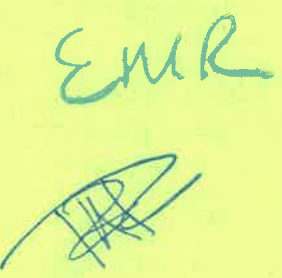
APPENDIX K

Information Data Processes and Data Exchange Layout



Attachment K Information Systems

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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 was created for the purpose of administering, negotiating and contracting health insurance plans that allow eligible beneficiaries, particularly those who are medically needy, to obtain quality hospital services.
Responsibilities	Moving in this direction, PRHIA is the entity responsible for negotiating on behalf of the Puerto Rico Department of Health, the federal coverage authorized by CMS (that is, Medicare Platino and Federal PRGHP, which is made up of the Medicaid and CHIP programs), with health insurance companies. PRHIA handles contracting matters with the coverage provided by the Health Program of the Government of the State of Puerto Rico "PRGHP" that serves the Population of the State or Commonwealth where it is determined that they are not eligible to receive benefits, under a coverage classification federal contracted health insurance companies. PRHIA oversees the administration of the services provided to eligible beneficiaries, under various health programs includingMedicare Platino; The PRHIA Information Systems Office is responsible for managing and processing the enrollment of all eligible beneficiaries and for validating premium payment processes for contracted health insurance.
About This Document	
Description	This document constitutes a reference manual, designed with the purpose of helping the Medicare Advantage Organizations (MAO) contracted by the PRHIA, in the enrollment processes of eligible

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	Beneficiaries. The eligibility and registration processes of the transactions that are executed daily, monthly and annually in the Information Systems Office of the PRHIA are defined. The criteria to be considered in the processes of registration and payment of the premiums according to the contract are explained. This version of the reference manual represents the first since the Plan VITAL became operational on November 1, 2018. With its introduction, Plan VITAL received its own Manual and in that sense, this document provides an exclusive reference of the processes to follow for Medicare Platino.
Purpose	This Manual acts as the main support document for the Processes to be followed in Medicare Platino.
Content Highlights	Among the issues to consider are the following: the initial eligibility and the transmission of the eligibility records of the Beneficiary in the Puerto Rico Medicaid Program. The information contained in the daily, monthly, and annual registries, where it contemplates the processing of new registries, updates, rejections and disaffiliations, exchange of information between the AEP and the health insurance companies, premium payment processes and the enrollment of eligible beneficiaries in historical data files. This document includes tables, diagrams, and examples that will help you understand the transactions. This will help improve efficiency and allow processes to be completed within agreed timeframes with a successful outcome.

Revision Form

Release No.	Date	Revision Description
20190611	6/11/2016	Baseline Version
20220321	03/21/2022	Update Version
20220609	06/09/2022	Update Version - **change will be effective from July 31, 2022 and January 2023)**

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20230607	06/07/2023	Update Version - for contract 2024

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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 Mediacre Platino. It also develops and supervises the administrative functions related to the beneficiaries' enrollment, providers, claims and premium payments.
ASES Information Systems Office	The 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.
Beneficiary	A person who is eligible to receive services under a State GHP Program (State Population), Federal GHP Program (Medicaid and CHIP), or Medicare Platino, under 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 a member loses their eligibility for the GHP Program. The Office of Medicaid is the only entity with authority to terminate

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	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 confirmation granted by the Medicaid office in Puerto Rico to a person who has completed the eligibility requirements to receive services under the GHP Program (Medicaid, CHIP or Commonwealth)
Certification Date	Date on which it is confirmed that a person has completed the eligibility requirements for the Medicaid Program and will receive health care services under the GHP Program (Medicaid, CHIP or Commonwealth)
Contractor	The Managed Care Organization that is a Party to this Contract, authorized as an insurer by the Puerto Rico Insurance Commissioner ("PRICO"), which hereby contracts with ASES under the GHP program for the provision of Covered Services and Benefits to Affiliates based on 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 eligibility data received from the Medicaid Program in Puerto Rico and subscription of the Contractors are carried out. These processes are carried out daily in the ASES Information Systems Office.

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Data	It is a value that the computer receives by different means, it represents the information that the programmer manipulates, assigns or establishes. Example: demographic data, health or other information elements suitable for a 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 that the Medicaid Office in Puerto Rico grants a member's eligibility for Medicare Platino.
Enrollment Effective Date	Date on which the Contractor enrolls an eligible Beneficiary in the database of its systems
PCP Effective Date	Date a change in a Primary Care Physician (PCP1 or PCP2) becomes effective.
Recertification Date	Date on which the Puerto Rico Medicaid Program reassesses the eligibility requirements of a Beneficiary.
Eligibility	It is granted when the requirements established for the Medicare Platino Program in the Puerto Rico Medicaid Office of the Department of Health are met.
Eligible Person	A person who meets the requirements established 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 Program.
Federal GHP	Federal coverage under the CFR regulations issued by the Centers

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	of Medicare and Medicaid Services granted according to the poverty level of the individual requesting
Government Health Insurance Plan (GHP)	It is the health plan that the government of Puerto Rico (previously known as "La Reforma" or "Plan Vital") grants through federal Medicaid funds. This plan addresses the health needs of the population with limited economic resources or special needs.
Health Insurer Code	This is the code assigned to the Insurance Company
HIPAA Transaction 834	The ANSI 834 EDI Enrollment Implementation Format is a standard file format for the electronic interchange of health plan enrollment data. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health plans or health insurance companies accept a standard enrollment format: ANSI 834A Version 5010. An 834 file contains an order of data, such as a subscriber's name, hire date, etc. in a data segment. The 834 is used to transfer enrollment information from the insurance coverage sponsor, benefits, or policy to a payer. The intent of this implementation guide is to meet the specific need of the health care industry for the initial enrollment and subsequent maintenance of individuals who are enrolled in insurance products. This implementation guide specifically addresses the enrollment and maintenance of healthcare products only. One or more separate flexible spending and retirement guidelines may be developed." **(This change will be effective from August 2023)**
HIPAA Transaction 820	Health Insurance Exchange Related Payments
HIPAA Transaction 270	Eligibility & Benefit Inquiry
HIPAA Transaction 271	Eligibility & Benefit Response
Identification Card (ID)	To access health services, includes the name of the beneficiary, contract number, assigned coverage, copayments, among others.

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Id Card Issue Date	This is the member ID card issue date.
Managed Care Services	The services provided to the Beneficiaries by the doctors who belong to the network of preferred providers in their Primary

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	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 that is assigned in the information systems of the Office of Medicaid in Puerto Rico to an individual, when they determine that he is eligible for Medicare Platino and continues to be an identifier number in the ASES information systems.
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

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	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 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" containingthe Certification decision (whether a person was determined eligible or ineligible for Medicaid, CHIP, or the Commonwealth Population).
New Id Card Issue Date	It is used for the future enrollment period, populated with the member's new ID card issue date.
Plan	The Contractor's Managed Care Plan offering services to enrollees under the GHP.
Plan Type	Plan identifier in ASES Information Systems (Code 01: Plan VITAL (GHP); Code 02 Medicare Platino.
Plan Version	Identification number according to the product approved by CMS, tied to the coverage code for contracted insurers
Medicare Platino Health Plans	It is a supplementary coverage to a Medicare Advantage Plan contracted by ASES, which covers the benefits and services that Medicare does not cover.
Premium Payment (PMPM Payment)	It is the rate established in the contract according to the actuarial analysis, which is carried out according to the trend of the eligible beneficiary's claims, comparing from the reference period to the

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	demonstration year. ASES makes a monthly payment after completing the enrollment process by the contracted insurer.
Potential Enrollee	A person who has been certified by the Puerto Rico Medicaid Program as eligible to enroll in the GHP Program whether based on 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 primary care physician (PCP), or primary care provider, is a health professional who practices general medicine. PCPs are our first stop for medical care. Most PCPs are physicians, provide continuity of care, and provide referrals to physicians, OB/GYNs, or pediatricians. 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	It is the date related to the process of updating eligibility in the ASES information systems, which is carried out daily and monthly. This date field is found in the defined file in (*.exp) format, for changes in beneficiaries sent by the contracted insurer in the date field in the file in (*.sus) format. In a new enrollment in Medicare Platino, the date field is used when the Beneficiary contracted the coverage services with the corresponding insurer in the contract. In Medicare Platino, the Process Date field must be prior to the Effective Date field of the new enrollment or change in question, but later than three (3) months prior to the Effective Date field 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.

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Re-enrollment	Refers to the process of re-enrollment for a Beneficiary of Federal GHP (Medicaid or CHIP) or State GHP (State Population) or Medicare Platino who has lost eligibility for a period of six (6) months. A Medicare Platino Beneficiary that recovers his/her eligibility within a period of two (2) consecutive months, may be enrolled automatically and prospectively under the Medicare Platino 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 once again eligible for services under the GHP Program. If you are registered with CMS and your cancellation is for at least six (6) months; will be reinstated in the insurer contracted by the system of the Medicaid Office in PR
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.

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Eligibility Concepts	
Eligibility Determination	For each applicant for the Government Health Insurance Plan, hereinafter GHP, an eligibility determination precedes the enrollment and premium payment processes carried out 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 if a person is eligible to receive medical services under the Federal GHP (Medicaid and CHIP) and the GHP State (Commonwealth Population) and Medicare Platino. The evaluation of eligibility for each of the programs is based on the requirements established in state and federal regulations. Generally, the eligibility assessment for an individual is determined by income level and its correlation with indigence levels. In Platinum Medicare, the applicant's age (65 years or older) or disability status referred to in Title XVIII of the Social Security Act is considered. In any of the categories of health plans, beneficiaries are certified annually. This means that your eligibility is normally extended for a period of one (1) year on each successful certification. However, for Medicare Platino the enrollment period may be extended for a period of eighteen (18) months. In those cases, in which the Medicaid Program has granted an eligibility period of less than twelve (12) months, the enrollment period 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

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	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 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

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	which the Beneficiary is certified by the Medicaid Office of Puerto Rico. 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 the contracted insurer establishes as the beginning of the coverage period for a Beneficiary. The Effective Date for Enrollment of a Beneficiary under a Medicare Platino Plan will fall on the first day of the month in which the Beneficiary's name appears in the CMS Prepaid Premium Plan List and the first day of the month in which the Beneficiary appears enrolled in the Medicare Platino plan of the contracted insurer. This information must be received in the ASES information systems in the data field of the Effective Date of the Enrollment Registry.
PCP/PMG Change Enrollment Effective Date	If an eligible beneficiary changes their PCP/PMG during the first five days of the month, the change will be effective the following month, if they change their PCP/PMG after the fifth day of the month, the change will be effective the second month after the change. Eligible beneficiaries may still receive services until the change is effective through the original PCP/PMG assigned by the contracting carrier.
Process Date	The Process Date is relevant both in cases of new enrollment of a Beneficiary and in cases of changes of PMG, PCP or Version of the Plan in relation to an enrollment record of an eligible Beneficiary. In the case of a new enrollment under a Medicare Platinum Plan, it refers to the date on which the Beneficiary contracted the coverage services with the contracted insurer. This date can be provided by the insurer under contract where the day on which a change of PMG/PCP or Plan Version was

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	processed in its information systems in the enrollment record of an eligible Beneficiary is identified. In Medicare Platino plans, the Processing Date must be prior to the Effective Date of the new enrollment. However, it must not date back more than three (3) months prior to that Effective Date.
Transfer of Beneficiaries to Medicare Platino Products	Medicare Advantage beneficiaries who receive Medicaid coverage can choose to transfer to Medicare Platino products offered by a contracting insurer of their choice or they can enroll in Medicare Platino products available to dual eligibles. In these cases, ASES and the contracting insurer must process a new enrollment in order to transfer the eligible Beneficiary from 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 Eligible Beneficiary's Medicaid coverage becomes effective.
Recovery of Eligibility and Prospective Enrollment	In those cases, in which an eligible Medicare Platino Beneficiary is disenrolled due to loss of eligibility under the Medicaid Program but regains said eligibility within two (2) consecutive months, he or she may be automatically and prospectively enrolled under the plan. Medicare Platino from the contracted insurer in question assigning the same PCP/PMG in which the Beneficiary was previously enrolled.
Retroactive Enrollment for Medicare Platino Plans	For Medicare Platino plans, enrollment may be retroactively extended from six (6) to eighteen (18) months prior to the date the eligible Beneficiary's enrollment is processed in ASES. The ASES Information Systems Office may accept the enrollment of an eligible Beneficiary of the Medicare Platino Plan for up to eighteen (18) retroactive months if the limits of the period to be enrolledare within the eligibility periods granted by the Program. Medicaid.
MEDICARE PLATINO ENROLLMENT PROCESS	
Main Process	
Description	ASES uses a variety of methods to enroll people eligible for Medicare Platino coverage, together with contracted insurers. The

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	following process is established to follow for the enrollment of Medicare Platino.
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. **(Once format 270 has been implemented by PRMP, the process will be followed according to addendum X)**
	Step 2: Response: ASES processes this query file and sends a response to the request in a (.res) file. This file includes information on the eligibility of the Beneficiary for the Medicaid Program, the coverage to which he was assigned, after the evaluation carried out (federal or state), with his demographic information in the information systems of ASES and the Office of Medicaid in PR**(Once format 271 has been implemented by PRMP, the process will be followed according to addendum X)**.
	Step 3: Enrollment: If the Beneficiary is eligible with defined coverage for Medicaid, the contracted insurer will complete an enrollment record where it will include the data as required in the established file delivery format.

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	Enrollment Rejections: Step 4a: Rejections in the registration file integrity validation process: Once the registration file validation process has been completed, it may have errors, a file in *.err format is generated. ASES sends to the insurer in contract to correct and resubmit for processing. The integrity validation criteria used is the following: the length of the content of the mandatory fields, the region and the data source. Step 4b: Rejections in the data quality validation process: Once the registration file validation process has been completed, it may have errors, a file in *.rjc format is generated. ASES sends to the insurer in contract to correct and resubmit for processing. Step 4c: Validated Enrollment Records: Once the validation process is completed, ASES will edit and update the data in the electronic enrollment record to identify the beneficiary eligible for Medicare Platino. A file in *.exp format will be sent to the insurer in contract. confirming the inscription.

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	Step 5: PCP/PMG Enrollment Updates and Plan Version: The contracting carrier must submit enrollment updates for an eligible Beneficiary to ASES for the PCP/PMG Version and Plan. The registration, validation, correction and forwarding processes will be carried out in ASES as established in steps 3 to 4c.
Enrollment Record	
Description	The registration process established for the insurers in contract has data of the eligible beneficiary and the purpose is to be able to highlight the details of the registrations, verify the accuracy and certainty of the information received. Enrollment confirms ASES and guarantees that the contracted insurer has sent a Platinum Medicare Eligible Beneficiary Welcome Packet and ID card. Medicare Platino Plans contracted with ASES require the assignment of Primary Care Physicians (PCP) to eligible beneficiaries by contracted insurers. The enrollment includes these fields, the Plan Type, the Plan Version, the date it was processed by the contracted insurer, and the Effective Date of Enrollment.
Enrollment Record Fields	
RECORD_TYPE	Code "E" identifies the entry as a registration record, for new registrations of eligible beneficiaries and for previously registered beneficiaries.
TRAN_ID *See Reference A for supporting information.	Field in the "layout" where the action to complete in the file received is identified in the information systems. You have to consider one of the values defined below. E=new enrollment C=Change of operator V= Version change I=IPA change 1=change PCP1 2=PCP2 change 3=PCP1 and PCP2 change
E	New Registration. This value in the "layout" field for "Trans_ID" is

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	used to register a new enrollment of an eligible Beneficiary, who has not been previously enrolled or is currently inactive. To consider in the previous enrollment processes, for the same insurer contracted or different from the previous registration, a "C" will be inserted. Note: For New Enrollments ("E"): It is required that all fields with the information about the contracting insurer, Plan Type, Plan Version, PMG and PCP1 be completed. PCP2 information will remain as optional information as required.
C	This value in the "layout" field for "Trans_ID" is used to record a change of contracting carrier. It is used when the eligible Beneficiary has selected a different contracting carrier than the one they are enrolled in. In Medicare Platino used for initial enrollment where eligible beneficiaries were previously enrolled in a GHP plan and decide to switch to Medicare Platino. Note: For Contracted Insurer Change Transactions ("C"): The process requires registering the name of the new contracted insurer selected and inserting information on the Type of Plan, Version of the Plan, Primary Medical Group, PCP1 and PCP2 (optional) and Date of Issuance of the ID Card and the Date of Registration Process.
V	This value in the "layout" field for "Trans_ID" is used to record a Plan Version Change. In contract insurers for Medicare Platino, it is the change from a product offered by the insurer in contract, to one that is identified under the same Plan Type. This transaction code can be considered when a GHP Beneficiary's coverage code changes. When this situation arises, the contracted insurer must reissue a health plan ID card that contains the new benefits and send a version change registration record to ASES, where the version number corresponds to the new coverage code . If the ASES process is not carried out, an automatic withdrawal of the eligible Beneficiary will be made in the contracted insurer where itwas omitted as required. In this situation, the Beneficiary will continue with his eligibility, so he will receive the medical services,

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	the contracted insurer will not be able to receive the payment rate until the required information is submitted. Note: For Plan Version Change Transactions ("V"): The code of the insurer in the Contractor contract and the information on the Type of Plan provided must coincide with the information in the ASES information systems. Only information about the new assigned Plan Version and information regarding the PMG Center and PCP1 will be provided.
I	This value in the "layout" field for "Trans_ID" is used where there is a primary medical group (PMG) change. It is used to register in the ASES information systems a change in the PMG selected by the eligible beneficiaries under the same insurer in contract, Type of Plan and Version. Note: For PMG Change Transaction ("I"): The information of the contracted insurer, Type of Plan and Version of the Plan must coincide with the information contained in the ASES information systems. New information will be sent to ASES regarding the new PMG that corresponds to the Beneficiary.
1	This value is used in the "layout" field for "Trans_ID" Change of PCP1 to register in the ASES information systems a change in the PCP1 selected by the eligible beneficiaries under the same insurer in contract, Type of Plan, Version and PMG . Note: For Transactions to Change PCP1 ("1"): the information on the contracted insurer, Plan Type, Plan Version and PMG received coincides with the information contained in the ASES information systems. You have to submit the new change information for PCP1 and not PCP2.
2	This value is used in the "layout" field for "Trans_ID" PCP2 change. It is used to record in the ASES information systems a change in the PCP2 selected by the eligible beneficiaries under the same insurer under contract, Type of Plan, Version and PMG. Note: For PCP2 ("2") Change Transactions: You will not have to

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	provide information about PCP1. The only information that may differ from that contained in the ASES records will be that related to the PCP2.
3	This value is used in the "layout" field for "Trans_ID" 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	Processing date. It is the date on which the eligible Beneficiary contracted the coverage services with the contracted insurer or the date the contracting insurer requested a change in PMG, Plan Version, Plan Type, or PCP.
REGION *See Reference B for supporting information.	This code corresponds according to the municipality to which the eligible Beneficiary received from the Medicaid Office in PuertoRico belongs.
CARRIER	Insurer code in contract for Medicare Platino defined in the ASESinformation systems to identify the insured.
MEMBER_PRIMARY_CENTER	Primary Medical Group (PMG) code.
ODSI_FAMILY_ID	Identifier assigned to the eligible beneficiary in the information systems of the Office of Medicaid in PR – Master Patient Index (MPI). The content of the field in the "layout" is defined as eleven (11) last digits of the MPI number. Insurers in contract for Medicare Platino obtain this code from the ASES query response.
MEMBER_SSN	Social Security number of the eligible beneficiary. This number must coincide in the ASES information systems.

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MEMBER_SUFFIX	Number that identifies a member within a family, it is defined with two digits. This is the second part of the identifier of the eligible beneficiaries in the ASES information system.
EFFECTIVE_DATE	The date the contracting insurers begin providing coverage to the eligible Beneficiary under the enrolled Plan or when the change for which the enrollment record was submitted becomes effective, including the effective date of the PMG change, PCP or Plan Version.
PLAN_TYPE	Type of Plan Code that identifies where the eligible beneficiary is enrolled.
PLAN_VERSION	Plan Version code that identifies where the eligible beneficiary is enrolled.
MPI- Master Patient Index.	Unique number assigned by the Medicaid office in PR to identify a beneficiary. It is used in the information systems of ASES and the Medicaid Office in PR.
PCP1	Is a unique identification number for covered health care providers. (NPI). It is used to identify the PCP1 assigned by the insurer under contract selected by eligible beneficiaries.
PCP1_EFFECTIVE_DATE	This is the effective date of PCP1's assignment. If there is a PCP1 change, the PCP1 Initial Effective Date will be maintained until the PCP1 Change Effective Date is reached.
PCP2	It is a unique identification number for covered health care providers (NPI). It is used to identify as a second option in the field of PCP2 assigned by the insurer under contract selected by the eligible beneficiaries.
PCP2_EFFECTIVE_DATE	This is the effective date of PCP2's assignment. If there is a PCP2 change, the PCP2 Initial Effective Date will be maintained until the PCP2 Change Effective Date is reached.
FAMILY_PRIMARY_CENTER	Not in use.

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PMG_TAX_EFF_DT	It is the date on which the transfer of the PMG of the Eligible Beneficiary became effective.
IPA-PCP_CHANGE_REASON	This field is not currently in use.
MEDICARE INDICATOR	Required for Medicare Platino enrollments only. (01=A&B, 03=A, 09=B).
Health Insurance Claim Number (HICN Number)	It is The Medicare Beneficiary Identifier (MBI) is the new identification number that has replaced SSN-based health insurance claim numbers (HICNs) on all Medicare transactions, such as billing, claim submissions and appeals. Required for enrollment of eligible beneficiaries in Medicare Platino.
Additional Data Elements	When the registration of a Beneficiary is validated, the ASES information system enters the data in the registration record.
REJECT IDENTIFIERS	These are the Reject Identifiers A = Accepted Enrollment M = Accepted Retroactively R = Rejected Enrollment
A = Accepted Enrollment	Identifier = "A": Used to identify an accepted enrollment to be applied on a current or future effective date. The update process transfers the registration fields of the insurer in contract, Type of Plan, Version of the Plan, PMG and PCP to the fields defined for new registrations in the file of the eligible Beneficiary. Until the new Effective Date is completed, the Beneficiary will remain under the current enrollment status (same contracted carrier, Plan, Version, PMG and PCP). During the month-end cycle, the new fields are moved into the current fields and enrollment becomes effective.
M = Accepted Retroactively	Identifier = "M": Indicates a retroactive enrollment, the Enrollment data (insurer under contract, Plan Type, Plan Version, PMG and PCP) are updated directly in the history of the eligible Beneficiary.
R = Rejected	Reject Identifier "R": Used when an enrollment record is not processed correctly because an error has been identified, indicates a record returned for correction.

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Reservation Number	Not applicable to Medicare Platino enrollments.
Error Codes one (1) to ten (10)	It is possible to record up to ten (10) error codes.
Update Date	This Date is used to identify the validation process of the daily cycle that is carried out in the ASES information systems.
Update User	Internal user code in the information systems in ASES.
IPA_ESPECIAL	Not applicable to Medicare Platino enrollments.
CONTRACT NUMBER	Contract number assigned by the insurer in the contract, to the eligible beneficiary in its information systems. This number is found as an identifier on the id card.
SPECIAL ENROLL	Not applicable to Medicare Platino enrollments.
PMG Tax ID	A tax identification number (TIN) is a nine-digit number used as a tracking number by the Internal Revenue Service (IRS). Information is required on all tax returns filed with the IRS. All U.S. Tax Identification Numbers (TINs) or tax identification that recognizes the service provider
Data Source	File format identifier *.sus where you have to consider MA in the data source field for Medicare Platino enrollments.
Enrollment Record Rejection	
Description	The registration process to be modified or updated may present some rejection if it does not meet the validation requirements in the ASES information systems. These rejections are sent daily to the insurers under contract in a defined file in *.rjc format, including error codes to be considered by the insurer, to resubmit corrected as appropriate.
ERROR CODES	See Enrollment Error Codes Table

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DISENROLLMENT	
Description	The disenrollment process can arise from any of the following events: when the PR Medicaid Office determines that the beneficiary does not meet the eligibility criteria for Medicare Platino (termination of eligibility), when the coverage code changes and if the change version of the plan was not sent correctly before the end of the month (programmatic cancellation) in the ASES information systems
Disenrollment Concepts	
Termination of Eligibility	Termination of eligibility refers to the cancellation of the health services transaction due to the expiration of the eligibility period. The cancellation of the beneficiary's eligibility will be received from the Medicaid Office in PR and will be carried out in the processes in the ASES information system on the last day of each month. ASES will be updating the information through the file in *.exp format. The contracting insurer must terminate the Medicare Platino Beneficiary.
Programmatic Disenrollment	Contract insurers must identify when a record received has a coverage code different from the one registered in their information system. This cancellation occurs when the Medicaid Office in PR sends a coverage change code for a Beneficiary and the insurer under contract has not submitted an enrollment with the new Version of the Plan related to the change of coverage. The contracting insurer 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 in the new Plan Version to match the new coverage code. This process must be sent to ASES to plan Version change before the end of thecurrent month. Beneficiaries who are not registered with a Version of the Plan that

	corresponds to the coverage code will be discharged during the month-end cycle in the ASES information systems. The insurer must re-enroll beneficiaries who have been canceled or terminated for this reason.
Carrier Change	When receiving an inscription from a contracted insurer and in the ASES information systems the beneficiary appears registered in another insurer, it is understood that the beneficiary made a change of insurer. The previous insurer will be notified in the file in *.exp format and it must cancel the beneficiary in its systems. If the change is prospective, the old insurer's enrollment data remains in the current data fields and the future insurer's data fills the new data fields. At the end of the month prior to the prospective enrollment effective date, the data in the new fields is moved to the current data fields and both insurers are notified. A recovery of the payment fee will be made if a payment has previously been made to an insurer 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.

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PREMIUM PAYMENT	
Description	The premium payment system according to the contract has the criterion of making payment only when the beneficiaries are enrolled before the first day of the month to which the payment corresponds. Beneficiaries registered after that date will be considered for the next payment, after all the updating and cancellation procedures in force in that month. To standardize the payment schedule for Medicare Platino (rate cell: 38) and state (rate cell: 40) beneficiaries. The detailed information of the premium payment for each beneficiary is transmitted to the insurer in an EDI 820 format file.
Premium Payment Concepts	
Payment Execution	On a monthly basis, the system performs an automatic execution of the payment. The premium paid by each member will depend on their classification in the Rate Cell. The payment of the premium corresponding to Rate Cell will be made on the first day of the month following the acceptance of the registration by ASES. ASES will not pay premiums to beneficiaries who are not duly registered in the ASES information systems, nor will it pay premiums to beneficiaries whose records contain transactions that have been rejected in the ASES information systems and have not been corrected within the established deadlines. by contract. This applies Plan Vital, not Medicare Platino

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Reasons for Not Executing a Payment	The payment rate will not be executed in favor of an insurer under contract for the following circumstances: (1) If the beneficiary is not registered in the ASES information systems before the first day of the month for which the payment transaction is being executed. (2) If the registration had been rejected by ASES and the insurer did not submit a new registration with the corresponding corrections (3) If the ASES eligibility data shows that the beneficiary had a disenrollment (blank card issuance date), cancellation of eligibility or change of insurer.
Monthly Payments	In this case, the system produces a payment for those beneficiaries whose registration has already been made effective before the first day of the month for which the payment operation is executed. The execution of the payment tariff is executed on the first day of the month.
Retroactive Payments	These payments are calculated when the Membership Effective Date falls in a period prior to the month in which the fee payment process is being executed. In other words, this type of payment is executed when payments corresponding to months prior to the month in which the payment is made are identified. Retroactive payments will be calculated based on the effective date of enrollment. The system will process the payments of registered beneficiaries with an Effective Date prior to the payment date in the case of monthly payments or prorated payments that have not been previously paid within the retroactive payment terms. Retroactive payments may result in an adjusted payment if they are the result of the cancellation of a previous enrollment or an insurer change by the insurer.

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<table>
<tr><td>Adjustments</td><td>A payment adjustment is calculated when there is a need to reverse a payment that was awarded to an insurer during a previous payment process. It occurs when, because of a retroactive payment calculation, a payment made in relation to the same beneficiary within the same period in which a change of insurer has been executed is identified. In these cases, an adjustment is made to the rate paid to the first insurer.</td></tr>
<tr><td>Special Adjustments</td><td>Generally, the special adjustments are carried out because 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. F or this type of adjustment, the insurer will receive a list of transactions inwhich they can identify the type of adjustment (for example: a deceased), the adjusted months and the amount adjusted. Thedescription of this list is found in Attachment 9, Special Adjustment File Layout.</td></tr>
<tr><td>Adjustment Type</td><td>The table below describes the various adjustment types identified by the payment process.
<table><tr><th>Adjustment Type Code</th><th>Description</th></tr><tr><td>1</td><td>DblPay</td></tr><tr><td>2</td><td>Deceased</td></tr><tr><td>4</td><td>COB</td></tr><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></table></td></tr>
</table>

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	10 — Ineligible 11 — Special Reconciliation 12 — Rate Cell 13 — Maternity Kick Payment
EDI 820 Payment File	The conciliation process that is carried out between ASES and the insurers in contract in relation to the payment of established rates must consider the content of the EDI 820 files. This file isgenerated monthly by insurer and Type of Plan, this includes the detail of the payments that correspond to each one of the beneficiaries enrolled in the insurers per month. This encompassesthe rate cell and, if applicable, adjustment type information for eachof those payments. This file does not distinguish whether the payment corresponds to an adjustment of a regular payment process or a special adjustment. ASES will deliver a separate file for the special adjustments to the insurer.

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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

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Reference B: Region Codes	
	<table><tr><td></td><td></td></tr><tr><td>North</td><td>A</td></tr><tr><td>Metro-North</td><td>B</td></tr><tr><td>East</td><td>E</td></tr><tr><td>Northeast</td><td>F</td></tr><tr><td>San Juan</td><td>J</td></tr><tr><td>Southeast</td><td>G</td></tr><tr><td>Southwest</td><td>S</td></tr><tr><td>Special</td><td>P</td></tr><tr><td>West</td><td>Z</td></tr></table>
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	<table><tr><td>**ENROLLMENT FILE [CCYYMMDD.sus]**</td></tr><tr><td>CC = Contractor Code</td></tr><tr><td>YY = Year</td></tr><tr><td>MM = Month</td></tr><tr><td>DD = Day</td></tr><tr><td>.sus = Identifies the file as an enrollment file. The enrollment file may contain records belonging to any of the regions contracted by the Contractor.</td></tr><tr><td>**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</td></tr></table>

<table>
<tr><td></td><td>(.sus)</td></tr>
<tr><td>2</td><td><table><tr><td>ELIGIBILITY FILE [VYYMMDD.ref]</td></tr><tr><td>a. V = indicates that it is an eligibility file</td></tr><tr><td>b. YY = Year</td></tr><tr><td>c. MM = Month</td></tr><tr><td>d. DD = Day</td></tr><tr><td>e. .ref = Indicates that it is a file containing the records of the beneficiaries' eligibility.</td></tr></table></td></tr>
<tr><td>3</td><td><table><tr><td>DATA EXPORT FILE [CCYYMMDD.exp]</td></tr><tr><td>b. CC = Contractor code</td></tr><tr><td>c. YY = Year</td></tr><tr><td>d. MM = Month</td></tr><tr><td>e. DD = Day</td></tr><tr><td>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)</td></tr></table></td></tr>
<tr><td>4</td><td><table><tr><td>ENROLLMENT FILE [CCYYMMDD.err]</td></tr><tr><td>a. CC= Contractor Code</td></tr><tr><td>b. YY = Year</td></tr><tr><td>c. MM = Month</td></tr><tr><td>d. DD = Day</td></tr><tr><td>e. .err = Indicates that the records it contains did not pass</td></tr></table></td></tr>
</table>

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<table>
<tr><td></td><td>the file integrity validation. These records are not going to be processed.
Notes:
The format is the same as the subscriptions file (.sus)</td></tr>
<tr><td>**5**</td><td>**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.
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<tr><td>**6**</td><td>**Contract fee payment Transactions [PRCC0YYMM0000.820]**
a. P = Identify contract fee payment
b. R = region code
c. CC = Insurer code</td></tr>
</table>

	d. 9 = Frequency e. YY = Year f. MM = Month g. 0000 = IPA Direct Contract h. .820 = Indicates that it is a file containing all contract fee 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.

