MEDICARE PLATINO CONTRACT

APPENDIX K (22)

INFORMATION DATA PROCESSES AND DATA EXCHANGE LAYOUT

You can get this notice in English, or in another way that's best for you. Call us at **1-787-641-4224** (TTY: 1-787-625-6955).
Usted puede obtener esta notificación en inglés, o en otro formato que sea mejor para usted. Llámenos al **1-787-641-4224** (TTY: 1-787-625-6955).

Número de caso: 32858
Fecha de la carta: 25 de mayo de 2021

Jerry Rosas Mcquire
737 Main Street
San Juan, PR 00901

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Notificación de Decisión - Solicitud de Beneficios Médicos

Procesamos su solicitud y determinamos la elegibilidad para los solicitantes que se muestran a continuación en el Resumen de Decisiones de Elegibilidad. Después del resumen encontrará detalles de los resultados de elegibilidad que pueden continuar en páginas adicionales. Asegúrese de leer ambos lados de cada página.

Resumen de Decisiones de Elegibilidad

Nombre	MPI	Elegibilidad	Fecha de Efectividad	Fecha de Vencimiento
Rosas Mcquire, Jerry	96000002846	Medicaid	1 de mayo de 2021	30 de septiembre de 2021

Nombre	MPI	Código Cubierta	Tope de Copagos	MCO/ MAO
Rosas Mcquire, Jerry	96000002846	100	0.00	MEN

MCO	FMH = First Medical Health Plan, MEN = Plan de Salud Menonita, MMH = MMM Multi Health, MOL = Molina Health Care, TSS = Triple-S Salud
MAO	HUM = Humana Health Plans, MCS = MCS Advantage, MMM = Medicare y Mucho Mas, TSA = Triple-S Advantage

Cómo Tomamos Nuestras Decisiones de Elegibilidad

Utilizando la información proporcionada en su solicitud, determinamos el tamaño del núcleo familiar y los ingresos de cada persona que se muestra en el Resumen de Decisiones de Elegibilidad. Se utilizo la información de cada persona con el propósito de corroborar si cumplía con los criterios para los programas de cubierta de salud y se determino a qué categoría pertenecen. Los ingresos fueron verificados para determinar si estaban dentro de los límites de la categoría correspondiente con los siguientes resultados:

Debido a la actual emergencia de salud pública, Rosas Mcquire, Jerry: determinamos que el tamaño de su núcleo familiar "Medicaid" es 1 y su ingreso "Medicaid" es $0.00 por mes. El límite de ingresos "Medicaid" para este tamaño de núcleo familiar es $1,247.00 por mes, por lo tanto, Jerry es elegible para la cubierta "Medicaid" desde 1 de mayo de 2021 a 30 de septiembre de 2021. Para copagos, contamos el tamaño de su núcleo familiar MAGI de 1 y un ingreso MAGI de $0.00 por mes, lo que resulta en un código de cubierta de 100

Uso de Su Cubierta de Beneficios Médicos

El/Los individuo(s) mostrado(s) anteriormente como elegible(s) puede(n) recibir servicios de salud de los proveedores de servicios médicos que acepten el plan de la compañía de seguros (MCO o MAO) bajo el cual está cubierto. La aseguradora le proveerá un Manual de Beneficiario donde explica en detalle cómo acceder a los servicios médicos.

El/Los nuevo(s) beneficiario(s) recibirá(n) de su compañía aseguradora una tarjeta de identificación para cada beneficiario. Mientras espera su tarjeta de identificación, cada persona puede acceder a servicios de salud utilizando su MPI, como se muestra arriba en el Resumen de Decisiones de Elegibilidad, o mostrándole al proveedor de servicios médicos una copia de esta notificación.

Si esta notificación es el resultado de una reevaluación debido a un cambio notificado que afecte su cubierta de beneficios, el/los beneficiario(s) recibirá(n) una nueva tarjeta de identificación.

Servicios y Costos de Salud

Los beneficiarios elegibles pueden obtener servicios de salud a través de sus compañías de seguros, como visitas al médico, atención hospitalaria y recetas médicas. No se deben pagar primas (costos mensuales) por esta cobertura de salud. Usted puede tener copagos para algunos servicios. Pero hay un límite a los posibles costos cada trimestre para aquellas personas elegibles bajo Medicaid o CHIP. La cantidad que cada persona puede pagar por copagos y el límite de costos trimestrales dependen del tamaño del núcleo familiar y de los ingresos calculados para determinar la elegibilidad de la persona. Hay más detalles sobre copagos y los topes de copago al final de esta sección. La compañía de seguros enviará para cada persona información más detallada sobre los servicios de salud y copagos.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

Llámenos al **1-787-641-4224** (TTY: 1-787-625-6955). Puede llamar de lunes a viernes, de 8:00 am a 4:00 pm. O acceda a **www.medicaid.pr.gov.** Si necesita asistencia adicional favor de acudir a la oficina de Medicaid de su preferencia.

Si no está de acuerdo con las decisiones reportadas en esta notificación, como el cálculo del tamaño del núcleo familiar o los ingresos de cualquier persona en esta notificación y cree que afecta la elegibilidad o el nivel de copagos, puede apelar. Consulte la sección al final de esta notificación para obtener más información sobre el proceso y los plazos para las apelaciones.

Copagos: Los copagos que se pueden cobrar por los servicios se basan en el ingreso MAGI y el tamaño del núcleo familiar MAGI para cualquier persona elegible como Medicaid o CHIP. Para cualquier persona elegible bajo el Programa Estatal, los cálculos se basan en los cálculos del Programa Estatal de ingreso y tamaño del núcleo familiar.

Tope de Copagos: (1) las regulaciones federales establecen que las personas elegibles para Medicaid o CHIP tienen un tope en los copagos totales que están obligados a hacer. (2) El límite es del 5% por trimestre, basado en el Ingreso MAGI tamaño del núcleo familiar MAGI del Individuo y para alcanzar el tope, los copagos pagados durante un trimestre por cada beneficiario en el núcleo familiar del Individuo que es Medicaid o CHIP se suman. Los trimestres se determinan a partir de la fecha de elegibilidad inicial del individuo. (3) Si, en el transcurso de un período de elegibilidad para Medicaid o CHIP, un beneficiario de Medicaid o CHIP cree que los copagos en un trimestre se han pagado por encima del tope, puede presentar una Solicitud de Reembolso de Copagos, que será evaluada por la Administración de Seguros de Salud de Puerto Rico (ASES). (4) La información sobre el Proceso de Reembolso y sobre la Solicitud está disponible en las oficinas locales del Programa Medicaid, en el sitio web del Programa de Medicaid (https://www.medicaid.pr.gov/) y en el sitio web de ASES (http://www.ases.pr.gov/). (5) La regla federal que exige límites máximos en copagos no se aplica a nadie que sea elegible bajo el Programa Estatal.

Debe Reportar Cambios

Debe notificar cualquier cambio que pueda afectar su cubierta de salud. Favor de reportar sus cambios y los de otras personas en su núcleo familiar, tales como:

- Si alguien se muda.
- Si los ingresos de alguien cambian.
- Si la composición de su hogar cambia.

Por ejemplo, alguien en su núcleo familiar se casa o se divorcia, queda embarazada, tiene o adopta un hijo.

Para reportar los cambios, llámenos al **1-787-641-4224** (TTY: 1-787-625-6955) o acceda a **www.medicaid.pr.gov**.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Si No Está de Acuerdo con las Decisiones Informadas en Esta Notificación

Puede apelar nuestras decisiones sobre su cubierta médica. Por ejemplo, puede apelar si está en desacuerdo con la determinación del tamaño del núcleo familiar, los ingresos, la ciudadanía, el estatus migratorio o el domicilio de cualquiera persona. También puede apelar qué tipo de cubierta de salud (Medicaid, CHIP o Estatal) se le otorgó o denegó, o el nivel de costo compartido (deducibles, copagos) requerido, basado en el código de cubierta.

Si tiene una necesidad urgente de atención médica, puede solicitar una apelación expedita (más rápida) para una pronta respuesta. Una necesidad urgente de atención de salud se define como una que podría resultar en un grave daño a la salud de la persona interesada si no se trata pronto. Si solicita una apelación expedita, es posible que deba proporcionar documentación de la necesidad de atención médica urgente.

Para solicitar una apelación, debe presentar la apelación por escrito dentro de los 30 días contados a partir de la fecha de esta notificación (que se encuentra en la parte superior de esta notificación). La solicitud de apelación se puede hacer: 1) en persona en cualquier oficina local del Programa Medicaid de Puerto Rico; 2) por correo a la siguiente dirección – Programa Medicaid de Puerto Rico, Departamento de Salud, P.O. Box 70184, San Juan, PR 00936-8184; 3) por fax (Fax) a – (787) 759-8361. El plazo que tiene para presentar una apelación expira el 24 de junio de 2021. La determinación en esta notificación será definitiva si usted no apela dentro del plazo de 30 días.

Una vez que solicite una apelación, trataremos de solucionar el desacuerdo por teléfono o personalmente. Si una llamada telefónica o una reunión no solucionan el asunto, usted tiene derecho a una audiencia justa.

Una audiencia es una reunión entre usted, personal del Programa Medicaid de Puerto Rico y un oficial de audiencias. En la audiencia puede explicar por qué no está de acuerdo con la decisión.
Para prepararse para su audiencia, puede:

- Solicitar una copia de su expediente antes de la audiencia.
- Traiga a alguien con usted a la audiencia, como un amigo, pariente o abogado, o venga solo.
- Traiga documentos, información o testigos para explicar su desacuerdo con la decisión.

Si una persona tiene cubierta de salud, y la decisión en esta notificación la elimina o la reduce, puede conservarla durante el período de apelación, siempre que la solicitud de apelación se realice dentro de los primeros 10 días a partir del recibo de esta notificación.
Decidiremos su apelación dentro de los 90 días de su solicitud.

Sinceramente,
Programa Medicaid de Puerto Rico
Departamento de Salud de PR
P.O. Box 70184
San Juan, PR 00936-8184

Siempre mantendremos su información segura y privada.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Llámenos al **1-787-641-4224** (TTY: 1-787-625-6955). Puede llamar de lunes a viernes, de 8:00 am a 6:00pm. O acceda a **www.medicaid.pr.gov.** Si necesita asistencia adicional favor de acudir a la oficina de Medicaid de su preferencia.

Attachment K
Information System

.820 Premium Payment
File Layout

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
ISA	**Interchange Control Header**	**R**					**Interchange Control Header**							
ISA01	Authorization Information Qualifier	R	ID	2 / 2			Authorization Information Qualifier	R	ID	2 / 2				00
ISA02	Authorization Information	R	AN	10 / 10			Authorization Information	R	AN	10 / 10				SPACES(10)
ISA03	Security Information Qualifier	R	ID	2 / 2			Security Information Qualifier	R	ID	2 / 2				00
ISA04	Security Information	R	AN	10 / 10			Security Information	R	AN	10 / 10				SPACES(10)
ISA05	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA06	Interchange Sender ID	R	AN	15 / 15			Interchange Sender ID	R	AN	15 / 15				ASES+SPACES(11)
ISA07	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA08	Interchange Receiver ID	R	AN	15 / 15			Interchange Receiver ID	R	AN	15 / 15				(CARRIER_NAME)+SPACES(VAR)
ISA09	Interchange Date	R	DT	6 / 6			Interchange Date	R	DT	6 / 6				SYSTEM DATE (YYMMDD)
ISA10	Interchange Time	R	TM	4 / 4			Interchange Time	R	TM	4 / 4				SYSTEM TIME (HHMM)
ISA11	Interchange Control Standards Identifier	R	ID	1 / 1		U	Repetition Separator	R	ID	1 / 1		^	Usage	^
ISA12	Interchange Control Version Number	R	ID	5 / 5		00401	Interchange Control Version Number	R	ID	5 / 5		00501	Values	00501
ISA13	Interchange Control Number	R	NO	9 / 9			Interchange Control Number	R	NO	9 / 9				SYSTEM DATE (YYMMDD)+001
ISA14	Acknowledgment Requested	R	ID	1 / 1			Acknowledgment Requested	R	ID	1 / 1				0
ISA15	Production Data	R	ID	1 / 1		P, T	Production Data	R	ID	1 / 1		P, T		P
ISA16	Component Element Separator	R	ID	1 / 1		|	Component Element Separator	R	ID	1 / 1		|		|
GS	**Functional Group Header**	**R**					**Functional Group Header**							
GS01	Functional Identifier Code	R	ID	2 / 2		PO, RA	Functional Identifier Code	R	ID	2 / 2				RA
GS02	Application Sender's Code	R	AN	2 / 15			Application Sender's Code	R	AN	2 / 15				ASES
GS03	Application Receiver's Code	R	AN	2 / 15			Application Receiver's Code	R	AN	2 / 15				(CARRIER_NAME)+SPACES(VAR)
GS04	Date	R	DT	8 / 8			Date	R	DT	8 / 8				SYSTEM DATE (YYYYMMDD)
GS05	Time	R	TM	4 / 8			Time	R	TM	4 / 8				SYSTEM TIME (HHMM)

ASES 820 4010A1 5010 SIDE B

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
GS06	Group Control Number	R	NO	1 / 9			Group Control Number	R	NO	1 / 9				1+SYSTEM DATE (YYMMDD)
GS07	Responsible Agency Code	R	ID	1 / 2			Responsible Agency Code	R	ID	1 / 2				X
GS08	Version / Release / Industry Identifier Code	R	AN	1 / 12		004010X061 A1	Version / Release / Industry Identifier Code	R	AN	1 / 12		005010X218	Values	005010X218
ST	**Transaction Set Header**	**R**					**Transaction Set Header**	**R**						
ST01	Transaction Set Identifier Code	R	R	3 / 3		820	Transaction Set Identifier Code	R	R	3 / 3		820		820
ST02	Transaction Set Control Number	R	ID	4 / 9			Transaction Set Control Number	R	ID	4 / 9				YYMM+CARRIER_ID+REGION+PLAN_TYPE
ST03							Implementation Convention Reference	R	AN	1 / 35		005010X218	New	005010X218
BPR	**Financial Information**	**R**					**Financial Information**	**R**						
BPR01	Transaction Handling Code	R	ID	1 / 2		C,D,U,I,P,U, X	Transaction Handling Code	R	ID	1 / 2		C,D,U,I,P,U, X		I
BPR02	Total Premium Payment Amount	R	R	1 / 18			Total Premium Payment Amount	R	R	1 / 18				Sum of CALC_AMOUNT for Carrier/Region/Plan_Type
BPR03	Credit or Debit Flag Code	R	ID	1 / 1		C,D	Credit or Debit Flag Code	R	ID	1 / 1		C,D		C
BPR04	Payment Method Code	R	ID	3 / 3		ACH,BOP,CHK,FWT,SWT	Payment Method Code	R	ID	3 / 3		ACH,BOP,CHK,FWT,NON,SWT	Values	CHK
BPR05	Payment Format Code	S	ID	1 / 10		CCP,CTX	Payment Format Code	S	ID	1 / 10		CCP,CTX		
BPR06	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,04	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,02,04	Values	
BPR07	Originating Depository Financial Institution (DFI) Identifier	S	AN	3 / 12			Originating Depository Financial Institution (DFI) Identifier	S	AN	3 / 12				
BPR08	Account Number Qualifier	S	ID	1 / 3		ALC,DA	Account Number Qualifier	S	ID	1 / 3		ALC,DA		
BPR09	Sender Bank Account Number	S	AN	1 / 35			Sender Bank Account Number	S	AN	1 / 35				
BPR10	Originating Company Identifier	S	AN	10 / 10			Originating Company Identifier	R	AN	10 / 10			Usage Req.	ASES_FEDERAL_TAX_ID
BPR11	Originating Company Supplemental Code	S	AN	9 / 9			Originating Company Supplemental Code	S	AN	9 / 9				

ASES 820 4010A1 - 5010 SIDE BY SIDE

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
BPR12	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,04	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,02,04	Values	
BPR13	Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12			Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12				
BPR14	Account Number Qualifier	S	ID	1 / 3		DA,SG	Account Number Qualifier	S	ID	1 / 3		DA,SG		
BPR15	Receiver Bank Account Number	S	AN	1 / 35			Receiver Bank Account Number	S	AN	1 / 35				
BPR16	Check Issue or EFT Effective Date	R	DT	8 / 8			Check Issue or EFT Effective Date	R	DT	8 / 8				Check Date
TRN	**Reassociation Key**	**R**					**Reassociation Trace Number**	**R**					**Desc.**	
TRN01	Trace Type Code	R	ID	1 / 2		1,3	Trace Type Code	R	ID	1 / 2		1,3		3
TRN02	Check or EFT Trace Number	R	AN	1 / 30			Check or EFT Trace Number	R	AN	1 / 50			Max	Check Number
TRN03	Originating Company Identifier	S	AN	10 / 10			Originating Company Identifier	S	AN	10 / 10				
TRN04	Originating Company Supplemental Code	S	AN	1 / 30			Originating Company Supplemental Code	S	AN	1 / 50			Max	
CUR	**Non-US Dollars Currency**	**S**					**Foreign Currency Information**	**S**						
CUR01	Entity Identifier Code	R	ID	2 / 3		2B,PR	Entity Identifier Code	R	ID	2 / 3		2B,PR		
CUR02	Currency Code	R	ID	3 / 3		MXP,CAD,USD	Currency Code	R	ID	3 / 3		MXP,CAD	Values	
CUR03	Exchange Rate	S	R	4 / 10									Usage Req.	
REF	**Premium Receiver Identification Key**	**S**					**Premium Receiver Identification Key**	**S**						
REF01	Reference Identification Qualifier	R	ID	2 / 3		14,18,2F,38,72	Reference Identification Qualifier	R	ID	2 / 3		14,17,18,2F,38,72,LB	Values	14
REF02	Premium Receiver Reference Identifier	R	AN	1 / 30			Premium Receiver Reference Identifier	R	AN	1 / 50			Max	CARRIER+REGION_ID +PRIMARY_CENTER
DTM	**Process Date**	**S**					**Process Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		
DTM02	Payer Process Date	R	DT	8 / 8			Payer Process Date	R	DT	8 / 8				
DTM	**Delivery Date**	**S**					**Delivery Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		
DTM02	Premium Delivery Date	R	DT	8 / 8			Premium Delivery Date	R	DT	8 / 8				
DTM	**Coverage Period**	**S**					**Coverage Period**	**S**						

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
DTM01	Date Time Qualifier	R	ID	3 / 3		582	Date Time Qualifier	R	ID	3 / 3		582		
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3			Date Time Period Format Qualifier	R	ID	2 / 3				
DTM06	Coverage Period	R	AN	1 / 35			Coverage Period	R	AN	1 / 35				
DTM							**Creation Date**	**S**					**New**	
DTM01							Date Time Qualifier	R	ID	3 / 3		097	New	
DTM02							Creation Date	R	DT	8 / 8			New	
N1	**Premium Receiver's Name**	**R**			**1000A**		**Premium Receiver's Name**	**R**			**1000A**			
N101	Entity Identifier Code	R	ID	2 / 3	1000A	PE	Entity Identifier Code	R	ID	2 / 3	1000A	PE		PE
N102	Information Receiver Last or Organization Name	R	AN	1 / 60	1000A		Information Receiver Last or Organization Name	R	AN	1 / 60	1000A			CARRIER_NAME
N103	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	N/U w/N102	FI
N104	Receiver Identifier	R	AN	2 / 80	1000A		Receiver Identifier	R	AN	2 / 80	1000A		N/U w/N102	CARRIER_FEDERAL_TAX_ID
N2	**Premium Receiver's Additional Name**	**S**					**Premium Receiver's Additional Name**	**S**						
N201	Receiver Additional Name	R	AN	1 / 60	1000A		Receiver Additional Name	R	AN	1 / 60	1000A			
N3	**Premium Receiver's Address**	**S**					**Premium Receiver's Address**	**S**						
N301	Receiver Address Line	R	AN	1 / 55	1000A		Receiver Address Line	R	AN	1 / 55	1000A			
N302	Receiver Address Line	S	AN	1 / 55	1000A		Receiver Address Line	S	AN	1 / 55	1000A			
N4	**Premium Receiver's City, State, Zip**	**S**					**Premium Receiver's City, State, Zip Code**	**S**					**Desc.**	
N401	Information Receiver City Name	R	AN	2 / 30	1000A		Information Receiver City Name	R	AN	2 / 30	1000A			
N402	Information Receiver State Code	R	ID	2 / 2	1000A		Information Receiver State Code	S	ID	2 / 2	1000A		Usage Req.	
N403	Information Receiver Postal Zone or ZIP Code	R	ID	3 / 15	1000A		Information Receiver Postal Zone or ZIP Code	S	ID	3 / 15	1000A		Usage Req.	
N404	Country Code	S	ID	2 / 3	1000A		Country Code	S	ID	2 / 3	1000A			
N407							Country Subdivision Code	S	ID	1 / 3	1000A		New	
RDM							**Premium Receiver's Remittance Delivery Method**	**S**					**New**	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 4010A1 - 5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	ASES
RDM01							Report Transmission Code	R	ID	1 / 2	1000A	BM,EM,FT,FX,IA,OL	New	
RDM02							Name	S	AN	1 / 60	1000A		New	
RDM03							Communication Number	S	AN	1 / 256	1000A		New	
N1	**Premium Payer's Name**	**R**			**1000B**		**Premium Payer's Name**	**R**			**1000B**			
N101	Entity Identifier Code	R	ID	2 / 3	1000B	PR	Entity Identifier Code	R	ID	2 / 3	1000B	PR		PR
N102	Premium Payer Name	S	AN	1 / 60	1000B		Premium Payer Name	S	AN	1 / 60	1000B			ASES_NAME
N103	Identification Code Qualifier	S	ID	1 / 2	1000B	1,9,24,75,EQ,FI,PI	Identification Code Qualifier	S	ID	1 / 2	1000B	1,9,24,75,EQ,FI,PI	N/U w/N102	FI
N104	Premium Payer Identifier	S	AN	2 / 80	1000B		Premium Payer Identifier	S	AN	2 / 80	1000B		N/U w/N102	ASES_FEDERAL_TAX_ID
N2	**Premium Payer's Additional Name**	**S**					**Premium Payer's Additional Name**	**S**						
N201	Premium Payer Additional Name	R	AN	1 / 60	1000B		Premium Payer Additional Name	R	AN	1 / 60	1000B			
N3	**Premium Payer's Address**	**S**					**Premium Payer's Address**	**S**						
N301	Premium Payer Address Line	R	AN	1 / 55	1000B		Premium Payer Address Line	R	AN	1 / 55	1000B			
N302	Premium Payer Address Line	S	AN	1 / 55	1000B		Premium Payer Address Line	S	AN	1 / 55	1000B			
N4	**Premium Payer's City State Zip**	**S**					**Premium Receiver's City, State, Zip Code**	**S**					**Desc.**	
N401	Premium Payer City Name	R	AN	2 / 30	1000B		Premium Payer City Name	R	AN	2 / 30	1000B			
N402	Premium Payer State Code	R	ID	2 / 2	1000B		Premium Payer State Code	S	ID	2 / 2	1000B		Usage Req.	
N403	Premium Payer Postal Zone or ZIP Code	R	ID	3 / 15	1000B		Premium Payer Postal Zone or ZIP Code	S	ID	3 / 15	1000B		Usage Req.	
N404	Country Code	S	ID	2 / 3	1000B		Country Code	S	ID	2 / 3	1000B			
N407							Country Subdivision Code	S	ID	1 / 3	1000B		New	
PER	**Premium Payer's Administrative Contact**	**S**					**Premium Payer's Administrative Contact**	**S**						
PER01	Contact Function Code	R	ID	2 / 2	1000B	IC	Contact Function Code	R	ID	2 / 2	1000B	IC		
PER02	Premium Payer Contact Name	R	AN	1 / 60	1000B		Premium Payer Contact Name	R	AN	1 / 60	1000B			
PER03	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,FX,TE	Communication Number Qualifier	R	ID	2 / 2	1000B	EM,FX,TE	Usage Req.	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1						ASES 820 5010						Notes	
	Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	4010A1 5010 SIDE B Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Changes	ASES
PER04	Communication Number	S	AN	1 / 80	1000B		Communication Number	R	AN	1 / 256	1000B		U. Req./Max	
PER05	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE		
PER06	Communication Number	S	AN	1 / 80	1000B		Communication Number	S	AN	1 / 256	1000B		Max	
PER07	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE		
PER08	Communication Number	S	AN	1 / 80	1000B		Communication Number	S	AN	1 / 256	1000B		Max	
N1							**Intermediary Bank Information**	**S**			**1000C**		**New**	
N101							Entity Identifier Code	R	ID	2 / 3	1000C	04,0B,8W,AK,BE,BK,C1,C2,IAT,MJ,RB,Z6,ZB,ZL	New	
N102							Name	S	AN	1 / 60	1000C		New	
N103							Identification Code Qualifier	S	ID	1 / 2	1000C	31,57,94,A3,A4,A6,CF,G,PA	New	
N104							Identification Code	S	AN	2 / 80	1000C		New	
N2							**Intermediary Bank Additional Name**	**S**					**New**	
N201							Name	R	AN	1 / 60	1000C		New	
N3							**Intermediary Bank's Address**	**S**					**New**	
N301							Address Information	R	AN	1 / 55	1000C		New	
N302							Address Information	S	AN	1 / 55	1000C		New	
N4							**Intermediary Bank's City, State, Zip Code**	**S**					**New**	
N401							City Name	R	AN	2 / 30	1000C		New	
N402							State or Province Code	S	ID	2 / 2	1000C		New	
N403							Postal Code	S	ID	3 / 15	1000C		New	
N404							Country Code	S	ID	2 / 3	1000C		New	
N407							Country Subdivision Code	S	ID	1 / 3	1000C		New	
PER							**Intermediary Bank's Administrative Contact**	**S**					**New**	
PER01							Contact Function Code	R	ID	2 / 2	1000C	IC	New	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 ASES 820 4010A1 - 5010 SIDE B Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	ASES
PER02							Name	R	AN	1 / 60	1000C		New	
PER03							Communication Number Qualifier	R	ID	2 / 2	1000C	EM,FX,TE	New	
PER04							Communication Number	R	AN	1 / 256	1000C		New	
PER05							Communication Number Qualifier	S	ID	2 / 2	1000C	EM,EX,FX,TE	New	
PER06							Communication Number	S	AN	1 / 256	1000C		New	
PER07							Communication Number Qualifier	S	ID	2 / 2	1000C	EM,EX,FX,TE	New	
PER08							Communication Number	S	AN	1 / 256	1000C		New	
ENT	**Organization Summary Remittance**	**S**			**2000A**		**Organization Summary Remittance**	**S**			**2000A**			
ENT01	Assigned Number	R	NO	1 / 6	2000A		Assigned Number	R	NO	1 / 6	2000A			
ENT02	Entity Identifier Code	R	ID	2 / 3	2000A	2L	Entity Identifier Code	R	ID	2 / 3	2000A	2L,AG,NH,RGA,UN	Values	
ENT03	Identification Code Qualifier	S	ID	1 / 2	2000A	1,9,FI	Identification Code Qualifier	R	ID	1 / 2	2000A	1,9,24,FI	U. Req./Values	
ENT04	Organization Identification Code	S	AN	2 / 80	2000A		Organization Identification Code	R	AN	2 / 80	2000A		Usage Req.	
ADX							**Organization Summary Remittance Level Adjustment for Previous Payment**	**S**			**2200A**		**New**	
ADX01							Premium Payment Adjustment Amount	R	R	1 / 18	2200A		New	
ADX02							Premium Payment Adjustment Reason	R	ID	2 / 2	2200A	52,53,80,81,86,BJ,H1,H6,RU,WO,WW	New	
RMR	**Organization Summary Remittance Detail**	**R**			**2300**		**Organization Summary Remittance Detail**	**R**			**2300**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300	11,1L,CT,IK	Reference Identification Qualifier	R	ID	2 / 3	2300	11,1L,CT,IK		
RMR02	Contract, Invoice, Account, Group, or Policy Number	R	AN	1 / 30	2300		Contract, Invoice, Account, Group, or Policy Number	R	AN	1 / 50	2300		Max	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 4010A1-5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
RMR03	Payment Action Code	S	ID	2 / 3	2300	PA,PI,PO,PP	Payment Action Code	S	ID	2 / 2	2300	PA,PI,PO,PP	Max	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300		Detail Premium Payment Amount	R	R	1 / 18	2300			
RMR05	Billed Premium Amount	S	R	1 / 18	2300		Billed Premium Amount	S	R	1 / 18	2300			
REF							**Premium Receivers Identification Key**	**S**			**2300A**		**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300A	14,17,18,2F,38,E9,LB,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300A		New	
DTM							**Organizational Coverage Period**	**S**			**2300A**		**New**	
DTM01							Date Time Qualifier	R	ID	3 / 3	2300A	582,AAG	New	
DTM02							Date	S	DT	8 / 8	2300A		New	
DTM05							Date Time Period Format Qualifier	S	ID	2 / 3	2300A	RD8	New	
DTM06							Date Time Period	S	AN	1 / 35	2300A		New	
IT1	**Summary Line Item**	**S**			**2310A**		**Summary Line Item**	**S**			**2310A**			
IT101	Line Item Control Number	R	AN	1 / 20	2310A		Line Item Control Number	R	AN	1 / 20	2310A			
SAC							**Service, Promotion, Allowance or Charge Information**	**S**			**2312A**		**New**	
SAC01							Allowance or Charge Indicator	R	ID	1 / 1	2312A	C	New	
SAC02							Service, Promotion, Allowance or Charge Code	R	ID	4 / 4	2312A	A172,B680,D940,G740	New	
SAC05							Amount	R	ID	1 / 15	2312A		New	
SLN	**Member Count**	**S**			**2315A**		**Member Count**	**S**			**2315A**			
SLN01	Line Item Control Number	R	AN	1 / 20	2315A		Line Item Control Number	R	AN	1 / 20	2315A			
SLN03	Information Only Indicator	R	ID	1 / 1	2315A	O	Information Only Indicator	R	ID	1 / 1	2315A	O		
SLN04	Head Count	R	R	1 / 15	2315A		Head Count	R	R	1 / 15	2315A			
SLN05	Unit or Basis for Measurement Code	R	ID	2 / 2	2315A	10,IE,PR	Unit or Basis for Measurement Code	R	ID	2 / 2	2315A	10,IE,PR		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 4010A1 - 5010 SIDE B Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
ADX	**Organization Summary Remittance Level Adj.**	**S**			**2320A**		**Organization Summary Remittance Level Adj.**	**S**			**2320A**			
ADX01	Adjustment Amount	R	R	1 / 18	2320A		Adjustment Amount	R	R	1 / 18	2320A			
ADX02	Adjustment Type	R	ID	2 / 2	2320A	20,52,53,AA ,H1,H6,IA,J3	Adjustment Reason Code	R	ID	2 / 2	2320A	20,52,53,AA ,H1,H6,IA,J3		
ENT	**Individual Remittance**	**S**			**2000B**		**Individual Remittance**	**S**			**2000B**			
ENT01	Assigned Number	R	NO	1 / 6	2000B		Assigned Number	R	NO	1 / 6	2000B			AUTONUMBER(+1) RESET TO 1 AT NEXT ST
ENT02	Entity Identifier Code	R	ID	2 / 3	2000B	2J	Entity Identifier Code	R	ID	2 / 3	2000B	2J		2J
ENT03	Identification Code Qualifier	R	ID	1 / 2	2000B	34,EI,ZZ	Identification Code Qualifier	R	ID	1 / 2	2000B	34,EI,II	Values	34
ENT04	Receiver's Individual Identifier	R	AN	2 / 80	2000B		Receiver's Individual Identifier	R	AN	2 / 80	2000B			MEMBER Social Security Number
NM1	**Individual Name**	**S**			**2100B**		**Individual Name**	**S**			**2100B**			
NM101	Entity Identifier Code	R	ID	2 / 3	2100B	EY,QE	Entity Identifier Code	R	ID	2 / 3	2100B	DO,EY,IL,QE	Values	QE
NM102	Entity Type Qualifier	R	ID	1 / 1	2100B	1	Entity Type Qualifier	R	ID	1 / 1	2100B	1		1
NM103	Individual Last Name	S	AN	1 / 35	2100B		Individual Last Name	S	AN	1 / 60	2100B		Max	MEMBER_LAST_NAME 1
NM104	Individual First Name	S	AN	1 / 25	2100B		Individual First Name	S	AN	1 / 35	2100B		Max	
NM105	Individual Middle Name	S	AN	1 / 25	2100B		Individual Middle Name	S	AN	1 / 25	2100B			
NM106	Individual Name Prefix	S	AN	1 / 10	2100B		Individual Name Prefix	S	AN	1 / 10	2100B			
NM107	Individual Name Suffix	S	AN	1 / 10	2100B		Individual Name Suffix	S	AN	1 / 10	2100B			
NM108	Identification Code Qualifier	S	ID	1 / 2	2100B	34,EI,N	Identification Code Qualifier	S	ID	1 / 2	2100B	34,EI,N		
NM109	Individual Identifier	S	AN	2 / 80	2100B		Individual Identifier	S	AN	2 / 80	2100B			
ADX							**Individual Premium Adjustment for Previous Payment**	**S**			**2200B**		**New**	
ADX01							Premium Payment Adjustment Amount	R	R	1 / 18	2200B		New	
ADX02							Adjustment Reason Code	R	ID	2 / 2	2200B	52,53,80,81, 86,BJ,H1,H6 ,RU,WO	New	
RMR -1	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	ASES
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7 ,CT,ID,IG,IK ,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7 ,CT,ID,IG,IK ,KW		11
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	FAMILY_ID+Member_Suffix+MPI+Municipio
RMR03	Payment Action Code	S	ID	2 / 2	2300B	Rate Cell							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			
REF - 1							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38, E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
DTM - 1	**Individual Coverage Period**	**S**					**Individual Coverage Period**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3	2300B	582	Date Time Qualifier	R	ID	3 / 3	2300B	582,AAG	Values	582
DTM02							Date	S	DT	8 / 8	2300B		Usage Req.	
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3	2300B	RD8	Date Time Period Format Qualifier	S	ID	2 / 3	2300B	RD8	Usage Req.	RD8
DTM06	Coverage Period	R	AN	1 / 35	2300B		Coverage Period	S	AN	1 / 35	2300B		Usage Req.	Coverage Start Dt-Coverage End Dt based upon CALC_DAYS. Use Accounting Dt for retro and adjustments. (YYYYMMDD)
RMR - 2	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7 ,CT,ID,IG,IK ,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7 ,CT,ID,IG,IK ,KW		IK
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	CARRIER_ID+REGION +BILLING_DATE(YYMM)
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			BILLED_AMOUNT

