Subscriber Eligibility/Benefit Date		S	Use this segment to convey the eligibility for the information contained in the corresponding EQ segment. This segment is only to be	

				used to override dates provided in loop 2100C. If this segment is sent, Carelon will verify eligibility for the date specified.	
	DTP01 – Date/Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 473 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD” RD8	
	DTP03 – Date Time Period		R	Date/Date Range in Inquiry	
LOOP 2100D	Dependent Level	>1			
Loop 2100D	Dependent Name		S	Will be present only if the patient is a dependent of a member and cannot be uniquely identified without the member’s information in the Subscriber Level.	
	NM101 – Entity ID Code		R	“03” – Dependent	03
	NM102 – Entity Type Qualifier		R	Allowed Values - “1” for person, “2” for non-person	1
	NM103 – Last Name/Org Name		R	Use this name if Dependent is the patient	
	NM104 – Name First		S	Use this name if Dependent is the patient	
	NM108 – ID Code Identifier		R	Allowed Values - “MI” Member Identification Number “ZZ” Mutually Defined	MI
	NM109 – ID Code		R	Use Member ID from membership card	

DMG	Dependent Demographic Information		R	Use this segment when needed to convey date of birth, gender information for the dependent.	
	DMG01 – Date Time Period Format		S	Date Express “CCYYMMDD” – D8	
	DMG02 – Date Time		S	Dependent’s Date of Birth	
	DMG03 – Gender		S	Dependent’s Gender M-Male F-Female	
LOOP 2110D	Dependent Eligibility Benefit Inquiry Information	>1	R	Use the EQ loop/segment when the Dependent is the patient whose eligibility is being verified. When the Dependent is not the patient, this loop must not be used.	
EQ	Dependent Eligibility or Benefit Inquiry		S		
	EQ01 – Service Type Code			“30” – Health Benefit Plan Coverage Carelton treats all inquiries as Service Type Code	
DTP	Subscriber Eligibility/Benefit Date		S	Use this segment to convey the eligibility for the information contained in the corresponding EQ segment. This segment is only to be used to override dates provided in loop 2100C. If this segment is sent, Carelon will verify eligibility for the date specified.	
	DTP01 – Date/Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 473 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD”	

				RD8	
	DTP03 – Date Time Period		R	Date/Date Range in Inquiry	

5.2. Health Care Eligibility Benefit Response Transactions (271) Data Requirements

INTERCHANGE CONTROL AND FUNCTIONAL GROUP SPECIFICATIONS

General

This section outlines the specifications for the Interchange Control and Functional Group header and trailer information.

LOOP ID / SEGMENT	ELEMENT/DESCRIPTION	USAGE	REQ	COMMENTS	VALUES
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Headers

ISA	Interchange Control Header			Fixed record length segment	
	ISA01 – Authorization Info Qualifier		R	No Authorization Info Present	00
	ISA02 – Authorization Information		R	10 spaces	
	ISA03 – Security Info Qualifier		R		00
	ISA04 – Security Information		R	10 spaces	
	ISA05 – Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA06 – Interchange Sender ID		R	“BEACON963116116”	
	ISA07 – Interchange ID Qualifier		R	Mutually Defined	ZZ
	ISA08 – Interchange Receiver ID		R	Carelon will use the Interchange ID Qualifier sent in the status request (ISA06)	
	ISA09 – Interchange Date		R	Format YYMMDD	
	ISA10 – Interchange Time		R	Format HHMM	
	ISA11 – Interchange Control Standards ID		R		U

LOOP ID / SEGMENT	ELEMENT/DESCRIPTION	USAGE	REQ	COMMENTS	VALUES
	ISA12 – Interchange Version Number		R		00401
	ISA13 – Interchange Control Number		R	Assigned by sender. Must equal IEA02	
	ISA14 – Acknowledgement Required		R		0
	ISA15 – Usage Indicator		R	“T” for testing, “P” for production	
	ISA16 – Component Element Separator		R		:
GS	Functional Group Header		R		
	GS01 – Functional ID Code		R	Code identifying a group of application related transaction sets. Valid value: “HB” Eligibility, Coverage, or Benefit Information (271)	HB
	GS02 – Application Sender's Code		R	Use “BEACON963116116”	
	GS03 – Application Receiver's Code		R	Submitted ID provided by Carelon	
	GS04 – Date		R	Format CCYYMMDD	
	GS05 – Time		R	Format HHMM	
	GS06 – Group Control Number		R	Assigned by sender. Must equal GE02	
	GS07 – Responsible Agency Code		R		X
	GS08 – Version/Release		R	“004010X092A1”	