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<table>
<tr>
<td>8</td>
<td>

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.

</td>
</tr>
</table>

Note: Once format 270/271 has been implemented by PRMP, the process will be followed according to addendum 2)

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APPENDICES

Addendum 1 - Notice of Decision
Addendum 2 - Eligibility and Enrollment
Addendum 3 - 820 Companion Guide and Prempay ADJ File Layout
Addendum 4 - CARRIER to ASES ver 4.1C_rev.20230221
Addendum 5 - ASES COB Data Submissions (Third Party Liability) 1.8.3rev20221114
Addendum 6 - ASES EFT Folder Organization - Insurance Carrier - v1.1 r20230316

PREPARED BY			
	Winda J. Lorenzo González	[signature]	06/12/2023
	(Print Name)	(Signature)	(Date)
REVIEWED BY			
	Miladis Costoso De Jesús	[signature]	06/12/2023
	(Print Name)	(Signature)	(Date)
APPROVED BY			
	Winda J. Lorenzo	[signature]	06/12/2023
	(Print Name)	(Signature)	(Date)

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ADDENDUM 1
Notice of Decision

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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

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

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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.

Rev-0220

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.

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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**.

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Contrato Número

EMR

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.

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Addendum 2

Eligibility and Enrollment

ADMINISTRACION DE
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Enrollment Export File Layout

Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
F		**Member (First Segment)**					
F	1	Record Type	1	1	F	F - Member (First Segment)	
F	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) The number correspond to the record group, not to the period order	
F	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	4	Social Security Number	11	9		Social Security Number of the insured member	
F	5	FILLER	20	2		filled with '00'	
F	6	FILLER	22	14		filled with blanks	
F	7	Person Id	36	11		Member's Person Id This Identifier is assigned to beneficiaries and related contact and household persons in the Eligibility Determination process.	
F	8	Contact Last Name	47	15		Last Name of the member's contact person	
F	9	Contact Second Last Name	62	15		Second Last Name of the member's contact person	
F	10	Contact First Name	77	20		First Name of the member's contact person	
F	11	Region	97	1	A, B, E, F, G, J, S, Z, P	Region code assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste P - Virtual	
F	12	Municipality	98	4	See Appendix Municipality Codes	Municipality Code Format: Zero fill, right justify.	
F	13	Facility	102	4		Facility Code Zero fill, right justify.	
F	14	FILLER	106	1		filled with blanks	
F	15	FILLER	107	1		filled with blanks	
F	16	Eligibility Effective Date	108	8		Effective start date of the eligibility period	
F	17	FILLER	116	1		filled with blanks	
F	18	FILLER	117	2		filled with blanks	

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F	19	Expiration Date	119	8		Re-certification cutoff date for the member's eligibility period. Changes to Re Certification Date are submitted in the "Cancellation / Extension Date"	
F	20	FILLER	127	1		filled with blanks	
F	21	Mailing Address 1	128	75		Address line of the current mailing address of the insured member	
F	22	Mailing Address 2	203	75		Second address line of the current mailing address of the insured member	
F	23	Mailing City	278	16		City name of the member's mailing address	
F	24	Mailing ZIP	294	5		First 5 digits of the zip code of the member's mailing address Format: Zero fill, right justify.	
F	25	Mailing ZIP4	299	4		Last 4 digits of the zip code of the member's mailing address Format: Zero fill, right justify.	
F	26	Residence Address 1	303	75		Address line of the current residential address of the insured member	
F	27	Residence Address 2	378	75		Second Address line of the current residential address of the insured member	
F	28	Residence City	453	16		City name of the member's residential address	
F	29	Residence Zip	469	5		First 5 digits of the Zip code of the member's residential address Format: Zero fill, right justify.	
F	30	Residence Zip4	474	4		Last 4 digits of the Zip code of the member's residential address Format: Zero fill, right justify.	
F	31	Communication Number	478	10		Member's communication number. Filled with a qualified phone number including the area code	
F	32	FILLER	488	2		filled with blanks	
F	33	FILLER	490	20		filled with blanks	
F	34	FILLER	510	2		filled with blanks	
F	35	FILLER	512	20		filled with blanks	
F	36	FILLER	532	2		filled with blanks	
F	37	FILLER	534	20		filled with blanks	
F	38	FILLER	554	2		filled with blanks	
F	39	FILLER	556	2		filled with blanks	
F	40	FILLER	558	6		filled with blanks	
F	41	FILLER	564	8		filled with blanks	
F	42	FILLER	572	3		filled with blanks	
F	43	FILLER	575	1		filled with blanks	
F	44	Eligible Members	576	2		Count of eligible members in the household of the insured member	

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F	45	Cancellation or Termination Code	578	2	06,07,08,09,10,13,30,31	Eligibility determination reason code for member's cancellation or termination 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 Filled with blanks when member has not received a cancellation or termination	
F	46	Carrier Code	580	2		Code of insurance carrier asigned to the member.	
F	47	Carrier Effective Date	582	8		Effective Start Date for the member's coverage period in the assigned Insurance Carrier Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	48	Carrier End Date	590	8		Effective End Date for the member's coverage period in the assigned Insurance Carrier Only for Transation Id = (H)istory or when thre is a carrier change in the future to a different carrier, otherwise filled with blanks Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	49	FILLER	598	3		Filled with blanks	
F	50	FILLER	601	3		Filled with blanks	
F	51	PMG Federal Tax Id	604	9		Federal Tax Id for the member's Primary Medical Group (PMG)	
F	52	New Carrier	613	2		New carrier code	
F	53	New PMG Federal Tax Id	615	9		Federal Tax Id for the PMG assigned to the insured member	ADMINISTRACION DE SEGUROS DE SALUD
F	54	New PMG Effective Date	624	8		Effective start date for the new PMG assigned to the insured member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	№ 24-0003 Contrato Número
F	55	Policy Number	632	13		Member's Policy Number (also known as Contract Number) assigned by the Insurance Carrier MCO contract number	
F	56	FILLER	645	1		Filled with blanks	

F	57	New Carrier Effective Date	646	8		Effective date for the carrier assigned to the member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	58	PMG Effective Date	654	8		Effective date for the PMG assigned to the insured member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	59	Certification Date	662	8		Member's certification date for the eligibility period Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	60	PCP Change Reason	670	2		Code of member's reason for changing PCP	
F	61	FILLER	672	1		Filled with blanks	
F	62	FILLER	673	8		Filled with blanks	
F	63	FILLER	681	11		Filled with blanks	
F	64	Case Number	692	10		Member's case number assigned by the Department of Health / Medicaid Program	
F	65	Extension or Cancellation Date	702	8		This field is used depending on the member's eligibility status in Record M, Field 38 (Eligibility Indicator) (1) Extension Date When the record Transation Id not valued 'I' this is the member's Extension date for the cutoff Recertification Date (2) Cancellation Date When the record Transation Id is valued 'I' this is the member's Termination or Cancellation date Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número
F	66	FILLER	710	8		Filled with blanks	
F	67	FILLER	718	2		Filled with blanks	
F	68	Gender	720	1	1,2,3	Gender identity of the insured member 1 - Male 2 - Female 3 - Unnkown	

F	69	New Id Card Issue Date	721	8		For future enrollment period, filled with the member's new Identification Card Issue Date. This field is filled with blanks when the insurance carrier has to submit an enrollment effectuation due to the addition of a subscriber or a change in the coverage code. Format: MMDDCCYY	
F	70	Member Start Date	729	8		Member's start date for the current period of continuous enrollment in current insurance carrier. Format: MMDDCCYY	
F	71	FILLER	737	3		Filled with blanks	
M		**Member (Second Segment)**					
M	1	Record Type	1	1	M	M - Member Second Segment	
M	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	
M	3	Process Date	3	8		Process Date for this transaction Format: MMDDYYYY	
M	4	Social Security Number	11	9		Member's social security number	
M	5	FILLER	20	2		filled with '00'	
M	6	FILLER	22	1		Filled with blanks	
M	7	FILLER	23	9		Filled with blanks	
M	8	FILLER	32	2		Filled with '01'	
M	9	Contact Person Id	34	11		Person Id assigned to the member's contact	
M	10	FILLER	45	3		filled with blanks	
M	11	Last Name	48	15		Member's Last Name	
M	12	Second Last Name	63	15		Member's Second Last Name	
M	13	First Name	78	20		Member's First Name	
M	14	Middle Initial	98	1		Member's Middle Initial	
M	15	FILLER	99	1		Filled with '0'	
M	16	Date Of Birth	100	8		Member's date of birth Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
M	17	FILLER	108	1		Filled with '0'	
M	18	Sex	109	1	1,2,3	Member's sex at birth 1 - Male 2 - Female 3 - Unknown	
M	19	FILLER	110	1		Filled with '0'	
M	20	FILLER	111	1		Filled with '0'	
M	21	FILLER	112	1		Filled with '0'	

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M	22	FILLER	113	1		Filled with blanks	
M	23	Social Security Benefits	114	1	1,2	Code to identify if the member receives social security benefits 1 - Yes 2 - No	
M	24	FILLER	115	1		Filled with blanks	
M	25	FILLER	116	2		Filled with '00'	
M	26	FILLER	118	1		Filled with '0'	
M	27	FILLER	119	1		Filled with '0'	
M	28	FILLER	120	1		Filled with '0'	
M	29	FILLER	121	1		Filled with '0'	
M	30	Marital Status Code	122	1	1,2,3,4,5	Code of the member's marital status 1 - Single 2 - Married 3 - Divorced 4 - Widowed 5 - Other	
M	31	FILLER	123	9		Filled with blanks	
M	32	Pregnancy Indicator	132	1	1,2	Member's pregnancy indicator at the moment of the eligibility evaluation 1 - Member is not pregnant 2 - Member is pregnant	
M	33	FILLER	133	1		filled with blanks	
M	34	MBI	134	11		Member's current Medicare Beneficiary Identifier filled with blanks if member does not have Medicare coverage	
M	35	FILLER	145	1		Filled with '0'	
M	36	FILLER	146	1		Filled with '0'	
M	37	FILLER	147	1		Filled with '0'	
M	38	Eligibility Indicator	148	1	Y,N	Member's eligibility indicator for this transaction Y - Yes, Member is Eligible N - No, Member is not Eligible	
M	39	Cancellation Code	149	2		Duplicated Field for Record F, Field 45 Filled with value in Record F, Field 45	
M	40	FILLER	151	2		Filled with blanks	
M	41	PMG NPI	153	10		PMG NPI Optional for Carrier Platino Filled with blanks if no PMG on record	
M	42	New PMG NPI	163	10		New PMG NPI Optional for Carrier Platino Filled with blanks if no PMG on record	

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M	43	PMG Medicaid Id	173	9		This is the PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Added
M	44	New PMG Medicaid Id	182	9		This is the New PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Added
M	45	FILLER	191	26		Filled with blanks	
M	46	Government Group	217	2	See Appendix Government Group Codes	Group identifier related to other federal and local government entities associated with the insured member	
M	47	Person Id	219	11		Member's Person Identifier This Identifier is assigned to beneficiaries and related contact and household persons by the Department of Health	
M	48	FILLER	230	10		Filled with blanks	
M	49	FILLER	240	5		Filled with blanks	
M	50	MPI	245	13		Member's master patient index (MPI) number	
M	51	Certification Date	258	8		Duplicate Field on Record F Field 59 Filled with value in Record F, Field 59	
M	52	Policy Number	266	13		Duplicate Field on Record F Field 55 Filled with value in Record F, Field 55	
M	53	PMG Code	279	4		Code of PMG assigned to the insured member. PMG code must be submittd to ASES in Report 12 by the Insurance Carrier in a weekly basis.	
M	54	PMG Effective Date	283	8		Effective Start Date of the member's assignment to the PMG Format: MMDDCCYY	
M	55	New PMG Code	291	4		Code of the PMG assigned to the insured member PMG Code must be provided by the Insurance Carrier in a weekly basis in Report 12.	
M	56	New PMG Effective Date	295	8		Effective Start Date of the PMG assigned to the insured member Format: MMDDCCYY	
M	57	PCP	303	15		NPI of the PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	

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M	58	PCP Effective Date	318	8		Effective start date for the PCP assigned to the insured member Format: MMDDCCYY	
M	59	Second PCP	326	15		NPI of the Second PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	60	Second PCP Effective Date	341	8		Effective start date for the second PCP assigned to the insured member Format: MMDDCCYY	
M	61	New PCP	349	15		NPI of the New PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	62	New PCP Effective Date	364	8		Effective start date for the New PCP assigned to the insured member Format: MMDDCCYY	
M	63	New Second PCP	372	15		NPI of the New Second PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	64	New Second PCP Effective Date	387	8		Effective start date for the New Second PCP assigned to the insured member Format: MMDDCCYY	
M	65	FILLER	395	15		Filled with blanks	
M	66	Id Card Issue Date	410	8		Member's Identification Card Issue Date This field is filled with blanks when the Insurance carrier has to submit an enrollment effectuation due to the addition of a subscriber or a change in the coverage code. Format: MMDDCCYY	
M	67	FILLER	418	1		Filled with blanks	
M	68	Primary Care Change Reason	419	2		Code use by the carrier for identifying the reason of the member's primary care change (primary care includes: PMG,PCP, Second PCP) This is an informative field that may be used for audit purposes. Fill with blanks if no PMG, PCP or Second PCP changes.	ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número
M	69	Program	421	1	1,2,3	Member's Affordability Insurance Program 1 - Medicaid 2 - CHIP 3 - Commonwealth	
M	70	FILLER	422	1		Filler	Change to filler as it is submitted in the Insurance Record

M	71	Carrier	423	2		Duplicate Field on Record F Field 46 Filled with value in Record F, Field 46	
M	72	Carrier Effective Date	425	8		Duplicate Field on Record F Field 47 Filled with value in Record F, Field 47	
M	73	New Carrier	433	2		Code of the insurance new carrier assigned to the member	
M	74	New Carrier Effective Date	435	8		Effective start date of the new carrier assigned to the insured member Format: MMDDCCYY	
M	75	Plan Type	443	2	01,02	Code of the Plan Type assigned to the insured member 01 - Vital 02 - Platino	
M	76	Plan Type Effective Date	445	8		Effective start date of the Plan Type assigned to the insured member Format: MMDDCCYY	
M	77	Plan Version	453	3		Code of the insurance carrier's product matching member's health coverage entitlement	
M	78	Plan Version Effective Date	456	8		Effective start date of the Plan Version assigned to the insured member Format: MMDDCCYY	
M	79	New Plan Type	464	2		Code of New Plan Type assigned to the insured member 01 - Vital 02 - Platino bb - Not assigned	
M	80	New Plan Type Effective Date	466	8		Effective start date of the new Plan Type assigned to the insured member Format: MMDDCCYY	
M	81	New Plan Version	474	3		Code of the new insurance product the carrier assigned to the member matching the requested Health Coverage	ADMINISTRACION DE SEGUROS DE SALUD
M	82	New Plan Version Effective Date	477	8		Effective start date of the new Plan Version assigned to the insured member Format: MMDDCCYY	№ 24 - 0003
M	83	FILLER	485	1		Filled with blanks	
M	84	FILLER	486	12		Filled with blanks	
M	85	FILLER	498	1		Filled with blanks	Contrato Número
M	86	FILLER	499	8		Filled with blanks	
M	87	Confined Coverage Code	507	3	See Appendix Coverage Codes	Federal Coverage Code for Hospitalization coverage entitlement when the beneficiary has Government Group Code in (03, 04, 97) representing a confined population. If not applicable leave blank This information will be shared if available	Added

M	88	Coverage Code	510	3	See Appendix Coverage Codes	Code for the member's health coverage entitlement A beneficairy with Government Group Code in (97) only has a Confined Coverage Code. If not aplicable leave blank	Changed Field Id, includes rule for Incarcerated population.
M	89	New Policy Number	513	13		Member's Policy Number (Contract Number) assigned by the Insurance Carrier.	Changed Field Id
M	90	Special Enroll	526	1	T, E, N	T - Retroactive Period E - Late Eligibility (used in new enrollments when a retro eligibility with more than 3 months is received) N = Deemed Newborn Filled with blanks if no special enroll period	Changed Field Id
M	91	Cost Sharing Exception Code	527	1	N,C,P,A,I,H	N - No exception C - Child P - Pregnant A - American Indian I - Institutionalized H - Hospice	Changed Field Id
M	92	Co-Payment Maximum	528	5		Maximum co-payment amount for the member's household. Format: filled with number, includes two decimal positions.	Changed Field Id
M	93	Extension Flag	533	1	N,A,U,P,X,H	N - No extension A - Pending Appeal U - Appeal closed P - Pregnancy X - Other extension H - Natural Disaster	Changed Field Id
M	94	Spend Down Indicator	534	1	N,S	Fill with blanks For future use: N - No spend-down involved S - Spend-down satisfied (If S, required at least one spend-down record on recod group)	Changed Field Id
M	95	Eligibility Group	535	3	See Appendix Eligibility Group Codes	Member's eligibility Group Code	Changed Field Id
M	96	Date of Death	538	8		Member's date of death as reported by the Department of Health Format: MMDDCCYY	Changed Field Id
M	97	Custom Property 1	546	8		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id

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M	98	Custom Property 2	554	8		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	99	Custom Property 3	562	15		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	100	Custom Property 4	577	15		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	101	Language Spoken	592	3	See Appendix Language Codes	Language Spoken is shared if available	Changed Field Id
M	102	Language Written	595	3	See Appendix Language Codes	Language Written is shared if available	Changed Field Id
M	103	Race	598	2	See Appendix Race and Ethinicity Codes	Race is shared if available	Changed Field Id
M	104	Ethnicity	600	2	See Appendix Race and Ethinicity Codes	Ethnicity is shared if available	Changed Field Id
M	105	FILLER	602	138		Filled with blanks	
O		**Household**					
O	1	Record Type	1	1		O - Household Record	
O	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número
O	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDYYYY	
O	4	Person Id	11	11		Member's Person Id	
O	5	Household Person 1	22	11		Person Id for member's household person 1	
O	6	Household Person 2	33	11		Person Id for member's household person 2	
O	7	Household Person 3	44	11		Person Id for member's household person 3	
O	8	Household Person 4	55	11		Person Id for member's household person 4	
O	9	Household Person 5	66	11		Person Id for member's household person 5	
O	10	Household Person 6	77	11		Person Id for member's household person 6	
O	11	Household Person 7	88	11		Person Id for member's household person 7	
O	12	Household Person 8	99	11		Person Id for member's household person 8	

O	13	Household Person 9	110	11		Person Id for member's household person 9	
O	14	Household Person 10	121	11		Person Id for member's household person 10	
O	15	Household Person 11	132	11		Person Id for member's household person 11	
O	16	Household Person 12	143	11		Person Id for member's household person 12	
O	17	Household Person 13	154	11		Person Id for member's household person 13	
O	18	Household Person 14	165	11		Person Id for member's household person 14	
O	19	Household Person 15	176	11		Person Id for member's household person 15	
O	20	Household Person 16	187	11		Person Id for member's household person 16	
O	21	Household Person 17	198	11		Person Id for member's household person 17	
O	22	Household Person 18	209	11		Person Id for member's household person 18	
O	23	FILLER	220	520		Fill with empty spaces.	
I		**Insurance (COB)**					
I	1	Record Type	1	1	I	I - Insurance (COB) Record	
I	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	
I	3	Proces Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
I	4	Person Id	11	11		Member's Person Id	
I	5	FILLER	22	2		filled with '01'	
I	6	Health Insurer Code	24	3	See Appendix ASES Insurer Codes	Code assigned to the Insurance Company by ASES	
I	7	Policy Number	27	20		Policy number assigned by the Insurance Company to the member. If it is Medicare, it will be filled with the MBI number	
I	8	Policy End Date	47	8			
I	9	Covered Services	55	40		20 coverage code fields (2 character each).	
I	10	Policy Effective Date	95	8		Effective Date for policy (Medicare benefits or private plans)	
I	11	FILLER	103	637			
R		**Rate Cell and Risk Score**					
R	1	Record Type	1	1	R	R - Rate Cell and Risk Score Record	
R	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	

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R	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
R	4	Person Id	11	11		Member's Person Id	
R	5	FILLER	22	14		Filled with blanks	
R	6	Rate Code	36	3		Member's adjudicated rate cell code. **Left justified, fill with blanks when rate code is less than 3 characters.**	Change Size from 2 to 3 characters
R	7	Risk Score	39	8		Member's adjudicated Risk Score Factor used to calculate capitation payments. This Risk Score is adjusted for Budget Neutrality. Format uses up to 3 digits NON Decimal and up to 4 decimal digits, **Examples:** **- 001.0000** **- 123.4567** **- 001.1200**	Added
R	8	Risk Score Indicator	47	1		Risk Score Indicator 0 = Risk Score is using a Default Value 1 = Risk Score is evaluated by using CDPS+RX Risk adjustment module including budget neutrality.	Added
R	9	Raw Risk Score	48	8		Risk Score Factor generated by the CDPS+RX Risk adjustment module Format uses same format as the Risk Score field If Risk Score indicator is 0 then this field will be filled with blanks.	Added
R	10	Effective Date	56	8		Member's rate cell and risk score effective start Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	Change position and now includes changes to the adjudicated risk score
R	11	End Date	64	8		Member's rate cell and risk score effective end. Filled with blanks when effective period ends with the end of the eligibility period If the member has a carrier change in the future, the rate cell end date will be populated. Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	Change position and now includes changes to the adjudicated risk score
R	12	FILLER	72	668	740	Filled with blanks	

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Language Codes

Code	Description
ARA	ARABIC
ARM	ARMENIAN
ASL	AMERICAN SIGN LANGUAGE
CAN	CANTONESE
ENG	ENGLISH
FAR	FARSI
FRE	FRENCH
GER	GERMAN
GRE	GREEK
HAC	HAITIAN-CREOLE
HIN	HINDI
HMG	HMONG
ITA	ITALIAN
JPN	JAPANESE
KHM	KHMER
KOR	KOREAN
LAO	LAOTIAN
MND	MANDARIN
OTH	OTHER
POL	POLISH
POR	PORTUGUESE
RUS	RUSSIAN
SMO	SAMOAN
SPA	SPANISH
TGL	TAGALOG
VIE	VIETNAMESE
YID	YIDDISH

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Race and Ethnicity Codes

Code	Description
Race	
01	White
02	Black/African American
03	American Indian/Alaska Native
04	Asian Indian
05	Chinese
06	Filipino
07	Japanese
08	Korean
09	Vietnamese
10	Other Asian
11	Asian Unknown
12	Native Hawaiian
13	Guamanian or Chamorro
14	Samoan
15	Other Pacific Islander
16	Native Hawaiian/Other Pacific Islander Unknown
17	Unspecified
Ethnicity	
00	Not of Hispanic or, Latino/a, or Spanish origin
01	Mexican, Mexican American, Chicano/a
02	Puerto Rican
03	Cuban
04	Another Hispanic, Latino, or Spanish origin
05	Hispanic or Latino Unknown
06	Ethnicity Unspecified

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Eligibility Group Codes

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	Former 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

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Government Group Codes

Español	English	Government Entity
01 Policía Estatal (Activo)	Police Officer with Active Employment	Puerto Rico Police Department
02 Veterano	Veteran	Department of Veterans Affairs
03 Administración de Instituciones Juveniles (AIJ)	Person in a Juvenile Detention Facility	Department of Correction And Rehabilitation
04 Psiquiatría Forense	Person in a Forensic Psychiatry Facility	
05 Confinado	Person in a Correctional Detention Facility	Department of Correction And Rehabilitation
06 Empleado público o pensionado del E.L.A.	Employee or Pensioner of the Commonwealth of Puerto Rico	Commonwealth of Puerto Rico
07 Esposo(a) de Policía (Cónyuge)	Spouse of Police Officer	Puerto Rico Police Department
08 Deambulante Veterano	Homeless - Veteran	Department of Veterans Affairs
09 Deambulante Severos Daños Salud Mental	Homeless - Severe Mental Health Damage	Puerto Rico Administration of Mental Health and Anti-Addiction Services
10 Deambulante	Homeless	
11 Hijo(a) de Policía (Hasta 25 años, inclusive)	Dependant of a Police Officer, Age 25 or less	Puerto Rico Police Department
12 Violencia Doméstica	Domestic Abuse	Woman's Advocate Office of Puerto Rico
13 Orden Ejecutiva Embarazadas	Executive Order for Pregnant Woman	
14 Deambulante (Otros)	Homeless (Others)	
15 Empleado Municipal Aguada	Employee of Aguada Municipality	Aguada
16 Empleado Municipal Aguadilla	Employee of Aguadilla Municipality	Aguadilla
17 Empleado Municipal Isabela	Employee of Isabela Municipality	Isabela
18 Empleado Municipal Moca	Employee of Moca Municipality	Moca
19 Empleado Municipal San Sebastián	Employee of San Sebastián Municipality	San Sebastián
20 Empleado Municipal Barranquitas	Employee of Barranquitas Municipality	Barranquitas
21 Empleado Municipal Bayamón	Employee of Bayamón Municipality	Bayamón
22 Empleado Municipal Cataño	Employee of Cataño Municipality	Cataño
23 Empleado Municipal Comerío	Employee of Comerío Municipality	Comerío
24 Empleado Municipal Corozal	Employee of Corozal Municipality	Corozal
25 Empleado Municipal Dorado	Employee of Dorado Municipality	Dorado
26 Empleado Municipal Naranjito	Employee of Naranjito Municipality	Naranjito
27 Empleado Municipal Orocovis	Employee of Orocovis Municipality	Orocovis
28 Empleado Municipal Toa Alta	Employee of Toa Alta Municipality	Toa Alta
29 Empleado Municipal Toa Baja	Employee of Toa Baja Municipality	Toa Baja
30 Empleado Municipal Vega Alta	Employee of Vega Alta Municipality	Vega Alta
31 Empleado Municipal Ceiba	Employee of Ceiba Municipality	Ceiba
32 Empleado Municipal Culebra	Employee of Culebra Municipality	Culebra
33 Empleado Municipal Fajardo	Employee of Fajardo Municipality	Fajardo
34 Empleado Municipal Luquillo	Employee of Luquillo Municipality	Luquillo
35 Empleado Municipal Río Grande	Employee of Río Grande Municipality	Río Grande
36 Empleado Municipal Vieques	Employee of Vieques Municipality	Vieques
37 Empleado Municipal Canóvanas	Employee of Canóvanas Municipality	Canóvanas
38 Empleado Municipal Carolina	Employee of Carolina Municipality	Carolina
39 Empleado Municipal Guaynabo	Employee of Guaynabo Municipality	Guaynabo
40 Empleado Municipal Loíza	Employee of Loíza Municipality	Loíza
41 Empleado Municipal Trujillo Alto	Employee of Trujillo Alto Municipality	Trujillo Alto
42 Empleado Municipal San Juan	Employee of San Juan Municipality	San Juan
43 Empleado Municipal Arecibo	Employee of Arecibo Municipality	Arecibo
44 Empleado Municipal Barceloneta	Employee of Barceloneta Municipality	Barceloneta
45 Empleado Municipal Camuy	Employee of Camuy Municipality	Camuy
46 Empleado Municipal Ciales	Employee of Ciales Municipality	Ciales
47 Empleado Municipal Florida	Employee of Florida Municipality	Florida
48 Empleado Municipal Hatillo	Employee of Hatillo Municipality	Hatillo
49 Empleado Municipal Lares	Employee of Lares Municipality	Lares

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EMR

50 Empleado Municipal Manatí	Employee of Manatí Municipality	Manatí
51 Empleado Municipal Morovis	Employee of Morovis Municipality	Morovis
52 Empleado Municipal Quebradillas	Employee of Quebradillas Municipality	Quebradillas
53 Empleado Municipal Utuado	Employee of Utuado Municipality	Utuado
54 Empleado Municipal Vega Baja	Employee of Vega Baja Municipality	Vega Baja
55 Empleado Municipal Aguas Buenas	Employee of Aguas Buenas Municipality	Aguas Buenas
56 Empleado Municipal Aibonito	Employee of Aibonito Municipality	Aibonito
57 Empleado Municipal Caguas	Employee of Caguas Municipality	Caguas
58 Empleado Municipal Cayey	Employee of Cayey Municipality	Cayey
59 Empleado Municipal Cidra	Employee of Cidra Municipality	Cidra
60 Empleado Municipal Gurabo	Employee of Gurabo Municipality	Gurabo
61 Empleado Municipal Humacao	Employee of Humacao Municipality	Humacao
62 Empleado Municipal Juncos	Employee of Juncos Municipality	Juncos
63 Empleado Municipal Las Piedras	Employee of Las Piedras Municipality	Las Piedras
64 Empleado Municipal Maunabo	Employee of Maunabo Municipality	Maunabo
65 Empleado Municipal Naguabo	Employee of Naguabo Municipality	Naguabo
66 Empleado Municipal San Lorenzo	Employee of San Lorenzo Municipality	San Lorenzo
67 Empleado Municipal Yabucoa	Employee of Yabucoa Municipality	Yabucoa
68 Empleado Municipal Cabo Rojo	Employee of Cabo Rojo Municipality	Cabo Rojo
69 Empleado Municipal Hormigueros	Employee of Hormigueros Municipality	Hormigueros
70 Empleado Municipal Lajas	Employee of Lajas Municipality	Lajas
71 Empleado Municipal Las Marías	Employee of Las Marías Municipality	Las Marías
72 Empleado Municipal Mayagüez	Employee of Mayagüez Municipality	Mayagüez
73 Empleado Municipal Rincón	Employee of Rincón Municipality	Rincón
74 Empleado Municipal Sabana Grande	Employee of Sabana Grande Municipality	Sabana Grande
75 Empleado Municipal San Germán	Employee of San Germán Municipality	San Germán
76 Empleado Municipal Maricao	Employee of Maricao Municipality	Maricao
77 Empleado Municipal Adjuntas	Employee of Adjuntas Municipality	Adjuntas
78 Empleado Municipal Arroyo	Employee of Arroyo Municipality	Arroyo
79 Empleado Municipal Coamo	Employee of Coamo Municipality	Coamo
80 Empleado Municipal Guánica	Employee of Guánica Municipality	Guánica
81 Empleado Municipal Guayama	Employee of Guayama Municipality	Guayama
82 Empleado Municipal Guayanilla	Employee of Guayanilla Municipality	Guayanilla
83 Empleado Municipal Jayuya	Employee of Jayuya Municipality	Jayuya
84 Empleado Municipal Juana Díaz	Employee of Juana Díaz Municipality	Juana Díaz
85 Empleado Municipal Patillas	Employee of Patillas Municipality	Patillas
86 Empleado Municipal Peñuelas	Employee of Peñuelas Municipality	Peñuelas
87 Empleado Municipal Ponce	Employee of Ponce Municipality	Ponce
88 Empleado Municipal Salinas	Employee of Salinas Municipality	Salinas
89 Empleado Municipal Santa Isabel	Employee of Santa Isabel Municipality	Santa Isabel
90 Empleado Municipal Villalba	Employee of Villalba Municipality	Villalba
91 Empleado Municipal Yauco	Employee of Yauco Municipality	Yauco
92 Empleado Municipal Añasco	Employee of Añasco Municipality	Añasco
93 Empleado Universidad de PR y sus Recintos	University of Puerto Rico	University of Puerto Rico
94 Empleado de Corporaciones Públicas	Government Corporation	Government Corporation
95 Program MEDIMED	Beneficiary	MEDIMED Program
97 Encarcelados	Incarcerated	Department Of Correction And Rehabilitation
96 Adfan Título IV - Asistencia para Adopción	Title IV-E federal adoption assistance	Administration for Childen and Families
99 Ninguno	None	None

