Attachment 9
Information System

Enrollment Manual

ENROLLMENT MANUAL
GHP

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TABLE OF CONTENTS

I. INTRODUCTION

The Puerto Rico Health Insurance Administration, hereinafter known as PRHIA or ASES, is a government corporation created in accordance with the Act No. 72 of September 7, 1993 as amended, also known as the "Puerto Rico Health Insurance Administration Act". PRHIA is created with the purpose of managing, negotiating and contracting of health plans that enable it to obtain, for its beneficiaries, particularly the medically needy, quality hospital and other medical services.

This document constitutes a reference manual, which establishes the requirements in the development of the systems, between the Information Systems Office of PRHIA and GHP Contractors, in accordance to the Government Health Plan (GHP) contract (Contract). This includes processes of eligibility, enrollment and premium payment. Any conflicts between this document and the applicable statutes, regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) or Contracts for the Provision of Physical and Behavioral Health Services under the GHP as between PRHIA and the GHP Contractors shall be resolved in favor of CMS guidance and such contracts, as amended.

Previously, a Contractor was assigned to each of the ASES regions and beneficiaries in each region could not select a Contractor or change Contractors unless they moved to another region. Beginning November 1, 2018, managed care organizations (MCOs) contracted with ASES under the GHP will cover enrollees island-wide, and enrollees will have choice of Contractors. To support implementation of the GHP program, all GHP enrollees up until September 30, 2018 will be auto-enrolled by ASES in Contractors based on an algorithm that considers the existing enrollee-provider relationships and household composition, among other factors. Enrollees will be notified of the Contractor's assignment. Those enrollees, along with New Enrollees certified during October 2018 which will have the opportunity to select a Contractor of their preference, will have the opportunity to change the Contractor assignment for any reason for the ninety (90) calendar day period between November 1, 2018, and January 31, 2019. New enrollees certified on or after November 1, 2018 will have the opportunity to select a Contractor of their preference and ninety (90) days from the certification date to opt for another selection.

II. DEFINITIONS

1. **Adjusted Payment:** Reversal of a payment that has been adjudicated during the payment process of a previous premium payment cycle.

2. **ASES:** Administración de Seguros de Salud de Puerto Rico (the Puerto Rico Health Insurance Administration (PRHIA)), the entity within the Government of Puerto Rico responsible for oversight and administration of the Government Health Plan (GHP) or its Agent.

3. **Auto-Assignment:** The assignment of an Enrollee to a PMG and a PCP by ASES, Contractor or Medicaid.

4. **Auto-Enrollment Process:** The Enrollment of a Potential Enrollee in a GHP Plan without any action by the Potential Enrollee, as provided in Article 5 of this Contract.

5. **Business Day:** Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. Puerto Rico's holidays, as defined in the Law for Compliance with the Fiscal Plan, Act No. 26 of April 29, 2017, or any other law enacted during the duration of this Contract regarding this subject, are excluded.

6. **Calendar Days:** All seven days of the week.

7. **Cancellation Date:** Is the date in which a member loses his or her eligibility for the GHP Program. The Medicaid Office is the only entity with the authority to cancel an enrollee's eligibility.

8. **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 Program (CHIP).

9. **Certification:** A decision by the Puerto Rico Medicaid Office, that a person is eligible for services under the GHP because the person is Medicaid Eligible, CHIP Eligible, or a member of the State Population.

10. **Certification Date:** As provided in Section 5.1.3 of this Contract, a decision by the Puerto Rico Medicaid Program that a person is eligible for services under the GHP Program because the person is Medicaid Eligible, CHIP Eligible, or a member of the State Population. Some public employees and pensioners may enroll in GHP without first receiving a Certification.

11. **Children's Health Insurance Program ("CHIP"):** The Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

12. **CHIP Eligible**: A child eligible to enroll in the GHP Program because he or she is eligible for CHIP.

13. **Contractor:** The Managed Care Organization that is a Party of this Contract, licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP program for the provision of Covered Services and Benefits to Enrollees on the basis of PMPM Payments.

14. **Coverage Code:** Code assigned by the Puerto Rico Medicaid Office to eligible beneficiaries, according to Federal, CHIP and State indigence criteria. Under GHP, the coverage code will coincide with the Plan Version.

15. **Covered Services:** Those Medically Necessary health care services (listed in Article 7 of this Contract) provided to Enrollees by Providers, the payment or indemnification of which is covered under this Contract.

16. **Daily Basis:** Each Business Day.

17. **Deemed Newborns:** Children born to a mother with Medicaid or CHIP eligibility on the date or delivery and are eligible from the date of birth. They will be granted an eligibility period of thirteen (13) months.

18. **Disenrollment:** The termination of an individual's enrollment in GHP or a Contractor. In the latter, the Enrollee will maintain their eligibility but will not be affiliated to any contractor.

19. **Domestic Violence Population:** Certain survivors of domestic violence referred by the Office of the Women's Advocate

20. **Dual Eligible Enrollee:** An Enrollee or potential enrollee eligible for both Medicaid and Medicare.

21. **Effective Date of Disenrollment:** The date on which an Enrollee ceases to be covered under the Contractor's plan, either because of an eligibility termination (cancellation) or because of a request for disenrollment coming from the MCO or from the Enrollee.

22. **Effective Date of Eligibility:** It is the start date of an eligibility period. It is assign by the Medicaid Office according to the evaluation performed and eligibility program determined (CHIP, Medicaid, State population).

23. **Effective Date of Contractor Change:** It is the start date of the enrollment of an enrollee in a selected Contractor. For changes made in the first twenty days of the month the Contractor enrollment will become effective in the first day of the month following the Contractor selection. For Contractor changes made after the first twenty days of the month the Contractor enrollment will be effective on the first day of the subsequent month (20 Days Rule).

24. **Enrollment Effective Date (Contractor Effective Date):** The date in which the eligible enrollee is enrolled in the contracted Contractor. This date considers the eligibility effective date or the Contractor change effective date.

25. **Enrollee Seed Sets:** These are groups of the GHP eligible by the auto-assignment algorithm execution date which are classified by their eligibility expiration date and Medicaid cancellation date. These groups are assigned to the contracted Contractors and define the delivery packages sent to the Contractors during the auto-assignment maintenance period.

26. **Eligibility:** Eligibility is determined by the Medicaid Office of the Puerto Rico Department of Health.

27. **Eligible Person:** A person eligible to enroll in the GHP Program, as provided in Section 1.3.1 of this Contract, by virtue of being Medicaid Eligible, CHIP Eligible, or an Other Eligible Person.

28. **Enrollee:** A person who is enrolled in a Contractor's GHP Plan, as provided in this Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 1.3.1 of the Contract.

29. **Enrollment:** The process by which an Eligible Person becomes an Enrollee of the Contractor's Plan.

30. **Federal Category:** Classification established by the Puerto Rico Medicaid Office for an Enrollee, according to established criteria of indigence levels. This category includes the population that benefits from the Medicaid and CHIP programs.

31. **Foster Care Population:** Children who are in the custody of the Department of Family's ADFAN Program and enrolled in the GHP.

32. **Government Health Insurance Plan (GHP):** The government health services program (formerly referred to as "La Reforma" or "MI Salud") offered by the Government, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health services.

33. **GHP Welcome Package:** The first welcome package that a Contractor sends to Enrollees upon enrollment.

34. **Health Insurance Claim Number (HICN):** Previously it was a Medicare enrollee's identification number and appeared in the enrollee's insurance card. A new Medicare Enrollee Identifier (MBI) replaced the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-049

35. **Identification Card (ID):** A card bearing an Enrollee's name, contract number, and co-payment amounts, and a customer service telephone number, which is used to identify the Enrollee in connection with the provision of services.

36. **Initial Auto-Enrollment:** The process by which an Eligible Person enrolled with a GHP contractor prior to November 1, 2018 is Auto-Enrolled with a contractor by ASES with an effective date of November 1, 2018.

37. **Initial Auto-Enrollment Enrollee:** An Eligible Person enrolled prior to November 1, 2018 with a GHP contractor who is Auto-Enrolled with a contractor by ASES with an effective date of November 1, 2018.

38. **Managed Care Organization (MCO):** An entity that is organized for the purpose of providing health care and is licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts with ASES for the provision of Covered Services and Benefits Island-wide on the basis of PMPM Payments, under the GHP program.

39. **MA-10:** Form issued by the Puerto Rico Medicaid Office, entitled "Notice of Action Taken or Application and/or Recertification" containing the Certification decision (whether a person was determined eligible or ineligible for Medicaid, CHIP, or the State Population).

40. **Medicaid:** The medical assistance federal/state joint government program established by Title XIX of the Social Security Act.

41. **Medicaid Eligible:** An individual eligible to receive services under Medicaid, who is eligible, on this basis, to enroll in the GHP Program.

42. **Medically Necessary Services:** Those services that meet the definition found in Section 7.2 of this Contract.

43. **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.

44. **Medicare Beneficiaries:** People older than sixty-five (65) years of age or disabled or people who have end state renal disease (ESRD), 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.

45. **Medicare Part A:** The part of the Medicare program that covers inpatient hospital stays, skilled nursing facilities, home health and hospice care.

46. **Medicare Part B:** The part of the Medicare program that covers physician, laboratories, outpatient, and preventive services.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-049

47. **Medicare Part C:** The part of the Medicare program that permits Medicare recipients to select coverage among various private insurance plans.

48. **Medicare Part D:** The Medicare prescription outpatient drug benefit.

49. **National Provider Identifier ("NPI"):** The 10-digit unique-identifier numbering system for Providers created by the Centers for Medicare & Medicaid Services (CMS), through the National Plan and Provider Enumeration System.

50. **Newborn:** A child born during the GHP eligibility period of his/her mother. For Federal beneficiaries the eligibility effective date corresponds to the date of birth or up to tree retroactive eligibility periods. For Commonwealth beneficiaries, the eligibility effective date corresponds to the certification date. It is required that the mother submit the newborn for Medicaid eligibility certification no later than ninety (90) days after the date of birth.

51. **New Enrollee:** An Eligible Person who became a Potential Enrollee after November 1, 2018..

52. **Open Enrollment:** A period of ninety (90) Calendar Days in which Enrollees have one (1) opportunity to select a different contractor, without cause, as set forth in Section 5.2.5 of the Contract.

53. **PCP Effective Date:** Date on which a PCP1 or PCP2 enrollment becomes effective.

54. **Plan Type:** Code 01 to identify members with GHP.

55. **Plan Version:** Product identification number that corresponds with the Plan Type. For GHP, the Plan Version will be the same as the code assigned to the beneficiaries by the Medicaid Office.

56. **PMPM Premium ("Per Member Per Month (PMPM)" Payment):** The fixed monthly amount that the Contracted Contractor is paid by ASES for each Enrollee to ensure that benefits under this contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.

57. **Potential Enrollee:** A person who has been certified by the Puerto Rico Medicaid Office as eligible to enroll in the GHP (whether on the basis of Medicaid Eligibility, CHIP eligibility or eligibility as a member of the Commonwealth Population), but who has not been yet enrolled with the Contracted Contractor.

58. **Primary Care Physician (PCP):** A licensed medical doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required Primary Care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician,, obstetrician/gynecologist, or pediatrician.

59. **Primary Medical Group (PMG):** 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 this Contract.

60. **Process Date:** For the export file (.exp) it is the date related to the daily run process. For the enrollment files (.sus) it is the date in which the changes in the enrollment records were processed at the Contractor.

61. **Prorated Payment:** A back payment that covers a fraction of the month prior to the month in which the premium payment is made. The prorated payments only apply to the Contractors specifically during the first eligibility month of the Commonwealth Population and newborns. The concept of prorated payments also applies to the adjusted payments considering the different reasons that trigger cancellations.

62. **Provider:** Any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

63. **Puerto Rico Medicaid Office (or "Medicaid Office"):** The subdivision of the Health Department that conducts eligibility determinations and offer a Contractor selection after a favorable outcome of such determination under GHP for Medicaid, CHIP, and the State Population programs.

64. **Recertification:** A determination by the Puerto Rico Medicaid Program that a person previously enrolled in the GHP subsequently received a Negative Redetermination Decision, is again eligible for services under the GHP Program..

65. **Redetermination:** The periodic Redetermination of eligibility of an individual for Medicaid, CHIP, or the State Population, conducted by the Puerto Rico Medicaid Program.

66. **Retroactive Payment:** Refers to a payment that corresponds to a period prior to the month in which the PMPM Payment is made.

67. **State Population (or "Commonwealth 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 listed in Section 1.3.1.2.1 of the contract.

68. **SYSPREM:** System that provides for the enrollment of an enrollee in historical data. It allows the update and/or enrollment of data that corresponds to eligibility periods prior to the cancellation period of the eligibility of an enrollee or before an enrollment to a different Contractor comes into effect.

III. MEDICAID ELIGIBILITY PROCESSES

A. Eligibility Determination

The Medicaid Office, which administers the Puerto Rico Medicaid Assistance Program, is the state plan agency with authority to determine whether a person is eligible to receive covered services under the GHP. Enrollees may be determined eligible to participate in the GHP as either a Federally-funded Medicaid beneficiary (Federal), Federally-funded CHIP beneficiary (CHIP), or be determined eligible as a State Population beneficiary (State). For both Medicaid and CHIP populations, eligibility criteria are established in the State Plan and in cooperation with CMS. For State beneficiaries, eligibility requirements are established by the Medicaid Program, except for public employees and pensioners included in Other Eligible Populations, which are determined by separate ASES policies.

B. MA-10

Pursuant to Section 5.1.2 of the Contract, the Puerto Rico Medicaid Program's determination that a person is eligible for the GHP is contained on Form MA-10, titled "Notification of Action Taken on Application and/or Recertification." A person who has received an MA-10 is referred to as a "Potential Enrollee."

The Potential Enrollee may access Covered Services using the MA-10 as a temporary Enrollee ID Card from the first day of the eligibility period specified on the MA-10 even if the person has not received an Enrollee ID Card. Only Medicaid, CHIP, and State Enrollees receive an MA-10 and may access Covered Services with the MA-10 as a temporary Enrollee ID Card. A Form MA-10 will be provided for each Household Potential Enrollee included in the Application and the authorized contact member.

The MA-10 form is valid for the eligibility period identified on Form MA-10 and may be used for a period of thirty (30) calendar days from the date of Certification for the purpose of demonstrating eligibility. See Attachment 9, MA-10 Form.

C. Effective Date of Eligibility

1. Federal Program Enrollee (Medicaid or CHIP)

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 Form MA-10.

The eligibility period specified on Form MA-10 may be a retroactive eligibility period which is up to three (3) months before the first day of the month in which the Potential Enrollee submits its eligibility application with the Medicaid Office for the Medicaid and CHIP populations only during which services can be retroactively covered. Retroactivity on the Effective Date of Eligibility is granted when the Potential Enrollee indicates that he/she incurred medical expenses prior to the current eligibility period, including any Medicaid or CHIP covered service(s) that is related to medications or services that elicit pharmacy expenses and that has not been paid for. The Effective Date of Eligibility will be within three (3) months before the month in which the Potential Enrollee is applying. If the Potential Enrollee is Medicaid or CHIP eligible in the month in which the service was eligible, the Potential Enrollee will be granted retroactive eligibility. The retroactive benefit does not apply to eligible State beneficiaries. Retroactive eligibility is evaluated to all Medicaid and CHIP Potential Enrollees that notify the Medicaid Office of their medical expenses and/or services utilization during the allowable three (3) month period. Note, a Potential Enrollee could be classified as a State Enrollee for their current eligibility period but be classified as a Federal Enrollee for any of the retroactive eligibility periods. The Medicaid Office will evaluate each retroactive month separately which may result, with different coverage code(s) or eligibility classification(s) from one retroactive month to another.

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.

A person may apply for Medicaid/CHIP on behalf of a person who has died during the same month in which they apply or up to three (3) months retroactively in the event the person would have been eligible in those months. The eligibility period will be from the first (1st) day of the month of the application until the date of death. This provision does not apply to State beneficiaries.

All Federal, CHIP and State pregnant women may have an eligibility period greater than twelve (12) months when adding the required sixty (60) days of postpartum coverage. The expiration date will be the last day of the month at the end of these sixty (60) days.

2. State Enrollees (State Category Beneficiaries)

The Effective Date of Eligibility for the State Population (see Section 1.3.1.2.1 of the Contract) is the eligibility period specified on the Form MA-10, and Potential Enrollees are eligible to be enrolled as of that date. Note, a Potential Enrollee could be classified as a State Enrollee for their current eligibility period but be classified as a Federal Enrollee for any of the retroactive eligibility periods. The Medicaid Office will evaluate each retroactive month separately which may result, with different coverage code(s) or eligibility classification(s) from one retroactive month to another.

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 Form MA-10. The State Enrollee may request a Contractor in the Medicaid Office for the new eligibility period at the time of certification.

All Federal, CHIP and State pregnant women may have an eligibility period greater than twelve (12) months when adding the required sixty (60) days of postpartum coverage. The expiration date will be the last day of the month at the end of these sixty (60) days.

D. Effective Date of Eligibility in the Case of Deemed Newborn

Table 1 Deemed Newborn's Eligibility Guidelines

Mother's Medicaid Classification	Child's Medicaid Classification	Child's Evaluation Outcomes	Eligibility Outcomes
Federal at the time of birth	Deemed Newborn	Federal Deemed Newborn	Retroactive Eligibility from the date of birth or from twelve (12) months back, whichever begins later
Evaluated and determined to be	Federally Evaluated	Federal/CHIP	Retroactive Eligibility from the date of birth or from

Mother's Medicaid Classification	Child's Medicaid Classification	Child's Evaluation Outcomes	Eligibility Outcomes
Federal at the time of birth			three (3) months back, whichever begins later
		Federal Deemed Newborn	Retroactive Eligibility from the date of birth or from twelve (12) months back, whichever begins later
Not Eligible or State or Evaluated and determined to be State at the time of birth	Independently Evaluated	Federal/CHIP	Retroactive Eligibility from the date of birth or from three (3) months back, whichever begins later
		State	Eligible from the Effective Date of Eligibility as noted on Form MA-10

As described in Table 1, if a mother is Federal at the time of birth the newborn is classified as a Deemed Newborn, enrolled in the mother's MCO and granted retroactive eligibility from the date of birth up to twelve (12) months. These cases will be identified in the eligibility record by including a letter 'N' (Deemed Newborn) in the second position in the Group Code field.

In the event that the mother is not currently eligible but is evaluated and found to be Federal at the time of the newborn's birth, the newborn will be evaluated for Federal eligibility and could be classified as either Federal, which would provide retroactive eligibility from the date of birth or from three (3) months back, whichever begins later, or Federal Deemed Newborn which would provide retroactive eligibility from the date of birth or from twelve (12) months back, whichever begins later.

If the mother, on the other hand, is not eligible or either State or Evaluated and determined to be State at the time of birth, the child will be evaluated independently. If the evaluation of the child results in federal classification, he or she will be granted retroactive eligibility from the date of birth or from three (3) months back, whichever begins later. If the result is State funded enrollment in the program, the child will be granted eligibility from the certification date.

E. Medicaid/CHIP Retroactive Eligibility

1. Medicaid/CHIP Retroactive Eligibility Period Effective Date

Under Medicaid or CHIP, the Effective Date of Eligibility corresponds to a retroactive period determined month by month. Each retroactive period or record shall correspond to one (1) calendar month. The Medicaid Office may grant up to four (4) eligibility periods for the same enrollee which may be comprised of three (3) retroactive periods and one (1) record for the current period. Each record of retroactivity will mark the beginning and end of the eligibility in relation to the period to which it corresponds. That is, each of the retroactive periods of eligibility granted will determine the start and completion of the Eligibility Effective Date for that particular period. See Table 1.

Retroactive eligibility periods prior to November 1, 2018 will correspond to the contracted MCO for the appropriate region according to the previous contract.

Retroactive Eligibility periods with effective date before Go Live will not be assigned a Contractor. For these cases, the Carrier, Carrier_eff_date, PCP, PCP_eff_date, PMG y PMG_eff_eff_date data fields will be left blank.

Table 2: Retroactive Eligibility Period Scenarios

Eligibility Period	X = indicates included period of each eligibility scenario						
Current Period	X	X	X	X			
Retroactive Period 1		X	X	X	X	X	X
Retroactive Period 2		X	X		X	X	
Retroactive Period 3		X			X		

2. Group of Records of Retroactive Periods

Each retroactive eligibility period involves a group of records. This information is sent to the Contractor on a daily basis in an Export (.exp) file. ASES could receive, for a single enrollee labeled as Federal (Medicaid, CHIP), up to three (3) retroactive eligibility enrollment records and one (1) current eligibility enrollment record in an enrollments file. A member may be eligible for one (1) to three (3) retroactive periods and not be eligible for the current term. In this case, sets of records for the retroactive periods may be received but none for the current eligibility period. Retroactive eligibility period will be from the first day of the month of retroactive eligibility until the last day of the month of retroactivity. An exception to this, will be first retroactive month for a newborn, which will begin with the date of birth.

Each retroactivity period is evaluated separately. That is the evaluation of the retroactive eligibility period is independent from that of the current period. A member

can have retroactive eligibility periods and not be currently eligible. Therefore, there can be a change in coverage from one period to the next.

Retroactive eligibility periods will be confirmed and sent to the Contractors in the daily eligibility file (.exp). Each period will have a group of records labeled with the '1', '2', '3' indicators in the *Tran_id* column. The indicators are unrelated to the order of the periods; they are only used to unify the group of records. These retroactive eligibility periods do not necessarily correspond to consecutives eligibility periods.

F. Enrollee Recertification

After a period of eligibility is granted to an Enrollee, two (2) or three (3) months in advance of the Eligibility Expiration Date, the Enrollee will undergo a Recertification Process, for a new eligibility period, that will be carried out by the Medicaid Office. This will allow the renewal of the covered services for the next period of twelve (12) months. The Re-certification Effective Date refers to the date Medicaid re-evaluates an Enrollee's eligibility. This date is provided on the Form MA-10. The Eligibility Expiration Date refers to the expiration date of the eligibility period granted to the enrollee by the Medicaid Office. A Federal and State enrollee which is recertified, will have its current eligibility period observed and will have a future Effective Date of Eligibility in the MA-10 for its next eligibility period which will start the next day after the current eligibility period expires.

G. Termination of Eligibility (Eligibility Cancellations)

Only the Medicaid Office may cancel and provide notice of the cancellation of an enrollee's eligibility. In the recertification process, all the beneficiaries that receive a negative eligibility determination for GHP will continue to be eligible to receive services under the GHP until the eligibility expiration date has been reached. The cancellation of health services transaction due to the expiration of the eligibility period will be notified by the Medicaid Office and will be reflected in the ASES databases on the last day of each month.

On a daily basis, ASES receives from Medicaid a file with the eligibility status of the beneficiaries. In such cases, ASES will send to the Contractors the contents of the files of those beneficiaries who have received a Negative Redetermination Decision within a period of twenty-four (24) hours or one (1) business day from the time it receives the file from the Medicaid Office. Note timeframes are subject to change at ASES, in the event of extraordinary circumstances, periods of maintenance or other unforeseen circumstances.

The termination of the eligibility period is marked by either the Expiration Date or the Medicaid Cancellation Date. At the moment of a certification or recertification of a member, an Expiration Date is established. If the eligibility of a member is extended for any of the reasons explained later in this document, the expected termination of such extension will

be expressed through the Medicaid Cancellation Date. Also, if the eligibility period of a member, extended or not, is terminated before the Expiration Date (for example, by the death of an enrollee, members identified in the PARIS file, or by voluntary resignation) or a previously stated Medicaid Cancellation Date (for example, by a pregnancy that ended prematurely), the date for the real cancellation of the eligibility period of a member will be stated in the Medicaid Cancellation Date. The ASES System identifies the cancellations, in the export file, with the letter "I" in the transaction_id field.

H. Appeals Processes

1. Appeals Process for Re-Certification

When an enrollee does not qualify during his/her re-certification process, he/she has the right to appeal his/her eligibility's negative redetermination within a term of fifteen (15) days. If a previously eligible Medicaid or CHIP member appeals within fifteen (15) days of an adverse eligibility determination, content "A" (In Appeal) or "X" will be sent to the insurance Contractor in the *Extension_flag* field. The member may not be cancelled during the appeals process even if the expiration date passes. When the appealing process is completed, Medicaid will send an update of the member's status to ASES. If the appeal is presented after the first fifteen (15) calendar days after the adverse eligibility determination, no extension will be issued. In this case, a cancellation will be received from Medicaid.

The following are the possible outcomes of the appeal process:

(a) If the appeal is found to be in favor of the enrollee: the expiration date will be updated to the appropriate one. He/she will be identified as eligible and the record marking the termination of the appeals process will be labeled with a "U" and will reflect a new eligibility period. If there were to be a change in coverage, a new enrollment with the new plan version must be sent, just as is currently done.

(b) If the appeal is found to be against the enrollee the Medicaid Office will send a cancellation with the original expiration date. He/she will be identified as ineligible, the termination of the appeals process will be labeled with an "N" and the Medicaid Cancellation Date will contain the corresponding cancellation date. The Contractor will keep offering services to the enrollee until it receives the cancellation in the eligibility file sent by ASES. ASES will continue paying premiums until the cancellation is received from Medicaid Office. Only Medicaid Office may cancel an enrollee. The cancellation's effective date will reflect the date that Medicaid specifies in the Medicaid Cancellation Date field if it differs from the eligibility expiration date.

(c) If the appeal is resolved only after a cancellation, the Contractor will receive the eligibility information only if the appeal is in favor of the enrollee and with updated dates with the new eligibility period.

2. Appealing at a Certification (either new or not active at the time)

If a person who is not active in the Medicaid Program requests eligibility and he/she does not qualify, he/she has the right to appeal the result of the evaluation. This type of appeal is an internal Medicaid Office process. The Medicaid Office will not send to ASES records of these processes unless the appeal is decided in the person's favor. In the case of Medicaid or CHIP eligible beneficiaries, a group of records will arrive with an effective date that may be retroactive to the first day of the month corresponding to the certification date. If more than three (3) months has passed, the Contractor will treat the enrollment as an emergency (*special enroll* = 'E'). For these cases, Medicaid will not send the retroactive eligibility in separate transactions. In the event the person is certified as a state funded State enrollee, the date of eligibility after a favorable appeal shall be prospective from the date of the favorable determination.

I. Eligibility Extensions

When Medicaid grants an eligibility extension, the date in which the extension expires is included in the Medicaid Cancellation Date field at the Family Eligibility table. For these cases, the Eligibility Expiration Date field is not updated since it encompasses the end of the original eligibility period granted by Medicaid before the extension.

1. Eligibility Extension Due to Pregnancy

If a pregnant woman is undergoing re-certification and she is determined to be ineligible, she cannot be terminated the last day of the month in which postpartum coverage expires. These cases will be labeled with the letter "P" in the *Extension flag* field. The Medicaid Office will send ASES a cancellation transaction at the appropriate point.

2. Eligibility Extension Due to Natural Disaster

If a natural disaster occurs, a determination will be made by the Department of Health's Medicaid Program to extend the eligibility of the population affected. The eligibility extension for natural disasters grants the extension period approved by CMS to the affected member. These cases will be labeled with the letter "H" in the *Extension flag* field. The Medicaid Office will send ASES an update transaction at the appropriate date. The granted extension's expected expiration date will be held in the Medicaid Cancellation Date field. The eligibility effective date and expiration date will not change because of the extension granted.

3. Beneficiaries With More Than One Extension Type

If an enrollee qualifies for more than one (1) type of extension, the extensions will be combined applying the extension with the longest eligibility period extension stated through the Medicaid Cancellation Date and the extension that grants the most benefits stated through the Extension Flag containing the appropriate Extension Code. For example, if an enrollee is granted the extension due to pregnancy and the extension due to a natural disaster, the extensions will be combined and his or her eligibility will be extended because of the natural disaster extension and will have the coverage benefits of the pregnancy extension.

4. Eligibility Extension Codes

N –Member eligibility period not extended
A – Member is amid an appeal process
U – Update to a member amid an appeal process. This states that the process has reached an outcome.
H – Member eligibility extended due to the occurrence natural disaster
P – Member eligibility extended due to pregnancy status

5. Member Eligibility Period Not Extended (N)

The enrollee does not have any type of extension. For these cases the Medicaid Cancellation Date cannot have a future date.

IV. ENROLLMENT IN GHP CONTRACTORS

A. General Enrollment Requirements

The Contractor must coordinate with ASES, the Medicaid Office and the Enrollment Counselor, as applicable, for all Enrollment and Disenrollment functions, as required under Section 5.2.1 of the Contract.

The Contractor must guarantee the maintenance, functionality, and reliability of all systems necessary for Enrollment and Disenrollment, pursuant to the Contract and this Manual.

B. Auto-Enrollment Algorithm

ASES developed an Auto-Enrollment algorithm, in accordance with the requirements in 42 CFR 438.54, designed to distribute the GHP population groups among GHP Contractors, with the goal of preserving the relationship of the Enrollees with their main healthcare providers. The algorithm prioritizes the enrollment of the High Cost High Need population, followed by the Dual Eligible Enrollees, Special Coverage Enrollees and the Non-Chronic Enrollees. The algorithm also seeks to keep Enrollees sharing a dwelling place with the same Contractor. The algorithm also takes into account Contractor capacity in order to accommodate enrollment changes and fluctuations during the initial enrollment periods. These considerations were factored in order to minimize Enrollee disruption as the GHP moves to an Island-wide delivery system while maintaining an equitable distribution of enrollment for all Contractors.

The Foster Care Population and Domestic Violence Population will be Auto-Enrolled in one contractor's plan and are not eligible to enroll into another contractor's plan.

C. Effective Date of Enrollment

The Effective Date of Enrollment for all Initially Auto-Enrolled Enrollees is November 1, 2018. Except as provided below, Enrollment, whether selected or automatic, will be effective as of the same date as the date demarking the beginning of the period of eligibility specified on Form MA-10 set forth in Section 5.2.6 of the Contract.

The Effective Date of Enrollment for a newborn whose mother is Medicaid or CHIP Eligible on the date of delivery (Deemed Newborn) is the date of his or her birth. The Effective Date of Enrollment for a newborn whose mother is a State Population Enrollee is the Effective Date of Eligibility established by the Puerto Rico Medicaid Program. A newborn shall be Auto-Enrolled pursuant to the procedures set forth in Section 5.2.7 of the Contract.

Changes in Enrollment requested by the Enrollee received during the first twenty (20) Calendar Days of the month will be effective the first Calendar Day of the following month (e.g., requests received January 10 will be effective February 1).

Changes in Enrollment received after the first twenty (20) Calendar Days of the month will be effective the first Calendar Day of the second month following the request to change Enrollment (e.g., requests received January 25 will be effective March 1).

D. Term of Enrollment

The Term of Enrollment with the Contractor shall be a period of twelve (12) consecutive months for all GHP Enrollees, unless a different contractor is selected during the applicable Open Enrollment Period described in Section 5.2.5 of the Contract, and except in cases in which the Puerto Rico Medicaid Program has designated an eligibility period shorter than twelve (12) months for an Enrollee who is a Medicaid or CHIP Eligible or a member of the State Population, in which case that same period shall also be considered the Enrollee's Term of Enrollment.

Such a shortened eligibility period may apply, at the discretion of the Puerto Rico Medicaid Program, when an Enrollee is pregnant, is homeless, or anticipates a change in status (such as receipt of unemployment benefits or in family composition). Section 5.3.3 of the Contract controls the Effective Date of Disenrollment.

Deemed Newborns have a Term of Enrollment of up to thirteen (13) months.

Pregnant Enrollees with a Term of Enrollment that expires during pregnancy or within sixty (60) Calendar Days of the post-partum period have an extended Term of Enrollment that expires on the last day of the month after sixty (60) Calendar days counted from the beginning of the post-partum period.

Except as otherwise provided in Section 5.2 of the Contract, and notwithstanding the Term of Enrollment provided in Section 5.2.3 of the Contract, Enrollees remain enrolled with the same contractor until the occurrence of an event listed in Section 5.3 of the Contract (Disenrollment).