Trailers

GE	Functional Group Trailer		R		
	GE01 – Number of Transaction Sets		R		
	GE02 – Group Number Control		R	Same as GS06	
IEA	Interchange Group Trailer		R		

LOOP ID / SEGMENT	ELEMENT/DESCRIPTION	USAGE	REQ	COMMENTS	VALUES
	IEA 01 – Number of Functional Groups		R		
	IEA 02 – Interchange Control Number		R	Same as ISA13	

ELIGIBILITY BENEFIT RESPONSE TRANSACTIONS

General

The purpose of this section is to clarify the data elements and segments that must be used for eligibility benefit response transactions. The following information is designed to help you complete the 271 transaction.

Detail Data

ST	Transaction Set Header	1	R		
	ST01 - Transaction set ID code		R	This element should be hard coded when submitting the inquiry.	270
	ST02 - Transaction set control number		R	Assigned by sender. Must equal SE02	
BHT	Beginning of HL Transaction	1	R		
	BHT01 - Hierarchical Structure Code		R	0022 – Information Source, Information Receiver, Subscriber, dependent	0022
	BHT02 - Transaction Set Purpose Code		R	“11” – Response	11
	BHT03 - Reference ID		R	This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. Assigned by Sender. Carelon will use the Submitter Transaction Identifier received in the 270 Eligibility Benefit Inquiry Transaction for real-time transactions.	
	BHT04 - Date		R	File creation date. Format CCYYMMDD	

	BHT05 - Time		R	File creation time. Format HHMM	
LOOP 2100A	Information Source Level	1	R		
NM1	Information Source Name		R		
	NM101 – Entity Identifier Code		R	Allowed Values – “2B” Third-Party Administrator “36” Employer “GP” Gateway Provider “P5” Plan Sponsor “PR” Payer	PR
	NM102 – Entity Type Qualifier		R	Allowed Values - “1” for person, “2” for non-person	2
	NM103 – Last Name/Org Name		R	Use “Carelon”	
	NM108 – ID Code Qualifier		R	Allowed Values - “24” Employers’ Identification Number “46” Electronic Transmitter Identification Number “FI” Federal Taxpayer’s ID Number “NI” National Association of Insurance Commissioners (NAIC) Identification “PI” Payer Identification “PP” Pharmacy Processor Number “XV” Health Care Financing Administration National Plan ID (Required if mandated) “XX” Health Care Financing Administration National Provider ID (Required if mandated)	PI
	NM109 – ID Code		R	Use “BEACON963116116”	
LOOP 2100B	Information Receiver Level	1			
NM1	Information Receiver Name	1	R		

	NM101 – Entity ID Code		R	Allowed Values – 1P – Provider 2B – Third-Party Administer 36 – Employer 80 – Hospital FA – Facility GP – Gateway provider P5 – Plan Sponsor PR – Payer	1P
	NM102 – Entity Type Qualifier		R	Allowed Values – “1” for person, “2” for non-person	
	NM103 – Last Name/Org Name		R	Last Name of Provider or Organization Name	
	NM104 – Name First		S	Required if NM102 is 1	
	NM105 – Name Middle		S	Required if NM102 is 1	
	NM107 – Name Suffix		S	Required if NM102 is 1	
	NM108 – ID Code Qualifier		R	Allowed Values - 24 – Employer’s Identification Number 34 – Social Security Number FI – Federal Taxpayer’s Identification Number PI – Payer Identification PP – Pharmacy Process Number SV – Service Provider Number XV – Health Care Financing Admin Nat’l Plan ID (required if Nat’l Plan ID is mandated for use) XX – Health Care Financing Admin. Nat’l Provider Identifier (requires value if Nat’l Provider is mandated for use)	SV
	NM109 – ID Code		R	Carelon Provider ID	
LOOP 2100C	Subscriber Level	>1			
TRN	Subscriber Trace Information		S	Use this segment to convey a unique trace or reference	