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Municipality Codes

Municipality Code	Municipality Name	Region Code
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
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S

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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	Manati	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayaguez	Z
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

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0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San Jose	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
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	

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TPL Covered Services

Code	Description
00	N/A
01	HOSPITALIZATION
02	HOSPITALIZATION Y AMBULATORY
03	HOSPITALIZATION, AMBULATORY Y DENTAL
04	HOSPITALIZATION, AMBULATORY, DENTAL Y MEDICINES
05	AMBULATORY
06	AMBULATORY Y MEDICINES
07	AMBULATORY Y DENTAL
08	AMBULATORY, MEDICINES Y DENTAL
09	HOSPITALIZATION, AMBULATORY Y MEDICINES
10	MEDICINES
11	DENTAL

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Record	Id	Field	Pos	Size	Codes	Notes	Version Changes
E		**Enrollment Effectuation and Maintenance**					
E	1	Record Type	1	1	E	E - Enrollment Effectuation and Maintenance	
E	2	Transaction Id	2	1	E,C,V,I,1, 2,3,D	<u>Effectuation of ASES Initiated Transactions:</u> This transaction is generated in response to the ASES Enrollment Export File E - Effectuation of addition of subscriber or change in coverage code <u>Effectaution of Carrier Initiated Transactions:</u> These transactions are generated to notify ASES of the effectuation of changes originated in the carrier I - PMG change 1 - PCP change 2 - Second PCP change 3 - PCP and Second PCP change D - Disenrollment Initiated by Carrier C - Plan Transfer to a Platino Carrier V - Plan version change in a Platino Carrier (within same coverage code)	
E	3	Process Date	3	8		Carrier's process date for the reported transaction For Transaction Id = E,I,V,1,2,3 Use the Id Card Issue Date For Transaction Id = C Use the member's attestation signature date For Transaction Id = D Use the date the disenrollment was processed Format: MMDDCCYY MM - Month DD - day CCYY - Century and Year	
E	4	Region	11	1	A, B, E, F, G, J, S, Z, P	Region code assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste P - Virtual	
E	5	Carrier	12	2		Insurance Carrier code assigned by ASES	

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E	6	PMG Code	14	4		Code of PMG assigned to the insured member. PMG Codes must be reported to ASES as requested in carrier's contract This is optional for Platino carriers	
E	7	Person Id	18	11		Member's Person Id	
E	8	SSN	29	9		Member's Social Security Number	
E	9	FILLER	38	2	01	Fill with '01'	
E	10	Effective Date	40	8		Effective date for the transaction For Transaction Id = E Use the **Carrier Effective Date** received from ASES in the Enrollment Export File (EXP) For Transaction Id = C For a prospective carrier change, use the **New Carrier Effective Date** received from ASES in the Enrollment Export File (EXP) For Transaction Id = V,1,2,3 Use the effective date for the change. Effective dates must comply with the Days-Rule established in the carrier contract for each transaction type. For Transaction Id = D Use the effective date of the disenrollment. Format: MMDDCCYY MM - Month DD - Day CCYYY - Century and Year	
E	11	Plan Type	48	2	01,02	01 - Government Health Insurance Plan (Vital) 02 - Medicare Advantage Special Needs Plan (Platino)	
E	12	Plan Version	50	3	See ref table	Insurance carrier product matching the member's health coverage as established in the carrier contract	
E	13	MPI	53	13		MPI of the insured member	
E	14	PCP	66	15		National Provider Identifier (NPI) of the PCP assigned to the insured member.	
E	15	PCP Effective Date	81	8		Effective start date of the PCP assigned to the insured member. Format: MMDDCCYY	
E	16	Second PCP	89	15		National Provider Identifier (NPI) of the Second Primary Care Physician assigned to the insured member. Fill with blanks if no Second PCP has been assigned to the member	
E	17	Second PCP Effective Date	104	8		Effective start date of the Second PCP assigned to the insured member. Fill with blanks if no Second PCP has been assigned to the member. Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day	
E	18	FILLER	112	4		Fill with blanks	

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E	19	PMG Effective Date	116	8		Effective start date of the PMG assigned to the insured member. For Platino carriers, fill with blanks if no PMG has been assigned to the member. Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day This is optional for Platino carriers	
E	20	Primary Care Change Reason	124	2	14,22,46, A4,AB,AC, AD,AE,AF ,AG,AH,AI ,AJ	14 - Voluntary Withdrawal 22 - Plan Change 46 - Current Customer Information File in Error A4 - Dissatisfaction with Office Staff AB - Dissatisfaction with Medical Care/Services Rendered AC - Inconvenient Office Location AD - Dissatisfaction with Office Hours AE - Unable to Schedule Appointments in a Timely Manner AF - Dissatisfaction with Physician's Referral Policy AG - Less Respect and Attention Time Given thatn to other Patients AH - Patiente Move to a New Location AI - No Reason Given AJ - Appointment Times not Met in a Timely Manner If None of the specific Maintenance reasons apply, send 'AI' No Reason Given	Change Reasons Added
E	21	FILLER	126	1		Filler	Change to filler as it is submitted in the Insurance Record
E	22	MBI	127	12		Member's current Medicare Beneficiary Identifier (MBI) Fill with blanks if member is not known to have Medicare coverage	
E	23	FILLER	139	1		Fill with blanks	
E	24	PCP Authorization Token	140	14		Fill with blanks For future use: Token received by the Carrier from ASES authorizing the PCP assignment to the insured member. This is used to maintain PCP's cap for assigned members The PCP Confirmation Code is obtained using a reservation system impemented as a webservice by ASES. It also validates the PCP NPI number is valid. Format: YYYYMMDD999999, ASES provided value	
E	25	FILLER	154	3		Fill with blanks	
E	26	FILLER	157	3		Fill with blanks	
E	27	FILLER	160	3		Fill with blanks	
E	28	FILLER	163	3		Fill with blanks	
E	29	FILLER	166	3		Fill with blanks	
E	30	FILLER	169	3		Fill with blanks	
E	31	FILLER	172	3		Fill with blanks	
E	32	FILLER	175	3		Fill with blanks	
E	33	FILLER	178	3		Fill with blanks	
E	34	FILLER	181	3		Fill with blanks	
E	35	FILLER	184	8		Fill with blanks	
E	36	Policy Number	192	13		Member's Policy Number (also known as Contract Number) assigned by the Insurance carrier	Change Field Id and Position

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E	37	Special Enroll	205	1	T, E, N	T - Retroactive Period E - Late Eligibility (used in new enrollments when a retro eligibility with more than 3 months is received) N = Deemed Newborn Fill with blanks if no retroactive period	Change Field Id and Position
E	38	PMG Federal Tax Id	206	9		Federal Tax Id of the member's assigned PMG This is optional for Platino carriers	Change Field Id and Position
E	39	Data_Source	215	2	MO,MA	Transaction Type of Entity Source MO - Vital Carrier MA - Platino Carrier	Change Field Id and Position
E	40	Disenrollment Reason	217	4	See Ref table Disenrollment Reasons	Carrier initiated Disenrollment, Required when Transaction Id = D For the use of each code please review the Disenrollment Reason Codes Align right, filled with spaces Fill with blanks when Transaction Id different than D	Change Field Id and Position
E	41	Disenrollment Date	221	8		Disenrollment event Date, Required when Transaction Id = 'D' For Disenrollment Reason = '03' this is the date of death Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day Fill with blanks when Transaction Id different than D	Change Field Id and Position
E	42	PMG NPI	229	10		National Provider Identifier (NPI) of the PMG assigned to the insured member This is optional for Platino carriers. Fill with blanks if not required	Change Field Id and Position
E	43	PMG Medicaid Id	239	9		This is the PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Added
TRAILER		**TRAILER**					
TRAILER	1	Record Type	1	7	TRAILER	TRAILER - Trailer Record	
TRAILER	2	FILLER	8	10		Fill with blanks	
TRAILER	3	Record Count	18	8		Total number of records in the file 99999999 Numeric - right justified - zero filled	
TRAILER	4	FILLER	26	10		Fill with blanks	
TRAILER	5	Record Length	36	3	248	248 - Numeric Constant	
TRAILER	6	FILLER	39	209		Fill with blanks	

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Effectuation errors (RJC)

Record	Field	Name	Position	Size	Codes	Notes/Comments	Version Change	Version Change Category
E		**Enrollment Effectuation and Maintenance**						
E	1	Record Type	1	1	E	E - Enrollment Effectuation and Maintenance	Previous Version: Field: RECORD_TYPE Notes/Comments: E - Enrollment Effectuation	No change required
E	2	Transaction Id	2	1	E,C,V,I,1,2,3,D	Transaction Type Identifier <u>Effectuation of ASES Initiated Transactions:</u> This transaction is generated in response to the ASES Enrollment Export File E - Effectuation of addition of subscriber or change in coverage code <u>Effectaution of Carrier Initiated Transactions:</u> These transactions are generated to notify ASES of the effectuation of changes originated in the carrier I - PMG change 1 - PCP change 2 - Second PCP change 3 - PCP and Second PCP change D - Disenrollment Initiated by Carrier C - Plan Transfer to a Platino Carrier V - Plan version change in a Platino Carrier (within same coverage code)	Enabled Disenrollmnet transaction for Vital Carriers Previous Version: Field: TRAN_ID Notes/Comments: 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	No change required

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E	3	Process Date	3	8		Carrier's process date for the reported transaction For Transaction Id = E,I,V,1,2,3 Use the Id Card Issue Date For Transaction Id = C Use the member's attestation signature date For Transaction Id = D Use the date the disenrollment was processed Format: MMDDCCYY MM - Month DD - day CCYY - Century and Year	Previous Version: Field: PROCESS_DATE Notes/Comments: MMDDYYYY - Date Enrolled in Carrier	No change required
E	4	Region	11	1	A, B, E, F, G, J, S, Z, P	Region code assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste P - Virtual	Previous Version: Field: REGION Notes/Comments: Region code	No change required
E	5	Carrier	12	2		Insurance Carrier code assigned by ASES	Previous Version: Field: CARRIER Notes/Comments: Carrier code	No change required
E	6	PMG Code	14	4		Code of PMG assigned to the insured member. PMG Codes must be reported to ASES as requested in carrier's contract This is optional for Platino carriers	Previous Version: Field: MEMBER_PRIMARY_CENTER Notes/Comments: Region code	No change required
E	7	Person Id	18	11		Member's Person Id	Previous Version: Field: ODSI_FAMILY_ID Notes/Comments:	No change required
E	8	SSN	29	9		Member's Social Security Number	Previous Version: Field: MEMBER_SSN Notes/Comments:	No change required

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E	9	FILLER	38	2	01	Fill with '01'	Previous Version: Field: MEMBER_SUFFIX Notes/Comments:	No change required
E	10	Effective Date	40	8		Effective date for the transaction For Transaction Id = E Use the **Carrier Effective Date** received from ASES in the Enrollment Export File (EXP) For Transaction Id = C For a prospective carrier change, use the **New Carrier Effective Date** received from ASES in the Enrollment Export File (EXP) For Transaction Id = V,1,2,3 Use the effective date for the change. Effective dates must comply with the Days-Rule established in the carrier contract for each transaction type. For Transaction Id = D Use the effective date of the disenrollment. Format: MMDDCCYY MM - Month DD - Day CCYYY - Century and Year	Previous Version: Field: EFFECTIVE_DATE Notes/Comments:MMDDYYYY-Card issue date for new Reforma enrollment (Trans_ID= E) or Effective date (1st day of month) for other Trans_ID's	No change required
E	11	Plan Type	48	2	01,02	01 - Government Health Insurance Plan (Vital) 02 - Medicare Advantage Special Needs Plan (Platino)	Field: PLAN_TYPE Notes/Comments: See Plan Type Table	No change required
E	12	Plan Version	50	3	See ref table	Insurance carrier product matching the member's health coverage as established in the carrier contract	Field: PLAN_VERSION Notes/Comments: Used to identify version of Plan within PLAN_TYPE (if needed)	No change required
E	13	MPI	53	13		MPI of the insured member	Previous Version: Field: MPI Notes/Comments: Alpha-numeric ej.-"0080012345678"	No change required
E	14	PCP	66	15		National Provider Identifier (NPI) of the PCP assigned to the insured member.	Previous Version: Field: PCP1 Notes/Comments: NPI number	No change required

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E	15	PCP Effective Date	81	8		Effective start date of the PCP assigned to the insured member. Format: MMDDCCYY	Previous Version: Field: PCP1_EFFECTIVE_DATE Notes/Comments: MMDDYYYY	No change required
E	16	Second PCP	89	15		National Provider Identifier (NPI) of the Second Primary Care Physician assigned to the insured member. Fill with blanks if no Second PCP has been assigned	Previous Version: Field: PCP1 Notes/Comments: NPI number	No change required
E	17	Second PCP Effective Date	104	8		Effective start date of the Second PCP assigned to the insured member. Fill with blanks if no Second PCP has been assigned to the member. Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day	Previous Version: Field: PCP1_EFFECTIVE_DATE Notes/Comments: MMDDYYYY	No change required
E	18	FILLER	112	4		Fill with blanks	Field: FAMILY_PRIMARY_CENTER Notes/Comments:	No change required
E	19	PMG Effective Date	116	8		Effective start date of the PMG assigned to the insured member. For Platino carriers, fill with blanks if no PMG has been assigned to the member. Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day This is optional for Platino carriers	Previous Version: Field: PMG_tax_ID_eff_dt Notes/Comments: MMDDYYYY, Required for MCOs	No change required

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E	20	Primary Care Change Reason	124	2	14,22,46,A4,AB,AC,AD,AE,AF,AG,AH,AI,AJ	14 - Voluntary Withdrawal 22 - Plan Change 46 - Current Customer Information File in Error A4 - Dissatisfaction with Office Staff AB - Dissatisfaction with Medical Care/Services Rendered AC - Inconvenient Office Location AD - Dissatisfaction with Office Hours AE - Unable to Schedule Appointments in a Timely Manner AF - Dissatisfaction with Physician's Referral Policy AG - Less Respect and Attention Time Given thatn to other Patients AH - Patiente Move to a New Location AI - No Reason Given AJ - Appointment Times not Met in a Timely Manner	Previous Version: Field: FILLER Notes/Comments: FILLER	Change required
E	21	FILLER	126	1		Filler	Field: MEDICARE INDICATOR Notes/Comments: 1=A&B, 3=A, 9=B	No change required
E	22	MBI	127	12		Member's current Medicare Beneficiary Identifier (MBI) Fill with blanks if member is not known to have Medicare coverage	Field: HIC NUMBER Notes/Comments: If it is Medicare, the MBI number will be included MBI number is 11 length	No change required
E	23	Reject Identifier	139	1	A,M,T,R	"A - Accepted T - Accepted for Retroactive Period (1,2,3) M - Accepted for History Period R - Rejected"	Field: Reject Identifier Notes/Comments: "A" = Accepted; "M" = MA Retroactive; "R" = Rejected; "X" = Deleted, ASES Field	No change required

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E	24	PCP Authorization Token	140	14		Fill with blanks For future use: Token received by the Carrier from ASES authorizing the PCP assignment to the insured member. This is used to maintain PCP's cap for assigned members The PCP Confirmation Code is obtained using a reservation system impemented as a webservice by ASES. It also validates the PCP NPI number is valid. Format: YYYYMMDD999999. ASES provided value	Previous Version: Field: Record Key Notes/Comments: YYYYMMDD999999, ASES Field	No change required
E	25	Error Code 1	154	3		Code of the first error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 1 Notes/Comments:	No change required
E	26	Error Code 2	157	3		Code of the second error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 2 Notes/Comments:	No change required
E	27	Error Code 3	160	3		Code of the third error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 3 Notes/Comments:	No change required
E	28	Error Code 4	163	3		Code of the fourth error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 4 Notes/Comments:	No change required
E	29	Error Code 5	166	3		Code of the fifth error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 5 Notes/Comments:	No change required
E	30	Error Code 6	169	3		Code of the sixth error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 6 Notes/Comments:	No change required
E	31	Error Code 7	172	3		Code of the seventh error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 7 Notes/Comments:	No change required

E	32	Error Code 8	175	3		Code of the eight error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 8 Notes/Comments:	No change required
E	33	Error Code 9	178	3		Code of the nineth error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 9 Notes/Comments:	No change required
E	34	Error Code 10	181	3		Code of the tenth error occurrence found in the carrier's effectuation file (.SUS) Filled with blanks if no error found at this position.	Previous Version: Field: Error Code 10 Notes/Comments:	No change required
E	35	FILLER	184	8		Fill with blanks	Previous Version: Field: FILLER Notes/Comments:	No change required
E	36	Policy Number	192	13		Member's Policy Number (also known as Contract Number) assigned by the Insurance carrier	Previous Version: Field: FILLER Notes/Comments:	No change required
E	37	Special Enroll	205	1	T, E, N	T - Retroactive Period E - Late Eligibility (used in new enrollments when a retro eligibility with more than 3 months is received) N = Deemed Newborn Fill with blanks if no retroactive period	Change Field Id and Position	Change required
E	38	PMG Federal Tax Id	206	9		Federal Tax Id of the member's assigned PMG This is optional for Platino carriers	Change Field Id and Position	Change required
E	39	Data_Source	215	2	MO,MA	Transaction Type of Entity Source MO - Vital Carrier MA - Platino Carrier	Change Field Id and Position	Change required
E	40	Disenrollment Reason	217	4	See Ref table Disenrollment Reasons	Carrier Initiated Disenrollment, Required when Transaction Id = D For the use of each code please review the Disenrollment Reason Codes Align right, filled with spaces Fill with blanks when Transaction Id different than D	Change Field Id and Position	Change required

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E	41	Disenrollment Date	221	8		Disenrollment event Date, Required when Transaction Id = 'D' For Disenrollment Reason = '03' this is the date of death Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day	Change Field Id and Position	Change required
E	42	PMG NPI	229	10		National Provider Identifier (NPI) of the PMG assigned to the insured member This is optional for Platino carriers. Fill with blanks if not required	Change Field Id and Position	Change required
E	43	PMG Medicaid Id	239	9		This is the PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Change Field Id and Position	Change required
TRAILER		**TRAILER**						
TRAILER	1	Record Type	1	7	TRAILER	TRAILER - Trailer Record	Previous Version: Field: RECORD_TYPE Notes/Comments: "TRAILER" for Record (Constant)	No change required
TRAILER	2	FILLER	8	10		Fill with blanks	Previous Version: Field: FILLER Notes/Comments: SPACES	No change required
TRAILER	3	Record Count	18	8		Total number of records in the file 99999999 Numeric - right justified - zero filled	Field: NUMBER OF RECORDS Notes/Comments: 99999999 Numeric - right justified - zero filled	No change required
TRAILER	4	FILLER	26	10		Fill with blanks	Previous Version: Field: FILLER Notes/Comments: SPACES	No change required

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TRAILE R	5	Record Length	36	3	248	248 - Numeric Constant	Field: RECORD LENGTH Notes/Comments: "248" (Numeric Constant)	No change required
TRAILE R	6	FILLER	39	209		Fill with blanks	Field sizex extended Previous Version: Field: FILLER Notes/Comments: SPACES	No change required

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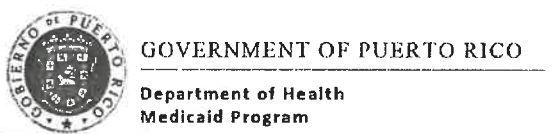
Reason Code	Reason for Disenrollment	Effective Date of Disenrollment
03	Death of Enrollee	First day of the month after death
04	CMS rejected Medicare Advantage Enrollment (Platino)	There are conditions in particular that CMS may reject a subscription submitted by the MAO. In this case, ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO.
05	Member enrollment was found to be an error	If the subscriber is not the correct person, the date of effectiveness is not correct and other possible errors then ASES will take the following action: If the member was in an MCO, it will be returned to the same MCO. If the member was subscribed to another MAO, the previous MAO must resubmit the subscription that corresponds to the effective date of the subscription of the MAO is disenrollment from.
06	Platino Enrollee lost Medicare Part A and/or Part B	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO and assign an MCO with the round robin method.
07	Member voluntary request terminatino (Platino)	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO.
08	Carrier requested termination (following contract prodecures)	
09	Incarceration	First day of the month after incarceration
10	Enrollee enters or stated in a residential institution under circumstances which rendered the individual ineligible for enrollment in Medicare Advantage, including when an Enrollee is admitted to the hospital that 1) is certified by Medicare as a long-term care hospital and 2) has a average stay for all patients greater than ninety-five (95) days.	First day of the month after following entry or first day of the month following classification of the stay as permanent, subsequent to entry.
11	Individual enrolled while ineligible for enrollment	Effective Date of Enrollment in the Contractor's Plan.
12	(PR) – Enrollee moved outside of Puerto Rico ADMINISTRACION DE SEGUROS DE SALUD № 24-0003	First day of the month after the update of the system with the new address. ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO. PRMP must proceed to cancel the member.
13	Change to another MAO Contrato Número	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO. The new MAO must submit the subscription as soon as possible and by the appropriate effective date.



Puerto Rico Medicaid Management Information System Services (PRMMIS)

HIPAA Transaction Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X279A1

270/271 Eligibility & Benefit Inquiry and Response

Companion Guide Version Number: 1.0

May 2023

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Preface

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

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1 INTRODUCTION

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

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

In addition to the row for each segment, one or more additional rows are used to describe PRMMIS's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a Notes/Comments column to provide additional information from PRMMIS for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 9: Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by PRMMIS.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

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1.1 Scope

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

The information contained in this Companion Guide applies to PRMMIS, which includes the following programs: TXIX or CHIP or CWLTH and Medicaid managed care programs. All of these programs use PRMMIS interChange for processing.

PRMMIS interChange will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain PRMMIS-specific information, though processed, may be denied. For example, a compliant 270 inquiry (270) created with an invalid PRMMIS member identification number will be processed by PRMMIS but will be denied.

Refer to this Companion Guide first if there is a question about how PRMMIS processes a HIPAA transaction. For further information, contact the PRMMIS Electronic Data Interchange (EDI) Department at (833) 209-8326. This guide is intended as a resource to assist carriers with PRMMIS interChange in successfully conducting EDI of administrative health care transactions. This document provides instructions for enrolling as a PRMMIS interChange carrier, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

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

The HIPAA requirements serve to:
Create better access to health insurance.
Limit fraud and abuse.
Reduce administrative costs.

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This guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to PRMMIS interChange. This guide supplements (but does not contradict) requirements in the ASC X12N 270/271 (version 005010X279A1) implementation. This information should be given to the carrier's business area to ensure that eligibility responses are interpreted correctly. This guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with PRMMIS interChange.

This Companion Guide must be used in conjunction with the TR3 instructions. The Companion Guide is intended to assist trading partners in implementing electronic 270/271 transactions that meet PRMMIS interChange processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this Companion Guide will occur periodically and new documents will be posted on PRMMIS LMS Puerto Rico LMS - Home.

1.3 References

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

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

1.4 Additional Information

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

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

1.5 National Provider Identifier

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

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

PRMMIS has determined that all providers, except for personal care only providers, specialized medical vehicle providers, and blood banks, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMMIS requires all health care providers to submit their NPI on electronic transactions.

1.6 Acceptable Characters

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

1.7 Acknowledgements

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

2 GETTING STARTED

2.1 Working with PRMMIS

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

Before PRMMIS can process transactions, the submitter is required to obtain a trading partner ID, create a Portal user account, and complete Production Authorization testing. Additional information is provided in the next section of this Companion Guide. Trading partners should exchange electronic health care transactions with PRMMIS interChange via MoveIT. Each trading partner must successfully complete testing. Upon successful completion of testing, production transactions may be exchanged.

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

3 CONNECTIVITY WITH PRMMIS / COMMUNICATIONS

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

3.1 Batch Eligibility Benefit Inquiry and Response

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

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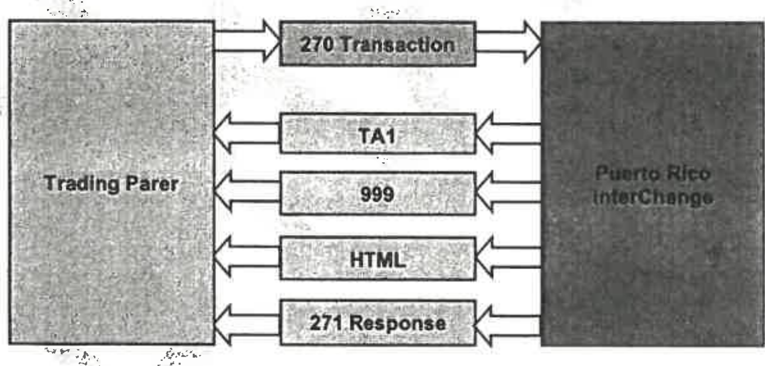
- First-level response — TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
- Second-level response — 999 will be generated — "Rejected" 999 (AK901 = R) when errors occur during 270 compliance validation (no 271 will be generated) or "Accepted" 999 (AK901 = A) if no errors are detected during the compliance validation.
- Third-level response — 271 will be generated indicating either the eligibility and benefits or AAA errors within request validation.

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

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error (AK901 = R). Transactions that pass this compliance check will generate an "Accepted" 999 (AK901 = A) file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 (AK901 = P) file back to the sender with an error message indicating the compliance error (all inquiries in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Files that have a compliance error will generate a proprietary HTML file that identifies the compliance error in a "human" readable format. Transactions that pass compliance checks, but failed to process (e.g., due to member not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the requested dates) do not generate AAA segments but will create a 271 using the information in our eligibility and benefit system.



3.2 Transmission Administrative Procedures

This section provides PRMMIS's specific transmission administrative procedures.

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

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

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3.3 Re-transmission Procedure

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

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

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate the file transfer as he or she normally does.

If a file fails compliance, errors must be corrected before re-transmission. Because PRMMIS does not allow duplicate files, before resubmiting a file it is required that a new file name, Interchange Group (ISA), and Transaction Control Numbers be changed.

3.4 Communication Protocol Specifications

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

The communication method currently available to get a member's Eligibility and Benefits from PRMMIS is MoveIT (SFTP) – see "MoveIT/SFTP guide" & "How to use MoveIt Guide" posted on PRMMIS LMS Puerto Rico LMS - Home.

3.5 Passwords

This section describes PRMMIS's use of passwords.

The Portal password must be reset every 60 days. The passwords are maintained by the external user. If a general user needs a password reset, he or she must contact the EDI Helpdesk at (833) 209-8326.

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

4 CONTACT INFORMATION

If the trading partner has questions beyond what is explained in this Companion Guide, refer to the contact information below to reach the appropriate PRMMIS support area.

4.1 Electronic Data Interchange Helpdesk

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

For questions related to PRMMIS's Eligibility and Benefits Request and Response, contact the EDI Helpdesk at (833) 209-8326.

4.2 Electronic Data Interchange Technical Assistance

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

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Electronic Data Interchange Customer Service can help with connectivity issues or transaction formatting issues at (833) 209-8326 (Monday – Friday, 8:30 a.m. – 4:30 p.m. Central Standard Time (CST).

4.3 Trading Partner ID

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

4.4 Applicable Web Sites

This section contains detailed information about useful Web sites and e-mail addresses.

Additional information is available on the following Web sites:

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

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

American Hospital Association (AHA) Central Office on *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is a resource for the ICD-9-CM codes used in medical transcription and billing, and for Level I Healthcare Common Procedure Coding System (HCPCS) procedure codes: www.ahacentraloffice.org/.

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

- Centers for Medicare & Medicaid Services (CMS) is the unit within HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/.
- The CMS is the resource for information related to HCPCS procedure codes: www.cms.hhs.gov/HCPCSReleaseCodeSets/.
- The CMS is the resource for Medicaid HIPAA information related to the Administrative Simplification provision: www.cms.gov/medicaid/hipaa/adminsim/.
- The CORE is a multi-phase initiative of CAQH; CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care: www.caqh.org/CORE_overview.php/.
- The CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives — the CORE and Universal Provider Datasource (UPD); CAQH aims to reduce administrative burden for providers and health plans: www.caqh.org/.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org/.

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- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org/.
- Medicaid HIPAA-Compliant Concept Model (MHCCM) presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit: www.mhccm.org/.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics, and national health information policy: www.ncvhs.hhs.gov/.
- National Council of Prescription Drug Programs (NCPDP) is the standards and codes development organization for pharmacy: www.ncpdp.org/.
- National Uniform Billing Committee (NUBC) is affiliated with the AHA and develops standards for institutional claims: www.nubc.org/.
- National Uniform Claim Committee (NUCC) is affiliated with the AMA. It develops and maintains a standardized data set for use by the non-institutional health care organizations to transmit claims and encounter information. The NUCC maintains the national provider taxonomy: www.nucc.org/.
- Office for Civil Rights (OCR) is the office within the HHS responsible for enforcing the Privacy Rule under HIPAA: www.hhs.gov/ocr/hipaa/.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA: www.aspe.hhs.gov/admnsimp/.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets: http://www.wpc-edi.com/.
- Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org/.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Other resources pertaining to the NPI: www.cms.hhs.gov/NationalProvIdentStand/.
- Implementation guides and non-medical code sets: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS): www.cms.hhs.gov/HIPAAGenInfo/ or aspe.hhs.gov/datacncl/adminsim.shtml.
- Information from CMS about ICD-9 and ICD-10 codes: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage or https://www.cms.gov/ICD10/.
- Quarterly updates to the HCPCS code set are available from CMS: www.cms.hhs.gov/HCPCSReleaseCodeSets/. (CPT-4, or Level 1 HCPCS, is maintained and licensed by the AMA and is available for purchase in various hardcopy and softcopy formats from of variety of vendors.)

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- Information at the federal level about Medicaid can be found at *www.cms.hhs.gov/home/medicaid.asp*.
- The CMS online manuals system and Internet-only manuals (IOM) system, including Transmittals and Program Memoranda, at *www.cms.hhs.gov/Manuals/*.
- Place of service codes are listed in the Medicare Claims Processing Manual and are maintained by the CMS at *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf*.