ASES 820 4010A1 - 5010 SIDE BY SIDE

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Element	4010A1 Identifier Description	4010A1 Usage Req.	4010A1 Type	4010A1 Min/Max	4010A1 Loop	4010A1 Req./Rec. Values	ASES 820 5010 SIDE BY SIDE 5010 Identifier Description	5010 Usage Req.	5010 Type	5010 Min-Max	5010 Loop	5010 Req./Rec. Values	Notes Changes	Notes ASES
REF - 2							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
ADX - 2	**Individual Premium Adjustment**	**S**			**2320B**		**Individual Premium Adjustment**	**S**			**2320B**			
ADX01	Adjustment Amount	R	R	1 / 18	2320B		Adjustment Amount	R	R	1 / 18	2320B			(CALC_AMMOUNT minus BILLED_AMOUNT)+adjustment_carrier_code
ADX02	Adjustment Reason Code	R	ID	2 / 2	2320B	20,52,53,AA,AX,H1,H6,IA,J3	Adjustment Reason Code	R	ID	2 / 2	2320B	20,52,53,AA,AX,H1,H6,IA,J3		IA
RMR - 3	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		KW
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	ERROR_CODES
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			0
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			
REF - 3							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
SE	**Transaction Set Trailer**	**R**					**Transaction Set Trailer**	**R**						
SE01	Transaction Segment Count	R	NO	1 / 10			Transaction Segment Count	R	NO	1 / 10				Count of segments including ST and SE
SE02	Transaction Set Control Number	R	AN	4 / 9			Transaction Set Control Number	R	AN	4 / 9				YYMM+CARRIER_ID+REGION+PLAN_TYPE
GE	**Functional Group Trailer**	**R**					**Functional Group Trailer**	**R**						
GE01	Number of Transaction Sets Included	R	NO	1 / 6			Number of Transaction Sets Included	R	NO	1 / 6				1

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22 - 003

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 4010A1 - 5010 SIDE B 5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
GE02	Group Control Number	R	NO	1 / 9			Group Control Number	R	NO	1 / 9				1+SYSTEM DATE(YYMMDD)
IEA	**Interchange Control Trailer**	**R**					**Interchange Control Trailer**	**R**						
IEA01	Number of Included Functional Groups	R	NO	1 / 5			Number of Included Functional Groups	R	NO	1 / 5				1
IEA02	Interchange Control Number	R	NO	9 / 9			Interchange Control Number	R	NO	9 / 9				SYSTEM DATE (YYMMDD)+001

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Attachment K
Information System

Carrier Eligibility File Layout

CARRIER ELIGIBLITY OUTPUT FILE - FAMILY RECORD

This file is created by the ASSIST export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. Modified on May 2003 for the direct contracting pilot project. See entries in bold. Modified on March 2004 for Smartcard project. See entries in bold and highlighted. Modified on July 2005 for Medicare Project. Modified on January 2008 to add tran_id = H for sysprem records. Modified for Mediti on January 2011. FIELDS IN YELLOW ARE NOT USED BY CARRIERS (Nov-1024). MAGI required changes to 7/2017. New Fileds MMIS 1/29/2018. ASES New Health Model 11/1/2018. Adrees fields size 201907. MEDITI3G **and Insurance Changes 202106.**

# Field	Record Fields	Position	Pos	Size	Notes
1	RECORD-TYPE	1	0	1	"F" for family
2	TRAN-ID	2	1	1	E=eligible, I=ineligible, R=reject, H= SYSPREM (history), "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period
3	PROCESS-DATE	3	2	8	MMDDYYYY
4	FAMILY-SSN	11	10	9	Member SSN
5	FAMILY-SUFFIX	20	19	2	"00"
6	Filler	22	21	14	fill blanks
7	FAMILY_ID	36	35	11	eleven last digit of MPI (MAGI Fam id) Previous version identify like MEMBER_ID
8	Contact last name 1	47	46	15	Paternal last name of contact person
9	Contact last name 2	62	61	15	Maternal last name of contact person
10	Contact first name	77	76	20	First name of contact person
11	REGION	97	96	1	
12	MUNICIPALITY	98	97	4	Zero fill, right justify.
13	FACILITY	102	101	4	Zero fill, right justify.
14	INVESTIGATION-IND	106	105	1	
15	TRANSACTION-TYPE	107	106	1	
16	EFFECTIVE-DATE	108	107	8	Start date of eligibility MMDDYYYY
17	FINANCIAL-RESP-PCT	116	115	1	
18	CERTIFIER-NUMBER	117	116	2	
19	EXPIRATION-DATE	119	118	8	End date of eligibility MMDDYYYY
20	COND-ELIG-IND	127	126	1	
21	MAILING-ADDRESS1	128	127	75	
22	MAILING-ADDRESS2	203	202	75	
23	MAILING-CITY	278	277	16	
24	MAILING-ZIP	294	293	5	Zero fill, right justify.
25	MAILING-ZIP4	299	298	4	Zero fill, right justify.
26	RESIDENCE-ADDRESS1	303	302	75	
27	RESIDENCE-ADDRESS2	378	377	75	
28	RESIDENCE-CITY	453	452	16	
29	RESIDENCE-ZIP	469	468	5	Zero fill, right justify.
30	RESIDENCE-ZIP4	474	473	4	Zero fill, right justify.
31	PHONE	478	477	10	Including area code
32	OTHER-INSURER1	488	487	2	Insurance co. code NOT USED
33	OTH-POLICY1	490	489	20	Policy number NOT USED
34	OTHER-INSURER2	510	509	2	Insurance co. code NOT USED
35	OTH-POLICY2	512	511	20	Policy number NOT USED
36	OTHER-INSURER3	532	531	2	Insurance co. code NOT USED
37	OTH-POLICY3	534	533	20	Policy number NOT USED
38	MEMBERS	554	553	2	# members in family
39	ODSI-MEMBERS-ELIGIBLE	556	555	2	# members eligible ODSI / optionals ELA-SB-Vet
40	USER-CODE	558	557	6	
41	ENTRY-DATE	564	563	8	MMDDYYYY
42	PCT-OF-POVERTY-LEVEL	572	571	3	Zero fill, right justify. NOT USED
43	DEDUCTIBLE-LEVEL-CODE	575	574	1	Zero fill, right justify. NOT USED
44	HCRE-MEMBERS-ELIGIBLE	576	575	2	# members eligible by ASES. Zero fill, right justify.
45	HCRE-DENIAL-CODE	578	577	2	See Cancel Reasons table
46	CARRIER-CODE	580	579	2	
47	EFFECTIVE-CARRIER-DATE	582	581	8	For Family Carrier . MMDDYYYY
48	ELA-ERRORS	590	589	10	Zero fill, right justify. NOT USED
49	MANCOMUNADO	600	599	1	Zero fill, right justify. NOT USED
50	FILLER	601	600	3	
51	PMG_Tax_ID	604	603	9	PMG Tax ID
52	NEW-CARRIER	613	612	2	New carrier code
53	NEW_PMG_Tax_ID	615	614	9	new IPA or PHO for families changing carrier
54	NEW_PMG_eff_date	624	623	8	MMDDYYYY - effective date of IPA/PHO change
55	CONTRACT NUMBER	632	631	13	MCO contract number
56	REGION ASES	645	644	1	
57	NEW CARRIER EFFECTIVE DATE	646	645	8	New Carrier MMDDYYYY
58	PMG_eff_date	654	653	8	MMDDYYYY

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

59	CERTIFICATION DATE	662	661	8	MMDDYYYY
60	PRIMARY CENTER PCP CHANGE REASO	670	669	2	Basado en tabla de Código de Razón.
61	AUTO_ENROLL_INDICATOR	672	671	1	0 = Not Auto; >0 = Auto Enroll
62	AUTO_ENROLL_DATE	673	672	8	MMDDYYYY
63	PAM NEW FAMILY_ID	681	680	11	New Family_id assigned by PAM for Meditis. Use as a reference only.
64	Application Number	692	691	10	Medicaid application form number
65	Medicaid_cancellation_dt	702	701	8	MMDDYYYY
66	Region_move_eff_dt	710	709	8	MMDDYYYY
67	Rate_cell	718	717	2	See Rate Cell Table
68	gender	720	719	1	1=Male, 2= Female, 3=Unnkown
69	new_card_id_date	721	720	8	*MMDDYYYY, For future enrollment*
70	**Eligibility_start_date**	729	728	8	
71	**FILLER**	737	736	3	
		740	739		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CARRIER ELIGIBLITY OUTPUT FILE - MEMBER RECORD

This file is created by the ASSIST export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. Modified on May 2003 for the direct contracting pilot project. Modified on March 2004 for Smartcard project. Modified on Sept. 2005 for Medicare Project. Modified August 2006 to add Coverage Fiels for new PSG contrating. Modified on January 2008 to add tran_id = H for sysprem records. Modified for Mediti on January 2011. MAGI required changes to 7/2017. New value in Extension flag field and Included MBI number. ASES New Health Plan Model 11/1/2018. Includes Customs Property fields for emporaries flags

# Field	Record Fields	Position	Pos	Size	Notes
1	RECORD-TYPE	1	0	1	"M" for member
2	TRAN-ID	2	1	1	E=eligible, I=ineligible, R=reject, H= SYSPREM (history), "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period order)
3	PROCESS-DATE	3	2	8	MMDDYYYY
4	FAMILY-SSN	11	10	9	Family-SSN = Member-SSN
5	FAMILY-SUFFIX	20	19	2	Zero fill, right justify.
6	FILLER	22	21	1	
7	MEMBER-SSN	23	22	9	Family-SSN = Member-SSN
8	MEMBER-SUFFIX	32	31	2	"01"
9	CONTACT_MEMBER	34	33	11	eleven last digit of MPI of contact member
10	FILLER	45	44	3	
11	LAST NAME 1	48	47	15	
12	LAST NAME 2	63	62	15	
13	FIRST NAME	78	77	20	
14	MIDDLE-INITIAL	98	97	1	
15	RELATIONSHIP	99	98	1	Zero fill, right justify. NOT USED
16	DATE-OF-BIRTH	100	99	8	MMDDYYYY
17	PLACE-OF-BIRTH	108	107	1	Zero fill, right justify. NOT USED
18	SEX	109	108	1	
19	CATEGORY	110	109	1	Zero fill, right justify. NOT USED
20	CATEGORY-2	111	110	1	Zero fill, right justify. NOT USED
21	CONDITION	112	111	1	Zero fill, right justify. NOT USED
22	SOURCE-CODE	113	112	1	
23	RECEIVE-SS	114	113	1	
24	MED-INS-CODE	115	114	1	Zero fill, right justify. NOT USED
25	POLICY	116	115	2	Zero fill, right justify. NOT USED
26	CLASS	118	117	1	Zero fill, right justify. NOT USED
27	CLASS-2	119	118	1	Zero fill, right justify. NOT USED
28	DENIAL-CAT	120	119	1	Zero fill, right justify. NOT USED
29	DENIAL-CAT-2	121	120	1	Zero fill, right justify. NOT USED
30	MARITAL-STATUS	122	121	1	
31	SSN	123	122	9	
32	PREG-IND	132	131	1	
33	ABSENT-PARENT	133	132	1	
34	HICN	134	133	11	
35	PILOT-CAT	145	144	1	Zero fill, right justify. NOT USED
36	PILOT-CLASS	146	145	1	Zero fill, right justify. NOT USED
37	PILOT-DENIAL	147	146	1	Zero fill, right justify. NOT USED
38	HCRE-ELIGIBILITY-IND	148	147	1	
39	HCRE-DENIAL-CODE	149	148	2	Zero fill, right justify.
40	OTHER-INSURER1	151	150	2	Insurance co. code NOT USED
41	OTH_POLICY1	153	152	20	Policy number NOT USED
42	OTHER-INSURER2	173	172	2	Insurance co. code NOT USED
43	OTH_POLICY2	175	174	20	Policy number NOT USED
44	OTHER-INSURER3	195	194	2	Insurance co. code NOT USED
45	OTH_POLICY3	197	196	20	Policy number NOT USED
46	GROUP-IDENT	217	216	2	See reference Table
47	MPI	219	218	11	eleven last digit of MPI (MAGI Fam id)
48	ELA-ERRORS	230	229	10	5 2-digit error codes for ELA-SB-Vet
49	AGENCY	240	239	5	Agency # for ELA / Group Num for SB. Zero fill, right justify.
50	*MASTER PATIENT INDEX (MPI)*	*245*	244	*13*	
51	*MEMBER CERTIFICATION DATE*	*258*	257	*8*	*MMDDYYYY*
52	*CONTRACT NUMBER*	*266*	265	*13*	*Include Suffix.*
53	*MEMBER PRIMARY CENTER*	*279*	278	*4*	*IPA code*
54	*MEMBER PRIMARY CENTER EFFECTIVE DATE*	*283*	282	*8*	*MMDDYYYY*
55	*MEMBER NEW PRIMARY CENTER*	*291*	290	*4*	
56	*MEMBER NEW PRIMARY CENTER EFFECTIVE DATE*	*295*	294	*8*	*MMDDYYYY*
57	*PCP1*	*303*	302	*15*	
58	*PCP1 EFFECTIVE DATE*	*318*	317	*8*	*MMDDYYYY*
59	*PCP2*	*326*	325	*15*	
60	*PCP2 EFFECTIVE DATE*	*341*	340	*8*	*MMDDYYYY*
61	*NEW PCP1*	*349*	348	*15*	
62	*NEW PCP1 EFFECTIVE DATE*	*364*	363	*8*	*MMDDYYYY*
63	*NEW PCP2*	*372*	371	*15*	
64	*NEW PCP2 EFFECTIVE DATE*	*387*	386	*8*	*MMDDYYYY*
65	*CARD ID NUMBER*	*395*	394	*15*	
66	*CARD ID DATE*	*410*	409	*8*	*MMDDYYYY*
67	*ELA INDICATOR*	*418*	417	*1*	*1=NO PREMIUM 2=PREMIUM Spaces when not ELA.*
68	*PRIMARY CENTER PCP CHANGE REASON*	*419*	418	*2*	*Basado en tabla de Código de Razón.*

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

69	*MEDICAID INDICATOR*	*421*	420	*1*	*1=Medicaid Federal, 2=SCHIPS 3=Estatal 4= Estatal otros*
70	*MEDICARE INDICATOR*	*422*	421	*1*	*1=A&B, 3=A, 9=B*
71	*CARRIER*	*423*	422	*2*	
72	*CARRIER_EFF_DATE*	*425*	424	*8*	*MMDDYYYY*
73	*NEW_CARRIER*	*433*	432	*2*	
74	*NEW_CARRIER_EFF_DATE*	*435*	434	*8*	*MMDDYYYY*
75	*PLAN_TYPE*	*443*	442	*2*	*"bb"=elegible no suscrito, Ver tabla Plan Type*
76	*PLAN_TYPE_EFF_DATE*	*445*	444	*8*	*MMDDYYYY*
77	*PLAN_VERSION*	*453*	452	*3*	*Version del plan MA suscrito*
78	*PLAN_VERSION_EFF_DATE*	*456*	455	*8*	*MMDDYYYY*
79	*NEW_PLAN_TYPE*	*464*	463	*2*	
80	*NEW_PLAN_TYPE_EFF_DATE*	*466*	465	*8*	*MMDDYYYY*
81	*NEW_PLAN_VERSION*	*474*	473	*3*	
82	*NEW_PLAN_VERSION_EFF_DATE*	*477*	476	*8*	*MMDDYYYY*
83	INSTITUTIONAL_STATUS	*485*	484	*1*	*Y or N*
84	HIC NUMBER MA	*486*	485	*12*	If it is Medicare, the MBI number will be included
85	AUTO_ENROLL_INDICATOR	*498*	497	*1*	*0 = Not Auto; >0 = Auto Enroll*
86	AUTO_ENROLL_DATE	*499*	498	*8*	*MMDDYYYY*
87	IPA_ESPECIAL	*507*	506	*1*	*1 = IPA Especial*
88	CMS_Cert_Status	*508*	507	*2*	*Status de Certificación en CMS*
89	Coverage_Code	*510*	509	*3*	
90	New Contract Number	*513*	512	*13*	
91	Special_Enroll	*526*	525	*1*	*E = Emergency, N = New Born*
92	Cost Sharing flag	*527*	526	*1*	N=No exception, C=Child, P=Pregnant, A=American Indian, I=Institutionalized, H=Hospice
93	Max copay	*528*	527	*5*	Max co-pay for household. Will include two decimal positions.
94	Extension Flag	*533*	532	*1*	N=No extension, A=Pending Appeal, U=Appeal closed, P=pregnancy, X=Other extension, H=Natural Desaster
95	Spend_down Flag	*534*	533	*1*	N=No spend-down involved, S=Spend-down satisfied (If S, required at least one spend-down recordon recod group)
96	Group_code	*535*	*534*	*3*	See group code table
97	Deceased Date	*538*	537	*8*	Format: MMDDYYYY. Member deceased date. Required where hcre_denial_code = '08' (Cancellation Reason). Reject if not 08 only in 'D' records.
98	Custom Property 1	*546*	545	*8*	Custom Value 1. The value used in this field is defined by ASES according to specific reporting requirements for an effective period. - See Reference Table "Custom Properties"
99	Custom Propoerty 2	*554*	553	*8*	Custom Value 1. The value used in this field is defined by ASES according to specific reporting requirements for an effective period. - See Reference Table "Custom Properties"
100	Custom Property 3	*562*	561	*15*	Custom Value 1. The value used in this field is defined by ASES according to specific reporting requirements for an effective period. - See Reference Table "Custom Properties"
101	Custom Property 4	*577*	576	*15*	Custom Value 1. The value used in this field is defined by ASES according to specific reporting requirements for an effective period. - See Reference Table "Custom Properties"

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CARRIER ELIGIBLITY OUTPUT FILE - Household Record

This file is created by the ASSIST export program and contains the MPIs related to Member_id, New record for MAGI Project to 10/2016

# Field	Record Fields	Position	Pos	Size	Notes
1	Record Type	1	0	1	"O"
2	TRAN_ID	2	1	1	E=eligible, I=ineligible, R=Reject, H= SYSPREM (history), "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period order)
3	Process_date	3	2	8	MMDDYYYY
4	MEMBER ID	11	10	11	eleven last digit of MPI (MAGI Fam id)
5	MPI_1	22	21	11	Medicaid MPI related
6	MPI_2	33	32	11	Medicaid MPI related
7	MPI_3	44	43	11	Medicaid MPI related
8	MPI_4	55	54	11	Medicaid MPI related
9	MPI_5	66	65	11	Medicaid MPI related
10	MPI_6	77	76	11	Medicaid MPI related
11	MPI_7	88	87	11	Medicaid MPI related
12	MPI_8	99	98	11	Medicaid MPI related
13	MPI_9	110	109	11	Medicaid MPI related
14	MPI_10	121	120	11	Medicaid MPI related
15	MPI_11	132	131	11	Medicaid MPI related
16	MPI_12	143	142	11	Medicaid MPI related
17	MPI_13	154	153	11	Medicaid MPI related
18	MPI_14	165	164	11	Medicaid MPI related
19	MPI_15	176	175	11	Medicaid MPI related
20	MPI_16	187	186	11	Medicaid MPI related
21	MPI_17	198	197	11	Medicaid MPI related
22	MPI_18	209	208	11	Medicaid MPI related
23	Filler	220	219	520	Fill with empty spaces.
		740	**739**		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CARRIER ELIGIBLITY OUTPUT FILE - Insurance Record