E. Contractor Notification Procedures Related to Redetermination

The Contractor must inform Enrollees who are Medicaid and CHIP Eligible and members of the State Population of an impending Redetermination through written notices. Such notices shall be provided ninety (90) Calendar Days, sixty (60) Calendar Days, and thirty (30) Calendar Days before the scheduled date of the Redetermination pursuant to Section 5.2.8 of the Contract.

F. Enrollment Procedures

For all Enrollees except Newborns, the Contractor must comply with the Auto-Enrollment process and issue to the Enrollee a notice informing the Enrollee of the PMG and PCP they are assigned to and their rights to change the PMG or PCP without cause during the applicable Open Enrollment Period.

Following, the Effective Date of Enrollment, the Enrollee has 90 Calendar Days to change his/her Auto-Assigned or Selected PMG and PCP without cause through the Contractor. The Contractor can offer counseling and assistance to the Enrollee in selecting a different PCP and PMG.

Enrollees under the Foster Care Population and Domestic Violence Population classification are not assigned to a PCP or PMG.

The Contractor must issue the Enrollee ID Card and a notice of Enrollment, as well as an Enrollee Handbook and Provider Directory either in paper or electronic form, within five (5) Business Days of Enrollment pursuant to Section 5.2.6.2 of the Contract. The notice of enrollment must clearly state the Effective Date of Enrollment. The notice of Enrollment will explain that the Enrollee is entitled to receive Covered Services through the Contractor.

All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 5.3 of the Contract and 42 CFR 438.56.

The Contractor must comply with 5.2.7 of the Contract regarding Procedures for Auto-Enrollment of Newborns.

G. Initial Membership Distribution

The Initially Auto-Enrolled Enrollees will be classified into Enrollee Seed Sets using the Eligibility Expiration Date and Medicaid Cancellation Date as the classification parameters.

This whole population will be processed for Contractor Auto-Enrollments, PMG and PCP Auto-Assignments. These Seed Sets will be included then in Delivery Packages that will contain the corresponding Enrollee Seed Set and Maintenance Set. The Maintenance Set will be constituted by any existing Enrollee seed set updates or new Enrollee information relayed by Medicaid before the Go-Live Date.

The period that begins on the Auto-Enrollment Algorithm Execution Date and finishes the day before the GHP Go-Live Date is known as the Auto-Enrollment Maintenance Period.

As Contractors receive these delivery packages with their corresponding membership (enrollment), Contractors are expected to issue GHP Welcome Packages to enrolled Enrollees and send the completed enrollment records to ASES as a confirmation of that action.

H. Initial Open Enrollment Period

In the first year of GHP, Enrollees certified as GHP eligible (Federal and State) and enrolled in the GHP prior to November 1, 2018, will be Auto-Enrolled in a Contractor (Initial Auto-Enrollment Enrollees). ASES will determine a Contractor's initial enrollment by applying the auto-enrollment algorithm described above.

As of day one of GHP Go-Live (November 1, 2018), Initially Auto-Enrolled Enrollees will have one (1) opportunity to change contractors without cause during their Open Enrollment Period, which shall begin on November 1, 2018 and end on January 31, 2019.

I. Enrollee Selection of Contractor

1. Initial Open Enrollment Period

Initially Auto-Enrolled Enrollees will have one (1) opportunity to change (select) contractors without cause during their Open Enrollment Period, which shall begin on November 1, 2018 and end on January 31, 2019. ASES will determine a Contractor's initial enrollment by applying the Auto-Enrollment algorithm described above. If the Enrollee does not make a change in contractor during the Initial Open Enrollment Period, the Enrollee will remain enrolled with his/her Auto-Enrolled contractor until Annual Open Enrollment Period described in Section 5.2.5.3 of the Contract, unless the Enrollee disenrolls from the contractor due to for cause disenrollment reasons as specified in Section 5.3.5 of the Contract.

2. Open Enrollment Period for New Enrollees

New Enrollees to the GHP will have the opportunity to select a contractor during the Medicaid eligibility process with the Puerto Rico Medicaid Program. If the New Enrollee does not select a Contractor, the Puerto Rico Medicaid Program will select a Contractor on behalf of the New Enrollee using an algorithm based on a Round-Robin order arrangement. New Enrollees shall be permitted to select a different Contractor once without cause, regardless of how the initial selection of the Contractor was made, during their Open Enrollment Period, which shall begin on the New Enrollee's Eligibility Certification Date and will extend for a period of ninety (90) days.

3. Annual Open Enrollment Periods

Each year, the GHP provides Enrollees with an Annual Open Enrollment Period. The Annual Open Enrollment Period consists of three (3) months from November 1 through January 31 of the following year. All Enrollees will have the opportunity to select a contractor without cause during the Annual Open Enrollment period. If the Enrollee does not make a change in contractor during the Annual Open Enrollment Period, the Enrollee will remain enrolled with his/her current contractor.

Annual Open Enrollment Periods:

- Year 1: November 1st 2018 through January 31st 2019 (Initial Year)
- Year 2: November 1st 2019 through January 31st 2020
- Year 3: November 1st 2020 through January 31st 2021
- Year 4: November 1st 2021 through January 31st 2022 (Option Year)

During each Annual Open Enrollment Period, all Enrollees will have one (1) opportunity to change contractors without cause during their Annual Open Enrollment Period. If a New Enrollee's Open Enrollment Period pursuant to Section 5.2.5.2 of the Contract coincides with the Annual Open Enrollment Period, the Open Enrollment Period in Section 5.2.5.2 controls.

When an Enrollee ceases to be part of the Domestic Violence or Foster Care population but continues to be an Eligible Person, the Enrollee may select a new contractor during an Open Enrollment Period.

When an Enrollee ceases to be eligible for the Platino Program but continues to be an Eligible Person, the Enrollee may select a new contractor during an Open Enrollment Period and must follow the for cause processes described in Section 5.3.5.4 of the Contract.

Figure 1 Illustration of Initial Auto Enrollment Operations

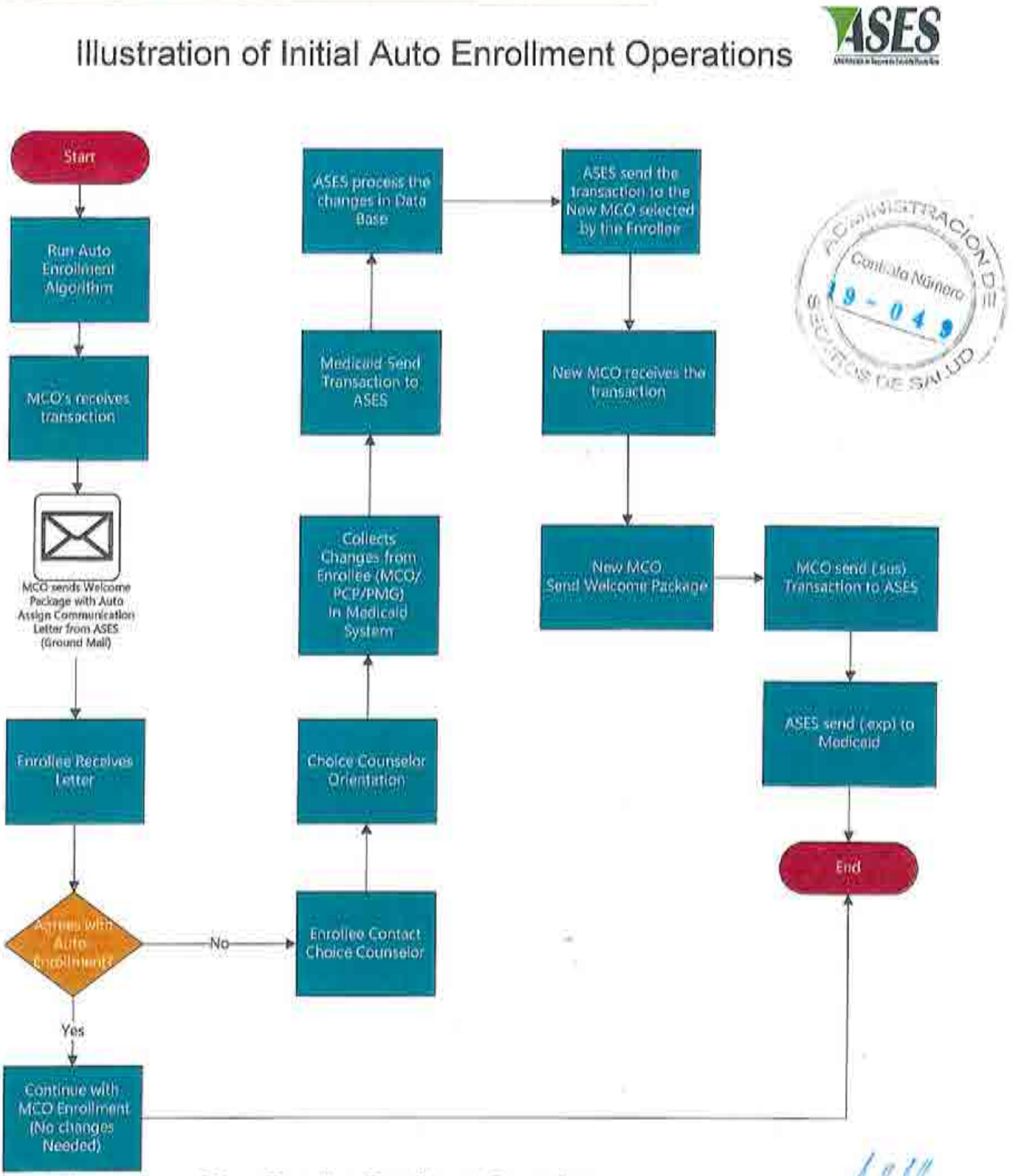


Figure 2 Illustration of New Enrollee Enrollment Operations

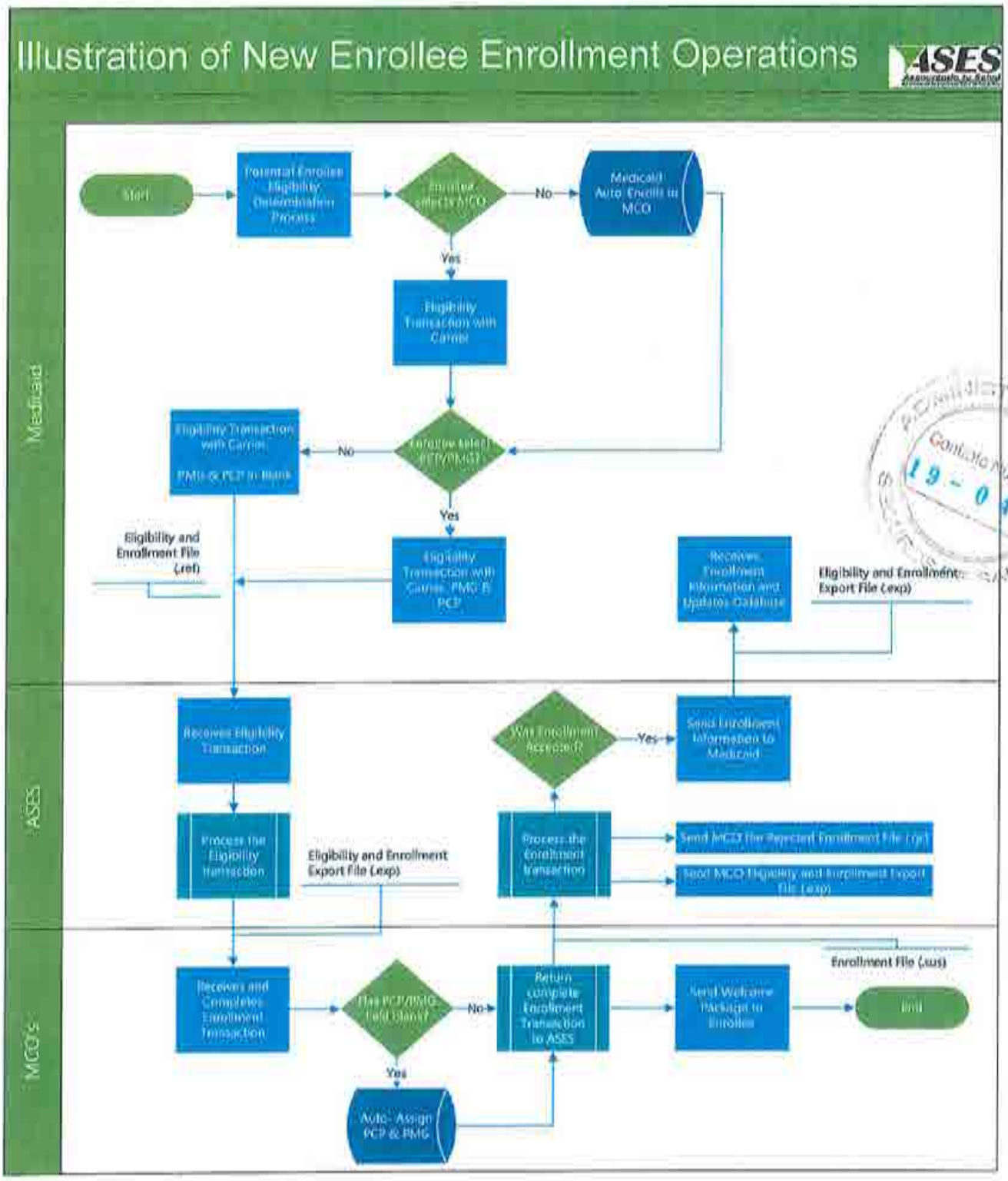
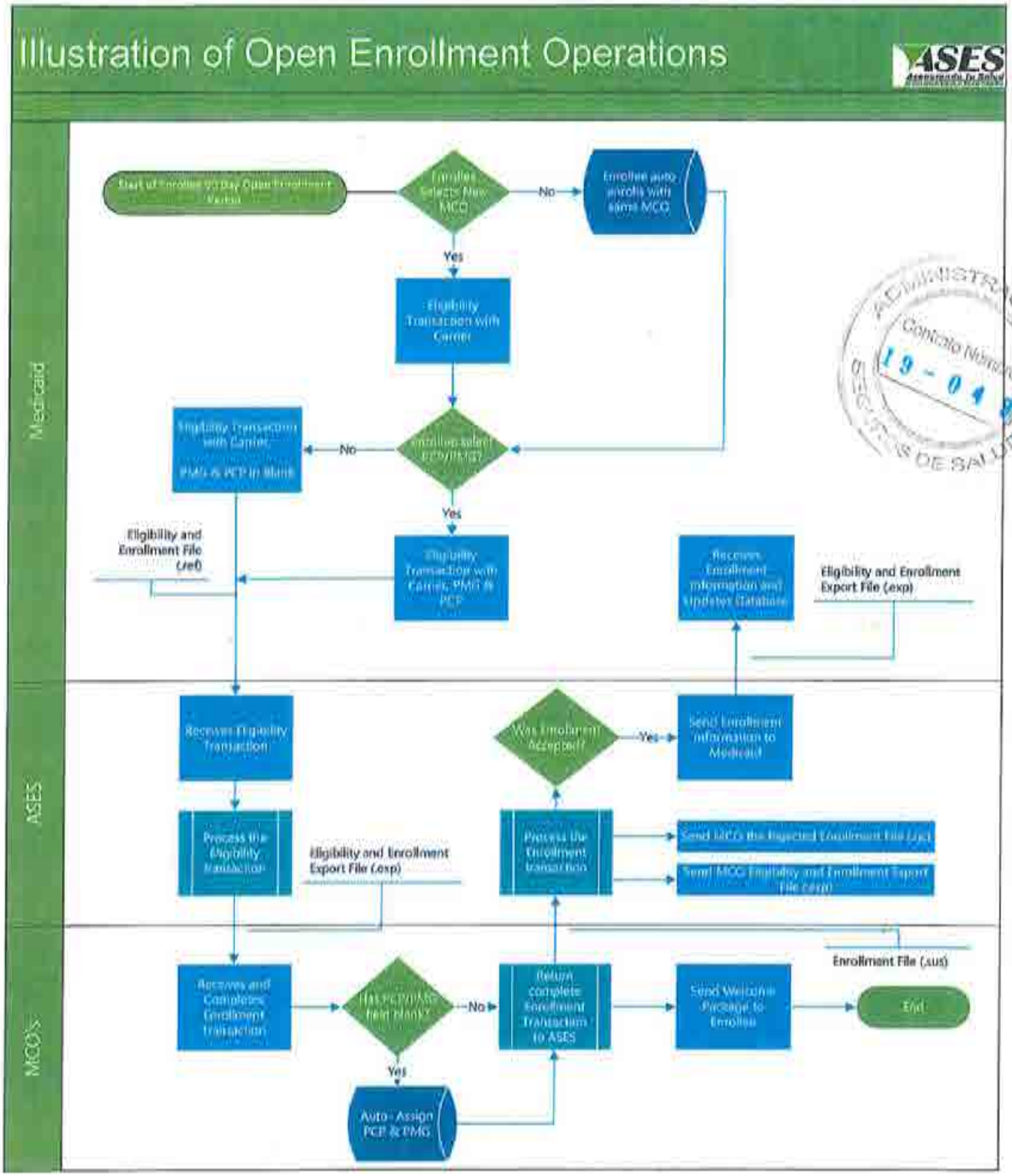


Figure 3 Illustration of Open Enrollment Operations



V. ENROLLMENT COUNSELOR OPERATIONS

ASES has procured Enrollment Counselor functions, available in-person at Medicaid Offices, by toll-free number and online, to help Enrollees understand the GHP and make informed choices for contractor enrollment. It is at the Enrollee's option to receive the services of the Enrollment Counselor. If any Enrollee actively selects a contractor during the applicable Open Enrollment Period (or at point of eligibility application for New Enrollees), the Enrollment Counselor will record the selected contractor and such information will be provided to ASES, through an enrollment (.sus) file, to formalize the enrollment process.

On an ongoing basis, Enrollees will have access to a Counselor to select a Contractor, PMG and PCP. New Enrollees and re-certified Enrollees will be able to select a Contractor taking into account the availability of an enrollment spot within the capacity of each Contractor and available PCPs. The Effective Date of Enrollment of the Contractor, PCP and PMG will coincide with the Effective Date of Eligibility pursuant to Section 5.2.2 of the Contract and as determined at the Medicaid Office. New and re-certified Enrollees are entitled to assistance by the Enrollment Counselor during the Open Enrollment Period applicable to each population regarding selection of a Contractor, PCP and PMG.

VI. DATA EXCHANGE BETWEEN MEDICAID, ASES AND CONTRACTORS

The following sections provides an overview of data exchange information between Medicaid, ASES and the Contractors. For specific data layout information, refer to Attachment 9 with the referenced layout files.

A. Data Exchange Between Medicaid, ASES and the Contractors

1. Medicaid and ASES Data Exchange (.ref file)

Under GHP, at the end of the certification process at Medicaid, a New Enrollee will have the opportunity to select a Contractor and the Medicaid Office will relay the resulting selection to ASES. The information relayed to ASES will include any eligibility information resulting from the process and the Contractor selection or auto enrollment.

2. ASES and the Contractors Data Exchange (.exp file)

The eligibility files from Medicaid (.ref) mentioned in the previous section are entered into the daily run cycle and are evaluated through an editing and verification program at the Information Systems Office at ASES. After receiving and processing the eligibility and Contractor data of each enrollee, ASES creates an electronic record that includes information which the Contractor can use to enroll the enrollee, such as information about the Plan Type (Federal or State) and Plan Version (coverage code) along with

their respective effective dates and other related data elements. On a daily basis, ASES sends accepted enrollments, new eligibility, updates and cancellations data to Contractors in a file (.exp)

Following receipt of the contractor's file, the contractor is required to send ID cards along with a GHP Welcome Package, to the new enrollees by postal mail in five (5) business days pursuant to Section 5.2.6.2 of the Contract.

The Enrollee, in turn, has ninety (90) days to request a change of the MCO, PCP and or PMG. The Contractor then produces the electronic enrollment record and submits it to ASES in a file (.sus) that accounts for the enrollments made. If either the Coverage Code, PCP or PMG of the enrollee changes, the Contractor must send an enrollment record to ASES reflecting the change as a confirmation of issuing a new plan identification card and sending it to the enrollee.

Generally, Contractors have a one business day to remit enrollment records to ASES. They must notify ASES of the information about the new Enrollees and send information about any changes performed on a record previously enrolled. Such notification must be sent on the next business day.

When an enrollee's data sent to a given Contractor is received with a different Contractor code than the one for the Contractor receiving the data, it means that the enrollee has been enrolled with a different Contractor. In this case, the previous Contractor must perform a disenrollment of the enrollee in its database. For these cases the Carrier Effective Date will be modified and the transaction will be sent to both contractors. The Tran_ID value for this transactions will be "E".

In the case that the Contractor has to update the information previously sent to ASES in relation to a new enrollment, or when it is appropriate to add a new enrollee that has been previously omitted, that update must occur the next business day after the information has been updated or that a new enrollee has been added. In these cases, ASES reserves the right not to accept new additions or corrections to the enrollment data after two (2) business days after the Effective Date of the Enrollment indicated in the Contractor's notification to ASES. Likewise, he Enrollee's PMG and/or PCP changes will take effect as stated in Section 5.4 of the Contract.

Records that are accepted without errors during the editing process are updated in the databases at ASES and the beneficiaries are duly enrolled. Any record that is accepted during the editing and verification processes will be stored in the ASES database tables.

The records for the rejected enrollments are returned to the Contractor with the

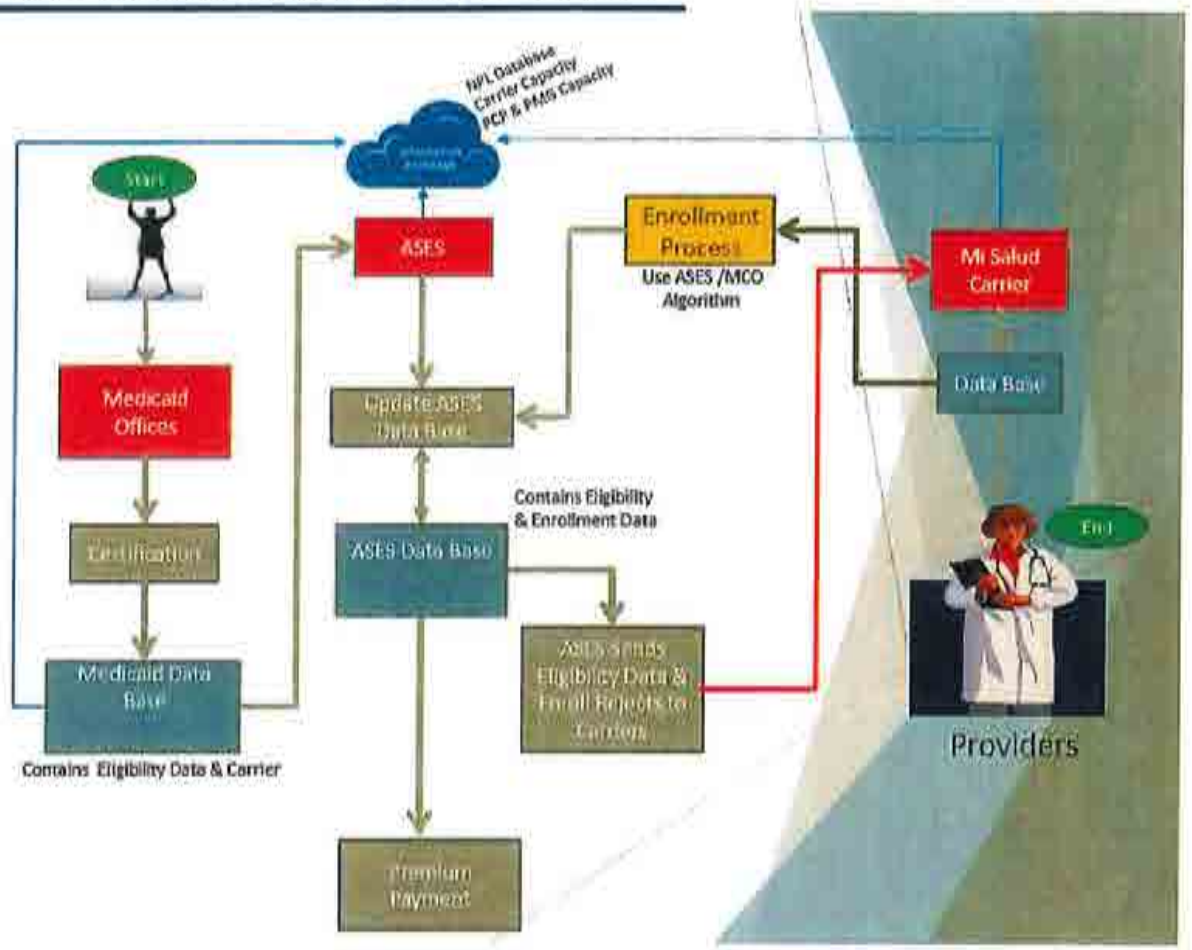
applicable reject codes in a file (.rjc) on a daily basis. The Contractor must correct any errors in the enrollment record and send the information back to ASES in a file (.sus) within two (2) business days. ASES will only pay the premiums related to those beneficiaries who are enrolled in the databases at ASES. Therefore, the execution of the payment of the corresponding premium for these rejected records will be delayed until the enrollment records are sent back with the correction of the indicated errors. It is important that the Contractor sends the corrected enrollment records within the timeframe specified no later than two (2) business days past the date on which ASES notifies the Contractor of the rejected subscriptions, after which the Contractor could start losing premium payments, as stated in Section 5.3.10 of the Contract.

ASES will identify late transactions by comparing the date of the rejection and the date of the resubmission. If the rejected transaction is reconciled, resent and accepted within the timeframe specified at Section 5.3.10 of the Contract, no payment suspension will occur. If it does not occur within two (2) days, it will be included for prospective payment, which shall be prorated from the day the file is accepted. Applies to Trans_ID V, E, C, but not Special Enrolls N, E, T.

During the premium payments process, the enrollments received during the month before the process run are considered.

The exchange of data regarding eligibility and enrollment processes between the Medicaid Office, ASES and the contracted Contractors occurs on a daily basis. In Figure 4, which is provided below, the information exchange processes described in the previous subsections are presented.

Figure 4 Medicaid/ASES/Contractors Data Flow



B. Enrollment Files

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

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

DATA EXPORT FILE [CCYYMMDD.exp]
b. CC = Contractor code
c. YY = Year
d. MM = Month
e. DD = Day
f. .exp = Indicates that it is a file containing all the eligibility and enrollment transactions processed during the daily run. See File Layout Attachment – Carrier Eligibility File Layout (.exp)

REJECTED ENROLLMENTS FILE [*.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.

Although geographic regions are no longer applicable, geographic regions will still be used for the nomenclature of the files that are sent to the Contractors and the internal processes of ASES.

C. GHP Enrollment

In order for an enrollment record to be accepted during the editing and validation processes, it is important to take into account the following considerations regarding concepts related to the enrollment processes:

1. Effective Date of Enrollment

a. The Contractor Effective Date

Please consult Section IV of this Manual and Section 5.2.2 of the Contract for a discussion of Effective Dates of Enrollment.

b. The PCP1, PCP2 and PMG Effective Dates

In cases of new Enrollees, the PCP1, PCP2 and PMG Effective Dates will match the Eligibility Effective Date. If a change for any of the PCPs or the PMG is performed through the Contractor, the Contractor will follow the specifications described under Section 5.4 of the contract where the management of those changes is defined.

The initial assignment of a PCP2 will only be effectuated through the Contractor and it will be responsible of indicating the PCP2 Effective Date in the enrollment record. It is under consideration if during Contractor changes, an attempt to conserve the PCP2 will be made.

c. Plan Version/Coverage Code Effective Date

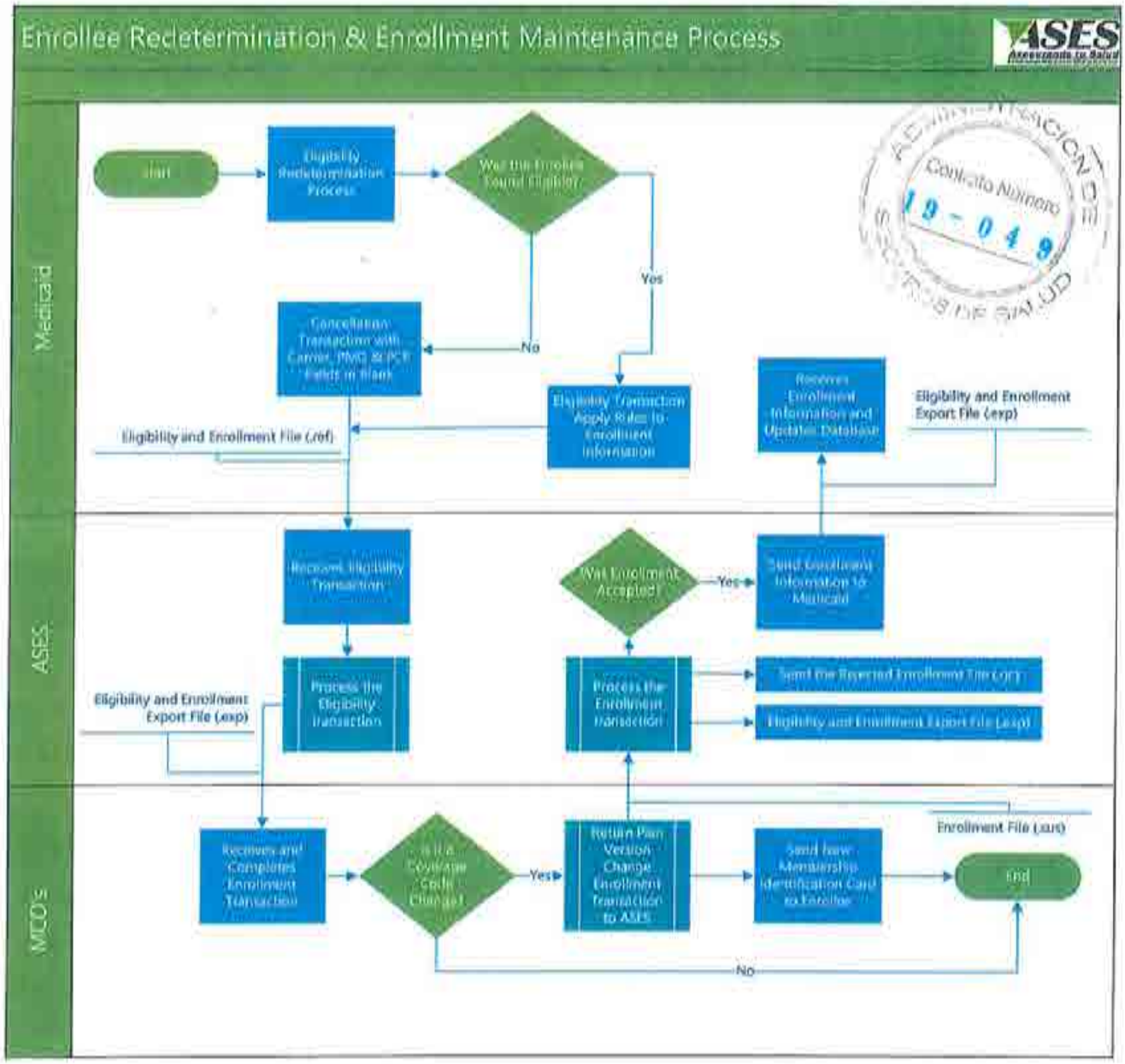
The coverage code only will change during the recertification process performed by Medicaid. When a recertification is performed, the Effective Date of Eligibility changes to that of the next period, hence the Plan Version Effective Date will match the Eligibility Effective Date.

2. Changes in Coverage Codes and Enrollment

The coverage code can only change at the recertification process or when the Enrollee requests a redetermination because the medical indigence level has changed. If at the recertification process, the coverage code of a GHP enrollee changes as described in Figure 5 below, the Contractor must send an enrollment record with the new plan version (that matches the coverage code) with the effective date of eligibility indicated

by Medicaid (eligibility effective date) and send a new healthcare insurance identification card to the enrollee.

Figure 5 Enrollee Recertification & Enrollment Maintenance



3. Process Date

Regarding the daily run files (.exp) the process date is the date in which the daily run was executed. The process date in the Contractor enrollment records (.sus)

corresponds to the date in which the Contractor issued the enrollee's healthcare insurance identification card.