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5 CONTROL SEGMENTS / ENVELOPES

5.1 ISA-IEA

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

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

- The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.
- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All dates/times are in the CCYYMMDDHHMM format.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 99 inquiries per Transaction Set (ST-SE).
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	00	Use "00" to indicate no Authorization Information Present.
C.4		ISA02	Authorization Information		Leave blank
C.4		ISA03	Security Information Qualifier	00	Use "00" to indicate no Security Information Present.
C.4		ISA04	Security Information		Leave blank
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value "ZZ
C.5		ISA06	Interchange Sender ID		Enter the six-digit numeric trading partner identification number assigned by PRMMIS interChange.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value "ZZ'
C.5		ISA08	Interchange Receiver ID	PRMP	Enter "PRMP".
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = Only generate interchange acknowledgment (TA1) if error in envelope.
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is production or test.
			Production Data	P	Enter value "P" to indicate that the file contains production data
			Test Data	T	Enter value "T" to indicate that the file contains test data.
C.6		ISA16	Component Element Separator	:	A colon ":" is recommended.

5.2 GS-GE

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

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

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

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Note: Puerto Rico only accepts files with one GS/GE loop per file.

GS – Functional Group Header

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that PRMMIS will be sending.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7	None	GS	Functional Group Header		

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7		GS01	Functional ID Code	HB	"HB" Eligibility, Coverage or Benefit Information (270).
C.7		GS02	Application Sender's Code		"PRMP" Puerto Rico Medicaid Program.
C.7		GS03	Application Receiver's Code		Carrier's Trading Partner ID supplied by PRMP.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010X2 70A1	Version/ Release/ Industry Identifier Code

GE – Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

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5.3 ST-SE

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

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

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ST – Transaction Set Header

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	270	270 Health Care Benefit & Enrollment Maintenance

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X279A1	This field contains the same value as GS08.

SE – Transaction Set Trailer

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

5.4 File Delimiters

PRMMIS requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Contact the EDI Helpdesk at (833) 209-8326 if there is a need to use a delimiter other than the following.

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

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

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

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

6 PRMMIS-SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 Terminology

The term "subscriber" will be used as a generic term throughout the Companion Guide.

6.2 Member Limit

File Size is restricted to 5,000 member inquiries per 270 transaction file.

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6.3 271 Interpretation Guidelines

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

- Puerto Rico Medicaid Program eligibility.
- Medicare coverage.

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

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

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

6.4 Notes on 270 Search Hierarchy

1. If a Medicaid ID (MID) is present, a search is made for a match on the member ID. If no member is found;
2. If last name, first name and Social Security number (SSN) are present in the 270, a search of the database is made for the name and SSN match. If no member is found or last name, first name, and SSN are not present;
3. If SSN and DOB are present, a search is made for a match on the SSN and DOB. If no member is found, a AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned.
4. If none of the above information is available to try any of the above searches, a AAA segment with a value of 15 (Required application data missing) in AAA03 is returned.
5. All members are enrolled in either the TXIX or CHIP or CWLTH programs. Members are defined as "subscribers." All requests should be submitted at the subscriber level. Any requests submitted at the dependent level that result in an error (Not Found) will be returned at the dependent level. If the member is a *subscriber* in PRMMIS's membership tables but was submitted in the Dependent loop on the 270 request (2100D), the member will be returned in the Subscriber loop on the 271 response (2100C).
6. If the search for a subscriber is successful, the subscriber's identifying information contained in the 271 response will be taken from the applicable eligibility table.
   Note: The INS segment is not used by PRMMIS.
7. If the search for a subscriber is unsuccessful, the subscriber's identifying information contained in the incoming 270 will be returned in the 271 response.

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6.5 270 Request

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

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

PRMMIS does not currently support an explicit service type code (EQ01) other than "30" (Health Benefit Plan Coverage).

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

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

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

Parameters for requesting past and future eligibility:

- A request can be for any date in the past.
- A date range can be for any 12-month (366-day) period in the past.
- A 271 AAA value of 62 or 63 will be returned if the date range validation fails.

When sending in single date inquiries, if an active plan is not found for the member, a subsequent request with a different date will need to be submitted.

6.6 271 Response

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

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

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

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

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

6.7 File Naming Convention for Managed Care 270 Inbound

File naming conventions for 270 files from Carriers:

Example:
Submission Date: 06/01/2023
Total Number of members: 9,500 (we recommend limiting each file to 5,000 members)

20230601_ABRV_270###.dat

Position 1 thru 8 = Date file was created **(YYYYMMDD format)**
9th position = **underscore**
Position 10 thru 13 = 4 character abbreviation of Carrier's (MCO/MAO) name
14th position = **underscore**
Position 15 thru 17 = Type of file – use **270**
Position 18 thru 20 = ### = Sequence number of each file submitted during the day (start with 01 and increment by one)
Position 21 thru 24 = Use **.dat** or **.txt** for every file

The standards above will avoid accidently overwriting files.
Files submitted with the same name will be rejected as a duplicate.

Example:

20230601_ABRV_270001.dat	**first 5,000 members**
20230601_ABRV_270002.dat	**remaining 4,500 members**

6.8 Scheduled Maintenance

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST.

7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 TA1 — Transaction Acknowledgement

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

7.2 999 — Functional Acknowledgement

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

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7.3 Report Inventory

There are no acknowledgement reports at this time.

8 TRANSACTION-SPECIFIC INFORMATION

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

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

In addition to the row for each segment, one or more additional rows are used to describe PRMMIS's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a row for each segment that PRMMIS has something additional, over and above, the information in the TR3s.

8.1 005010X279A1 — 270 Health Care Eligibility Benefit Inquiry

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
63	None	BHT	Beginning of Hierarchical Transaction		
63	None	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.
64	None	BHT02	Transaction Set Purpose Code	13	PRMMIS interChange validates only Code 13 (Request).
64	None	BHT04	Transaction Set Creation Date	CCYYMMDD	Date the transaction was created
69	2100A	NM1	Information Source Name		
69	2100A	NM101	Entity Identifier Code	PR	Enter "PR" to indicate payer.
70	2100A	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
70	2100A	NM103	Information Source Last or Organization Name	PRMMIS	Enter "PRMMIS".
71	2100A	NM108	Identification Code Qualifier	PI	Enter "PI" to indicate payer identification.
71	2100A	NM109	Information Source Primary Identifier	PRMP	
75	2100B	NM1	Information Receiver Name		

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
75	2100B	NM101	Entity Identifier Code	P5	Plan Sponsor
75	2100B	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
75	2100B	NM103	Information Source Last or Organization Name		Enter Carrier's Name
77	2100B	NM108	Identification Code Qualifier	XX	Enter carrier's National Provider Identifier (NPI)
78	2100B	NM109	Information Receiver Identification Number		Enter the 10-digit NPI.
79	2100B	REF	Information Receiver Additional ID		Any data submitted in this segment will not be used in processing the inquiry.
81	2100B	N3	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
82	2100B	N4	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
84	2100B	PRV	Information Receiver Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
90	2100B	TRN	Subscriber Trace Number		This segment may be used to assign a trace number to a transaction. 271 responses will contain as many TRN segments as were present on the received 270 inquiry as well as an additional segment originated by the information source.
90	2100B	TRN01	Trace Type Code		Enter 1 = Current Transaction Trace Number
91	2000C	TRN02	Trace Number		Use this field to assign a unique trace or reference number for this transaction.
91	2000C	TRN03	Trace Assigning Entity Identifier		Use this field for an identification number of the entity that originated the reference identification in TRN02. *Note: The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.*
92	2100C	NM1	Subscriber Name		Note: See section 6.6 for rules on search hierarchy.
92	2100C	NM101	Entity Identifier Code	IL	Enter IL = Subscriber
93	2100C	NM102	Entity Type Qualifier	1	Enter 1 = Person
93	2100C	NM103	Subscriber Last Name		Enter the subscriber's last name.
93	2100C	NM104	Subscriber First Name		Enter the subscriber's first name.
95	2100C	NM108	Identification Code Qualifier	MI	MI = Member ID.

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
96	2100C	NM109	Subscriber Primary Identifier		Enter the subscriber's member ID.
97	2100C	REF	Subscriber Additional Information		Note: See section 6.4 for rules on search hierarchy.
98	2100C	REF01	Reference Identification Qualifier	SY	Enter SY - Social Security number (SSN)
99	2100C	REF02	Subscriber Supplemental Identifier		Enter SSN as qualified by field REF01.
100	2100C	N3	Subscriber Address		Any data submitted in this segment will not be used in processing the inquiry.
101	2100C	N4	Subscriber City, State, ZIP Code		Any data submitted in this segment will not be used in processing the inquiry.
103	2100C	PRV	Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
107	2100C	DMG	Subscriber Demographic Information		The DMG segment should only be used if the subscriber's date of birth (DOB) is to be provided.
108	2100C	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
108	2100C	DMG02	Subscriber Birth Date		
110	2100C	INS	Multiple Birth Sequence Number		Any data submitted in this segment will not be used in processing the inquiry.
113	2100C	HI	Subscriber Health Care Diagnosis Code		Any data submitted in this segment will not be used in processing the inquiry.
122	2100C	DTP	Subscriber Date		The DTP segment can be used to specify a date or range of dates for which eligibility will be verified. If no DTP segment is present, the member's eligibility will be provided for the date the transaction is processed.
123	2100C	DTP01	Date Time Qualifier	291	291 = Eligibility
123	2100C	DTP02	Date Time Period Qualifier	D8 RD8	
			Single Date	D8	
			Range of Dates	RD8	
123	2100C	DTP03	Date Time Period		Enter the date(s) of inquiry for the subscriber's benefits in the format CCYYMMDD or CCYYMMDD-CCYYMMDD.
124	2110C	EQ	Subscriber Eligibility or Benefit Inquiry		

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
124	2110C	EQ01	Service Type Code	30	PRMP only supports service type code "30" (Health Benefit Plan Coverage).
136	2110C	AMT	Subscriber Spend Down Amount		Any data submitted in this segment will not be used in processing the inquiry.
136	2110C	AMT	Subscriber Spend Down Total Billed Amount		Any data submitted in this segment will not be used in processing the inquiry.
138	2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		Any data submitted in this segment will not be used in processing the inquiry.
142	2110C	REF	Subscriber Additional Information		Any data submitted in this segment will not be used in processing the inquiry.
144	2110C	DTP	Subscriber Eligibility / Benefit Date		Any data submitted in this segment will not be used in processing the inquiry.
146	2000D		Dependent Level		Because each subscriber and each of his/her dependents is assigned a unique identification number, dependents are treated as subscribers in the PRMMIS interChange system. Any data submitted at the dependent level will be processed as a subscriber.

8.2 005010X279A1 — 271 Health Care Eligibility Benefit Response

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
211		BHT	Beginning of Hierarchical Transaction		
211	2000A	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.
211	2000A	BHT02	Transaction Set Purpose Code	11	PRMMIS interChange returns Code 11 (Response).
211	2000A	BHT03	Submitter Transaction Identifier		The value in this field will be identical to the unique transaction identifier received in the BHT03 field of the 270 inquiry.
215	2000A	AAA	Request Validation		This segment will be used in the response if the PRMMIS interChange eligibility tables are unavailable at the time of processing.
215	2000A	AAA01	Valid Request Indicator	N Y	
			Indicate that the request or an element in the request is not valid.	N	
			request is valid, however the transaction has been rejected as identified by the code in AAA03.	Y	
215	2000A	AAA03	Reject Reason Code	42	This field will contain "42" to indicate that PRMMIS interChange is unable to respond at the current time.

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
215	2000A	AAA04	Follow-up Action Code	P	This field will contain a "P" to indicate that the inquiry must be resubmitted.
218	2100A	NM1	Information Source Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
221	2100A	PER	Information Source Additional Information		This segment will contain PRMMIS helpdesk information.
226	2100A	AAA	Request Validation		This segment will be returned if an error was detected in the 2100A loop of the 270 inquiry.
226	2100A	AAA03	Reject Reason Code	04 41 42 79	This field will contain "79" to indicate that invalid participant identification has been entered in loop 2100A, field NM109 of the 270 inquiry.
			Authorized Quantity Exceeded	04	Transaction exceeds the number of patient requests allowed.
			Authorization/Access Restrictions	41	Entity identified in GS02 is not authorized to submit 270 transactions.
			Unable to Respond at Current Time	42	Entity identified in either ISA08 or GS03 is unable to process the transaction at the current time.
			Invalid Participant Identification	79	Value in either GS02 or GS03 is invalid.
226	2100A	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
232	2100B	NM1	Information Receiver Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
236	2100B	REF	Information Receiver Additional Identification		This segment will not be returned.
E-44	2100B	N3	Information Receiver Address		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
E-45	2100B	N4	Information Receiver City, State, ZIP Code		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
238	2100B	AAA	Information Receiver Request Validation		This segment will be returned if there was a problem with the 2100B loop, NM1 receiver name segment of the 270 inquiry.
238	2100B	AAA03	Reject Reason Code	41 43 51 79	
			Authorization/Access Restrictions	41	
			Invalid/Missing Provider Identification	43	
			Provider Not on File	51	
			Invalid Participant Identification	79	
238	2100B	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
241	2100B	PRV	Information Receiver Provider Information		This segment will not be returned.
246	2000C	TRN	Subscriber Trace Number		This segment will be used to return the trace number received in the associated subscriber loop of the inquiry (TRN01 = 2).

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
246	2000C	TRN	Subscriber Trace Number		This segment will be used to assign a unique PRMMIS interChange trace number (TRN01 = 1).
249	2100C	NM1	Subscriber Name		If the member is found the values returned to the receiver in this segment will be from our membership database. If the member is not found the data in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
253	2100C	REF	Subscriber Additional Identification		The member's SSN will be returned if the member was found in the PRMMIS interChange database.
253	2100C	REF01	Reference Identification Qualifier	SY	"SY" = Social Security Number
253	2100C	REF02	Subscriber Supplemental Identifier		This field will contain SSN.
257	2100C	N3	Subscriber Address		This segment will be used to indicate a subscriber's street address. The address will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
259	2100C	N4	Subscriber City, State, ZIP Code		This segment will be used to indicate a subscriber's additional address information. The information will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
262	2100C	AAA	Subscriber Request Validation		This segment will be used to report any errors detected in the associated 2100C loop of the inquiry.
262	2100C	AAA03	Reject Reason Code	15 42 43 48 51 52 57 58 60 61 62 63 72 73 75	
			Required application data missing	15	
			Unable to respond at current time	42	
			Invalid/missing provider identification	43	
			Invalid/missing referring provider identification	48	
			Provider not on file	51	
			Service dates not within provider plan enrollment	52	
			Invalid/missing dates of service	57	
			Invalid date of birth	58	
			Date of birth follows date(s) of service	60	

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
			Date of death precedes date(s) of service	61	
			Date of service not within allowable inquiry period	62	
			Dates of service not within the same calendar month	63	
			Invalid subscriber ID	72	
			Invalid/missing subscriber name	73	
			Subscriber not found	75	
262	2100C	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
265	2100C	PRV	Provider Information		This segment will not be returned.
268	2100C	DMG	Subscriber Demographic Information		This segment will be used to indicate a subscriber's DOB. If the member is found the DOB will appear as it is contained in the information source's files. If the member is not found and the DMG segment was in the inquiry this segment will contain the information as it was sent in the inquiry.
271	2100C	INS	Subscriber Relationship		This segment will not be returned.
274	2100C	HI	Subscriber Health Care Diagnosis Code		This segment will not be returned.
283	2100C	DTP	Subscriber Date		This segment will contain the requested eligibility date in the format CCYYMMDD.
285	2100C	MPI	Subscriber Military Personnel Information		This segment will not be returned.
289	2110C	EB	Subscriber Eligibility or Benefit Information		
291	2110C	EB01	Eligibility or Benefit Information	1 6	PRMMIS interChange returns these codes.
			Active Coverage	1	
			Inactive	6	
292	2110C	EB02	Benefit Coverage Level Code	IND	Health Benefit Plan Coverage
293	2110C	EB03	Service Type Code	30	
298	2110C	EB04	Insurance Type Code	MA MB MC OT	
			Medicare Part A	MA	Indicates Medicare Part A Coverage.
			Medicare Part B	MB	Indicates Medicare Part B Coverage.
			Medicaid	MC	PRMMIS is the coverage being referenced.
			Other	OT	Indicates Medicare Part D (Prescription Drug) Coverage or Other Insurance Coverage.
299	2110C	EB05	Plan Coverage Description		This field will contain the benefit plan name and associated coverage and group codes, separated by pipe delimiter. For example, TXIX|110|MPM
309	2110C	HSD	Health Care Services Delivery		This segment will not be returned.
314	2110C	REF	Subscriber Additional Information		The REF segment will occur at this level of the response in association with Medicare coverage(EB01 = R) to provide the health insurance claim (HIC) number (MBI).
317	2110C	DTP	Subscriber Eligibility/Benefit Date		

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TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
317	2110C	DTP01	Date Time Qualifier	307	This field will contain "307" to indicate eligibility.
317	2110C	DTP03	Eligibility or Benefit Date Time Period		This field will contain the date or dates related to the eligibility or benefit information in the 2110C loop.
319	2110C	AAA	Subscriber Request Validation		This segment will not be returned.
322	2110C	MSG	Message Text		This segment can contain a number of different messages that describe a subscriber's benefits/status: In conjunction with Medicaid eligibility, the MSG segment will contain a message if the subscriber has additional eligibility that has not been displayed.
324	2110C	III	Subscriber Eligibility or Benefit Additional Information		This segment will not be returned.
328	2110C	LS	Loop Header		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
335	2120C	N3	Subscriber Benefit Related Entity Address		This segment will not be returned.
336	2120C	N4	Subscriber Benefit Related City, State, ZIP Code		This segment will not be returned.
339	2120C	PER	Subscriber Benefit Related Contact Information		This segment will not be returned.
344	2120C	PRV	Subscriber Benefit Related Provider Information		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
346	2120C	LE	Loop Trailer		This segment will not be returned.

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APPENDICES

1. Implementation Checklist

Contact the EDI Helpdesk at (833) 209-8326 or via e-mail using the Contact link at the bottom of the Portal home page with any questions.

2. Business Scenarios

Terminology

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

Member Limit

File Size is restricted to 5,000 member inquiries per 270 transaction file.

271 Interpretation Guidelines

PRMP eligibility and benefit information will be returned in a PRMMIS 5010 standard X12 271 eligibility response transaction.

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

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

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

PRMMIS Eligibility

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain one of the following values: • "1" — Indicates active coverage. • "6" — Indicates inactive coverage.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.
2110C	EB03	Service Type Code	If active coverage is indicated in EB01, this field will contain a value of 30
2110C	EB04	Insurance Type Code	This field will contain the value "MC" to indicate that PRMMIS is the coverage being referenced.
2110C	EB05	Plan Coverage Description	This field will contain the benefit plan name, concatenated with coverage code and group code For example, TXIX|110|MPM.

Medicare

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value "R" to indicate other or additional payer.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.
2110C	EB03	Service Type Code	This field will not be populated as PRMMIS is not the true information source.
2110C	EB04	Insurance Type Code	This field will contain one of the following values:

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			• "MA" — Indicates that Medicare Part A is the coverage being referenced. • "MB" — Indicates that Medicare Part B is the coverage being referenced. • "OT" — Indicates Medicare Part D (Prescription Drug) coverage.

3. Transmission Examples

Sample 5010 Generic 271 Member Loop

NM1*IL*1*MEMBERLAST|LASTNAME2*FIRST*M***MI*12345678901~	**Medicaid Name and Number**
REF*SY*123456789~	**SSN**
N3*4321 OCEAN BLVD*APT 2~	**Member Address**
N4*MENASHA*WI*53714~	
DMG*D8*19451003*M~	**DOB, Gender**
DTP*307*RD8*20100101-20101231~	**270 Range of Coverage Queried**
EB*1*IND*30*MC*TXIX|110|MPM~	**Medicaid**
DTP*307*RD8*20101201-20101231~	
EB*R*IND**MA~	**Medicare Part A Coverage**
REF*F6*3333333333~	**HIC Number (MBI)**
DTP*307*RD8*20100901-20100930~	
DTP*307*RD8*20101001-22991231~	
EB*R*IND**MB~	**Medicare Part B Coverage**
REF*F6*3333333333~	**HIC Number (MBI)**
DTP*307*RD8*20100901-22991231~	

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4. Frequently Asked Questions

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

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

Q: Is there a limit to the number of inquiries I can submit at once?
A: We recommend you follow HIPAA requirements for a maximum of 5,000 inquiries per file. Also, only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

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

- Member address.
- Member ID, SSN, and/or other agency ID.
- PRMMIS Medicaid benefit plan.
- Medicare Part A, B, D if available.

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

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

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5. Change Summary

Version 1.1 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised

Version 1.0 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 06/2023
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	ALL PAGES				270/271 transaction is new to Puerto Rico's PRMMIS.

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Record	Field	Name	Position	Size	Codes	Notes/Comments	Version Change	Version Change Category
R		Response						
R	1	RECORD_TYPE	1	1	R	R - Eligibility Response	Previous Version: Field: Notes/Comments:	No changes required
R	2	Inquiry's Process Date	2	8		Filled with same value received in the eligibility inquiry.	Previous Version: Field:CARRIER_PROCESS_DATE Notes/Comments:YYYYMMDD	No changes required
R	3	Inquiry's Social Security Number	10	9		Filled with same value received in the eligibility inquiry.	Previous Version: Field: BENEFICARY SSN Notes/Comments:	No changes required
R	4	Inquiry's Last Name	19	15		Filled with same value received in the eligibility inquiry.	Previous Version: Field: 1ST_LAST_NAME Notes/Comments:	No changes required
R	5	Inquiry's Second Last Name	34	15		Filled with same value received in the eligibility inquiry.	Previous Version: Field: 2ND_LAST_NAME Notes/Comments:	No changes required
R	6	Inquiry's First Name	49	20		Filled with same value received in the eligibility inquiry.	Previous Version: Field: FIRST_NAME Notes/Comments:	No changes required
R	7	Inquiry's Sex	69	1		Filled with same value received in the eligibility inquiry.	Previous Version: Field: SEX Notes/Comments: 1 = Male, 2 = Female	No changes required
R	8	Inquiry's Date of Birth	70	8		Filled with same value received in the eligibility inquiry.	Previous Version: Field:CARRIER_DATE OF BIRTH Notes/Comments:YYYYMMDD	No changes required
R	9	Inquiry's Region	78	1		Filled with same value received in the eligibility inquiry.	Previous Version: Field: CARRIER_REGION Notes/Comments:	No changes required
R	10	Inquiry's Carrier	79	2		Filled with same value received in the eligibility inquiry.	Previous Version: Field: CARRIER Notes/Comments: Carrier Code	No changes required
R	11	Last Name	81	15		Member's Last Name	Previous Version: Field: ASES_1ST_LAST_NAME Notes/Comments:	No changes required
R	12	Second Last Name	96	15		Member's Second Last Name	Previous Version: Field: ASES_2ND_LAST_NAME Notes/Comments:	No changes required
R	13	First Name	111	20		Member's First Name	Previous Version: Field: ASES_FIRST_NAME Notes/Comments:	No changes required
R	14	Sex	131	1	1,2	Member's sex at birth 1 - Male 2 - Female	Previous Version: Field: ASES_SEX Notes/Comments: Carrier Code	No changes required
R	15	Date Of Birth	132	8		Member's date of birth Format: CCYYMMDD	Previous Version: Field: ASES_DATE OF BIRTH Notes/Comments: Carrier Code	No changes required
R	16	Region	140	1	A, B, E, F, G, J, S, Z, P	Code of the region assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste P - Virtual	Previous Version: Field: ASES_REGION Notes/Comments: Carrier Code	No changes required
R	17	Eligibility Indicator	141	1	Y,N	Member's eligibility status Y - Eligible for the Effective Date in the inquiry N - NOT eligible for the Effective Date in the inquiry	Previous Version: Field: ELEGIBILITY_INDICATOR Notes/Comments: Y or N	No changes required
R	18	Person Id	142	11		Member's Person Id This identifier is assigned to beneficiaries and related contact and household persons in the Eligibility Determination process.	Previous Version: Field: ODSI_FAMILY_ID Notes/Comments:	No changes required
R	19	FILLER	153	2		Filled with blanks	Previous Version: Field: MEMBER_SUFFIX Notes/Comments:	No changes required
R	20	MPI	155	13		Member's MPI number Format: Alpha numeric value. Example "0080012345678"	Previous Version: Field: MPI Notes/Comments:	No changes required

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R	21 Program	168	1 1,2,3	Affordability Insurance Program 1 - Medicaid 2 - CHIP 3 - Commonwealth	Previous Version: Field: MEDICAID_INDICATOR Notes/Comments:	No changes required
R	22 Eligibility Effective Date	169	8	YYYYMMDD	Previous Version: Field: ELEGIBILITY_EFFECTIVE_DATE Notes/Comments: YYYYMMDD	No changes required
R	23 Eligibility Expiration Date	177	8	YYYYMMDD	Previous Version: Field: ELEGIBILITY_EXPIRATION_DATE Notes/Comments: YYYYMMDD	No changes required
R	24 Process Date	185	8	Response Process Date Format: CCYYMMDD	Previous Version: Field: ASES_PROCESS_DATE Notes/Comments: YYYYMMDD	No changes required
R	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)	Previous Version: Field: MESSAGE_CODE Notes/Comments: 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)	No changes required
R	26 Deductible Level	199	1		Previous Version: Field: ASES_DEDUCTIBLE_LEVEL Notes/Comments:	No changes required
R	27 Municipality	200	4 See Ref table	Municipality Code Format: Zero fill, right justify.	Previous Version: Field: MUNICIPIO Notes/Comments: Código Municipio en	No changes required
R	28 Inquiry's Effective Date	204	8	Filled with same value received from the insurance carrier inquiry.	Previous Version: Field: FECHA DE EFECTIVIDAD Notes/Comments: Para uso en queries historicos. Formato YYYYMMDD.	No changes required
R	29 Health Coverage	212	3 See Ref table		Previous Version: Field: CODIGO DE CUBIERTA Notes/Comments: Código de Cubierta (Coverage Code)	No changes required
R	30 FILLER	215	5		Previous Version: Field: FILLER Notes/Comments:	No changes required

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Record	Field	Name	Position	Size	Codes	Notes/Comments	Version Change	Version Change Category
Q		**Query**						
Q	1	Record Type	1	1		Q - Eligibility Inquiry		No changes required
Q	2	Process Date	2	8		Inquiry Date Format: CCYYMMDD	Previous Version: Field:PROCESS_DATE Notes/Comments:YYYYMMDD	No changes required
Q	3	Social Security Number	10	9		Member's Social Security Number	Previous Version: Field: BENEFICARY SSN Notes/Comments:	No changes required
Q	4	Last Name	19	15		Member's Last Name	Previous Version: Field: 1ST_LAST_NAME Notes/Comments:	No changes required
Q	5	Second Last Name	34	15		Member's Second Last Name	Previous Version: Field: 2ND_LAST_NAME Notes/Comments:	No changes required
Q	6	First Name	49	20		Member's First Name	Previous Version: Field: FIRST_NAME Notes/Comments:	No changes required
Q	7	Sex	69	1	1,2	Member's sex at birth 1 - Male 2 - Female	Previous Version: Field: SEX Notes/Comments: 1 = Male, 2 = Female	No changes required
Q	8	Date of Birth	70	8		Member's date of birth Format: CCYYMMDD	Previous Version: Field:DATE OF BIRTH Notes/Comments:YYYYMMDD	No changes required
Q	9	Region	78	1	A, B, E, F, G, J, S, Z	Region code assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste	Previous Version: Field: REGION Notes/Comments:	No changes required
Q	10	Carrier	79	2		Code of the carrier performing the eligibility inquiry	Previous Version: Field: CARRIER Notes/Comments: Carrier Code	No changes required
Q	11	Effective Date	81	8		Effective date to be verified for the members's eligibility status. This is the expected enrollment start date with the MA-SNP Insurance Carrier Format: CCYYMMDD	Version change requires to always fill this field Previous Version: Field: FECHA DE EFECTIVIDAD Notes/Comments: 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.	Change required
Q	12	MPI	89	13		Member's MPI number	Changes requires to use the full MPI number Previous Version: Field: MPI_number Notes/Comments: MPI number Last eleven digits	Change required

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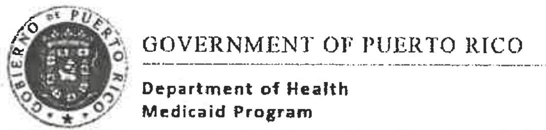

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on Instructions Related to Benefit Enrollment and Maintenance (834)

Companion Guide Version Number: 1.3

May 2023

Puerto Rico Medicaid Management Information System Services

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

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This companion guide does not replace the HIPAA ANSI ASC X12N Implementation Guide. Nor does it contain any actions that would result in a Non-Compliant Transaction.

This companion guide is subject to change without prior notice. Trading Partners are responsible for periodically checking for companion guide updates on the PRDOH website.

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) Implementation Guide, and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid Program. Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Benefit Enrollment and Maintenance (834) ASC X12N (version 005010X220A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1 INTRODUCTION

This section describes how TR3, also called 834 ASC X12N (005010X220A1), which was adopted under HIPAA, will be detailed with the use of a table. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid Program (PRMP) has additional information to provide over and above the information in the TR3. That information can do the any of the following:

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

In addition to the row for each segment, one or more additional rows are used to describe PRMP's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 10: Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Notes/Comments
193	2100C	NM1	Subscriber Name		This type of row exists to indicate that a new segment has begun. It is shaded at 10 percent and notes or comments about the segment itself go in this cell.
196	2100C	REF	Subscriber Additional Identification		
197	2100C	REF01	Reference Identification Qualifier	18 49 6P HJ N6	These are the only codes transmitted by Puerto Rico Medicaid Program.
			Plan Network Identification Number	N6	This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information		
231	2110C	EB13-1	Product/Service ID Qualifier	AD	This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

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Scope

PRMP developed 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to:

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- Specific Codes and/or Values that PRMP will default on Outbound Transactions
- Specific Codes and/or Values that are unique to PRMP to accept an Inbound Transaction

PRMP Companion Guides will not create a Non-Compliant Transaction.

This companion guide is intended to be used in conjunction with the ASC X12N/005010X220A1 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with PRMP. It does not change the requirements of the IG in any way.

Refer to the companion guide first if there is a question about how PRMP processes a HIPAA transaction. For further information, contact prmmis_edi_support@gainwelltechnologies.com. This document is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with PRMP interChange in successfully conducting EDI of administrative health care transactions. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

Overview

PRMP and all other covered entities are required by HIPAA to comply with the EDI standards for health care, as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required by HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The Health Insurance Portability and Accountability Act of 1996 directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

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The Health Insurance Portability and Accountability Act of 1996 serves to:

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

The 834 transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The intent is the initial enrollment and subsequent maintenance of individuals who are enrolled in healthcare. This transaction specifically addresses the enrollment and maintenance of healthcare only.

The payer refers to a third party entity that pays claims or administers the insurance benefit. A sponsor is the party that ultimately pays for the coverage or benefit. A member is an individual eligible for coverage because of his or her association with a sponsor. An insured individual is a member who has been enrolled for coverage under PRMP.

This Companion Guide contains the format and establishes the data contents of the Enrollment Transaction Set (834) for use within the context of an EDI environment. The 834 is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The intent of this implementation guide is to meet the health care industry's specific need for the initial enrollment and subsequent maintenance of individuals who are enrolled in Managed Care Organizations (MCO) or Medicare Advantage Organizations(MAO)-referred to as "carriers" in the rest of this document. This implementation guide specifically addresses the enrollment and maintenance of health care products only.