This file is created by the ASSIST export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. This **Insurance Record** is adeded for the Meditis Implementation on Febrary 2011. MAGI changes to 7/2017. NMCI changes to 4/1/2018. Insurance changes 202106

# Field	Record Fields	Position		Size	Notes
1	RECORD-TYPE	1	0	1	"I" for Insurance
2	TRAN-ID	2	1	1	**E=eligible, "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period order)**
3	PROCESS-DATE	3	2	8	MMDDYYYY
4	Family_id	11	10	11	**eleven last digit of MPI (MAGI Fam id)**
5	Member Suffix	22	21	2	**"01"**
6	Health Insurer Code	24	23	3	Code identifies Insurance Company
7	Policy Number	27	26	20	**If it is Medicare, the MBI number will be included**
8	Policy-EXPIRATION-DATE	47	46	8	MMDDYYYY
9	Covered Services	55	54	40	20 coverage code fields (2 character each).
10	**Policy Effective Date**	**95**	**94**	**8**	**Effective Date for policy (Medicare benefits or private plans)**
11	***FILLER***	**103**	**102**	**637**	
		740	739		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Cancellation Code	Cancellation Description
	Not Cancelled
06	Change in Family Composition
07	Income Changes
08	Death of the enrollee
09	Moving Out of State
10	Incarceration of the enrollee
13	Enrollee Found Not Eligible
30	Other Reasons
31	Voluntary Closing

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Group Code			
type	**code**	**title**	**description**
Status	A	Automatic	Automatically eligible
Status	M	MAGI	Qualified under MAGI
Status	N	Non-MAGI	Qualified under non-MAGI
Status	T	Transition	Transition period with temporary medical expense deduction
Status	H	History	History Data with eligibility conversion
Category	E	Title IV-E Child	Title IV-E Foster Care or Adoptive Assistance Child
Category	N	Deemed Newborn	Deemed Newborn
Category	C	Child	Child and not excepted
Category	P	Parent/CR	Parent or Other Caretaker Relative
Category	W	Pregnant Woman	Pregnant Woman
Category	X	Formaer Foster Care Child	ADFAN & Medicaid at 18th birthday and less than 26 years old
Category	T	Adult	19 years and less than 65 w/o Medicare
Category	A	Aged	65 years or older
Category	B	Blind	Blind
Category	D	Disabled	Disabled
Eligibility	M	Medicaid - Categorical	Eligible for Medicaid - Categorically Needy
Eligibility	C	CHIP	Eligible for MAGI CHIP or MOE CHIP
Eligibility	N	Medicaid - Medically Needy	Eligible for Medicaid - Medically Needy
Eligibility	S	State	Eligible for Commonwealth-only coverage
Eligibility	I	INELIGIBLE	Not eligible for any coverage

Custom Property	Definition
Custom Property 1	Identify Eligibles due to Changes in Poverty Level associated to the COVID19
	Identify members tranfered from Commonwealth to Medicaid Program for New PRPL
Custom Property 2	For future use
Custom Property 3	For future use
Custom Property 4	For future use

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Eff Start Date	Eff End Date	Domain (Values)	Instructions
November 01, 2020	September 30, 2021	COVID19	Left Justified.
November 15, 2020	Septiembre 30, 221	COVID192	Left Justified.
-	-	-	
-	-	-	
-	-	-	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Attachment K
Information System

Enrollment Record Layout

Enrollment Manual

Enrollment Error Codes

ENROLLMENT AND CARRIER IPA/PCP CHANGE FILE

This file is received by ASES from the insurance companies and TPO's on a daily basis. It contains data pertinent to **new enrollment** and families which have selected to **change their enrollment** to the organization producing the file. **Modified for Medicare Plans Enrollment on September 2005. Concept change form one record per family enrolled to one record per member. Modify to include special enroll field on novembre 2007 Modified on April 2013 to include Trailer record for the Migracion Project. MAGI project changes 7/2017. MMIS/NMCI changes 1/29 - 4/1/2018.** ASES New Health Model changes eff 11/1/2018

Member Record

Record Fields	Position	Size	Required/Optional	Notes
RECORD_TYPE	1	1	R	"E" for Enrollment Record (Constant)
TRAN_ID	2	1	R	E=new enrollment, P=Plan Type change, C=Carrier change, V= Version change, I=IPA change, 1=PCP1 change, 2=PCP2 change, 3=PCP1 and PCP2 change, For Platino, carriers 'D' = Disensollment
PROCESS_DATE	3	8	R	MMDDYYYY - **Date Enrolled in Carrier**
REGION	11	1	R	Region code
CARRIER	12	2	R	Carrier code
MEMBER_PRIMARY_CENTER	14	4	R	
ODSI_FAMILY_ID	18	11	R	
MEMBER_SSN	29	9	R	
MEMBER_SUFFIX	38	2	R	
EFFECTIVE_DATE	40	8	R	MMDDYYYY- Card issue date for new Reforma enrollment (Trans_ID= E) or Effective date (1st day of month) for other Trans_ID's
PLAN_TYPE	48	2	R	See Plan Type Table
PLAN_VERSION	50	3	R	Used to identify version of Plan within PLAN_TYPE (if needed)
MPI	53	13	R	Alpha-numeric ej.-"0080012345678"
PCP1	66	15	R	**NPI number**
PCP1_EFFECTIVE_DATE	81	8	R	MMDDYYYY
PCP2	89	15	O	**NPI number**
PCP2_EFFECTIVE_DATE	104	8	O	MMDDYYYY, If PCP2 has the NPI number
FAMILY_PRIMARY_CENTER	112	4		
PMG_tax_ID_eff_dt	116	8	R	MMDDYYYY, Required for MCOs
IPA_PCP_CHANGE_REASON	124	2	O	Code Table to be supplied, Requires in IPA-PCP change
MEDICARE INDICATOR	126	1	R	1=A&B, 3=A, 9=B
HIC NUMBER	127	12	O	**If it is Medicare, the MBI number will be included**
Reject Identifier	139	1	R	"A" = Accepted; "M" = MA Retroactive; "R" = Rejected; "X" = Deleted, ASES Field
Record Key	140	14	R	YYYYMMDD999999, ASES Field
Error Code 1	154	3	O	Indicates error (see error code table), ASES Field
Error Code 2	157	3	O	Indicates error (see error code table), ASES Field
Error Code 3	160	3	O	Indicates error (see error code table), ASES Field
Error Code 4	163	3	O	Indicates error (see error code table), ASES Field
Error Code 5	166	3	O	Indicates error (see error code table), ASES Field
Error Code 6	169	3	O	Indicates error (see error code table), ASES Field
Error Code 7	172	3	O	Indicates error (see error code table), ASES Field
Error Code 8	175	3	O	Indicates error (see error code table), ASES Field
Error Code 9	178	3	O	Indicates error (see error code table), ASES Field
Error Code 10	181	3	O	Indicates error (see error code table), ASES Field

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Update Date	184	8	R	YYYYMMDD , ASES Field
Update User	192	8	R	"SYSTUPD "
IPA_ESPECIAL	200	1	O	1 = IPA Especial
Contract Number	201	13	R	Character left justified
Special Enroll	214	1	O	E = Emergency N = Deemed Newborn T = Retroactive Period
PMG_tax_id	215	9	O	PMG Tax ID
Data_Source	224	2	O	MC=MCC MA=Platino CO=Counselor
Filler	226	4	R	
	230			

TRAILER Record				
Record Fields	**Position**	**Size**		**Notes**
RECORD_TYPE	1	7		**"TRAILER"** for Record (Constant)
FILLER	8	10		SPACES
NUMBER OF RECORDS	18	8		99999999 Numeric - right justified - zero filled
Filler	26	10		SPACES
RECORD LENGTH	36	3		"230" (Numeric Constant)
Filler	39	191		SPACES
	230			

*** **NUMBER OF RECORDS** FIELD CONTAINS THE SUM OF THE NUMBER OF RECORDS IN THE FILE **NOT INCLUDING THE TRAILER.**

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Validation Response Code	Response Type	Focus Field(s)	Special Enroll	Data Source	Validation Response Issues/Scenarios	Possible Action(s)
011	IC	Record Type	Any	Any	Invalid content for the Record Type.	Valid content for Record Type is: E = Enrollment.
021	BF	Tran Id	Any	Any	The Tran Id field is blank.	Insert valid content.
022	CIC	Tran Id	Any	MO	The Tran Id should be E, C, I, 1, 2 or 3.	Change the Tran Id to E, C, I, 1, 2 or 3. Otherwise, check the Data Source.
				MA	Invalid content for the Tran Id.	Insert valid content.
				JC CO	The Tran Id should be C.	Change the Tran Id to C. Otherwise, check the Data Source.
023	CIC	Tran Id	T	Any	The Tran Id should be E or C.	Change the Tran Id to E or C. Otherwise check the Special Enroll.
031	IC	Process Date	Any	Any	Invalid Process Date.	Insert a valid date.
032	RIC	Process Date	Any	Any	The enrollment Process Date is before 1/1/2010.	Insert a date on or after 1/1/2010.
033	CIC	Process Date, Effective Date, PMG Tax Id Effective Date, PCP1 Effective Date	Any	JC CO	The enrollment Effective Date, PCP1 Effective Date and PMG Tax Id Effective Date should follow the carrier enrollment change's twenty days rule using the enrollment change Process Date as reference.	Check the enrollment Process Date. Otherwise, check the Effective Date, PCP1 Effective Date or PMG Tax Id Effective Date.
034	CIC	Process Date	Not T	MO JC CO	The enrollment Process Date should be on or before the ASES process date.	Check the enrollment Process Date. Otherwise, check the Data Source.
035	CIC	Process Date, Effective Date	Not T	MA	The enrollment Process Date should be before the enrollment Effective Date. The enrollment Process Date should be on or after three months before the enrollment Effective Date.	Check that the enrollment Process Date is set appropriately. Otherwise, check the enrollment Effective Date.

			T		The enrollment Process Date should be on or after the first day of the month following the enrollment Effective Date.	Check that the enrollment Process Date is on or after the first day of the month following the enrollment Effective Date. Otherwise, check the enrollment Effective Date.
036	RIC	Process Date, PCP1 Effective Date	Any	Any	The enrollment Process Date is more than three months before the PCP1 Effective Date.	Check that the enrollment Process Date is set appropriately. Otherwise, check the PCP1 Effective Date.
037	RIC	Process Date, PCP2 Effective Date	Any	Any	The enrollment Process Date is more than three months before the PCP2 Effective Date.	Check that the enrollment Process Date is set appropriately. Otherwise, check the PCP2 Effective Date.
038	RIC	Process Date, PMG Tax Id Effective Date	Any	Any	The enrollment Process Date is more than three months before the PMG Tax Id Effective Date.	Check that the enrollment Process Date is set appropriately. Otherwise, check the PMG Tax Id Effective Date.
041	BF	Region	Any	Any	The Region field is blank.	Insert valid content.
042	RIC	Region	Any	Any	The Region is different from the ASES process region. This is put in place to prevent a silent enrollment rejection.	Contact ASES to initiate a case review.
043	CIC	Region	Any	MO	If the Tran Id is C, then the Region should not be P.	Check the Tran Id. Otherwise, check the Region.
				MA JC CO	The Region should not be P.	Check the Region. Otherwise, check the Data Source.
051	BF	Carrier	Any	Any	The Carrier field is blank.	Insert valid content.
052	IC	Carrier	Any	Any	Invalid content for the Carrier code.	Insert valid content.
053	CAI	Carrier, Effective Date	T	MO	The Tran Id is C, but the currently enrolled carrier found at ASES member data for the retroactive eligibility period corresponding to the enrollment Effective Date matches the Carrier field.	Check the Carrier. Otherwise, check the Tran Id or if an enrollment is needed.

			Not T	MA CO	The Tran Id is C, but the currently enrolled carrier found at ASES member data matches the Carrier field.	
054	CAI	Carrier, PMG Tax Id, PCP1	Not T	MO	The Tran Id is E, but the current enrollment information (carrier, PMG tax id or PCP1) found at ASES member data does not match the Carrier, PMG Tax Id or PCP1 fields.	Check the Tran Id. Otherwise, check member data sent by ASES and if the enrollment still applies.
					The Tran Id is C, but the prospective enrollment information (carrier, PMG tax id or PCP1) found at ASES member data does not match the Carrier, PMG Tax Id or PCP1 fields.	
				JC CO	The Tran Id is C, but the prospective enrollment carrier found at ASES member data matches the Carrier field.	Check if the enrollment transaction is needed.
055	CAI	Carrier, Effective Date	Not T	Any	The contract information, corresponding to the enrollment Carrier and Effective Date, indicates that it does not cover the municipality found at ASES member data.	Check the enrollment Effective Date. Otherwise, check the Carrier.
			T		The contract information, corresponding to the enrollment Carrier and Effective Date, indicates that it does not cover the municipality found at ASES member data for the retroactive eligibility period corresponding to the enrollment Effective Date.	
056	CIC	Carrier, Region	Any	Any	The Region is P then Data Source should be MO and the Carrier should be 09.	Check that the Data Source is MO and the Carrier is 09. Otherwise, check the Region.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

057	CAI	Carrier, PMG Tax Id, PMG Tax Id Effective Date, PCP1 Effective Date, PCP2 Effective Date	Not T	MO	The Tran Id is I, the PMG Tax Id Effective Date is after the ASES process date and the Carrier is the same as the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ► The prospectively enrolled carrier at ASES member data is neither blank nor the same as the Carrier. ► The card id date at ASES member data is not populated. ► The prospective enrollment effective date at ASES member data is not the same as the PMG Tax Id Effective Date.	Check the Tran Id and the enrollment information against ASES data and make adjustments accordingly. Otherwise, check if the enrollment still applies.
					The Tran Id is I, the PMG Tax Id Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier at ASES member data is different from the Carrier. ►The new card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PMG Tax Id Effective Date.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

					The Tran Id is I, the PMG Tax Id Effective Date is on or before the ASES process date, but at least one of the following situations occur: ►The Carrier is different from the currently enrolled carrier at ASES member data. ►The card id date at ASES member data is not populated.	
					The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date and the Carrier and PMG are the same as the currently enrolled carrier and PMG at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier and PMG at ASES member data are neither blank nor the same as the Carrier and PMG. ►The card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PCP1 Effective Date.	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

					The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier at ASES member data is different from the Carrier. ►The prospectively enrolled PMG at ASES member data is different from the PMG. ►The prospective enrollment card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PCP1 Effective Date.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date, the Carrier is the same as the currently enrolled carrier at ASES member data and the PMG is different from the currently enrolled PMG at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier at ASES member data is different from the Carrier. ►The prospectively enrolled PMG at ASES member data is different from the PMG. ►The prospective enrollment card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PCP1 Effective Date.
	The Tran Id is 1 or 3, the PCP1 Effective Date on or before the ASES process date, but at least one of the following situations occur: ►The Carrier is different from the currently enrolled carrier at ASES member data. ►The PMG is different from the currently enrolled PMG at ASES member data. ►The card id date at ASES member data is not populated.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

					The Tran Id is 2, the PCP2 Effective Date is after the ASES process date and the Carrier and PMG are the same as the currently enrolled carrier and PMG at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier and PMG at ASES member data are neither blank nor the same as the Carrier and PMG. ►The card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PCP2 Effective Date.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

					The Tran Id is 2, the PCP2 Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ►The prospectively enrolled carrier at ASES member data is different from the Carrier ►The prospectively enrolled PMG at ASES member data is different from the PMG. ►The prospective enrollment card id date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not populated. ►The prospective enrollment effective date at ASES member data is not the same as the PCP2 Effective Date.	

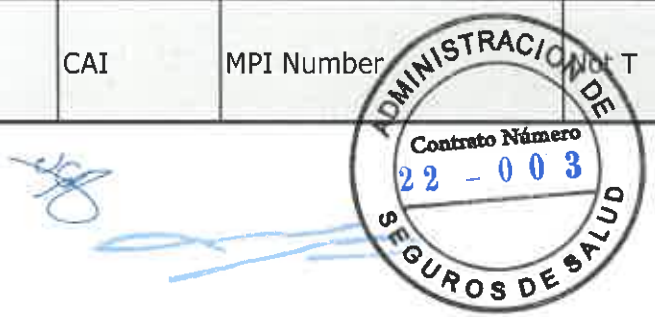
ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

					The Tran Id is 2, the PCP2 Effective Date is after the ASES process date, the Carrier is the same as the currently enrolled carrier at ASES member data and the PMG is different from the currently enrolled PMG at ASES member data, but at least one of the following situations occur: ▶The prospectively enrolled carrier at ASES member data is different from the Carrier. ▶The prospectively enrolled PMG at ASES member data is different from the PMG. ▶The prospective enrollment card id date at ASES member data is not populated. ▶The prospective enrollment effective date at ASES member data is not populated. ▶The prospective enrollment effective date at ASES member data is not the same as the PCP2 Effective Date.	
					The Tran Id is 2, the PCP2 Effective Date is on or before the ASES process date but at least one of the following situations occur: ▶The Carrier is different from the currently enrolled carrier. ▶The PMG is different from the currently enrolled PMG. ▶The card id date at ASES member data is not populated.	

061	CIC	PMG Tax Id	Any	Any	If the Tran Id is E, C, V or I and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PMG then the PMG Tax Id should not be blank.	Insert a PMG Tax Id. Otherwise check the Carrier, Plan Version, Effective Date or Tran Id.
062	CAI	PMG Tax Id, Tran Id	Not T	Any	The Tran Id is 1, 2, or 3 and the PMG Tax Id is not blank but the PMG is different from the currently enrolled PMG in ASES member data.	Change the PMG Tax Id accordingly. Otherwise check the Tran Id.
063	CAI	PMG Tax Id, Tran Id	Not T	Any	The Tran Id is I and PMG is required for the plan (Carrier, Plan Version) by the given enrollment Effective Date but the PMG is the same as the currently enrolled PMG in ASES member data.	Check the PMG Tax Id. Otherwise, check if the change is still needed.
071	BF	Family Id	Any	Any	The Family Id field is blank.	Insert valid content.
072	IC	Family Id	Any	Any	The content for the field is not 11 characters long and hence is invalid.	Insert content that is 11 characters long.
073	CAI	Family Id, Region	Not T	Any	The member (Region, Family Id) was not found in ASES data.	Check the Family Id and Region.
081	BF	Member SSN	Any	Any	The Member SSN field is blank.	Insert valid content.
082	IC	Member SSN	Any	Any	The content for the field is not 9 characters long and hence is invalid.	Insert content that is 9 characters long.
091	BF	Member Suffix	Any	Any	The Member Suffix field is blank.	Insert valid content.
092	IC	Member Suffix	Any	Any	Invalid content for the Member Suffix.	Valid content for Member Suffix is 01.
093	CAI	Member Suffix, Family Id, Region	Not T	Any	The member (Region, Family Id, Member Suffix) was not found in ASES data.	Check that the Member Suffix is 01. Otherwise check the Family Id and Region.
101	IC	Effective Date	Any	Any	Invalid enrollment Effective Date.	Insert a valid date.

102	RIC	Effective Date	Any	Any	The enrollment Effective Date is before 1/1/2010.	Insert a date on or after 1/1/2010.
103	CIC	Effective Date	Any	MO	If the Tran Id is E then the Effective Date should be before the ASES process date.	Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.
104	CIC	Effective Date	Not T	MO	If the Tran Id is E then the enrollment Effective Date should be before the ASES process date.	Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.
				JC CO	If the Tran Id is C then the enrollment Effective Date should be on or after the first day of the month following the ASES process date.	
105	CIC	Effective Date	Any	MA	If the Tran Id is not 1, 2 or 3 then the enrollment Effective Date should be a first day of the month.	Change the enrollment Effective Date to be a first day of the month. Otherwise, check the Tran Id.
107	CAI	Effective Date	Not T	MO MA	The member (Region, Family Id) had an interruption of eligibility after the enrollment Effective Date.	Change the enrollment Effective Date appropriately.
109	CAI	Effective Date	Not T	Any	The Effective Date is within a retroactive eligibility period for the member.	Change the enrollment Effective Date appropriately.
10A	CAI	Special Enroll	E	MO	The Tran Id is E, but the ASES member data does not indicate Medicaid federal program membership and thus Late Eligibility enrollment does not apply.	Change the Special Enroll field content. Otherwise, check the enrollment Effective Date.
10B	CAI	Effective Date, Special Enroll	N	MO	The Tran Id is E, but the enrollment Effective Date occurs before the member birth date found at ASES member data. The Tran Id is E, but the Effective Date occurs more than a year after the member birth date found at ASES member data.	Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.

					The Tran Id is E, but ASES member data does not indicate Medicaid Deemed Newborn classification.	Change the Special Enroll appropriately. Otherwise, check the enrollment Effective Date, Tran Id.
10D	CIC	Special Enroll	E	Any	The Plan Type should be 01 and the Data Source should be MO.	Check the Plan Type, Data Source or Special Enroll.
111	BF	Plan Type	Any	Any	The Plan Type field is blank.	Insert valid content.
112	CIC	Plan Type	Any	MA	The Plan Type should be 02.	Check that the Plan Type is 02.
				JC	The Plan Type should be 01.	Check that the Plan Type is 01.
				CO		
				MO		
				Any	The content for the field is not 2 characters long and hence is invalid.	Insert content that is 2 characters long.
113	CAI	Plan Type, Carrier, Plan Version, Effective Date	Any	Any	A match for the Carrier and Plan Version according to the given enrollment Effective Date was not found in ASES data.	Check the Carrier and Plan Version. Otherwise, check the enrollment Effective Date.
121	BF	Plan Version	Any	Any	The Plan Version field is blank.	Insert valid content.
122	IC	Plan Version	Any	Any	The content for the field is not 3 characters long and hence is invalid.	Insert content that is 3 characters long.
123	CAI	Plan Version, Effective Date	Any	Any	A match for the Plan Version according to the given enrollment Effective Date was not found in ASES data.	Check the Plan Versio. Otherwise, check the Effective Date.
131	IC	MPI Number	Any	Any	The content for the field is not 13 characters long and hence is invalid.	Insert content that is 13 characters long.
132	CAI	MPI Number	Not T	Any	The member (Region, MPI Number) was not found at ASES member data.	Check the MPI Number. Otherwise check the Region.



141	CIC	PCP1	Any	Any	If the Tran Id is not 2 and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1, then the PCP1 should not be blank.	Insert a PCP1. Otherwise check the Carrier, Plan Version, Effective Date or Tran Id.
142	CIC	PCP1	Not T	Any	If the Tran Id is 2, then the PCP1 should be blank.	Clear the PCP1 field. Otherwise, check the Tran Id.
151	CIC	PCP1 Effective Date	Any	Any	If the Tran Id is not 2 and the plan (carrier, plan version) contract corresponding to the Effective Date requires a PCP1, then the PCP1 Effective Date should contain a valid date.	Insert a valid date. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
152	CIC	PCP1 Effective Date	Any	Any	If the Tran Id is not V and the PCP1 Effective Date is populated, then the PCP1 Effective Date should be on or after 2015-01-01 and the plan (Carrier, Plan Version) contract corresponding to the enrollment Effective Date should require a PCP1.	Insert a valid date if appropriate. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
153	CIC	PCP1 Effective Date	Any	Any	If Tran Id is not 2 and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date does not require a PCP1 then PCP1 Effective Date should be blank.	Clear the PCP1 Effective Date field. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
154	CIC	PCP1 Effective Date	Not T	Any	If the Tran Id is 2 then, the PCP1 Effective Date should be blank.	Clear the PCP1 Effective Date field. Otherwise, check the Tran Id.

155	CIC	PCP1 Effective Date	Any	Any	If the Tran Id is E and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 then the PCP1 Effective Date should be on or before the ASES process date.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
156	CIC	PCP1 Effective Date	Any	Any	If the Tran Id is C, the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 and the PCP1 Effective Date is on or before the month of the ASES process date, then the PCP1 Effective Date should be a first day of the month.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
157	CIC	PCP1 Effective Date, PCP1	Any	Any	If the PCP1 Effective Date is blank, then the PCP1 should be blank.	Clear the PCP1 field. Otherwise, check the PCP1 Effective Date.
					If the PCP1 Effective Date is not blank, then the PCP1 should not be blank.	Insert a PCP1. Otherwise, clear the PCP1 Effective Date field.
158	CAI	PCP1 Effective Date, PCP1, Effective Date	Any	Any	The PCP1 is not blank and the Tran Id is E, C or I, but the PCP1 Effective Date is different from the enrollment Effective Date.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id or Effective Date.
			Not T		The PCP1 is not blank and the Tran Id is V, 1 or 3, but the PCP1 Effective Date is earlier than the current enrollment effective date at ASES member data.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id.
161	CIC	PCP2	Not T	Any	If the Tran Id is 2, then PCP2 should not be blank.	Insert a PCP2. Otherwise, check the Tran Id.
162	CIC	PCP2	Not T	Any	If the Tran Id is 1, then the PCP2 should be blank.	Clear the PCP2 field. Otherwise, check the Tran Id.