D. Late Enrollment Due to Delayed Eligibility

The late enrollment processes involve the processing of an enrollment in the ASES databases for retroactive eligibility periods, or for delays in the receipt of eligibility periods (for example, because of a resolution of an appeal of eligibility in favor of an enrollee). Cases in which the eligibility record arrives late from Medicaid (for example, because of a possible internal Medicaid appeal process), have to be identified with the letter 'E' in the special_enroll field.

The letters "E" or "C" in the *Tran_ID* field will be included for delayed eligibility period enrollments, just like in SYSPREM cases (See Section VI).

The periods identified as delayed eligibility periods do not have a deadline for payment purposes.

E. Retroactive Eligibility Period Enrollment

Refer above to Section 3.E.2. In the same enrollment file, no more than one (1) enrollee may be included for the same member unless it is a subscription for a current eligibility period and one (1) to three (3) subscriptions for retroactive eligibility periods.

Each enrollment with retroactive eligibility period will be validated against the member's eligibility history. Therefore, the Contractor's effective date for each enrollment must correspond to the date of each retroactive period in ASES's member's eligibility history. Retroactive period enrollments will be labeled with the letter "T" in the *Special_enroll* field.

The letter "E" in the *Tran_ID* field will be included for retroactive eligibility period enrollments.

The periods identified as retroactive (1, 2, 3) eligibility periods do not have a deadline for payment purposes.

F. Enrollment Record

The enrollment record that is used by Contractors to notify ASES of the enrollment of an enrollee contains a series of data that are used for the purpose of informing the details of the enrollment made and to verify their accuracy and certainty. The enrollment transaction is the Contractor's confirmation and guarantee that the enrollee has been successfully

enrolled in the Contractor databases and that a GHP Welcome Package or membership card has been sent to the enrollee.

The Plan Type code for the GHP is "01". At the moment in which the enrollment record is generated the Plan Version is the same as the Coverage Code for the GHP Plans. Currently, ASES contracts falls under the managed care category in which it is required that each member has a designated PCP.

G. Enrollment Record Fields

The record of each enrollee's enrollment contains the following information that must be provided by the Contractor:

1. **RECORD_TYPE**–In every case, and regardless of the transaction in question, this field requires the insertion of code "E" that identifies the entry as an enrollment record for both new enrollments of beneficiaries and changes on records of beneficiaries previously enrolled.

2. **TRAN_ID** - This field allows the ASES systems to identify the action to take on the record submitted. It can contain one of the values listed below:

   a. **E** = New Enrollment. This value identifies that the record is a new enrollment for an enrollee who has not been previously enrolled. It could also imply that this is a retroactive enrollment record for transactions not previously enrolled. For transactions previously enrolled, either by the same or one that is different from the previous enrollment, a "C" would be inserted.

   b. **C** = Contractor Change. Used when the enrollee has selected a different Contractor than the one in which he/she is presently enrolled. It could also identify a retroactive enrollment record in cases that are carried out by a Contractor different than that arising from the ASES database or by the same Contractor if it has to make a change on a previous enrollment.

   c. **V** = Plan Version Change. For MCOs, this transaction code is used when a GHP enrollee's coverage code changes. In these cases, the Contractor must reissue a health plan ID card displaying the new benefits and submit a version change enrollment record to ASES where the Version number should be equal to the new coverage code. This transaction confirms that the new insurance card was sent to the enrollee. Failure to submit said information to ASES, will trigger an automatic disenrollment of the enrollee at the end of the month, from the Contractor that omits the timely submission. While in these circumstances the enrollee continues being

eligible to receive the medical services, the Contractor will remain unable to claim a premium payment for said enrollee until a submission of the required information is performed.

d. **I** = PMG (Primary Medical Group) Change. It is used to register, in ASES, a change in the beneficiaries' requested-PMG under the same Contractor, Plan Type and Plan Version.

   Initially the PCP/PMG will be assigned to the enrollee by the Medicaid office, ASES or the Contractor according to the enrollee's zip code (physical address) and the enrollment capacity of the PCP/PMG. If the daily files (.exp) arrived to the Contractor without a PCP/PMG assigned the Contractor must perform the auto-assignment of PCP/PMG, send the insurance card to the enrollee and send the enrollment record to ASES containing the auto-assigned information. Then the enrollee may proceed to make changes and select a different PCP/PMG.

e. **1 = PCP1 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP1 under the same Contractor, Plan Type, Plan Version and PMG. For changes regarding the PCP1 the enrollment capacity of the PCP will be taken into consideration. The enrollee may make changes afterwards. The PCP1 Effective Date is required.

f. **2 = PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP2 under the same Contractor, Plan Type, Plan Version, PMG and PCP1. For changes regarding the PCP2 the enrollment capacity of the PCP will be taken into consideration. The enrollee may make changes afterwards. The PCP2 Effective Date is required.

g. **3 = PCP1 and PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP1 and PCP2 under the same Contractor, Plan Type, Plan Version and PMG. For changes regarding the PCP1 y PCP2 the enrollment capacity of the PCP will be taken into consideration. The enrollee may make changes afterwards. The PCP1 and Effective Dates are required.

h. **D = Disenrollment** (used for Platino carriers) When the beneficiary loose the medicare benefits or if the enrollment is wrong, the Platino carrier may can made a disenrollment.

   As we have seen, the content of the Tran_id field determines what type of transaction is going to be executed through the enrollment record sent to ASES. Some of the authorized transactions are broken down below. Table 3 below

identifies the information that each change will require and states the fields that will be impacted by each one.

Table 3: Hierarchy Table

TRAN_ID	CONTRACTOR	Plan Version	Primary Center	PCP1	PCP2
E -New Enrollment	Must be **the same** as in ASES DB	Y	Y	Y	O
C -Change Contractor	Must be **different** from ASES DB	Y	Y	Y	O
V -Version Change	Must be **the same** as in ASES DB	Must be **different** from ASES DB	Y	Y	O
I -Change Primary Medical Group	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** from ASES DB	Y	O
1 -Change PCP1	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** from ASES DB	N
2 -Change PCP2	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** from ASES DB
3 -Change PCP1 & PCP2	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** from ASES DB	Must be **different** from ASES DB

Legend:

Y = Information required for the transaction type specified.
O = Optional information.
N = Information that should not be sent for the transaction type specified.

(A) New enrollment ("E"): The system will require all fields related to the information about the Contractor, Plan Type, Plan Version, Primary Medical Group and PCP1 to be completed. The PCP2 information will remain as optional

information for some cases. The Contractor will be assigned by the Medicaid office. The PCP/PMG will be assigned by Medicaid, ASES or the Contractor. If the PCP/PMG were assigned by the Medicaid office or ASES, the Contractor will return the enrollment record with the card issue date as the process date of the enrollment after sending the GHP Welcome Package to the Enrollee.

(B) Change of Contractor ("C"): The system will require registering the name of the new Contractor and inserting information regarding the Plan Type, Plan Version, Primary Medical Group, PCP1, PCP2 (optional) and card issue date as the process date of the enrollment after sending the GHP Welcome Package to the Enrollee.

(C) Plan Version Change ("V"): The Contractor code and Plan Type information provided must match the information in the ASES databases. Only information regarding the new assigned Plan Version will be provided. Information should also be provided in relation to the Primary Medical Group and PCP1 Center.

(D) Primary Medical Group Change ("I"): Information regarding the Contractor, Plan Type and Plan Version must match the information contained in the ASES databases. Only new information will be sent to ASES regarding the new Primary Medical Group (PMG) that corresponds to the enrollee.

(E) Change of PCP1 ("1"): It will be necessary that the information of Contractor, Plan Type, Plan Version and Primary Medical Group provided coincide with the information contained in the ASES databases. It will be necessary to submit the new information regarding the change in PCP1 and it will not be necessary to provide information on the PCP2.

(F) Change of PCP2 ("2"): It will not be necessary to provide information about the PCP1. The only information allowed to differ with the one contained in the ASES records will be the one related to the PCP2.

(G) 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.

3. **PROCESS_DATE**–Process Date. Refers to the date on which the enrollee contracted the coverage services with the corresponding Contractor. It also refers to the date on which the Contractor processed a change in PMG, Plan Version, Plan Type or PCP.

4. **REGION**–Contains the region code assigned by ASES. This code must correspond to the region assigned to the enrollee in the ASES database considering the physical

address. The region code is used only to facilitate the daily run processes, premium payments and for reporting purposes. The data will still be divided by region for the daily run files, end of month and premium payment. See Table 4 below for more information about the Region Codes.

Table 4: Region Codes

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

5. **CONTRACTOR (carrier)** –Two digit Contractor code assigned by ASES to each of the Contractors with the purpose of identification.

6. **MEMBER_PRIMARY_CENTER** – PMG code.

7. **FAMILY_ID** – Eleven last digits of MPI number assigned by the Medicaid Office. This is the first part of the identifier for the beneficiaries in the ASES database.

8. **MEMBER_SSN** - Social Security number of the member. It is required that this number matches with the one for the member in the ASES database.

9. **MEMBER_SUFFIX**–Two digit number which identifies a member within a family. This is the second part of the identifier for the beneficiaries in the ASES database.

10. **EFFECTIVE_DATE**–Date in which the Contractors start providing coverage for the enrollee under the enrolled Plan or the change for which the enrollment record was submitted becomes effective. This date also refers to the date in which the PMG, PCP or Plan Version change becomes effective.

11. **PLAN_TYPE** – Plan Type code that identifies the one under which the member is enrolled.

12. **PLAN_VERSION** – Plan version code that identifies the coverage under which the member is enrolled.

13. **MPI**- Master Patient Index. It is a unique number that identifies a member in the ASES and Medicaid Office's databases.

14. **PCP1**–NPI Number. It is used to identify the PCP1 assign or selected by the beneficiaries.

15. **PCP1_EFFECTIVE_DATE**–Date in which the PCP1 assignment became effective. If there is a change of PCP1, the initial PCP1 Effective Date will be kept until the Effective Date of the PCP1 Change has been reached.

16. **PCP2**– NPI number. It is used to identify the PCP2 selected by the beneficiaries.

17. **PCP2_EFFECTIVE_DATE**–Date in which the PCP2 assignment was effective. If there is a change of PCP2, the initial PCP2 Effective Date will be kept until the Effective Date of the PCP2 Change has been reached.

18. **FAMILY PRIMARY CENTER** – Not in use.

19. **PMG_eff_date (previous FAMILY_PRIMARY_CENTER_EFF_DATE field)** –Date in which the assignment of the enrollee's PMG became effective. This field is not currently in use.

20. **IPA_PCP_CHANGE_REASON** – This field is not currently in use.

21. **MEDICARE INDICATOR** – Not in use

22. **HIC NUMBER**–MBI number only for dual eligible members.

23. **IPA_ESPECIAL**–A code "1" indicates that the member is assigned to a special IPA which is not the family IPA. Used for GHP enrollment.

24. **CONTRACT NUMBER**–Contract number assigned by the Contractor. It should be the number by which the member is identified in the Contractors' ID card and internally in their database.

25. **SPECIAL ENROLL**–It is used to identify:
    (1) the enrollment for **deemed newborns** that are beneficiaries of the Federal Programs by including a letter "N" in the field;

(2) the enrollment for the case when the Medicaid Office sends an eligibility record that is retroactive more than three (3) months from the date in which the record is sent to ASES and therefore to the Contractor by including a letter "E" in the field; and
(3) the enrollment for a retroactive eligibility period by including a letter "T" in the field.

26. **Other data elements complimented by ASES** – When an enrollee's record is validated, the ASES system enters the following data in the enrollment record:

a. **Reject Identifier** - As a result of the validations, the record could be accepted or rejected. This field contains the codes that specify the result of said validation.

"A" = Accepted;
"M" = Accepted Retroactively;
"T" = Retroactive Eligibility Period Enrollment
"R" = Rejected: Will be present only in the .rjc file.

Identifier = "A"
Identifies an accepted enrollment that will be applied on a current or future effective date. In this case, the update process moves the enrollment fields of the Contractor, Plan Type, Plan Version, PMG and PCP to the fields intended for new enrollments in the enrollee record. Until such time as the new Effective Date is reached, the enrollee will remain under the current enrollment condition (same Contractor, Plan, Version, PMG and PCP). During the end-of-month cycle, the new fields are moved to the current fields and the enrollment becomes effective.

Identifier = "M"
Indicates a retroactive enrollment. In these cases, Enrollment data (Contractor, Plan Type, Plan Version, PMG and PCP) are updated directly in the enrollee's historical record.

Identifier = "T"
It identifies a successfully processed retroactive enrollment.

Identifier "R"
In cases when an enrollment record is not successfully processed because an error has been identified, it indicates a record returned for correction.

b. **Record Key** – Internal number assigned by the ASES system.

c. **Error Codes one (1) to ten (10)** – It is possible to record up to ten error codes.

27. **Update Date** – Date for which the validation is run. Corresponds to the date of the daily cycle the validation run was a part of.

28. **Update User** – ASES internal user code.

29. **PMG Tax ID** – Include PMG Tax ID

30. **Data Source** – Will always contain "MO" to denote the enrollment comes from a Contractor.

Note:
It is up to the Contractors to process the enrollment records corresponding to the months prior to November 1, 2018 under the region model. This includes the retroactive eligibility periods (1,2,3 and late eligibility periods).

H. Rejection of an Enrollment Record

An enrollment record related to any type of enrollment, modification or update transaction could be rejected if it does not pass the validation tests at the ASES systems. As mentioned above, rejected enrollments are sent daily to Contractors in a file (.rjc) that includes error codes for records that have not successfully passed the validation process. Contractors must correct identified errors and resubmit the corrected records to ASES with the next file submission, meaning the next business day. For the adequate correction of these errors please refer to the Error Codes Table provided in Section VII.

I. Rejected Enrollment Management

The daily process of Contractors in relation to rejected enrollments should include:

(1) **Receipt** of rejected enrollment records;
(2) **Evaluation** of rejection codes received;
(3) **Identification** of situations in which rejection is not clear for consultation with ASES;
(4) **Timely** correction of identified errors;
(5) **Transfer** of the corrected records to ASES in a 24 hour period.

VII. ERROR CODES TABLE

The following table contains the error codes produced by the validation program. Additional descriptions and possible corrective actions have been included to assist in the correction process. See Attachment 9 Error Codes Table.

VIII. GHP DISENROLLMENT (CANCELLATION/TERMINATION OF ELIGIBILITY)

A. Disenrollment from the GHP

The process of a disenrollment from the GHP occurs when the Medicaid Office determines that an enrollee is no longer eligible for GHP.

A GHP disenrollment occurs when the Medicaid Office determines that (1) an enrollee has lost eligibility to receive medical services coverage under the GHP; (2) the eligibility period granted by the Medicaid Office has expired and other reasons specified in Table 5 below:

Table 5: Cancellations Code & Cases Description

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

Medicaid will notify the eligibility cancellation to ASES, and ASES will notify the Contractor of the cancellation. Such notification shall be effectuated by means of a daily transfer of the daily process Export (.exp) files to the Contractor together with records containing information on new beneficiaries to be enrolled. A letter "I" in the Tran_Id field identifies the cancellation records in the daily process Export (.exp) files. This will be done within five (5) calendar days after a final determination on the eligibility cancellation.

B. GHP Disenrollment Effective Date

The Medicaid Office is the only institution authorized to perform the disenrollment of the eligibility of an enrollee. This date is indicated by Medicaid in the Medicaid Cancellation Date field.

Cancellations may be received any day of the month. Hence, these cancellations should have a value in the field Medicaid_Cancellation_Date.

the The effective date of such cancellations will be determined by the Medicaid Office and expressed in the Medicaid Cancellation Date field. For said reason cancellations received any day of the month should have a value in the field Medicaid_Cancellation_Date.

IX. CONTRACTOR DISENROLLMENT

A. Disenrollment from the Contractor

The process of a disenrollment from a Contractor occurs when a disenrollment from the plan is requested by the Contractor or the Enrollee and has been approved by ASES.

A Contractor disenrollment occurs when a request for re-enrollment has been received from an Enrollee or a Contractor as set forth in Sections 5.3.4 of Contract.

B. Disenrollment Initiated by the Enrollee

All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 5.3 of the Contract and 42 CFR 438.56. Such notification must clearly explain the process for exercising this disenrollment right, as well as the coverage alternatives available to the Enrollee based on their specific circumstance.

An Enrollee wishing to request Disenrollment must submit an oral or written request to ASES or to the Contractor. If the request is made to the Contractor, the Contractor shall forward the request to ASES, within five (5) Business Days of receipt of the request, with a recommendation of the action to be taken.

An Enrollee may request Disenrollment from the Contractor's Plan without cause once during the applicable Open Enrollment Period in accordance with Section 5.2.5.

An Enrollee may request Disenrollment from the Contractor's Plan for cause at any time, pursuant to Section 5.3.5.4 of the Contract.

In these cases in which the Enrollee changes contractors, the Contractor that loses the Enrollee will be required to complete the transfer of said Enrollee by completing the information asked for in Attachment 9 Member History Move Input File Layout and Attachment 9 MCO Change Transfer Member Information File Layout within the applicable timeframes. For the moment, the layouts should be submitted before the date in which the Enrollment Date becomes Effective.

C. Effective Date of Temporary Payment Suspension

For programmatic purposes of the ASES Information Systems Office, this Effective Date of Temporary Payment Suspension refers to the day on which premium payments are suspended for an Enrollee. This temporary suspension takes place in those cases in which the Medicaid Office has sent a change of coverage code for an Enrollee and the Contractor has not submitted an enrollment with the new plan version related to the change of coverage. This occurs during the end of month processes. During this process the Card Issue Date field is left blank but the enrollee keeps being eligible and enrolled with the Contractor.

Although in cases of Temporary Payment Suspension the eligibility period will continue for the beneficiaries on behalf of whom the Medicaid Office has sent a change of coverage code for an enrollee and the Contractor has not submitted an enrollment with the new plan version related to the change of coverage, the premium payment cannot be processed until a new enrollee enrollment is sent by the Contractor with the information of the new plan version related to the change of coverage. Once the new plan version is received, premium payments will resume, subject to section 5.3.10 of the Contract.

X. CONTRACTORS RESPONSIBILITIES IN THE ENROLLMENT PROCESS

In summary, as part of the enrollment process, it will be the responsibility of the Contractors to ensure compliance with the duties described in Table 6 below.

Table 6: Enrollment Transaction Contractors Responsibilities

Change or Modification	Action Required
1. Transfer of Daily Eligibility Files.	Daily Update of Eligibility Files in the Contractor's databases.
2. New Enrollments.	GHP Contractors should start the enrollment process with the enrollee and verify each of the enrollments made including the enrollment of newborns (N) and late eligibility cases. They must also enroll beneficiaries who have an Effective Date prior to a cancellation period.
3. Contractor Change.	When an enrollee requests a Contractor change through Medicaid, ASES or the Counselor, the ASES system will produce update record containing the new Contractor and that record will be sent to both the new and the previous Contractor. The previous Contractor should disaffiliate the member in its databases, and the new Contractor should perform the PMG/PCP Auto Assignment and the enrollment process with ASES.

4. Changes to the enrollment data. (Change of Plan Version, PMG and/or PCP).	Identify beneficiaries who have changed Plan Version, PMG and/or PCP (1 or 2) and notify these changes. The Contractor's system must be updated in accordance with these modifications as failure to do so may lead to the rejection of the enrollment record in future transactions or to the Disenrollment of the enrollee from the Contractor during the end of month processes.
5. Change in the demographic data of a enrollee. This information is received from the Medicaid Office but does not cause a change in the enrollment.	The Contractor must update the enrollee's record with the new data in its database. If the enrollee informs the Contractor of an address and/or phone change, a recommendation should be made to the enrollee to notify of the change to the Medicaid Office in order to keep the data up to date.
6. Rejected Records	Correct the rejected records and resend them to ASES.
7. Cancellation of Enrollee: Only the Medicaid Office may cancel the eligibility of an enrollee, having the effect that until such notice of Medicaid is received the enrollee will remain active in the databases of both ASES and the Contractors even when the period of eligibility granted has expired.	Identify the cases of beneficiaries with canceled or denied coverage and take action about these, as they are the only beneficiaries to whom services may be denied.
8. Temporary Suspension	Contractors should identify when a record received has a different coverage code than is recorded in their databases. In these cases, Contractors must assess whether the new coverage code requires the enrollee to be enrolled in a different "Plan Version". If so, they must re-enroll these beneficiaries under the new "Plan Version" to correspond with the new coverage code. Subsequently, a change of "Plan Version" must be sent to ASES before the end of the current month. Beneficiaries who are not registered with a "Plan Version" that corresponds with the coverage code will be temporarily suspended from premium payments (blanks will be included in the Card Issue Date field) until corrected, subject to Section 5.3.10.

XI. PREMIUM PAYMENTS

The premium payment system operates under the concept that premiums are calculated and paid only in relation to beneficiaries who are already enrolled before the first day of the month to which the payment corresponds. Beneficiaries enrolled after that date will be considered for the next payment of the corresponding premium.

On a monthly basis, the system performs an automatic execution of payment in which the payment that corresponds to each one of the Contractors is calculated using the Member Assigned Rate Cell ID as described in Table 7 below according to the beneficiaries that are enrolled in the ASES databases.

Table 7: Rate Cells

RateCellsId	RateCellsDec	PC_pop	HCHN_Flag
01	Under 1	CHIP	N
02	Age 1-6	CHIP	N
03	Age 7-13	CHIP	N
04	Age 14+	CHIP	N
05	Diabetes	CHIP	Y
06	Pulmonary	CHIP	Y
07	Under 1	Commonwealth	N
08	Age 1-6	Commonwealth	N
09	Age 7-13	Commonwealth	N
10	Cancer	Commonwealth	Y
11	Diabetes/Low Cardio	Commonwealth	Y
12	Female 14-18	Commonwealth	N
13	Female 19-44	Commonwealth	N
14	Female 45+	Commonwealth	N
15	High Cardio	Commonwealth	Y
16	Male 14-18	Commonwealth	N
17	Male 19-44	Commonwealth	N
18	Male 45+	Commonwealth	N
19	Pulmonary	Commonwealth	Y
20	Renal	Commonwealth	Y
21	Part A Only	Dual Eligible	N
22	Part A and B	Dual Eligible	N
23	All	Foster Child/Domestic Abuse	N
24	Under 1	Medicaid	N
25	Age 1-6	Medicaid	N
26	Age 7-13	Medicaid	N
27	Cancer	Medicaid	Y
28	Diabetes/Low Cardio	Medicaid	Y
29	Female 14-18	Medicaid	N
30	Female 19-44	Medicaid	N
31	Female 45+	Medicaid	N
32	High Cardio	Medicaid	Y
33	Male 14-18	Medicaid	N
34	Male 19-44	Medicaid	N
35	Male 45+	Medicaid	N
36	Pulmonary	Medicaid	Y
37	Renal	Medicaid	Y
38	EAP	Medicaid/Commonwealth	N
39	Maternity Delivery Kick Payment	Medicaid/Commonwealth/CHIP	N

The premium paid for each enrollee will depend on his or her rate cell classification. ASES actuaries are responsible for providing the definition and the methodology for the application of the rate cells. Among the rate cells, they also differentiate twelve (12) of them which identify beneficiaries who are patients with complex and costly care needs suffering from chronic diseases or special limitations. These beneficiaries constitute a population known as the High Cost High Need (HCHN) population. In Table 7, the HCHN rate cells are the ones with a RateCellID that forms part of the following list: 05, 06, 10, 11, 15, 19, 20, 27, 28, 32, 36, 37.

Rate Cells updates will be performed on a monthly basis during the End of Month processes and will be notified through the .cncl files. These updates will be effective as of the first day of the following month and will be used for the payments corresponding to that month onwards.

Premium payments will be made on the first day of the month following the acceptance of the enrollment record by ASES. ASES is not obligated to pay premiums for beneficiaries who are not duly enrolled according to ASES's databases nor for beneficiaries whose records contain transactions that have been rejected in the ASES databases and have not been corrected within the periods established by contract.

The payment system calculates several payment categories as listed below:

A. Types of Payments

1. Monthly Payments

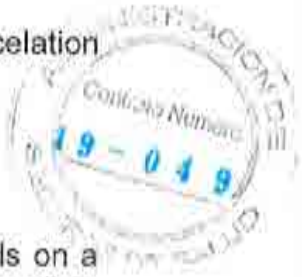
In this case the system produces a payment for those beneficiaries whose enrollment has already taken effect before the first day of the month for which the payment transaction is executed. The execution of premium payment is run on the first day of the month.

2. Prorated Payments

Prorated payments are usually calculated for beneficiaries of the GHP funded solely through state funds (State) who have been enrolled at some point in a month prior to the month in which the premium payments are to be made. The payment in these cases will satisfy a portion of the month and not a month in its entirety. Under the state-funded GHP a daily prorated premium is calculated for the first premium payment from the certification date of the enrollment that falls on that previous month. In contrast, with the federal population the first premium payment is effectuated for the entire month in which the enrollee is eligible.

However, prorated payments are generated for all of the beneficiaries that Medicaid cancels during the month for different reasons. In these cases, as the payment would have been done already in advance, an adjustment would be done according to the cancellation date provided by Medicaid. Also, newborns that are not classified as deemed newborns and that are evaluated as any other federal member will have prorated payments for the first month from the date of birth.

Other reason for prorate payment are the special adjustment for deceased, cancelation during the month. (e.g. PARIS file members matched, volunteers, etc.)



3. Retroactive Payments

These payments are calculated when the Effective Date of the Enrollment falls on a period prior to the month for which the premium payment process is being executed. In other words, this type of payment is executed when payments are identified corresponding to months prior to the month in which a premium payment is made. The retroactive payments will be computed based on the Enrollment Effective Date. The system will process the premiums for enrolled beneficiaries with an Effective Date prior to the payment date in the case of monthly premiums or prorated premiums that have not been previously paid within the time limits for retroactive payments. Retroactive payments may result in an adjusted payment if they are the result of a Contractor's cancellation of a previous enrollment or Contractor change.

Premiums are paid retroactively when a Contractor has submitted a late enrollment. Late enrollments could be produced for any of the following reasons: (1) the enrollee has been identified as a deemed newborn (in the second letter of the group code ='N); (2) Medicaid has provided a late eligibility record (3) processing of the records rejected by the ASES System for any of the reasons described in the Table of Errors. Refer to Attachment 9 Enrollment Error Codes.

Deemed Newborns born to a Medicaid-eligible mother shall be provided coverage from the date of birth. The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the child is certified eligible by the Medicaid Office. Babies identified as deemed newborns must be identified with the letter 'N' in the special enroll field provided in the enrollment record.

The Medicaid Late Eligibility Cases are the cases that the Medicaid office sent late (with more than three (3) months from the date of the certification) for a variety of reasons. These cases must be identified by the Contractor in the enrollment record with the letter 'E' in the special_enroll field.

Correction of Enrollment Errors: these are the cases in which the Contractors have to correct, repeatedly, the enrollment records that have been rejected by the ASES system. These records must be corrected in a maximum period of 2 business days.

4. Prorated Retroactive Payments

The prorated retroactive payments are calculated taking into consideration the cases in which the Enrollment Effective Date falls on the first month considered for a retroactive payment. These are partial payments of the first month of the eligibility period of beneficiaries. These type of payments are used for GHP State funded State beneficiaries, deemed newborns and newborns.

5. Adjustments

A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a Contractor during a previous premium payment process. It occurs when, as a result of a retroactive payment calculation, a payment made in relation to the same enrollee is identified within the same period that has been effected under a Contractor change or Plan Version change. The adjustments are calculated for those cases where an enrollee changes Contractor and the Contractor executed a late enrollment after ASES had disbursed payment to the first Contractor in a previous payment transaction. In these cases an adjustment of premium paid to the first Contractor is made.

6. Special Adjustments

Generally, the special adjustments are carried out as a result of internal audit processes that reveal that a wrongly adjudicated payment (like for example, deceased beneficiaries, duplicate payments, PARIS eligibility match, etc.) must be reverted or that, on the contrary, an omitted payment must be adjudicated. For this type of adjustment, the Contractor will receive a list of transactions in which they can identify the type of adjustment (for example: a deceased), the adjusted months and the amount adjusted. The description of this list is found in Attachment 9, Special Adjustment File Layout.

Special audit adjustment file [prempay_adj_CC_all_MMDDYYYY.txt]
a. prempay_adj = Premium Payment special adjustment
c. CC = Contractor code
d. all = all regions
d. MM = Month
e. DD = Day (always 01)
f. YY = Year
g. .txt = text file created monthly base like premium payment process

Note: **Attachment 9, Special Adjustment File Layout**

B. ASES Reasons for not Executing a Premium Payment

A premium payment will not be executed in favor of a Contractor in the following circumstances:

(1) If the enrollee is not enrolled in the ASES databases before the first day of the month for which the payment transaction is being executed;
(2) If the enrollment had been rejected by ASES and a new enrollment was not submitted by the Contractor with the relevant corrections
(3) If ASES eligibility data demonstrates that the enrollee had a disenrollment (blank Card Issue Date), eligibility cancellation or changed the Contractor.
(4) If for late enrollment.

C. EDI 820 Payment File

The reconciliation process carried out between ASES and the Contractors in relation to the payment of premiums must take into account the content of the EDI 820 files. This file is produced monthly by region, Contractor and Plan Type. It includes details of the types of payment that correspond to each of the beneficiaries assigned to the Contractors contracted for the month in question. Refer to Attachment 9, Special Adjustment File Layout.

In this file, a distinction is not made about if the payment corresponds to an adjustment from a regular premium payment process or a special adjustment. Thus, in cases when special adjustments proceed, ASES will provide a separated file for the special adjustments to the Contractor. The file name is described below.

Premium Payment Transactions [PCC0YYMM0000.820]
a. P = Identify Premium Payment
c. CC = Contractor code
d. 9 = Frequency
e. YY = Year
f. MM = Month
g. 0000 = IPA Direct Contract
h. .820 = Indicates that it is a file containing all premium payment transactions processed monthly run.
Note: Attachment 9, Premium Payment Detail 820 File Layout

XII. SYSPREM: ENROLLMENT IN HISTORICAL DATA

Generally, enrollments are applied to the current eligibility data contained in the ASES databases. The eligibility period starts from the first notification of eligibility in ASES, as the first record received about an enrollee or after a cancellation period in cases of beneficiaries who have been canceled and then re-certified, and extends until a cancellation related to said eligibility is received from Medicaid.

At any time the status of the Enrollee may change. If the Enrollee's status changes before a Contractor send an enrollment on time or a record is not corrected in a timely manner, the Enrollee's enrollment data will remain unregistered in the ASES databases, which will prevent the processing of the corresponding premium payment. This is due to the fact that the payment system does not make premium payments for beneficiaries who are not enrolled at the moment in which it corresponds to process the premium payment. As an example, in these cases, if an Enrollee is canceled or is enrolled by a second Contractor, the first Contractor will be prevented, during the validation phase of the system, from enrolling the enrollee in a period previous to the cancellation or the enrollment from the second Contractor. The main function of SYSPREM will be to allow the registration of the Enrollee's enrollment in historical data in those cases that cannot be processed as current enrollments.

A. SYSPREM Functionality

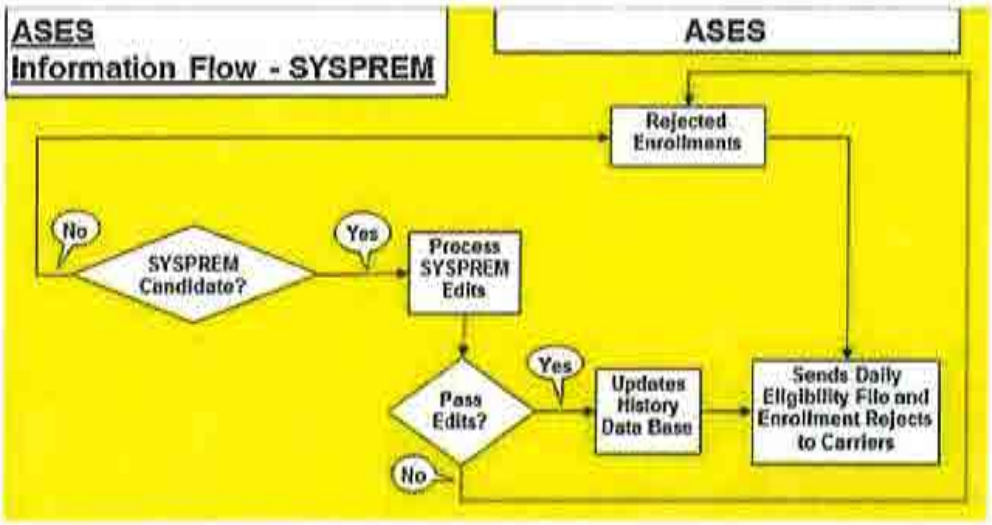
Among the main functions of this system is the identification of enrollment records that are candidates for processing in historical data because they are enrollments that do not correspond to a current period of eligibility or current status.