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

requirements in the ASC X12N 834 (version 005010X220A1) implementation. This information should be given to the "carrier's" business area to ensure that Benefit Enrollment and Maintenance transactions are interpreted correctly. This companion guide provides communications-related information a trading partner needs to obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with PRMP.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic Benefit Enrollment and Maintenance transactions that meet PRMP processing standards, by identifying pertinent structural and data-related requirements and recommendations.

As utilized by the PRPM, this transaction is designed to accomplish the function of sending enrollment information to PRMP participating Carriers.

The 834 X12 is the Enrollment Roster for PRMP. There are 2 file types that are sent – the full and the changes file.

834 Full/Audit File: This is a full file extract of the members enrolled with a Carrier at a specific point in time each month. It contains the most current information related to that member. This file is used to keep "carrier's" system in sync with PRMP. As a result, INS03 in Loop 2000 (Member Level Detail) as well as HD01 in Loop 2300 (Health Coverage) will be set to 030 (audit or full file).

834 Changes File: This file reflects any changes made to a member's demographic, eligibility or enrollment information. It is generated five days a week (Monday through Friday). The Carriers should not assume that new membership results in the automatic termination of prior coverage. There will be multiple member level details (Loop 2000) to indicate movement from the old to the new coverage.

Loop 2300 is used to indicate coverage information which may include additional coverage for incarcerated members. In the changes file, there could be up to 10 changes listed per day per coverage for each recipient id if the information in the 2300 loop is updated. When multiple changes to a specific coverage appear, they are sorted in descending order of date and time.

The 834 file comprises of separate transaction sets (ST-SE) for each Carrier's "assignee" Provider Medicaid ID. Within each set, the member details are grouped in the following sequence: ADD records (INS03 = 021) are followed by CHANGE (INS03 = 001) and finally by TERMINATION (INS03 = 024).

References & Applicable Web Sites

For more information regarding the ASC X12 standards for EDI 834 (version 005010X220A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at http://www.wpc-edi.com/.

For information about EDI software and services, visit: http://www.1edisource.com.

Additional information is available on the following Web sites:

- Accredited Standards Committee X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes: www.x12.org.
- Centers for Medicare and Medicaid Services (CMS) is the unit within the HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.htm.

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- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org.
- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs) and is responsible for clinical and administrative data standards: www.hl7.org.
- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics and national health information policy; for more information, refer to: www.ncvhs.hhs.gov.
- Office for Civil Rights (OCR) is the office within the federal HHS responsible for enforcing the Privacy Rule under HIPAA, which can be found at: www.hhs.gov/ocr/hipaa.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA, which can be found at: www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets, which can be found at: www.wpc-edi.com/.
- The WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES), at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Implementation guides and non-medical code sets are at: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS) are available at: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html.
- The CMS online manuals system and Internet only manuals (IOM) system, including transmittals and program memoranda, can be found at: www.cms.hhs.gov/Manuals/.

Additional Information

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

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

National Provider Identifier

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

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

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

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

Acceptable Characters

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

Acknowledgements

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

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters – the first 20 characters will be used to identify the file through PRMMIS.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

File Naming Convention for Managed Care 834 Inbound

Carriers will send an 834 to PRMMIS Monday through Friday.

Suggested file naming conventions for inbound 834 files from Carriers:

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Example:
Submission Date: 06/01/2023
Total Number of transactions: 100,000 Members

20230601_ABRV_8341DI.dat

Position 1 thru 8 = Date file was created **(YYYYMMDD format)**
9th position = **underscore**
Position 10 thru 13 = 4 character abbreviation of Carrier's (MCO/MAO) name
14th position = **underscore**
Position 15 thru 17 = Type of file – use **834**
Position 18 thru 18 = Sequence number of each file submitted during the day
19th position = File type (D = Daily)
20th position = Direction (I = Inbound)
Position 21 thru 24 = Use **.dat** or **.txt** for every file

The standards above will avoid accidently overwriting files. Do not send multiple files with the same name on the same day.

Note: Any data file that is 5MB or larger is required to be zipped or compressed before transmitting it to EDI.

File Naming Convention for Managed Care 834 Outbound

Two types of 834 Outbound files for Carriers:

1. 834 Daily runs Monday through Friday every week (834DO).
2. 834 Audit runs on the 1st work day of every month (834MO).

File Name format for Outbound 834:

1. BatchID_834DO_TradingPartnerID_YYYYMMDD.dat - Daily
2. BatchID_834MO_TradingPartnerID_YYYYMMDD.dat – Audit

BatchID is the unique ID assigned by PRMMIS to each file.

TradingPartnerID is the Carrier's Trading Partner ID.

Testing:

- Files must have T in ISA15.
- Files must have zero in ISA14.
- File Names cannot contain spaces or special characters
- Zip or compressed files are allowed, but compressed files must contain only one X12 file
- Zip files must contain the extension .zip (not case sensitive)

Production:

- Files must have P in ISA15.
- Files must have zero in ISA14.
- File Names cannot contain spaces or special characters
- Zip or compressed files are allowed, but compressed files must contain only one X12 file
- Zip files must contain the extension .zip (not case sensitive)

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2 GETTING STARTED

Testing Overview

Test transactions (ISA15 value of "T") must be sent to our Testing (UAT) environment.

Production transactions (ISA15 value of "P") must be sent to our Production environment (PROD).

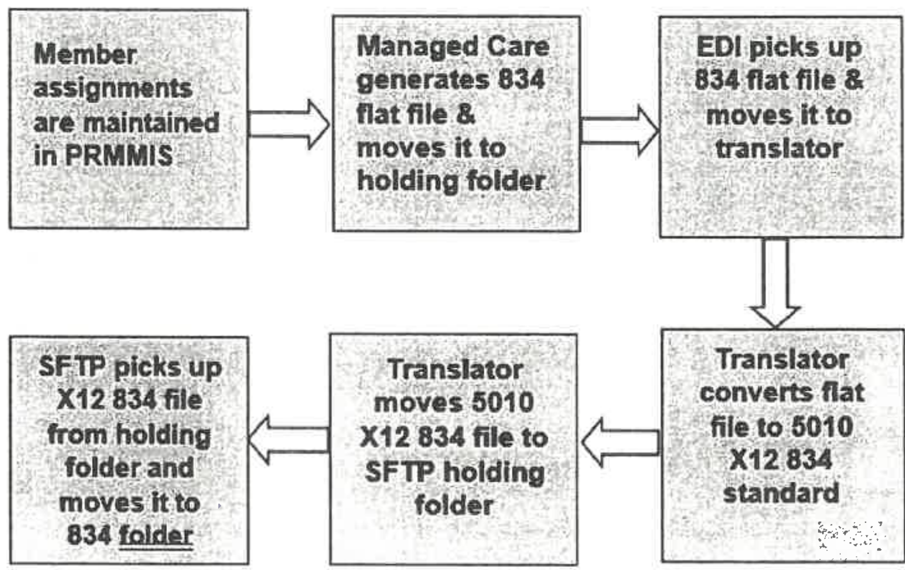
Reminder: Submitters are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains Personal Health Information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.

3 CONNECTIVITY WITH PUERTO RICO MEDICAID PROGRAM / COMMUNICATIONS

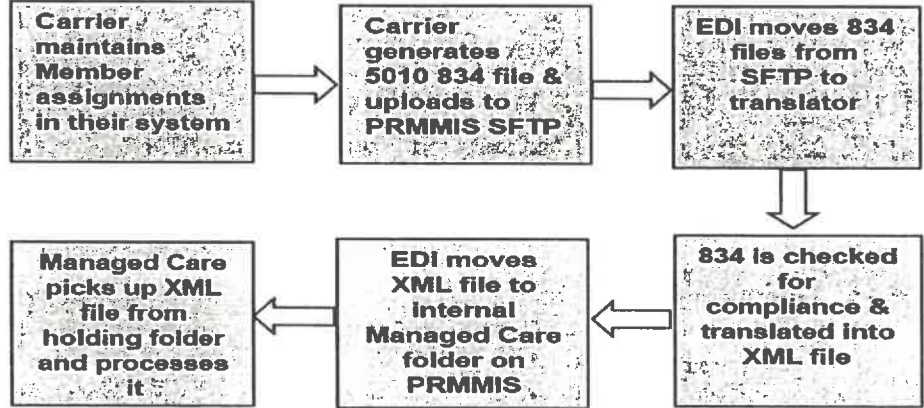
This section describes the process for downloading HIPAA 834 transactions, along with various security requirements and exceptions to handling procedures.

Process Flows

Outbound 834 - Retrieval of Puerto Rico Medicaid Program's Benefit Enrollment and Maintenance daily or monthly 834 file via Carrier's 834 folder on PRMMIS SFTP Site.



Inbound 834 - Submission of Carrier's (MCO/MAO) daily 834 file using their upload 834 folder on PRMMIS SFTP Site. Carrier is responsible for picking up TA1 or 999 acknowledgement, and the HTML error file if file fails compliance, from the "response" folder.



Transmission Administrative Procedures

Access to MoveIT (SFTP) is available only to authorized users. Submitters are required to be PRMP trading partners.

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Re-transmission Procedure

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate their file transfer as they normally would.

Batch

Trading partners can submit all batch transactions to PRMMIS and download acknowledgements and response files. The user must have their own internet connection to access the FTP server.

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4 CONTACT INFORMATION

Refer to this companion guide with your questions, then use the contact information below for questions not answered by this guide.

Electronic Data Interchange Helpdesk

If you have questions related to PRMP's 834, contact the EDI Helpdesk by email at prmmis_edi_support@gainwelltechnologies.com or by phone at 1-833-209-8326.

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5 CONTROL SEGMENTS / ENVELOPES

ISA - Interchange Control Header

This section describes PRMP's use of the ISA. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

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

- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format (24 hour)
- Payer ID can be found in all companion guides.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted are identified by an ISA and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below shows the fields that PRMP will be sending.

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

Note: PRMMIS sends files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.3	None	ISA	Interchange Control Header			The ISA is a fixed-length record with fixed-length elements.
C.4		ISA01	Authorization Information Qualifier	00	IN	No authorization information present.
C.4		ISA02	Authorization Information		IN	[10 spaces]
C.4		ISA03	Security Information Qualifier	00	IN	No security information present.
C.4		ISA04	Security Information		IN	[10 spaces]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	IN	
C.4		ISA06	Interchange Sender ID		IN	Inbound: Carrier's Trading Partner ID supplied by PRMP, [6 digits left justified and 9 spaces]. Outbound: "PRMP" Puerto Rico Medicaid Program. [4 characters left justified and 11 spaces].
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	IN	
C.5		ISA08	Interchange Receiver ID		IN	Inbound from Carriers: "PRMP" Puerto Rico Medicaid Program., [4 characters left justified and 11 spaces]. Outbound to Carriers: Carrier's Trading Partner ID supplied by PRMP, [6 digits left justified and 9 spaces].

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TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.5		ISA09	Interchange Date		IN	The date format is YYMMDD.
C.5		ISA10	Interchange Time		IN	The time format is HHMM.
C.5		ISA11	Repetition Separator	^	IN	A Caret "^" will be sent.
C.5		ISA12	Interchange Control Version Number	00501	IN	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		IN	The interchange control number assigned in ISA13 will be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	IN	No interchange acknowledgment requested (TA1). ***Note:*** TA1 will be sent if file envelope is corrupted.
C.6		ISA15	Usage Identifier	T & P	IN	Code indicating whether the data enclosed is production or test.
			Test Data	T		File submitted to PRMMIS test environment.
			Production Data	P		File submitted to PRMMIS production environment.
C.6		ISA16	Component Element Separator	:	IN	A colon ":" will be sent.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number.		Must be identical to the value in ISA13

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GS - Functional Group Header

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that PRMMIS will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.7	None	GS	Functional Group Header			
C.7		GS01	Functional ID Code	BE	IN	"BE" Health Care Benefit Enrollment and Maintenance (834).
C.7		GS02	Application Sender's Code		IN	Inbound: Carrier's Trading Partner ID supplied by PRMP. Outbound: "PRMP" Puerto Rico Medicaid Program.
C.7		GS03	Application Receiver's Code		IN	Inbound: "PRMP" Puerto Rico Medicaid Program. Outbound: Carrier's Trading Partner ID supplied by PRMP.
C.7		GS04	Date		IN	The date format is CCYYMMDD.
C.8		GS05	Time		IN	The time format is HHMM.
C.8		GS06	Group Control Number		IN	Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	IN	"X" Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010 X220A1	IN	Version/ Release/ Industry Identifier Code

GE - Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

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ST-SE Transaction Set

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

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

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Reqd	Notes/Comments
70	None	ST	Transaction Set Header			
70		ST01	Transaction Set Identifier Code	834	IN	834 Health Care Benefit & Enrollment Maintenance
70		ST02	Transaction Set Control Number		IN	The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010 X220A1		This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Reqd	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER			
496		SE01	Transaction Segment Count		IN	Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		IN	The Transaction Set Control Number in ST02 and SE02 must be identical.

File Delimiters

PRMMIS uses the following delimiters in the 834 file:

- **Data Element:** Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The data element delimiter is an asterisk (*).
- **Repetition Separator:** ISA11 defines the repetition separator to be used throughout the entire transaction. The repetition separator is a caret (^).
- **Component-Element:** ISA16 defines the component element delimiter to be used throughout the entire transaction. The component-element delimiter is a colon (:).
- **Data Segment:** Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The data segment delimiter is a tilde (~).

These characters (* : ~ ^) can not be present within the data content of the transaction elements.

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6 PUERTO RICO MEDICAID PROGRAM-SPECIFIC BUSINESS RULES AND LIMITATIONS

Trading Partner Identification Number

The EDI team will create any needed Trading Partner Profiles during the PRMP's implementation of the 834.

Testing

Production Authorization Testing will be required for inbound 834 files.

Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

Limits

There is no file size restriction on how many records will be reported in an 834.

Scheduled Maintenance

PRMMIS recycles the servers every night between 00:00 a.m. to 01:00 a.m. AST.

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. AST.

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7 Notes on 834 Benefit Enrollment and Maintenance

834 - Daily
A daily 834 is generated to report demographic, eligibility and enrollment changes on existing members. Daily files are produced Monday through Friday, if available.

834 – Monthly Audit
An 834 monthly Audit file is produced on the 1st working day of the month to provide a full list of members for the Plan for the current month. 834 Audit transactions contain a complete Roster that includes new, current, and terminated members. No past changes will be reported. The 834 daily files will use the same formats as the 834 audit files.

The 834 files will be available for retrieval for six months. If an 834 file is needed after six months, contact the EDI Helpdesk via e-mail using prmmis_edi_support@gainwelltechnologies.com

Usage of REF segment for Recipient IDs
There is guidance around the various recipient identifiers provided using the **REF (Member Supplemental Identifier)** segment in the 2000 loop.

• When REF01 = F6, this is the **recipient's Medicare ID** as provided by the eligibility system. This is provided when the recipient has Medicare. Where possible, this is the new Medicare Beneficiary ID. In other instances, it is still the recipient's HIC Number.

• When REF01 = Q4, this is the **recipient's linked (or secondary) id**. This is an Inactive ID in PRMMIS that is linked to the recipient's primary ID. The secondary ID is usually a historical ID for the recipient. If the recipient is found to have multiple IDs, the recipient IDs are linked and only one ID remains as primary, all other linked IDs become secondary. The 834 will have the most recent linked ID (secondary ID) in the chain when a recipient has multiple linked IDs.

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8 ACKNOWLEDGEMENTS AND/OR REPORTS

Acknowledgements

TA1 — Transaction Acknowledgement
PRMMIS will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will not be sent. The submitted 834 will need to be corrected and resubmitted.

999 — Functional Acknowledgement
This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. PRMMIS will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced then claims/encounters will not be sent to the claims engine for adjudication. The submitted 834 will need to be corrected and resubmitted.

HTML – Compliance Check HTML Report
This file informs the submitter that the transaction had envelope or compliance errors and provides information about the error in a more readable format.

Report Inventory

There are no acknowledgement reports at this time.

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9 TRANSACTION-SPECIFIC INFORMATION

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

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

In addition to the row for each segment, one or more additional rows are used to describe PRMP's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3.

005010X220A1 — 834 Health Care Benefit Enrollment and Maintenance

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
32			BGN	Beginning Segment			
32	1/1		BGN01	Transaction Set Purpose Code	00 15 22	IN	
				Original	00		Indicates the first time the transaction is sent.
				Resubmission	15		Sent when the original transmission was incorrect, has yet to be processed by the receiver, and a new corrected transmission is being sent.
				Information Copy	22		Sent when the original transmission was lost or not processed, and the sender is passing another transmission that is the same as the original.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
33	1/50		BGN02	Transaction Set Reference Number		IN	Example: INITIAL 20230701 0001 This element is 50 characters of free form text to identify this specific file's information. Example: • Positions 1-7, Report ID, valid values are "INITIAL" or "FINAL". • Positions 8–8, Space. • Positions 9–14, Enrollment month in a CCYYMM format. • Positions 15–15, Space. • Positions 16–19, Sequence number of the transaction set indicating the order that the transaction sets are created and the order in which the transaction sets are to be processed.
33	8/8		BGN03	Transaction Set Creation Date		IN	Date when the X12 file was generated
33	4/8		BGN04	Transaction Set Creation Time		IN	Time when the X12 file was generated. Format used - HHMM
33	2/2		BGN05	Time Zone Code	TS		"TS" = Atlantic Standard Time
35	1/50		BGN06	Original Transaction Set Reference Number			Required when there is a previously sent transaction to cross-reference.
35	1/2		BGN08	Action Code	2 4 RX	IN	
				Change (Update)	2		Identify a transaction of additions, terminations and changes to the current enrollment.
				Verify	4		Identify a full enrollment transaction to verify that the sponsor's and payer's systems are synchronized.
				Replace	RX		Identify a full enrollment transmission.
36			REF	Transaction Set Policy Number			
36	2/3		REF01	Reference Identification Qualifier	38		"38" = Master Policy Number
36	1/50		REF02	Master Policy Number			Carrier's Trading Partner ID supplied by PRMMIS.
37			DTP	File Effective Date			This segment communicates the start and end date of the coverage period associated with this premium payment. ***Note:*** Segment can be repeated.
37	3/3		DTP01	Date Time Qualifier	007 090 091 303 382 388		ADMINISTRACION DE SEGUROS DE SALUD № 24-0003
				Effective	007		
				Report Start	090		Contrato Número

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Report End	091		
				Maintenance Effective	303		
				Enrollment	382		
				Payment Commencement	388		
37	2/3		DTP02	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD.
37	1-35		DTP03	Date Time Period			
38			QTY	Transaction Set Control Totals			
38	2/2		QTY01	Trace Type Code	TO		"TO" = Total
38	1/15		QTY02	Record Totals			
39		1000 A	N1	Sponsor Name			
39	2/3	1000 A	N101	Entity Identifier Code	P5		"P5" = Plan Sponsor
39	1/60	1000 A	N102	Plan Sponsor Name	PRMP		
40	1/2	1000 A	N103	Identification Code Qualifier	FI		"FI" = Federal Taxpayer's Identification Number
40	2/80	1000 A	N104	Sponsor Identifier			
41		1000 B	N1	Payer			
41	2/3	1000 B	N101	Entity Identifier Code	IN	IN	"IN" = Insurer
41	1/60	1000 B	N102	Insurer Name		IN	Name of carrier
42	1/2	1000 B	N103	Identification Code Qualifier	FI	IN	"FI" = Federal Taxpayer's Identification Number
42	2/80	1000 B	N104	Insurer Identification Code		IN	Federal Tax ID of carrier
43		1000 C	N1	TPA/Broker Name			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
45		1100 C	ACT	TPA/Broker Account Information			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
47		2000	INS	Member Level Detail			PRMP considers the Member as the Subscriber/Member in all reporting situations.
48	1/1	2000	INS01	Member Indicator	Y	IN	"Y" = Yes
48	2/2	2000	INS02	Individual Relationship Code	18	IN	"18" = Self
49	3/3	2000	INS03	Maintenance Type Code	001 021 024 025 030	IN	
				Change (Daily)	001		Indicate a change to an existing subscriber/dependent record.
				Addition	021		Add a subscriber.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Cancellation or Termination	024		Cancellation, termination, or deletion of a subscriber.
				Reinstatement	025		Outbound only: Code used for reinstatement of a cancelled subscriber record.
				Audit or Compare (Monthly)	030		Outbound only: Sending a full file (BGN08 = '4' or 'RX') to verify that the sponsor and payer databases are synchronized.
49	2/3	2000	INS04	Maintenance Reason Code		IN	See Appendix A for list of possible codes. When INS04=03, the date of death is indicated as the Medicaid end date in the 2000 loop
51	1/1	2000	INS05	Benefit Status Code	A	IN	"A" = Active
51	1/1	2000	INS06-1	Medicare Plan Code	A B C D E	IN	
				Medicare Part A	A		
				Medicare Part B	B		
				Medicare Part A and B	C		
				Medicare Part D	D		
				No Medicare	E		
52	2/2	2000	INS08	Employment Status Code	AC TE		Status of the subscriber in Medicaid.
				Active	AC		
				Terminated	TE		
53	2/3	2000	INS11	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
54	1/35	2000	INS12	Member Individual Death Date			Outbound: (Cancellation or Termination)
55		2000	REF	Subscriber Identifier			
55	2/3	2000	REF01	Reference Identification Qualifier	OF	IN	"OF" = Subscriber Number
55	1/35	2000	REF02	Subscriber Identifier	PRMMIS medicaid id MPI	IN	Subscriber ID as assigned by PRMP.
56		2000	REF	Member Policy Number			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
57		2000	REF	Member Supplemental Identifier			Additional details are provided in Section 7 - Notes on 834 Benefit Enrollment and Maintenance. ***Note:*** Segment can repeat 13 times.
57	2/3	2000	REF01	Reference Identification Qualifier	F6 Q4		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Health Insurance Claim (HIC) Number	F6		MBI
				Prior Identifier Number	Q4		To pass the Identifier Number under which the member had previous coverage with the payer.
57	1/50	2000	REF02	Member Supplemental Identifier			
58		2000	DTP	Member Level Dates			Required when enrolling a member or when the sponsor is informed of a change to any applicable date listed in DTP01. Only those dates that apply to the particular insurance contract need to be sent. ***Note:*** Segment can repeat 24 times.
58	3/3	2000	DTP01	Date Time Qualifier			See Appendix B for list of valid qualifiers.
59	2/3	2000	DTP02	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD.
59	1/35	2000	DTP03	Status Information Effective Date			
62		2100 A	NM1	Member Name			
62	2/3	2100 A	NM101	Entity Identifier Code	74 IL	IN	
				Corrected Insured	74		This code is used if this transmission is correcting the identifier information on a member already enrolled. ***Note:*** Usage of this code requires the sending of an NM1 with code '70' in loop 2100B.
				Insured or Subscriber	IL		This code is used when enrolling a new member or updating a member with no change in identifying information.
63	1/1	2100 A	NM102	Entity Type Qualifier	1	IN	"1" = Person
63	1/60	2100 A	NM103	Member Last Name		IN	last name #1 & last name #2 with pipe delimiter to separate
63	1/35	2100 A	NM104	Member First Name		IN	
63	1/25	2100 A	NM105	Member Middle Name			
64	1/2	2100 A	NM108	Identification Code Qualifier	34		"34" = Social Security Number
64	2/80	2100 A	NM109	Member Identifier			Social Security Number
65		2100 A	PER	Member Communications Numbers			
66	2/2	2100 A	PER01	Contact Function Code	IP		"IP" = Insured Party
66	2/2	2100 A	PER03	Communication Number Qualifier	TE		"TE" Telephone
66	1/256	2100 A	PER04	Communication Number			Member's Telephone Number if on file

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
66	2/2	2100 A	PER05	Communication Number Qualifier	TE		"TE" Telephone
66	1/256	2100 A	PER06	Communication Number			Member's 2nd Telephone Number if on file
68		2100 A	N3	Member Residence Street Address			Required when enrolling new member or when changing a member's address.
68	1/55	2100 A	N301	Member Address Line			
68	1/55	2100 A	N302	Member Address Line2			
69		2100 A	N4	Member City, State, ZIP Code			Required when enrolling new member or when changing a member's address.
69	2/30	2100 A	N401	Member City Name			
69	2/2	2100 A	N402	Member State Code			
70	3/15	2100 A	N403	Member Zip Code			***Note:*** If zip +4 is unknown send 9998.
70	1/2	2100 A	N405	Location Qualifier	CY		"CY" = County/Parish
70	1/30	2100 A	N406	Location Identifier		IN	Contains 3-digit county code See Appendix F for list of valid codes.
71		2100 A	DMG	Member Demographics			Required when enrolling new member or changing member's demographis information or terminating member.
71	2/3	2100 A	DMG01	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
71	1/35	2100 A	DMG02	Member Birth Date			
72	1/1	2100 A	DMG03	Gender Code	F M U		
				Female	F		
				Male	M		
				Unknown	U		This code is to be used only when the gender is unknown or when it can not be sent due to reporting restrictions.
72	1/1	2100 A	DMG04	Marital Status Code	B D I M R S U W X		ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número
				Registered Domestic Partner	B		
				Divorced	D		
				Single	I		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Married	M		
				Unreported	R		
				Separated	S		
				Unmarried (Single or Divorced or Widowed)	U		This code should be used if the previous status is unknown.
				Widowed	W		
				Legally Separated	X		
72		2100 A	DMG05	Composite Race Or Ethnicity Information			***Note:*** Element can repeat up to 10 times.
73	1/1	2100 A	DMG05 - 1	Race Code			See Appendix C for list of possible codes.
73	1/3	2100 A	DMG05 - 2	Code List Qualifier Code	RET		"RET" = Classification of Race or Ethnicity
73	1/1	2100 A	DMG05 - 3	Ethnicity Code			See Appendix C for list of possible codes.
76		2100 A	EC	Employment Class Code			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
79		2100 A	ICM	Member Income			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
81		2100 A	AMT	Member Policy Amounts			***Note:*** Segment can repeat up to 7 times
81	1/3	2100 A	AMT01	Amount Qualifier Code	C1		Co-Payment Amount
81	1/18	2100 A	AMT02	Contract Amount			
82		2100 A	HLH	Member Health Information			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
84		2100 A	LUI	Member Language			Required if the sponsor knows that the member's primary language is not English, and such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. ***Note:*** Segment can repeat as needed.
84	1/2	2100 A	LUI01	Identification Code Qualifier	LE		"LE" ISO 639 Language Codes
85	2/80	2100 A	LUI02	Language Code			SPA for example
85	1/80	2100 A	LUI03	Language Description			SPANISH for example
85	1/2	2100 A	LUI04	Language Use Indicator	6 7		
				Language Writing	6		
				Language Speaking	7		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
86		2100 B	NM1	Incorrect Member Name			Required if a corrected name is being sent in loop 2100A or if previously supplied demographics are being changed. If only the demographics are being changed, the code in NM101 in loop 2100A will be IL, and the code in NM101 in this loop will be 70.
86	2/3	2100 B	NM101	Entity Identifier Code	70		"70" = Prior Incorrect Insured ***Note:*** This code identifies that the information that follows is previously reported enrollment information that is being corrected.
87	1/1	2100 B	NM102	Entity Type Qualifier	1		"1" = Person
87	1/60	2100 B	NM103	Prior Incorrect Member Last Name			last name & last name 2 with pipe delimiter to separate
87	1/35	2100 B	NM104	Prior Incorrect Member First Name			
87	1/25	2100 B	NM105	Prior Incorrect Member Middle Name			Middle initial only in PRMMIS
87	1/2	2100 B	NM108	Identification Code Qualifier	34		"34" = Social Security Number
88	2/80	2100 B	NM109	Prior Incorrect Insured Identifier			Prior incorrect Social Security Number
89		2100 B	DMG	Incorrect Member Demographics			Required when changing previously supplied demographics.
89	2/3	2100 B	DMG01	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
90	1/35	2100 B	DMG02	Prior Incorrect Insured Birth Date			
90	1/1	2100 B	DMG03	Prior Incorrect Insured Gender Code	F M U		
				Female	F		
				Male	M		
				Unknown	U		This code is to be used only when the gender is unknown or when it can not be sent due to reporting restrictions.
90	1/1	2100 B	DMG04	Marital Status Code	B D I M R S U W X		ADMINISTRACION DE SEGUROS DE SALUD
				Registered Domestic Partner	B		№ 24-0003
				Divorced	D		
				Single	I		Contrato Número
				Married	M		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Unreported	R		
				Separated	S		
				Unmarried (Single or Divorced or Widowed)	U		This code should be used if the previous status is unknown.
				Widowed	W		
				Legally Separated	X		
90		2100 B	DMG05	Composite Race Or Ethnicity Information			
90	1/1	2100 B	DMG05 - 1	Race Code			See Appendix C for list of possible codes.
90	1/3	2100 B	DMG05 - 2	Code List Qualifier Code	RET		"RET" = Classification of Race or Ethnicity
91	1/30	2100 B	DMG05 – 3	Ethnicity Code			See Appendix C for list of possible codes.
92		2100 C	NM1	Member Mailing Address			When the member mailing address is different from the residence address sent in loop 2100A.
92	2/3	2100 C	NM101	Entity Identifier Code	31		"31" = Postal Mailing Address
92	1/1	2100 C	NM102	Entity Type Qualifier	1		"1" = Person
94		2100 C	N3	Member Mailing Street Address			
94	1/55	2100 C	N301	Member Mailing Address Line		IN	
94	1/55	2100 C	N302	Member Mailing Address Line2			
95		2100 C	N4	Member Mailing City, State, ZIP			
95	2/30	2100 C	N401	Member Mailing City Name		IN	
95	2/2	2100 C	N402	Member Mailing State Code			
96	3/15	2100 C	N403	Member Mailing ZIP Code			***Note:*** If zip +4 is unknown send 9998.
97		2100 D	NM1	Member Employer			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
106		2100 E	NM1	Member School			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
114		2100 F	NM1	Custodial Parent			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
123		2100 G	NM1	Responsible Person			The person(s) who are Responsible for the member. ***Note:*** Loop can repeat up to 13 times.
123	2/3	2100 G	NM101	Entity Identifier Code	QD		Responsible Party
124	1/1	2100 G	NM102	Entity Type Qualifier	1		"1" = Person