				number.	
	TRN01 – Trace Type Code		R	Valid Values – “1” Current Transaction Trace Numbers “2” Referenced Transaction Trace Numbers If any trace numbers were received in the 270, Carelon will use “2”	
	TRN02 – Trace Number		R	Carelon will use the Trace Number(s) received in the 270	
	TRN03 – Trace Assigning Entity Identifier		R	Carelon will use the Trace Assigning Entity Identifier received in the 270	
	TRN04 – Trace Assigning Entity Additional Identifier		S	Carelon will use the Trace Assigning Entity Additional Identifier received in the 270	
NM1	Subscriber Name		R		
	NM103 – Subscriber Last Name		S	Carelon will use the Subscriber’s Last Name from the eligibility file	
	NM104 – Subscriber First Name		S	Carelon will use the Subscriber’s First Name from the eligibility file	
	NM105 – Subscriber Middle Name		S	Carelon will use the Subscriber’s Middle Name from the eligibility file	
	NM108 – ID Code Identifier		R	Allowed Values - “MI” Member Identification Number “ZZ” Mutually Defined	MI
	NM109 – ID Code		R	Use Member ID from membership card Carelon will use the Subscriber’s ID from the eligibility file	
DMG	Subscriber Demographic Information		S	Use only if the subscriber is the patient and if the	

				information is available in the database	
	DMG01 – Date Time Period Format Qualifier		S	Date Express “CCYYMMDD” – D8	D8
	DMG02 – Date Time Period		S	Subscriber’s Date of Birth from the eligibility file	
	DMG03 – Gender Code		S	Subscriber’s Gender M-Male F-Female Subscriber’s Gender from the eligibility file	
DTP	Subscriber Date		S	Use this segment to convey the eligibility date(s) for the subscriber.	
	DTP01 – Date Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 472 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	D6 Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD” RD8	D8
	DTP03 – Date Time Period		R	Carelon will use the Eligibility Date form the eligibility file	
LOOP 2110C	Subscriber Eligibility or Benefit Information	>1	R		
EB	Subscriber Eligibility or Benefit Information		S	This segment is required if the subscriber is the person whose eligibility or benefits are being described	
	EB01 – Eligibility or Benefit Information		R	The minimum data for a HIPAA-compliant response for a person that has been located is 1-Active Coverage or 6-Inactive	
	EB03 – Service Type Code		S	Carelon will use “30” Health Benefit Plan Coverage	

DTP	Subscriber Eligibility/Benefit Date		S	Use this segment to convey the eligibility for the information contained in the corresponding EB segment.	
	DTP01 – Date/Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 473 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	D6 Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD” RD8 If date range is submitted, eligibility is checked for the First Date	
	DTP03 – Date Time Period		R	Carelon will use the Eligibility Date from the eligibility file	
LOOP 2100D	Dependent Level	>1	S		
TRN	Subscriber Trace Information		S	Use this segment to convey a unique trace or reference number.	
	TRN01 – Trace Type Code		R	Valid Values – “1” Current Transaction Trace Numbers “2” Referenced Transaction Trace Numbers If any trace numbers were received in the 270, Carelon will use “2”	
	TRN02 – Trace Number		R	Carelon will use the Trace Number(s) received in the 270	
	TRN03 – Trace Assigning Entity Identifier		R	Carelon will use the Trace Assigning Entity Identifier received in the 270	
	TRN04 – Trace Assigning Entity Additional Identifier		S	Carelon will use the Trace Assigning Entity Additional Identifier received in the 270	

LOOP 2100D	Dependent Name	1	S	Will be present only if the patient is a dependent of a member and cannot be uniquely identified without the member's information in the Subscriber Level.	
	NM101 – Entity ID Code		R	"03" – Dependent	03
	NM102 – Entity Type Qualifier		R	Allowed Values - "1" for person, "2" for non-person	1
	NM103 – Last Name/Org Name		R	Carelon will use the Patient's Last Name from the eligibility file	
	NM104 – Name First		S	Carelon will use the Patient's First Name from the eligibility file	
DMG	Dependent Demographic Information		S	Use only if Dependent is the patient if the information is available in the database	
	DMG01 – Date Time Period Format Qualifier		S	Date Express "CCYYMMDD" – D8	D8
	DMG02 – Date Time Period		S	Dependent's Date of Birth from the eligibility file	
	DMG03 – Gender Code		S	Dependent's Gender from the eligibility file Allowed values - M-Male F-Female	
DTP	Dependent Date		S	Use this segment to convey the eligibility date(s) for the Dependent.	
	DTP01 – Date/Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 473 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	Date Expressed "CCYYMMDD" – D8	D8