B. Contractors Eligibility File

The Contractor's daily eligibility file will include enrollee information updated in historical data by the SYSPREM subsystem. In these transactions, the Tran_id field will contain an "H" to identify the historical data. Contractors must identify this type of transaction without affecting the current data when processing the eligibility file. Once a transaction is received, which must be processed through SYSPREM, a process of verification and validation of the information that is contained in the record is carried out. Once the validation tests have been passed, the record, in the database, containing the information corresponding to historical transactions is updated. Those records that do not successfully complete the verification processes will be sent in a file of rejected enrollments to the corresponding Contractor for correction.

The Figure 2 below shows the validation process performed for the purpose of processing a candidate record for SYSPREM.

Figure 5: Validation Process under SYSPREM



C. Premium Payments for SYSPREM

The run for the monthly premium payment will include all SYSPREM records that have been processed during the previous month. The payment for these transactions is calculated based on monthly periods from the Enrollment Effective Date of the SYSPREM to:

(1) The month in which the enrollee was enrolled with a different Contractor,
(2) The month in which the enrollee is cancelled or
(3) Until the date of current billing.

D. SYSPREM Error Codes

The following is a breakdown of the Error Codes that will trigger an evaluation under SYSPREM:

Table 8: Primary Error Codes for SYSPREM

Code	Primary Error Description
107	Effective Date prior to the current family eligibility period.
108	Effective date prior to the current enrollee eligibility period.
280	The family must be eligible in the current eligibility data.
281	The enrollee must be eligible in the current eligibility data.
177	Enrolled with another Contractor on or after the effective date.

Table 9: Secondary Error Codes for SYSPREM

Code	Secondary Error Description
083	Social Security Number Not Found.
093	Suffix not found.
132	MPI Not Found.
222	Currently enrolled with the same Contractor
223	Currently enrolled with another Contractor
225	Incorrect Social Security Number
226	Incorrect MPI Number
22F	Error found in other beneficiaries of the family (GHP).

The following is a breakdown of the Error Codes that could appear during an evaluation under SYSPREM:

Table 10: SYSPREM Error Codes

Code	New Error Codes Description
996	Sysprem record successfully inserted in history.
980	The Process Date of the enrollment record must be greater than the Process Date of the previous enrollment record for the enrollee who appears previously enrolled for the month corresponding to the Effective Date of the enrollment.
981	The enrollee must not have beneficiaries of his family with errors not acceptable by SYSPREM in the same enrollment file.
982	The enrollment record must not have an Effective Date prior to 01/01/2006.
983	Enrolled in history for the Effective Date of the enrollment record.
984	It is a New Enrollment, the Effective Date is not first of the month and the enrollee is already subscribed in another Contractor at the Effective Date specified.
985	It is a New Enrollment and the Effective Date should be at least as recent as the enrollee's Certification Date at the specified Effective Date.
986	For SYSPREM processing, the Enrollment Effective Date should be before the Effective Date of the current enrolled record at the ASES databases.

In summary, SYSPREM will process and/or enroll transactions in history in those cases in which the enrollment cannot be applied to current data or to current periods of eligibility. Some beneficiaries will not appear as enrolled in history because they are not eligible for the Effective Date or because they are enrolled with a different Contractor. Contractors need to evaluate the cases rejected by SYSPREM in order to identify errors in the assigned Effective Date and the correctness of the beneficiaries' data included in the enrollment record.

XIII. REFERENCES

See Attachment 09

XIV. APPROVALS

Revision Sheet

Project Sponsor: _____
Date

Project Manager: _____
Date

Steering Committee: _____
Date

Steering Committee: _____
Date

Steering Committee: _____
Date

Steering Committee: _____
Date

Attachment 9
Information System

MA-10 Form

MA-10
Rev. 06/2017 (Español)

Departamento de Salud de Puerto Rico – PROGRAMA MEDICAID
NOTIFICACIÓN DE ACCION TOMADA SOBRE SOLICITUD O REEVALUACIÓN

Número Caso: _____ Núm. de Solicitud: _____ Fecha de Certificación: 07/06/2018

Municipio de Residencia: _____ Región de Medicaid: _____ Región de ASES: Noreste

Se ha evaluado la información que usted ha ofrecido y se ha corroborado con los documentos que se le han solicitado, y los cuales constan en nuestro expediente, y hemos determinado:

Resultados de determinación de elegibilidad -

Nombre	MPI	Otro Plan Médico	Ingreso Elegibilidad	Unidad Familiar	Elegibilidad	Fecha Efectividad	Fecha Vencimiento
		NO	$620.00	03	Medicaid	01/06/2018	31/05/2019
		NO	$620.00	03	Medicaid	01/06/2018	31/05/2019
		NO	$620.00	03	Medicaid	01/06/2018	31/05/2019
		Persona de Contacto					

Resultados de determinación para copagos -

Nombre	MPI	Ingreso para Copagos	Unidad Familiar	Elegibilidad	Código Cubierta	Tope de Copagos
		$620.00	03	Medicaid	110	$93.00
		$620.00	03	Medicaid	110	$93.00
		$620.00	03	Medicaid	110	$93.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04[illegible]

CERTIFICO QUE HE LEIDO ESTA NOTIFICACIÓN.

Nombre, Firma de Certificador

Fecha

Nombre y Firma del Solicitante, Beneficiario o Representante

Fecha

Nombre y Firma del Testigo

Fecha

Para el Cliente / Para el Expediente

Departamento de Salud de Puerto Rico – PROGRAMA MEDICAID
NOTIFICACIÓN DE ACCION TOMADA SOBRE SOLICITUD O REEVALUACIÓN

Número Caso: _____ Núm. de Solicitud: _____ Fecha de Certificación: 07/06/2018

Municipio de Residencia: _____ Región de Medicaid: _____ Región de ASES: Noreste

NOTAS:

A. Tope de Copagos: (1) La reglamentación federal establece que las personas elegibles a Medicaid o CHIP tendrán un tope en el total de los copagos. (2) El tope es de un 5% trimestral, y se determine a base del Ingreso MAGI de la Unidad Familiar MAGI y para llegar al tope se suman los copagos que pagan por trimestre cada uno de los beneficiarios que son Medicaid o CHIP de la unidad familiar MAGI. (3) Si en el transcurso del período de elegibilidad, un beneficiario a Medicaid o CHIP considera que pagó más de un 5% por concepto de copagos en un trimestre, él o ella pueden radicar una Solicitud de Reembolso de Copagos, la cual será evaluada por la Administración de Seguros de Salud de Puerto Rico (ASES). (4) La información sobre el Proceso de Reembolso y la Solicitud están disponible en las Oficinas Locales del Programa Medicaid y en la página web del Programa Medicaid (https://www.medicaid.pr.gov/) y en la de ASES (http://www.ases.pr.gov/). (5) La regla federal no aplica a quien es elegible Estatal.

B. Determinaciones de Elegibilidad y para Copagos: (1) Usted tiene derecho a radicar una apelación y solicitar una audiencia para que se revise la determinación de elegibilidad y/o la determinación para copagos que se les notifican mediante esta MA-10 cuando no está conforme con la decisión tomada en su caso. (2) La solicitud debe ser presentada por escrito y dentro de un plazo de 30 días, contados a partir de la Fecha de Certificación indicada en esta MA-10. (3) La misma podrá someterse - (a) en persona: en cualquier Oficina Local del Programa Medicaid de PR, (b) por correo a la siguiente dirección: Programa Medicaid, Departamento de Salud, P.O. Box 70184, San Juan, PR 00936-8184, o (c) por facsímil (fax): al número (787) 759-6361. (4) El término para apelar vence el: 7 de julio de 2018. (5) La determinación será final si usted no apela dentro del término de 30 días.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9 - 0 4 9

CERTIFICO QUE HE LEIDO ESTA NOTIFICACIÓN.

Nombre, Firma de Certificador

Fecha

Nombre y Firma del Solicitante, Beneficiario o Representante

Fecha

Nombre y Firma del Testigo

Fecha

Para el Cliente / Para el Expediente

MA-10
Rev. 06/2017 (Español)

Departamento de Salud de Puerto Rico – PROGRAMA MEDICAID
NOTIFICACIÓN DE ACCION TOMADA SOBRE SOLICITUD O REEVALUACIÓN

Número Caso: _____ Núm. de Solicitud: _____ Fecha de Certificación: 08/08/2017

Municipio de Residencia: _____ Región de Medicaid: _____ Región de ASES: Noreste

Se ha evaluado la información que usted ha ofrecido y se ha corroborado con los documentos que se le han solicitado, y los cuales constan en nuestro expediente, y hemos determinado:

Resultados de determinación de elegibilidad -

Nombre	MPI	Otro Plan Médico	Ingreso Elegibilidad	Unidad Familiar	Elegibilidad	Fecha Efectividad	Fecha Vencimiento
		NO	$1,057.39	01	Inelegible		
		Persona de Contacto					

Resultados de determinación para copagos -

Nombre	MPI	Ingreso para Copagos	Unidad Familiar	Elegibilidad	Código Cubierta	Tope de Copagos
		$1,419.39	01	Inelegible	000	

NOTAS:

A. Tope de Copagos: (1) La reglamentación federal establece que las personas elegibles a Medicaid o CHIP tendrán un tope en el total de los copagos. (2) El tope es de un 5% trimestral, y se determina a base del Ingreso MAGI de la Unidad Familiar MAGI y para llegar al tope se suman los copagos que pagan por trimestre cada uno de los beneficiarios que son Medicaid o CHIP de la unidad familiar MAGI. (3) Si en el transcurso del período de elegibilidad, un beneficiario a Medicaid o CHIP considera que pagó más de un 5% por concepto de copagos en un trimestre, él o ella pueden radicar una Solicitud de Reembolso de Copagos, la cual será evaluada por la Administración de Seguros de Salud de Puerto Rico (ASES). (4) La información sobre el Proceso de Reembolso y la Solicitud están disponible en las Oficinas Locales del Programa Medicaid y en la página web del Programa Medicaid (https://www.medicaid.pr.gov/) y en la de ASES (http://www.ases.pr.gov/). (5) La regla federal no aplica a quien es elegible Estatal.

B. Determinaciones de Elegibilidad y para Copagos: (1) Usted tiene derecho a radicar una apelación y solicitar una audiencia para que se revise la determinación de elegibilidad y/o la determinación para [illegible] le notifican mediante esta MA-10 cuando no está conforme con la decisión tomada en su caso. (2) La solicitud debe ser presentada por escrito y dentro de un plazo de 30 días, contados a partir de la Fe[illegible] indicada en esta MA-10. (3) La misma podrá someterse - (a) en persona; en cualquier Oficina Local del Programa Medicaid de PR, (b) por correo a la siguiente dirección: Programa Medicaid, Depa[illegible]ud, P.O. Box 70184, San Juan, PR 00936-8184, o (c) por facsímil (fax): al número (787) 759-8361. (4) El término para apelar vence el: 7 de septiembre de 2017. (5) La determinación será final si usted no apela dentro del término de 30 días.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

CERTIFICO QUE HE LEIDO ESTA NOTIFICACIÓN.

Nombre, Firma de Certificador

Fecha

Nombre y Firma del Solicitante, Beneficiario o Representante

Fecha

Nombre y Firma del Testigo

Fecha

Para el Cliente / Para el Expediente

Attachment 9
Information System

Carrier Eligibility File Layout
(.exp)

CARRIER ELIGIBLITY OUTPUT FILE

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

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"F" for family
2	TRAN-ID	2	1	E=eligible, I=ineligible, R=reject, H= SYSPREM (history), "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period
3	PROCESS-DATE	3	8	MMDDYYYY
4	FAMILY-SSN	11	9	Member SSN
5	FAMILY-SUFFIX	20	2	"00"
6	Filler	22	14	fill blanks
7	FAMILY_ID	36	11	eleven last digit of MPI (MAGI Fam id) Previous version identify like MEMBER_ID
8	Contact last name 1	47	15	Paternal last name of contact person
9	Contact last name 2	62	15	Maternal last name of contact person
10	Contact first name	77	20	First name of contact person
11	REGION	97	1	
12	MUNICIPALITY	98	4	Zero fill, right justify.
13	FACILITY	102	4	Zero fill, right justify.
14	INVESTIGATION-IND	106	1	
15	TRANSACTION-TYPE	107	1	
16	EFFECTIVE-DATE	108	8	Start date of eligibility MMDDYYYY
17	FINANCIAL-RESP-PCT	116	1	
18	CERTIFIER-NUMBER	117	2	
19	EXPIRATION-DATE	119	8	End date of eligibility MMDDYYYY
20	COND-ELIG-IND	127	1	
21	MAILING-ADDRESS1	128	25	
22	MAILING-ADDRESS2	153	25	
23	MAILING-CITY	178	16	
24	MAILING-ZIP	194	5	Zero fill, right justify.
25	MAILING-ZIP4	199	4	Zero fill, right justify.
26	RESIDENCE-ADDRESS1	203	25	
27	RESIDENCE-ADDRESS2	228	25	
28	RESIDENCE-CITY	253	16	
29	RESIDENCE-ZIP	269	5	Zero fill, right justify.
30	RESIDENCE-ZIP4	274	4	Zero fill, right justify.
31	PHONE	278	10	Including area code
32	OTHER-INSURER1	288	2	Insurance co. code NOT USED
33	OTH-POLICY1	290	20	Policy number NOT USED
34	OTHER-INSURER2	310	2	Insurance co. code NOT USED
35	OTH-POLICY2	312	20	Policy number NOT USED
36	OTHER-INSURER3	332	2	Insurance co. code NOT USED
37	OTH-POLICY3	334	20	Policy number NOT USED
38	MEMBERS	354	2	# members in family
39	ODSI-MEMBERS-ELIGIBLE	356	2	# members eligible ODSI / optionals ELA-SB-Vet
40	USER-CODE	358	6	
41	ENTRY-DATE	364	8	MMDDYYYY
42	PCT-OF-POVERTY-LEVEL	372	3	Zero fill, right justify. NOT USED
43	DEDUCTIBLE-LEVEL-CODE	375	1	Zero fill, right justify. NOT USED
44	HCRE-MEMBERS-ELIGIBLE	376	2	# members eligible by ASES. Zero fill, right justify.
45	HCRE-FINANCIAL-CODE	378	2	See Financial Reasons Table
46	CARRIER-CODE	380	2	
47	EFFECTIVE-CARRIER-DATE	382	8	For Family Carrier . MMDDYYYY
48	ELA-ERRORS	390	10	Zero fill, right justify. NOT USED
49	MANCOMUNADO	400	1	Zero fill, right justify. NOT USED
50	FILLER	401	3	
51	PMS-TRX-ID	404	9	PMS-TRX-ID
52	NEW-CARRIER	413	2	New carrier code
53	NEW-HCRE-FINANCIAL-CODE	415	2	New HCRE = Financial Responsibility Percentage Table
54	NEW-EFFECTIVE-DATE	417	8	MMDDYYYY - Effective date of NEW HCRE change
55	CONTRACT NUMBER	432	13	MCO contract number
56	REGION ASES	445	1	
57	NEW CARRIER EFFECTIVE DATE	446	8	New Carrier MMDDYYYY
58	PMS-TRX-ID	454	9	MMDDYYYY

59	CERTIFICATION DATE	462	8	MMDDYYYY
60	PRIMARY CENTER PCP CHANGE REASO	470	2	Basado en tabla de Código de Razón.
61	AUTO_ENROLL_INDICATOR	472	1	0 = Not Auto; >0 = Auto Enroll
62	AUTO_ENROLL_DATE	473	8	MMDDYYYY
63	PAM NEW FAMILY_ID	481	11	New Family_id assigned by PAM for Meditis. Use as a reference only.
64	Application Number	492	10	Medicaid application form number
65	Medicaid_cancellation_dt	502	8	MMDDYYYY
66	Region_move_eff_dt	510	8	MMDDYYYY
67	Rate_cell	518	2	500 Rate Cell table
68	group	520	1	1 Male; 2 Female; 3=Unknown
	next_card_id_date	521	8	MMDDYYYY (use future enrollment
69	FILLER	529	11	
		540		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9-049

CARRIER ELIGIBLITY OUTPUT FILE

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-045

69	MEDICAID INDICATOR	421	1	1=Medicaid Federal, 2=SCHIPS 3=Estatal 4= Estatal otros
70	MEDICARE INDICATOR	422	1	1=A&B, 3=A, 9=B
71	CARRIER	423	2	
72	CARRIER_EFF_DATE	425	8	MMDDYYYY
73	NEW_CARRIER	433	2	
74	NEW_CARRIER_EFF_DATE	435	8	MMDDYYYY
75	PLAN_TYPE	443	2	"bb"=elegible no suscrito, Ver tabla Plan Type
76	PLAN_TYPE_EFF_DATE	445	8	MMDDYYYY
77	PLAN_VERSION	453	3	Version del plan MA suscrito
78	PLAN_VERSION_EFF_DATE	456	8	MMDDYYYY
79	NEW_PLAN_TYPE	464	2	
80	NEW_PLAN_TYPE_EFF_DATE	466	8	MMDDYYYY
81	NEW_PLAN_VERSION	474	3	
82	NEW_PLAN_VERSION_EFF_DATE	477	8	MMDDYYYY
83	INSTITUTIONAL_STATUS	485	1	Y or N
84	HIC NUMBER MA	486	12	If it is Medicare, the MBI number will be included
85	AUTO_ENROLL_INDICATOR	498	1	0 = Not Auto; >0 = Auto Enroll
86	AUTO_ENROLL_DATE	499	8	MMDDYYYY
87	IPA_ESPECIAL	507	1	1 = IPA Especial
88	CMS_Cert_Status	508	2	Status de Certificación en CMS
89	Coverage_Code	510	3	
90	New Contract Number	513	13	
91	Special_Enroll	526	1	E = Emergency N = New Born
92	Cost Sharing flag	527	1	N=No exception, C=Child, P=Pregnant, A=American Indian, I=Institutionalized, H=Hospice
93	Max copay	528	5	Max co-pay for household. Will include two decimal positions.
94	Extension Flag	533	1	N=No extension, A=Pending Appeal, U=Appeal closed, P=pregnancy, X=Other extension, H=Natural Desaster
95	Spend_down Flag	534	1	N=No spend-down involved, S=Spend-down satisfied (If S, required at least one spend-down recordon recod group)
96	[illegible]	[illegible]	[illegible]	[illegible]
97	Filler	538	2	
		540		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

CARRIER ELIGIBLITY OUTPUT FILE - Household Record

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

# Field	Record Fields	Position	Size	Notes
1	Record Type	1	1	"O"
2	TRAN_ID	2	1	E=eligible, I=ineligible, R=Reject, H= SYSPREM (history), "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period order)
3	Process_date	3	8	MMDDYYYY
4	MEMBER ID	11	11	eleven last digit of MPI (MAGI Fam id)
5	MPI_1	22	11	Medicaid MPI related
6	MPI_2	33	11	Medicaid MPI related
7	MPI_3	44	11	Medicaid MPI related
8	MPI_4	55	11	Medicaid MPI related
9	MPI_5	66	11	Medicaid MPI related
10	MPI_6	77	11	Medicaid MPI related
11	MPI_7	88	11	Medicaid MPI related
12	MPI_8	99	11	Medicaid MPI related
13	MPI_9	110	11	Medicaid MPI related
14	MPI_10	121	11	Medicaid MPI related
15	MPI_11	132	11	Medicaid MPI related
16	MPI_12	143	11	Medicaid MPI related
17	MPI_13	154	11	Medicaid MPI related
18	MPI_14	165	11	Medicaid MPI related
19	MPI_15	176	11	Medicaid MPI related
20	MPI_16	187	11	Medicaid MPI related
21	MPI_17	198	11	Medicaid MPI related
22	MPI_18	209	11	Medicaid MPI related
23	Filler	220	320	Fill with empty spaces.
		540		

CARRIER ELIGIBLITY OUTPUT FILE - Insurance Record

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

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"I" for Insurance
2	TRAN-ID	2	1	**E=eligible, "1", "2", "3" = retroactive period (1,2,3 respond to records group, do not respond to period order)**
3	PROCESS-DATE	3	8	MMDDYYYY
4	Family_id	11	11	**eleven last digit of MPI (MAGI Fam id)**
5	Member Suffix	22	2	**"01"**
6	Health Insurer Code	24	3	Code identifies Insurance Company
7	Policy Number	27	20	**If it is Medicare, the MBI number will be included**
8	Policy-EXPIRATION-DATE	47	8	MMDDYYYY
9	Covered Services	55	40	20 coverage code fields (2 character each).
10	***FILLER***	95	***445***	
		540		

*** All are Text Fields

Attachment 9
Information System

Enrollment Record Layout
(.sus)

ENROLLMENT AND CARRIER IPA/PCP CHANGE FILE

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

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

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Attachment 9
Information System

Special adjustment File Layout

Special Adjustment Payments Layouts This file layout is for ascii file created by HIA+ to included special adjustment transactions. **This file is created tab delimited format.**		
Field	size	Comments
Carrier	2	
Carrier name	20	
Region	1	
Region name	19	
Billing date	10	Premium payment process date mm/dd/yyyy
Adjustment type	1	
Adjustment type description	25	
Adjustment amount	6,2	
Original payment	6,2	
Final payment	6,2	
MPI number	13	
Deceased date	10	If adjustment type is decease otherwise is blank, format mm/dd/yyyy
Account date	10	Date to which the payment corresponds

5/22/2017

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Attachment 9
Information System

Premium Payment Detail
820 file Layout

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
ISA	**Interchange Control Header**	**R**					**Interchange Control Header**							
ISA01	Authorization Information Qualifier	R	ID	2 / 2			Authorization Information Qualifier	R	ID	2 / 2				00
ISA02	Authorization Information	R	AN	10 / 10			Authorization Information	R	AN	10 / 10				SPACES(10)
ISA03	Security Information Qualifier	R	ID	2 / 2			Security Information Qualifier	R	ID	2 / 2				00
ISA04	Security Information	R	AN	10 / 10			Security Information	R	AN	10 / 10				SPACES(10)
ISA05	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA06	Interchange Sender ID	R	AN	15 / 15			Interchange Sender ID	R	AN	15 / 15				ASES+SPACES(11)
ISA07	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA08	Interchange Receiver ID	R	AN	15 / 15			Interchange Receiver ID	R	AN	15 / 15				(CARRIER_NAME)+SPACES(VAR)
ISA09	Interchange Date	R	DT	6 / 6			Interchange Date	R	DT	6 / 6				SYSTEM DATE (YYMMDD)
ISA10	Interchange Time	R	TM	4 / 4			Interchange Time	R	TM	4 / 4				SYSTEM TIME (HHMM)
ISA11	Interchange Control Standards Identifier	R	ID	1 / 1		U	Repetition Separator	R	ID	1 / 1		^	Usage	^
ISA12	Interchange Control Version Number	R	ID	5 / 5		00401	Interchange Control Version Number	R	ID	5 / 5		00501	Values	00501
ISA13	Interchange Control Number	R	NO	9 / 9			Interchange Control Number	R	NO	9 / 9				SYSTEM DATE (YYMMDD)+001
ISA14	Acknowledgment Requested	R	ID	1 / 1			Acknowledgment Requested	R	ID	1 / 1				0
ISA15	Production Data	R	ID	1 / 1		P, T	Production Data	R	ID	1 / 1		P, T		P
ISA16	Component Element Separator	R	ID	1 / 1		|	Component Element Separator	R	ID	1 / 1		|		|
GS	**Functional Group Header**	**R**					**Functional Group Header**							
GS01	Functional Identifier Code	R	ID	2 / 2		PO, RA	Functional Identifier Code	R	ID	2 / 2				RA
GS02	Application Sender's Code	R	AN	2 / 15			Application Sender's Code	R	AN	2 / 15				ASES
GS03	Application Receiver's Code	R	AN	2 / 15			Application Receiver's Code	R	AN	2 / 15				(CARRIER_NAME)+SPACES(VAR)
GS04	Date	R	DT	8 / 8			Date	R	DT	8 / 8				SYSTEM DATE (YYYYMMDD)
GS05	Time	R	TM	4 / 8			Time	R	TM	4 / 8				SYSTEM TIME (HHMM)

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

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 Identifier Description BY SIDE Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	ASES
BPR12	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,04	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,02,04	Values	
BPR13	Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12			Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12				
BPR14	Account Number Qualifier	S	ID	1 / 3		DA,SG	Account Number Qualifier	S	ID	1 / 3		DA,SG		
BPR15	Receiver Bank Account Number	S	AN	1 / 35			Receiver Bank Account Number	S	AN	1 / 35				
BPR16	Check Issue or EFT Effective Date	R	DT	8 / 8			Check Issue or EFT Effective Date	R	DT	8 / 8				Check Date
TRN	**Reassociation Key**	**R**					**Reassociation Trace Number**	**R**					**Desc.**	
TRN01	Trace Type Code	R	ID	1 / 2		1,3	Trace Type Code	R	ID	1 / 2		1,3		3
TRN02	Check or EFT Trace Number	R	AN	1 / 30			Check or EFT Trace Number	R	AN	1 / 50			Max	Check Number
TRN03	Originating Company Identifier	S	AN	10 / 10			Originating Company Identifier	S	AN	10 / 10				
TRN04	Originating Company Supplemental Code	S	AN	1 / 30			Originating Company Supplemental Code	S	AN	1 / 50			Max	
CUR	**Non-US Dollars Currency**	**S**					**Foreign Currency Information**	**S**						
CUR01	Entity Identifier Code	R	ID	2 / 3		2B,PR	Entity Identifier Code	R	ID	2 / 3		2B,PR		
CUR02	Currency Code	R	ID	3 / 3		MXP,CAD,USD	Currency Code	R	ID	3 / 3		MXP,CAD	Values	
CUR03	Exchange Rate	S	R	4 / 10									Usage Req.	
REF	**Premium Receiver Identification Key**	**S**					**Premium Receiver Identification Key**	**S**						
REF01	Reference Identification Qualifier	R	ID	2 / 3		14,18,2F,38,72	Reference Identification Qualifier	R	ID	2 / 3		14,17,18,2F,38,72,LB	Values	14
REF02	Premium Receiver Reference Identifier	R	AN	1 / 30			Premium Receiver Reference Identifier	R	AN	1 / 50			Max	CARRIER+REGION_ID+PRIMARY_CENTER
DTM	**Process Date**	**S**					**Process Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		
DTM02	Payer Process Date	R	DT	8 / 8			Payer Process Date	R	DT	8 / 8				
DTM	**Delivery Date**	**S**					**Delivery Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		
DTM02	Premium Delivery Date	R	DT	8 / 8			Premium Delivery Date	R	DT	8 / 8				
DTM	**Coverage Period**	**S**					**Coverage Period**	**S**						

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
DTM01	Date Time Qualifier	R	ID	3 / 3		582	Date Time Qualifier	R	ID	3 / 3		582		
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3			Date Time Period Format Qualifier	R	ID	2 / 3				
DTM06	Coverage Period	R	AN	1 / 35			Coverage Period	R	AN	1 / 35				
DTM							**Creation Date**	**S**					**New**	
DTM01							Date Time Qualifier	R	ID	3 / 3		097	New	
DTM02							Creation Date	R	DT	8 / 8			New	
N1	**Premium Receiver's Name**	**R**			**1000A**		**Premium Receiver's Name**	**R**			**1000A**			
N101	Entity Identifier Code	R	ID	2 / 3	1000A	PE	Entity Identifier Code	R	ID	2 / 3	1000A	PE		PE
N102	Information Receiver Last or Organization Name	R	AN	1 / 60	1000A		Information Receiver Last or Organization Name	R	AN	1 / 60	1000A			CARRIER_NAME
N103	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	N/U w/N102	FI
N104	Receiver Identifier	R	AN	2 / 80	1000A		Receiver Identifier	R	AN	2 / 80	1000A		N/U w/N102	CARRIER_FEDERAL_TAX_ID
N2	**Premium Receiver's Additional Name**	**S**					**Premium Receiver's Additional Name**	**S**						
N201	Receiver Additional Name	R	AN	1 / 60	1000A		Receiver Additional Name	R	AN	1 / 60	1000A			
N3	**Premium Receiver's Address**	**S**					**Premium Receiver's Address**	**S**						
N301	Receiver Address Line	R	AN	1 / 55	1000A		Receiver Address Line	R	AN	1 / 55	1000A			
N302	Receiver Address Line	S	AN	1 / 55	1000A		Receiver Address Line	S	AN	1 / 55	1000A			
N4	**Premium Receiver's City, State, Zip**	**S**					**Premium Receiver's City, State, Zip Code**	**S**					**Desc.**	
N401	Information Receiver City Name	R	AN	2 / 30	1000A		Information Receiver City Name	R	AN	2 / 30	1000A			
N402	Information Receiver State Code	R	ID	2 / 2	1000A		Information Receiver State Code	S	ID	2 / 2	1000A		Usage Req.	
N403	Information Receiver Postal Zone or ZIP Code	R	ID	3 / 15	1000A		Information Receiver Postal Zone or ZIP Code	S	ID	3 / 15	1000A		Usage Req.	
N404	Country Code	S	ID	2 / 3	1000A		Country Code	S	ID	2 / 3	1000A			
N407							Country Subdivision Code	S	ID	1 / 3	1000A		New	
RDM							**Premium Receiver's Remittance Delivery Method**	**S**					**New**	

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

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

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

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

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

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	ASES 820 5010 Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	ASES
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		11
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	FAMILY_ID+Member_Suffix+MPI+Municipio
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			
REF - 1							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
DTM - 1	**Individual Coverage Period**	**S**					**Individual Coverage Period**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3	2300B	582	Date Time Qualifier	R	ID	3 / 3	2300B	582,AAG	Values	582
DTM02							Date	S	DT	8 / 8	2300B		Usage Req.	
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3	2300B	RD8	Date Time Period Format Qualifier	S	ID	2 / 3	2300B	RD8	Usage Req.	RD8
DTM06	Coverage Period	R	AN	1 / 35	2300B		Coverage Period	S	AN	1 / 35	2300B		Usage Req.	Coverage Start Dt-Coverage End Dt based upon CALC_DAYS. Use Accounting Dt for retro and adjustments. (YYYYMMDD)
RMR - 2	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		IK
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	CARRIER_ID+REGION+BILLING_DATE(YYMM)
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			BILLED_AMOUNT

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

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

Attachment 9
Information System

Member MCO Move Notification File Layout

Member MCO Change Notification File Layout:				
Format: Windows text (.TXT) file, with **no** special characters (tabs, etc.)				
Field	**Start**	**End**	**Length**	**Comments**
OLDMBR	1	18	18	Member ID
OLDCAR	19	27	9	Old Carrier ID
OLDACC	28	42	15	Old Account ID
OLDGRP	43	57	15	Old Group ID
NEWMBR	58	75	18	Member ID
NEWCAR	76	84	9	New Carrier ID
NEWACC	85	99	15	New Account ID
NEWGRP	100	114	15	New Group ID

Notes Regarding Member Moves:

* Please complete all items.