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
124	1/60	2100 G	NM103	Responsible Party Last or Organization Name			
124	1/35	2100 G	NM104	Responsible Party First Name			
124	1/25	2100 G	NM105	Responsible Party Middle Name			
125	1/2	2100 G	NM108	Identification Code Qualifier	ZZ		ZZ = mutually defined
125	2/80	2100 G	NM109	Responsible Party Identifier			PRMMIS medicaid id/MPI
126		2100 G	PER	Responsible Person Communications Numbers			Required when the Responsible Person contact information is provided to the sponsor.
127	2/2	2100 G	PER01	Contact Function Code	RP		"RP" = Responsible Person
127	2/2	2100 G	PER03	Communication Number Qualifier	TE		"TE" = Telephone
127	1/256	2100 G	PER04	Communication Number			
127	2/2	2100 G	PER05	Communication Number Qualifier	TE		"TE" = Telephone
128	1/256	2100 G	PER06	Communication Number			
129		2100 G	N3	Responsible Person Street Address			
129	1/55	2100 G	N301	Responsible Person Address Line			
129	1/55	2100 G	N302	Responsible Person Address Line2			
130		2100 G	N4	Responsible Person City, State, ZIP			
130	2/30	2100 G	N401	Responsible Person City Name			
131	2/2	2100 G	N402	Responsible Person State Code			
131	3/15	2100 G	N403	Responsible Person ZIP			***Note:*** If zip +4 is unknown send 9998.
132		2100 H	NM1	Drop Off Location			The Drop Off Location loop does not meet the situational requirements to be used by Puerto Rico Medicaid.
137		2200	DSB	Disability Information			The Disability Information loop does not meet the situational requirements to be used by Puerto Rico Medicaid.
140		2300	HD	Health Coverage			When enrolling a new member or when adding, updating, removing coverage or auditing an existing member. ***Note:*** Loop can repeat up to 99 times.
140	3/3	2300	HD01	Maintenance Type Code	001 002 021 024 025 026 030 032	IN	**001, 002, 021, 024, 025, 26** and **032** are used with the 834 change file. **030** is used with the monthly 834 full file.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Change	001		
				Delete	002		Use this code for deleting an incorrect coverage record.
				Addition	021		
				Cancellation or Termination	024		Use this code for cancelling/terminating a coverage
				Reinstatement	025		Outbound Only.
				Correction	026		This code is used to correct an incorrect record.
				Audit or Compare	030		Outbound Only.
				Employee Information Not Applicable	032		
141	2/3	2300	HD03	Insurance Line Code	**HMO**		HMO – Health Maintenance Organization ***Note:*** The dates on this loop are associated with the assignment plan.
142	1/50	2300	HD04	Plan Coverage Description	**Appendix G**	IN	See Appendix G for layout of HD04. 834 Inbound Managed Care Region is required for INBOUND.
142	3/3	2300	HD05	Coverage Level Code	IND		"IND" = Individual
143		2300	DTP	Health Coverage Dates			***Note:*** Segment can repeat up to 6 times.
143	3/3	2300	DTP01	Date Time Qualifier	300 303 343 348 349 543 695	IN	
				Enrollment Signature Date	300		
				Maintenance Effective	303		This is the effective date of a change where a member's coverage is not being added or removed.
				Premium Paid to Date End	343		
				Benefit Begin	348		This is the effective date of coverage. This code must always be sent when adding or reinstating coverage.
				Benefit End	349		The termination date represents the last date of coverage in which claims will be paid for the individual being terminated.
				Last Premium Paid Date	543		
				Previous Period	695		This value is only to be used when reporting Previous Coverage Months.
144	2/3	2300	DTP02	Date Time Period Format Qualifier	D8 RD8	IN	
				Date Expressed in Format CCYYMMDD.	D8		ADMINISTRACION DE SEGUROS DE SALUD

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	RD8		This value is only to be used when reporting Previous Coverage Months.
144	1/35	2300	DTP03	Coverage Period		IN	
145		2300	AMT	Health Coverage Policy			The Health Coverage Policy segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
146		2300	REF	Health Coverage Policy Number			The Health Coverage Policy Number segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
148		2300	REF	Prior Coverage Months			The Prior Coverage Month segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
150		2300	IDC	Identification Card			The Identification Card segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
152		2310	LX	Provider Information	If needed this loop repeats in this order: PMG1 PCP1 PCP2		Provide information about the primary care providers and/or managed care organizations sleceted by the member. ***Note:*** Loop can repeat up to 30 times.
152	1/6	2310	LX01	Assigned Number			This is a sequential number representing the number of loops (providers) for this member.
153		2310	NM1	Provider Name			
153	2/3	2310	NM101	Entity Identifier Code	P3 Y2	IN	
				Primary Care Provider	P3		PCP1/PCP2
				Managed Care Organization	Y2		PMG1
154	1/1	2310	NM102	Entity Type Qualifier	1 2	IN	
				Person	1		
				Organization	2		
154	1/60	2310	NM103	Provider Last or Organization Name			
154	1/35	2310	NM104	Provider First Name			
154	1/25	2310	NM105	Provider Middle Name		IN	Medicaid ID Assigned to Provider by PRMMIS
154	1/10	2310	NM106	Provider Name Prefix	PCP1 PCP2	IN	Use to indicate change to PCP1 or PCP2

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
155	1/2	2310	NM108	Identification Code Qualifier	34 FI SV XX	IN	
				Social Security Number	34		
				Federal Taxpayer's Identification Number	FI		
				Service Provider Number	SV		
				CMS National Provider Identifier (NPI)	XX		
155	2/80	2310	NM109	Provider Identifier		IN	
155	2/2	2310	NM110	Entity Relationship Code	25 26 72	IN	
				Established Patient	25		
				Not Established Patient	26		
				Unknown	72		
156		2310	N3	Provider Address			
156	1/55	2310	N301	Provider Address Line		IN	
156	1/55	2310	N302	Provider Address Line			
157		2310	N4	Provider City, State, ZIP			
157	2/30	2310	N401	Provider City Name		IN	
157	2/2	2310	N402	Provider State Code			
158	3/15	2310	N403	Provider Postal Zone or ZIP Code			Note: If zip +4 is unknown send 9998.
158	2/3	2310	N404	Country Code			Required when the address is outside the United States of America. Use the alpha-2 country codes from Part 1 of ISO 3166.
159		2310	PER	Provider Communications Number			Segment can repeat twice
160	2/2	2310	PER01	Contact Function Code	IC		IC Information Contact
160	2/2	2310	PER03	Communication Number Qualifier	TE		24 hour Telephone Number
160	1/256	2310	PER04	Communication Number			
162		2310	PLA	Provider Change Reason			To report the reason and the effective date that a member changes providers as described by the NM1 segment in Loop 2310.
162	1/2	2310	PLA01	Action Code	2	IN	"2" Change (Update)
162	2/2	2310	PLA02	Entity Identifer Code	IP	IN	"1P" Provider
162	8/8	2310	PLA03	Effective Date	CCYY MMDD	IN	This is the effective date of the change of PCP

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
163	2/3	2310	PLA05	Maintenance Reason Code	14 22 46 AA AB AC AD AE AF AG AH AI AJ	IN	
				Voluntary Withdrawal	14		
				Plan Change	22		
				Current Customer Information File in Error	46		
				Dissatisfaction with Office Staff	AA		
				Dissatisfaction with Medical Care/Services Rendered	AB		
				Inconvenient Office Location	AC		
				Dissatisfaction with Office Hours	AD		
				Unable to Schedule Appointments in a Timely Manner	AE		
				Dissatisfaction with Physician's Referral Policy	AF		
				Less Respect and Attention Time Given than to Other Patients	AG		
				Patient Moved to a New Location	AH		
				No Reason Given	AI		
164		2320	COB	Coordination of Benefits			Required whenever an individual has another insurance plan with benefits similar to those covered by the insurance product specified in the HD segment for this occurrence of Loop ID-2300. Loop can repeat 5 times.
164	1/1	2320	COB01	Payer Responsibility Sequence Number Code	P S T U		
				Primary	P		
				Secondary	S		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Tertiary	T		
				Unknown	U		
164	1/50	2320	COB02	Member Policy Number			Required when the policy number is available.
164	1/1	2320	COB03	Coordination of Benefits Code	1		"1" Coordination of Benefits
165	1/2	2320	COB04	Service Type Code	1 35 48 50 54 89 90 A4 AG AL BB		Required when detailed COB coverage information is agreed to be exchanged. Up to 9 values can be listed separated by value in ISA11 - Repetition Separator. The preferred repetition separator is a caret (^).
				Medical Care	1		
				Dental Care	35		
				Hospital - Inpatient	48		
				Hospital - Outpatient	50		
				Long Term Care	54		
				Free Standing Prescription Drug	89		
				Mail Order Prescription Drug	90		
				Psychiatric	A4		
				Skilled Nursing Care	AG		
				Vision (Optometry)	AL		
				Partial Hospitalization (Psychiatric)	BB		
166		2320	REF	Additional Coordination Of Benefits Identifiers			Required if additional COB identifiers are supplied by the subscriber. Can repeat 4 times.
166	2/3	2320	REF01	Reference Identification Qualifier	60 6P		
				Account Suffix Code	60		
				Group Number	6P		
167	1/50	2320	REF02	Member Group Number			
168		2320	DTP	Coordination Of Benefits Eligibility Dates			Required when the submitter needs to send effective dates for coordination of benefits. Can repeat 2 times.
168	3/3	2320	DTP01	Date/Time Qualifier	344 345		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Coordination of Benefits Begin	344		
				Coordination of Benefits End	345		
168	2/3	2320	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
168	1/35	2320	DTP03	Coordination of Benefits Date			
169		2330	NM1	Coordination Of Benefits Related Entity			Required to send the name of the insurance company when provided to the sponsor. Can repeat 3 times.
169	2/3	2330	NM101	Entity Identifier Code	36 GW IN		
				Employer	36		
				Group	GW		
				Insurer	IN		
170	1/1	2330	NM102	Entity Type Qualifier	2		"2" = Non-Person Entity
170	1/60	2330	NM103	Coordination of Benefits Insurer Name			Required to send the insurance company name if no standard identifier is available to pass in NM109.
170	1/2	2330	NM108	Identification Code Qualifier	FI NI		
				Federal Taxpayer's Identification Number	FI		
				National Association of Insurance Commissioners (NAIC) Identification	NI		
170	2/80	2330	NM109	Coordination of Benefits Insurer Identification Code			Required when supplied by the employee to the sponsor.
171		2330	N3	Coordination Of Benefits Related Entity Address			Can repeat 2 times.
171	1/55	2330	N301	Address Information			
171	1/55	2330	N302	Address Information			
172		2330	N4	Coordination Of Benefits Other Insurance Company City, State, Zip Code			
172	2/30	2330	N401	Coordination of Benefits Other Insurance Company City Name			
173	2/2	2330	N402	Coordination of Benefits Other Insurance Company State Code			
173	3/15	2330	N403	Coordination of Benefits Other Insurance Company Postal Zone or ZIP Code			*Note:* If zip +4 is unknown send 9998.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
173	2/3	2330	N404	Country Code			Required when the address is outside the United States of America. Use the alpha-2 country codes from Part 1 of ISO 3166.
174		2330	PER	Administrative Communications Contact			Required when detailed COB coverage information is agreed to be exchanged.
174	2/2	2330	PER01	Contact Function Code	CN		"CN" = General Contact
175	2/2	2330	PER03	Communication Number Qualifier	TE		"TE" = Telephone
175	1/256	2330	PER04	Communication Number			
176		2700	LS	Additional Reporting Categories			
176	1/4	2700	LS01	Loop Identifier Code	2700		Constant "2700" (start loop)
		2710	LX	Member Reporting Categories			
177	1/6	2710	LX01	Assigned Number	1		Start with 1 and increment by 1
		2750	N1	Reporting Category			
178	2/3	2750	N101	Entity Identifier Code	75		Constant "75" (Participant)
178	1/60	2750	N102	Member Reporting Category Name			Constant "ADDITIONAL MEMBER IDENTIFICATION DATA"
		2750	REF	Reporting Category Reference			
179	2/3	2750	REF01	Reference Identification Qualifier	ZZ		Constant "ZZ" (Mutually Defined)
179	1/50	2750	REF02	Member Reporting Category Reference ID	**See Appendix H**	IN	multiple values delimited by pipe character. . For 834 Inbound. Enrollment confirmed is required Y/N value. Plan Version is required for Platino carriers.
		2750	DTP	Reporting Category Date			
181	3/3	2750	DTP01	Date Time Qualifier	007		Constant "007" (Effective)
181	2/3	2750	DTP02	Date Time Period Format Qualifier	RD8		Constant "RD8" (Start thru end dates)
181	1/35	2750	DTP03	Member Reporting Category Effective Date(s)	CCYYMMDD-CCYYMMDD		CCYYMMDD-CCYYMMDD
		2700	LE	Additional Reporting Categories Loop Termination			
183	1/4	2700	LE01	Loop Identifier Code	2700		Constant "2700" (end loop)

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APPENDICES

Appendix A – Maintenance Reason Codes (INS04)

(Subject to change/addition by Gainwell, grayed out = not applicable.)

Code	Description	Notes/Comments
1	Divorce	
2	Birth	
3	Death	
4	Retirement	
5	Adoption	
6	Strike	
7	Termination of Benefits	
8	Termination of Employment	
9	Consolidation Omnibus Budget Reconciliation Act (COBRA)	
10	Consolidation Omnibus Budget Reconciliation Act (COBRA) Premium Paid	
11	Surviving Spouse	
14	Voluntary Withdrawal	Inbound Only
15	Primary Care Provider (PCP) Change	
16	Quit	
17	Fired	
18	Suspended	
20	Active	
21	Disability	
22	Plan Change	Outbound Only Use this code when a member changes from one Plan to a different Plan. This is not intended to identify changes to a Plan.
25	Change in Identifying Data Elements (demographic)	Outbound Only Use this code when a change has been made to the primary elements that identify a member. Such primary elements include the following: first name, last name, Social Security Number, date of birth, and employee identification number.
26	Declined Coverage	Use this code when a member declined a previously active coverage.
27	Pre-Enrollment	Use this code to enroll newborns prior to receiving the newborn's application.
28	Initial Enrollment	Inbound Only Use this code the first time the member selected coverage with the Plan Sponsor.
29	Benefit Selection	Outbound Only Use this code when a member changes benefits within a Plan.
31	Legal Separation	
32	Marriage	
33	Personnel Data	Outbound Only Use this code for any data change that is not included in any of the other allowed codes. An example would be change in Coordination of Benefits information.
37	Leave of Absence with Benefits	
38	Leave of Absence without Benefits	
39	Lay Off with Benefits	
40	Lay Off without Benefits	
41	Re-enrollment	

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Code	Description	Notes/Comments
43	Change of Location	Outbound Only Use this code to indicate a change of address.
59	Non Payment	Outbound Only
AA	Dissatisfaction with Office Staff	
AB	Dissatisfaction with Medical Care/Services Rendered	
AC	Inconvenient Office Location	
AD	Dissatisfaction with Office Hours	
AE	Unable to Schedule Appointments in a Timely Manner	
AF	Dissatisfaction with Physician's Referral Policy	
AG	Less Respect and Attention Time Given than to Other Patients	
AH	Patient Moved to a New Location	
AI	No Reason Given	Outbound Only
AJ	Appointment Times not Met in a Timely Manner	
AL	Algorithm Assigned Benefit Selection	
EC	Member Benefit Selection	Use this code for initial and subsequent enrollment when an insurance carrier needs to recognize that a member made an explicit plan choice.
XN	Notification Only	Outbound Verify Only Use this code in complete enrollment transmissions. This is used when INS03 is equal to 030 (Audit/Compare).
XT	Transfer	Use this code when a member has an organizational change (i.e. a location change within the organization) with no change in benefits or plan.

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Appendix B – Member Level Date Qualifiers (DTP01)

(Subject to change/addition by Gainwell, grayed out = not applicable.)

Code	Description	Notes/Comments
50	Received	Used to identify the date an enrollment application is received.
286	Retirement	
296	Initial Disability Period Return To Work	
297	Initial Disability Period Last Day Worked	
300	Enrollment Signature Date	
301	Consolidated Omnibus Budget Reconciliation Act(COBRA) Qualifying Event	
303	Maintenance Effective	This code is used to send the effective date of a change to an existing member's information, excluding changes made in Loop 2300.
336	Employment Begin	
337	Employment End	
338	Medicare Begin	
339	Medicare End	
340	Consolidated Omnibus Budget Reconciliation Act(COBRA) Begin	
341	Consolidated Omnibus Budget Reconciliation Act(COBRA) End	
350	Education Begin	This is the start date for the student at the current educational institution.
351	Education End	This is the expected graduation date the student at the current educational institution.
356	Eligibility Begin	The date when a member could elect to enroll or begin benefits in any health care plan through the employer. This is not the actual begin date of coverage, which is conveyed in the DTP segment at position 2700.
357	Eligibility End	The eligibility end date represents the last date of coverage for which claims will be paid for the individual being terminated.
383	Adjusted Hire	
385	Credited Service Begin	The start date from which an employee's length of service, as defined in the plan document, will be calculated.
386	Credited Service End	The end date to be used in the calculation of an employee's length of service, as defined in the plan document.
393	Plan Participation Suspension	
394	Rehire	
473	Medicaid Begin	
474	Medicaid End	

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Appendix C – Race or Ethnicity Codes (DMG05-1)

Code	Description	Notes/Comments
7	Not Provided	
8	Not Applicable	
A	Asian or Pacific Islander	
B	Black	
C	Caucasian	
D	Subcontinent Asian American	
E	Other Race or Ethnicity	
F	Asian Pacific American	
G	Native American	
H	Hispanic	
I	American Indian or Alaskan Native	
J	Native Hawaiian	
N	Black (Non-Hispanic)	
O	White (Non-Hispanic)	
P	Pacific Islander	
Z	Mutually Defined	

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Appendix F – County Codes in Puerto Rico (N406)

CODE	COUNTY
004	Adjuntas
008	Aguada
012	Aguadilla
016	Aguas Buenas
020	Aibonito
024	Anasco
028	Arecibo
032	Arroyo
036	Barceloneta
040	Barranquitas
044	Bayamon
048	Cabo Rojo
052	Caguas
056	Camuy
060	Canovanas
064	Carolina
068	Catano
072	Cayey
076	Ceiba
080	Ciales
084	Cidra
088	Coamo
092	Comerio
096	Corozal
100	Culebra
104	Dorado
108	Fajardo
112	Florida
116	Guanica
120	Guayama
124	Guayanilla
128	Guaynabo
132	Gurabo
136	Hatillo
140	Hormigueros
144	Humacao
148	Isabela
152	Jayuya
156	Juana Diaz
160	Juncos
164	Lajas
168	Lares
172	Las Marias
176	Las Piedras
180	Loiza
184	Luquillo
188	Manati
192	Maricao
196	Maunabo
200	Mayaguez
204	Moca
208	Morovis
212	Naguabo
216	Naranjito
220	Orocovis
224	Patillas
228	Penuelas
232	Ponce
236	Quebradillas
240	Rincon
244	Rio Grande
248	SabanaGrande
252	Salinas
256	San German
266	San Juan
276	San Lorenzo
280	SanSebastian
284	Santa Isabel
288	Toa Alta
292	Toa Baja
296	TrujilloAlto
300	Utuado
304	Vega Alta
308	Vega Baja
312	Vieques
316	Villalba
320	Yabucoa
324	Yauco
000	OTHER STATE

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Appendix G – Plan Coverage Description (HD04)

Fields will be separated by pipe character " | ".

order	benefit information	value	size	+ pipe
1	MANAGED CARE REGION	1 char	1	2
2	PLAN TYPE (01 or 02) - GHIP (medicaid) and MASNP (medicaid and medicare)	01 or 02	2	3
3	COVERAGE CODE (AIJ/F will be a separate eligibility segment)	3 char	3	4
4	GROUP CODE	3 char	3	4
5	GROUP VIII INDICATOR	Y or N	1	2
6	EMERGENCY INDICATOR (00 = no, 01 = COVID19, 02 = COVID192) (future use TBD)	00,01,02	2	3
7	INCARCERATION INDICATOR (I = Incarcerated, A = AIJ, F = Forensic Psychiatric, space = not incarcerated)	I, A, F, SPACE	1	2
8	FOSTER CARE INDICATOR	Y or N	1	2
9	DOMESTIC ABUSE INDICATOR	Y or N	1	2
10	GENDER IDENTITY (M or F or U)	M, F, U	1	2
11	AUTO ASSIGNMENT INDICATOR Y/N (to a specific carrier)	Y or N	1	2
12	RAW RISK SCORE (123.5678)	8 char	8	9
13	MEMBER RISK SCORE (as provided by actuary and stored in PRMMIS) (123.5678)	8 char	8	9
14	RATE CELL - 8/31 will be derived based on ASES rules until post P3	3 char	3	3
			35	49

Field 1 Managed Care Region is required for 834 inbound. Check Appendix I for valid Managed Care values.

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Appendix H – Member Reporting Category Reference ID (2750 REF02)

Fields will be separated by pipe character " | ".

order	ADDITIONAL MEMBER IDENTIFICATION DATA	value	size	+ pipe
1	ENROLLMENT CONFIRMATION	Y or N	1	2
2	PLAN VERSION	3 char	3	4
3	TRADING PARTNER id of previous carrier	9 char	9	10
4	ACTIVE STATE POLICE	Y or N	1	2
5	POLICE SPOUSE	Y or N	1	2
6	POLICE CHILD < 26 YRS OLD	Y or N	1	2
7	REHABILITATION CENTER	Y or N	1	2
8	MENTAL HEALTH FACILITY	Y or N	1	2
9	ADOPTION ASSISTANCE	Y or N	1	2
10	HOMELESS	Y or N	1	2
11	UNIVERSITY EMPLOYEE	Y or N	1	2
12	PUBLIC CORPORATION EMPLOYEE	Y or N	1	2
13	PUBLIC EMPLOYEE OR PENSIONER	Y or N	1	2
14	EMPLOYMENT MUNICIPALITY	3 char	3	3
			26	39

Note: Employment Municipality contains the municipality which is the same as county. See Appendix F for values.

Field 1 Enrollment Confirmation is required for 834 Inbound
Field 2 Plan Version is required for 834 Inbound for MAO (Platino carriers).

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Appendix I – Managed Care Region

Region	Puerto Rico Region Name
A	North
B	Metro-North
E	East
F	North-East
G	South-East
Z	West
J	San Juan
S	South-West
P	Virtual Region

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Change Summary

Version 1.3 Revision Log
Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 05-05-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
			Gainwell		Removed DRAFT watermark
	47	HD04	Gainwell		Removed "TBD ASES" from field 3 – coverage code
			Gainwell		Removed Appendix D and Appendix E as not applicable for PRMP
	8	Scope	Gainwell		Corrected EDI HelpDesk email address.
	40	Appendix A	Gainwell		Removed "DRAFT" and changed statement to "Subject to change/addition by Gainwell, grayed out = not applicable."
	42	Appendix B	Gainwell		Removed "DRAFT" and changed statement to "Subject to change/addition by Gainwell, grayed out = not applicable."

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Version 1.2 Revision Log
Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Approved by:__________ Date: 04/17/2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
ALL					Added column "Req'd" to indicate fields required for 834 INBOUND.
	47	Appendix G, HD04	Gainwell		Removed "TRADING PARTNER id of previous carrier". Added "Raw Risk Score". Removed comment regarding rate cell calculation as it will be a part of 834. Moved Managed Care Region to order #1 and renumbered. This data element is required on INBOUND 834.
2750	48	Appendix H, Loop 2750	Gainwell		Added "Enrollment Confirmation". Added "Plan Version".. Added "TRADING PARTNER id of previous carrier". Renumbered. Added notes regarding INBOUND required data elements.
		Title Page Footer	Gainwell		Changed version to 1.2 and updated other references to April instead of March.
2310	34	NM106 Provider Name Prefix	Gainwell	PCP1 PCP2	Added this as a place to indicate add/change for PCP1 or PCP2
	49	Appendix I	Gainwell		New to identify Managed Care Region valid values

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EMR

Version 1.1 Revision Log
Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: ____________

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission
	11-12		Gainwell		10/27/2022: Revised file name conventions
	9	834 Audit File 834 Changes File	Gainwell		02/01/2023: Corrected INS01 to INS03
	45	Appendix G HD04	Gainwell		02/03/2023: Removed "plan version" from HD04, Appendix G, and renumbered
	9	834 Changes File	Gainwell		Removed sentence *"Membership spans should not be used to process changes (INS03 = 001)."* as it does not provide any value.
		Appendix G HD04	Gainwell		03/07/2023: Added data element #14 for Trading partner id of previous carrier
			Gainwell		03/07/2023: Version changed to "1.1"

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ADDENDUM 3

*.820 Premium Payment Companion Guide and Prempay ADJ File Layout

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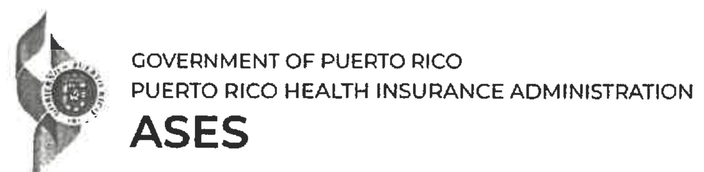

Puerto Rico Medicaid Enterprise - Health Insurance Plans

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Companion Guide

Instructions related to the ASC X12 Payroll Deducted and Other Group Premium Payment For Insurance Products (820) transaction, based on the 005010X218 Implementation Guide for the Issuers contracted by the the Puerto Rico Health Insurance Administration (ASES) Act No. 72, for the following Health Insurance Plans: Government Health Plan (GHP) known as *Plan Vital*, and Medicare Advantage Special Needs Plan (MA-SNP) known as *Medicare Platino*

Version 1.0.2
February 01, 2023

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1 Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

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3 Revision History

Version	Date	Description
v1.0	10/28/2022	First version published for review.
v1.0.1	11/16/2022	Adjustments to Loop 2300B to Include PMG NPI and PMG Location Id and also instructions for transactions where the Risk Score does not apply.
v1.0.2	02/01/2023	Inclusion of appendix 7.4 to include new rate cell codes V15 - CHIP Non Dual Aged, Blind, Disabled V16 - Commonwealth Non Dual Aged, Blind, Disabled

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4 Introduction

4.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

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

4.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

4.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

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4.4 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

4.5 Updates

Changes to this guide are published on the ASES website: https://www.asespr.org

4.6 Contacts

See the ASES website for contact information: https://www.asespr.org

4.7 Conventions

Most of the companion guide is in table format (see example below). Only loops, elements, or segments with clarifications or comments are listed. For further information, please see the TR3 for the transaction.

a) Convention Example

Page	*Loop*	*Reference*	*Name*	*Codes*	*Notes/Comments*
56	1000A	N1	Premium Receiver's Name		
56		N101	Entity Identifier Code	PE	PE - Payee
56		N102	Payee Organization Name		Value = Carrier's organization legal name
57		N103	Identification Code Qualifier	F1	F1 - Federal Taxpayer's Identification Number
57		N104	Payee's Tax Identification Number		Value = Carrier's Federal Tax Id

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b) Convention Fields

Column Name	*Description*
Loop	Loop Number
Reference	Segment Reference
Name	Segment Name, Segment Element
Codes	Standard Codes used
Comments	Comments or clarifications, values, data length, and repeats are also listed here. Clarifications in field length only indicate what ASES uses or returns to process the transaction. ASES still accepts the minimum and maximum field lengths required by the TR3 for each element.
Page	Page of the TR3 on which the loop, segment, or element is listed.

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5 Transaction 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

5.1 Control Segments

5.1.1 Header

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
C.3		None	ISA	Interchange Control Header		
C.4	2/2		ISA01	Authorization Information Qualifier	00	00 - No authorization information present
C.4	10/10		ISA02	Authorization Information		Filled with 10 spaces
C.4	2/2		ISA03	Security Information Qualifier	00	00 - No Security Information Present
C.4	10/10		ISA04	Security Information		Filled with 10 spaces
C.4	2/2		ISA05	Interchange ID Qualifier	30	30 - US Federal Tax Identification Number
C.4	15/15		ISA06	Interchange Sender Id		Value = 660500678
C.5	2/2		ISA07	Interchange ID Qualifier	ZZ	ZZ - Mutually Defined
C.5	15/15		ISA08	Interchange Receiver Id		Value = Trading Partner ID
C.5	6/6		ISA09	Interchange Date		The date format is YYMMDD
C.5	4/4		ISA10	Interchange Time		The time format is HHMM

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
C.5	1/1		ISA11	Repetition Separator		
C.5	5/5		ISA12	Interchange Control Version Number	00501	00501 - Standards Approved for Publication by ASC X12
C.5	9/9		ISA13	Interchange Control Number		
C.6	1/1		ISA14	Acknowledgement Requested		
C.6	1/1		ISA15	Interchange Usage Indicator	P,T	P - Production Data T - Test Data
C.6	1/1		ISA16	Component Element Separator		
C.7		None	GS	Functional Header		
C.7	2/2		GS01	Functional Identifier Code		
C.7	2/15		GS02	Application's Sender Code		Value = 660500678
C.7	2/15		GS03	Application's Receiver Code		Value = Trading Partner ID
C.7	8/8		GS04	Date		Functional Group creation date, The date format is CCYYMMDD
C.8	4/8		GS05	Time		Functional Group creation time, The time format is HHMM
C.8	1/9		GS06	Group Control Number		Value = ASES assigned control number formatted as YYMMDD-CC (YY year MM month DD day - CC carrier code)
C.8	1/2		GS07	Responsible Agency Code	X	X - Accredited Standards Committee X12

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
C.8	1/12		GS08	Version / Release / Industry Identifier Code		Value = 005010X218

5.1.2 Trailer

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
C.9			GE	Functional Group Trailer		
C.9	1/6		GE01	Number of Transactions Sets Included		1
C.9	1/9		GE02	Group Control Number		1+SYSTEM DATE(YYMMDD)
C.10			IEA	Interchange Control Trailer		
C.10	1/5		IEA01	Number of Included Functional Groups		1
C.10	9/9		IEA02	Interchange Control Number		SYSTEM DATE (YYMMDD)+001

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5.2 Transaction Segments

5.2.1 Header

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
35			ST	820 Header		
35	3/3		ST01	Transaction Set Identifier Code	820	820 - Payment Order / Remittance Advice
35	4/9		ST02	Transaction Set Control Number		Value = ASES assigned control number formatted as YYDDDCCPP (YYDDD julian date format CC carrier code PP Plan type)
35	1/35		ST03	Implementation Convention Reference		Value = 005010X218
36			BPR	Financial Information		
37	1/2		BPR01	Transaction Handling Code	I	I - Remittance Information Only
37	1/18		BPR02	Monetary Amount		Value = Total Premium Payment Amount
38	1/1		BPR03	Credit/Debit Flag Code	C	C - Credit
38	3/3		BPR04	Payment Method Code	NON	NON - Non Payment Data
40	10/10		BPR10	Originating Company Identifier		Value = 660500678
42	8/8		BPR16	Date		Value = Check Issue or EFT Date

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
43			TRN	Reassociation Trace Number		
43	1/2		TRN01	Trace Type Code	3	3 - Financial Reassociation Trace Number
43	1/50		TRN02	Reference Identification		Value = Check or EFT Trace Number
44	10/10		TRN03	Originating Company Identifier		Value = 660500678
48			REF	Premium Receiver Identification Key		
48	2/3		REF01	Reference Identification Qualifier	18	14 - Plan Number
49	1/50		REF02	Premium Receiver Reference Identifier		Value = ASES assigned code for the carrier's health plan
50			DTM	Process Date		
50	3/3		DTM01	Date/Time Qualifier	009	009 - Process
50	8/8		DTM02	Payer Process Date		Value = Date expressed as CCYYMMDD
56		1000A	N1	Premium Receiver's Name		
56	2/3		N101	Entity Identifier Code	PE	PE - Payee
56	1/60		N102	Payee Organization Name		Value = Carrier's organization legal name
57	1/2		N103	Identification Code Qualifier	FI	FI - Federal Taxpayer's Identification Number
57	2/80		N104	Payee's Tax Identification		Value = Carrier's Federal Tax Id

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
				Number		
64		1000B	N1	Premium Payer's Name		
64	2/3		N101	Entity Identifier Code	PR	PR - Payer
64	1/60		N102	Payer Name		Value = ASES
65	1/2		N103	Identification Code Qualifier	FI	FI - Federal Taxpayer's Identification Number
65	2/80		N104	Payer Identifier		Value = 660500678