	DTP03 – Date Time Period		R	Carelon will use the Eligibility Date from the eligibility file	
LOOP 2110D	Dependent Eligibility Benefit Response Information	>1	S		
EB	Dependent Eligibility Benefit Response Information		S	This segment is required if the dependent is the person whose eligibility is being described	
	EB01 – Eligibility or Benefit Information		R	The minimum data for a HIPAA-compliant response for a person has been located is 1-Active Coverage or 6-Inactive	
	EB03 – Service Type Code		S	Carelon will use “30” Health Benefit Plan Coverage	
DTP	Dependent Eligibility/Benefit Date		S	Use this segment to convey the eligibility information contained in the corresponding EQ segment.	
	DTP01 – Date/Time Qualifier		R	Allowed Values - 307 – Eligibility 435 – Admission 473 – Services	307
	DTP02 – Date Time Period Format Qualifier		R	D^ Date Expressed “CCYYMMDD” – D8 Range of Dates Expressed “CCYYMMDDCCYYMMDD” RD8 If date range is submitted, eligibility is checked for the First Date.	
	DTP03 – Date Time Period		R	Carelon will use the Eligibility Date from their eligibility file	

PURPOSE

- This application is for a health care provider, business associate or vendor to establish a trading partner relationship with Carelon Behavioral Health (Carelon) to conduct electronic data interchange (EDI) transactions.
- This form is also utilized by the health care provider to authorize a billing intermediary (billing service/clearing house) to submit claims via the EDI transactions to Carelon on the health care provider's behalf.

TERMS OF USE:

1. Responsibilities and Obligations:

- A. Carelon is making EDI services available to you as a contracted health care provider who has rendered services to the members of the health plans Carelon provides behavioral health services or as a business associate or vendor to conduct business with Carelon. In using this service, you may be allowed access to certain confidential or individually identifiable protected health information (hereinafter "Protected Health Information") which you agree to take certain precautions, comply with certain practices, and implement certain procedures required by HIPAA regulations, applicable laws and Carelon for the purposes of guarding data integrity and safeguarding the confidentiality of Protected Health Information.
- B. The required edits, minimum submission standards, the Trading Partner/EDI Gateway Setup form must be fulfilled and maintained by all providers and billing agencies submitting EDI transactions to Carelon.
- C. The trading partner agrees that the transactions will be performed in accordance to all federal and state regulations.
- D. The trading partner certifies that an exact copy of the EDI transactions submitted to Carelon will be held by the originator at least for a period of 90 days or until the submission has been finalized as to reimbursement or rejection in the case of claims (whichever period of time is less)
- E. The contracted health care provider agrees to comply with any laws, rules and regulations governing the Carelon's Behavioral Health program and agrees to accept, as payment for claims in full the amounts paid in accordance with the fee schedules provided for under Carelon's Behavioral Health program.
- F. The health care provider agrees to keep any records necessary to disclose fully the extent of services furnished to recipients for which payment is claimed as outlined in the provider's Provider Services Agreement with Carelon, and on request, furnish to Carelon any information regarding payments claimed by the provider for furnishing services under the Carelon Behavioral Health program.
- G. The individual provider is ultimately responsible for accuracy and valid reporting of all claims transactions submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with the HIPAA Regulations and all policies stated by Carelon.
- H. All information supplied by Carelon or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.
- I. You agree to use Protected Health Information for claims administration purposes only, consistent with applicable laws.
- J. You agree not to use or further disclose Protected Health Information in a manner that, if undertaken by Carelon, would violate the requirements of the HIPAA Regulations.
- K. You agree to not use or further disclose protected health information other than as permitted or required by this Agreement. You agree to use appropriate safeguards to prevent any use or disclosure of Protected Health Information that is not permitted under applicable law.
- L. You acknowledge that you are acting as an independent contractor, and you are not an agent of Carelon and have no authority to represent Carelon as to any matters.