**Forms missing information will be returned and request will be delayed until completed.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04

Attachment 9
Information System

Enrollment Error Codes

Subscription Error Table Rev. 7/26/2017

Error Code	Error Message	Additional Description	Possible Corrective Actions
011 (Record Type)	Invalid Record Type Code.	**This field is required to be filled with code "E" in every case.**	Fill with code "E".
021 (Tran_ID)	Tran_ID field is blank.	**This field is required to be filled with information about the type of transaction being processed.**	Fill this field with the corresponding code.
022 (Tran_ID)	Invalid "Tran ID".	**An invalid transaction code has been identified.**	Fill this field with a valid transaction code.
023 MAGI	If the field "Special Enroll" has been filled with code "T", then the field "Tran_ID" should contain code "E" for new enrollments or code "C" if the transaction is about a carrier change.	**For retroactive transactions ("T"), the field Tran_ID should be filled with code "E" or "C", accordingly.**	Verify and correct the information contained in the field
031 (Process_Date)	Process date field is blank.		
032 (Process_Date)	Invalid process date.		
033 (Process_Date)	Except for the cases about newborns, for GHIP transactions, the process date should be lesser or equal to the effective date of the new enrollment or the change that is notified and greater or equal to three months before the effective date.	**For GHIP (Plan Type = 01) the process date should be lesser or equal to the effective date of the new enrollment or the change notified. The process date should fall within three (3) months before the effective date.**	Compare the process date with the effective date of the new subscription or the change about the record notified.
034 (Process_Date)	For GHIP transactions with Tran_Id = "E" and process date greater or equal to '11/16/2006', the effective date cannot be equal to '11/01/2006'.	**Special code for the coverage code conversion of November 2006.**	Verify the effective date.
035 (Process_Date)	For Platino transactions, the process date should be within three (3) months before the effective date.	**For Platino (Plan Type = 02 or 03) the process date should be before the effective date. The process date of the new enrollment or change in the enrollment record should fall within three months before the effective date.**	Compare the process date to the effective date and correct.
041 (Region)	Region code field is blank.		Fill the field with the corresponding region code.

042 (Region)	Invalid region code.		Verify and fill the field with the corresponding region code.
051 (Carrier)	Carrier code field is blank.		Verify and fill the field with the corresponding carrier code.
052 (Carrier)	Invalid carrier code provided.		Verify and fill the field with the corresponding carrier code.
053 (Carrier)	The carrier has notified that a change of carrier has been performed but the carrier notifying the change is the same as the one registered in ASES's database.	**The enrollment has code "C" (carrier change) in the "Tran_ID" field and the carrier is the same as the one identified in the beneficiary's record in ASES.**	Verify if the record should have been sent with another "Tran_ID" (V or I, for example). If that's not the case, the beneficiary is already enrolled in the database with the submitting carrier and no further action is required.
054 (Carrier)	If the "Plan Type" = 01, the "Tran_ID" is "C" or "D" and the enrollment effective date ("Effective Date") is in the future, this date should on or before the first of the month three months in the future from the current date.	**The future disenrollment or carrier change transactions should have effective dates on or before the first of the month three months in the future from the current date.**	The effective date of the future disenrollment or carrier change transactions should fall on or before the first of the month three months in the future from the current date.
061 (IPA o PHO code)	It has been identified that the "Tran_ID" is "E", "C", "P", "V" or "I". These changes require that the Primary Medical Group (PMG) field contains PMG information.	**Specifying the Primary Medical Group is required when the enrollment for a GHIP carrier, or a Platino carrier for which the PMG is required, has a "Tran_ID" "E", "C", "P", "V" or "I".**	Provide the corresponding PMG code.
62 (IPA o PHO Code)	The "Tran_ID" is "1", "2" or "3" and the specified PMG is different from the PMG enrolled in the ASES databases.	**The enrollment is about a PCP change but the transaction contains a PMG different from the one that is currently enrolled in the ASES records.**	The PCP changes are accepted in the ASES databases if the record concurs with the carrier code, Plan Type, Version and PMG that is registered in the current data. Verify if the intention is to change both the PMG and the PCP and submit a PMG change (Tran_ID=I) with new PMG and PCP codes. If that is not the case, then correct the PMG field.
063	The "Tran_ID" is "I" and the Primary Medical Group (PMG) specified is equal to the Primary Medical Group stated in the current data from the ASES databases.	**The carrier has sent a PMG change related to a beneficiary but the PMG stated in the current data from ASES databases concurs with the one sent.**	Verify if the record should have been sent with another "Tran_ID". If that is not the case, the beneficiary is already enrolled in the databases with the corresponding PMG and no further action is required.

(IPA o PHO Code)			
064 (IPA o PHO Code)	If the transaction is about a disenrollment (Tran_ID="D"), the field "Member Primary Center" should be blank.		Verify if the transaction is about a disenrollment. If that is the case, remove the PMG information.
071 (ODSI_Family_ID)	"Family ID" information is required and the corresponding field is blank.		Include the eleven (11) characters code corresponding to the "Family ID" assigned by ASES.
072 (ODSI_Family_ID)	The "Family ID" code provided does not contain eleven (11) characters.		Include the eleven (11) characters code corresponding to the "Family ID" assigned by ASES.
073 (ODSI_Family_ID)	The "Family ID" was not found at the region specified.	**The "Family_ID" was not found under the corresponding region in the ASES eligibility records.**	Verify if the "Family ID" sent is the correct one. Verify if the region code corresponds with the beneficiary.
081 (Member_SSN)	The beneficiary's social security number is required and the field is blank.		Include the beneficiary's social security number.
082 (Member_SSN)	The beneficiary's social security number does not contain nine (9) characters.		Verify this information and provide the beneficiary's social security number.
091 (Member_Suffix)	The information related to the suffix that identifies the beneficiary is required and the corresponding field is blank.	ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 10-049	Provide the suffix that identifies the beneficiary.
092 (Member_Suffix)	The suffix that identifies the beneficiary that was provided by the carrier does not contain two (2) characters.		Provide the two (2) characters suffix that identifies the beneficiary.
093 (Member_Suffix)	The suffix that identifies the beneficiary was not found in the ASES eligibility records databases under the region and family identifier specified.	**A record for the beneficiary's suffix was not found, under the region and family identifier specified, in the ASES database.**	Verify that the suffix assigned in the carrier's database concurs with the one registered in the ASES database. If the "Family_ID" contains an error this error code will appear.
101 (Effective_Date)	The effective date information is required and the field is blank.		Provide the effective date.

102 (Effective_Date)	Invalid Effective Date.		Provide a valid effective date.
103 (Effective_Date)	For new enrollments under a GHIP plan, the effective date should be before the daily run date ("Run Process Date") at ASES.	**For a new enrollment under the GHIP plan (Plan Type=01) and Tran_ID=E the effective date should be before the daily run date at ASES. It is presumed that a beneficiary has been enrolled with the carrier before the enrollment record has been sent to ASES. The new enrollments should not be sent with future effective dates.**	Verify the dates and proceed to correct.
104 (Effective_Date)	**For transactions related to the GHIP plan (Plan Type=01) which "Tran_ID" is not "1", "2", "3", "E", "O" o "D", the effective date should be after the enrollment process date and it should be on the first of the following month.** Only applies to GHIP plans and only when the transaction is not about a PCP change, a new enrollment or a disenroll ("D").	**For transactions related to the GHIP plan (Plan Type=01) which "Tran_ID" is not "1", "2", "3", "E", "O" o "D", the effective date should be after the process date and it should be on the first of the following month after the process date at ASES.**	Verify the dates and proceed to correct.
105 (Effective_Date)	The Platino plans enrollment effective date that does not have Tran_ID "1", "2", "3" or "D", should be on the first of the month of the beneficiary's enrollment.		Verify that the Platino enrollment effective date is on the first of the month of the beneficiary's enrollment.
106 (Effective_Date)	For a disenrollment transaction (TRAN_ID="D"), the transaction effective date should be on the first of the following month.		
107 (Effective_Date)	The enrollment effective date of the transaction sent should fall within the family group's last eligibility period.	**The eligibility of the family, to which the beneficiary corresponds, was cancelled after the effective date of the enrollment sent.**	These cases will be submitted as candidates for enrollment in the historical data under the enrollment system (SYSPREM).

109 **MAGI (Effective_Date)**	A code 'T' was not included in the 'Special Enroll' field and a SYSRETRO record, specifying an eligibility period that covers the enrollment effective date sent by the carrier, has been identified.	**A code 'T' was not included in the 'Special Enroll' field for an enrollment that corresponds to a SYSRETRO period.**	Verify if the transaction is about a retroactive enrollment under MAGI. If that is the case, include code "T" in the "Special Enroll" field.
10A **(Effective_Date) Emergencias**	If the field "Special_Enroll" ="E", then, **for** GHIP beneficiaries funded through state funds, **the effective date should be greater or equal than the Certification Date. For federally funded GHIP beneficiaries (Medicaid and CHIP), the Effective Date should be greater or equal than the Eligibility Effective Date.**	**For emergency cases the effective date cannot be before the certification date (State funded GHIP) or the eligibility effective date (Federally GHIP, Medicaid and CHIP).**	Verify the effective dates and certification date and proceed to correct.
10B **(Effective_Date)**	If the field "Special_Enroll" ="N", the effective date should be greater or equal than the beneficiary's birth date and it should not surpass the period of a year calculated from the birth date.	**The newborn enrollments' effective date cannot be before the birth date nor can it extend for more than one (1) year calculated from the birth date.**	Verify that the effective date concurs with the birth date and that it does not surpass the period of one (1) year calculated from the birth date.
111 **(Plan_Type)**	The Plan Type code is required and the field is blank.		Include the required information related to the Plan Type.
112 **(Plan_Type)**	The provided Plan Type code does not contain two (2) characters.		Verify and provide the corresponding Plan Type code.
113 **(Plan_Type)**	The provided Plan Type, Carrier Code and Plan Version are incorrect.	**The enrollment records are required to correspond with the Plan Type and Plan Version contracted with ASES by the carrier.** **The Plan Version code, for Platino plans, should concur with the Plan Version code assigned by ASES; for GHIP plans, this code should equate to the**	Verify this information and correct.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

114 **(Plan_Type)**	For disenrollment transactions (Tran_ID ="D"), code "01" (GHIP) should be included in the "Plan Type" field.		Verify the transaction type and include code 01 (GHIP) in the Plan Type field.
121 **(Plan_Version)**	The Plan Version code is required and the field is blank.		Include the information corresponding with the Plan Version.
122 **(Plan_Version)**	The Plan Version code does not contain three (3) characters.		Verify the information and provide the three (3) characters code corresponding to the Plan Version.
123 **(Plan_Version)**	The provided Plan Version code is invalid for the specified Effective Date.	**The Plan Version code should be one that is active at the Effective Date indicated.**	Verify the Plan Version code and/or Effective Date.
124 **(Plan_Version)**	Invalid Plan Version code. If the transaction is about a disenrollment (Tran_ID="D"), the plan version code should be 001.	**If the transaction is about a disenrollment (Tran_ID =D), then the Plan Version field should contain the code "001".**	Verify the transaction type and include the corresponding code.
131 **(MPI)**	The provided "MPI Number" does not contain thirteen (13) characters.		Verify the included code. Provide the thirteen (13) characters code of the corresponding MPI Number.
132 **(MPI)**	The "MPI Number" does not concur with the ASES records for the region specified.		Verify that the correct MPI Number has been provided. Verify if the region code sent corresponds with the region to which the beneficiary corresponds.
141 **(PCP1)**	The PCP1 field is blank and the transaction is not type "2" or "D" (which require this field to be blank).	**The PCP1 field should not be blank if the PCP1 is required and the transaction is not type "2" or "D".**	Verify the transaction type and include the corresponding PCP1 code.
142 **(PCP1)**	The PCP1 should be blank when the Tran ID is "2" or "D".	**If the transaction is about a PCP2 change or a disenrollment, the PCP1 field should be blank.**	Verify the transaction type. If the transaction is about a PCP2 change, remove the information included in the PCP1 field.
151 **(PCP1_Effective Date)**	The PCP1 field is blank and the Tran_ID is neither "2" nor "D".	**The PCP1 field is blank or the provided date is invalid in a transaction for which the PCP1 information was required.**	Verify and correct.

		required.	
152 (PCP1_Effective Date)	An invalid effective date was provided for the PCP1 Effective Date and this information was required.	**The PCP1 effective date field is blank or the provided date is invalid.**	Verify the error and correct.
153 (PCP1_Effective Date)	**There is information in the PCP1 effective date field and the transaction is not about a PCP2 change or a disenrollment and the PCP1 is not required.**	**The PCP1 effective date should be blank when the enrollment does not imply a PCP2 change and the PCP1 is not required.**	Verify and correct.
154 (PCP1_Effective Date)	The field corresponding with the PCP1 effective date should be blank when the transaction is about a PCP2 change or a disenrollment.	**The PCP1 effective date should be blank when the transaction is about a PCP2 change or a disenrollment.**	Verify and correct.
155 (PCP1_Effective Date)	**For transactions of new enrollment, the PCP1 effective date should be before the daily run process date at ASES.**	**For the GHIP plan ("Plan Type=01") the date for a new enrollment should be before the daily run process date at ASES. It is presumed that the beneficiary was enrolled before the enrollment record was sent to ASES. New enrollment records are not performed with future dates.**	Verify and correct.
156 (PCP1_Effective Date)	Barring new enrollment transactions, the PCP1 effective date should concur with the first day of the following month.	**For transactions about a PCP1 change, the PCP1 effective date should be on the first day of the month following the notification of the change.**	Verify the effective date provided for the PCP1 change.
157 (PCP1_Effective Date)	If the PCP1 field is not blank, the field corresponding with the PCP1 effective date should not be blank.	**When there is data in the PCP1 field, there should be a valid date in the PCP1 effective date field and vice versa.**	If the transaction is about the PCP1, verify and include the information in the appropriated field.

158 **(PCP1_Effective Date)**	For enrollments having Tran_ID 'E','C' or 'I', in which the PCP1 field is not blank, the PCP1 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','1','3', in which the PCP1 field is not blank, the PCP1 effective date should be greater or equal than the existing enrollment effective date.	**For enrollments having Tran_ID 'E','C' or 'I', in which the PCP1 field is not blank, the PCP1 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','1','3', in which the PCP1 field is not blank, the PCP1 effective date should be greater or equal than the existing enrollment effective date.**	Verify the provided PCP1 effective date.
161 **(PCP2)**	The PCP2 field is blank and the transaction is about a PCP2 change or a PCP1 and PCP2 change (Tran_ID= "2" or "3").	**The transactions about a PCP2 change or a PCP1 and PCP2 change require information in the PCP2 field.**	Verify and include the information missing in the PCP2 field.
162 **(PCP2_Effective Date)**	The PCP2 field should be blank when the transaction is not about a PCP2 change or a PCP1 and PCP2 change (Tran_ID= "2" or "3").	**If the transaction is about a PCP1 change or a disenrollment (Tran_ID="1" or "D") the PCP2 field should be blank.**	Verify if the transaction is about a PCP1 change or a disenrollment. If that is the case, remove the information from the PCP2 field.
171 **(PCP2_Effective Date)**	The PCP2 effective date field is blank and the transaction is about a PCP2 change or a PCP1 and PCP2 change (Tran_ID "2" or "3").	**The transactions about a PCP2 change or a PCP1 and PCP2 change (Tran_ID "2" or "3") require a valid effective date in the PCP2 effective date field.**	Verify and correct.
172 **(PCP2_Effective Date)**	Invalid PCP2 effective date.	**An invalid date has been found in the PCP2 effective date field.**	Verify the PCP2 effective date and correct.
173 **(PCP2_Effective Date)**	**For transactions of new enrollment in which the PCP1 field is not blank, the PCP2 effective date should be before the daily run process date at ASES.**	**For new enrollments (Tran_ID=E) under a GHIP plan ("Plan Type=01) the PCP2 effective date should be before the daily run process date at ASES. It is presumed that the beneficiary was enrolled before the enrollment record was sent to ASES. The system will not be able to process new enrollments**	Verify these dates and proceed to correct.

		with future dates in this field.	
174 **(PCP2_Effective Date)**	Barring new enrollment transactions, the PCP2 effective date should concur with the first day of the month following the notification of the change.	**For transactions about a PCP2 change, the PCP2 effective date should be on the first day of the month following the notification of the change.**	Verify that the PCP2 effective date is on the -first day of the month following the notification of the change.
175 **(PCP2_Effective Date)**	If the PCP2 field is not blank, the field corresponding with the PCP1 effective date should not be blank and vice versa.	**When there is data in the PCP2 field, there should be a valid date in the PCP2 effective date field and vice versa.**	Verify the related fields and proceed to include the missing information.
176 **(PCP2_Effective Date)**	If the transaction is about a disenrollment (Tran_ID="D"), then the PCP2 effective date field should be blank.		Verify the transaction type and remove any PCP2 information that is not required.
177 **(PCP2_Effective Date)**	It has been identified that the beneficiary is already enrolled with another carrier for a date equal or after the Effective Date of the enrollment sent. This error applies to cases of new enrollment and carrier change.	**The beneficiary is already enrolled at ASES with another carrier for a date equal or after the effective date of the enrollment sent.**	Verify that the effective date sent to ASES corresponds with the appropriated date.
178 **(PCP2_Effective Date)**	For enrollments having Tran_ID 'E','C' or 'I', in which the PCP2 field is not blank, the PCP2 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','2','3', in which the PCP2 field is not blank, the PCP2 effective date should be greater or equal than the existing enrollment effective date.	**For enrollments having Tran_ID 'E','C' or 'I', in which the PCP2 field is not blank, the PCP2 effective date should be equal to the effective date of the enrollment to be applied. For enrollments having Tran_ID 'P','V','2','3', in which the PCP2 field is not blank, the PCP2 effective date should be greater or equal than the existing enrollment effective date.**	Verify the provided PCP2 effective date.

181 **(Family_Primary_ Center)**	For GHIP plans, it is required to provide information about the Family Primary Medical Group.	For GHIP plans, the information about the Family Primary Medical Group is required.	Include the corresponding Primary Medical Group code for the corresponding Family.
182 **(Family_Primary_ Center)**	The transaction did not require information about the Family Primary Medical Group and information was provided for said field.	ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 19-049	Verify the transaction type and remove the information not required from the corresponding field.
183 **(Family_Primary_ Center)**	If the transaction is about a disenrollment (Tran_ID="D"), the Primary Medical Group field should be blank.	**The transaction is about a disenrollment "D" and there is information in the Primary Medical Group field.**	Verify the transaction type and remove the information not required from the PMG field.
191 **(Family_Primary_ Center Effective _Date)**	The effective date for the Family Primary Medical Group is clank and the information in this field is required.		Include a valid effective date in the Family Primary Medical Group field.
192 **(Family_Primary_ Center Effective _Date)**	The Family Primary Medical Group effective date included is not valid.	**An invalid date was found in the Family Primary Medical Group effective date field.**	Verify the PMG effective date and provide the corresponding date.
193 **(Family_Primary_ Center Effective _Date)**	The information for the Family Primary Medical Group is not required and there should be no information in this field.	**The information for the Family Primary Medical Group is not required and there is information in this field.**	If this information should not be sent, remove the information provided in this field.
194 **(Family_Primary_ Center Effective _Date)**	If the transaction is about a disenrollment (Tran_ID="D") this field should be blank.		If the transaction is about a disenrollment, remove the information provided in this field.
200 **(IPA PCP Change Reason)**	If the transaction is about a disenrollment (Tran_ID="D"), then the PMG or PCP Change Reason field should be blank.	If the transaction is about a disenrollment, then the PMG or PCP Change Reason field should be blank.	If the transaction is about a disenrollment, remove the information provided in the PMG or PCP Change Reason field should be blank.

211 **Medicaid_IND**	The Plan Version and Type are incorrect. The beneficiary does not receive medical services under Federal Medicaid.	**The Plan Version and Type codes provided by the carrier require that the beneficiary is eligible to receive services under Federal Medicaid and the ASES database states that the beneficiary is not eligible for that coverage.**	Verify and submit the corresponding information.
221 **(Relationship Edit)**	Duplicate enrollment.	**Two or more enrollment records with the same Family_ID and suffix were identified in the same daily run process cycle at ASES.**	Verify this information.
222	The transaction is about a new enrollment and the beneficiary is already enrolled under the same carrier trying to enroll it through this transaction.	**The transaction is about a new enrollment and it has been identified that the beneficiary is already enrolled under the same carrier as the one sending the enrollment.**	Verify if the record should have been sent with another "Tran_ID" like, for example, "V" or "I". If that is not the case, the beneficiary is already enrolled and no further action is required.
223	The transaction is about a new enrollment and the beneficiary is already enrolled with another carrier.	**The transaction is about a new enrollment (Tran_ID = "E") and beneficiary records of enrollment under another carrier have been found at the ASES database.**	Verify if the enrollment record should have been sent with a carrier change code included in the "Tran_ID".
224	The beneficiary was not eligible for the effective date indicated by the carrier.		Verify the effective date.
225 **(Member_SSN)**	The social security number provided was not found in the ASES databases current data.		Verify and correct the social security number.
226 **(MPI)**	The MPI Number sent was not found in the ASES databases current data.		Verify and correct the MPI Number.
227 **(Plan Type change)**	The transaction is about a Plan Type change and the carrier sending it is different from the carrier currently enrolled in the ASES databases.	**Only the carrier registered in the ASES database at the moment a Plan Type change is submitted may submit a Plan Type change in the enrollment record.**	Verify if the record should have been sent with another Tran_ID.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9-049

228 **(Plan Version change)**	The transaction is about a plan version change (Trans_ID= "V") and the carrier or plan type submitted do not concur with the data found in the ASES database.	**The plan type changes are accepted by the system if they are sent by the same carrier and under the same plan type registered in the current data at ASES.** **Only the carrier registered in the ASES database at the moment a Plan Version change is submitted may submit a Plan Version**	Verify if the record should have been sent with another Tran_ID.
229 **(IPA change)**	The transaction is about a PMG change (Trans_ID= "I") and the carrier, plan type or plan version submitted do not concur with the data found in the ASES database.	**The PMG changes are permitted if they are sent by the carrier, plan type and plan version registered in the current data at ASES.** **Only the carrier registered in the ASES database at the moment a PMG change is submitted may submit a PMG change in the enrollment record.**	Verify if the record should have been sent with another Tran_ID.
22A **(PCP1, PCP2 o PCP1 and PCP2 change)**	The transaction is about a PCP1, PCP2 or PCP1 and PCP2 change ("Tran_ID" ="1", "2" o "3") and the carrier, Plan Type, Plan Version and PMG do not concur with the current data in the ASES databases.	**The PCP changes are permitted under the same carrier, Plan Type, Plan Version and PMG as stated by the beneficiary's current data at ASES. This error suggests that the beneficiary is currently enrolled under another carrier, Plan Type, Plan Version or PMG in the ASES database.**	Verify if the record should have been sent with another Tran_ID.
22B **(PCP1 Effective Date; PCP2_Effective_Date)**	If the transaction is about a PCP1 and PCP2 change (Tran ID=3), both the PCP1 and PCP2 effective dates should be future or retroactive dates.	**Both the PCP1 and PCP2 effective dates should be future or retroactive dates.**	Verify the dates for PCP1 and PCP2 and correct.

22D	Invalid date values for enrollments of future effect. This error applies to all the transactions that are not of type "D".	**The PCP, PMG, Plan Version and carrier changes cannot be sent with dates more than four (4) months into the future. This error applies to all the transactions that are not of type "D".**	
22E	If the plan type is GHIP ("Plan Type" =01), then the plan version should be equal to the "Coverage Code".	**For the GHIP enrollment record ("Plan Type" 01) the plan version code should concur with the coverage code registered in ASES database for the beneficiary being enrolled.**	Verify and correct.
22F	All GHIP beneficiaries from a same family group will be rejected if a record corresponding to any of them is marked with an error code.	**When a GHIP beneficiary's enrollment record contains an error, every record from beneficiaries belonging to the same family group receives a 22F error code. This has the effect of maintaining all the beneficiary records under a same family record and avoids the partial processing of the family in a same daily run process cycle at ASES.**	Verify and correct every additional error identified other than the 22F codes for every GHIP beneficiary in the family.
22G	if PLAN_TYPE="02" or "03" (Platino) then PLAN_VERSION in the Enrollment record should match the PLAN_VERSION with the same	**For Platino enrollments: The member Coverage Code is assigned a specific Version in the Plan Detail Table. If a different Version is used this error will be produced. For members with Coverage Code 310, 320 or 330 the Version for Coverage Code 110 must be used.**	Correct Version and submitt Enrollment again.
250 **(HIC Number)**	If the transaction is about a disenrollment (Tran_ID="D") the HIC Number field should be blank.	**There should be no information in the "HIC Number" field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment ("D"), remove the information provided in the HIC Number field.
251 **(HIC Number)**	If the enrollment is for a Platino, the HIC Number should be eleven (11) characters long.	**If the enrollment is for a Platino, the HIC Number should be eleven (11) characters long.**	Correct the HIC Number and submit the Enrollment again.

260 **(IPA_Special)**	If the transaction is about a disenrollment (Tran_ID="D") the IPA_SPECIAL field should be blank.	**There should be no information in the IPA_SPECIAL field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment ("D"), remove the information provided in the IPA_SPECIAL field.
270 **(Medicare Indicator)**	If the transaction is about a disenrollment ("Tran_ID" = "D") the "Medicare Indicator" field should be blank.	**There should be no information in the Medicare Indicator field if the transaction is about a disenrollment ("D").**	If the transaction is about a disenrollment "D", remove the information provided in the Medicare Indicator field.
280	The family should be eligible at the moment the record is being processed.	**Family not eligible at the moment the record is being processed.**	
281	The beneficiary should be eligible at the moment the record is being processed.	**Beneficiary not eligible at the moment the record is being processed.**	
998	Record number is blank.	**Transaction without Record Number. Does not constitute an error. No further action required.**	No action required.
999	The record number sent does not concur with a previous record number from a previous transfer.	**The record number sent does not concur with a record number from a previous transfer. Does not constitute an error. No further action required.**	No action required.

Attachment 9
Information System

Special adjustment File Layout

Special Adjustment Payments Layouts This file layout is for ascii file created by HIA+ to included special adjustment transactions. **This file is created tab delimited format.**		
Field	size	Comments
Carrier	2	
Carrier name	20	
Region	1	
Region name	19	
Billing date	10	Premium payment process date mm/dd/yyyy
Adjustment type	1	
Adjustment type description	25	
Adjustment amount	6,2	
Original payment	6,2	
Final payment	6,2	
MPI number	13	
Deceased date	10	If adjustment type is decease otherwise is blank, format mm/dd/yyyy
Account date	10	Date to which the payment corresponds

5/22/2017

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Attachment 9
Information System

MCO Change Transfer
Member Information
File Layout

Field #	Field Name	Sys Req	Type	Length	Start	End	Comments	MC-21 Comments
1	CARRIER	YES	A/N	9	1	9	Carrier ID	Required
2	ACCOUNT	YES	A/N	15	10	24	Account ID	Required
3	GROUP	YES	A/N	15	25	39	Group ID	Required
4	MEMBER ID	YES	A/N	18	40	57	Member ID	Required
5	PERSON CODE	NO	A/N	3	58	60		Required ASES -- Will be filled with 01 by default (MAGI)
6	RELATIONSHIP CODE	NO	A/N	1	61	61	0=Not Specified; 1=Cardholder; 2=Spouse; 3=Child; 4=Other	
7	LAST NAME	YES	A/N	25	62	86		Required
8	FIRST NAME	YES	A/N	15	87	101		Required
9	MIDDLE INITIAL	NO	A/N	1	102	102		Required
10	SEX	NO	A/N	1	103	103	F=Female; M=Male	Required
11	DATE OF BIRTH	NO	N	8	104	111	CCYYMMDD	Required
12	MULTIPLE BIRTH CODE	NO	N	1	112	112		
13	MEMBER TYPE	NO	A/N	1	113	113	1=Dependent Parent; 2=Disabled Dependent; 3=Spousal Equivalent; 4=Student; 5=Non-student dependent; 6=COBRA; 7=COBRA wait	

14	LANGUAGE CODE	NO	A/N	3	114	116	**100**=English (DEFAULT); **200**=French; **300**=Spanish Additional values provided in **Language Code** table	
15	DUR FLAG	NO	A/N	1	117	117	Not currently supported (DEFAULT=Y)	
16	DUR KEY (ASES PCP)	NO	A/N	18	118	135		Required – ASES Position 1-10 PCP License Number; Position 11: Blank; Positions 12-18 PCP Specialty Code
17	SOCIAL SECURITY NUMBER	NO	N	9	136	144	999999999	Required - Beneficiary SSN
18	ADDRESS1	NO	A/N	40	145	184		Not Required but Highly Recommended
19	ADDRESS2	NO	A/N	40	185	224		Not Required but Highly Recommended
20	ADDRESS3	NO	A/N	40	225	264		Not Required but Highly Recommended
21	CITY	NO	A/N	20	265	284		Not Required but Highly Recommended

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

22	STATE	NO	A/N	2	285	286		Not Required but Highly Recommended
23	ZIP	NO	A/N	5	287	291		Not Required but Highly Recommended
24	ZIP2	NO	A/N	4	292	295		Not Required but Highly Recommended
25	ZIP3	NO	A/N	2	296	297		Not Required but Highly Recommended
26	COUNTRY	NO	A/N	4	298	301	(DEFAULT=USA)	Required: Used for the 4-Digits ASES City Code (Municipality Code)
27	PHONE	NO	N	10	302	311	9999999999	Required: ASES HOH SSN Position 1 must be 0
28	FAMILY FLAG	NO	A/N	1	312	312	N=No; Y=Yes	
29	FAMILY TYPE	NO	A/N	1	313	313	1=Family; 2=Cardholder; 3=Cardholder & Spouse; 4=Cardholder & Dependents; 5=Spouse & Dependents; 6=Dependents; 7=Spouse only; 8=Member + 1; 9=Cardholder plus 1 Dependent; A=Cardholder + 2	Not Required 2=Cardholder; Recommended
30	FAMILY ID	NO	A/N	18	314	331		Required: ASES Family ID Number First 11 positions must be filled.