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5.2.2 Detail

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
105		2000B	ENT	Remittance Information		
106	1/6		ENT01	Assigned Number		It will begin with 1 and be incremented by one each time an ENT is used in the transaction.
106	2/3		ENT02	Entity Identifier Code	2J	2J - Individual
106	1/2		ENT03	Identification Code Qualifier	34	34 - Social Security Number
106	2/80		ENT04	Identification Code		Value = Member's Social Security Number
107		2100B	NM1	Individual Name		
107	2/3		NM101	Entity Identifier Code	IL	Insured or Subscriber
108	1/1		NM102	Entity Qualifier Type	1	1 - Person
108	1/60		NM103	Name Last		Value = Member's First Last Name (if there is a second last name separate by |)
108	1/35		NM104	Name First		Value = Member First Name
108	1/25		NM105	Name Middle		Value = If available, it will be sent. It will always be a single character
109	1/2		NM108	Identification Code Qualifier	N	N - Insured's Unique Identification Number
109	2/80		NM109	Individual Identifier		Value = Members's Medicaid Id Number (11 digits)
112		2300B	RMR	Individual Premium Remittance Detail		
112	2/3		RMR01	Reference Identification	AZ	AZ - Health Insurance Policy Number

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
				Qualifier		
113	1/50		RMR02	Reference Identification		The field will be populated with multiple values separated by "|". The values correspond to: - Member's MPI (13 digits) - Member's PMG NPI (10 digits) - Member's PMG Location Id (9 digits) Notes: - PMG NPI and Location Id are optional for Medicare Platino and Virtual Population. - PMG Location Id refers to the *Medicaid Id* assigned to the provider per each service location.
113	1/18		RMR04	Detailed Premium Payment Amount		Value = Payment Amount
113	1/18		RMR05	Billed Premium Amount		Required when the insurer sent an Invoice and the paid amount is different than the amount invoiced. If not required by this implementation Guide do not send.
114			REF	Reference Information		
114	2/3		REF01	Reference Information Qualifier	ZZ	ZZ - Mutually Defined

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
114	1/50		REF02	Reference Identification ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número		The field will be populated with multiple fields separated by "|". The fields are: - Transaction Type (size = 3) - Internal Control Number (ICN) (size = 18) - Payment Category (size = 4) - Payment Reason (size = 3) - Rate Cell Code (size = 3) - Risk Score Factor (size = 8) Notes: - The ICN for a Reverse Transaction will be the original transaction ICN - Risk Score Factor is only submitted for Plan Vital Capitation Payments (Payment Category = CP01)
115			DTM	Individual Coverage Period		Required when the premium payer is not paying from an invoice, but paying on account for a coveraged period. If not required by this implementation guide do not send.
115	3/3		DTM01	Date/Time Qualifier	582	582 - Report Period
76	2/3		DTM05	Date Time Period Format Qualifier	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD
76	1/35		DTM06	Date Time Period		Value = Coverage Period
117			ADX	Individual Premium Adjustment for Current		Required when the paid amount differs from the billed amount (RMR05 is present) in the related RMR

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
				Payment		segment. If not required by this implementation guide do not send.
117	1/18		ADX01	Adjustment Amount		Adjustment amount, signed if negative.
118	2/2		ADX02	Adjustment Reason Code	52, 53, H6	52 - Credit for Previous Overpayment 53 - Remittance for Previous Underpayment H6 - Partial Payment Remitted

6.2.3 Trailer

Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
78			SE	Transaction Set Trailer		
78	1/10		SE01	Transaction Segment Count		Value = Refer to TR3
78	4/9		SE02	Transaction Set Control Number		Value = ASES assigned control number formatted as YYDDDCCPP (YYDDD julian date format CC carrier code PP Plan type)

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6 Appendixes

6.1 Transaction Types

Code	*Description*
PAY	Payment
REV	Reversal

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6.2 Payment Categories

Code	*Description*
CP01	Capitation Payment
CP02	Capitation Payment - Medicaid Wraparound
SP01	Maternity Delivery Kick Payment
SP02	Correctional Facility Hospital Case Payment

6.3 Payment Reasons

Code	*Description*
000	Regular Payment
001	Rate Adjustment
002	Rate Cell Change Adjustment
003	Deceased Member Adjustment
004	Reconciliation Adjustment

6.4 Rate Cell Codes

6.4.1 Capitation Payment

The following codes are for coverage periods previous to January 01, 2023

Code	Rate Cell
01	CHIP Age 0
02	CHIP Age 1-6
03	CHIP Age 7-13
04	CHIP Age 14+
05	CHIP Diabetes
05	CHIP Pulmonary
07	CW Age 0
08	CW Age 1-6
09	CW Age 7-13
10	CW Cancer
11	CW Diabetes / Low Cardio
11	CW Diabetes / Low Cardio
12	CW Female Age 14-18
13	CW Female Age 19-44
14	CW Female Age 45+
15	CW High Cardio
16	CW Male Age 14-18
17	CW Male Age 19-44
18	CW Male Age 45+
19	CW Pulmonary
20	CW Renal
21	Dual A
22	Dual AB
23	Foster or Domestic Abuse

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Code	Rate Cell
24	Medicaid Age 0
25	Medicaid Age 1-6
27	Medicaid Cancer
27	Medicaid Cancer
28	Medicaid Diabetes / Low Cardio
29	Medicaid Female Age 14-18
30	Medicaid Female Age 19-44
31	Medicaid Female Age 45+
31	Medicaid Female Age 45+
32	Medicaid High Cardio
33	Medicaid Male Age 14-18
34	Medicaid Male Age 19-44
35	Medicaid Male Age 45+
36	Medicaid Pulmonary
37	Medicaid Renal
38	Medicaid Platino
40	CW Platino
43	PRPL CHIP Age 0
44	PRPL CHIP Age 1-6
45	PRPL CHIP Age 7-14
46	PRPL CHIP Age 14+
47	PRPL Medicaid Age 0
48	PRPL Medicaid Age 1-6
49	PRPL Medicaid Age 7-13
50	PRPL Medicaid Female Age 14-18
51	PRPL Medicaid Female Age 19-44
52	PRPL Medicaid Female Age 45+
53	PRPL Medicaid Male Age 14-18
54	PRPL Medicaid Male Age 19-44
55	PRPL Medicaid Male Age 45+

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Code	Rate Cell
56	Transferred Medicaid Age 0
57	Transferred Medicaid Age 1-6
58	Transferred Medicaid Age 7-13
59	Transferred Medicaid Cancer
60	Transferred Medicaid Diabetes / Low Cardio
60	Transferred Medicaid Diabetes / Low Cardio
61	Transferred Medicaid Female Age 14-18
62	Transferred Medicaid Female Age 19-44
63	Transferred Medicaid Female Age 45+
64	Transferred Medicaid High Cardio
65	Transferred Medicaid Male Age 14-18
66	Transferred Medicaid Male Age 19-44
67	Transferred Medicaid Male Age 45+
68	Transferred Medicaid Pulmonary
69	Transferred Medicaid Renal
70	Transferred CHIP Age 0
71	Transferred CHIP Age 1-6
72	Transferred CHIP Age 7-13
73	Transferred CHIP Age 14+
74	Transferred CHIP Diabetes
75	Transferred CHIP Pulmonary

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The following codes are for coverage periods on or after January 01, 2023

Code	Rate Cell
V01	Medicaid - Age 18 and under

Code	Rate Cell
V02	Medicaid Age 19+
V03	Medicaid Non Dual Aged, Blind, Disabled
V04	CHIP All Ages
V05	Commonwealth - Age 18 and under
V06	Commonwealth - Age 19+
V11	Dual A
V12	Dual AB
V13	Foster or Domestic Abuse
V15	CHIP Non Dual Aged, Blind, Disabled
V16	Commonwealth Non Dual Aged, Blind, Disabled

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6.4.2 Capitation Payment - Medicaid Wraparound

The following codes are for coverage periods previous to January 01, 2023

Code	Rate Cell
38	Medicaid Platino
40	CW Platino

The following codes are for coverage periods on or after January 01, 2023

Code	Rate Cell
P01	Medicaid Platino
P02	CW Platino

6.4.3 Case Rate Payments

The following codes are for coverage periods previous to January 01, 2023

Code	Rate Cell
39	Medicaid Maternity Kick Payment
41	CHIP Maternity Kick Payment
42	CW Maternity Kick Payment
90	Correctional Facility Hospital Case

The following codes are for coverage periods on or after January 01, 2023

Code	Rate Cell
V07	Medicaid Maternity Kick Payment
V08	CHIP Maternity Kick Payment
V09	CW Maternity Kick Payment
V10	Correctional Facility Hospital Case

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6.5 File Naming Convention

Files sent out to the carriers will use the following naming conventions:

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Premium Payment Transactions: [PYYYYMM_CCPT_SS.820]

File Name Part	Meaning
P	Fixed Text for Payment Identifier
YYYY	Year
MM	Month
_	Fixed Text for Separator
CC	Carrier Code
PT	Plan Type
_	Fixed Text for Separator
00	Month payment sequence starting in 00
.820	File Extension Identifier

Example: P202301_0101_00.820

Outbound 820 for pay date 01/01/2023 for Carrier 01 Plan Type 01.

ADDENDUM 4

CARRIER to ASES

ver 4.1C_rev.20230221

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Carrier to ASES Data Submissions

New File Layouts

Version 4.1C

February 21, 2023

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MedInsight@asespr.org

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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.

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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.

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.

Version 4.0C

Claims Transaction Handling requirements were modified for reversals and adjustments.
Data File Naming Conventions requirements were modified.
Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for providers/groups that do not qualify for an NPI.
Encounter Lag Reports requirements were added.
Capitation Adjustments specifications and Capitation Input File Layout fields were modified.
CLAIMSERVICES Input File Layout new field added, and field description was modified.
ATTACHMENT II - CARRIER CODES – updated
Descriptions and/or validation rules of the Municipality and Region fields were added, for Outside of Puerto Rico.

Version 4.1C

Descriptions and/or validation rules were added to the CLAIMSERVICES and Capitation Input File Layouts, to the Plan Type related fields, applicable to Government Employee Carriers.
Descriptions and/or validation rules were added to the CLAIMSERVICES, to the Primary Center field, applicable to claims for Plan Version 970.
ATTACHMENT IV - PLACE OF SERVICE CODES – updated
ATTACHMENT VI – PLAN VERSION LIST – updated

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IPA Code Deliverable Data Format at IPA, CAPITATION and NETWORK Input File Layouts were changed.
Specialty and Specialty Code fields at NETWORK Input File Layouts were changed.

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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:

- must include the claim id of the original claim to be adjusted or reversed, at the field named Original Claim Id Number, and
- may have the same claim ID and line number or a different claim ID and 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.

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On the other hand, if an encounter needs to be submitted as a Fee For Service claim the carrier must:

- reverse the original service, by submitting the reversal with a claim line status code of 'R' and the same values as the original claim for the following fields: claim ID, service line number and Original Claim Id Number
- submit a new Fee for Service claim record, that may have the same claim ID and line number or a different claim ID and line number.

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. In addition, the IPA and Provider files shall include the IPA and providers associated with currently submitted capitation 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,
- any "Out of Network" providers included on the CLM file,
- all providers included on the CAP file (only applicable for the Provider File and excluding PMGs).

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. Consequently, for providers that don't qualify to obtain an NPI by the nature of its business, the carrier may submit the Tax Id of the provider as the PROV_ID to which the capitation payment is made. The carrier will have to present an official notification to ASES of every provider that was reported with a Tax Id in lieu of an NPI.

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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.

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

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for the provider / member / experience date with the amount(s) to be added or subtracted from the previously reported amount(s), specifically for the following fields: Capitation Amount, Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent. 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, a Capitation Amount of -$10.00, and the corresponding adjustments to the Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent fields as well. 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, Capitation and Encounter Lag Reports

Carriers are required to submit encounter, claims and capitation payment reports, called lag reports, on a monthly basis. These reports will be used to reconcile the data submitted. Claims and capitation data that do not match the lag reports on paid amount, and/or encounter claims data that do not match the lag reports on record counts within a reasonable percentage will be deemed invalid and must be corrected.

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The claims and capitation 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_"		
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

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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

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South	201801	201802	242.22
North	201801	201803	70,989.16
…	…	…	…

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

1. Count of Claims records representing encounters 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,
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:

ENCOUNTERLAG_ccyymms.xls(x)

Where:

Characters 1-13	Always "ENCOUNTERLAG_"		
Characters 14-15	cc	=	Carrier Code (See attachment II)
Characters 16-17	yy	=	Last two digits of year
Characters 18-19	mm	=	Month – last full paid month in the lag.
Character 20	s	=	sequence number of file submission.
Character 21	Always "."		
Characters 22-24(25)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

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

Claim Type	Region	Incurred Month	Paid Month	Encounters Count
Medical	East	201801	201801	5,000
Medical	South	201801	201802	24,200
Medical	North	201801	201803	7,654
…	…	…	…	…

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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.

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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

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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 be compressed and 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.zip

Where:	Character 1	Always "**D**"		
	Characters 2-3	**cc**	=	Carrier Code (See attachment II)

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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

Characters 13-16 .zip = Extension code identifying a compressed file

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.ZIP
Providers	D9918040.PRV.ZIP
IPA	D9918040.IPA.ZIP
Capitation	D9918040.CAP.ZIP
Network	D9918040.NET.ZIP

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

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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 "O" = Outside Puerto Rico	**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" or "O". **For plan type "04", "05", "06" and "09" value must be "X".**

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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 **07 = Commercial non-Law 95** **08 = Advantage non-Law 95** **09= LAW 95 Pensioned Police**	**XX**	Required **Must equal "01", "02", "03", "04", "05", "06", "09"** 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 Government Employee Carrier ID for ELA-GHP ("ELA Puros"). **Values of "07" or "08" must correspond to carrier, which is not plan type "01"-"06" or "09".** **Value "09" must correspond to government employee carrier ID for Pensioned Police.**
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", "06" and "09" (Government Employee) Not required for Plan Type "01", "02", or "03".
5	claim_id	**Claim ID**	Unique Identification number within Carrier for the claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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".
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.

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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
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

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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
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", except on claims from plan version 970. 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

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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.
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.

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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
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.

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CLAIMSERVICES INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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.
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.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
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.
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.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
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.
49	Icd_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	Icd_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.

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
51	Icd_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	Icd_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.
53	Icd_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	Icd_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.

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
55	Icd_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	Icd_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.
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.

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
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.
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

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
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.
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".

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
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"
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.

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
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.

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#	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", "09" 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.

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#	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.

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#	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.

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#	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.

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#	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

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#	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","09"**

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#	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" , "06" or "09".**
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", "06" or "09"**
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", "06" and "09"** 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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	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.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
142	original_claim_id	**Original Claim ID Number**	For adjustments or reversals, must be the original claim ID reported by the carrier.	**X(20)**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A" or "R". Right justified. For claims without adjustment or reversal, this field must be left blank. Left justified, blank filled to 20 characters if value is less than 20 characters.
143	Filler	End of Record Filler	Fixed filler with "*"	**X**	Required Must be = "*"

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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

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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

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#	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".

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#	*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.

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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. For Pharmacy claims must be blank
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".

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#	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

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#	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

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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(10)**	**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

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EMR

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					580

ADMINISTRACION DE SEGUROS DE SALUD
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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; except for the adjustments or reversals that must be the unique ID previously reported. This number is used to avoid duplicated Capitation records.	**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	**lpa**	**IPA ID**	**Carrier assigned ID of IPA/HCO. This must be filled when IPA/HCO is involved (Must always be filled for Plan Type "01" by MCOs/TPAs)**	**X(10)**	**Required if Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier and found in the IPA file. Left justified, blank field to the right.**

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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 "O" = Outside Puerto Rico	**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" or "O". **For plan type "04", "05" "06" and "09", 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 For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
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.

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CAPITATION INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
13	member_suffix	**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 2 digits (numeric) ADMINISTRACION DE SEGUROS DE SALUD № 24-0003 Contrato Número
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.
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.

CAPITATION INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
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 № 24-0003 Contrato Número
19	days	**Capitation days**	Number of days included in capitation amount.	S99	Required Must be a number 3 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 2 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

CAPITATION INPUT FILE LAYOUT

#	Field	Name	Description	Deliverable Data Format	Validation Rules
20	mem_percent	**Capitation percentage**	Percentage (days / month days)	**S999**	Required Must be a number 4 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 3 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
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 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
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					193

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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(10)**	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

ADMINISTRACION DE SEGUROS DE SALUD
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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'.

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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 (first). See Specialty Code description in Attachment III**	**X(40)**	**Optional**
19	specialty_code	**Specialty Code**	**Provider Specialty (first). 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

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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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
RECORD LENGTH					962

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENTS

ADMINISTRACION DE
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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

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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

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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

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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	O	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	O

* 0666 is valid only for use with Municipality Service on CLAIMSERVICES Input File and/or Municipality on CAPITATION Input File.

NOTE: Any municipality code may appear in region SPECIAL.

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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	(discontinued) 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
37	(discontinued) Salud Dorada con Medicare	Medicare Platino

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
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
62	ABARCA	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	(discontinued) Ryder Health Plan, Inc.	Government Employee
75	Triple-S Salud Inc.	Government Employee

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ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
76	(discontinued) BHP	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	(discontinued) MAPFRE	Government Employee
79	MCS Life Insurance Company	Government Employee
80	(discontinued) 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	(discontinued) Molina Healthcare of Puerto Rico, Inc.	Government Employee
87	Triple-S Advantage	Government Employee
88	(discontinued) MMM-First Plus	Government Employee
89	(discontinued) Panamerican Life Insurance Group (PALIG)	Government Employee
90	(discontinued) Delta Dental	Government Employee
91	MMM Multi Health, LLC	Government Employee
95	(discontinued) FHC	MBHO
96	(discontinued) American Health Medicare	Government Employee

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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

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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)
44	Infectious Disease

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ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
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
66	Rheumatology
67	Occupational Therapy

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ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
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
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology

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ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
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
DD	Dentist
DF	Dialysis Facility
EC	Emergency Care Facility
EN	Endodontist

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ATTACHMENT III - SPECIALTY CODES

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

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ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Z4	Cardiovascular Surgery Program

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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 Provided Other than in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.**
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. (e.g., emergency shelters, individual or family shelters).**
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	**Telehealth Provided in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.**
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.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
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.
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.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
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
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.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
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.
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.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
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	**Non-residential Opioid Treatment Facility**	**A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).**
59	Unassigned	N/A
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

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
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.

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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

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ATTACHMENT VI – PLAN VERSION LIST

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	09	100				Plan Vital
01	09	110				Plan Vital
01	09	120				Plan Vital
01	09	130				Plan Vital
01	09	220				Plan Vital
01	09	230				Plan Vital
01	09	300				Plan Vital
01	09	310				Plan Vital
01	09	320				Plan Vital
01	09	330				Plan Vital
01	09	970				Encarcelados
01	10	100				Plan Vital
01	10	110				Plan Vital
01	10	120				Plan Vital
01	10	130				Plan Vital
01	10	220				Plan Vital
01	10	230				Plan Vital
01	10	300				Plan Vital
01	10	310				Plan Vital
01	10	320				Plan Vital
01	10	330				Plan Vital
01	10	970				Encarcelados
01	12	100				Plan Vital
01	12	110				Plan Vital
01	12	120				Plan Vital
01	12	130				Plan Vital
01	12	220				Plan Vital
01	12	230				Plan Vital
01	12	300				Plan Vital
01	12	310				Plan Vital
01	12	320				Plan Vital

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	12	330				Plan Vital
01	12	970				Encarcelados
01	13	100				Plan Vital
01	13	110				Plan Vital
01	13	120				Plan Vital
01	13	130				Plan Vital
01	13	220				Plan Vital
01	13	230				Plan Vital
01	13	300				Plan Vital
01	13	310				Plan Vital
01	13	320				Plan Vital
01	13	330				Plan Vital
01	13	970				Encarcelados
02	29	004				Medicare Platino - MA-SNP
02	29	005				Medicare Platino - MA-SNP
02	29	014				Medicare Platino - MA-SNP
02	29	015				Medicare Platino - MA-SNP
02	29	017				Medicare Platino - MA-SNP
02	29	018				Medicare Platino - MA-SNP
02	29	019				Medicare Platino - MA-SNP
02	29	020				Medicare Platino - MA-SNP
02	29	023				Medicare Platino - MA-SNP
02	29	024				Medicare Platino - MA-SNP
02	29	025				Medicare Platino - MA-SNP
02	29	026				Medicare Platino - MA-SNP
02	33	005				Medicare Platino - MA-SNP
02	33	006				Medicare Platino - MA-SNP
02	33	007				Medicare Platino - MA-SNP
02	33	008				Medicare Platino - MA-SNP
02	33	009				Medicare Platino - MA-SNP
02	33	010				Medicare Platino - MA-SNP
02	33	015				Medicare Platino - MA-SNP

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	33	016				Medicare Platino - MA-SNP
02	33	017				Medicare Platino - MA-SNP
02	33	018				Medicare Platino - MA-SNP
02	33	019				Medicare Platino - MA-SNP
02	33	020				Medicare Platino - MA-SNP
02	34	003				Medicare Platino - MA-SNP
02	34	004				Medicare Platino - MA-SNP
02	34	011				Medicare Platino - MA-SNP
02	34	012				Medicare Platino - MA-SNP
02	34	029				Medicare Platino - MA-SNP
02	34	030				Medicare Platino - MA-SNP
02	34	031				Medicare Platino - MA-SNP
02	34	032				Medicare Platino - MA-SNP
02	34	035				Medicare Platino - MA-SNP
02	34	036				Medicare Platino - MA-SNP
02	34	043				Medicare Platino - MA-SNP
02	34	044				Medicare Platino - MA-SNP
02	34	045				Medicare Platino - MA-SNP
02	34	046				Medicare Platino - MA-SNP
02	34	047				Medicare Platino - MA-SNP
02	34	048				Medicare Platino - MA-SNP
02	34	049				Medicare Platino - MA-SNP
02	34	050				Medicare Platino - MA-SNP
02	34	051				Medicare Platino - MA-SNP
02	34	052				Medicare Platino - MA-SNP
02	34	053				Medicare Platino - MA-SNP
02	34	054				Medicare Platino - MA-SNP
02	34	055				Medicare Platino - MA-SNP
02	34	056				Medicare Platino - MA-SNP
02	42	005				Medicare Platino - MA-SNP
02	42	006				Medicare Platino - MA-SNP
02	42	007				Medicare Platino - MA-SNP

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	42	008				Medicare Platino - MA-SNP
02	42	013				Medicare Platino - MA-SNP
02	42	014				Medicare Platino - MA-SNP
02	42	015				Medicare Platino - MA-SNP
02	42	016				Medicare Platino - MA-SNP
02	42	017				Medicare Platino - MA-SNP
02	42	018				Medicare Platino - MA-SNP
02	42	019				Medicare Platino - MA-SNP
02	42	020				Medicare Platino - MA-SNP
02	42	021				Medicare Platino - MA-SNP
02	42	022				Medicare Platino - MA-SNP
02	42	023				Medicare Platino - MA-SNP
02	42	024				Medicare Platino - MA-SNP
02	46	003				Medicare Platino - MA-SNP
02	46	004				Medicare Platino - MA-SNP
02	46	005				Medicare Platino - MA-SNP
02	46	006				Medicare Platino - MA-SNP
02	46	007				Medicare Platino - MA-SNP
02	46	008				Medicare Platino - MA-SNP
02	46	011				Medicare Platino - MA-SNP
02	46	012				Medicare Platino - MA-SNP
02	46	013				Medicare Platino - MA-SNP
02	46	014				Medicare Platino - MA-SNP
02	46	015				Medicare Platino - MA-SNP
02	46	016				Medicare Platino - MA-SNP
02	46	017				Medicare Platino - MA-SNP
02	46	018				Medicare Platino - MA-SNP
02	46	019				Medicare Platino - MA-SNP
02	46	020				Medicare Platino - MA-SNP
02	46	025				Medicare Platino - MA-SNP
02	46	026				Medicare Platino - MA-SNP
02	46	027				Medicare Platino - MA-SNP

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	46	028				Medicare Platino - MA-SNP
04	71	401	Oro	Regular	MCO	
04	71	402	Plata	Regular	MCO	
04	71	402	Altenativa 1 Plata	Regular	MCO	
04	71	404	Alternativa 2 Rubi	Regular	MCO	
04	71	405	Diamante	Regular	MCO	
04	71	407	Mandatoria	Regular	MCO	
04	71	408	Alterno 1	Regular	MCO	
04	71	409	Alterno 2	Regular	MCO	
06	71	400	Coverage 400 (ELA)	Regular	HMO	
09	71	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	72	501	Oro	Regular	HMO	
05	72	502	Plata	Regular	HMO	
05	72	503	Bronce	Regular	HMO	
05	72	504	Rubi	Regular	HMO	
05	72	505	ELA Flex	Auto-Enrollment	HMO POS	
05	72	506	ELA Relax	Auto-Enrollment	HMO POS	
05	72	507	MMM ELA Relax (HMO-POS)	Auto-Enrollment	HMO	
05	72	508	MMM ELA Premium (HMO-POS)	Auto-Enrollment	HMO	
05	72	509	MMM ELA Advantage	Auto-Enrollment	HMO	
05	72	510	ELA CASH	Regular	HMO	
05	72	511	ELA GRANDE	Regular	HMO	
05	72	512	ELA DINAMICO	Regular	HMO	
04	75	401	Oro	Regular	MCO	
04	75	402	Plata	Regular	MCO	
04	75	403	Bronce	Regular	MCO	
04	75	404	Rubi	Regular	MCO	
04	75	405	Diamante	Regular	MCO	
04	75	406	Complementaria de Medicare	Regular	MCO	
04	75	407	Mandatoria Universal	Regular	MCO	
04	75	408	Alterna 1 Equilibrio	Regular	MCO	
06	75	400	Coverage 400 (ELA)	Regular	HMO	

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
09	75	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	77	501	Oro	Regular	HMO	
05	77	502	Plata	Regular	HMO	
05	77	503	Bronce	Regular	HMO	
05	77	504	Rubi	Regular	HMO	
05	77	505	PR I	Auto-Enrollment	HMO	
05	77	506	PR II	Auto-Enrollment	HMO	
05	77	507	PR III	Auto-Enrollment	PPO	
05	77	508	US Acess Only	Auto-Enrollment	HMO	
05	77	509	HMO FL	Auto-Enrollment	HMO	
05	77	510	ELA Rubí MAX	Auto-Enrollment	HMO	
05	77	511	ELA HMO Bronce	Auto-Enrollment	HMO	
05	77	512	ZAFIRO		HMO	
05	77	513	Basic Deluxe		HMO	
04	78	401	Oro	Regular	MCO	
04	78	402	Plata	Regular	MCO	
04	78	403	Bronce	Regular	MCO	
04	78	404	Rubi	Regular	MCO	
04	78	405	Diamante	Regular	MCO	
04	78	406	Complementaria de Medicare	Regular	MCO	
04	78	407	Mandatoria	Regular	MCO	
04	78	408	Alterno 1	Regular	MCO	
04	78	409	Alterno 2	Regular	MCO	
05	79	501	Oro	Regular	HMO	
05	79	502	Plata	Regular	HMO	
05	79	503	Bronce	Regular	HMO	
05	79	504	Rubi	Regular	HMO	
05	79	505	ELA Crédito	Auto-Enrollment	HMO	
05	79	506	ELA Ahorro	Auto-Enrollment	HMO	
05	79	507	ELA Crédito Rubí	Auto-Enrollment	HMO	
05	79	508	ELA ENLACE ACERO OSS-PDS	Auto-Enrollment	HMO	
05	79	509	Gobierno Ahorro	Auto-Enrollment	HMO	

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
05	79	510	ELA TE AYUDA OSS-PDS	Regular	HMO	
05	79	511	ELA MAXIMO OSS-PDS	Regular	HMO	
05	79	512	ELA Gobierno Extra	Regular	HMO	
04	80	401	Oro	Regular	MCO	
04	80	402	Plata	Regular	MCO	
04	80	403	Bronce	Regular	MCO	
04	80	404	Rubi	Regular	MCO	
04	80	405	Diamante	Regular	MCO	
04	80	406	Complementaria de Medicare	Regular	MCO	
04	80	407	Mandatoria	Regular	MCO	
04	80	408	Alterno 1	Regular	MCO	
04	80	409	Alterno 2	Regular	MCO	
04	80	410	Mandatorio ULTRA	Regular	MCO	
04	80	411	Alternativa 1 MAX	Regular	MCO	
04	80	412	Alternativa 2 FIT	Regular	MCO	
04	82	403	Bronce	Regular	MCO	
04	82	404	Alternativa 1 Premium ELA RUBI	Regular	MCO	
04	82	405	Diamante	Regular	MCO	
04	82	406	Complementaria de Medicare	Regular	MCO	
04	82	407	Alternativa 2 Classic ELA RUBI	Regular	MCO	
04	82	408	Alterno 1	Regular	MCO	
04	82	409	Alterno 2	Regular	MCO	
06	82	400	Coverage 400 (ELA)	Regular	HMO	
09	82	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	87	501	Oro	Regular	HMO	
05	87	502	Plata	Regular	HMO	
05	87	503	Bronce	Regular	PPO	
05	87	504	Rubi	Regular	HMO	
05	87	505	ELA Royal	Auto-Enrollment	HMO	
05	87	506	ELA Óptimo	Auto-Enrollment	HMO	
05	87	507	ELA Royal Plus	Auto-Enrollment	HMO	
05	87	508	ELA Titán	Auto-Enrollment	HMO	

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Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
05	87	509	ELA Óptimo Plus	Auto-Enrollment	HMO	
05	88	501	MMM ELA Advantage	Regular	PPO	
05	88	502	Plata	Regular	PPO	
05	88	503	Bronce	Regular	PPO	
05	88	504	Rubi	Regular	PPO	
05	88	505	Premium	Auto-Enrollment	PPO	
05	88	506	Premium 2	Auto-Enrollment	PPO	
05	88	507	Plus	Auto-Enrollment	PPO	
06	91	400	Coverage 400 (ELA)	Regular	HMO	
09	91	400	Coverage 400 (ELA)	Retired Policemen	HMO	

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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

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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.

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Addendum 5

Coordination Of Benefits (COB)

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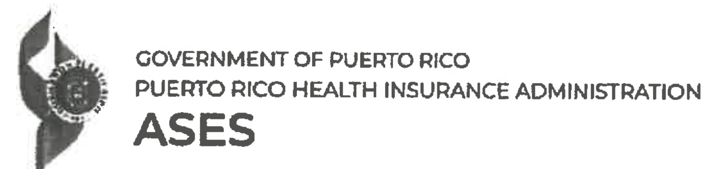

Puerto Rico Medicaid Enterprise - Health Insurance Plans

ASES COB Data Submissions (Third Party Liability)
Interface Control Document

ADMINISTRACION DE
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Change History

Version	Release	Author	Description of Change
1.8.1		ASES	Initial Document
1.8.2	03/01/2020	ASES	Field SSN Optional for INSURANCE_COVERAGE (C,G or F) Added Field MBI For Medicare Beneficiaries INSURANCE_COVERAGE (C,G or F)) please include the MBI number. The field size is 11 characters.
1.8.3	01/01/2023	ASES	Standardized Service Codesfor all Insurers

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Preface

This document is prepared to comply with the 27 Act of 2010 which add a new Article VIII Section 4 of Act No. 72 of September 7, 1993, as amended, known as the "Law of Health Insurance Administration of Puerto Rico."; establish a requirement for insurers and others to share information of eligibility with the Health Insurance Administration or its duly authorized Subcontractor; allow recovery of fees paid by the Administration, and for other purposes.