171	CIC	PCP2 Effective Date	Not T	Any	If the Tran Id is 2 or 3, then pcp2 effective date should contain a valid date.	Insert a valid date. Otherwise, check the Tran Id.
172	RIC	PCP2 Effective Date	Any	Any	The PCP2 Efective Date is before 1/1/2010.	Insert a date on or after 1/1/2010.
173	CIC	PCP2 Effective Date, PCP2	Any	Any	If Tran Id is E and PCP2 is not blank then PCP2 Effective Date should be on or before the ASES process date.	Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id or PCP2.
174	CIC	PCP2 Effective Date	Any	Any	If the Tran Id is C and the PCP2 Effective Date is on or before the month of the ASES process date, then the PCP2 Effective Date should be a first day of the month.	Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id.
175	CIC	PCP2 Effective Date, PCP2	Any	Any	If the PCP2 Effective Date is blank, then the PCP2 should be blank.	Clear the PCP2 field. Otherwise, check the PCP2 Effective Date.
					If the PCP2 Effective Date is not blank, then the PCP2 should not be blank.	Insert a PCP2. Otherwise, clear the PCP2 Effective Date field.
177	CAI	Effective Date, Process Date			The Tran Id is E or C, the enrollment Effective Date is on or before the ASES process date, but for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is before the historical enrollment period effective date.	Check the Effective Date. Otherwise, check if the enrollment still applies.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 0 0

			The Tran Id is E or C, the current enrollment carrier is populated at ASES member data, the enrollment Effective Date is on or before the ASES process date and on or before the current enrollment effective date at ASES member data, but the Process Date is on or before the process date for the current enrollment at ASES member data.	
		MA	The Tran Id is C, the prospective enrollment carrier is populated at ASES member data, the Carrier is different from the prospective enrollment carrier at ASES member data, the Effective Date is after the ASES process date and on or before the prospective enrollment effective date at ASES member data but the Process Date is on or before the process date for the prospective enrollment at ASES member data.	Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.
		Not T	The Tran Id is E or C, the current enrollment carrier is populated at ASES member data, for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is the same as the historical enrollment period effective date, but the Process Date is on or before the process date for the historical enrollment period at ASES member data.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

				MO	The Tran Id is E, the current enrollment carrier is populated at ASES member data, the enrollment Effective Date is on or before the ASES process date, but it is also on or before the current enrollment effective date at ASES member data.	Check the Effective Date. Otherwise, check if the enrollment still applies.
					The Tran Id is E or C, the enrollment Effective Date is on or before the ASES process date, but for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is before the historical enrollment period effective date.	
					The Tran Id is E, the enrollment Effective Date is on or before the ASES process date, but the current enrollment carrier is not populated at ASES member data.	Check if the enrollment still applies.
			T		The Tran Id is E or C, there is a previous retroactive eligibility enrollment at ASES member data for the period implicated by the enrollment Effective Date and the enrollment Effective Date is on or after the previous retroactive eligibility enrollment Effective Date but the Process Date is on or before the process date of the previous retroactive eligibility enrollment.	Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

178	CAI	PCP2 Effective Date, PCP2, Effective Date	Any		The PCP2 is not blank and the Tran Id is E, C or I, but the PCP2 Effective Date is different from the enrollment Effective Date.	Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id or Effective Date.
			Not T		The PCP2 is not blank and the Tran Id is V, 1 or 3, but the PCP2 Effective Date is earlier than the current enrollment effective date at ASES member data.	Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id.
179	CAI	Process Date, Effective Date	Not T	MA	The Tran Id is E or C, the prospective enrollment carrier and effective date are populated at ASES member data, the enrollment Effective Date is the same as the prospective enrollment effective date at ASES member data and the Carrier is different from the prospective enrollment carrier at ASES member data but the Process Date is on or before the process date of the prospective enrollment at ASES member data.	Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.
181	CIC	PMG Tax Id	Any	Any	If the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a family PMG then PMG Tax Id should not be blank.	Insert a PMG Tax Id. Otherwise check the Carrier, Plan Version or Effective Date.
191	CIC	PMG Tax Id Effective Date	Any	Any	If the plan (Carrier, Plan version) contract corresponding to the Effective Date requires a PMG then the PMG Tax Id Effective Date should contain a valid date.	Insert a valid date. Otherwise, check the Effective Date, Carrier and Plan Version.
192	RIC	PMG Tax Id Effective Date	Any	Any	The PMG Tax Id Effective Date should be on or after 1/1/2010.	Insert a date on or after 1/1/2010.

211	CAI	PMG Tax Id Effective Date	Not T	Any	The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date, but a record identifying the member as Federal Medicaid was not found at ASES member data and the PMG Tax Id Effective Date is not populated.	Insert a valid PMG Tax Id Effective Date. Otherwise, check the Effective Date, Carrier and Plan Version.
			T	MO	The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date but a retroactive eligibility record identifying the member as Federal Medicaid was not found at ASES member data and the PMG Tax Id Effective Date is not populated.	
221	DR	Region, Family Id, Data Source	Not T	Any	Only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions is allowed.	Include only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions.
			T		Only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch is allowed.	Include only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch.
			Not T	MO	The Tran Id is E but the Carrier is the same as the currently enrolled carrier at ASES member data and the card id date at ASES member data is populated.	Check if an enrollment is needed. Otherwise, check the Tran Id or Carrier.
				MA		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

222	CAI	Carrier	T	Any	The Tran Id is E but the Carrier and Plan Version are the same as the currently enrolled for the corresponding retroactive eligibility period at ASES member data and the card id date at ASES member data is populated.	Check if an enrollment is needed. Otherwise, check the Tran Id, Carrier or Plan Version.
223	CAI	Carrier	Not T	MO	The Tran Id is E but the Carrier is different from the currently enrolled carrier at ASES member data.	Check if an enrollment still applies. Otherwise, check the Tran Id or Carrier.
				MA		
			T	Any	The Tran Id is E but the Carrier is different from the currently enrolled for the corresponding retroactive eligibility period at ASES member data.	
224	CAI	Effective Date, Special Enroll	Not T	MO	The member is not eligible by the enrollment Effective Date at ASES member data.	Check the Effective Date.
				MA		
			T	MO	The member is not eligible at ASES member data by (i.e. there was no retroactive eligibility period corresponding to) the enrollment Effective Date.	
				MA		
225	CAI	Member SSN	Not T	MO	The Member SSN is not the same as the one found at ASES member data.	Check the Member SSN.
				MA		
				JC	The Member SSN is not the same as the one found at ASES member historical data.	
				CO		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

			T	MO	The Member SSN is not the same as the one from the corresponding retroactive eligibility record at ASES member data.	
226	CAI	MPI Number	Not T	Any	The MPI Number is not the same as the one from ASES member data.	Check the MPI Number.
			T		The MPI Number is not the same as the one from the corresponding retroactive eligibility record at ASES member data.	
228	CAI	Carrier, Data Source	Not T	MA	Tran Id is V but the Carrier is different from the currently enrolled at ASES member data.	Check the Carrier. Otherwise, check the Tran Id.
				MO JC CO	Tran Id is V.	Check the Tran Id. Otherwise, check the Data Source.
229	CAI	Carrier, Plan Type, Plan Version	Not T	Any	Tran Id is I but the Carrier or Plan Version are different from the currently enrolled at ASES member data.	Check the Carrier or Plan Version. Otherwise, check the Tran Id.
22A	CAI	Carrier, Plan Type, Plan Version, PMG Tax Id	Not T	Any	Tran Id is 1, 2 or 3, but the Carrier, Plan Version or PMG Tax Id are different from the currently enrolled at ASES member data.	Check the Carrier, Plan Version or PMG Tax Id. Otherwise, check the Tran Id.
22B	CIC	PCP1 Effective Date, PCP2 Effective Date	Not T	Any	If Tran Id is 3 then the PCP1 Effective Date and the PCP2 Effective Date should both be prospective or both be immediate relative to the ASES process date.	Check the PCP1 Effective Date or PCP2 Effective Date. Otherwise, check the Tran Id.
22D	CIC	Effective Date, PMG Tax Id Effective Date, PCP1 Effective Date, PCP2 Effective Date	Any	Any	The Effective Date, PCP1 Effective Date, PCP2 Effective Date and PMG Tax Id Effective Date should not be later than 4 months after the ASES process date.	Check the Effective Date, PCP1 Effective Date, PCP2 Effective Date or PMG Tax Id Effective Date.

22E	CAI	Plan Version, Effective Date	Not T	MO	The Plan Version is different from the coverage code found at ASES member data according to the enrollment Effective Date.	Check the Plan Version. Otherwise, check the Effective Date.
			T		The Plan Version is different from the coverage code found at ASES member data for the retroactive eligibility record according to the enrollment Effective Date.	
22G	CAI	Plan Version, Effective Date	Not T	MA	The Plan Version does not correspond with the coverage code found at ASES member data according to the enrollment Effective Date.	Check the Plan Version. Otherwise, check the Effective Date.
			T		The Plan Version does not correspond with the coverage code found at ASES member data for the retroactive eligibility record according to the enrollment Effective Date.	
230	BF	Data Source	Any	Any	The Data Source field is blank.	Insert valid content.
231	IC	Data Source	Any	Any	Invalid content.	Insert valid content.
232	CIC	Data Source	Any	MO JC CO	Plan Type should be 01.	Change the Plan Type to 01. Otherwise, check the Data Source.
233	CIC	Data Source	Any	MA	The Plan Type should be 02.	Change the Plan Type to 02. Otherwise, check the Data Source.
251	CIC	HIC Number, Plan Type	Any	MA	The content for the field is not 11 characters long and hence is invalid.	Insert content that is 11 characters long.
280	CAI	Region, Family Id	Not T	Any	The member (Region, Family id) was found in ASES data but is not currently eligible.	Check Region, Family Id and Effective Date.

281	CAI	Region, Family Id	Not T	Any	The member (Region, Family id) was not found in ASES data.	Check Region and Family Id.
980	CAI	Effective Date	Not T	MO	The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data, but there is a later assignment or enrollment to another carrier that is effective during the same month at ASES member historical data.	Check the Effective Date.
				MA	The enrollment is a Platino SYSPREM candidate but, at ases member historical data, there is a later assignment or enrollment to another carrier that is effective on the same date or later during the same month and the process date for said assignment or enrollment is on or after the Process Date for the SYSPREM candidate.	Check the Process Date. Otherwise, check the Effective Date.
982	CAI	Effective Date	Not T	MA	The enrollment is a Platino SYSPREM candidate, but the Effective Date is before 2015-01-01.	Check the Effective Date.
					The enrollment is a VITAL SYSPREM candidate, but the Effective Date is before 2018-01-01.	

				MO	The enrollment is a VITAL SYSPREM candidate and the Effective Date is on or after 2018-01-01, but there is not an eligible record in ASES member historical data containing an enrollment carrier and effective date which matches the SYSPREM candidate record Carrier and Effective Date	Check the Carrier or Effective Date.
983	CAI	Carrier, Plan Type, Plan Version	Not T	MO	The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data but the period implicated by the Effective Date is already enrolled under the same enrollment information (Carrier, Plan Version) at ASES member historical data.	Check the Carrier or Plan Version. Otherwise, check the Effective Date or if the enrollment is still needed.
				MA	The enrollment is a Platino SYSPREM candidate, but the period implicated by the Effective Date is already enrolled under the same enrollment information (Carrier, Plan Version) at ASES member historical data.	
984	CAI	Carrier, Effective Date	Not T	MO	The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data but the period implicated by the Effective Date is already enrolled under another carrier at ASES member historical data.	Check the Effective Date. Otherwise, check the Carrier or if the enrollment still applies.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

				MA	The enrollment is an Platino SYSPREM candidate and the Tran Id is E but the period implicated by the Effective Date is already enrolled under another carrier at ASES member historical data.	Check the Effective Date. Otherwise, check the Tran Id, Carrier or if the enrollment still applies.
985	CAI	Special Enroll	E	MO	The enrollment is a Late Enrollment (Special Enroll "E") SYSPREM candidate, but the group code from determined sysprem base record at ASES member historical data does not identify the member as a federal program beneficiary.	Check the Special Enroll. Otherwise, check if the enrollment still applies.
986	CAI	Effective Date	Not T	MO MA	The enrollment is a SYSPREM candidate and the member is currently eligible, but the Effective Date is on or after the enrollment effective date at ASES member data.	Check the Effective Date.
				MA	The enrollment is a SYSPREM candidate and the member is currently not eligible but the Effective Date is on or after the eligibility cancellation date at ASES member data.	
987	CAI	Member SSN	Not T	MO MA	The enrollment is a SYSPREM candidate but the Member SSN was not found at ASES member historical data.	Check the Member SSN.
988	CAI	N/A	Not T	MO MA	A SYSPREM base record could not be determined and, hence, the SYSPREM enrollment failed. This is a catchall to prevent a silent enrollment failure.	Check if enrollment still applies. Contact ASES to continue a joint investigation.

989	CAI	Special Enroll, Effective Date	N	MO	The enrollment is a Newborn Enrollment (Special Enroll "N") SYSPREM candidate, but a record containing a group code identifying the member as Deemed Newborn was not found at ASES member historical data.	Check the Special Enroll. Otherwise, check if the enrollment still applies.
996	ACK	N/A	Not T	MA MO	The enrollment was successfully processed as a historical enrollment (SYSPREM).	Confirm enrollment through the member data received from ASES on the same ASES process date.

Data Source Code	Data Source
MO	VITAL Carrier
MA	Platino Carrier
JC	Just Cause Process
CO	Enrollment Counselor

Any

MO, JC, CO

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22-003

Response Type Code	Response Type
BF	Blank Field Error
IC	Invalid Content Error
CIC	Conditionally Invalid Content
RIC	Relative Invalid Content
DR	Duplicate Records
CAI	Contextual Applicability Issue
HEA	Historical Enrollment Acknowledgement

Response Type Description
Field has been left blank
Field content is invalid.
Field content is invalid according to another field.
Field content is invalid in comparison to ther field or data.
Record is duplicate in a certain context.
Some issue in the in the context
Historical Enrollment Acknowledgement

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Special Enrollment Code	Special Enrollment Type
T	Retroactive Eligibility Enrollment
N	Deemed Newborn Enrollment
E	Late Eligibility Enrollment
	Ordinary Enrollment

Any

Not T

SYSPREM Classification Validation Code	Data Sources
107	MA. MO
280	MA, MO
177	MA, MO

SYSPREM Trand Id Code	Data Sources
E	MA, MO
C	MA

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

SYSPREM Allowed Validation Code	Data Sources
222	MA, MO
223	MA, MO
053	MA
054	MA, MO
211	MA, MO
225	MA, MO
132	MA, MO
226	MA, MO

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Transaction Id Codes	Data Source	Transaction Id Type
E	MO	New or Immediate Enrollment
	MA	
C	MO	Prospective Enrollment
	JC	
	CO	
	MA	Enrollment Carrier Change
I	MO	Enrollment PMG Change
	MA	
1	MO	Enrollment PCP1 Change
	MA	
2	MO	Enrollment PCP2 Change
	MA	
3	MO	Enrollment PCP1 and PCP2 Change
	MA	
V	MO	Enrollment Plan Version Change
	MA	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PLATINO PROGRAM ENROLLMENT MANUAL

TABLE OF CONTENTS

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

INTRODUCTION

Puerto Rico Health Insurance Administration

Description	The Puerto Rico Health Insurance Administration, hereinafter known as PRHIA or ASES, is a government corporation created in accordance with the Act No. 72 of September 7, 1993 as amended, also known as the "Puerto Rico Health Insurance Administration Act". PRHIA is created with the purpose of management, negotiation and contracting of health insurance plans that enable it to obtain, for its beneficiaries, particularly the medically needy, quality hospital services.
Responsibilities	Moving in that direction, PRHIA is the entity responsible of the negotiation, in representation of the Puerto Rico Health Department, the federal coverage authorized by CMS (this is, Medicare Platino and Federal PRGHP, which is constituted by the programs Medicaid and CHIP), with the corresponding health insurance companies. In addition, PRHIA manages issues of contracting related to the coverage provided by the State Puerto Rico Government Health Program "PRGHP" which addresses the State or Commonwealth Population which is found to be non-eligible to receive the benefits under a federal coverage classification with the contracted health insurance companies. Also, the PRHIA is charged with the administration of the services provided to the eligible beneficiaries under various health programs including the Platino Program and is responsible of executing the daily informatics operations and promoting its good performance. The PRHIA Information Systems Office is responsible of the management and processing of the enrollments for all the beneficiaries that are recipient of the services that the government administrated health insurance plans provide and is also responsible of validating the processes in progression to the payments of the contracted health insurance premium.

About This Document

Description	This document constitutes a reference manual designed with the purpose of aiding the Medicare Advantage Organizations (MAO) contracted by the PRHIA, in the Beneficiary enrollment processes. Within it, the topics about eligibility and enrollment related to transactions that are processed daily at the PRHIA Information Systems Office are addressed, and the implications that these transactions have over the enrollment processes and the corresponding premium payments are discussed. This version of the reference manual represents the first since the VITAL Program became operational on November 1, 2018. With its introduction, the VITAL Program received its very own Enrollment Manual and to that effect, this document delivers an exclusive reference of the enrollment processes for the Platino Program.

Purpose	This Enrollment Manual acts as the main support document for the Platino Program Enrollment Processes.
Content Highlights	Among the particular topics addressed, the following are noteworthy: the initial determination of eligibility and the transmission of the records of eligibility of the Beneficiary from the Medicaid Program, information contained within the enrollment records, daily Beneficiary enrollment processes (like the processing of new enrollments, updates, rejections and disenrollments), information exchange between the PRHIA and the health insurance companies, premium payment processes and the enrollment of beneficiaries in historical data archives. This document also contains tables, diagrams and examples that will help in the process of understanding all of the mentioned transactions which in turn will improve the efficiency and enable that the tasks related can be completed within the corresponding timeframes agreed with a successful outcome.

Revision Form

Release No.	Date	Revision Description
20190611	6/11/2016	Baseline Version

TERMS AND CONCEPTS

Definitions

Adjustments	A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a Contractor during a previous premium payment process.
ASES	Puerto Rico Health Insurance Administration (ASES for its acronym in Spanish). It is a public corporation created by Law in order to manage MCO services administered to the eligible population. Specifically, it is the organization responsible for the supervision and management of the Puerto Rico Government Health Insurance Plan (State and Federal GHP). In addition, it is the entity responsible for contracting the Medicare Advantage Organizations that will provide managed care to beneficiaries of the Platino Program. It also develops and supervises the administrative functions related to the beneficiaries' enrollment, providers, claims and premium payments.
ASES Information Systems Department	The Information Systems Office is the Department responsible of the management and processing of the enrollments for all the beneficiaries that are recipient of the services that the government administrated health insurance plans provide and is also responsible of validating the processes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	in progression to the payments of the contracted health insurance premium.
Beneficiary	A person who is eligible to receive services under a State GHP (State Population), Federal GHP (Medicaid and CHIP) Program or Platino Program, by virtue of federal and local laws and regulations.
Business Day	Every official working day of the week (Monday, Tuesday, Wednesday, Thursday, Friday). Puerto Rico holidays are excluded.
Calendar Days	The seven days of the week, except as otherwise stated.
Cancellation Date	The date in which a member loses his or her eligibility for the GHP Program. The Medicaid Office is the only entity with the authority to cancel an enrollee's eligibility.
Contractor	Provides Managed Care Services to beneficiaries. It is responsible for contracting with PMG's, PCP's and other providers. The Contractor charges ASES a PMPM Premium for its services.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health and Human Services which is responsible for the Medicare, Medicaid and the Children's Health Insurance Plan (CHIP).
Certification	A decision by the Puerto Rico Medicaid Program that a person is eligible for services under the GHP Program because the person is Medicaid Eligible or a member of the Commonwealth Population.
Certification Date	Date in which a person visits the Medicaid Program to apply for healthcare services and receives a favorable decision by the Puerto Rico Medicaid Program that a person is eligible for services under the GHP Program because the person is Medicaid Eligible, CHIP Eligible, or a member of the State Population.
Contractor	The Managed Care Organization that is a Party of this Contract, licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP program for the provision of Covered Services and Benefits to Enrollees on the basis of PMPM Payments.
Coverage Code	Code assigned by the Medicaid Program of Puerto Rico to all beneficiaries eligible to receive healthcare services under Federal and State GHP. This code establishes the level of indigence and, therefore, the Plan Type that should apply according to such a code. In the State GHP plans ("Commonwealth Population") the coverage code will coincide with the Plan Version.
Daily Run Processes Date	Day on which the validation processes of the data received from the Medicaid Program or the Contractors is carried out. These processes are carried out daily in the ASES Information Systems Office.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Data	A series of meaningful electrical signs that may be manipulated, assigned or data set: demographic. Health or other information elements suitable for specific use.
Disenrollment	The process by which an Enrollee's membership in the Contractor's Medicare Platino terminates.
Dual Eligible Beneficiaries	An Enrollee or potential enrollee eligible for both Medicaid and Medicare Programs.
Effective Date of Disenrollment	The date on which an Enrollee ceases to be covered under the Contractor's Plan.
Eligibility Effective Date	The period of eligibility specified for the population covered under the GHP Plan.
Enrollment Effective Date	Date on which the Contractor enrolls a Beneficiary in its database.
PCP Effective Date	Date on which a PCP1 or PCP2 change becomes effective.
Recertification Date	Date on which the Medicaid Program reevaluates a Beneficiary's eligibility.
Eligibility	Eligibility is determined by the Medicaid Program of the Puerto Rico Department of Health. Once the applicants are certified as eligible by the Medicaid Program, ASES is responsible for administering posterior business processes related to the provision of medical attention services.
Eligible Person	A person whom the Department of Health and/or the federal government determines to be eligible for Medicaid and who meet all other conditions for enrollment in the Medicare Platino Program.
Enrollee	An Eligible Person who, either personally or through an authorized representative, has enrolled in the Contractor's Medicare Platino Product.
Federal GHP	Program that offers coverage to the eligible population under the Medicaid Program.
Government Health Insurance Plan (GHP)	The Government Health Services Program (formerly referred as "La Reforma" or "Vital") offered by the Government of Puerto Rico, and administered by ASES, which serves mixed population of Medicaid Eligible, CHIP Eligible, and other Eligible Persons, and emphasizes integrated delivery of physical and behavioral health services.
Identification Card (ID)	Insurance Card that the Contractor offers to the Beneficiary, which identifies said Beneficiary by his name and contract number, and includes information about coverage, copayments, and customer service and health counselor phone numbers.

Managed Care Services	The services provided to the Beneficiaries by the doctors who belong to the network of preferred providers in their Primary Medical Group (PMG). The Primary Care Physician (PCP) is the primary service provider and responsible for periodically evaluating the Beneficiary's health and coordinating medical services.
Master Patient Index (MPI)	Unique number which identifies a Member in ASES and the Medicaid databases.
Medicare Advantage Organization (MAO)	A public or private organization licensed by the Insurance Commissioner Office of Puerto Rico as a risk-bearing entity that is under contract with CMS to provide the Medicare Advantage Benefit Package.
Medicaid	The medical assistance federal/state joint government program established by Title XIX of the Social Security Act. It also refers to the Program through which, in Puerto Rico, eligibility is determined for the Government Health Insurance Plan for an individual with low income, no income or limited resources, in compliance with regulations established by the Federal government and the Commonwealth of Puerto Rico.
Medicare	The Federal Program of medical assistance for persons over sixty-five (65) and certain disabled persons under Title XVIII of the Social Security Act.
Medicare Beneficiaries	People older than sixty-five (65) years of age or disabled or people who have kidney conditions, who are eligible for Medicare Part A coverage which covers hospital services or Parts A and B, which cover hospital, ambulatory and medical care services.
Medicare Part A	The part of the Medicare program that covers inpatient hospital stays, skilled nursing facilities, home health and hospice care.
Medicare Part B	The part of the Medicare program that covers physician, outpatient, home health, and preventive services.
Medicare Part C	The part of the Medicare program that permits Medicare recipients to select coverage among various private insurance plans.
Medicare Platino	A program administered by ASES for Dual Eligible Beneficiaries, in which Managed Care Organizations (MCOs) or other insurers under contract with ASES function as Part C plans to provide services covered by Medicare, and also provide a "wraparound" benefit Covered Services and Benefits under the GHP.
National Provider Identifier (NPI)	The unique identifying number system for health care providers created by the Centers for Medicare and Medicaid Services (CMS), through the National Plan and Provider Enumeration System.
Notice of Decision	Form issued by the Puerto Rico Medicaid Program, entitled "Notice of Action Taken or Application and/or Recertification" containing the Certification

	decision (whether a person was determined eligible or ineligible for Medicaid, CHIP, or the Commonwealth Population).
Plan	The Contractor's Managed Care Plan offering services to enrollees under the GHP.
Plan Type	Code 01: VITAL (GHP); Code 02 Medicare Platino.
Plan Version	Product identification number that corresponds with the Plan Type. For GHP Plans, the Plan Version will be the same as the coverage code assigned to the beneficiaries by the Medicaid Program. For Platino Plans, ASES will assign a Plan Version code for each contracted product.
Platino Health Plans	Medicare Advantage Organization (MAO) contracted with ASES. They have specific plans that cover beneficiaries with dual eligibility (Medicare Part A and Part B). ASES pays a monthly premium to these insurance companies to cover a differential between ASES and Medicare Advantage ("wraparound" benefit).
Premium Payment (PMPM Payment)	The fixed monthly amount that the Contracted Contractor is paid by ASES for each Enrollee to ensure that benefits under this contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.
Potential Enrollee	A person who has been certified by the Puerto Rico Medicaid Program as eligible to enroll in the GHP Program whether on the basis of Medicaid Eligibility, CHIP eligibility or eligibility as a member of the Commonwealth Population, but who has not yet enrolled with the Contractor.
Primary Care Physician (PCP)	A licensed medical doctor (MD) who is a provider and who within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required by Enrollees, provides continuity of care, and provides referrals for medicine physician, obstetrician/gynecologist, or pediatrician. This type of provider is contracted as part of the PMG on a PMPM basis.
Primary Medical Group (PMG-IPA)	A grouping of associated Primary Care Physicians and other Providers for the delivery of services to GHP Enrollees using a coordinated care model. PMGs may be organized as provider care organizations, or as another group of Providers who have contractually agreed to offer a coordinated care model to GHP Enrollees under the terms of the Contract. This Type of provider is contracted by the Contractor on a PMPM basis.
Process Date	For the export file (.exp) it is the date related to the daily run process. For the enrollment files (.sus) it is the date in which the changes in the enrollment records were processed at the Contractor. In the case of a new enrollment under a Platino Plan, it refers to the date on which the Beneficiary contracted the coverage services with the corresponding Contractor. In Platino plans, the Process Date must be prior to the Effective Date of the new enrollment