31	ORIGINAL FROM DATE	NO	N	7	332	338	CYYMMDD	
32	BENEFIT RESET DATE	NO	N	7	339	345	CYYMMDD	
33	MEMBER FROM DATE	YES	N	7	346	352	CYYMMDD	Required
34	MEMBER THRU DATE	YES	N	7	353	359	CYYMMDD	Required
35	OVERRIDE PLAN	NO	A/N	10	360	369	Must be valid (on file)	Required – Benefit Plan for Member (if other than the Group Plan)
36	OVERRIDE PLAN EFFECTIVE DATE	NO	N	7	370	376	CYYMMDD; must be valid	Required – If field 35 Plan is populated
37	BRAND	NO	N	5	377	381	999V99	
38	GENERIC	NO	N	5	382	386	999V99	
39	COPAY 3	NO	N	5	387	391	999V99	
40	COPAY 4	NO	N	5	392	396	999V99	
41	CLIENT PRODUCT CODE	NO	A/N	6	397	402		
42	CLIENT RIDER CODE	NO	A/N	6	403	408		
43	CARE FROM DATE	NO	N	7	409	415	CYYMMDD	Required - If Field 45 is populated
44	CARE THRU DATE	NO	N	7	416	422	CYYMMDD	Required - If Field 45 is populated
45	CARE NETWORK	NO	A/N	10	423	432	Must be valid (on file)	**Required – ASES IPA Number**
46	CARE NETWORK PLAN OVERRIDE	NO	A/N	10	433	442		Required - Benefit Plan for Member
47	CARE NETWORK PLAN FROM DATE	NO	N	7	443	449	CYYMMDD	Required
48	CARE FACILITY	NO	A/N	6	450	455	Must be valid (on file)	

49	CARE QUALIFIER	NO	A/N	10	456	465	Must be valid (on file)	
50	PCP ID	NO	A/N	15	466	480	Primary Care Physician; must be valid (on file)	
51	PCP ID QUALIFIER	NO	A/N	2	481	482		
52	PCP ID STATE	NO	A/N	3	483	485		
53	ALTERNATE INSURANCE FROM DATE	NO	N	7	486	492	CYYMMDD	This field can be coded 2 different ways. 1) The member can have a unique from and thru. 2) Or if the field is blank the system will default to the from and thru date located in fields 33 and 34
54	ALTERNATE INSURANCE THRU DATE	NO	N	7	493	499	CYYMMDD	This field can be coded 2 different ways. 1) The member can have a unique from and thru. 2) Or if the field is blank the system will default to the from and thru date located in fields 33 and 34

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

55	ALTERNATE INSURANCE FLAG	NO	A/N	1	500	500	**D**=Dual Coverage; **N**=No; **X**=Y/Dual Coverage; **Y**=Yes; **0**=Additional Coverage; **1**=Adtl Coverage, othrCarrier	1. If the member has a primary plan (COB) the field will be coded as a Y. 2.If the member is terminated from the primary plan (COB) the field will be coded as N. 3.If Filed # 55 is populated, then; Fileds #53 and 54 are required. If "Y" and Fields 53 - 54 are populated with "0" then the default system date will be member eligibility from/thru date.
56	ALTERNATE INSURANCE CODE	NO	A/N	10	501	510		
57	ALTERNATE INSURANCE ID	NO	A/N	18	511	528		
58	CARD FLAG	NO	A/N	1	529	529	**N**=No; **Y**=Yes (Flag to indicate whether a card record should be created)	
59	CARD QUANTITY	NO	N	1	530	530	How many card records have been requested	
60	MEDICARE PART-D CONTRACT NUMBER	NO	A/N	5	531	535		

61	MEDICARE HIC	NO	A/N	20	536	555	This field is changed from 11 to 20 bytes on the input file. This field populates a record on the member supplemental ID file (RCMSI) with qualifier 06. The from/thru dates of the supplemental ID record are the member from/thru dates (fields 33 & 34 on this layout)	
62	PBP NUMBER	NO	A/N	3	556	558		
63	SEGMENT ID	NO	A/N	3	559	561		
64	ENROLLMENT SOURCE	NO	A/N	1	562	562	The source of the enrollment; Valid Values are: **A**=Auto-enrolled by CMS; **B**=Beneficiary election; **C**=Facilitated enrollment by CMS; **D**=Systematic enrollment by CMS (rollover)	

65	SUBSIDY LEVEL	NO	A/N	3	563	565	Part D low-income premium subsidy category; Valid **000**=No subsidy; **025**=25% subsidy level; **050**=50% subsidy level; **075**=75% subsidy level; **100**=100% subsidy level	
66	CO-PAY CATEGORY	NO	A/N	1	566	566	**U**=US Territory Subsidy; **0**=None, not low-income; **1**=Copay Category 1; **2**= Copay Category 2; **3**= Copay Category 3; **4**=Copay Category 4; **5**=Unknown Category	
67	CO-PAY CATEGORY EFFECTIVE DATE	NO	N	8	567	574	YYYYMMDD	

68	COVERAGE TYPE 1 (PRIMARY)	NO	A/N	1	575	575	ADD COVERAGE RECORD WITH A TYPE OF 1. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of 1 to be added. **Blank** will not add a record. If field #68=**Y** and field #69=**D**, both BIN and PCN is required; If field #69=**O**, only one of fields 72-78 is required.	
69	COVERAGE TYPE 1 CATEGORY	NO	A/N	1	576	576	Valid values: **D**=Medicare Part D; **O**=Other	
70	COVERAGE TYPE 1 FROM DATE	NO	N	7	577	583	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 1 record.	

71	COVERAGE TYPE 1 THRU DATE	NO	N	7	584	590	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 1 record.	
72	PRIMARY BIN	NO	A/N	6	591	596		Required - ASES To inform the 3 digits Alt Ins Company Number
73	PRIMARY PROCESSOR CONTROL NUMBER	NO	A/N	10	597	606		
74	PRIMARY SUBMITTED GROUP	NO	A/N	15	607	621		
75	PRIMARY HELPDESK PHONE	NO	A/N	10	622	631		
76	PRIMARY MEMBER ID	NO	A/N	20	632	651		
77	PRIMARY PERSON CODE	NO	A/N	3	652	654		
							L=Supplemental; M=Medigap; N=State Program (Non Qualified SPAP); O=Other;	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-048

78	PRIMARY SUPPLEMENTAL TYPE	NO	A/N	1	655	655	P=Patient Assistance Program (PAP); **Q**=Qualified State Pharmaceutical Assistance Program (SPAP); **R**=Charity; **S**=AIDS Drug Assistance Program; **T**=Federal Health Program; **1**=Medicaid; **2**=Tricare **3**=Major Medical	
79	PRIMARY COVERAGE ID	IF COVG TYPE 0 OR BLANK #NAME?	A/N	10	656	665		
80	COVERAGE TYPE 2 (SECONDARY)	NO	A/N	1	666	666	ADD COVERAGE RECORD WITH A TYPE OF 2. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of 2 to be added. **Blank** will not add a record. If field #80=**Y** and field #81=**D**, both BIN and PCN is required; If field #81=**O**, only one of fields 84-89 is required.	

81	COVERAGE TYPE 2 CATEGORY	IF COVG TYPE 2=Y	A/N	1	667	667	Valid values: **D**=Medicare Part D; **O**=Other	
82	COVERAGE TYPE 2 FROM DATE	NO	N	7	668	674	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 2 record.	
83	COVERAGE TYPE 2 THRU DATE	NO	N	7	675	681	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 2 record.	
84	SECONDARY BIN	IF COVG TYPE 2 CAT=D	A/N	6	682	687		
85	SECONDARY PROCESSOR CONTROL NUMBER	IF COVG TYPE 2 CAT=D	A/N	10	688	697		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-048

86	SECONDARY SUBMITTED GROUP	NO	A/N	15	698	712		
87	SECONDARY HELPDESK PHONE	NO	A/N	10	713	722		
88	SECONDARY MEMBER ID	NO	A/N	20	723	742		
89	SECONDARY PERSON CODE	NO	A/N	3	743	745		
90	SECONDARY SUPPLEMENTAL TYPE	NO	A/N	1	746	746	See **PRIMARY SUPPLEMENTAL TYPE** valid values above.	
91	SECONDARY COVERAGE ID	IF COVG TYPE 2 CAT=O	A/N	10	747	756		
92	COVERAGE TYPE 3 (TERTIARY)	NO	A/N	1	757	757	ADD COVERAGE RECORD WITH A TYPE OF 3. Valid values for this field are **Y** & **Blank**. Y causes a coverage type of 3 to be added. Blank will not add a record. If field #92=**Y** and field #93=**D**, both BIN and PCN is required; If field #93=**O**, only one of fields 96-101 is required.	

93	COVERAGE TYPE 3 CATEGORY	IF COVG TYPE 3=Y	A/N	1	758	758	Valid values: **D**=Medicare Part D; **O**=Other	
94	COVERAGE TYPE 3 FROM DATE	NO	N	7	759	765	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 3 record.	
95	COVERAGE TYPE 3 THRU DATE	NO	N	7	766	772	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 3 record.	
96	TERTIARY BIN	IF COVG TYPE 3 CAT=D	A/N	6	773	778		
97	TERTIARY PROCESSOR CONTROL NUMBER	IF COVG TYPE 3 CAT=D	A/N	10	779	788		
98	TERTIARY SUBMITTED GROUP	NO	A/N	15	789	803		

99	TERTIARY HELPDESK PHONE	NO	A/N	10	804	813		
100	TERTIARY MEMBER ID	NO	A/N	20	814	833		
101	TERTIARY PERSON CODE	NO	A/N	3	834	836		
102	TERTIARY SUPPLEMENTAL TYPE	NO	A/N	1	837	837	See **PRIMARY SUPPLEMENTAL TYPE** valid values above.	
103	TERTIARY COVERAGE ID	IF COVG TYPE 3 CAT=O	A/N	10	838	847		
104	COVERAGE TYPE 4 (QUATERNARY)	NO	A/N	1	848	848	ADD COVERAGE RECORD WITH A TYPE OF 4. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **4** to be added. **Blank** will not add a record. If field #104=**Y** and field #105=**D**, both BIN and PCN is required; If field #105=**O**, only one of fields 108-113 is required.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

105	COVERAGE TYPE 4 CATEGORY	IF COVG TYPE 4=Y	A/N	1	849	849	Valid values: **D**=Medicare Part D; **O**=Other	
106	COVERAGE TYPE 4 FROM DATE	NO	N	7	850	856	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 4 record.	
107	COVERAGE TYPE 4 THRU DATE	NO	N	7	857	863	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 4 record.	
108	QUATERNARY BIN	IF COVG TYPE 4 CAT=D	A/N	6	864	869		

ADMINISTRACION DE SEGUROS DE SAL
Contrato Número 19-049

109	QUATERNARY PROCESSOR CONTROL NUMBER	IF COVG TYPE 4 CAT=D	A/N	10	870	879		
110	QUATERNARY SUBMITTED GROUP	NO	A/N	15	880	894		
111	QUATERNARY HELPDESK PHONE	NO	A/N	10	895	904		
112	QUATERNARY MEMBER ID	NO	A/N	20	905	924		
113	QUATERNARY PERSON CODE	NO	A/N	3	925	927		
114	QUATERNARY SUPPLEMENTAL TYPE	NO	A/N	1	928	928	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
115	QUATERNARY COVERAGE ID	IF COVG TYPE 4 CAT=O	A/N	10	929	938		
116	COVERAGE TYPE 5 (FIFTH)	NO	A/N	1	939	939	ADD COVERAGE RECORD WITH A TYPE OF 5. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **5** to be added. **Blank** will not add a record. If field #116=**Y** and field	

							#117=**D**, both BIN and PCN is required; If field #117=**O**, only one of fields 120-125 is required.	
117	COVERAGE TYPE 5 CATEGORY	IF COVG TYPE 5=Y	A/N	1	940	940	Valid values: **D**=Medicare Part D; **O**=Other	
118	COVERAGE TYPE 5 FROM DATE	NO	N	7	941	947	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 5 record.	
119	COVERAGE TYPE 5 THRU DATE	NO	N	7	948	954	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 5 record.	
120	FIFTH BIN	IF COVG TYPE 5 CAT=D	A/N	6	955	960		
121	FIFTH PROCESSOR CONTROL NUMBER	IF COVG TYPE 5 CAT=D	A/N	10	961	970		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato número
19-049

122	FIFTH SUBMITTED GROUP	NO	A/N	15	971	985		
123	FIFTH HELPDESK PHONE	NO	A/N	10	986	995		
124	FIFTH MEMBER ID	NO	A/N	20	996	1015		
125	FIFTH PERSON CODE	NO	A/N	3	1016	1018		
126	FIFTH SUPPLEMENTAL TYPE	NO	A/N	1	1019	1019	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
127	FIFTH COVERAGE ID	IF COVG	A/N	10	1020	1029		
128	COVERAGE TYPE 6 (SIXTH)	NO	A/N	1	1030	1030	ADD COVERAGE RECORD WITH A TYPE OF 6. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **6** to be added. **Blank** will not add a record. If field #128=**Y** and field #129=**D**, both BIN and PCN is required; If field #129=**O**, only one of fields 132-137 is required.	
129	COVERAGE TYPE 6 CATEGORY	IF COVG TYPE	A/N	1	1031	1031	Valid values: **D**=Medicare Part D; **O**=Other	

130	COVERAGE TYPE 6 FROM DATE	NO	N	7	1032	1038	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 6 record.	
131	COVERAGE TYPE 6 THRU DATE	NO	N	7	1039	1045	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 6 record.	
132	SIXTH BIN	IF COVG TYPE 6 CAT=D	A/N	6	1046	1051		
133	SIXTH PROCESSOR CONTROL NUMBER	IF COVG TYPE 6 CAT=D	A/N	10	1052	1061		
134	SIXTH SUBMITTED GROUP	NO	A/N	15	1062	1076		
135	SIXTH HELPDESK PHONE	NO	A/N	10	1077	1086		
136	SIXTH MEMBER ID	NO	A/N	20	1087	1106		

137	SIXTH PERSON CODE	NO	A/N	3	1107	1109		
138	SIXTH SUPPLEMENTAL TYPE	NO	A/N	1	1110	1110	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
139	SIXTH COVERAGE ID	IF COVG TYPE 6 CAT=O	A/N	10	1111	1120		
140	COVERAGE TYPE 7 (SEVENTH)	NO	A/N	1	1121	1121	ADD COVERAGE RECORD WITH A TYPE OF 7. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **7** to be added. **Blank** will not add a record. If field #140=**Y** and field #141=**D**, both BIN and PCN is required; If field #141=**O**, only one of fields 144-149 is required.	
141	COVERAGE TYPE 7 CATEGORY 7=Y	IF COVG TYPE	A/N	1	1122	1122	Valid values: **D**=Medicare Part D; **O**=Other	

142	COVERAGE TYPE 7 FROM DATE	NO	N	7	1123	1129	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 7 record.	
143	COVERAGE TYPE 7 THRU DATE	NO	N	7	1130	1136	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 7 record.	
144	SEVENTH BIN	IF COVG TYPE 7 CAT=D	A/N	6	1137	1142		
145	SEVENTH PROCESSOR CONTROL NUMBER	IF COVG TYPE 7 CAT=D	A/N	10	1143	1152		
146	SEVENTH SUBMITTED GROUP	NO	A/N	15	1153	1167		
147	SEVENTH HELPDESK PHONE	NO	A/N	10	1168	1177		
148	SEVENTH MEMBER ID	NO	A/N	20	1178	1197		

149	SEVENTH PERSON CODE	NO	A/N	3	1198	1200		
150	SEVENTH SUPPLEMENTAL TYPE	NO	A/N	1	1201	1201	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
151	SEVENTH COVERAGE ID	IF COVG TYPE 7 CAT=O	A/N	10	1202	1211		
152	COVERAGE TYPE 8 (EIGHTH)	NO	A/N	1	1212	1212	ADD COVERAGE RECORD WITH A TYPE OF 8. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **8** to be added. **Blank** will not add a record. If field #152=**Y** and field #153=**D**, both BIN and PCN is required; If field #153=**O**, only one of fields 156-161 is required.	

153	COVERAGE TYPE 8 CATEGORY	IF COVG TYPE 8=Y	A/N	1	1213	1213	Valid values: D=Medicare Part D; O=Other	
154	COVERAGE TYPE 8 FROM DATE	NO	N	7	1214	1220	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 8 record.	
155	COVERAGE TYPE 8 THRU DATE	NO	N	7	1221	1227	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 8 record.	
156	EIGHTH BIN	IF COVG TYPE 8 CAT=D	A/N	6	1228	1233		

157	EIGHTH PROCESSOR CONTROL NUMBER	IF COVG TYPE 8 CAT=D	A/N	10	1234	1243		
158	EIGHTH SUBMITTED GROUP	NO	A/N	15	1244	1258		
159	EIGHTH HELPDESK PHONE	NO	A/N	10	1259	1268		
160	EIGHTH MEMBER ID	NO	A/N	20	1269	1288		
161	EIGHTH PERSON CODE	NO	A/N	3	1289	1291		
162	EIGHTH SUPPLEMENTAL TYPE	NO	A/N	1	1292	1292	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
163	EIGHTH COVERAGE ID	IF COVG TYPE 8 CAT=O	A/N	10	1293	1302		
164	COVERAGE TYPE 9 (NINTH)	NO	A/N	1	1303	1303	ADD COVERAGE RECORD WITH A TYPE OF 9. Valid values for this field are **Y** & **Blank**. **Y** causes a coverage type of **9** to be added. **Blank** will not add a record. If field #164=**Y** and field #165=**D**, both BIN and PCN is required; If field #165=**O**, only one of fields 168-173 is required.	

165	COVERAGE TYPE 9 CATEGORY	IF COVG TYPE 9=Y	A/N	1	1304	1304	Valid values: **D**=Medicare Part D; **O**=Other	
166	COVERAGE TYPE 9 FROM DATE	NO	N	7	1305	1311	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member From Date (field 32 in this layout) to create the Coverage Type 9 record.	
167	COVERAGE TYPE 9 THRU DATE	NO	N	7	1312	1318	CYYMMDD. If populated, use this value; if blank, all 9999999s, or all 0000000s, use Member Thru Date (field 33 in this layout) to create the Coverage Type 9 record.	
168	NINTH BIN	IF COVG TYPE 9 CAT=D	A/N	6	1319	1324		
169	NINTH PROCESSOR CONTROL NUMBER	IF COVG TYPE 9 CAT=D	A/N	10	1325	1334		
170	NINTH SUBMITTED GROUP	NO	A/N	15	1335	1349		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

171	NINTH HELPDESK PHONE	NO	A/N	10	1350	1359		
172	NINTH MEMBER ID	NO	A/N	20	1360	1379		
173	NINTH PERSON CODE	NO	A/N	3	1380	1382		
174	NINTH SUPPLEMENTAL TYPE	NO	A/N	1	1383	1383	See **PRIMARY SUPPLEMENTAL** **TYPE** valid values above.	
175	NINTH COVERAGE ID	IF COVG TYPE 9 CAT=O	A/N	10	1384	1393		
176	Qualifier	NO	N	2	1394	1395	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	Required for ASES PSG Special Conditions Cov Qual= 01 (ICD-9). Special condition codes will vary among MCO's.
177	Type	NO	N	1	1396	1396	1 = CM / 2 = PCS	
178	DIAGNOSIS CODE 1	NO	A/N	20	1397	1416		Required - ASES for the Special Conditions Coverage . Refer to Tab PSG Spec Cov Codes

179	DIAGNOSIS CODE 1 EFFECTIVE FROM DATE	YES	N	7	1417	1423	CYYMMDD	Required - if field 178 is populated
180	DIAGNOSIS CODE 1 EFFECTIVE THRU DATE	YES	N	7	1424	1430	CYYMMDD	Required - if field 179 is populated
181	Qualifier	NO	N	2	1431	1432	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
182	Type	NO	N	1	1433	1433	1 = CM / 2 = PCS	
183	DIAGNOSIS CODE 2	NO	A/N	20	1434	1453		
184	DIAGNOSIS CODE 2 EFFECTIVE FROM DATE	YES	N	7	1454	1460	CYYMMDD	
185	DIAGNOSIS CODE 2 EFFECTIVE THRU DATE	YES	N	7	1461	1467	CYYMMDD	

186	Qualifier	NO	N	2	1468	1469	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
187	Type	NO	N	1	1470	1470	1 = CM / 2 = PCS	
188	DIAGNOSIS CODE 3	NO	A/N	20	1471	1490		
189	DIAGNOSIS CODE 3 EFFECTIVE FROM DATE	YES	N	7	1491	1497	CYYMMDD	
190	DIAGNOSIS CODE 3 EFFECTIVE THRU DATE	YES	N	7	1498	1504	CYYMMDD	
191	Qualifier	NO	N	2	1505	1506	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
192	Type	NO	N	1	1507	1507		
193	DIAGNOSIS CODE 4	NO	A/N	20	1508	1527		
194	DIAGNOSIS CODE 4 EFFECTIVE FROM DATE	YES	N	7	1528	1534	CYYMMDD	

195	DIAGNOSIS CODE 4 EFFECTIVE THRU DATE	YES	N	7	1535	1541	CYYMMDD	
196	Qualifier	NO	N	2	1542	1543	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
197	Type	NO	N	1	1544	1544	1 = CM / 2 = PCS	
198	DIAGNOSIS CODE 5	NO	A/N	20	1545	1564		
199	DIAGNOSIS CODE 5 EFFECTIVE FROM DATE	YES	N	7	1565	1571	CYYMMDD	
200	DIAGNOSIS CODE 5 EFFECTIVE THRU DATE	YES	N	7	1572	1578	CYYMMDD	
201	Qualifier	NO	N	2	1579	1580	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
202	Type	NO	N	1	1581	1581	1 = CM / 2 = PCS	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

203	DIAGNOSIS CODE 6	NO	A/N	20	1582	1601		
204	DIAGNOSIS CODE 6 EFFECTIVE FROM DATE	YES	N	7	1602	1608	CYYMMDD	
205	DIAGNOSIS CODE 6 EFFECTIVE THRU DATE	YES	N	7	1609	1615	CYYMMDD	
206	Qualifier	NO	N	2	1616	1617	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
207	Type	NO	N	1	1618	1618	1 = CM / 2 = PCS	
208	DIAGNOSIS CODE 7	NO	A/N	20	1619	1638		
209	DIAGNOSIS CODE 7 EFFECTIVE FROM DATE	YES	N	7	1639	1645	CYYMMDD	
210	DIAGNOSIS CODE 7 EFFECTIVE THRU DATE	YES	N	7	1646	1652	CYYMMDD	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 19 - 01 3

211	Qualifier	NO	N	2	1653	1654	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
212	Type	NO	N	1	1655	1655	1 = CM / 2 = PCS	
213	DIAGNOSIS CODE 8	NO	A/N	20	1656	1675		
214	DIAGNOSIS CODE 8 EFFECTIVE FROM DATE	YES	N	7	1676	1682	CYYMMDD	
215	DIAGNOSIS CODE 8 EFFECTIVE THRU DATE	YES	N	7	1683	1689	CYYMMDD	
216	Qualifier	NO	N	2	1690	1691	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
217	Type	NO	N	1	1692	1692	1 = CM / 2 = PCS	

218	DIAGNOSIS CODE 9	NO	A/N	20	1693	1712		
219	DIAGNOSIS CODE 9 EFFECTIVE FROM DATE	YES	N	7	1713	1719	CYYMMDD	
220	DIAGNOSIS CODE 9 EFFECTIVE THRU DATE	YES	N	7	1720	1726	CYYMMDD	
221	Qualifier	NO	N	2	1727	1728	The Qualifier differentiates between an ICD-9 Diagnosis Code and ICD-10 Diagnosis Code. 01 = ICD-9 / 02 = ICD-10	
222	Type	NO	N	1	1729	1729	1 = CM / 2 = PCS	
223	DIAGNOSIS CODE 10	NO	A/N	20	1730	1749		
224	DIAGNOSIS CODE 10 EFFECTIVE FROM DATE	YES	N	7	1750	1756	CYYMMDD	
225	DIAGNOSIS CODE 10 EFFECTIVE THRU DATE	YES	N	7	1757	1763	CYYMMDD	
226	ALLERGY CODE 1	NO	A/N	3	1764	1766		
227	ALLERGY CODE 2	NO	A/N	3	1767	1769		
228	ALLERGY CODE 3	NO	A/N	3	1770	1772		
229	ALLERGY CODE 4	NO	A/N	3	1773	1775		
230	ALLERGY CODE 5	NO	A/N	3	1776	1778		

231	ALLERGY CODE 6	NO	A/N	3	1779	1781		
232	HEIGHT	NO	N	5	1782	1786	99999; Client-defined	REQUIRED: ASES PlanType First 3 positions must be zeroes. (Format is 000XX)
233	WEIGHT	NO	N	5	1787	1791	99999; Client-defined	REQUIRED: ASES Plan Version First 2 positions must be zeroes. (Format is 00XXX)
234	BLOOD TYPE	NO	A/N	1	1792	1792	**1**=A+ **2**=A- **3**=B+ **4**=B- **5**=AB+ **6**=AB- **7**=O+ **8**=O-	
235	CONTACT LENS CODE	NO	A/N	1	1793	1793	**1**=Yes; **2**=No	
236	SMOKING CODE	NO	A/N	1	1794	1794	**0**=Not a smoker; **1**=Heavy; **2**=Moderate; **3**=Light	
237	PREGNANCY CODE	NO	A/N	1	1795	1795	1=Yes; **2**=No	If Dx Code is OBG then 1=Y
238	ALCOHOL CODE	NO	A/N	1	1796	1796	**0**=Not a Drinker, **1**=Heavy; **2**=Moderate; **3**=Light	
239	MISC CODE 1	NO	A/N	1	1797	1797	Reserved for future use	
240	MISC CODE 2	NO	A/N	1	1798	1798	Reserved for future use	

241	MEMBER ID CARD DATA FROM DATE	NO	N	7	1799	1805	CYYMMDD (DEFAULTS to Member Effective Date if no "true" Effective Date)	
242	MEMBER ID CARD DATA THRU DATE	NO	N	7	1806	1812	CYYMMDD (DEFAULTS to Member Thru Date if no "true" Thru Date)	
243	MEMBER ID CARD LOGO	NO	A/N	5	1813	1817		
244	MEMBER ID CARD DATA	NO	A/N	10	1818	1827	ID card information specific to an individual member	
245	MEMBER CLIENT DEFINED DATA EFFECTIVE DATE	NO	N	7	1828	1834	CYYMMDD; Effective date for Client-Defined Data (DEFAULTS to Member From Date)	
246	MEMBER CLIENT DEFINED DATA THRU DATE	NO	N	7	1835	1841	CYYMMDD; Last date that applies to Client-Defined Data (DEFAULTS to 1391231)	

247	MEMBER CLIENT DEFINED DATA	NO	A/N	256	1842	2097	Data, provided by Client, used for back-end processing (commonly called "pass-thru data"); this field is used for Client-specific information that does not require any processing by RxCLAIM.	
248	MEMBER ID CARD TEXT1	NO	A/N	30	2098	2127		Required ASES – MPI # First 13 positions must be filled
249	MEMBER ID CARD TEXT2	NO	A/N	30	2128	2157		
250	MEMBER ID CARD TEXT3	NO	A/N	30	2158	2187		
251	MEMBER COPAY OVERRIDE FROM DATE	NO	N	7	2188	2194	CYYMMDD; Member Copay Override From Date	Require if Diagnosis Code is OBGY. Date range should be the pregnancy period.
252	MEMBER COPAY OVERRIDE THRU DATE	NO	N	7	2195	2201	CYYMMDD; Member Copay Override Thru Date	Require if Diagnosis Code is OBGY. Date range should be the pregnancy period.
253	MEMBER COPAY OVERRIDE COPAY SCHEDULE	NO	A/N	10	2202	2211	Must be valid (on file)	Require if Diagnosis Code is OBGY. Member Copay Override for $0 Copay

254	MEMBER COPAY OVERRIDE COPAY SCHEDULE SCHEDULE STEP NBR	NO	N	2	2212	2213	Copay Schedule Step Number (01-99)	Require if Field 233 is populated. Require value will be 02
255	MEDICARE TYPE (from Member)	NO	A/N	1	2214	2214	Defines the Medicare ID on the Member file (RCMBR); valid values: **1**=Medicare Part-D; **2**=Medicare Part-D Wrap Coverage; **3**=Medicare Employer Drug Subsidy; **A**=Secondary Part A; **B**=Part B; **D**=Parts A&B Age 65; **M**=Parts A&B; **N**=Not Covered; **R**=Renal; **U**=Secondary, Unknown; **W**=Secondary, Working/TEFRA; **Y**=Yes, Undefined	
256	MEDICARE FROM DATE (from Member)	NO	N	7	2215	2221	CYYMMDD; defines the effective date of the Medicare ID on file RCMBR	

257	MEMBER MEDICARE ID (from Member)	NO	A/N	11	2222	2232	Member Medicare ID (on RCMBR)	
258	SPEND-DOWN AMOUNT	NO	N	9	2233	2241	9999999V99	
259	COB PRICING TYPE	NO	A/N	2	2242	2243	**00**=No COB Pricing; **01**=CD-P, FT=DFT, DFT-CC=AD F1 **02**=DFT-CC=CAD, CAD-P=AD F1; **03**=AD=L(CDFT-P) | (CDFT-CC) F1; **04**=Approve Submitted Patient Pay; **05**=$0 Patient Pay; **06**=Approve Submitted Amt Clmd; **07**=L(CFT-P) | (CFT-CPP) | SPP; **08**=CDFT-P=CAD, CAD-CC=AD F1; **09**=DFT-APP=AAD, AAD-P=FAD F1; **10**=CFT<P:AD/PP=0; AD=CFT-P-PP; **11**=AD=CFT-P-L[PP | (CFT-P)]; **12**=CDFT=OthAmt, DFT-PP=AD; **13**=RxPrice-P-PP=AD;	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-048

							14=AD=L DFT | OthAmt **15**=AD=L CDFT-P\ CDFT-CC **16**=L (SCFT-P) | (CCFT-PP) F1 **17**=DFT – L (SPP|CPP) – P=AD **18**=AD=H(CCFT| SCFT) - P F1 **19**=DFT-CC=CAD, CAD-P=AAD F1 **20**=Client Amount Due as CC **21**=DFT=L CDFT|OPRA,DFT-PP=AD **22**=DFT=OPRA, DFT-PP=AD(w/Acc) **23**=AD=L(DFT-P-PP) | (OPRA-PP) **24**=COB 16: - AD:AD=0,PP=DFT	
260	MEDICARE PART D FROM DATE	NO	N	7	2244	2250	CYYMMDD; defines the From date of the Medicare Part D (RCMMD)	
261	MEDICARE PART D THRU DATE	NO	N	7	2251	2257	CYYMMDD; defines the Thru date of the Medicare Part D (RCMMD)	

262	ELECTRONIC MAIL	NO	A/N	80	2258	2337	Member e-mail	
263	SUPPLEMENTAL ID FROM DATE	NO	N	7	2338	2344	CYYMMDD; defines the From date of the Supplemental ID (RCMSI)	
264	SUPPLEMENTAL ID THRU DATE	NO	N	7	2345	2351	CYYMMDD; defines the Thru date of the Supplemental ID (RCMSI)	
265	MTM TERMINATION REASON CODE	NO	A/N	2	2352	2353	**01**=Death **02**=Disenrollment from Plan **04**=Other	
266	MTM TERMINATION DATE	Conditio nal	N	8	2354	2361	CCYYMMDD If not provided when termination reason is provided, then use system date as termination date	
267	MTM TERMINATION STATUS	NO	A/N	1	2362	2362	Valid values are A=Active and I= Inactive	
268	MSI ALTERNATE ID	N	A/N	20	2363	2382	The member's MSI Unique ID. This field populates a record on the member supplemental ID file (RCMSI) with qualifier 07	
269	MSI FROM DATE	N	N	7	2383	2389	CYYMMDD	

270	MSI THRU DATE	N	N	7	2390	2396	CYYMMDD	
271	ALTERNATE INSURANCE TYPE	N	A/N	1	2397	2397	**Blank** = *BLANK **A**=Medicare Part B & D **B**=Medicare Part B **C**=Commercial **D**=Medicare Part D **O**=Other	
272	HIM FROM DATE	NO	N	7	2398	2404	CYYMMDD; defines the From date of the Member HIM record	
273	HIM THRU DATE	NO	N	7	2405	2411	CYYMMDD; defines the Thru date of the Member HIM record	
274	HIM PLAN ID	NO	A/N	14	2412	2425	The Assigned Qualified Health Plan Identifier is the Standard Component Identifier plus the Variation Component. The Standard Component ID generated by CMS is a 14 characters (alphanumeric): • A five digit Issuer ID • Two character State ID	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
09-049

							• Three digit Product Number • Four digit Standard Component Number An example is as follows: 12345VA0020021	
275	HIM CSR LEVEL	NO	N	2	2426	2427	The Variant Component ID is 2 characters (Numeric) with the following values and description • **00** - Non-Exchange variant • **01** - Exchange variant (no CSR) • **02** - Open to Indians below 300%FPL • **03** - Open to Indians above 300%FPL • **04** - 73% AV Level Silver Plan CSR • **05** - 87% AV Level Silver Plan CSR • **06** - 94% AV Level Silver Plan CSR * **32** - Medicaid Zero CSR Plan Var * **36** - Medicaid 94% AVLvlSil Pln	

276	HIM PLAN METAL INDICAT	NO	A	1	2428	2428	**B** = Bronze **S** = Silver **G** = Gold **P** = Platinum **C** = Catastrophic	
277	MEMBER ETHNICITY INDIC	A NO	A/N	2	2429	2430	**AL** = Alaskan **HS**=Hispanic **LT**=Latino **SP**=Spanish **AS**=Asian Indian **BK**=Black **AA**=African American **CH**=Chinese **FO**=Filipino **GN**=Guamanian **CO**=Chamorro **JP** = Japanese **KR** = Korean **NH** = Native Hawaiian **OA** = Other Asian **PI** = Pacific Islander **SA** = Samoan **VI** = Vietnamese **WH** = White **OT** = Other Must exist in valid values list	
278	MEMBER APTC INDICATOR	NO	A	1	2431	2431	Y = Yes N = No	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

279	HIM GRACE PERIOD EFFECTIVE DATE	NO	N	7	2432	2438	CYYMMDD; defines the Start Date of the Member HIM Grace Period	
280	HIM GRACE PERIOD TERMINATION DATE	NO	N	7	2439	2445	CYYMMDD; defines the End Date of the Member HIM Grace Period	
281	Dual Medicare/Medicaid From Date	NO	Date	7	2446	2452	CYYMMDD	
282	Dual Medicare/Medicaid Thru Date	NO	Date	7	2453	2459	CYYMMDD	
283	Dual Medicare/Medicaid Medicaid COC End Date	NO	Date	7	2460	2466	CYYMMDD	
284	Filler	N	A/N	234	2467	2700	Reserved for future use	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Attachment 9
Information System

Query and Response files Layouts

ELIGIBILITY QUERY FILE LAYOUT

August 1, 2008

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

Query Record

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

*** All are Text Fields

QUERY RESPONSE FILE LAYOUT

October 20, 2008

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

Query Response Record

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

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-014

Attachment 9
Information System

MedInsight Layout

Carrier to ASES Data Submissions

New File Layouts

Version 3.0A rev2

September 7, 2018

ASES
Administración de Seguros de Salud de Puerto Rico

MedInsight@asespr.org

TABLE OF CONTENTS

Version Changes

Version 3.0A

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

CAPITATION Input File Layout

CAPITATION TYPE field was modified.