The insurer shall provide for the physical safeguarding of its Data processing facilities and the Systems and Information housed therein. The Insurer shall provide ASES with access to Data facilities upon ASES's request. The physical security provisions shall be in effect for the life of this Contract.

The Insurer shall ensure that the operation of all of its Systems is performed in accordance with Puerto Rico and Federal regulations and guidelines related to security and confidentiality of the protected information managed by the Insurer, and shall strictly comply with HIPAA Privacy and Security Rules, as amended, and with the Breach Notification Rules under the HITECH Act.

The Insurer will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the Data communications network inside of an Insurer's Span of Control.

The Insurer shall submit all reports electronically to ASES's FTP site unless directed otherwise by ASES. ASES shall provide the Insurer with access to the FTP site. The email generated by the FTP upload will be used as the time stamp for the submission of the report(s).

The Insurer Data transfers shall occur in standard format as prescribed by ASES and will be compliant with HIPAA and Federal regulations. The Insurer shall submit in formats as prescribed by ASES so long as ASES's direction does not conflict with any Federal law. With each submitted file the Insurer will include a Transmittal Sheet to indicate the record's totals submitted. See a Transmittal Sheet model in Appendix IV.

ASES will make available a secure FTP server, accessible via the Internet, for receipt of electronic files and reports from the Insurer. The Insurer shall provide a similar system for ASES to transmit files and reports deliverable by ASES to the Insurer. When such systems are not operational, ASES and the Insurer shall agree mutually on alternate methods for the exchange of files.

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1 Introduction

1.1 Coordination of Benefits (COB)

Some people who are beneficiaries of the Government Health Plan of Puerto Rico, which thrives on federal funds under certain circumstances may be eligible to receive benefits for a private plan or other health insurance funded by the Government of Puerto Rico. In accordance with applicable laws and federal guidelines, Medicaid is the payer of last resort and the rest of the remedies must be exhausted before resorting to the services under the Medicaid funds provided.

By provision of Public Law 109-171, the Federal Government will require governments of the states and territories beneficiaries of Medicaid funds, authorizing him to health insurers to share certain information with the State agency responsible for administering the program Medicaid. The collection of this information facilitates coordination of services and the sound administration of the funds received and ensures that Medicaid is not paying for care to be covered by another payer.

1.2 Data Validation Process

All files will pass through a validation process. Validation will check the basic structure of the file and its records and may result in a file being rejected. Such rejections may be caused for example, by file names which fail to follow the naming convention, a file containing wrong length records, wrong field coding or other basic tests.

All files which are rejected will be notified to the Insurer with an explanation of why the file is rejected. No records from such a file will be retained in the system and the Insurer will be required to resubmit 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.

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1.3 General Notes on data layout 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 9(7)v99 where v represents an 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 9(7)v99 where v represents an implied decimal 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

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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	[ ]

2 File Naming Convention

All data files to be delivered to ASES by the Insurers must follow the naming conventions below. Files which do not fit the naming convention will be ignored and the Insurer 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 Insurer, dates and file type. If not named correctly the file cannot be processed properly.

The general format of file names will be – **cccyymms.fff**

Where:	Character 1-3	ccc	=	Insurer Code (See attachment I)
	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

COB for COORDINATION OF SERVICES

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Files are always dated for the month being reported. For example, when sending coverage information in September 2013 the yymm part of the file name will be 1309 while the file will be sent to ASES in October.

Examples of completing this naming convention are –

For imaginary Insurer 096 in the files for COB in April 2013 will be named as follows –

Coordination of Services 09613040.COB

When the COB file is rejected, the corrected file will be re-submitted as

09612041.COB

The error log generated when the COB file is rejected will reference the rejected file name with ERR extension on it. The error file name will look as

09612041.ERR

All data files submitted must include a Transmittal Sheet with the following file name format.

The general format of file names will be – **Cccyymmdds-tr.xls**

Where:	Character 1-3	ccc	=	Insurer's Code(See attachment I)
	Character 4-5	yy	=	Last two digits of year
	Characters 6-7	mm	=	Month
	Characters 8-9			
	Character 10	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 …

Characters 11-13	Always "-tr"
Character 14	Always "."
Characters 15-17	Extension code identifying type of file (Always XLS)

XLS for MS EXCEL FILE FORMAT

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Examples of completing this naming convention are –

For imaginary Insurer 096 in the Transmittal Sheet for file submitted in April 23, 2013 will be named as follows –

Transmittal Sheet 0961304230-tr.XLS

Data File Text Format

All files should be generated using one of the following text formats:
utf-8 o
text/plain; charset=us-ascii
Include Windows EOL (End of Line) on each record.

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3 File Layout - Insurer COB File - COB Record

#	Field	Description	Pos	Size	Deliverable Data Format	Validation Rules
1	RECORD_TYPE	Record Type	1	1	"I" for Insurance	Required.
2	TRAN_ID	Insurance status with Insurer	2	1	A=Active, I=Inactive	Required.
3	PROCESS_DATE	Date of report. Last day of month.	3	8	MMDDYYYY	Required.
4	PROCESS_BEG_DATE	Identify the initial date that reflects the total time covered by the reported data.	11	8	MMDDYYYY	Required.
5	HEALTH_INSURER_CODE	Code that identifies Insurance Company	19	3	(See Appendix I)	Required.
6	GROUP_NUMBER	Group number	22	20	X(20)	Required. Must be left justified, blank filled to the right.
7	POLICY_NUMBER	Policy or Contract number.	42	20	Required.	
8	POLICY_EFFECTIVE_DATE	Start Date of Covered Individual's Primary Coverage by Insurer.	62	8	MMDDYYYY	Required.
9	POLICY_TERMINATION_DATE	End Date of Covered Individual's Primary Coverage.	70	8	MMDDYYYY	Required if the policy does have a termination date, otherwise leave blank.
10	INSURANCE_TYPE	Insurance Type	78	1	1=Private; 2=Medicare; 3=Medicaid	Required.

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#	Field	Description	Pos	Size	Deliverable Data Format	Validation Rules
11	INSURANCE_COVERAGE	Insurance Coverage	79	20	(See Appendix II) Include all coverage codes with Insurance for covered individual.Concatenate all codes.	Required. For Medicare coverage Plans use letter C,F or G only. DO NOT USE COMMAS TO SEPARATE CODES.
12	COVERED_SERVICES	Covered Services	99	20	(See Appendix III) Identify the Insurer's service type codes. Concatenate all codes.	Required. DO NOT USE COMMAS TO SEPARATE CODES.
13	SSN	Covered Individual's social security number.	119	9	(X9)	Required if INSURANCE_COVERAGE NOT in (C,G or F)
14	LAST_NAME_1	Covered Individual's first last name	128	25	X(25)	Required Must be left justified, blank filled to the right.
15	LAST_NAME_2	Covered Individual's second last name	153	25	X(25)	Required if he Individual has a Second Last Name. Must be left justified, blank filled to the right.
16	FIRST_NAME	Covered Individual's First Name	178	25	X(25)	Required Must be left justified, blank filled to the right.
17	MIDDLE_INITIAL	Covered Individual's Middle Initial	203	1	X(1)	Required if he Individual has a Middle Initial
18	RELATIONSHIP	Covered Individual's Relation to	204	1	1 = Policy Holder, 2 = Spouse, 3 = Child, 4 = Other, 5 =	Required.

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		Policy Holder			Domestic Partner	
19	DATE_OF_BIRTH	Covered Individual's Date of Birth	205	8	MMDDYYYY	Required.
20	GENDER	Covered Individual's Sex Code	213	1	0 - Unknown 1 - Male 2 – Female	Required.
21	RX_BIN	Pharmacy Insurance BIN.	214	6	X(6)	Required if INSURANCE_COVERAGE in (P,C or F)
22	RX_PCN	Pharmacy Insurance Processor Control Number (PCN).	220	10	Pharmacy Insurance Processor Control Number (PCN).	Required if INSURANCE_COVERAGE in (P,C or F)

#	Field	Description	Pos	Size	Deliverable Data Format	Validation Rules
23	RX_GROUP	Pharmacy Insurance Group ID.	230	15	Alternate Insurance Group ID	Required if INSURANCE_COVERAGE in (P,C or F)
24	MBI	Medicare Beneficiary Identifier (MBI)	245	11	X(11)	Required if INSURANCE_COVERAGE in (C,G or F)
25	*FILLER*	End of Record Filler	256	1	*	Required.
			256			
*** All are Text Fields						

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4 File Layout - Error COB File

#	Field	Pos	Size	Deliverable Data Format	Notes
1	RECORD_LINE	1	6	X(6)	Record line number.
2	ERROR_CODE	7	5	X(3)	Three digits error code
3	FIELD_NAME	12	25	X(25)	Field Name
4	DESCRIPTION	37	50	X(50)	Description
5	FILLER	87	1	*	End of Record Filler
		88			

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5 Appendixes

Appendix 1 - Insurer Codes

ASES Insurer Code	Legal Name
001	MEDICARE HOSP.Y AMBULATORIO - Parte A B
002	MMM HEALTHCARE, LLC
003	MEDICARE HOSP. - PARTE A
004	MMM HEALTHCARE, LLC
005	MCS ADVANTAGE, INC.
006	TRIPLE S ADVANTAGE, INC.
007	LA CRUZ AZUL DE PUERTO RICO
008	TRIPLE-S
009	MEDICARE AMBULATORIO - PARTE B
010	INTERNATIONAL MEDICAL CARD
011	ASOCIACION DE MAESTROS
012	HUMANA INSURANCE OF PUERTO RICO, INC.
013	COSVI DE P.R.
014	MCS
015	HOSPITAL DE LA CONCEPCIÓN
016	HUMANA
017	SERVICIOS DE SALUD BELLA VISTA
018	AUXILIO MUTUO
019	UNION TRABAJADORES DE MUELLES
020	GOLDEN CROSS HEALTH PLAN
021	PLAN DE SALUD MENONITA DE P. R.
022	AETNA LIFE INS. CO.
023	AMERICAN CENTRAL INVESTOR LIFE
024	AMERICAN FAMILY LIFE INSURANCE

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025	AMERICAN HOME ASSURANCE
026	ALLSTATES INSURANCE CO.
027	AMERICAN HARDWARE LIFE INS.
028	AMERICAN NATIONAL INS. CO.
029	ATLANTIC SOUTHERN INS. CO.
030	AMERICAN CENTRAL INVESTOR INS. CO.
031	ARGONAUT INS. CO.
032	CONFEDERATION LIFE INS. CO.
033	COMBINED INS. CO.
034	CROWN LIFE INSURANCE CO.
035	CONNECTICUT GENERAL LIFE INS. CO.
036	COOPERATIVA SEGUROS MULTIPLES
037	COMMUWEALTH INS. CO.
038	CONTINENTAL ASSURANCE CO.
039	CHAMPURS, BLUE SHIELD OF CALIFORNIA
040	CONFEDERATION LIFE GROUP HEALTH CLAIMS
041	GENERAL ACCIDENT AND INSURANCE CORP.
042	INTERCONTINENTAL LADIES GARMENT WORKERS
043	JOHN HANCOCK
044	LINCOLN NATIONAL LIFE INS. CO.
045	LA ATLANTICA
046	LINCOLN INCOME LIFE INS. CO.
047	MUTUAL LIFE INC.
048	MUTUAL LIFE INC.
049	MASSACHUSSETS MUTUAL LIFE INS. CO.
050	METROPOLITAN LIFE INS.
051	MONEY MUTUAL LIFE INS. OF N. Y.
052	NATIONAL LIFE INS. CO.
053	N.M.U. PENSION AND WELFARE PLAN
054	NEW ENGLAND MUTUAL LIFE INS. CO.

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055	NORTH AMERICAN CO. LIFE INS. CO.
056	NATIONAL HOME LIFE INS.
057	NEW YORK LIFE INS. CO.
058	OCCIDENTAL LIFE INS.
059	PROVIDENT LIFE AND ACCIDENT INS. CO.
060	PRUDENTIAL LIFE INS. CO.
061	PACIFIC MUTUAL LIFE INS. CO.
062	PUERTO RICAN AMERICAN INS. CORP.
063	PLAN UNION MARINOS MERCANTES
064	PILOT LIFE INS. CO.
065	PAN AMERICAN LIFE INS. CO.
066	PLAN DE SALUD U.I.A.
067	REPUBLIC NATIONAL LIFE INS. CO.
068	SEAFARES WELFARE MEDICAL PLAN
069	SUN LIFE ASSURANCE CO.
070	SALUD PREVENTIVA, INC.
071	SECURITY NATIONAL LIFE INS. CO.
072	STATE MUTUAL LIFE INS. CO. OF AMERICA
073	THE PRUDENTIAL INS. CO.
074	TRANS OCEANIC LIFE INS.
075	TRANS WORLD INS. CO.
076	THE BANKERS LIFE
077	THE CARBORUNDUM CO. OF P.R.
078	THE NEW YORK LIFE INS. CO.
079	THE HERFORD INS. CO.
080	THE MUTUAL LIFE INS. CO. OF NEW YORK
081	THE GUARDIAN LIFE INS. CO.
082	THE EQUITABLE LIFE ASSURANCE
083	THE TRAVELERS INS. CO.
084	THE MONEY MUTUAL LIFE INS. CO.
085	UNITED BENEFITS LIFE INS. CO.

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086	UNITED OF OMAHA
087	UNITED LIFE INS. CO.
088	SERVI MEDICAL
089	PLAN DE LA POLICIA
090	FIRST MEDICAL ADVANTAGE
091	AUXILIO MUTUO ADVANTAGE
092	RYDERS HEALTH PLAN
093	CIGNA
094	COSVI ADVANTAGE
095	MAPFRE ADVANTAGE
096	AMERICAN HEALTH MEDICARE
097	SALUD DORADA ADVANTAGE
098	MEDICARE PLATINO
099	OTRAS COMPANIAS ASEGURADORAS
100	ACCA
101	COVEL
102	FONDO DEL SEGURO DEL ESTADO
103	TRICARE
104	CIGNA PREFERED
105	CIGNA EXCLUSIVE
106	CANADA LIFE
107	CHAMPUS/CHAMPVA
108	MEDPLUS
109	COLVER
110	GLOBAL HEALTH PLAN
111	HOFFA
112	INTEGRATE COMMUNITY HEALTH
113	PROSALUD
114	INTERNATIONAL MANAGED CARE
115	MMM
116	NIÑOS LISIADOS (DEPT DE SALUD)

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117	OPTIONS
118	PALIC
119	PROSAM
120	UTM
121	UTI
122	UIA
123	UNITEDHEALTHCARE INS. CO.
124	SDM HEALTH MANAGEMENT, INC.
125	PHARMACY INSURANCE CORPORATION OF AMERICA
126	MCS ADVANTAGE, INC.
127	PROSALUD HMO, CORP.
128	FEDERACION DE MAESTROS DE PUERTO RICO
129	FIRST PLUS
130	DELTA DENTAL
131	CONSTELLATION HEALTH
132	MOLINA HEALTHCARE
133	ENVISION RX
134	CORRECTIONAL HEALTH SERVICES CORP.
135	OPTIMA HEALTH PR
136	MEDICARE FARMACIA - PARTE D
137	PLATINO - CONSTELLATION HEALTH
138	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
139	PLATINO - MCS CLASSICARE
140	MMM HEALTHCARE, LLC
141	PLATINO - PREFERRED MEDICARE CHOICE (PMC)
142	TRIPLE S ADVANTAGE, INC.

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Appendix 2 -Insurance Coverage

Code	Definition
A	Ambulance Services
R	Ambulatory Rehabilitation Services
D	Dental Services
T	Diagnostic Testing Services
E	Emergency Room Services
H	Hospitalization Services
M	Maternity and Prenatal Services
S	Medical and Surgical Services
C	Medicare Advantage Plans with prescription drug coverage
G	Medicare Advantage Plans without prescription drug coverage
F	Medicare stand-alone Part D Plans for prescription drug coverage
V	Mental Health Hospitalization Services
W	Mental Health Services
N	Non-Emergency Transportation Services (NEMT)
P	Pharmacy Services

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Appendix 3 - Services Type Codes

Code	Definition	COB Industry Code Equivalence (834)
A	Medical Care	1
B	Dental Care	35
C	Hospital - Inpatient	48
D	Hospital - Outpatient	50
E	Long Term Care	54

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F	Free Standing Prescription Drug	89
G	Mail Order Prescription Drug	90
H	Psychiatric	A4
I	Skilled Nursing Care	AG
J	Vision (Optometry)	AL
K	Partial Hospitalization (Psychiatric)	BB

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Appendix 4 - Error Codes

Error	Description
DTE	Data Type Error
EOL	End Of Line Error: Bad Filler
LEN	Unexpected Record Length
R1202	Unexpected NULL value for TRAN_ID field
R1204	Unexpected NULL value for PROCESS_DATE field
R1206	Unexpected NULL value for INSURANCE_TYPE field
R1208	Unexpected NULL value for INSURANCE_COVERAGE field
R1210	Unexpected NULL value for COVERED_SERVICES field
R1212	Invalid value for HEALTH_INSURER_CODE field
R1214	Unexpected NULL value for GROUP_NUMBER field
R1216	Unexpected NULL value for POLICY_NUMBER field
R1218	Unexpected NULL value for RELATIONSHIP field
R1220	Unexpected NULL value for RX_BIN field based on COVERED_SERVICES Field
R1222	Unexpected NULL value for RX_PCN field based on COVERED_SERVICES Field
R1224	Unexpected NULL value for RX_GROUP field based on COVERED_SERVICES Field
R1459	Unexpected NULL value for PROCESS_BEG_DATE field
R1479	Unexpected NULL value for GENDER field
R1481	Unexpected NULL value for SSN field
R1483	Unexpected NULL value for POLICY_TERMINATION_DATE field
R1485	Unexpected NULL value for POLICY_EFFECTIVE_DATE field
R1499	Invalid value for COVERED_SERVICES field
R562	Invalid value for GENDER field
R563	Invalid value for INSURANCE_COVERAGE field
R564	Invalid value for HEALTH_INSURER_CODE field
R565	Unexpected NULL value for RECORD_TYPE field

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R566	Invalid value for RELATIONSHIP field
R567	Invalid value for TRAN_ID field
R568	PROCESS_DATE is not set to the last day of the month
R569	Invalid value for PROCESS_BEG_DATE field
R570	Invalid value for GROUP_NUMBER field
R572	Unexpected NULL value for LAST_NAME_1 field
R573	Unexpected NULL value for FIRST_NAME field
R574	Invalid value for DATE_OF_BIRTH field
R575	Invalid value for POLICY_EFFECTIVE_DATE field
R576	Invalid value for POLICY_TERMINATION_DATE field
R577	Invalid value for INSURANCE_TYPE field
R578	Invalid value for SSN field
R571	Invalid value for POLICY_NUMBER field
R5632	Invalid value for COVERED_SERVICES field

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Appendix 3 - Transmittal Sheet

NOMBRE DE ASEGURADORA
HOJA DE TRAMITE ARCHIVOS COB
ENVIO DE ARCHIVOS

FECHA DE ENVIO:

ENVIADO A: ASES_COB@asespr.org

ENVIADO POR:

	USO ASEGURADORA				USO DE ASES	
	NOMBRE DEL ARCHIVO	NUMERO DE RECORDS	TAMAÑO ARCHIVO	VIA FTP	PROCESO EN ASES DD/MM/AA	INIC. OPERADOR
1		0	0	FTP Server		
2				FTP Server		
3				FTP Server		

PARA USO DE ASES

RECIBIDO EN ASES POR: FECHA: / /

******************INSTRUCCIONES ESPECIALES:*****************************

SE ENVIARA ESTA HOJA DE TRAMITE ADJUNTA AL ARCHIVO POR FTP
TIENE QUE LLENAR TODOS LOS ENCASILLADOS QUE LE CORRESPONDE A LA ASEGURADORA.

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Addendum 6

EFT Folder Organization
Insurance Carrier

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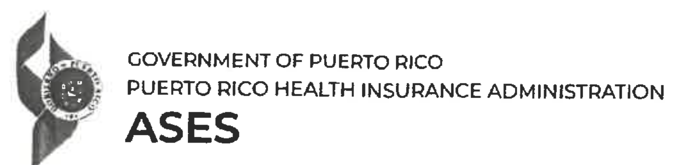

Puerto Rico Medicaid Enterprise - Health Insurance Plans

ASES Enterprise File Transfer (EFT) Folder Organization

Insurance Carrier

Version 1.1
Effective May 01, 2023

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- "Benefit Enrollment and Maintenance" Folder 8
- "Premium Payment" Folder 8
- Encounter Data Folder 9
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Document Information

Required Information	Description
Owner:	ASES
Date:	03/16/2023

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Revision History

Version	Date	Description of Change
1.0	10/01/2022	Initial Folder Structure
1.1	03/16/2023	Criteria to consider for law 95

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Preface

The purpose of this document is to describe how the folders are organized in the ASES Enterprise File Transfer (EFT) solution for the Data Exchange between ASES and the Insurance Carriers.

ASES EFT solution is also known as *"ASES Secure FTP"* and it's currently contracted with CITRIX which uses a secure FTP protocol.

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ASES EFT Location

The location for the ASES EFT solution (ASES Secure FTP) is in the following URL:

https://asessecurevdr.sharefile.com/

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Reporting Guidelines Folder

ASES publishes all reporting and data exchange guidelines in the following folder:

Reporting_Guidelines

Folder Organization

Here are how the files are organized for Insurance Carriers.

Folder Categories

Container Folders

[Environment Root Folder]

This is the primary access for the Data Exchange for a specific environment.

[Environment Root Folder] can be one of the following:

Production: ASES_FTP
Test: ASES_FTP_TEST

[Insurance Carrier Root Folder]

This is the Root Folder for an Insurance Carrier within the environment [Insurance Carrier Root Folder] will be replaced with the corresponding FTP_CarrierName assigned to the Insurance Carrier.

Regular Folder

This Folder contains files for ad-hoc for manual business processes.

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Automated Processing Folder

This Folder contains files for automated business processes.

Data Exchange Folders

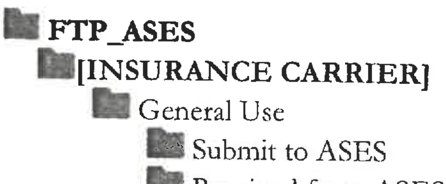
Within container folders there are Data Exchange Folders that identify the direction of the information been shared

Received From ASES:
These folders contain all data exchange the Insurance Carrier **receives from ASES**.

Received From ASES:
These folders contain all data exchange the Insurance Carrier **submits from ASES**.

"General Use" Folder

This folder is used for manual sharing of information that is not automated in any of the other folders. The "General Use" folder is located under the following path:

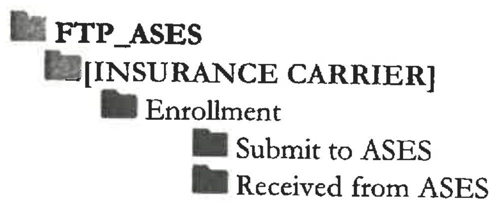


"Benefit Enrollment and Maintenance" Folder

This folder is used for sharing data associated with the Benefit Enrollment and Maintenance business processes.

- Received From ASES:
  - Enrollment Export Files (.EXP, .CNCL, .ALL)
- Submit to ASES:
  - Enrollment Effectuation Files (.SUS)
  - FAM95/MEM95
  - Coordination of Benefits (.COB)

The "Benefit Enrollment and Maintenance Folder" folder is located under the following path:



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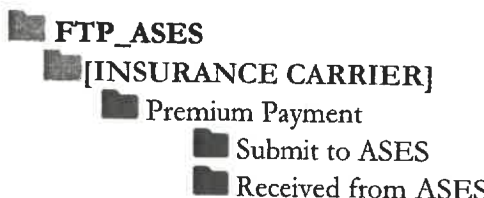
"Premium Payment" Folder

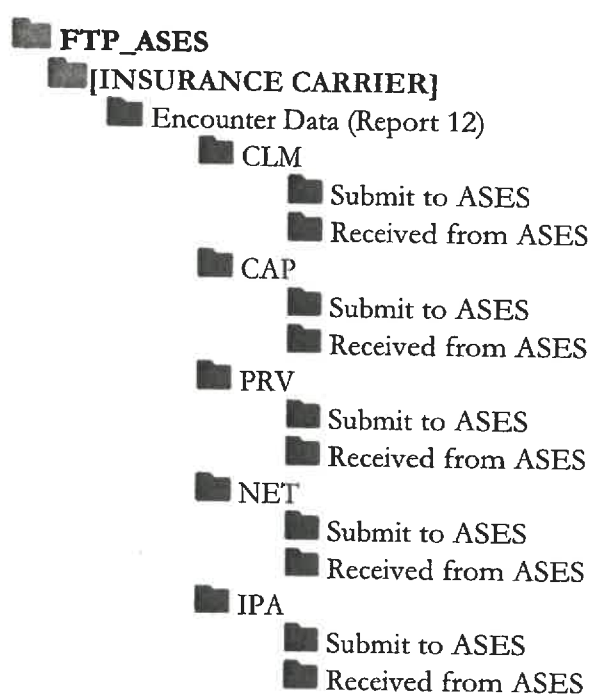
This folder is used for sharing data associated with the Premium Payment business processes.

- Received From ASES:
  - 820 Files
- Submit to ASES:
  - OTP Files

The "Benefit Enrollment and Maintenance Folder" folder is located under the following path:



Encounter Data Folder



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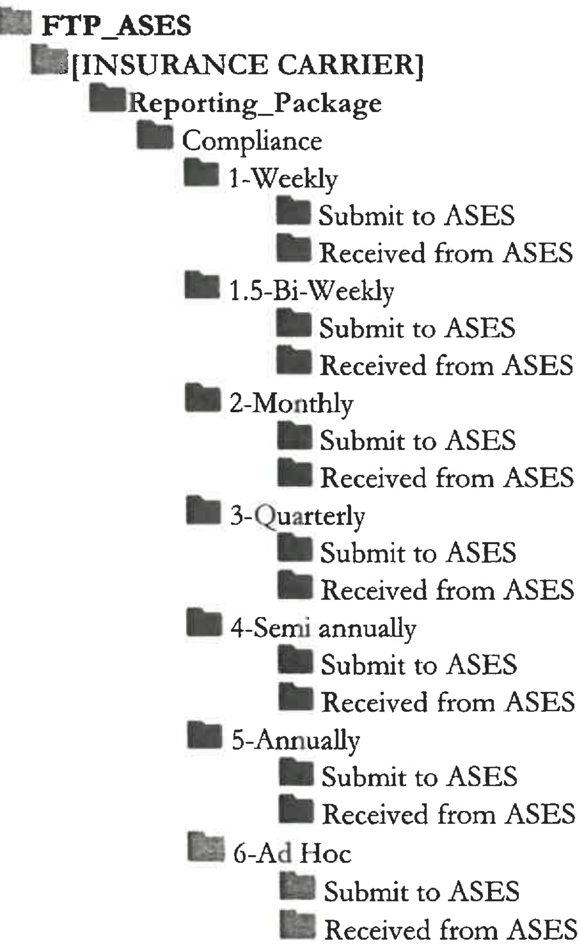
Reporting Package Folders

This folder is used for sharing information associated with the Reporting Package business processes as it is stated in the Reporting Guide.

An Example for the Compliance business process data exchange is as follows:



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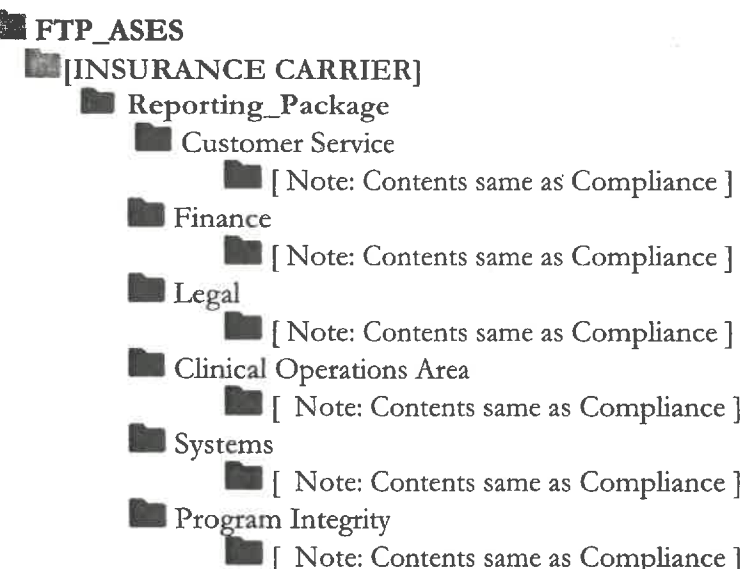
The other Reporting Packages business processes share the same structure:

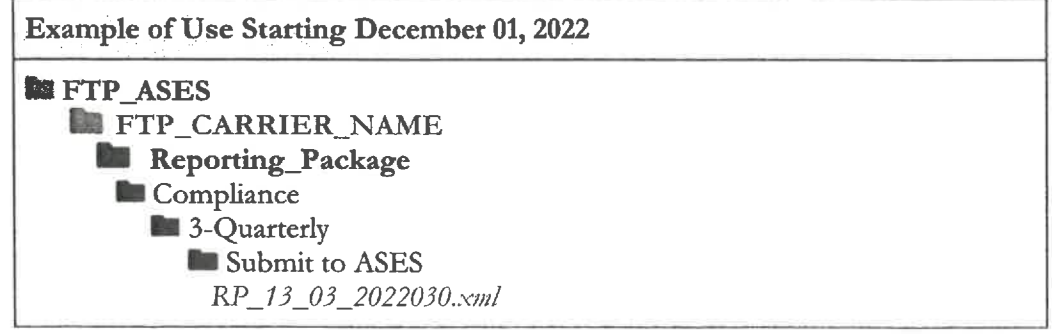


All contents for the *"Reporting_Package"* folders, are explained in the following guides shared by ASES:

- Plan Vital Reporting Guide
- Medicare Platino Reporting Guide
- Law 95 Reporting Guide

Example for Insurance Carrier submission (MCOs/MAOs):

Quarterly submission for report 03 "Fraud, Waste and Abuse": RP_13_03_2022030.xml. (Production Environment)



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Some Insurance Carriers used a different folder organization in the past. Please note that this <u>will no longer be supported:</u>

Example of Use Before December 01, 2022

Directorio para Reportes
    CARRIER_NAME
        Compliance
            3-Quarterly
                RP_13_03_2022030.xml

Other Guidelines

- No Entity other than ASES should create folders or subfolders without the written authorization of ASES, as they will be deleted without prior notice and files placed in a folder not authorized by ASES will not be considered received.

- For Test environments the folder structure will be the same as the Production Environment, except that the root folder will be as follows:
  - For QA Tests the root folder is:
    - FTP_ASES_TEST

  - For other required tests that are used in parallel, a specific structure can be created using a number after the word TEST, this environment will be created on demand. Example of root folders:
    - FTP_ASES_TEST01
    - FTP_ASES_TEST02

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