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 003

	or the change in question, but subsequent to the three (3) months prior to the Effective Date of the new enrollment or change.
Provider	A natural Person or facility authorized to offer healthcare services under the laws of the Government of Puerto Rico.
Re-enrollment	Refers to the process of re-enrollment for a Beneficiary of Federal GHP (Medicaid or CHIP) or State GHP (State Population) or Platino who has lost eligibility for a period of two (2) months. A Platino Medicare Beneficiary that recovers his/her eligibility within a period of two (2) consecutive months, may be enrolled automatically and prospectively under the Platino Medicare plan of the Contractor in question.
Recertification	A determination by the Puerto Rico Medicaid Program that a person previously enrolled in the GHP subsequently received a Negative Redetermination Decision, is again eligible for services under the GHP Program.
Retroactive Payment	Refers to a payment that corresponds to a period prior to the month in which the premium payment is made.
Special Adjustments	The special adjustments are carried out as a result of internal audit processes that reveal that a wrongly adjudicated payment must be reverted or that, on the contrary, an omitted payment must be adjudicated.
State Population	A group eligible to participate in the GHP as Other Eligible Persons, with no Federal participation supporting the cost of their coverage, which is comprised of low-income persons and other groups.
SYSPREM	System that provides for the enrollment of a Beneficiary in historical data. It allows the update and/or enrollment of data that corresponds to eligibility periods prior to the cancellation period of the eligibility of a Beneficiary or before an enrollment to a different Contractor comes into effect.
SYSRETRO	Term used by ASES which means retroactive eligibility record.
Eligibility Concepts	
Eligibility Determination	For each applicant to the Government Health Insurance Plan, hereinafter GHP, an eligibility determination precedes to the enrollment and premium payment processes performed at the ASES Information Systems Office. The Medicaid Program of the Commonwealth of Puerto Rico, which administers the Puerto Rico Medical Assistance Program, is the entity with authority to determine whether a person is eligible to receive medical services under the Federal GHP (Medicaid and CHIP) and State GHP (Commonwealth Population). The Medicaid Program is also responsible for certifying that a potential Platino Beneficiary is eligible to receive Medicaid coverage. The evaluation of the eligibility to each of the programs is based on criteria that comply with applicable state and federal regulations. Generally, the

	guiding criterion for determining the eligibility of an individual for the State GHP or Federal GHP is the level of income and its correlation with the levels of indigence. In the case of Platino Medicare plans, the age of the applicant (65 years or more) or the disability status as referred to in Title XVIII of the Social Security Act are considered. In any of the categories of the health plans, beneficiaries are annually certified. This means that normally their eligibility is extended for a period of one (1) year on each successful certification. Nevertheless, for Platino Medicare plans, the enrollment period may be extended for a period of eighteen (18) months. In those cases, in which the Medicaid Program had granted a period of eligibility of less than twelve (12) months, the period of enrollment will correspond to the shorter period granted.
Notice of Decision	The determination of eligibility of the Puerto Rico Medicaid Program granted to an applicant under both GHP programs is contained in a Notice of Decision, which is provided to the Beneficiary on the day it is certified. The potential Beneficiary may receive covered medical services by submitting the Notice of Decision to the health care provider from the day they were certified by the Medicaid Program until the day they receive their health insurance card by regular mail. Only eligible applicants for Federal GHP (Medicaid and CHIP) and State GHP (State Population) receive a Notice of Decision and can access covered medical services by submitting it.
Eligibility Effective Date	The Effective Date of Eligibility for purposes of a Medicaid or CHIP Potential Enrollee is the first day of the month in which the Medicaid Office determines eligibility. This should be the same date indicated as the eligibility period on the Notice of Decision. When an Enrollee re-certification is filed, and the Enrollee is again eligible, as determined by the Medicaid Office, the Effective Date of Eligibility for the subsequent period is generally the 1st of the month after eligibility expires from the previous eligibility period. If an Enrollee does not apply for Re-certification at the Medicaid Office once his/her eligibility period has expired, the eligibility for the GHP is lost. This will happen even in cases in which the Enrollee's eligibility was lost for at least one (1) day. The Effective Date of Eligibility for a new eligibility period for these cases will be the first (1st) day of the month of the new application for certification. The Effective Date of Eligibility for the State Population is the eligibility period specified on the Notice of Decision, and Potential Enrollees are eligible to be enrolled as of that date. Recertification for State Enrollees in which the Enrollee is found eligible again, the Effective Date of Eligibility is the first (1st) day of the month after the current eligibility expires. The date of certification for State beneficiaries will be when the certification is completed. If a State Enrollee's eligibility period expires before re-certification, the State Enrollee's eligibility will be processed as a new case and the Effective Date of Eligibility will be the new Effective Date of Eligibility provided in Notice of

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	Decision.
Certification Date and its Relationship with the Effective Date	The date on which the Medicaid Program issued an eligibility determination is known as the Certification Date. Under the State GHP the Effective Date will always coincide with the Certification Date and it would mark the beginning of the eligibility period granted to the Beneficiary. Under Federal GHP (Medicaid and CHIP), the Effective Date will fall in the first day of the month in which the Beneficiary is certified by the Medicaid Office. In both cases, the Certification Date is provided on the Notice of Decision.
Dual Eligible	An Enrollee or Potential Enrollee eligible for both Medicaid and Medicare (Part A or Part A and B).
Enrollment Concepts	
Effective Date of Enrollment	The Effective Date of an Enrollment refers to the date that a Contractor establishes as the beginning of the coverage period for a Beneficiary. The Effective Date for a Beneficiary's Enrollment under a Platino Medicare Plan will fall on the first day of the month in which the name of the Beneficiary appears on the CMS Prepaid Premium Plans List and on the first day of the month in which it appears enrolled in the Platino Medicare plan of the Contractor in question. Said information should be provided to ASES in the Enrollment Record's Effective Date data field.
PCP/PMG Change Enrollment Effective Date	If an enrollee changes PCP/PMG during the first five days of the month the change will be effective in the subsequent month. If an enrollee changes PCP/PMG after the fifth day of the month the change will be effective in the second month subsequent to the change. The enrollees can still receive services until the change is effective through the original PCP/PMG assigned by the Contractor.
Process Date ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 22 - 0 033	The Process Date has relevance both in cases of new enrollment of a Beneficiary and in cases of changes of PMG, PCP or Plan Version in relation to a record of enrollment of a Beneficiary. In the case of a new enrollment under a Platino Plan, it refers to the date on which the Beneficiary contracted the coverage services with the corresponding Contractor. This could be, also, a date provided by the Contractor that identifies the day on which a change of PMG/PCP or Plan Version in the record of a Beneficiary's enrollment was processed in its databases. In Platino plans, the Process Date must be prior to the Effective Date of the new enrollment. However, it must not go back beyond three (3) months prior to that Effective Date.
Transfer of Beneficiaries to Platino Products	Medicare Advantage beneficiaries who are granted Medicaid coverage may elect to transfer to the Medicare Platino products offered by their preferred Contractor or may enroll to Medicare Platino products available to dual eligible individuals. In these cases, ASES and the Contractor must process a

	new enrollment for the purpose of transferring the Beneficiary of the Medicare Advantage product to Medicare Platino. To the extent possible, such enrollments will be effective on the first day of the month in which the Beneficiary's Medicaid coverage is effective.
Recovery of Eligibility and Prospective Enrollment	In those cases in which the enrollment of a Platino Medicare Beneficiary is canceled due to the loss of eligibility under the Medicaid Program, but which recovers that eligibility within a period of two (2) consecutive months, it may be enrolled automatically and prospectively under the Platino Medicare plan of the Contractor in question assigning the same PCP/PMG in which the Beneficiary was previously enrolled.
Retroactive Enrollment for Platino Plans	For Platino plans, the enrollment may be extended retroactively from six (6) to eighteen (18) months prior to the date on which the Beneficiary's enrollment is processed at ASES. That is, the Information Systems Office of ASES may accept an enrollment of a Beneficiary of the Platino Plan for up to eighteen (18) retroactive months as long as the limits of the period to be enrolled fall within periods of eligibility granted by the Medicaid Program.

PLATINO PROGRAM ENROLLMENT PROCESS

Main Process

Description	ASES is able to employ a variety of methods for the purpose of subscribing persons who are eligible to receive coverage under Medicare Platino plans. This includes enrollment assisted by Platino Contractors, enrollment by ASES or a combination of both. The procedure used for the enrollment under the Platino Medicare Program is described below.
Eligibility Query Preceding a Medicare Platino Enrollment *See Reference C for Files Nomenclature	**Step 1a: CMS Query/Enrollment:** The Contractor requests a verification of a Beneficiary's eligibility for the Medicare Program with CMS and proceeds to enroll the Beneficiary accordingly. **Step 1b: ASES Query:** Through a file (".qry"), the Contractor requests to ASES a verification of a Beneficiary's eligibility for the Medicaid Program.
	Step 2: Response: ASES processes this query file and sends a response to the request in a file (.res). This file includes information regarding the Beneficiary's eligibility for the Medicaid Program, Medicaid Program specification for which the Beneficiary is eligible (federal or state), and the data that identifies the Beneficiary in the database, both at Medicaid and ASES.
	Step 3: Enrollment: If the Beneficiary is eligible for Medicaid coverage, the Contractor will complete an enrollment record that will include data corresponding to the health plan under which the Beneficiary is to be enrolled.
	Enrollment Rejections: **Step 4a: Enrollment File Integrity Validation Rejections:** While processing the enrollments file it is possible for an integrity validation error to occur. In these cases an error file (.err file) will be produced and a corrected version of the file in question should be resubmitted by the Contractor. The

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	length of the content of the required fields, the region and the data source is considered. **Step 4b: Enrollment Records Data Quality Validation Rejections:** While processing the enrollments file it is possible for a data quality validation error to occur. In these cases a rejection file (.rjc file) will be produced and a corrected version of the file in question should be resubmitted by the Contractor. **Step 4c: Validated Enrollment Records:** Once appropriately validated, ASES will edit and update the data in the electronic enrollment record to identify the individual as a Platino Medicare Beneficiary. A daily export (.exp) file is then sent to the Contractor that contains the data that shows the Beneficiary's enrollment to Medicare Platino.
	Step 6: PCP/PMG and Plan Version Enrollment Updates: Further enrollment updates for a given enrolled Beneficiary may be submitted by the Contractor to notify ASES of changes in the Beneficiary's enrollment pertaining to the PCP/PMG and Plan Version. Such enrollment updates will be submitted as enrollment records that will be subject to the processes, validations, corrections and resubmissions described in steps 3 thru 4c.
Enrollment Record	
Description	The enrollment record that is used by Contractors to notify ASES of the enrollment of a Beneficiary contains a series of data that are used for the purpose of informing the details of the enrollment made and to verify the accuracy and certainty of these. The enrollment transaction is the Contractor's confirmation and guarantee that the enrollee has been successfully enrolled in the Contractor databases and that a Platino Welcome Package or membership card has been sent to the enrollee. The Platino Program plans contracted with ASES require the assignment of Primary Care Physicians (PCPs) to beneficiaries by the Contractors. The enrollment record includes these fields as well as the Plan Type and the Plan Version. The enrollment record also reports the date in which a Beneficiary has been processed by the Contractor and the Effective Date of Enrollment.
Enrollment Record Fields	
RECORD_TYPE	In every case, and regardless of the transaction in question, this field requires the insertion of code "E" that identifies the entry as an enrollment record for both new enrollments of beneficiaries and changes on records of beneficiaries previously enrolled.
TRAN_ID	This field allows the ASES systems to identify the action to take on the record submitted. It can contain one of the values listed below. E=new enrollment C=Carrier change V= Version change I=IPA change 1=PCP1 change

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

*See Reference A for supporting information.	2=PCP2 change 3=PCP1 and PCP2 change
E	New Enrollment. This value identifies that the record is a new enrollment for a Beneficiary who has not been previously enrolled or that is currently inactive. For transactions previously enrolled, either by the same Contractor or one that is different from the previous enrollment, a "C" would be inserted. Note: For New Enrollments("E"): The system will require all fields related to information about the Contractor, Plan Type, Plan Version, PMG and PCP1 to be completed. The PCP2 information will remain as optional information for some cases.
C	Contractor Change. Used when the Beneficiary has selected a different Contractor than the one in which he/she is presently enrolled. It is also used for initial enrollment in Platino Plans when the beneficiaries were previously enrolled in a GHP plan and they opt to change to Platino. Note: For Change of Contractor Transactions ("C"): The system will require registering the name of the new Contractor and inserting information regarding the Plan Type, Plan Version, Primary Medical Group, PCP1 and PCP2 (optional) and Card Issue Date as the Process Date of the enrollment.
V	Plan Version Change. For Platino Contractors, it implies a change from a product the Contractor offers to one which is identified under the same Plan Type. This transaction code is also used when a GHP Beneficiary's coverage code changes. In these cases, the Contractor must reissue a health plan ID card displaying the new benefits, and submit a version change enrollment record to ASES where the version number corresponds to the new coverage code. **Failure to submit said information to ASES, will trigger an automatic disenrollment of the Beneficiary from the Contractor that omits the timely submission.** While in these circumstances the Beneficiary continues being eligible to receive the medical services, the Contractor will remain unable to claim a premium payment for said Beneficiary until a submission of the required information is performed. Note: For Plan Version Change Transactions ("V"): The Contractor code and Plan Type information provided must match the information in the ASES databases. Only information regarding the new assigned Plan Version will be provided. Information should also be provided in relation to the PMG and PCP1 Center.
I	Primary Medical Group (PMG) Change. It is used to register, in ASES, a change in the beneficiaries' selected PMG under the same Contractor, Plan Type and Version. Note: For PMG Change Transaction ("I"): Information regarding the Contractor, Plan Type and Plan Version must match the information contained in the ASES databases. Only new information will be sent to

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	ASES regarding the new PMG that corresponds to the Beneficiary.
1	PCP1 change. It is used to register, in ASES, a change in the beneficiaries' selected PCP1 under the same Contractor, Plan Type, Version and PMG. Note: For Change of PCP1 Transactions ("1"): It will be necessary that the information of Contractor, Plan Type, Plan Version and PMG provided coincide with the information contained in the ASES databases. It will be necessary to submit the new information regarding the change in PCP1 and it will not be necessary to provide information on the PCP2.
2	PCP2 change. It is used to register, in ASES, a change in the beneficiaries' selected PCP2 under the same Contractor, Plan Type, Version and PMG. Note: For Change of PCP2 ("2") Transactions: It will not be necessary to provide information about the PCP1. The only information allowed to differ with the one contained in the ASES records will be the one related to the PCP2.
3	PCP1 and PCP2 change. It is used to register, in ASES, a change in the beneficiaries' selected PCP1 and PCP2 under the same Contractor, Plan Type, Version and PMG. Note: For Change of PCP1 and PCP2 ("3"): It will be necessary to submit new information regarding the assigned PCP1 and PCP2. The information provided regarding the other fields should remain unchanged.
PROCESS_DATE	Process Date. Refers to the date on which the Beneficiary contracted the coverage services with the corresponding Contractor. It also refers to the date on which the Contractor processed a change in PMG, Plan Version, Plan Type or PCP.
REGION *See Reference B for supporting information.	Contains the region code assigned by ASES. This code must correspond to the region assigned to the Beneficiary in the ASES database. ASES is responsible for assigning this code to Platino Contractors. The Platino Plan Contractors obtain this code directly from ASES after a request process initiated for these purposes.
CARRIER	Two-digit Platino Contractor code assigned by ASES to each of the Contractors with the purpose of identification.
MEMBER_PRIMARY_CENTER	Primary Medical Group (PMG) code.
ODSI_FAMILY_ID	Eleven (11) last digits of the MPI number assigned by the Medicaid Office. Platino Contractors obtain this code from the ASES query response.
MEMBER_SSN	Social Security number of the member. It is required that this number matches with the one for the member in the ASES database.
	Two-digit number which identifies a member within a family. This is the

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

MEMBER_SUFFIX	second part of the identifier for the beneficiaries in the ASES database.
EFFECTIVE_DATE	Date in which the Contractors start providing coverage for the Beneficiary under the enrolled Plan or the change for which the enrollment record was submitted becomes effective. This date also refers to the date in which the PMG, PCP or Plan Version change becomes effective.
PLAN_TYPE	Plan Type code that identifies the one under which the member is enrolled.
PLAN_VERSION	Plan Version code that identifies the one under which the member is enrolled.
MPI- Master Patient Index.	It is a unique number that identifies a member in the ASES and Medicaid Program's databases.
PCP1	PCP1's NPI number. It is used to identify the PCP1 assigned by the Contractor or selected by the beneficiaries.
PCP1_EFFECTIVE_DATE	Date in which the PCP1 assignment became effective. If there is a change of PCP1, the initial PCP1 Effective Date will be kept until the Effective Date of the PCP1 Change has been reached.
PCP2	PCP2's NPI number. It is used to identify the PCP2 assigned by the Contractor or selected by the beneficiaries.
PCP2_EFFECTIVE_DATE	Date in which the PCP2 assignment was effective. If there is a change of PCP2, the initial PCP2 Effective Date will be kept until the Effective Date of the PCP2 Change has been reached.
FAMILY_PRIMARY_CENTER	Not in use.
PMG_TAX_EFF_DT	Date in which the assignment of the Beneficiary's PMG became effective.
IPA_PCP_CHANGE_REASON	This field is not currently in use.
MEDICARE INDICATOR	Required for Platino enrollments only. (01=A&B, 03=A, 09=B).
Health Insurance Claim Number (HICN Number)	MBI Number. Refers to the number assigned by the Social Security Administration to an applicant with the purpose of identifying him as a Medicare Beneficiary. The HICN appears in the Beneficiary's insurance card. All Medicare Beneficiary claims are processed according to this number. It is required for Platino beneficiaries' enrollment.
Additional Data Elements	When a Beneficiary's record is validated, the ASES system enters the following data in the enrollment record.
REJECT IDENTIFIERS	A = Accepted Enrollment M = Accepted Retroactively R = Rejected Enrollment

A = Accepted Enrollment	Identifier = "A": Identifies an accepted enrollment that will be applied on a current or future effective date. In this case, the update process moves the enrollment fields of the Contractor, Plan Type, Plan Version, PMG and PCP to the fields intended for new enrollments in the Beneficiary record. Until such time as the new Effective Date is reached, the Beneficiary will remain under the current enrollment condition (same Contractor, Plan, Version, PMG and PCP). During the end-of-month cycle, the new fields are moved to the current fields and the enrollment becomes effective.
M = Accepted Retroactively	Identifier = "M": Indicates a retroactive enrollment. In these cases, Enrollment data (Contractor, Plan Type, Plan Version, PMG and PCP) are updated directly in the Beneficiary's historical record.
R = Rejected	Reject Identifier "R": In cases when an enrollment record is not successfully processed because an error has been identified, it indicates a record returned for correction.
Reservation Number	Not applicable to Platino enrollments.
Error Codes one (1) to ten (10)	It is possible to record up to ten (10) error codes.
Update Date	Date for which the validation is run. Corresponds to the date of the daily cycle the validation run was a part of.
Update User	ASES internal user code.
IPA_ESPECIAL	Not applicable to Platino enrollments.
CONTRACT NUMBER	Contract number assigned by the Contractor. It should be the number by which the member is identified in the Contractors' ID card and internally in their database.
SPECIAL ENROLL	Not applicable to Platino enrollments.
PMG Tax ID	Include PMG Tax ID Number.
Data Source	**Specify "MA" for Platino enrollments.**
Enrollment Record Rejection	
Description	An enrollment record related to any type of enrollment, modification or update transaction could be rejected if it does not pass the validation tests at the ASES systems. As mentioned above, rejected enrollments are sent daily to Contractors in a rejection file (.rjc) that includes error codes for records that have not successfully passed the validation process. Contractors must correct identified errors and resubmit the corrected records to ASES with the next file submission.

ERROR CODES	See Enrollment Error Codes Table
DISENROLLMENT	
Description	The process of a disenrollment occurs only when ASES or the Medicaid Program determines that a Beneficiary is no longer eligible for GHP or Medicare Platino (termination of eligibility) or in those cases where a disenrollment is produced in response to a Coverage Code change if a corresponding Plan Version change is not successfully submitted before the end of the month after said coverage code change occurs (programmatic disenrollment).
Disenrollment Concepts	
Termination of Eligibility	The termination of eligibility refers to the cancellation of health services transaction due to the expiration of the eligibility period. It will be notified by the Medicaid Program and will be reflected in the ASES databases on the last day of each month. In these cases, ASES will be updating the information through the export file. Only the Medicaid Program may notify the cancellation of a Beneficiary's eligibility. Accordingly, the Contractor must disenroll the Beneficiary from the Platino Program.
Programmatic Disenrollment	Contractors should identify when a record received has a different coverage code than is recorded in their databases. This disenrollment takes place in those cases in which the Medicaid Program has sent a change of coverage code for a Beneficiary and the Contractor has not submitted an enrollment with the new Plan Version related to the change of coverage. In these cases, Contractors must assess whether the new Coverage Code requires the Beneficiary to be enrolled in a different Plan Version. If so, they must re-enroll these beneficiaries under the new Plan Version to correspond with the new coverage code. Subsequently, a change of Plan Version must be sent to ASES before the end of the current month. Beneficiaries who are not registered with a Plan Version that corresponds with the coverage code will be disenrolled in the run of the end-of-month cycle in the ASES databases. The carrier should re-enroll the beneficiaries that have been cancelled or disenrolled for this reason.
Carrier Change	When Beneficiary's data is received by ASES with a different carrier code from the one that appears in ASES database, it could mean that the Beneficiary has been enrolled with a different Contractor. In this case, the previous Contractor will be notified through the export file where a different carrier code than its own will occupy the carrier field. Accordingly, the

	previous Contractor must disenroll the Beneficiary in its database. In the case that the change is prospective, the previous Contractor enrollment data remains in the current data fields and the future Contractor data occupies the new data fields. At the end of the month previous to the prospective enrollment effective date, the new fields data is moved to the current data fields and both Contractors are duly notified. A premium payment recoupment will be performed if a payment has been previously granted to a Contractor that loses the Beneficiary retroactively.
Effective Date of Disenrollment	The effective date of disenrollment will fall on the last day of the month in which any of the events mentioned above take place.
SYSPREM	
Description	The main function of SYSPREM will be to allow the registration of the Beneficiary's enrollment in historical data in those cases that cannot be processed as current enrollments. Contractors must modify their systems so that the SYSPREM data is not included as current data when processing the eligibility file. Once a transaction is received, which must be processed through SYSPREM, a process of verification and validation of the information that is contained in the record is carried out. Once the validation tests have been passed, the record, in the database, containing the information corresponding to historical transactions is updated. Those records that do not successfully complete the verification processes will be sent in a file of rejected enrollments to the corresponding carrier for correction. Some beneficiaries will not appear as enrolled in history because they are not eligible for the Effective Date or because they are enrolled with a different carrier. Carriers need to evaluate the cases rejected by SYSPREM in order to identify errors in the assigned Effective Date and the correctness of the beneficiaries' data included in the enrollment record.
SYSPREM Classification Codes: Primary Error Codes	
Description	The following are enrollment validation error codes that represent base cause for classification for SYSPREM processing.
107	Effective Date before ineligibility period.
177	Effective date on or before current enrollment.
280	Not currently eligible.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
22 - 0 0 3

SYSPREM Allowed Error Codes: Secondary Error Codes	
Description	The following are enrollment validation error codes that are allowed as secondary to any Classification Codes during a SYSPREM candidate enrollment record evaluation.
053	Currently enrolled in same carrier (Platino Carrier Change).
132	Failed MPI match in current data.
211	Coverage limited to Federal Medicaid and beneficiary is not currently classified as so.
222	Currently enrolled in same carrier (Immediate Enrollment).
223	Currently enrolled in another carrier (Immediate Enrollment).
225	Failed SSN match in current data.
226	Failed MPI match for the given family id and member suffix.
SYSPREM Validation Error Codes	
Description	SYSPREM will perform certain validations in the process of evaluating candidate enrollment records for registering in historical data.
980	The latest enrollment from ASES historical data with effective date on or after but during the same month as the Effective Date of the Enrollment candidate to SYSPREM was processed later by the source of the enrollment.
982	Platino enrollment Effective Date is earlier than '2015-01-01'.
983	Already enrolled in the same carrier in ASES historical data by the Effective Date specified in the enrollment candidate to SYSPREM.
984	Already enrolled in ASES historical data by the Effective Date specified in the enrollment with Tran_Id = 'E' candidate to SYSPREM.
986	Effective Date is on or later than current enrollment Effective Date or Cancellation Date.
987	Member SSN not found in ASES historical data.
988	The MPI number specified by the enrollment candidate to SYSPREM did not match the MPI number found in ASES historical data by the stated Effective Date.

996	Not an error, but a notification that the record was processed by SYSPREM.

PREMIUM PAYMENT

Description	The premium payment system operates under the concept that premiums are calculated and paid only in relation to beneficiaries who are already enrolled before the first day of the month to which the payment corresponds. Beneficiaries enrolled after that date will be considered for the next payment of the corresponding premium, following all processing of updates and cancellations effective in that month. In order to standardize the payment schedule with VITAL, a Rate Cell was assigned for both Medicaid (Rate Cell: 38) and State (Rate Cell: 40) Platino beneficiary classifications. The detailed premium payment information for each beneficiary is relayed to the Contractor through the EDI 820 Payment File.
Premium Payment Concepts	
Payment Execution	In a monthly fashion, the system performs an automatic execution of payment. The premium paid for each enrollee will depend on his or her Rate Cell classification. Premium payments corresponding to Rate Cell 38 (EAP Medicaid) and Rate Cell 40 (EAP Commonwealth) will be made on the first day of the month following the acceptance of the enrollment by ASES. ASES will not pay premiums on beneficiaries that are not duly enrolled in the ASES databases nor will it pay premiums for beneficiaries whose records contain transactions that have been rejected in the ASES databases and have not been corrected within the periods established by contract.
Reasons for Not Executing a Payment	A premium payment will not be executed in favor of a Contractor in the following circumstances: (1) If the enrollee is not enrolled in the ASES databases before the first day of the month for which the payment transaction is being executed; (2) If the enrollment had been rejected by ASES and a new enrollment was not submitted by the Contractor with the relevant corrections (3) If ASES eligibility data demonstrates that the enrollee had a disenrollment (blank Card Issue Date), eligibility cancellation or changed the Contractor.
Monthly Payments	In this case the system produces a payment for those beneficiaries whose enrollment has already taken effect before the first day of the month for

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

	which the payment transaction is executed. The execution of premium payment is run on the first day of the month.
Retroactive Payments	These payments are calculated when the Effective Date of the Enrollment falls on a period prior to the month for which the premium payment process is being executed. In other words, this type of payment is executed when payments are identified corresponding to months prior to the month in which a premium payment is made. The retroactive payments will be computed based on the Enrollment Effective Date. The system will process the premiums for enrolled beneficiaries with an Effective Date prior to the payment date in the case of monthly premiums or prorated premiums that have not been previously paid within the time limits for retroactive payments. Retroactive payments may result in an adjusted payment if they are the result of a Contractor's cancellation of a previous enrollment or Contractor change.
Adjustments	A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a Contractor during a previous premium payment process. It occurs when, as a result of a retroactive payment calculation, a payment made in relation to the same enrollee is identified within the same period under which a Contractor change has been executed. In these cases, an adjustment to the premium paid to the first Contractor is made.
Special Adjustments	Generally, the special adjustments are carried out as a result of internal audit processes that reveal that a wrongly adjudicated payment (like for example, deceased beneficiaries, duplicate payments, PARIS eligibility match, etc.) must be reverted or that, on the contrary, an omitted payment must be adjudicated. For this type of adjustment, the Contractor will receive a list of transactions in which they can identify the type of adjustment (for example: a deceased), the adjusted months and the amount adjusted. The description of this list is found in Attachment 9, Special Adjustment File Layout.
Adjustment Type	The table below describes the various adjustment types identified by the premium payment process.