PROVIDER Input File layout

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

CLAIMSERVICES Input File Layout - Added

New fields added to the layout.

Data Validation and Auditing Change

New section regarding data validation and auditing added.

Version 3.0A rev2

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.

Introduction

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

Claims Transaction Handling

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

Paid or Denied FFS Claims

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

Encounter Claims

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

Provider, IPA and Network Files

The Provider, IPA, and Network files are to be submitted weekly, every Wednesday and must include the latest available data from the day prior to the submission date. For each weekly submission within a given month, keep the same file naming convention, but increment the sequence number, starting with 1, then 2,3,4.

The PRV, IPA, and NET file shall include every Provider, IPA, and Network record that is active in your system, not just the records associated with currently submitted claim records. ASES will be using this data to keep a current complete list of available Providers and IPAs.

The Provider file includes both providers directly contracted with the carrier and sub-contracted providers. Network file shall include "In Network" providers, including the subcontractor's network, and "Out of Network" providers.

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

For pharmacy claims only

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

Capitation Files

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

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 (normalized group average).

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

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

Capitation Adjustments

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

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

Data Validation and Audit Process

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

Failure to conform to any of the submission requirements will result in the rejection and return of the applicable data file(s). No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next

month's files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

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

Claims and Capitation Lag Reports

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

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

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

CLAIMLAG_ccyymms.xls(x)

Where:

Characters 1-9	Always "CLAIMLAG_"		
Characters 10-11	cc	=	Carrier Code (See attachment II)
Characters 12-13	yy	=	Last two digits of year
Characters 14-15	mm	=	Month – last full paid month in the lags.

Character 16	s	=	sequence number of file submission.
Character 17	Always "."		
Characters 18-20(21)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

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

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

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

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

CAPLAG_ccyymms.xls(x)

Where:

Characters 1-7	Always "CAPLAG_"		
Characters 8-9	cc	=	Carrier Code (See attachment II)
Characters 10-11	yy	=	Last two digits of year
Characters 12-13	mm	=	Month – last full paid month in the lags.
Character 14	s	=	sequence number of file submission.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Character 15 Always "."
Characters 16-18(19) Extension code for excel file, can be xls or xlsx depending on Excel version.

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

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

Primary Carrier ID

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

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

General Notes on Field Level Requirements

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

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

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

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

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

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

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

- s - Leading sign
- 9(7) - 7 decimal digits

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

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

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

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

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

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

Data File Naming Conventions

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

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

The general format of file names will be –

Dccyymms.fff

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

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

Character 9 Always "."

Characters 10-12 Extension code identifying type of file

CLM	for	CLAIMSERVICES
PRV	for	PROVIDERS
IPA	for	IPA
CAP	for	CAPITATIONS
NET	for	NETWORK

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

Examples of completing this naming convention are –

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	Carrier ID	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	99	Required Must be two (2) digits (numeric).). Must equal a valid Carrier ID as assigned by ASES.
2	region_code	Region Code	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions	X	Required Must be valid ASES Region code
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	XX	Required Must equal "01", "02", "03", "04", "05" 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.

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

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

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

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
21	primary_center	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	X(10)	Must be present on all claims of Plan Type 01 May be present on claims of other Plan Types When present it indicates the Primary Care Center (IPA/HCO etc) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Carrier ID and IPA.
22	ssn_mainh	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	X(9)	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
23	ssn	**Patient Social Security**	Social Security Number of member	X(9)	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
24	member_suffix	**ASES Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	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"

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
28	birth_date	**Birth Date**	Member Date of Birth in YYYYMMDD format	YYYYMMDD	Required Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date. Must be equal or earlier than Admit Date.
29	municipality_res	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	XXXX	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
30	municipality_code	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I.	XXXX	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled. For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
31	drg_code	**DRG Code**	Diagnosis Related Group Code	XXXX	Must be a valid DRG Code
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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
34	drg_rel_weight	**Relative DRG Weight**	Indicates the relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year.	X(6)	If populated, must be a valid weight without any decimal points. Left justified, blank filled. A DRG weight of 2.397 should be reported as 2397.
35	pre_auth_num	**Pre-Authorization Number**	The number identifying pre-authorization. An unique identification number, that indicates the services provided on this claim have been authorized by the carrier (Also called Prior Authorization)	X(20)	Should be supplied when available. Left justified, blank filled to 20 characters if value is less than 20 characters.
36	proc_code	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	X(15)	For claims from CMS1500 / UB-04, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code. For Pharmacy claims this must be all blanks.
37	cpt_mod_1	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code.
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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
29-049

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

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

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

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
58	icd_diag_12	Twelfth ICD Diagnosis code	Non-Pharmacy/Dental ICD diagnosis code.	X(8)	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
59	icd_proc_01	Primary ICD Procedure code	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Principal Surgery)	X(10)	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
60	icd_proc_02	Second ICD10 Procedure code	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	X(10)	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
61	icd_proc_03	Third ICD Procedure code	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	X(10)	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
62	icd_proc_04	Fourth ICD Procedure code	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	X(10)	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
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.

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
65	pcp_prov_id	PCP Provider	National Provider Identifier (NPI) of the member's PCP.	X(20)	Required for Plan Type "01" claims Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI
66	att_prov_id	Attending Provider	National Provider Identifier (NPI) of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician.	X(20)	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
67	att_taxonomy	Attending Provider Taxonomy	Indicates the corresponding provider taxonomy of billing entity/provider, to define provider's type, classification, and area of specialization. The taxonomy code for the institution billing/caring for the beneficiary.	X(12)	Required Left justified, blank field to the right.
68	ref_prov_id	Referring Provider	National Provider Identifier (NPI) of referring provider, when applicable.	X(20)	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.
69	ref_prov_taxonomy	Referring Provider Taxonomy	Indicates the corresponding provider taxonomy of referring provider, to define provider's type, classification, and area of specialization.	X(12)	Left justified, blank field to the right.
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".

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

#	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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

#	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.

#	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" 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.

#	*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.

#	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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

#	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

#	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"

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

#	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", or "05".
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", or "05"
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" and "05" 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.

#	*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.

#	*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.

#	*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.

#	*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.

#	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.

#	*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.

#	*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.

#	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.

#	*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 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 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.

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
134	occurrence_code_03	Third Occurrence Code	A code to describe 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 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 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 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.

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

RECORD LENGTH	957

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.
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
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

PROVIDERS INPUT FILE LAYOUT

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

PROVIDERS INPUT FILE LAYOUT

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

PROVIDERS INPUT FILE LAYOUT

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

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
40	facility_group_ind_code	Facility Group Indicator Code	Indicates whether the SUBMITTING-STATE-PROV-ID is assigned to an individual, a group of providers, or a facility.	XX	Required Must be a valid value "01" = Facility – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a facility. "02" = Group – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a group of individual practitioners. "03" = Individual – The entity identified by the associated SUBMITTING-STATE-PROV-ID is an individual practitioner.
41	license_entity	License Issuing Entity ID	Indicates the identity of the entity issuing the license or accreditation.	X(50)	Required whenever a value is captured in the LICENSE-OR-ACCREDITATION-NUMBER data element. Must be left justified, blank filled to the right (Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name.) If LICENSE-TYPE = 1 (State, county, or municipality professional or business license) and the license-issuing entity is a state, then enter the applicable ANSI state numeric code. If LICENSE-TYPE = 2 (DEA license), then enter the text string "DEA". If LICENSE-TYPE = 3 (Professional society accreditation), then enter the text string identifying the professional society issuing the accreditation If LICENSE-TYPE = 4 (CLIA accreditation), then enter the text string identifying the CLIA accreditation body's name
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.

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
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
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
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 = ""

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*	
RECORD LENGTH						963

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

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

IPA INPUT FILE LAYOUT

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

CAPITATION INPUT FILE LAYOUT

	Field	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	Carrier ID	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	99	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	Capitation ID	Capitation payment ID must be a unique ID within carrier.	X(20)	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	Capitation Type	Capitation type code defined as: "01"= Admin "02"= Dental "03"= DME ... See Attachment VII	99	Required Must be two (2) digits (numeric). Must be a valid code. See Capitation Type List in Attachment VII
4	cap_date	Capitation Date	Date capitation paid.	YYYYMMDD	Required Must be a valid date
5	expr_date	Experience Date	Experience date of capitation payment. This is the date for which the capitation payment applies.	YYYYMMDD	Required Must be a valid date
6	prov	Provider ID	Carrier assigned Provider ID of the provider to which the capitation payment is made.	X(20)	Required Must be a valid Provider ID
7	pop_npi	Provider NPI	National Provider Identifier (NPI) of the provider to which the capitation payment is made.	X(10)	Required Left justified, blank field to the right.
8	ipa	IPA ID	Carrier assigned ID of IPA/HCO. This must be filled when Capitation type is PCP and IPA/HCO is involved (Must always be filled for Plan Type 01 by MCOs/TPAs when capitation payment is for PCP services)	X(4)	Required if Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier Left justified, blank field to the right.

CAPITATION INPUT FILE LAYOUT

	Field	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	region_code	Region	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL	X	Required Must be valid ASES Region code
10	municipality_code	Municipality	Municipality of residence of member. See Municipality Code in Attachment I.	XXXX	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
11	member_ssn	Member SSN	Social Security Number of member	9(9)	Required Must be 9 digits (numeric) Right justified, zero filled
12	household_id	ASES Household ID	Household ID as supplied in ASES Eligibility data	X(11)	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
13	member_suffix	Member Suffix	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	99	Required Must be 2 digits (numeric)
14	cap_amt	Capitation Amount	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	S9(7)v99	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

CAPITATION INPUT FILE LAYOUT

	Field	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
15	gross_cap_amt	Gross Capitation Amount	Gross Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	S9(7)v99	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
16	net_cap_amt	Net Capitation Amount	Net Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	S9(7)v99	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 5 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
17	risk_type	MPI Risk Type	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" If the risk is shared then the value =' SHR' Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR".	XXX	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM the only value should be "UNK"
18	tier	Member capitation tier	Member capitation tier 0001 Medicare A&B Male 0002 Medicare A Male 0006 Medicare A&B Female 0007 Medicare A Female 0008 0-11 Months 0009 12-23 Months 0010 24 Months - 10 Years 0011 11 - 18 Years 0024 19 - 35 Female 0025 19 - 35 Male 0026 36 - 54 Female 0027 36 - 54 Male 0028 55 - 64 Female 0029 55 - 64 Male 0031 65 + Female 0032 65 + Male	X(4)	Required

CAPITATION INPUT FILE LAYOUT

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

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	X	Required
5	pmg	IPA Code	The identification number of the primary medical group. If not applicable enter "N/A". Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters	X(4)	Required IPA/HCO code assigned by Carrier Must be left justified, blank filled to the right
6	pmg_name	PMG Name	The name or title of the primary medical group.	X(80)	Required
7	npi	NPI	The national provider identification number. All providers are required to have an NPI number.	X(10)	Required
8	provider_duplicate_entry	Provider Duplicate Entry	Indicate if the provider is entered multiple times in the list. A provider may be entered multiple times if the provider has more than one office location providing services. Enter a "0" for the first entry of the provider in the list. Enter an "X" for any duplicate entries of the same provider in the list.	X	Required

NETWORK INPUT FILE LAYOUT

	Field	Name	Description	Deliverable Data Format	Validation Rules
9	assigned_lives	Assigned lives	The number of assigned lives to the provider as of the last day of the reporting period. If the provider has multiple office locations, the number of assigned lives must be entered for the first entry (not a duplicated entry) for the provider. This number should include the sum of all office locations of the provider. If the provider does not have or require assigned lives, enter "0" in this column.	9999	Required
10	credential	Credential	Identify if the provider is up to date with all credentialing requirements as of the last day of the reporting period. Enter "Yes" for a fully credentialed/recredentialed provider, enter "No" if the provider requires credentialing/recredentialing. If the provider is not required to submit credentialing/recredentialing, enter "N/A" in this column.	XXX	Required
11	credential_eff_date	Credential Effective Date	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	YYYYMMDD	Required
12	credential_exp_date	Credential Expiration Date	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	YYYYMMDD	Optional
13	federal_tax_id	Provider SSN or EIN	The federal identification number of the provider. If the provider does not have a federal identification number, enter "N/A" 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
14	prov_id	Provider ID	Provider ID as assigned by carrier *SEE NOTES – Changes and Additions in Data File Layouts: PHARMACY PROVIDER IDs*	X(20)	Required Must be left justified and blank filled to the right
15	ccn	CCN	CMS Certification Number formerly known as the Medicare Provider Number.	X(20)	Optional

NETWORK INPUT FILE LAYOUT

	Field	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
16	contract_eff_date	Contract effective date	The provider's contract effective date.	YYYYMMDD	Required
17	contract_term_date	Contract termination date	The provider's contract termination date.	YYYYMMDD	Required
18	specialty	Specialty	Provider Specialty (third). See Specialty Code description in Attachment III	X(40)	Optional
19	specialty_code	Specialty Code	Provider Specialty (third). See Specialty Code in Attachment III	XX	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
20	name	Name	The full name of the provider.	X(80)	Optional Must be left justified, blank filled to the right
21	last_name1	Last Name 1	The last name of the provider. If the provider has two last names, this should be the first name.	X(30)	Required Must be left justified, blank filled to the right
22	last_name2	Last Name 2	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	The first name of the provider.	X(50)	Required Must be left justified, blank filled to the right
24	mi	MI	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

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
41	contact_person	Contact person	The provider's contact person.	X(80)	Optional

NETWORK INPUT FILE LAYOUT

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

ATTACHMENTS


ADMINISTRACION DE
Contrato Número
19-049
SEGUROS DE SALUD

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

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Culebra	F	0100
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
Manati	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200

Ordered By Code		
CODE	MUNICIPALITY	REGION
0100	Culebra	F
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	Manati	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

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
Utuado	A	0300

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
0300	Utuado	A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

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

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

NOTE: Any municipality code may appear in region SPECIAL.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

ATTACHMENT III - SPECIALTY CODES

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

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	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV – PLACE OF SERVICE CODES

CODE	Name	Description
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.
16-19	Unassigned	N/A
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	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.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
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

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
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/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-048

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
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.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-0419

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Carrier Name	Plan Type	Plan Version
04	First Medical Health Plan, Inc.	01	100
04	First Medical Health Plan, Inc.	01	110
04	First Medical Health Plan, Inc.	01	120
04	First Medical Health Plan, Inc.	01	130
04	First Medical Health Plan, Inc.	01	220
04	First Medical Health Plan, Inc.	01	230
04	First Medical Health Plan, Inc.	01	300
04	First Medical Health Plan, Inc.	01	310
04	First Medical Health Plan, Inc.	01	320
04	First Medical Health Plan, Inc.	01	330
05	PMC Medicare Choice, LLC	01	100
05	PMC Medicare Choice, LLC	01	110
05	PMC Medicare Choice, LLC	01	120
05	PMC Medicare Choice, LLC	01	130
05	PMC Medicare Choice, LLC	01	220
05	PMC Medicare Choice, LLC	01	230
05	PMC Medicare Choice, LLC	01	300
05	PMC Medicare Choice, LLC	01	310
05	PMC Medicare Choice, LLC	01	320
05	PMC Medicare Choice, LLC	01	330
06	Triple-S Salud, Inc.	01	100
06	Triple-S Salud, Inc.	01	110
06	Triple-S Salud, Inc.	01	120
06	Triple-S Salud, Inc.	01	130
06	Triple-S Salud, Inc.	01	220
06	Triple-S Salud, Inc.	01	230

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Carrier Name	Plan Type	Plan Version
06	Triple-S Salud, Inc.	01	300
06	Triple-S Salud, Inc.	01	310
06	Triple-S Salud, Inc.	01	320
06	Triple-S Salud, Inc.	01	330
07	Molina Healthcare of Puerto Rico, Inc.	01	100
07	Molina Healthcare of Puerto Rico, Inc.	01	110
07	Molina Healthcare of Puerto Rico, Inc.	01	120
07	Molina Healthcare of Puerto Rico, Inc.	01	130
07	Molina Healthcare of Puerto Rico, Inc.	01	220
07	Molina Healthcare of Puerto Rico, Inc.	01	230
07	Molina Healthcare of Puerto Rico, Inc.	01	300
07	Molina Healthcare of Puerto Rico, Inc.	01	310
07	Molina Healthcare of Puerto Rico, Inc.	01	320
07	Molina Healthcare of Puerto Rico, Inc.	01	330
08	MMM Multi Health, LLC	01	100
08	MMM Multi Health, LLC	01	110
08	MMM Multi Health, LLC	01	120
08	MMM Multi Health, LLC	01	130
08	MMM Multi Health, LLC	01	220
08	MMM Multi Health, LLC	01	230
08	MMM Multi Health, LLC	01	300
08	MMM Multi Health, LLC	01	310
08	MMM Multi Health, LLC	01	320
08	MMM Multi Health, LLC	01	330
29	Medicare y Mucho Mas	02	004
29	Medicare y Mucho Mas	02	005

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Carrier Name	Plan Type	Plan Version
29	Medicare y Mucho Mas	02	008
29	Medicare y Mucho Mas	02	009
29	Medicare y Mucho Mas	02	010
29	Medicare y Mucho Mas	02	011
29	Medicare y Mucho Mas	02	012
29	Medicare y Mucho Mas	02	013
29	Medicare y Mucho Mas	02	017
29	Medicare y Mucho Mas	02	018
29	Medicare y Mucho Mas	02	021
29	Medicare y Mucho Mas	02	022
33	Preferred Medicare Choice	02	005
33	Preferred Medicare Choice	02	006
33	Preferred Medicare Choice	02	007
33	Preferred Medicare Choice	02	008
33	Preferred Medicare Choice	02	009
33	Preferred Medicare Choice	02	010
33	Preferred Medicare Choice	02	015
33	Preferred Medicare Choice	02	016
34	MCS Advantage	02	003
34	MCS Advantage	02	004
34	MCS Advantage	02	011
34	MCS Advantage	02	012
34	MCS Advantage	02	017
34	MCS Advantage	02	018
34	MCS Advantage	02	019
34	MCS Advantage	02	020

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Carrier Name	Plan Type	Plan Version
34	MCS Advantage	02	021
34	MCS Advantage	02	022
34	MCS Advantage	02	023
34	MCS Advantage	02	024
34	MCS Advantage	02	025
34	MCS Advantage	02	026
34	MCS Advantage	02	027
34	MCS Advantage	02	028
34	MCS Advantage	02	029
34	MCS Advantage	02	030
34	MCS Advantage	02	031
34	MCS Advantage	02	032
34	MCS Advantage	02	035
34	MCS Advantage	02	036
34	MCS Advantage	02	043
34	MCS Advantage	02	044
42	Humana	02	005
42	Humana	02	006
42	Humana	02	007
42	Humana	02	008
42	Humana	02	013
42	Humana	02	014
42	Humana	02	015
42	Humana	02	016
45	Constellation Health, LLC	02	001
45	Constellation Health, LLC	02	002

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Carrier Code	Carrier Name	Plan Type	Plan Version
45	Constellation Health, LLC	02	003
45	Constellation Health, LLC	02	004
45	Constellation Health, LLC	02	005
45	Constellation Health, LLC	02	006
45	Constellation Health, LLC	02	007
45	Constellation Health, LLC	02	008
45	Constellation Health, LLC	02	009
45	Constellation Health, LLC	02	010
45	Constellation Health, LLC	02	011
45	Constellation Health, LLC	02	012
46	Triple-S Advantage	02	003
46	Triple-S Advantage	02	004
46	Triple-S Advantage	02	005
46	Triple-S Advantage	02	006
46	Triple-S Advantage	02	007
46	Triple-S Advantage	02	008
46	Triple-S Advantage	02	011
46	Triple-S Advantage	02	012
46	Triple-S Advantage	02	013
46	Triple-S Advantage	02	014
46	Triple-S Advantage	02	015
46	Triple-S Advantage	02	016

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

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VIII - HOUR CODES

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

00	12:00 a.m.

Attachment 9
Information System

837 Layout Guides

NCPDP
837 Dental
837 Institutional
837 Professional

HIPAA Transaction
Standard Companion Guide

Refers to the NCPDP Post Adjudication Standard V4.2

Puerto Rico Department of Health Post Adjudication Companion Guide

Companion Guide Version Number: 2.Ø

June 2Ø17

For Module I Implementation

Puerto Rico Medicaid Management Information System,
Fiscal Agent Services

Disclosure Statement

Preface

This Companion Guide to the NCPDP Post Adjudication 4.2 Implementation Guide clarifies and specifies the data content when exchanging electronically with Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the Post Adjudication 4.2 Implementation Guides, are compliant with NCPDP. This Companion Guide is intended to convey information that is within the framework of the Post Adjudication 4.2 Implementation Guides. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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Table of Contents

1 Introduction

This section describes how the NCPDP Post Adjudication (4.2) Implementation Guides (IGs) will be detailed with the use of a table. The table contains a row for each segment that Puerto Rico Department of Health (PRDoH) has something additional, over and above, the information in the IGs.

In addition to the row for each segment, one or more additional rows are used to describe PRDoH usage for composite and simple data elements and for any other information. The following table is an example:

SHADED Rows represent "segments" in the NCPDP Post Adjudication Implementation Guide.
NON-SHADED rows represent "data elements" in the NCPDP Post Adjudication Implementation Guide.

Field	Field Name	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-Ø4	RECORD TYPE	M	P	A/N	2	1	2	
6Ø1-Ø9	TOTAL RECORD COUNT	M	P	N	1Ø	3	12	
895	TOTAL NET AMOUNT DUE	M	P	D	12	13	24	

1.1 Scope

This Companion Guide (CG) is to be used in addition to the NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code list.

This Companion Guide contains two types of data; instructions for electronic communications with PRDoH (Communications/Connectivity Instructions) and supplemental information for creating transactions for PRDoH while ensuring compliance with the associated Post Adjudication 4.2 Implementation Guide.

The Transaction Instruction component is included in the CG when PRDoH wants to clarify the Implementation Guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by NCPDP's copyrights and Fair Use statement.

1.2 Overview

The Transaction Instruction component of this companion guide must be used in conjunction with an associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List. 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 NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List and is in conformance NCPDP's Fair Use and Copyright statements.

1.3 References

The CORE v5Ø1Ø Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2ØØ3.

2 NCPDP Post Adjudication Transaction Standard Version 2.2 File Information

The batch specifications contained in this document include the header, detail and trailer. Batch files should contain one header record, one trailer record, and a maximum of 25,ØØØ transaction details.

- Post Adjudication History Header (Occurs 1);
- Post Adjudication History Detail (Occurs 1 to 25,ØØØ);
- Post Adjudication History Compound Detail 1 (Occurs 1 as Applicable with Detail Record);
- Post Adjudication History Compound Detail 2 (Occurs 1 as Applicable with Detail Record); and,
- Post Adjudication History Trailer (Occurs 1).

Batch files should have a creation date in the batch header that is valid and less than 3Ø days old from the submission date of the file. Values in the header and trailer will be edited to verify that they contain appropriate values.

2.1 Record Delimiter

Carriage returns only – UNIX-based system (record length n+1)

2.2 Over Punch Sign Requirements

Positive Signed		Negative Signed	
Numeric	Graphic	Numeric	Graphic
Ø	{	0	}
1	A	1	J
2	B	2	K
3	C	3	L
4	D	4	M
5	E	5	N
6	F	6	O
7	G	7	P
8	H	8	Q
9	I	9	R

Examples

1. 1Ø} is -1ØØ
2. 45A is 451

Decimal points are usually implied not explicit in the text. Using numbers with two decimal digits: 1ØØØ} is -1ØØ.ØØ

2.3 Additional NCPDP Post Adjudication Transaction Standard Version 2.2 File Information.

Following is a list of the field, use, field name and values/comments for Puerto Rico Medicaid using the batch NCPDP Batch Transaction Standard Version v1.1 and Telecommunication Standard Version v5.1.

The following definitions are given to ensure consistency of interpretation:

- **Field** – The Post Adjudication Transaction Standard Version 2.2 field number;
- **Field Name** – The Post Adjudication Transaction Standard Version 2.2 field name;
- **Mandatory or Situational** – Field designation, Indicates whether a field is mandatory or situational. Mandatory fields may be mandatory by the NCPCP Post Adjudication Transaction Standard Version 2.2 and/or required by the processor. If a field is situational and data does not exist for the field, the field MUST be populated with the appropriate padding;
  - M – Mandatory field;
  - S – Situational field;
- **Source** – Data source;
  - C – Submitted Claim or the Processor's response to the Submitted Claim;
  - P – Processor/Payer;
- **Format** – Field format values;
  - A/N – Alpha/Numeric, upper case when alpha, always left justified, space filled, upper case, printable characters and default values of spaces;
    - Example: X(14) represents "1234ABC44bbbbb";
  - N – Unsigned Numeric, always right justified, zero filled and when used for dollar fields, have default values of zeros;
    - Example: 9(7)v999 represents "9999999999";

    NX – Numeric Extended, are always right justified and zero filled, with the right most position reserved for the sign. The field must be blank when not reported. The symbol "b" indicates a "blank" or a "positive" value. The symbol "-"indicates a negative value. Zeros represent a valid numeric value and do not mean "null". All decimals are implied not explicit;
    - Example: 9999v99- represents a negative 9999.99 9999v99b – represents a positive 9999.99.
  - R – Numeric Ø – 9 with decimal point;

For numeric values that have a varying number of decimal positions, a decimal data element may contain an explicit decimal point and is used. This data element type is represented as "R.".

The decimal point always appears if it is at any place other than the right most position. If the value is an integer (decimal point at the right most position), the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1, ØØØ, ØØØ, ØØØ, ØØØ) is prohibited. The length of a

decimal type data element does not include the decimal point. A value of 12345.67 is valid in a field defined with a maximum length of 7.

- Example: A transmitted value of 12.34 represents a decimal value of 12.34 a transmitted value of 25.4 when applied to a monetary use represents $25.4Ø.

- **Size** – The field length size;
- **Start** – The starting position in the record of the field;
- **End** – The ending position in the record of the field ; and,
- **Values/Comments** – Defines the Puerto Rico Medicaid required values or default values for each field.

3 Transaction Specific Information

This section describes how the NCPDP Post Adjudication 4.2 Implementation Guide (IG), Data Dictionary, and the External Code List will be used. The tables contain a row for each segment that PRDoH has something additional, over and above, the information in the IGs in addition to any other information tied directly to a segment, composite or simple data element pertinent to trading electronically with PRDoH.

3.1 POST ADJUDICATION HISTORY HEADER RECORD

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA- Post Adjudication History Header Record	M	P	A/N	2	1	2	
1Ø2-A2	VERSION/RELEASE NUMBER	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	42- Version 4.2	M	P	A/N	2	3	4	PRDoH uses 42-
879	SENDING ENTITY IDENTIFIER	Party creating the data enclosed or the entity for whom the data is being enclosed.	n/a	M	P	A/N	24	5	28	
8Ø6-5C	BATCH NUMBER	This number is assigned by the processor/sender. A number generated by the sender to uniquely identify this batch from others, especially when multiple batches may be sent in one day.	n/a	M	P	N	7	29	35	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
88Ø-K2	CREATION DATE	Date the file was created.	n/a	M	P	N	8	36	43	Format CCYYMMDD
88Ø-K3	CREATION TIME	Time file was created.	n/a	M	P	N	4	44	47	Format HHMM
88Ø-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	n/a	M	P	A/N	24	48	71	
6Ø1-Ø6	REPORTING PERIOD START DATE	The first day of the period being reported in the file.	n/a	M	P	N	8	72	79	Format CCYYMMDD
6Ø1-Ø5	REPORTING PERIOD END DATE	The last day of the period being reported in the file.	n/a	M	P	N	8	8Ø	87	Format CCYYMMDD
7Ø2-MC	FILE TYPE	Code identifying whether the file contained test or production data.	T- Test- In processing systems, the test environment P- Production- In processing systems, the live environment	M	P	A/N	1	88	88	
981-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file updates or a file delete	O- Original Submission (New)- a new file	M	P	A/N	1	89	89	Please use value "O"
888	SUBMISSION NUMBER	Indicates the number of times a data set has been resent.	Blank- Not Specified ØØ- First Submission Ø1- First Resubmission Ø2- Second Resubmission Ø3-99 Number of Resubmission	M	P	A/N	2	9Ø	91	
	FILLER	n/a	n/a	M	P	A/N	36Ø9	92	37ØØ	

3.2 POST ADJUDICATION HISTORY DETAIL RECORD

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	DE- Post Adjudication History Detail Record	M	P	A/N	2	1	2	
398	RECORD INDICATOR	Action to be taken on the record.	Blank- Not Specified Ø- New Record 1- Overwrite existing record 2- Delete existing record	S	P	A/N	1	3	3	.
SECTION DENOTES ELIGIBILITY CATEGORY:										
248	ELIGIBLE COVERAGE CODE	Coverage Level Code. Code indicating the level of coverage being provided for the insured.	IND- Individual	S	P	A/N	3	4	6	IND- Individual
898	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client.	n/a	S	P	A/N	1Ø	7	16	
899	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibility data.	n/a	S	P	A/N	1Ø	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for	n/a	S	P	A/N	15	27	41	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		the member when submitted by the client.								
27Ø	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement.	n/a	S	P	A/N	6	42	47	
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client.	n/a	S	P	A/N	2Ø	48	67	
22Ø	CLIENT ASSIGNED LOCATION CODE	The location of the member within the Client's Company from Client eligibility when submitted by the client.	n/a	S	P	A/N	2Ø	68	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.	n/a	S	P	A/N	2ØØ	88	287	
SUBSECTION DENOTES CARDHOLDER INFORMATION:										
3Ø2-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.	n/a	M	C/P	A/N	2Ø	288	3Ø7	1. The number that the submitter transmits in this position is echoed back to the submitter in

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
										the 835 and other transactions. This field is mapped to bytes 28-42 of the flat file fed into MMIS. It can only be 15 bytes because that's all we allow in MMIS for this field. The NCPDP allows for 2Ø bytes in field 3Ø2-C2. If you put more than 15 bytes in field 3Ø2-C2 of the NCPDP, the translator will truncate and only move the first 15 bytes into the MMIS field.
716-SY	LAST NAME	Last name.	n/a	S	P	A/N	35	3Ø8	342	
717-SX	FIRST NAME	First name.	n/a	S	P	A/N	35	343	377	
718	MIDDLE INITIAL	Middle initial.	n/a	S	P	A/N	1	378	378	
28Ø	NAME SUFFIX	Individual name suffix.	n/a	S	P	A/N	1Ø	379	388	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	4Ø	389	428	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	4Ø	429	468	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
726	CITY	Free-form text for city name.	n/a	S	P	A/N	3Ø	469	498	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	Puerto Rico- 42	S	P	A/N	2	499	5ØØ	42- Puerto Rico
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.	n/a	S	P	A/N	15	5Ø1	515	
B36-1W	ENTITY COUNTRY CODE	Code of the country.	n/a	S	P	A/N	2	516	517	
214	CARDHOLDER DATE OF BIRTH	Date of Birth of Member.	n/a	S	P	N	8	518	525	
721-MD	GENDER CODE	Code identifying the gender of the individual.	Blank- Unknown 1- Male 2- Female	S	P	N	1	526	526	
274	MEDICARE PLAN CODE	This represents if the member is eligible for Medicare coverage as provided in eligibility data.	Blank- Not specified A- Medicare Part A - Part of the Original Medicare Plan managed by the federal government. Covers some, but not all, of the expenses incurred for inpatient hospital care or medical care that a person may receive at a skilled nursing facility (not a custodial care facility). Some hospice care and some home health care are also covered. Limitations apply, and have deductibles, copays, or other costs to satisfy. B- Medicare Part B - Part of the Original Medicare Plan	S	P	A/N	1	527	527	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			managed by the federal government. This covers medically necessary services from doctors or outpatient hospital care. It also helps with costs associated with some physical and occupational therapist services and some home health care services. A person typically must sign up for Part B and pay a monthly premium in order to benefit from coverage. C- Medicare Part C - Part of Medicare includes medical and other benefits provided through private health benefits companies (approved by the federal government) known as Medicare Advantage Plans. Plans cover the same or better benefits as the Original Medicare Plan with easy-to-budget copay and coinsurance amounts when a person uses a network doctor and hospital. D- Medicare Part D - The optional Medicare prescription drug coverage. X- Medicare Part Unknown - Person is eligible for a Medicare plan but the plan is unidentified Z- Not Medicare Eligible - Person is not eligible for any Medicare plan.							
288	PAYROLL CLASS	A field defined by the client indicating the	Blank- Not Specified 1- Hourly 2- Salary	S	P	A/N	1	528	528	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-044