2. Changes, Updates, Governing Law

These terms of use may change from time to time, and changes will be on the EDI Gateway so that you will always be aware of our terms of use. By continuing to conduct EDI transactions described above after changes have been made to these terms of use, you are agreeing to accept these changes. You may not amend or modify these terms of use without prior written agreement from Carelon. The laws of the Commonwealth of Massachusetts shall govern these terms of use. You agree to submit to the exclusive jurisdiction of the courts in the Commonwealth of Massachusetts and waive any jurisdictional venue or inconvenient forum objections to such court.

3. Termination

Carelon may terminate these terms of use, any rights granted to you hereunder and your access to this web site at any time, with or without cause, without notice and without penalty.

4. Unauthorized Use/Misuse

Unauthorized use or misuse of EDI transactions (for fraudulent, malicious and/or deceptive purposes) may constitute crimes or torts under state or federal law. Any such violations will be pursued and prosecuted to the fullest extent permitted by law.



Carelon Behavioral Health
500 Unicorn Park Drive, Woburn, MA

EDI Transactions / Billing Intermediary Authorization

A. PROVIDER / TRADING PARTNER INFORMATION: Please complete all applicable questions

Carelon Provider ID:	_____	Tax ID:	___
Organization Name:	_____		
Address:	_____		
City:	_____	State:	_____
Zip:	_____		
Contract Contact:	_____	Title:	_____
Telephone:	_____	Fax:	_____
Email:	_____		

B. TRANSACTIONS: Check all that apply

1. Type of Transactions:	
_____ 837P	Health Care Claim – Professional
_____ 837I	Health Care Claim – Institutional
_____ 835	Health Care Claim Payment/Remittance Advice
_____ 276/277	Health Care Claim Status Request and Response
_____ 270/271	Health Care Eligibility/Benefit Inquiry and Information Response
_____ 278	Health Care Services Review – Request for Review and Response
_____ Other (Explain)	_____
2. Health Care Claims Submission Method: _____ Direct _____ Billing Service/Clearing House _____ Not Applicable	

C. TECHNICAL / BILLING INTERMEDIARY CONTACT INFORMATION:

Technical Contact:	_____	Title:	_____
Billing Service	_____	Name:	_____
_____	Address:	_____	
City:	_____	State:	_____
Zip:	_____		
Telephone:	_____	Fax:	_____
Email:	_____		

D. CERTIFICATION: To be completed by the Executive Director/Contract Contact of Provider, Business Associate or vendor.

<ul style="list-style-type: none">• The undersigned hereby authorizes the Billing Agency listed in Section C to submit claims to Carelon on my/our behalf in accordance with the applicable Carelon billing procedures. (if applicable)• The undersigned has read and accepts the ‘Terms of Use’.	
Signature:	_____
Date:	_____
Name:	_____ (Please print)
Title:	_____ (Please print)
Phone:	_____
Fax:	_____
Email:	_____



Carelon Behavioral Health
500 Unicorn Park Drive, Woburn, MA

Trading Partner / EDI Gateway Setup Form

PURPOSE

- This application is for collecting technical information to establish a trading partner account with Carelon Behavioral Health (Carelon) to conduct EDI transactions.
- This application is also for the trading partner to obtain a submitter identification number and password for using the EDI Gateway available at <https://bhsedi.Carelonhs.com>.

TERMS OF USE

Introduction

Carelon is making the services on the EDI Gateway available to you as an authorized representative ("User" or "You") of a health care provider, business associate or vendor who has rendered services to the members of the health plans Carelon provides behavioral health services. In using this service, you may be allowed access to certain confidential or individually identifiable protected health information (hereinafter "Protected Health Information"). In exchange for such access, you agree to take certain precautions, comply with certain practices, and implement certain procedures required by applicable law and Carelon for the purposes of guarding data integrity and safeguarding the confidentiality of Protected Health Information, all as more specifically described below.