Adjustment Type Code	Description
1	DblPay
2	Deceased
4	COB

	<table><tr><td>5</td><td>Rate Adjustment</td></tr><tr><td>6</td><td>Reverse Adjustments</td></tr><tr><td>7</td><td>Fix Rate</td></tr><tr><td>8</td><td>Full Month Adjustment</td></tr><tr><td>9</td><td>Newborn</td></tr><tr><td>10</td><td>Ineligible</td></tr><tr><td>11</td><td>Special Reconciliation</td></tr><tr><td>12</td><td>Rate Cell</td></tr><tr><td>13</td><td>Maternity Kick Payment</td></tr></table>
EDI 820 Payment File	The reconciliation process carried out between ASES and the Contractors in relation to the payment of premiums must take into account the content of the EDI 820 files. This file is produced monthly by region, Contractor and Plan Type. It includes details for the premium payments that correspond to each of the beneficiaries assigned to the Contractors for the months in question. This encompasses the rate cell and, if applicable, the adjustment type information for each of those premium payments. In this file, a distinction is not made about if the payment corresponds to an adjustment from a regular premium payment process or a special adjustment. Thus, in cases when special adjustments proceed, ASES will provide a separated file for the special adjustments to the Contractor.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

REFERENCES

Reference A: Enrollment Hierarchy Table

Note: The table on the right identifies the information that each change will require and states the fields that will be impacted by each one.

Legend

Y: Information required for the transaction type specified.

O = Optional information.

N = Information that should not be sent for the transaction type specified.

Tran Id	Contractor	Plan Type	Version	PMG	PCP1	PCP2
E	Y	Y	Y	Y	Y	O
C	Different than ASES	Y	Y	Y	Y	O
P	Same as ASES	Different than ASES	Y	Y	Y	O
V	Same as ASES	Same as ASES	Different than ASES	Y	Y	O
I	Same as ASES	Same as ASES	Same as ASES	Different than ASES	Y	O
1	Same as ASES	Same as ASES	Same as ASES	Same as ASES	Y	N
2	Same as ASES	Same as ASES	Same as ASES	Same as ASES	N	Y
3	Same as ASES	Same as ASES	Same as ASES	Same as ASES	Y	Y

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Reference B: Region Codes

Region	Data Region Codes
North	A
Metro-North	B
East	E
Northeast	F
San Juan	J
Southeast	G
Southwest	S
Special	P
West	Z

Reference C: File Nomenclature

The tables below explain the nomenclature for several files that play important roles in the exchange of data pertaining with the eligibility and enrollment of beneficiaries.

1

ENROLLMENT FILE [CCYYMMDD.sus]
CC = Contractor Code
YY = Year
MM = Month
DD = Day
.sus = Identifies the file as an enrollment file. The enrollment file may contain records belonging to any of the regions contracted by the Contractor.
Notes: ✓ Files received at 9:00 am are entered in the ASES daily cycle. ✓ If a file is received after 9:00 am, it will be entered in the next day's cycle. See File Layout Attachment – Enrollment Record Layout (.sus)

2

ELIGIBILITY FILE [VYYMMDD.ref]
a. V = indicates that it is an eligibility file
b. YY = Year
c. MM = Month
d. DD = Day
e. .ref = Indicates that it is a file containing the records of the beneficiaries' eligibility

3	**DATA EXPORT FILE [CCYYMMDD.exp]** b. CC = Contractor code c. YY = Year d. MM = Month e. DD = Day f. .exp = Indicates that it is a file containing all the eligibility and enrollment transactions processed during the daily run. See File Layout Attachment – Carrier Eligibility File Layout (.exp)
4	**ENROLLMENT FILE [CCYYMMDD.err]** a. CC= Contractor Code b. YY = Year c. MM = Month d. DD = Day e. .err = Indicates that the records it contains did not pass the file integrity validation. These records are not going to be processed. **Notes:** The format is the same as the subscriptions file (.sus)
5	**REJECTED ENROLLMENTS FILE [CCYYMMDD.rjc]** a. CC= Contractor Code b. YY = Year c. MM = Month d. DD = Day e. .rjc= Indicates that it is a file containing the records of the beneficiaries who have been rejected. **Notes:** ASES will continue to run a separate edition and update cycle for each region. Enrollments are filtered through various editing and verification programs and identified as valid or rejected. This process produces a file (.rjc) that contains all the records that are rejected. See File Layout Attachment – Rejected Enrollment (.rjc) Note the (.rjc) and (.sus) share the same layout structure.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

6	**Premium Payment Transactions [PRCC0YYMM0000.820]** a. P = Identify Premium Payment b. R = region code c. CC = Contractor code d. 9 = Frequency e. YY = Year f. MM = Month g 0000 = IPA Direct Contract h. .820 = Indicates that it is a file containing all premium payment transactions processed monthly run.
7	**Eligibility Query File [CCYYMMDD.qry]** a. CC= Carrier Code b. YY=Year c. MM=Month d. DD=Day e. .qry =Indicates that is a file for eligibility verification. **Notes:** A '.qry' file is submitted by the carriers to verify a person's eligibility for the Medicare Platino Plan and GHIP Plans if necessary. Consequently, ASES generates a response in a '.res' (response) file with the requested information.
8	**Eligibility Query Response File [CCYYMMDD.res]** a. CC=Carrier Code b. YY=Year c. MM=Month d. DD=Day e. .res = Indicates that it is a query response file. Notes: This file is sent by ASES in response to a query file.

PREPARED BY			
IT Business Analyst	Rose A. Vázquez		June 2021
	(Print name)	(signature)	(date)
REVIEWED BY			
Project Leader/Information Systems Representative	Miladis Costoso		June 2021
	(Print name)	(signature)	(date)
APPROVED BY			
Information Systems Operations Division Manager	Ramiro Rodriguez		June 2021
	(Print name)	(signature)	(date)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Attachment 9
Information System

MedInsight Layout

Carrier to ASES Data Submissions

New File Layouts

Version 4.0B

April 27, 2020

MedInsight@asespr.org

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
2-003

TABLE OF CONTENTS

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

Version Changes

Version 3.0A

ASES file layouts ver. 3.0A for submission by Carriers for data generated from July 2018 forward

CAPITATION Input File Layout

CAPITATION TYPE field was modified.

PROVIDER Input File Layout

The descriptions for the provider address fields was changed to specify that it refers to the provider's physical address.
New fields added to the layout.

CLAIMSERVICES Input File Layout - Added

New fields added to the layout.

Data Validation and Auditing Change

New section regarding data validation and auditing added.

Version 3.0A rev3

Provider, Network, and IPA Files Layout

Frequency of Provider, Network, and IPA files changed from monthly to weekly.
Content of Provider, Network, and IPA files changed from only those entities that are present in claims to all active records.

CLAIMSERVICES Input File Layout

PLAN TYPE field and PLAN VERSION LIST were modified.

Version 3.0A rev4

Content of Provider and Network files changed from all active records to all active records, and "Out of Network" providers present in claims.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

Version 3.0A rev5

Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for "Out of Network" providers.

Version 4.0B

Additional Provider and Network files content requirements were added, for required fields that are unavailable for "Out of Network" providers.

New descriptions and/or validation rules were added to the CLAIMSERVICES Input File Layout, applicable to GHIP and Government Employee Carriers.

CARRIER CODES, PLAN VERSION LIST and Place of Service Codes were modified.

Introduction

The island of Puerto Rico's Medicaid program, the Government Health Plan (GHP) was established in 1993 with the passing of Law 72. Through Law 72, the program to administer the Medicaid program for roughly 1.3 Milliman people, the Administración de Seguros de Salud (ASES) was established. In order to continuously review health care utilization, expenditures, and performance in Puerto Rico and to enhance the ability of ASES to make informed and cost-effective health care choices, ASES has partnered with Milliman, Inc. to provide ASES with a data warehouse and analytics system. ASES has been capturing data from its managed care health carriers for many years to populate in the data warehouse and other systems. This layout document provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES.

Claims Transaction Handling

All Claims files are to be submitted on a monthly basis, for all Claims PAID in the month of the file submitted. All adjustments of an adjudicated claim line are accepted in the CLAIMSERVICES file. Do not send claims that are in an open status, such as pended claims, held, rejected, or pre-adjudicated claims. Claims reversals and adjustments happen as follows:

Paid or Denied FFS Claims

Individual service lines are adjusted or reversed at the line level with additional adjustment services marked with a claim line status code of 'A' or 'R', while the original claim has a status code of 'P' for paid, 'D' for denied claims, or 'E' for encounter claims. The adjusted or reversed service may have the same claim ID and line number or may have the same claim ID and a different line number.

Encounter Claims

Claims representing encounters have no allowed or paid amounts and are therefore not able to be adjusted monetarily. If an encounter needs to be updated to change any of the fields of the encounter, the adjusting claim must have a claim line status code (sv_stat field) of 'E' and the claim ID and service line number must be the same as the encounter being adjusted. Our process will remove the original encounter so that duplicate encounters will not be counted in the data.

Provider, IPA and Network Files

The Provider, IPA, and Network files are to be submitted weekly, every Wednesday and must include the latest available data from the day prior to the submission date. For each weekly submission within a given month, keep the same file naming convention, but increment the sequence number, starting with 0, then 1, 2, 3.

The IPA file shall include every IPA that is active in your system. The PRV and NET files shall include every Provider and Network record that is active in the carrier's and/or sub-contractor's system, and "Out of Network" providers associated with currently submitted claim records. ASES will be using this data to keep a current complete list of available Providers and IPAs.

The Provider and Network files must include all "In Network" providers directly contracted or sub-contracted with the carrier, and any "Out of Network" providers included on the CLM file. For "Out of Network" provider records, the carrier's will report as much information as available on their systems. The carrier shall submit "Out of Network" provider records with a contract effective date equal to '99991231'. For any required fields for which the carrier does not have valid information, the fields must be left blank.

ASES is requesting that provider NPIs are to always be used as the PROV_ID in order to assist in provider attribution and reporting across all Carriers. ASES will not accept the carrier's own provider id as the provider ID for medical claim, unless the carrier presents a valid reason for not using NPI's.

For pharmacy claims only

For pharmacy providers, only the NPI number will be accepted as the provider ID. Carriers must include pharmacy providers in their provider files sent to ASES and the IDs must be consistent within the carriers' claims.

Capitation Files

All Capitation files are to be submitted on a monthly basis, for all Capitation PAID in the month of the file submitted. The amount to be reported on capitation records must represent any costs associated with providing services which are not reported in claims and encounters. This may come from formal contracts with providers such as HCO/PCPs, or any other financial arrangement or allocation of costs.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

The cap_amount field should represent a calculation which includes the earned capitation for the period for each member. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

The gross_cap_amount field should represent a calculation that includes the earned capitation for the period for each member (not the group average).

The net_cap_amount field should represent a calculation which includes the earned capitation for the period for each member (gross_cap_amount) less claims paid amounts, if any, chargeable against the provider risk. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

Capitation records shall be provided for all members enrolled in the PMG's regardless of their risk coverage. The risk coverage type will be identified with a new risk type field.

Capitation Adjustments

There may be circumstances in which capitation payments which have already been reported, need to be adjusted or reversed in a later month. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record for the provider / member / experience date with an amount to be added or subtracted from the previously reported amount. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date and a Capitation Amount of -$10.00. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

Note that, as Capitation net amounts for any particular record may be negative, a reversal in such a case would be a positive amount.

Data Validation and Audit Process

After the files are loaded, Milliman will employ an automated validation process, File Field and Quality Checks (FFQC), to ensure that the format and content of each submitted file is valid and complete. Monthly files that do not pass the reconciliation process and the data audit process will be rejected. Load threshold levels for individual data elements submitted are validated against those pre-established levels defined by ASES and Milliman.

Failure to conform to any of the submission requirements will result in the rejection and return of the applicable data file(s). No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next month's files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

Due to the large amount and complexity of the data processed, it is more efficient to resubmit an entire file rather than to correct data within the file. Partial replacement files or record specific corrections will not be accepted.

Claims and Capitation Lag Reports

Carriers are required to submit claims and capitation payment reports, called lag reports, on a monthly basis. These reports will be used to reconcile the data submitted. Data that does not match the lag reports on paid amount within a reasonable percentage will be deemed invalid and must be corrected. The lag reports submitted by the carrier will be considered to be financially accurate and may be used for other purposes, including negotiations or other financial analyses. Therefore, it is in the carrier's best interests to produce lag reports that are either from another source that the actual files that are submitted, or to verify that the lag reports tie to financial reports.

The required claims lag reports need to be an Excel file with the following characteristics:

1. Claims paid amounts by:
    a. Region code of member as defined by ASES,
    b. Incurred month with deliverable data format YYYYMM,
    c. Paid month with deliverable data format YYYYMM, and
2. Claim type for claims, where can be filled in with one of the following default values: Medical, Pharmacy and Dental.
3. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.
4. Naming of the claims lag reports should be as follows:

    CLAIMLAG_ccyymms.xls(x)

    Where:

    Characters 1-9 Always "CLAIMLAG_"

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

Characters 10-11	cc	=	Carrier Code (See attachment II)
Characters 12-13	yy	=	Last two digits of year
Characters 14-15	mm	=	Month – last full paid month in the lags.
Character 16	s	=	sequence number of file submission.
Character 17	Always "."		
Characters 18-20(21)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Paid Amount
Medical	East	201801	201801	50,823.43
Medical	South	201801	201802	45,534.00
Medical	North	201801	201803	986,796.36
Pharmacy	East	201801	201801	686.89
Pharmacy	South	201801	201802	2,342.22
Dental	North	201801	201803	780,989.16
…	…	…	…	…

The required capitation lag reports need to be an Excel file with the following characteristics:

1. Capitation paid amounts by:
   a. Region code of member as defined by ASES,
   b. Capitation experience month (period for which the capitation payment applies) with deliverable data format YYYYMM,
2. Paid month with deliverable data format YYYYMM.
3. The report must include at least all paid and experience months going back 2 full years prior to the month the report is run.
4. Naming of the capitation lag reports should be as follows:

CAPLAG_ccyymms.xls(x)

Where:

Characters 1-7	Always "CAPLAG_"		
Characters 8-9	cc	=	Carrier Code (See attachment II)

Characters 10-11	yy	=	Last two digits of year
Characters 12-13	mm	=	Month – last full paid month in the lags.
Character 14	s	=	sequence number of file submission.
Character 15	Always "."		
Characters 16-18(19)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the capitation lag report data should look for claims is as follows:

Region	Incurred Month	Paid Month	Capitation Paid Amount
East	201801	201801	5,023.43
South	201801	201802	4,534.00
North	201801	201803	98,796.36
East	201801	201801	66.89
South	201801	201802	242.22
North	201801	201803	70,989.16
…	…	…	…

Primary Carrier ID

The *Primary Carrier ID* field in the ClaimServices Input File Layout identifies the entity (MBHO, Sub Contractor Entity, or TPA) which provides services to the enrollees throughout a special or capitated financial arrangement. Another field called *Carrier ID* field contains the ID of the carrier directly contracted with ASES and the one generating the ClaimServices Input File. The ClaimServices Input File will contain the same value in the *Carrier ID* and *Primary Carrier ID* fields when the carrier generating the ClaimServices Input File is the carrier providing services to the enrollees. If this entity does not have an assigned carrier ID from ASES, the *Primary Carrier ID* can be filled in with one of the following 4 default values that represents the type of entity:

MH – Mental Health
VS – Vision
DN – Dental
OT – Other/Unknown

General Notes on Field Level Requirements

Date Fields - All date fields in the following data layout are defined to the same size and format as YYYYMMDD. An 8 byte field where YYYY = 4 digit year, MM = 2 digit month and DD = 2 digit day. 1 digit month and day values must always have the leading zero (0). Date fields must contain a valid date with months between 01 and 12 and days between 01 and maximum day in month. July 1, 2006 will be coded as 20060701.

Amount Fields – All amount fields representing money must be numeric and are defined as 9 bytes in the format s9(7)v99 where v represents and implied decimal point. This allows a maximum of 7 digits for dollars plus the last two digits for cents. These numbers are always right justified and zero filled to the left. As examples:

$1.23 will be coded as	000000123
$100.00 will be coded as	000010000

All amount fields are positive and follow the above definition unless clearly specified otherwise.

End of Record Filler – All file layouts have been designed to end with a filler field of 1 byte which must always be coded as an "*" character. This is done to avoid issues between different systems when generating and transferring ASCII files in which ending field may be empty. The fixed End of Record Filler guarantees that all records in a file can be constructed to the fixed length format as defined in the layouts.

Justification and filling of Fields – The layouts have all been specified to provide fixed length fields and fixed length records. While other methods can be used, it is felt that this provides the best common ground for working with multiple entities each of which uses varying systems. To be sure everyone understands the same about the comments on justification and filling the following examples are given to help keep this concept clear.

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically numeric field are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a s9(7)v99 the following conventions apply:

- `S` - Leading sign
- `9(7)` - 7 decimal digits

- v - Implied decimal point
- 99 - 2 digits after the implied decimal point

The following examples illustrate how data will look in the field:

Value	Field
12.50	000001250
101	000010100
1,234.56	000123456
1,000,000	100000000
-1,234.56	-00123456

All alphanumeric fields must be filled completely. If the value of data in the field is less than the width of the field then care must be taken to ensure that the field is filled with blanks. Allowing "NULLS" or other special characters through may cause unexpected results and make reading, loading and validation of the data difficult. Typically alphanumeric field are left justified and filled to the right with blanks to complete the field. In a field specified as alphanumeric such a X(20) the following examples illustrate how data will look in the field where the [ ] characters represent the start and end of the field –

Value	Field
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]
(Metro-North Region)	[(Metro-North Region)]

MPI Number fields – In all files in which MPI Number is required, carriers should code all 9s if the MPI is unknown. This should not be true for any current beneficiary. This exception will continue until such time as ASES determines that the issue of MPI being unavailable has disappeared from historical data. For Government Employee MPI should be filled with Contract Number.

Data File Naming Conventions

All data files to be delivered to ASES by the carriers must follow the naming conventions below. Files which do not fit the naming convention will be ignored and the carrier deemed to have failed in delivery of such a file.

File names must adhere strictly to this naming convention as the structure includes information for identification of the carrier, dates and file type. If not named correctly the file cannot be processed properly.

The general format of file names will be –

Dccyymms.fff

Where:	Character 1	Always "**D**"		
	Characters 2-3	**cc**	=	Carrier Code (See attachment II)
	Character 4-5	**yy**=	Last two digits of year	
	Characters 6-7	**mm**	=	Month
	Character 8	**s**	=	sequence number of file submission.

All submission start with s = 0 and continue in numeric if files are re-submitted to 9
If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …

Character 9	Always "."	
Characters 10-12	Extension code identifying type of file	
CLM	for	CLAIMSERVICES
PRV	for	PROVIDERS
IPA	for	IPA
CAP	for	CAPITATIONS
NET	for	NETWORK

Files are always dated for the month being reported. For example, when sending claims paid in July 2018 the **yymm** part of the file name will be **1807** while the file will be sent to ASES in August.

Examples of completing this naming convention are –

For imaginary carrier 99 in the files for ClaimServices and payments in April 2018 will be named as follows –

ClaimServices	D9918040.CLM
Providers	D9918040.PRV
IPA	D9918040.IPA
Capitation	D9918040.CAP
Network	D9918040.NET

When the Capitation file is rejected, the corrected file will be re-submitted as
D9918041.CAP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	99	Required Must be two (2) digits (numeric).). Must equal a valid Carrier ID as assigned by ASES.
2	region_code	**Region Code**	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions	X	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X". For plan type "04", "05" and "06", value must be "X".
3	plan_type	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD 04 = Law 95 Commercial 05 = Law 95 Advantage 06 = Law 95 ELA-GHP	XX	Required Must equal "01", "02", "03", "04", "05", "06" Value "01' must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID. Values of "04" or "05" must correspond to government employee Carrier ID. Value "06' must correspond to an ELA-GHP ("ELA Puros") carrier.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
4	contract_type	**Contract Type**	Contract type to distinguish multiple plans within Plan Type. For government employee claims indicates contract type: 1 = Family 2 = Couple 3 = Individual 4 = Optional Dependent	X	Required for Plan Type "04", "05" and "06" (Government Employee) Not required for Plan Type "01", "02", or "03".
5	claim_id	**Claim ID**	Unique Identification number within Carrier with the addition of the claim_parent. May be Carrier's Internal Claim Identification number. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	X(20)	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
6	sv_line	**Service Line Number**	Number identifying individual service within a given claim.	XXXXX	Required Must be a maximum of 5 digits. ID of the Service Line within the Claim ID. Duplicates within Claim ID and Service Line Number on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier).
7	bill_type	**Bill Type**	Originating bill type – U=UB-04 / Institutional H=HCFA/CMS1500 / Individual / Professional P=Pharmacy Claim D=Dental Claim	X	Required Must equal "U", "H", "P" or "D"

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
8	ub_bill_type	**UB Type of Bill**	Type of Bill on the UB claim form. The type of bill encodes facility type, bill classification, and description.	**XXX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard three digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
9	sv_stat	**Claim Line Status**	Indicates payment action on the service represented by this record. P= Paid D=Denied A=Adjustment R=Reversal E=Encounter	**X**	Required Must equal "P", "D", "A", "R" or "E" If value is "E", service will have zero Paid Amount.
10	adj_code	**Adjustment Reason Code**	Adjustment reason code explaining why a claim payment was adjusted. Codes used are the X12 code list maintained by CMS and NUCC. The code set can be found at the following site: http://www.x12.org/codes/claim-adjustment-reason-codes/	**XXX**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A". Right justified. For claims without adjustment, this field must be left blank.
11	forced_claim_ind	**Forced Claim Indicator**	This code indicates if the claim was processed by forcing it through a manual override process.	**X**	'Y'- Yes 'N' - No
12	adm_date	**Admit Date**	For UB-04 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	**YYYYMMDD**	Required Must be a valid date
13	dis_date	**Discharge Date**	For UB-04 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	**YYYYMMDD**	Required Must be a valid date Must be equal or later than Admit Date

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	from_date	**Service From Date**	Begin date of the treatment.	**YYYYMMDD**	Required Must be a valid date.
15	to_date	**Service To Date**	End date of the treatment.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service From Date
16	paid_date	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service To Date
17	rec_date	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Discharge Date
18	entry_date	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Received Date
19	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
20	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
21	primary_center	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Must be present on all claims of Plan Type "01" May be present on claims of other Plan Types When present it indicates the Primary Care Center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Carrier ID and IPA.
22	ssn_mainh	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
23	ssn	**Patient Social Security**	Social Security Number of member	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
24	member_suffix	**ASES Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be ASES Assigned member suffix. All numeric value 01 to 99.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
25	patient_name	**Patient Name**	Member Name	**X(30)**	Required Must be left justified, blank filled to the right.
26	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
27	sex	**Sex Code**	Gender of member M = Male F = Female	**X**	Required Must equal "M" or "F"
28	birth_date	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date. Must be equal or earlier than Admit Date.
29	municipality_res	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
30	municipality_code	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled. For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
31	drg_code	**DRG Code**	Diagnosis Related Group Code	**XXXX**	Must be a valid DRG Code

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
32	drg_type	**DRG Type Code**	DRG Type Code, representing the type of DRG Code submitted on the claim.	**X**	Required when DRG is provided. Must be one of the following: 1= MS DRG 2= CMS DRG 3= AP DRG 4= APR DRG
33	drg_outlier_amt	**DRG Outlier Amount**	Additional amount paid by carrier on a claim that is associated with either a cost outlier or length of stay outlier.	**S9(7)v99**	For claims submitted on Uniform Bill (UB) claim form. Must be zero for encounters. Must be zero for Services with Payment Status of "D". On non-UB claims must be blank.
34	drg_rel_weight	**Relative DRG Weight**	Indicates the relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year.	**X(6)**	If populated, must be a valid weight without any decimal points. Left justified, blank filled. A DRG weight of 2.397 should be reported as 2397.
35	pre_auth_num	**Pre-Authorization Number**	The number identifying pre-authorization. An unique identification number, that indicates the services provided on this claim have been authorized by the carrier (Also called Prior Authorization)	**X(20)**	Should be supplied when available. Left justified, blank filled to 20 characters if value is less than 20 characters.
36	proc_code	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	**X(15)**	For claims from CMS1500 / UB-04, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code. For Pharmacy claims this must be all blanks.
37	cpt_mod_1	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
38	cpt_mod_2	**Procedure Modifier Code 2**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code Must be left blank for encounters
39	cpt_mod_3	**Procedure Modifier Code 3**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
40	cpt_mod_4	**Procedure Modifier Code 4**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
41	cpt_mod_5	**Procedure Modifier Code 5**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
42	cpt_mod_6	**Procedure Modifier Code 6**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
43	rev_code	**Revenue Code**	For UB-04 Claims NUBC Revenue Code	**X(4)**	Required for UB-04 claims. When present it must be a valid Revenue code. Must be zero filled to the left.
44	rx_ndc	**National Drug Code**	For Pharmacy only. National Drug Code value for prescribed drug in 5 4 2 format	**X(11)**	Required on Pharmacy claims. Must be a valid NDC code in 5 4 2 format filling all 11 bytes. For non-Pharmacy claims must be blank.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 00

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
45	tooth_code	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	**XXX**	Must be present on Dental claims when Procedure code requires Tooth Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.
46	surface_code	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	**X(7)**	Must be present on Dental claims when procedure code requires Surface Code. Must be a valid Surface Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.
47	Icd_diag_01	**Primary ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
48	Icd_diag_02	**Second ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
49	lcd_diag_03	**Third ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
50	lcd_diag_04	**Fourth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
51	lcd_diag_05	**Fifth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
52	lcd_diag_06	**Sixth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22 - 00 8

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
53	lcd_diag_07	**Seventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
54	lcd_diag_08	**Eighth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
55	lcd_diag_09	**Ninth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
56	lcd_diag_10	**Tenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
57	Icd_diag_11	**Eleventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
58	Icd_diag_12	**Twelfth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
59	icd_proc_01	**Primary ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
60	icd_proc_02	**Second ICD10 Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
61	icd_proc_03	**Third ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
62	icd_proc_04	**Fourth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
63	icd_proc_05	**Fifth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
64	icd_proc_06	**Sixth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
65	pcp_prov_id	**PCP Provider**	National Provider Identifier (NPI) of the member's PCP.	**X(20)**	Required for Plan Type "01" claims Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI
66	att_prov_id	**Attending Provider**	National Provider Identifier (NPI) of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
67	att_taxonomy	**Attending Provider Taxonomy**	Indicates the corresponding provider taxonomy of billing entity/provider, to define provider's type, classification, and area of specialization. The taxonomy code for the institution billing/caring for the beneficiary.	**X(12)**	Required Left justified, blank field to the right.
68	ref_prov_id	**Referring Provider**	National Provider Identifier (NPI) of referring provider, when applicable.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.
69	ref_prov_taxonomy	**Referring Provider Taxonomy**	Indicates the corresponding provider taxonomy of referring provider, to define provider's type, classification, and area of specialization.	**X(12)**	Left justified, blank field to the right.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
70	bill_prov_id	**Billing Provider**	National Provider Identifier (NPI) of the provider billing for the service.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
71	network_affiliation	**Network Affiliation**	Indicates if the service provider is in the preferred provider network or not. Y = Yes N = No	**X**	Required Must be "Y" or "N".
72	primary_carrier_id	**Primary Carrier ID**	Value that identifies the primary carrier providing service to the patient. May be the same as the carrier_id field or another carrier as a sub-contractor – a MBHO, Vision, or Dental plan. See Carrier ID List in Attachment II	**XX**	Required Must be two (2) digits (alpha-numeric). Must equal a valid Carrier ID as assigned by ASES if one has been assigned. If sub-contracted entity does not have a carrier code assigned by ASES, the following default codes may be used to represent the type of sub-contracted entity is the primary carrier: MB – Mental Health VS – Vision DN – Dental OT – Other/Unknown Carrier Type
73	pos_code	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	**XX**	Required Must be a valid Place of service Code.
74	cob_code	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise.	**X**	Required Must be "Y" or "N"

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
75	amt_billed	**Billed Amount**	For non-Pharmacy Cost of service as billed by the provider.	**S9(7)v99**	Required for non-Pharmacy claims. Must be a number on all non-pharmacy records. Cannot be left blank for non-pharmacy.
76	amt_allowed	**Allowed Amount**	For non-Pharmacy Amount allowed for the service by the carrier.	**S9(7)v99**	Required for non-Pharmacy claims. Must be a number on all records Must be zero for encounters or denied services (Payment Status (sv_stat) = "E" or "D") Cannot be left blank For sv_stat "P" (Payment Status = "paid") this must be greater than zero.
77	deduct	**Deductible**	Amount paid by member before payments by the carrier begin for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
78	copay	**Co-Pay**	Amount paid by member as dollar co-payment for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
79	cob	**COB Amount**	Amount paid by other Health Insurance attributable to this service.	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
80	coins	**Coinsurance Amount**	Amount paid by member as percentage of cost for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
81	amt_paid	**Paid Amount**	Amount paid by carrier for this service	**S9(7)v99**	Required Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with sv_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – For non-Pharmacy: amt_paid = amt_allowed - deduct - copay - cob - coins For Pharmacy: amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee **For Plan Type "02", "03", "04", "05", "06" only** - amt_paid may be zero if the appropriate calculation above results in 0.00. For Plan Type "01" the amt_paid must be greater than zero.
82	enc_proxy_price	**Encounter Proxy Price**	This field shows the amount that would have been paid for this exact same service if it had been processed as a Fee For Service claim. It does not represent an actual dollar disbursement.	**S9(7)v99**	Required on Encounter claims. On non-encounter claims, it must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
83	rx_disc	**Drug Discount**	For Pharmacy only Amount Discounted at the Pharmacy This is the discount given from AWP to get the Ingredient Cost When drug is paid from a MAC list the discount amount will be Zero (0) This field does not form part of the calculation to get Amount Paid but can be used with Ingredient Cost to work back to AWP.	**S9(7)v99**	Required on Pharmacy claims. On non-Pharmacy claims must be blank.
84	rx_ingr_cost	**Ingredient Cost**	For Pharmacy only. Cost of ingredient(s) dispensed for this Service.	**S9(7)v99**	Required on Pharmacy claims. Must be greater than zero. On non-Pharmacy claims must be blank.
85	rx_disp_fee	**Dispensing Fee**	For Pharmacy only. Dispensing fee charged by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. Must be a number On non-Pharmacy claims must be blank.
86	rx_total_disp	**Total Quantity Dispensed**	For Pharmacy only. Total quantity of drug dispensed by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. For non-Pharmacy claims must be blank. May include decimal point. This field is only applicable when the NDC code billed can be quantified in discrete units. Left justified, blank filled.
87	rx_days_supply	**Prescription Days**	For Pharmacy only. Number of days prescribed and dispensed.	**999**	Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank.
88	rx_drug_type	**Drug Type Code**	For Pharmacy only. Code identifying type of drug on pharmacy claims.	**XX**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
89	rx_daw	**Dispensed As Written**	For Pharmacy only. Code indicating "Dispense as written" status of the prescription on pharmacy claims	**X(6)**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank Valid Codes are – 0 - NO DISPENSE AS WRITTEN 1 - PHYSICIAN writes DISPENSE AS WRITTEN 2 - PATIENT REQUESTED 3 - PHARMACIST SELECTED BRAND 4 - GENERIC NOT IN STOCK 5 - BRAND DISPENSED, PRICED AS GENERIC 6 - OVERRIDE 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW 8 - GENERIC NOT AVAILABLE 9 - OTHER
90	rx_refill_cnt	**Refill Count**	For Pharmacy only. The number of refills specified by the physician writing the prescription on pharmacy claims.	**9(6)**	Required on Pharmacy claims When present must be a number On non-Pharmacy claims must be blank
91	rx_par	**Participating Pharmacy Flag**	For Pharmacy only Indicates whether prescription was dispensed by a participating pharmacy on pharmacy claims Valid values – "Y" = participating pharmacy "N" = non-participating pharmacy	**X(7)**	Required on Pharmacy claims Left justified, blank filled Must be "Y" or "N" On non-Pharmacy claims must be blank

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
92	compound_dosage_form	**Compound Dosage Form**	For Pharmacy only. Indicates the Dosage form of the complete compound mixture. Compound code are identified as: 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema Blank = Not Specified	**XX**	Required on Pharmacy claims On non-Pharmacy claims must be blank All numeric, right justified, zero filled.
93	compound_drug_ind	**Compound Drug Indicator**	For Pharmacy only. Indicator for whether to specify if the drug is compound or not. Y= Drug is compound N= Drug is not compound	**X**	Required on Pharmacy claims. On non-Pharmacy claims must be blank. Must be "Y" or "N"
94	date_prescribed	**Prescription Date**	For Pharmacy claims, this is the date where a prescription was written for the member individual.	**YYYYMMDD**	Required on Pharmacy claims. Must be a valid date. Must be on or before Service From Date. For non-Pharmacy claims must be blank.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
95	ndc_unit_type	**NDC Unit of Measure**	A code to indicate the basis by which the quantity of the National Drug Code is expressed. Value must be equal to a valid value. Valid Values: "F2" = International Unit "GR" = Gram "ME" = Milligram "ML" = Milliliter "UN" = Unit	**XX**	Required on Pharmacy claims. For non-Pharmacy claims must be blank. Describes the basis of the amount reported on the NDC Quantity-QUANTITY and RX-CLAIM-QUANTITY-ALLOWED Fields.
96	prescription_num	**Prescription ID**	The unique identification number assigned by the pharmacy or supplier to the prescription. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
97	rx_quantity_allowed	**RX quantity allowed**	The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month.	**X(9)**	Required on Pharmacy claims For non-Pharmacy claims must be blank. Must be without any decimal points May include decimal point. For example, an amount of 30 should be coded as 3000. This field is only applicable when the NDC code being billed can be quantified in discrete units and should be described by the **NDC-UNIT-OF-MEASURE** field. Left justified, blank filled.
98	rebate_eligible_indicator	**Rebate Eligible Indicator**	An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.	**X**	"Y"- Yes "N"- No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
99	ub_dis_stat	**UB Discharge Status Code**	On UB-04 claims, Patient Status Code at discharge.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard two digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
100	risk_type	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Shared risk agreement should be identified as "SHR" Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM only value can be "UNK"
101	stop_loss_flag	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member Otherwise "N". When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"	**X**	Required Must be filled ""Y" or "N"
102	applied_cost	**Cost Applied To**	For Medicare Platino, defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	**X**	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled and be a valid value. Not Required for Plan Type "01", "04", "05", "06"

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
103	ases_split_amt	**ASES Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to ASES coverage.	**S9(7)v99**	Must be filled if Cost Applied To = "1" or "3" Not Required for Plan Type "01", "04", "05" or "06".
104	cms_split_amt	**CMS Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to CMS (MA) coverage.	**S9(7)v99**	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 2 or 3 Not Required for Plan Type "01", "04", "05" or "06"
105	off_island	**Off Island Flag**	Indicator for whether service was located off of the islands of Puerto Rico, Culebra, and Vieques.	**X**	Required Y=Off Island N=On Island
106	plan_version	**Plan Version**	Plan Version to distinguish multiple plans within the Plan Type. Always three numeric characters, e.g. 001 See Plan Version List in Attachment VI	**XXX**	Required Must be a 3 digit Plan Version Code Carrier ID, Plan Type, and Plan Version must validate with a plan definition contracted with ASES. Required for Plan Type "02", "03" (Medicare Platino), "04", "05" and "06" Not Required for Plan Type "01"
107	sv_units	**Units of Service**	Number of occurrences of service	**9(10)**	When present must be a number.
108	claim_type	**Claim Type**	Claim Type: I=Inpatient O=Outpatient P=Professional	**X**	Required for all medical claims. For Rx and Dental claims, this field can be left blank. Must equal "I", "O" or "P" if populated.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
109	admission_hour	**Admission Hour**	For UB-04 claims, this is the hour of admission. The hour code must be a two-digit code, based on 24-hour clock. See Hour Codes in Attachment VIII	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See attachment VIII for the codes to be used.
110	discharge_hour	**Discharge Hour**	For UB-04 claims this is the hour of discharge. The hour code must be a two-digit code, based on 24-hour clock.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See Hour Codes in Attachment VIII
111	admission_type	**Admit Type**	Admit type code indicates the primary reason (priority) for admission. Admission codes: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information Not Available	**X**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Bill (UB) data specifications manual.
112	adm_prov_id	**Admitting Provider Id**	National Provider Identifier (NPI) of member's admitting provider.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
113	adm_prov_taxonomy	**Admitting Provider Taxonomy**	Indicates the corresponding provider taxonomy of admitting provider, to define provider's type, classification, and area of specialization.	**X(12)**	Generally, the provider taxonomy requires 10 bytes. However, two additional bytes have been provided for future expansion. Must be left justified and blank filled to the right
114	check_eff_date	**Check Date**	Check Date is the date when the check or electronic remittance for payment is processed.	**YYYYMMDD**	Must be a valid date. Must be on or after Service To Date. Not required for denied claims.
115	check_num	**Check Number**	Check Number is the check or electronic remittance number for payment.	**X(50)**	Must be left blank for Services with Payment Status of "E". Left justified, blank filled to 50 characters if value is less than 50 characters. Not required for denied claims.
116	claim_rem_code_01	**First Remittance Advice Remark Codes (RARCs)**	Indicates the first RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
117	claim_rem_code_02	**Second Remittance Advice Remark Codes (RARCs)**	Indicates the second RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
118	claim_rem_code_03	**Third Remittance Advice Remark Codes (RARCs)**	Indicates the third RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
119	claim_rem_code_04	**Fourth Remittance Advice Remark Codes (RARCs)**	Indicates the fourth RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
120	poa_ind_1	**First Present on Admission (POA) Indicator**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
121	poa_ind_2	**Second Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
122	poa_ind_3	**Third Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
123	poa_ind_4	**Fourth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
124	poa_ind_5	**Fifth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
125	poa_ind_6	**Sixth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
126	poa_ind_7	**Seventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
127	poa_ind_8	Eighth **Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
128	poa_ind_9	**Ninth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
129	poa_ind_10	**Tenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
130	poa_ind_11	**Eleventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
131	poa_ind_12	**Twelfth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
132	occurrence_code_01	**First Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
133	occurrence_code_02	**Second Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
134	occurrence_code_03	Third Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
135	occurrence_code_04	Fourth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
136	occurrence_code_05	Fifth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
137	occurrence_code_06	Sixth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
138	occurrence_code_07	Seventh Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
139	occurrence_code_08	Eighth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
140	occurrence_code_09	Ninth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
141	occurrence_code_10	Tenth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
142	Filler	End of Record Filler	Fixed filler with "*"	X	Required Must be = "*"

RECORD LENGTH	957

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	prov_carrier	**Prov Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	prov_id	**Prov ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right. If NPI is used, must be 10 digit numeric NPI. For all providers found in the CLAIMSERVICES files, must be the NPI.
3	prov_lname	**Prov Lname**	For an individual, Last Names (Apellidos) For an entity (other than an individual), the entity name	**X(50)**	Required Must be left justified, blank filled to the right
4	prov_fname	**Prov Fname**	For an individual, First Name (Nombre)	**X(30)**	Required for Individual providers Must be left justified, blank filled to the right
5	prov_mname	**Prov Mname**	For an individual, Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
6	prov_name_type	**Prov Name Type Indicator**	Indicator that tells if the provider is an individual or an entity. Valid values are: "I" = Individual "E" = Entity	**X(1)**	Required
7	prov_addr1	**Prov Addr1**	First line of provider's physical address	**X(45)**	Required Must be the physical address and use second and third line as needed. Must be left justified, blank filled to the right
8	prov_addr2	**Prov Addr2**	Second line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
9	prov_addr3	**Prov Addr3**	Third Line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
10	prov_city	**Prov City**	Provider's city	**X(45)**	Required Must be left justified, blank filled to the right
11	prov_state	**Prov State**	Provider's state	**X(45)**	Required Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
12	prov_zip	**Prov Zip**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
13	prov_country	**Prov Country**	Provider's country	**X(45)**	Required Must be left justified, blank filled to the right
14	prov_tel	**Prov Telephone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
15	prov_ext	**Prov Ext**	Provider's telephone extension	**X(20)**	Optional Must be left justified, blank filled to the right
16	prov_email	**Prov Email**	Provider's e-mail address	**X(40)**	Optional If supplied it must fit e-mail address format rules Must be left justified, blank filled to the right
17	prov_contact	**Prov Contact**	Name of contact person if provider is not an individual	**X(50)**	Optional Must be left justified, blank filled to the right
18	prov_type	**Prov Type**	Type of provider. See Provider Type Codes in Attachment V	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Provider Type Code
19	taxonomy1	**Taxonomy 1**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Required Must be left justified, blank filled to the right Must be a valid taxonomy Code.
20	spec1	**Specialty Code 1**	Provider Specialty (first). See Specialty Code in Attachment III	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
21	taxonomy2	**Taxonomy 2**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
22	spec2	**Specialty Code 2**	Provider Specialty (second). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
23	taxonomy3	**Taxonomy 3**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
24	spec3	**Specialty Code 3**	Provider Specialty (third). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
25	taxonomy4	**Taxonomy 4**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
26	spec4	**Specialty Code 4**	Provider Specialty (fourth). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
27	network_specialist	**Preferred Network Specialist**	Indicates if the service provider is a participating specialist of the preferred network in the PMG	**X**	Required Must be "Y" or "N"
28	federal_tax_id	**Federal Tax ID**	SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
29	tax_id_indicator	**Federal Tax ID Indicator**	Identifies if the federal tax ID provided in field *federal_tax_id* is a SSN or EIN. Valid values: "SSN" "EIN"	**X(3)**	Required Should be supplied when available
30	licence_number	**License Number**	State License Number	**X(15)**	Required Should be supplied when available Must be left justified, blank filled to the right
31	npi	**NPI**	National Provider Identifier	**X(10)**	Required Must be 10 digit numeric NPI. For all providers found in the CLAIMSERVICES files, the NPI must be provided. If none exists must be "N/A".

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
32	dea_number	**DEA Number**	DEA number	**X(20)**	Optional Should be supplied when available Must be left justified, blank filled to the right
33	medicare_number	**Medicare Number**	Medicare number	**X(20)**	Optional Must be left justified, blank filled to the right
34	medicaid_number	**Medicaid Number**	Medicaid number	**X(20)**	Optional. Must be left justified, blank filled to the right.
35	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Provider Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
36	clia_id	**CLIA Number**	Indicates the Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures. CLIA number consists of ten alphanumeric positions.	**X(10)**	Required for providers with specialty code equals to "Clinical Laboratory". Left justified, blank field to the right.
37	accepting_new_pat	**Accepting New Patient Indicator**	Indicates if the provider is accepting new patients (members) or not. Valid values: 0 = No 1 = Yes 8 = N/A – The individual only practices as a member of a group.	**X**	Must be a valid value.
38	dob	**Birth Date**	For an individual, Provider Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required for an individual; left blank for an entity. Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
39	dod	**Death Date**	For an Individual Provider, Date of Death in YYYYMMDD format.	**YYYYMMDD**	Optional for an individual; left blank for an entity Should be supplied when available Must be a valid date Cannot be in later than the Extract Date Cannot be greater than 150 years ago compared to Extract Date. Cannot be equal or less than the date of birth. A provider with a date of death before the Extract Date cannot be listed as a provider for an eligible individual.
40	facility_group_ind_code	**Facility Group Indicator Code**	Indicates whether the SUBMITTING-STATE-PROV-ID is assigned to an individual, a group of providers, or a facility.	**XX**	Required Must be a valid value "01" = Facility – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a facility. "02" = Group – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a group of individual practitioners. "03" = Individual – The entity identified by the associated SUBMITTING-STATE-PROV-ID is an individual practitioner.
41	license_entity	**License Issuing Entity ID**	Indicates the identity of the entity issuing the license or accreditation.	**X(50)**	Required whenever a value is captured in the LICENSE-OR-ACCREDITATION-NUMBER data element. Must be left justified, blank filled to the right (Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name.) If LICENSE-TYPE = 1 (State, county, or municipality professional or business license) and the license-issuing entity is a state, then enter the applicable ANSI state numeric code. If LICENSE-TYPE = 2 (DEA license), then enter the text string "DEA". If LICENSE-TYPE = 3 (Professional society accreditation), then enter the text string identifying the professional society issuing the accreditation. If LICENSE-TYPE = 4 (CLIA accreditation), then enter the text string identifying the CLIA accreditation body's name. If LICENSE-TYPE = 5 (Other accreditation), then enter the text string identifying the entity issuing the accreditation. If LICENSE-TYPE = 9 (Unknown), then enter "Unknown".

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
42	license_type	**License Type**	A code to identify the kind of provider's license. Valid values: "1" = State, county, or municipality professional or business license "2" = DEA license "3" = Professional society accreditation "4" = CLIA accreditation "5" = Other "9" = Unknown	**X**	Required whenever a provider is required by the state's agency requires one in order to be a Medicaid/CHIP provider. Must be a valid value. If provider has more than one license, please report the one with lowest valid value. Example: for a provider with both "1" = State, county, or municipality professional or business license and "2" = DEA license, report "1" = State, county, or municipality professional or business license.
43	prov_dba	**Provider DBA Name**	The provider's name that is commonly used by the public when the "doing-business-as" (`) name is different from the legal name. DBA is an abbreviation for "doing business as." Registering a DBA is required to operate a business under a name that differs from the company's legal name.	**X(50)**	Leave the field empty when DBA name equals the legal name
44	sex	**Sex Code**	For an individual, indicates the provider's gender. Valid values: M = Male F = Female U = Unknown	**X**	Must be a valid value
45	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
46	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	YYYYMMDD	Optional
47	contract_eff_date	**Contract effective date**	The provider's contract effective date.	YYYYMMDD	Required for contracted providers. For "Out of Network" providers, please report as '99991231'.
48	contract_term_date	**Contract termination date**	The provider's contract termination date.	YYYYMMDD	For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
49	Filler	**End of Record Filler**	Fixed filler with "*"	X	Required Must be = "*"
RECORD LENGTH					**963**

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 0 0 3

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	ipa	**IPA Code**	Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters.	**X(4)**	Required IPA/HCO code assigned by Carrier Must be left justified, blank filled to the right
3	ipa_desc	**IPA Description**	Name of IPA/HCO	**X(80)**	Required Must be left justified, blank filled to the right
4	ipa_addr1	**IPA Addr1**	IPA/HCO's first line of address	**X(45)**	Required Must be left justified, blank filled to the right
5	ipa_addr2	**IPA Addr2**	IPA/HCO's second line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
6	ipa_addr3	**IPA Addr3**	IPA/HCO's third line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
7	ipa_city	**IPA City**	IPA/HCO's city	**X(45)**	Required Must be left justified, blank filled to the right
8	ipa_state	**IPA State**	IPA/HCO's state	**X(45)**	Required Must be left justified, blank filled to the right
9	ipa_zip	**IPA Zip**	IPA/HCO's zip code. Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric. Must be 5 or 9 digits in length.
10	ipa_country	**IPA Country**	IPA/HCO's country	**X(45)**	Required Must be left justified, blank filled to the right
11	ipa_home_phone	**IPA Home Phone**	Home telephone number of contact person for IPA/HCO	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
12	ipa_work_phone	**IPA Work Phone**	Principal work telephone number of IPA/HCO.	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
13	ipa_ext	**IPA Ext**	Telephone extension at IPA Work Phone for contact person	**X(20)**	Optional Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	federal_tax_id	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	ipa_npi	**IPA NPI**	National Provider Identifier (NPI) of the IPA., where possible,	**X(10)**	Required Left justified, blank field to the right.
17	ipa_adm_lname	**IPA Administrator Lname**	IPA/HCO Administrator Last Names (Apellidos)	**X(50)**	Required Must be left justified, blank filled to the right
18	Ipa_adm_fname	**IPA Administrator Fname**	IPA/HCO Administrator First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
19	prov_mname	**IPA Administrator Mname**	IPA/HCO Administrator Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
20	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**574**

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	**Capitation ID**	Capitation payment ID must be a unique ID within carrier.	**X(20)**	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	**Capitation Type**	Capitation type code defined as: "01"= Admin "02"= Dental "03"= DME … See Attachment VII	**99**	Required Must be two (2) digits (numeric). Must be a valid code. See Capitation Type List in Attachment VII
4	cap_date	**Capitation Date**	Date capitation paid.	**YYYYMMDD**	Required Must be a valid date
5	expr_date	**Experience Date**	Experience date of capitation payment. This is the date for which the capitation payment applies.	**YYYYMMDD**	Required Must be a valid date
6	prov	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id of the provider to which the capitation payment is made.	**X(20)**	Required Must be a valid Provider ID found in PRV File. Must be left justified and blank filled to the right. If NPI is used, must be 10 digit numeric NPI. If Tax Id is used, must be 9 digits in significant positions.
7	pcp_npi	**Provider NPI**	National Provider Identifier (NPI) of the provider to which the capitation payment is made.	**X(10)**	Required Must be the NPI, or if none exists, must be "N/A". Left justified, blank field to the right.
8	ipa	**IPA ID**	Carrier assigned ID of IPA/HCO. This must be filled when Capitation type is PCP and IPA/HCO is involved (Must always be filled for Plan Type "01" by MCOs/TPAs when capitation payment is for PCP services)	**X(4)**	Required If Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier Left justified, blank field to the right.

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	region_code	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL "X" = All Regions	X	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X". For plan type "04", "05" and "06", value must be "X".
10	municipality_code	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
11	member_ssn	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric) Right justified, zero filled
12	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
13	member_suffix	**Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	**99**	Required Must be 2 digits (numeric)
14	cap_amt	**Capitation Amount**	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
15	gross_cap_amt	**Gross Capitation Amount**	Gross Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
16	net_cap_amt	**Net Capitation Amount**	Net Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
17	risk_type	**MPI Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" If the risk is shared then the value =' SHR' Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR".	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM the only value should be "UNK"
18	tier	**Member capitation tier**	Member capitation tier 0001 Medicare A&B Male 0002 Medicare A Male 0006 Medicare A&B Female 0007 Medicare A Female 0008 0-11 Months 0009 12-23 Months 0010 24 Months - 10 Years 0011 11 - 18 Years 0024 19 - 35 Female 0025 19 - 35 Male 0026 36 - 54 Female 0027 36 - 54 Male 0028 55 - 64 Female 0029 55 - 64 Male 0031 65 + Female 0032 65 + Male	**X(4)**	Required

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
19	days	**Capitation days**	Number of days included in capitation amount.	**99**	Required
20	mem_percent	**Capitation percentage**	Percentage (days / month days)	**999**	Required
21	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
22	mpi	**MPI Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data	**X(13)**	Required Must be a valid MPI number
23	Federal_Tax_ID	**Federal Tax ID (SSN or EIN)**	The federal identification number of the provider to which the capitation payment is made. If the provider does not have a federal identification number, enter '999999999' in this column. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
24	filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**185**

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier	**Carrier ID**	ASES assigned carrier code. Must be (2) digits (numeric)	**99**	Required Must be two (2) digit s (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	provider_type	**Provider Type**	PCP, Specialist, Dentist, X-Ray, Ancillary Services, Special Case, Laboratory, Other Facility, Hospital	**X(20)**	Required Must be left justified, blank filled to the right
3	month	**Month**	Date field with the first day of month. Ex: 5/1/2014	**YYYYMMDD**	Required Must be a valid date.
4	region	**Region**	The ASES region code. (If the provider has multiple locations specify the Region for current address) Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "O" = Outside Puerto Rico	**X**	Required
5	pmg	**IPA Code**	The identification number of the primary medical group. If not applicable enter "N/A" Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters	**X(4)**	Required IPA/HCO code assigned by Carrier Must be left justified, blank filled to the right
6	pmg_name	**PMG Name**	The name or title of the primary medical group. If not applicable enter "N/A"	**X(80)**	Required
7	npi	**NPI**	The national provider identification number. All providers are required to have an NPI number.	**X(10)**	Required
8	provider_duplicate_entry	**Provider Duplicate Entry**	Indicate if the provider is entered multiple times in the list. A provider may be entered multiple times if the provider has more than one office location providing services. Enter a "**0**" for the first entry of the provider in the list. Enter an "**X**" for any duplicate entries of the same provider in the list.	**X**	Required

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	assigned_lives	**Assigned lives**	The number of assigned lives to the provider as of the last day of the reporting period. If the provider has multiple office locations, the number of assigned lives must be entered for the first entry (not a duplicated entry) for the provider. This number should include the sum of all office locations of the provider. If the provider does not have or require assigned lives, enter "0" in this column.	**9999**	Required
10	credential	**Credential**	Identify if the provider is up to date with all credentialing requirements as of the last day of the reporting period. Enter "Yes" for a fully credentialed/recredentialed provider, enter "No" if the provider requires credentialing/recredentialing. If the provider is not required to submit credentialing/recredentialing, enter "N/A" in this column.	XXX	Required
11	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required
12	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Optional
13	federal_tax_id	**Provider SSN or EIN**	The federal identification number of the provider. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
14	prov_id	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right If NPI is used, must be 10 digit numeric NPI.
15	ccn	**CCN**	CMS Certification Number formerly known as the Medicare Provider Number.	**X(20)**	Optional
16	contract_eff_date	**Contract effective date**	The provider's contract effective date.	**YYYYMMDD**	Required For "Out of Network" providers, please report as '99991231'