User's Responsibilities and Obligations

- By registering herein, you agree that you have the legal authority, right and ability to agree to these "EDI Gateway" terms of use and that you will use bhsedi.Carelonhs.com in a manner consistent with the terms of use. You represent that you have the right to access information about the health plan members as the treating provider or his/her designee. You further agree that you will comply with all applicable laws and regulations and that you will maintain the confidentiality of any information you access through this website. You agree that you will protect the integrity, confidentiality and availability of all electronically transmitted or electronically maintained protected health information exchanged through this website as required by any applicable laws or regulations.
- The required edits, minimum submission standards, the EDI Transactions / Billing Intermediary Authorization form must be fulfilled and maintained by all providers and billing agencies submitting EDI transactions to Carelon.
- The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Carelon.
- You agree to use Protected Health Information for claims administration purposes only, consistent with applicable laws.
- You agree not to use or further disclose Protected Health Information in a manner that, if undertaken by Carelon, would violate the requirements of the HIPAA Privacy Regulations.
- You agree to not use or further disclose protected health information other than as permitted or required by this Agreement. You agree to use appropriate safeguards to prevent any use or disclosure of Protected Health Information that is not permitted under applicable law.
- Your user name and password are intended to protect your privacy and the protected health information of the health plan's members and yourself. You are responsible for keeping your user name and password confidential and you hereby agree that you will not disclose your user name or password to others. You agree that you will be solely responsible for all activity or transactions that are tracked to your user name and password through this web site.
- You acknowledge that you are acting as an independent contractor, and you are not an agent of Carelon and have no authority to represent Carelon as to any matters.

Changes, Updates, Governing Law

These terms of use may change from time to time, and changes will be posted here so that you will always be aware of our terms of use. By using the "EDI Gateway" at bhsedi.Carelonhs.com or doing any of the activities described above after changes have been made to these terms of use, you are agreeing to accept these changes. You may not amend or modify these terms of use without prior written agreement from Carelon. The laws of the Commonwealth of Massachusetts shall govern these terms of use. You agree to submit to the exclusive jurisdiction of the courts in the Commonwealth of Massachusetts and waive any jurisdictional venue or inconvenient forum objections to such court.

Termination

Carelon may terminate these terms of use, any rights granted to you hereunder and your access to this web site at any time, with or without cause, without notice and without penalty. It is the contracted provider's responsibility to inform Carelon of any changes in employee status of staff members who have a submitter ID and password.

Unauthorized Use/Misuse

Unauthorized entry (commonly referred to as hacking) into any portion of bhsedi.Carelonhs.com, or misuse (for fraudulent, malicious and/or deceptive purposes) may constitute crimes or torts under state or federal law. Any such violations will be pursued and prosecuted to the fullest extent permitted by law.



Carelon Behavioral Health
500 Unicorn Park Drive, Woburn, MA

Trading Partner / EDI Gateway Setup Form

A. TRADING PARTNER INFORMATION:

Organization	Name: _____
Address: _____	
City: _____ State: _____	
Zip: _____	Carelon Provider ID: _____
(if applicable)	
Technical Contact: _____	Title: _____
Telephone: _____	Fax: _____
Email: _____	

B. TECHNICAL INFORMATION: Check all that apply

1. Submission Method:	_____ Carelon EDI Gateway _____ Magnetic Media (will require Transmittal & Authorizing Signature Forms)
2. Types of Transactions:	
_____ 837P	Health Care Claim – Professional v4010
_____ 837I	Health Care Claim – Institutional
_____ 835	Health Care Claim Payment/Remittance Advice
_____ 276/277	Health Care Claim Status Request and Response
_____ 270/271	Health Care Eligibility/Benefit Inquiry and Information Response
_____ 278	Health Care Services Review – Request for Review and Response
_____ Other (Explain)	_____
3. Acknowledgment Required:	_____ Receiver ID: _____
4. Practice Management System:	_____

C. CERTIFICATION: To be completed by person having signature authority

The undersigned has read and accepts the 'Terms of Use'.	
Signature: _____	Date: _____
Name: _____	(Please print)
Title: _____	(Please print)
Phone: _____	Fax: _____
Email: _____	

For Carelon Use only:

Date Application Received: _____	Staff: _____		
File Naming Convention: _____			
Test Environment:			
Submitter ID	Date activated	Date Notified	Staff
_____	_____	_____	_____
Production Environment:			
Submitter ID	Date activated	Date Notified	Staff
_____	_____	_____	_____
Notes: _____			