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	contract_term_date	**Contract termination date**	The provider's contract termination date.	**YYYYMMDD**	Required For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
18	specialty	**Specialty**	Provider Specialty (third). See Specialty Code description in Attachment III	**X(40)**	Optional
19	specialty_code	**Specialty Code**	Provider Specialty (third). See Specialty Code in Attachment III	**XX**	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
20	name	**Name**	The full name of the provider.	**X(80)**	Optional Must be left justified, blank filled to the right
21	last_name1	**Last Name 1**	For an individual, the last name of the provider. If the provider has two last names, this should be the first name. For an entity (other than an individual), the entity name	**X(30)**	Required Must be left justified, blank filled to the right
22	last_name2	**Last Name 2**	For an individual, the last name of the provider. If the provider has two last names, this should be the second name.	**X(30)**	Optional Must be left justified, blank filled to the right
23	first_name	**First Name**	For an individual, the first name of the provider.	**X(50)**	Required Must be left justified, blank filled to the right
24	mi	**MI**	For an individual, the middle name of the provider.	**X(30)**	Optional Must be left justified, blank filled to the right
25	addr1	**Address Line 1**	The first line of the physical address of the provider.	**X(45)**	Required Must be the physical address and use second line as needed. Must be left justified, blank filled to the right
26	addr2	**Address Line 2**	The second line of the physical address of the provider.	**X(45)**	Must be left justified, blank filled to the right
27	city	**City**	The city of the provider.	**X(45)**	Optional Must be left justified, blank filled to the right
28	zip	**Zip code**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	phone	**Phone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
30	fax	**Fax**	The primary fax number of the provider. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
31	sunday	**Sunday working hours**	The Sunday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
32	monday	**Monday working hours**	The Monday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
33	tuesday	**Tuesday working hours**	The Tuesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
34	wednesday	**Wednesday working hours**	The Wednesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
35	thursday	**Thursday working hours**	The Thursday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
36	friday	**Friday working hours**	The Friday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
37	saturday	**Saturday working hours**	The Saturday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
38	ncpdp_id	**NCPDP ID**	The National Council for Prescription Drugs ID	**X(10)**	Optional
39	state	**State**	The provider's address state.	**X(45)**	Optional Must be left justified, blank filled to the right
40	license_number	**License number**	The Provider's license number.	**X(10)**	Required Should be supplied when available Must be left justified, blank filled to the right
41	contact_person	**Contact person**	The provider's contact person.	**X(80)**	Optional

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*	
RECORD LENGTH						**956**

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENTS

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Adjuntas	S	0004
Aguada	Z	0008
Aguadilla	Z	0012
Aguas Buenas	E	0016
Aibonito	G	0020
Añasco	Z	0024
Arecibo	A	0028
Arroyo	G	0032
Barceloneta	A	0036
Barranquitas	G	0040
Bayamón	B	0044
Cabo Rojo	Z	0048
Caguas	E	0052
Camuy	A	0056
Canovanas	F	0060
Carolina	F	0064
Cataño	B	0068
Cayey	E	0072
Ceiba	F	0076
Ciales	A	0080
Cidra	E	0084
Coamo	G	0088
Comerio	B	0092
Corozal	B	0096
Culebra	F	0100

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B
0096	Corozal	B
0100	Culebra	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Dorado	B	0104
Fajardo	F	0108
Florida	A	0112
Guanica	S	0116
Guayama	G	0120
Guayanilla	S	0124
Guaynabo	B	0128
Gurabo	E	0132
Hatillo	A	0136
Hormigueros	Z	0140
Humacao	E	0144
Isabela	Z	0148
Jayuya	S	0152
Juana Diaz	G	0156
Juncos	E	0160
Lajas	Z	0164
Lares	A	0168
Las Marias	Z	0172
Las Piedras	E	0176
Loiza	F	0180
Luquillo	F	0184
Manatí	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S
0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F
0188	Manatí	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Moca	Z	0204
Morovis	A	0208
Naguabo	E	0212
Naranjito	B	0216
Orocovis	G	0220
Patillas	G	0224
Peñuelas	S	0228
Ponce	S	0232
Puerta de Tierra	J	0264
Puerto Nuevo	J	0270
Quebradillas	A	0236
Rincon	Z	0240
Rio Grande	F	0244
Rio Piedras	J	0272
Sabana Grande	Z	0248
Salinas	G	0252
San German	Z	0256
San José	J	0274
San Juan	J	0266
San Lorenzo	E	0276
San Sebastian	Z	0280
Santa Isabel	G	0284
Toa Alta	B	0288
Toa Baja	B	0292
Trujillo Alto	F	0296

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z
0252	Salinas	G
0256	San German	Z
0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San José	J
0276	San Lorenzo	E
0280	San Sebastian	Z
0284	Santa Isabel	G
0288	Toa Alta	B
0292	Toa Baja	B
0296	Trujillo Alto	F

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Utuado	A	0300
Vega Alta	B	0304
Vega Baja	A	0308
Vieques	F	0312
Villalba	G	0316
Yabucoa	E	0320
Yauco	S	0324
Outside Puerto Rico	--	0666

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0300	Utuado	A
0304	Vega Alta	B
0308	Vega Baja	A
0312	Vieques	F
0316	Villalba	G
0320	Yabucoa	E
0324	Yauco	S
0666	Outside Puerto Rico	--

* 0666 is valid only for use with Municipality Service on CLAIMSERVICES Input File

NOTE: Any municipality code may appear in region SPECIAL.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
01	(discontinued) Triple-S Salud, Inc.	MCO
02	(discontinued) Humana	MCO
03	(discontinued) Triple-S Salud, Inc.	TPA
04	(discontinued) First Medical Health Plan, Inc.	MCO
05	(discontinued) PMC Medicare Choice, LLC	MCO
06	(discontinued) Triple-S Salud, Inc.	MCO
07	(discontinued) Molina Healthcare of Puerto Rico, Inc.	MCO
08	(discontinued) MMM Multi Health, LLC	MCO
09	First Medicaid Health Plan, Inc. (NHM)	MCO
10	MMM Multi Health, LLC (NHM)	MCO
11	Molina Healthcare of Puerto Rico, Inc. (NHM)	MCO
12	Plan de Salud Menonita (NHM)	MCO
13	Triple-S Salud, Inc. (NHM)	MCO
17	(discontinued) MCS	MCO
25	(discontinued) La Cruz Azul de P.R.	MCO
27	(discontinued) MCS Life	Medicare Platino
28	(discontinued) Red Medica	Medicare Platino
29	MMM Healthcare, INC	Medicare Platino
31	(discontinued) Triple-S Salud, Inc.	Medicare Platino
33	Preferred Medicare Choice	Medicare Platino
34	MCS Advantage	Medicare Platino
35	(discontinued) COSVIMed	Medicare Platino

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
37	(discontinued) Salud Dorada con Medicare	Medicare Platino
39	(discontinued) MAPFRE	Medicare Platino
41	(discontinued) Health Medicare Ultra	Medicare Platino
42	Humana	Medicare Platino
44	(discontinued) Auxilio Platino	Medicare Platino
45	(discontinued) Constellation Health, LLC	Medicare Platino
46	Triple-S Advantage	Medicare Platino
47	(discontinued) American Health	Medicare Platino
48	(discontinued) MMM-First Plus	Medicare Platino
49	(discontinued) First Medical Health Plan, Inc.	Medicare Platino
51	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
52	(discontinued) Humana	TPA – Direct Contract
53	(discontinued) MCS	TPA – Direct Contract
54	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
55	(discontinued) COSVI	TPA – Direct Contract
60	(discontinued) Caremark	PBM
64	MC-21	PBM
70	(discontinued) ASSMCA	Mental Health Pilot
71	Plan de Salud Hospital Menonita	Government Employee
72	MMM Healthcare, INC	Government Employee
73	(discontinued) National Life Insurance Company	Government Employee
74	Ryder Health Plan, Inc.	Government Employee

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
75	Triple-S Salud Inc.	Government Employee
76	(discontinued) BHP	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	MAPFRE	Government Employee
79	MCS Life Insurance Company	Government Employee
80	PROSSAM	Government Employee
81	Asociacion de Maestros de Puerto Rico	Government Employee
82	First Medical Health Plan, Inc.	Government Employee
83	(discontinued) APS	MBHO
84	(discontinued) APS	Government Employee
85	PMC Medicare Choice, LLC	Government Employee
86	Molina Healthcare of Puerto Rico, Inc.	Government Employee
87	Triple-S Advantage	Government Employee
88	(discontinued) MMM-First Plus	Government Employee
89	Panamerican Life Insurance Group (PALIG)	Government Employee
90	Delta Dental	Government Employee
91	MMM Multi Health, LLC	Government Employee
95	(discontinued) FHC	MBHO
96	(discontinued) American Health Medicare	Government Employee

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist in Private Practice
16	Obstetrics / Gynecology
17	Hospice and palliative care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
21	Cardiac electrophysiology

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
22	Pathology
23	Sports medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation
26	Psychiatry
27	Geriatric psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
31	Intensive cardiac rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
44	Infectious Disease
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
65	Physical Therapist

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
66	Rheumatology
67	Occupational Therapy
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
BB	Blood Bank
CV	Cardiac Catheterization Facility
DC	Detox Center

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
DD	Dentist
DF	Dialysis Facility
EC	Emergency Care Facility
EN	Endodontist
G1	Geneticist
HE	Health Educator
HN	Home Health Nurse
HV	HIV Ambulatory Antibiotic Facility
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
N1	Neonatology
NI	Neonatal ICU
O1	Occupational Medicine
OP	Optical
P1	Perinatology
P2	Pediatric Surgery
PC	Clinic – Primary Level
PE	Periodontist
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 22 - 00 3

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
RT	Respiratory Therapist
SH	State Hospital
SP	State Psychiatric Hospital
ST	Short Term Intervention Center (Behavioral Health-Stabilization Unit)
XR	X-ray Facility
Z4	Cardiovascular Surgery Program

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan		
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
09	Prison / Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
18	Place of Employment- Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus- Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT V - PROVIDER TYPE CODES

CODE	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
AM	Ambulance
AS	Ambulatory Surgical Center
BB	Blood Bank
CL	Clinical Facility
DE	Dentist
DM	Durable Medical Equipment (DME)
EM	Emergency Facility
HH	Home Health Agency
HO	Hospital
HS	Hospice
LA	Laboratory
MD	Medical Doctor (Physician)
RX	Pharmacy
SN	Skilled Nursing Facility (SNF)
UF	Urgent Care facility
XR	Radiology Facility
ZZ	Other

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
09	01	100	GHIP			
09	01	110	GHIP			
09	01	120	GHIP			
09	01	130	GHIP			
09	01	220	GHIP			
09	01	230	GHIP			
09	01	300	GHIP			
09	01	310	GHIP			
09	01	320	GHIP			
09	01	330	GHIP			
10	01	100	GHIP			
10	01	110	GHIP			
10	01	120	GHIP			
10	01	130	GHIP			
10	01	220	GHIP			
10	01	230	GHIP			
10	01	300	GHIP			
10	01	310	GHIP			
10	01	320	GHIP			
10	01	330	GHIP			
11	01	100	GHIP			
11	01	110	GHIP			
11	01	120	GHIP			
11	01	130	GHIP			
11	01	220	GHIP			
11	01	230	GHIP			
11	01	300	GHIP			
11	01	310	GHIP			

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
11	01	320	GHIP			
11	01	330	GHIP			
12	01	100	GHIP			
12	01	110	GHIP			
12	01	120	GHIP			
12	01	130	GHIP			
12	01	220	GHIP			
12	01	230	GHIP			
12	01	300	GHIP			
12	01	310	GHIP			
12	01	320	GHIP			
12	01	330	GHIP			
13	01	100	GHIP			
13	01	110	GHIP			
13	01	120	GHIP			
13	01	130	GHIP			
13	01	220	GHIP			
13	01	230	GHIP			
13	01	300	GHIP			
13	01	310	GHIP			
13	01	320	GHIP			
13	01	330	GHIP			
29	02	004	MA-SNP			
29	02	005	MA-SNP			
29	02	010	MA-SNP			
29	02	011	MA-SNP			
29	02	012	MA-SNP			
29	02	013	MA-SNP			
29	02	014	MA-SNP			
29	02	015	MA-SNP			

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
29	02	017	MA-SNP			
29	02	017	MA-SNP			
29	02	017	MA-SNP			
29	02	018	MA-SNP			
29	02	018	MA-SNP			
29	02	019	MA-SNP			
29	02	020	MA-SNP			
29	02	023	MA-SNP			
29	02	024	MA-SNP			
29	02	025	MA-SNP			
29	02	026	MA-SNP			
29	02	041	MA-SNP			
29	02	047	MA-SNP			
29	02	049	MA-SNP			
33	02	005	MA-SNP			
33	02	006	MA-SNP			
33	02	007	MA-SNP			
33	02	008	MA-SNP			
33	02	009	MA-SNP			
33	02	010	MA-SNP			
33	02	015	MA-SNP			
33	02	016	MA-SNP			
33	02	048	MA-SNP			
33	02	061	MA-SNP			
34	02	002	MA-SNP			
34	02	003	MA-SNP			
34	02	004	MA-SNP			
34	02	011	MA-SNP			
34	02	012	MA-SNP			
34	02	017	MA-SNP			

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
34	02	021	MA-SNP			
34	02	022	MA-SNP			
34	02	023	MA-SNP			
34	02	024	MA-SNP			
34	02	025	MA-SNP			
34	02	026	MA-SNP			
34	02	027	MA-SNP			
34	02	028	MA-SNP			
34	02	028	MA-SNP			
34	02	029	MA-SNP			
34	02	029	MA-SNP			
34	02	030	MA-SNP			
34	02	031	MA-SNP			
34	02	032	MA-SNP			
34	02	035	MA-SNP			
34	02	036	MA-SNP			
34	02	036	MA-SNP			
34	02	037	MA-SNP			
34	02	043	MA-SNP			
34	02	044	MA-SNP			
34	02	045	MA-SNP			
34	02	046	MA-SNP			
34	02	047	MA-SNP			
34	02	048	MA-SNP			
34	02	049	MA-SNP			
34	02	050	MA-SNP			
34	02	051	MA-SNP			
34	02	052	MA-SNP			
42	02	005	MA-SNP			
42	02	006	MA-SNP			

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
42	02	007	MA-SNP			
42	02	008	MA-SNP			
42	02	013	MA-SNP			
42	02	014	MA-SNP			
42	02	015	MA-SNP			
42	02	016	MA-SNP			
42	02	016	MA-SNP			
42	02	017	MA-SNP			
42	02	018	MA-SNP			
42	02	018	MA-SNP			
42	02	019	MA-SNP			
42	02	019	MA-SNP			
42	02	020	MA-SNP			
46	02	003	MA-SNP			
46	02	004	MA-SNP			
46	02	005	MA-SNP			
46	02	006	MA-SNP			
46	02	007	MA-SNP			
46	02	008	MA-SNP			
46	02	011	MA-SNP			
46	02	012	MA-SNP			
46	02	013	MA-SNP			
46	02	014	MA-SNP			
46	02	015	MA-SNP			
46	02	016	MA-SNP			
46	02	017	MA-SNP			
46	02	018	MA-SNP			
46	02	019	MA-SNP			
46	02	020	MA-SNP			
46	02	021	MA-SNP			

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
46	02	022	MA-SNP			
46	02	023	MA-SNP			
46	02	024	MA-SNP			
46	02	024	MA-SNP			
46	02	025	MA-SNP			
46	02	026	MA-SNP			
46	02	028	MA-SNP			
46	02	032	MA-SNP			
71	04	401	Law 95 Commercial	Regular	Oro	MCO
71	04	402	Law 95 Commercial	Regular	Plata	MCO
71	04	403	Law 95 Commercial	Regular	Bronce	MCO
71	04	404	Law 95 Commercial	Regular	Rubi	MCO
71	04	405	Law 95 Commercial	Regular	Diamante	MCO
71	04	406	Law 95 Commercial	Regular	Complementaria de Medicare	MCO
71	04	407	Law 95 Commercial	Regular	Mandatoria	MCO
71	04	408	Law 95 Commercial	Regular	Alterno 1	MCO
71	04	409	Law 95 Commercial	Regular	Alterno 2	MCO
71	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
72	05	501	Law 95 Advantage	Regular	Oro	HMO
72	05	502	Law 95 Advantage	Regular	Plata	HMO
72	05	503	Law 95 Advantage	Regular	Bronce	HMO
72	05	504	Law 95 Advantage	Regular	Rubi	HMO
72	05	505	Law 95 Advantage	Auto-Enrollment	ELA Flex	HMO POS
72	05	506	Law 95 Advantage	Auto-Enrollment	ELA Relax	HMO POS
72	05	507	Law 95 Advantage	Auto-Enrollment	MMM ELA Relax (HMO-POS)	HMO
72	05	508	Law 95 Advantage	Auto-Enrollment	MMM ELA Premium (HMO-POS)	HMO
72	05	509	Law 95 Advantage	Auto-Enrollment	MMM ELA Advantage	HMO
72	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
75	04	401	Law 95 Commercial	Regular	Oro	MCO
75	04	402	Law 95 Commercial	Regular	Plata	MCO

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
75	04	403	Law 95 Commercial	Regular	Bronce	MCO
75	04	404	Law 95 Commercial	Regular	Rubi	MCO
75	04	405	Law 95 Commercial	Regular	Diamante	MCO
75	04	406	Law 95 Commercial	Regular	Complementaria de Medicare	MCO
75	04	407	Law 95 Commercial	Regular	Mandatoria	MCO
75	04	408	Law 95 Commercial	Regular	Alterno 1	MCO
75	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
77	05	501	Law 95 Advantage	Regular	Oro	HMO
77	05	502	Law 95 Advantage	Regular	Plata	HMO
77	05	503	Law 95 Advantage	Regular	Bronce	HMO
77	05	504	Law 95 Advantage	Regular	Rubi	HMO
77	05	505	Law 95 Advantage	Auto-Enrollment	PR I	HMO
77	05	506	Law 95 Advantage	Auto-Enrollment	PR II	HMO
77	05	507	Law 95 Advantage	Auto-Enrollment	PR III	PPO
77	05	508	Law 95 Advantage	Auto-Enrollment	US Acess Only	HMO
77	05	509	Law 95 Advantage	Auto-Enrollment	HMO FL	HMO
77	05	510	Law 95 Advantage	Auto-Enrollment	ELA HMO Rubí	HMO
77	05	511	Law 95 Advantage	Auto-Enrollment	ELA HMO Bronce	HMO
78	04	401	Law 95 Commercial	Regular	Oro	MCO
78	04	402	Law 95 Commercial	Regular	Plata	MCO
78	04	403	Law 95 Commercial	Regular	Bronce	MCO
78	04	404	Law 95 Commercial	Regular	Rubi	MCO
78	04	405	Law 95 Commercial	Regular	Diamante	MCO
78	04	406	Law 95 Commercial	Regular	Complementaria de Medicare	MCO
78	04	407	Law 95 Commercial	Regular	Mandatoria	MCO
78	04	408	Law 95 Commercial	Regular	Alterno 1	MCO
78	04	409	Law 95 Commercial	Regular	Alterno 2	MCO
78	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
79	05	501	Law 95 Advantage	Regular	Oro	HMO
79	05	502	Law 95 Advantage	Regular	Plata	HMO

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
79	05	503	Law 95 Advantage	Regular	Bronce	HMO
79	05	504	Law 95 Advantage	Regular	Rubi	HMO
79	05	505	Law 95 Advantage	Auto-Enrollment	ELA Crédito	HMO
79	05	506	Law 95 Advantage	Auto-Enrollment	ELA Ahorro	HMO
79	05	507	Law 95 Advantage	Auto-Enrollment	ELA Crédito Rubí	HMO
79	05	508	Law 95 Advantage	Auto-Enrollment	ELA Enlace	HMO
79	05	509	Law 95 Advantage	Auto-Enrollment	Classicare Gobierno Ahorro	HMO
80	04	401	Law 95 Commercial	Regular	Oro	MCO
80	04	402	Law 95 Commercial	Regular	Plata	MCO
80	04	403	Law 95 Commercial	Regular	Bronce	MCO
80	04	404	Law 95 Commercial	Regular	Rubi	MCO
80	04	405	Law 95 Commercial	Regular	Diamante	MCO
80	04	406	Law 95 Commercial	Regular	Complementaria de Medicare	MCO
80	04	407	Law 95 Commercial	Regular	Mandatoria	MCO
80	04	408	Law 95 Commercial	Regular	Alterno 1	MCO
80	04	409	Law 95 Commercial	Regular	Alterno 2	MCO
80	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
82	04	401	Law 95 Commercial	Regular	Oro	MCO
82	04	402	Law 95 Commercial	Regular	Plata	MCO
82	04	403	Law 95 Commercial	Regular	Bronce	MCO
82	04	404	Law 95 Commercial	Regular	Rubi	MCO
82	04	405	Law 95 Commercial	Regular	Diamante	MCO
82	04	406	Law 95 Commercial	Regular	Complementaria de Medicare	MCO
82	04	407	Law 95 Commercial	Regular	Mandatoria	MCO
82	04	408	Law 95 Commercial	Regular	Alterno 1	MCO
82	04	409	Law 95 Commercial	Regular	Alterno 2	MCO
82	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
84	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
85	06	400	Law 95 - ELA-Puro (Cubierta ASES)	Regular	Coverage 400 (ELA)	HMO
87	05	501	Law 95 Advantage	Regular	Oro	HMO

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Carrier Code	Plan Type	Plan Version Code	Plan Type Description	Plan Act	Plan Version Description	Plan Version Access
87	05	502	Law 95 Advantage	Regular	Plata	HMO
87	05	503	Law 95 Advantage	Regular	Bronce	PPO
87	05	504	Law 95 Advantage	Regular	Rubi	HMO
87	05	505	Law 95 Advantage	Auto-Enrollment	ELA Royal	HMO
87	05	506	Law 95 Advantage	Auto-Enrollment	ELA Óptimo	HMO
87	05	507	Law 95 Advantage	Auto-Enrollment	ELA Royal Plus	HMO
87	05	508	Law 95 Advantage	Auto-Enrollment	ELA Titán	HMO
87	05	509	Law 95 Advantage	Auto-Enrollment	ELA Óptimo Plus	HMO
88	05	501	Law 95 Advantage	Regular	Oro	PPO
88	05	502	Law 95 Advantage	Regular	Plata	PPO
88	05	503	Law 95 Advantage	Regular	Bronce	PPO
88	05	504	Law 95 Advantage	Regular	Rubi	PPO
88	05	505	Law 95 Advantage	Auto-Enrollment	Premium	PPO
88	05	506	Law 95 Advantage	Auto-Enrollment	Premium 2	PPO
88	05	507	Law 95 Advantage	Auto-Enrollment	Plus	PPO

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VII – CAPITATION TYPE LIST

Cap type code	Cap type description
01	Admin
02	Dental
03	DME
04	Emergency Room
05	Extended Hours Services
06	Glasses and Contact Lenses
07	Home Health Care
08	Hospital
09	Lab/Medical Imaging
10	Medical Transportation
11	Mental Health
12	Mental Health Facility
13	Occupational/Physical/Speech Therapy
14	On Call Services
15	Pharmacy
16	Preventative
17	Primary Care Physician
18	Primary Medical Group
19	Prosthetics and Orthotics
20	RAF
21	Specialist
22	Other

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22-0093

ATTACHMENT VIII - HOUR CODES

CODE	Description
Codes included in this table are designed for completeness of fields that require providing the hour using a two-digit code, based on 24-hour clock.	
01	1:00 a.m.
02	2:00 a.m.
03	3:00 a.m.
04	4:00 a.m.
05	5:00 a.m.
06	6:00 a.m.
07	7:00 a.m.
08	8:00 a.m.
09	9:00 a.m.
10	10:00 a.m.
11	11:00 a.m.
12	12:00 noon
13	1:00 p.m.
14	2:00 p.m.
15	3:00 p.m.
16	4:00 p.m.
17	5:00 p.m.
18	6:00 p.m.
19	7:00 p.m.
20	8:00 p.m.
21	9:00 p.m.
22	10:00 p.m.
23	11:00 p.m.
00	12:00 a.m.

Attachment K
Information System

Query and Response files Layouts

ELIGIBILITY QUERY FILE LAYOUT

August 1, 2008

This file is produced by MA Carriers and sent to ASES to verify the elegibility of Medicare Beneficiaries in the GHIP (Reforma). **NMCI changes 04/2018 .**

Query Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"Q" for Query
2	PROCESS_DATE	2	8	YYYYMMDD
3	BENEFICARY SSN	10	9	
4	1ST_LAST_NAME	19	15	
5	2ND_LAST_NAME	34	15	
6	FIRST_NAME	49	20	
7	SEX	69	1	1 = Male, 2 = Female
8	DATE OF BIRTH	70	8	YYYYMMDD
9	REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	FECHA DE EFECTIVIDAD	81	8	Para uso en queries historicos. Entrar fecha en que comienza la suscripcion del Beneficiario. Formato YYYYMMDD. El dia debe ser primero de mes. Si el query no es historico se deja en blanco.
12	**MPI_number**	**89**	**11**	**MPI number Last eleven digits**
		100		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003

QUERY RESPONSE FILE LAYOUT

October 20, 2008

This file is sent by ASES to Carriers as a response to query records. The Response Record informs if a Beneficiary is elegible for GHIP (Reform) coverage. It provides the key data elements which the Carrier will use to notify enrollment to ASES once approved by CMS.

Query Response Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"R" for Response
2	CARRIER_PROCESS_DATE	2	8	YYYYMMDD
3	**BENEFICARY SSN**	10	9	
4	CARRIER_1ST_LAST_NAME	19	15	
5	CARRIER_2ND_LAST_NAME	34	15	
6	CARRIER_FIRST_NAME	49	20	
7	CARRIER_SEX	69	1	1 = Male, 2 = Female
8	CARRIER_DATE OF BIRTH	70	8	YYYYMMDD
9	CARRIER_REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	ASES_1ST_LAST_NAME	81	15	
12	ASES_2ND_LAST_NAME	96	15	
13	ASES_FIRST_NAME	111	20	
14	ASES_SEX	131	1	1 = Male, 2 = Female
15	ASES_DATE OF BIRTH	132	8	YYYYMMDD
16	**ASES_REGION**	140	1	
17	ELEGIBILITY_INDICATOR	141	1	**Y or N**
18	**ODSI_FAMILY_ID**	142	11	
19	**MEMBER_SUFFIX**	153	2	
20	**MPI**	155	13	Alpha-numeric ej.-"0080012345678"
21	MEDICAID_INDICATOR	168	1	**1 = Federal Medicaid**
22	ELEGIBILITY_EFFECTIVE_DATE	169	8	YYYYMMDD
23	ELEGIBILITY_EXPIRATION_DATE	177	8	YYYYMMDD
24	ASES_PROCESS_DATE	185	8	YYYYMMDD
25	MESSAGE_CODE	193	6	Spaces= no errors, **01=MPI no match**, 02=Sex no match, 03=DOB no match, 04=Region no match, 05=Miembro de municipio no contratado por Carrier, 06=Empleado ELA, 07=SSN no match (history records)
26	ASES_DEDUCTIBLE_LEVEL	199	1	
27	MUNICIPIO	200	4	Código Municipio en ASES
28	FECHA DE EFECTIVIDAD	204	8	Para uso en queries historicos. Formato YYYYMMDD.
29	CODIGO DE CUBIERTA	212	3	Código de Cubierta (Coverage Code)
30	FILLER	215	5	
		220		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
22 - 003