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		payroll class of the member.								
SUBSECTION DENOTES PATIENT INFORMATION:										
331-CX	PATIENT ID QUALIFIER	Code qualifying the 'Patient ID' (332-CY).	Blank -Not Specified Ø1- Social Security Number – Code indicating that the information to follow is the 9-digit number assigned to an individual by the Social Security Administration for various purposes, including paying and reporting taxes. 1J- Facility ID Number - ID number assigned by the LTC Facility to the patient Ø2- Driver's License Number – Indicator defining the information to follow as the patient's license to operate a motor vehicle Ø3- U.S. Military ID – An identification number given to an active or retired member of the US Armed Services or their dependents. Ø4- Non-SSN-based patient identifier assigned by health plan – An identification number given to a member by the health plan that is not based on the member's SSN. Ø5- SSN-based patient identifier assigned by health plan – An identification number given to a member by the health plan that is based on the member's SSN with modifications so the number is not equal to the SSN.	S	P	A/N	2	529	53Ø	"Ø6"

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø6- Medicaid ID - A number assigned by a state Medicaid agency Ø7- State Issued ID - An ID issued by a state for the purpose of identifying the individual for legal requirements. Ø8- Passport ID - A document number found within an official identification document that is supplied to an individual by a national government. Ø9- Medicare HIC# - The identification of person assigned by Medicare. 1Ø- Employer Assigned ID - The identification of a person assigned by the employer. 11- Payer/PBM Assigned ID - The identification of a person assigned by the payer or pharmacy benefit manager. 12- Alien Number (Government Permanent Residence Number) - The ID number assigned by the government for the individual in the country as a permanent resident. 13- Government Student VISA Number – The ID number assigned by the government for the individual in the country on a student VISA. 14- Indian Tribal ID - An ID assigned by an Indian Tribal Authority to identify an individual.							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-043

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			99- Other - Different from those implied or specified. n/a							
332-CY	PATIENT ID	ID assigned to the patient.		S	P	A/N	2Ø	531	55Ø	RECIPIENT MEDICAID NUMBER. It should only be 1Ø bytes and is mapped to bytes 18-27 of the flat file. The 332-CY field in the NCPDP allows for 2Ø bytes but there are no Medicaid ID numbers more than 1Ø bytes.
716-SY	LAST NAME	Last name.	n/a	S	P	A/N	35	551	585	
717-SX	FIRST NAME	First name.	n/a	S	P	A/N	35	586	62Ø	
718	MIDDLE INITIAL	Middle initial.	n/a	S	P	A/N	1	621	621	
28Ø	NAME SUFFIX	Individual name suffix.	n/a	S	P	A/N	1Ø	622	631	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	4Ø	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	4Ø	672	711	
728	CITY	Free-form text for city name.	n/a	S	P	A/N	3Ø	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	Puerto Rico- 42	S	P	A/N	2	742	743	42-Puerto Rico
73Ø	ZIP/POSTAL CODE	Code defining international postal code	n/a	S	P	A/N	15	744	758	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		excluding punctuation.								
A43-1K	PATIENT COUNTRY CODE	Code of the country.	n/a	S	P	A/N	2	759	76Ø	
3Ø4-C4	DATE OF BIRTH	Date of Birth of Member.	n/a	S	P	N	8	761	768	
3Ø5-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Blank- Unknown 1- Male 2- Female	S	P	N	1	769	769	
247	ELIGIBILITY/ PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship between two individuals or entities	ØØ- Not Applicable Ø1- Spouse Ø2- Son or Daughter Ø3- Father or Mother Ø4- Grandfather or Grandmother Ø5- Grandson or Granddaughter Ø6- Uncle or Aunt Ø7- Nephew or Niece Ø8- Cousin Ø9- Adopted Child 1Ø- Foster Child 11- Son-in-law or Daughter-in-law 12- Brother-in-law or Sister-in-law 13- Mother-in-law or Father-in-law 14- Brother or Sister 15- Ward 16- Stepparent 17- Stepson or Stepdaughter	S	P	N	2	77Ø	771	ØØ

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			18- Self 19- Child - Dependent between the ages of Ø and 19; age qualifications may vary depending on policy 2Ø- Employee 21- Unknown 22- Handicapped Dependent 23- Sponsored Dependent - Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy 24- Dependent of a Minor Dependent 25- Ex-spouse 26- Guardian 27- Student - Dependent between the ages of 19 and 25 attending school; age qualifications may vary depending on policy 28- Friend 29- Significant Other 3Ø- Both Parents - The residence or legal custody of the student is with both parents 31- Court Appointed Guardian 32- Mother 33- Father 34- Other Adult 36- Emancipated Minor - A person who has been judged by a court of competent jurisdiction to be allowed to act in his or her own interest; no adult is legally							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			responsible for this minor; this may be declared as a result of marriage 37- Agency Representative 38- Collateral Dependent - Relative related by blood or marriage who resides in the home and is dependent on the insured for a major portion of their support 39- Organ Donor - Individual receiving medical service in order to donate organs for a transplant 4Ø- Cadaver Donor - Deceased individual donating body to be used for research or transplants 41- Injured Plaintiff 43- Child Where Insured Has No Financial Responsibility - Child is covered by the insured but the insured is not the legal guardian 45- Widow 46- Widower 47- State Fund - The state affiliated insurance organization providing coverage and or benefits to the claimant 48- Stepfather 49- Stepmother 5Ø- Foster Parent 51- Emergency Contact 52- Employer 53- Life Partner 55- Adopted Daughter 56- Adopted Son							

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			57- Adoptive Father 58- Adoptive Mother 59- Adoptive Parents 6Ø- Annuitant 61- Aunt 62- Brother 63- Brother-in-law 64- Business 65- Business Associate 66- Business Insurance Trust 67- Business Partner 68- Charity 7Ø- Children of Marriage 71- Company 72- Corporation 73- Creditor 74- Daughter 75- Daughter-in-Law 76- Dependent 78- Estate 79- Ex-wife 8Ø- Family Member 81- Father-in-Law 82- Fiancé (Male) 83- Finance (Female) 84- Fiduciary 86- Foster Daughter 87- Foster Father 88- Foster Mother 9Ø- Foster Son 91- God Daughter 92- God Father							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			93- God Parents 94- God Son 95- Grandchildren 96- Granddaughter 97- Grandfather 98- Grandmother 99- Grandparents A1- Grandson A2- Great Aunt A3- Ex-husband A4- Half Brother A5- Half Sister A6- Husband A7- Institution A8- Mortgage Holder A9- Mother-in-Law B1- Nephew B2- Niece B3- Parents-in-Law B4- Partnership B5- Partner B6- Personal Insurance Trust B7- Sister B8- Sister-in-Law B9- Sole Proprietorship C1- Son C2- Son-in-Law C3- Step Brother C4- Step Children C5- Step Daughter C8- Step Sister C9- Step Son							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			D1- Trust D2- Trustee D3- Uncle D4- Wife D5- Teacher D6- School Counselor D7- School Principal D8- Other School Administrator D9- Coach E1- Activity Sponsor E2- Supervisor E3- Co-worker E4- Minister or Priest E5- Ecclesiastical or Religious Leader E6- God Mother E7- Probation Officer E8- Accountant E9- Advisor F1 -Alma Mater F2 -Applicant F3- Banker F8- Clergyman F7- Client F8 -Club or Organization Officer F9- Doctor G2- Educator/Teacher/Instructor G3- Betrothed G4- Insured G5- Lawyer G6- Medical Care Provider G7- Neighbor							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
79-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			G8- Other Relationship G9- Other Relative H1- Owner H4- Payer N1- None OT- Non-applicable Individual Relationship Category ZZ- Mutually Defined							
2Ø8	AGE	Calculated from Date of Birth (3Ø4-C4).	n/a	S	P	N	3	772	774	Calculated from Date of Birth (3Ø4-C4).
3Ø3-C3	PERSON CODE	Code assigned to a specific person within a family.	n/a	S	P	A/N	3	775	777	
3Ø6-C6	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø- Not Specified 1- Cardholder - The individual that is enrolled in and receives benefits from a health plan 2- Spouse - Patient is the husband/wife/partner of the cardholder 3- Child - Patient is a child of the cardholder 4- Other - Relationship to cardholder is not precise	S	C	N	1	778	778	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.	Ø- Not Specified 1- No Override – Eligibility denial cannot be superseded 2- Override – Eligibility denial is being superseded 3- Full Time Student – A dependent child enrolled as a full time student at a school	S	C	A/N	1	779	779	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			4- Disabled Dependent – A dependent, regardless of age, whoever is disabled 5- Dependent Parent - A dependent who is the parent. 6- Significant Other – Partner other than the spouse							
336-8C	FACILITY ID	ID assigned to the patient's clinic/host party.	n/a	S	P	A/N	1Ø	78Ø	789	
SECTION DENOTES BENEFIT CATEGORY:										
3Ø1-C1	GROUP ID	ID assigned to the cardholder group or employer group.	n/a	M	P	A/N	15	79Ø	8Ø4	PRDoH does not use this data element.
215	CARRIER NUMBER	Account Number assigned during installation.	n/a	S	P	A/N	9	8Ø5	813	
757-U6	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.	n/a	S	P	A/N	15	814	828	
24Ø	CONTRACT NUMBER	Account Number assigned during installation for segments of business	n/a	S	P	A/N	8	829	836	

ADMINISTRACION DE SEGUROS DE
Contrato
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.	Blank- Not Specified 1- Mail Order Only - Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service. 2- Mail Order Member Paper Only – Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service and only when the claim is submitted by the member via a request for reimbursement. 3- Card Only - Claims accepted for payment only when the prescription is dispensed at retail pharmacies. 4- Member Paper Only – Claims accepted for payment when the claim is submitted by the member requesting reimbursement. 5- Standard Program (Integrated Card, Mail Service & Member Paper Programs) – Claims accepted from all types of dispensing providers and paper claims submitted requesting reimbursement after dispensing. 6- Card and member paper only - Claims accepted for payment only when the prescription is dispensed at a retail pharmacy, or when a paper claim is	S	P	A/N	1	837	837	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			submitted by the member requesting reimbursement 7- Mail and Card Only - Claims accepted for payment only when dispensed by mail service or retail pharmacies; claims submitted by the member requesting reimbursement are not covered. 8- Discount Card Program – Claims accepted but members are required to pay 1ØØ% copay for all types of pharmacy claims.							
279	MEMBER SUBMITTED CLAIM PROGRAM CODE	A one-position field indicating the type of member submitted claim program used to process this claim.	Blank-Not Specified 1- Paper Claim Direct - Patient has submitted a paper claim for reimbursement after the pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction. The patient pays 1ØØ%. 2- Paperless Claim Direct – The pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction and the patient pays 1ØØ%. The patient does not need to send in a paper claim as the billing transaction will trigger the reimbursement to the member after a defined period of time. 3- Paper Submit Only – Patient must submit a paper claim as there is no Point of Sale (POS) component.	S	P	A/N	1	838	838	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			4- Paper Claim Direct With Dual Pricing - Same as #1 but reimbursement to a patient may differ if no billing transaction (POS claim) was transmitted. 5- Paperless Claim Direct With Dual Pricing – Same as # 2 but reimbursement to the patient may differ if paper claim is received. 6- Paperless Claim Direct With Mail Pricing 7- Paperless Claim Direct and Paper Submit 8- Paper Claim Direct W/ Dual Pricing Determined by Days' Supply							
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non- Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- Bypass all system edits. Pays claims at full amount billed with no copay. I- Bypasses all system edits. Pays claims at full amount billed with copay applied. J- Bypasses all system edits. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.	S	P	A/N	1	839	839	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non- Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- Bypass all system edits. Pays claims at full amount billed with no copay. I- Bypasses all system edits. Pays claims at full amount billed with copay applied.	S	P	A/N	1	84Ø	84Ø	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			J- Bypasses all system edits. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.							
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non- Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- Bypass all system edits. Pays claims at full amount billed with no copay. I- Bypasses all system edits. Pays claims at full amount billed with copay applied. J- Bypasses all system edits. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.	S	P	A/N	1	841	841	
241	COPAY MODIFIER ID	Unique drug list ID that is coordinated for use with the clients copay set-up. Processor defined codes.	n/a	S	P	A/N	1Ø	842	851	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-Not Specified 1- Medicare Part B (Plan Cutback) - A reduction in a quantity of a medical service covered by Medicare Part B 2- Medicare Part B with days' supply cutback - A reduction in the days' supply of a service/drug covered by Medicare Part B	S	P	A/N	1	852	852	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-048

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			C- Net Check limit cutback - A reduction in the net amount of a check D- Days' Supply cutback – A reduction in the days' supply I- Ingredient Cost cutback - A reduction in the ingredient cost Q- Quantity cutback - A reduction in the quantity							
293	PREFERRED ALTERNATIVE FILE ID	Indicates the preferred alternative file ID number used to determine processing.	n/a	S	P	A/N	1Ø	853	862	
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ-Not Specified by patient Ø1- No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2- Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received. Ø3- Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered. Ø4- Other coverage exists-payment not collected - Code	S	C	N	2	863	864	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received. Ø8- Claim is billing for patient financial responsibility only - Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection.							
291	PLAN BENEFIT CODE	Determines the method by which Insulin and OTC claims are paid. Defined by processor.	n/a	S	P	A/N	2	865	866	
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan.	192Ø- MEDICAID - A program, financed jointly by the federal government and the states, that provides health coverage for mostly low-income women and children as well as nursing-home care for low-income elderly.	S	P	A/N	4	867	87Ø	"192Ø" - Medicaid
SECTION DENOTES PHARMACY CATEGORY:										
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Ø1- National Provider Identifier (NPI) - A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).	M	C	A/N	2	871	872	Puerto Rico uses Qualifier Ø1 – National Provider Identifier (NPI). For Atypical Providers, please

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø5- Medicaid- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.							submit the Qualifier value, Ø5 - Medicaid ID.
2Ø1-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.	n/a	M	C	A/N	15	873	887	This is to whom the payment was made. This is usually the SERVICE PROVIDER

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
										(PHARMACY) NPI.
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Ø1- National Provider Identifier (NPI) Ø5- Medicaid	S	P	A/N	2	888	889	Puerto Rico uses Qualifier Ø1 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, Ø5 - Medicaid ID.
2Ø1-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.	n/a	S	P	A/N	15	89Ø	9Ø4	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.	n/a	S	P	A/N	7	9Ø5	911	
833-5P	PHARMACY NAME	Pharmacy name.	n/a	S	P	A/N	7Ø	912	981	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	4Ø	982	1Ø21	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	4Ø	1Ø22	1Ø61	
728	CITY	Free-form text for city name.	n/a	S	P	A/N	3Ø	1Ø62	1Ø91	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	Puerto Rico- 42	S	P	A/N	2	1Ø92	1Ø93	
73Ø	ZIP/POSTAL CODE	Code defining international postal code	n/a	S	P	A/N	15	1Ø94	11Ø8	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		excluding punctuation.								
887	SERVICE PROVIDER COUNTRY CODE	Indicates the county of the pharmacy	n/a	S	P	A/N	3	11Ø9	1111	
A93	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider	n/a	S	P	A/N	2	1112	1113	
732	TELEPHONE NUMBER	Telephone Number	n/a	S	P	N	1Ø	1114	1123	
B1Ø-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.	n/a	S	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (29Ø).	Blank- Not Used 1- Processor-defined - The processor supports and maintains their own codes. 2- Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only) - The values are from the NCPDP Pharmacy Database. 3- Other	S	P	A/N	1	1132	1132	
29Ø	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product.	n/a	S	P	A/N	2	1133	1134	
15Ø	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).	Blank- Not Used 1- Processor-defined - The processor supports and maintains their own codes. 2- Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only) - The	S	P	A/N	1	1135	1135	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			values are from the NCPDP Pharmacy Database. 3- Other							
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.	n/a	S	P	A/N	1	1136	1136	
266	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.	Blank- Not Specified Y- In Network – The dispensing pharmacy was under contract with the plan to provide services N- Out of Network – The dispensing pharmacy was not under contract with the plan	S	P	A/N	1	1137	1137	
545-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.	n/a	S	P	A/N	1Ø	1138	1147	
SECTION DENOTES PRESCRIBER CATEGORY:										
466-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411- DB).	Ø1- National Provider Identifier (NPI) Ø5- Medicaid	S	C	A/N	2	1148	1149	Puerto Rico uses Qualifier Ø1 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, Ø5 - Medicaid ID.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-01

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
411-DB	PRESCRIBER ID	ID assigned to the prescriber.	n/a	S	C	A/N	15	115Ø	1164	This is the prescribing physician's NPI.
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411- DB).	Ø1- National Provider Identifier (NPI) Ø5- Medicaid	S	P	A/N	2	1165	1166	Puerto Rico uses Qualifier Ø1 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, Ø5 - Medicaid ID.
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.	n/a	S	P	A/N	15	1167	1181	This is the prescribing physician's NPI.
296	PRESCRIBER TAXONOMY	The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.	The values can be obtained from the following link: http://www.wpc-edi.com/codes/taxonomy	S	P	A/N	1Ø	1182	1191	
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.	Blank- Not Specified Ø1- Active Ø2- Retired (Inactive) Ø3- Voluntary Inactive Ø4- Deceased Ø5- Pending health plan approval Ø6- License Revoked Ø7- Utilization Review Sanctioned	S	P	A/N	2	1192	1193	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø8- Fraud Conviction (Inactive) Ø9- Administration Action (Inactive) 1Ø- Terminated 11- Decertified 12- Reopened after Sanction or Decertification 13- Federal Sanction 14- Out of Network: Participating 15- Out of Network: Non-Participating 16- In Network: Participating 17- In Network: Non-Participating							
716-SY	LAST NAME	Last name	n/a	S	P	A/N	35	1194	1228	
717-SX	FIRST NAME	First name	n/a	S	P	A/N	35	1229	1263	
732	TELEPHONE NUMBER	Telephone Number	n/a	S	P	N	1Ø	1264	1273	
81Ø-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number	n/a	S	C/P	N	8	1274	1281	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL)	Ø1- National Provider Identifier (NPI) Ø5- Medicaid	S	C/P	A/N	2	1282	1283	Puerto Rico uses Qualifier Ø1 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, Ø5 – Medicaid ID.
421-DL	PRIMARY CARE	ID assigned to the primary care provider. Used when the	n/a	S	C/P	A/N	15	1284	1298	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-043

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	PROVIDER ID	patient is referred to a secondary care provider.								
716-SY	LAST NAME	Last name	n/a	S	P	A/N	35	1299	1333	
717-SX	FIRST NAME	First name	n/a	S	P	A/N	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	1- Paid – Code indicating that the transaction was adjudicated using plan rules and was payable. 2- Rejected – Code indicating that the transaction was denied/rejected 3- Reversed – Code indicating that the paid transaction was cancelled 4- Adjusted – Code indicating that the previous transaction was changed 5- Captured – Code indicating the receipt of the transaction but no judgment has been made regarding eligibility of the patient or payment. 6- Reverse – Captured- Code indicating that the captured transaction was cancelled.	M	P	A/N	1	1369	1369	
218	CLAIM MEDIA TYPE	Claim submission type code.	Blank-Not Specified 1- POS Claim –A Point-Of-Sale transaction submitted in a real-time mode. 2- Batch Claim – A non real-time transaction submitted when an immediate response is not available or required.	M	P	A/N	1	137Ø	137Ø	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			3- Pharmacy Submitted Paper Claim (UCF) – A non- electronic transaction submitted via an NCPDP- developed Universal Claim Form. 4- Member Submitted Paper Claim (Direct Member Reimbursement (DMR) – A claim submitted by the member requesting reimbursement. 5- Other – Different from the codes already specified							
395	PROCESSOR PAYMENT CLARIFICATION CODE	Provides additional information of the status of the payment of the claim.	Blank- Not Specified Ø1-Ø9- Paid 1Ø-19- Reversals 2Ø-29- Adjustments 3Ø-39- Rejects	M	P	A/N	2	1371	1372	PRDoH requires "Blank" for this data element.
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/ Service Reference Number Qualifier	1- Rx Billing Transaction- A billing for a prescription or OTC drug product 2- Service Billing – Transaction is a billing for a professional service performed.	M	C	A/N	1	1373	1373	
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	n/a	M	C	N	12	1374	1385	PRESCRIPTION NUMBER
436-E1	PRODUCT/SERVICE ID QUALIFIER	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC	M	C	A/N	2	1386	1387	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 1Ø- PPAC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 34- UPN 36- NDC 99- Other							
4Ø7-D7	PRODUCT/SERVICE ID	ID of the product dispensed or service provided.	n/a	M	C	A/N	19	1388	14Ø6	NDC drug code if a compound drug is being reported, this field should be all zeros.
4Ø1-D1	DATE OF SERVICE	Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long- term	n/a	M	C	N	8	14Ø7	1414	CCYYMMDD

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		care setting only.								
578	ADJUDICATION DATE	Date the claim or adjustment is processed.	n/a	M	P	N	8	1415	1422	
2Ø3	ADJUDICATION TIME	Time the claim or adjustment is processed.	n/a	S	P	N	6	1423	1428	
283	ORIGINAL CLAIM RECEIVED DATE	The date the pharmacy submitted the claim electronically for a paper claim-matching program.	n/a	S	P	N	8	1429	1436	
219	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.	n/a	S	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.	n/a	S	P	N	8	1442	1449	
239	COMMUNICATION TYPE INDICATOR	For Mail Service Claims Only – Identifies the type of communication used by either prescriber or patient to initiate the request for the fill.	Blank- Not Specified E- Email (Electronic mail) – F- Fax I- Interactive Voice Response Unit (IVRU) D- Directly delivered to pharmacy (delivery service/mail/walk in) P- Electronic Prescription V- Customer Service (phoned in)	S	P	A/N	2	145Ø	1451	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			W- Website							
3Ø7-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.	The Centers for Medicare and Medicaid Services (CMS) maintains this code set. The complete code set is available at: https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html	S	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	ØØ- Not Specified – Other patient residence not identified below. Ø1- Home – Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence. Ø2- Skilled Nursing Facility – A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital. For Medicare Part B use only. Ø3- Nursing Facility – A facility which primarily provides to resident's 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. Ø4- Assisted Living Facility – Congregate residential facility with self-contained living units	S	C	N	2	1454	1455	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			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. Ø5- 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. For Medicare Part B use only. Ø6- Group Home – Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community. Ø7- 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. Not applicable to Pharmacy Benefits Ø8- 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								

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			possible from outpatient visits to a hospital- based or hospital-affiliated facility. Not applicable to Pharmacy Benefits Ø9- Intermediate Care Facility/Mentally Retarded – A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF. 1Ø- Residential Substance Abuse Treatment Facility – A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do 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. Not applicable to Pharmacy Benefits 11- Hospice – A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. 12- Psychiatric Residential Treatment Facility – 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. Not applicable to Pharmacy Benefits							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			13- 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. Not applicable to Pharmacy Benefits 14- 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). Not applicable to Pharmacy Benefits 15- Correctional Institution – A facility that provides treatment and rehabilitation of offenders through a program of penal custody.							
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø- Not Known 1- Written – Prescription obtained via paper. 2- Telephone – Prescription obtained via oral instructions or interactive voice response using a phone. 3- Electronic – Prescription obtained via SCRIPT or HL7 Standard transactions. 4- Facsimile – Prescription obtained via transmission using a fax machine.	S	C	N	1	1456	1456	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-048

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			5- Pharmacy – This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, interchange transfers, file buys, software							
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date the member submitted claim became payable, which could differ from the check date.	n/a	S	P	N	8	1457	1464	
217	CLAIM DATE RECEIVED IN THE MAIL	Date paper claim was received in the mail.	n/a	S	P	N	8	1465	1472	
268	INTERNAL MAIL ORDER PRESCRIPTION/SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.	n/a	S	P	A/N	15	1473	1487	
1Ø2-A2	VERSION/RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	42	S	C	A/N	2	1488	1489	PRDoH uses version 4.2- "42"
216	CHECK DATE	Member Claims – Actual member check date	n/a	S	P	N	8	149Ø	1497	Date Claim Paid Mask: CCYYMMDD

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-0449

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		Nonmember Claims – Pharmacy check date								
287	PAYMENT/ REFERENCE ID	Identifies ID assigned by sender to reference individual pharmacy and member reimbursement. Check or EFT trace number.	n/a	S	P	A/N	3Ø	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related 'Prescription/Service Reference Number' (4Ø2-D2) to which the service is associated.	n/a	S	C	N	12	1528	1539	
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the 'Associated Prescription/Service Reference Number' (456-EN).	n/a	S	C	N	8	154Ø	1547	
442-E7	QUANTITY DISPENSED	Quantity dispensed expressed in metric decimal units.	n/a	S	C	N	1Ø	1548	1557	Quantity dispensed if a compound drug is being reported. This field should be all zeros.
4Ø3-D3	FILL NUMBER	The code indicating whether the prescription is	Ø- Original dispensing – The first dispensing Ø1-99- Refill number – Number of the replenishment	S	C	N	2	1558	1559	Indicates new RX (blank) or number of refills used

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		an original or a refill.								
4Ø5-D5	DAYS SUPPLY	Estimated number of days the prescription will last.	n/a	S	C	N	3	156Ø	1562	Days Supply Dispensed
414-DE	DATE PRESCRIPTION WRITTEN	Date prescription was written.	n/a	S	C	N	8	1563	157Ø	
	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Ø- No Product Selection Indicated – This is the field default value that is appropriately used for prescriptions for single source brand, co- branded/co-licensed, or generic products. For a multi-source branded product with available generic(s), DAW Ø is not appropriate, and may result in a reject. 1- Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification. 2- Substitution Allowed-Patient Requested Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the	S	C	A/N	1	1571	1571	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 3- Substitution Allowed-Pharmacist Selected Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 4- Substitution Allowed-Generic Drug Not in Stock – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace. 5- Substitution Allowed-Brand Drug Dispensed as a Generic – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			utilizing the brand product as the generic entity. 6- Override-This value is used by various claims processors in very specific instances as defined by that claims' processor and/or its client(s). 7- Substitution Not Allowed-Brand Drug Mandated by Law – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace. 8- Substitution Allowed-Generic Drug Not Available in Marketplace – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. 9- Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.							
415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber.	ØØ- No refills authorized Ø1-99- Authorized Refill number – with 99 being as needed, refills unlimited	S	C	N	2	1572	1573	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	Ø- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- Manufacturer Unit Dose – A code used to indicate a distinct dose as determined by the manufacturer. 3- Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- Pharmacy Unit Dose Patient Compliance Packaging – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- Pharmacy Multi-drug Patient Compliance Packaging – Packaging that may contain drugs from multiple manufacturers combined to	S	C	N	1	1574	1574	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			ensure compliance and safe administration. 6- Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- Remote Device Multi-drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
6ØØ-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- Each – Being one or individual. GM- Grams – A metric unit of mass equal to one thousandth of a kilogram. ML- Milliliters – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1575	1576	
418-DI	LEVEL OF SERVICE	Coding indicating the type of service the provider rendered.	ØØ- Not Specified Ø1- Patient consultation – A professional service involving provider/patient discussion of disease, therapy or medication regimen, or other health issues	S	C	N	2	1577	1578	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø2- Home delivery – A provision of medications from pharmacy to patient's place of residence Ø3- Emergency – An urgent provision of care Ø4- 24 hour service – A provision of care throughout the day and night Ø5- Patient consultation regarding generic product selection – A professional service involving discussion of alternatives to brand-name medications Ø6- In-Home Service – A provision of care in patient's place of residence							
343-HD	DISPENSING STATUS	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	Blank- Not Specified P- Partial Fill – A dispensing of less than the prescribed quantity, the balance of which will be dispensed at a later time. C- Completion of Partial Fill – Dispensing the remaining quantity of a prescription when the entire amount could not be supplied at the original dispensing (fill).	S	C	A/N	1	1579	1579	
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used	n/a	S	C	N	1Ø	158Ø	1589	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		In association with a 'P' or 'C' in 'Dispensing Status' (343-HD).								
46Ø-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.	n/a	S	C	N	1Ø	159Ø	1599	
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Days' supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	n/a	S	C	N	3	16ØØ	16Ø2	
254	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (ØØ) or by refill number (Ø1-99) as calculated by system based on historical claims data. This field represents the Fill Number as	ØØ- New – Original Ø1-99- Refill number – Number of the replenishment	S	P	N	2	16Ø3	16Ø4	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		calculated (not submitted by pharmacy)								
4Ø6-D6	COMPOUND CODE	Code indicating whether or not the prescription is a compound.	Ø- Not Specified 1- Not a Compound – Medication that is available commercially as a dispensable product 2- Compound – Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner's prescription	S	C	N	1	16Ø5	16Ø5	
996-G1	COMPOUND TYPE	Clarifies the type of compound.	Ø1- Anti-infective – A medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites Ø2- Ionotropic – A medicinal product intended to correct irregular heart rhythms Ø3- Chemotherapy – A medicinal product intended to treat cancer Ø4- Pain management – A regimen of therapy intended to ameliorate mild to severe discomfort Ø5- TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition – Products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts	S	C	A/N	2	16Ø6	16Ø7	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø6- Hydration – A product intended to restore body fluids Ø7- Ophthalmic – A product intended to be applied to or instill in the surface of the eye 99- Other – Not defined by other available codes							
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.	NO LONGER USED FOR VERSION 4.2	S	C	N	2	16Ø8	16Ø9	NO LONGER USED FOR VERSION 4.2
995-E2	ROUTE OF ADMINISTRATION	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.	Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the International Health Terminology Standards Development Organization (IHTSDO) http://www.ihtsdo.org/snomed-ct/	S	C	A/N	11	161Ø	162Ø	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- Not Specified Only to be used when needed to conform in fixed file layout specifications. Ø1- International Classification of Diseases (ICD9) – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to	S	C	A/N	2	1621	1622	

ADMINISTRACION DE SERVICIOS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. Ø2- International Classification of Diseases-1Ø – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-1Ø - CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code.							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø3- National Criteria Care Institute (NCCI) – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Ø4- The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED) – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- Common Dental Terminology (CDT) – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and							

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-0499

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1623	1637	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- Not Specified Only to be used when needed to conform in fixed file layout specifications. Ø2- International Classification of Diseases-1Ø – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a	S	C	A/N	2	1638	1639	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			diagnosis as defined by ICD-1Ø-CM. Ø3- National Criteria Care Institute (NCCI) Ø4- The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED) Ø5- Common Dental Terminology (CDT) Ø7- American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	164Ø	1654	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- Not Specified Only to be used when needed to conform in fixed file layout specifications. Ø2- International Classification of Diseases-1Ø Ø3- National Criteria Care Institute (NCCI) Ø4- The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED Ø5- Common Dental Terminology (CDT) Ø7- American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)	S	C	A/N	2	1655	1656	
424-DO	DIAGNOSIS CODE	Code identifying the	n/a	S	C	A/N	15	1657	1671	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		diagnosis of the patient.								
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- Not Specified Only to be used when needed to conform in fixed file layout specifications. Ø2- International Classification of Diseases-1Ø Ø3- National Criteria Care Institute (NCCI) Ø4- The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED) Ø5- Common Dental Terminology (CDT) Ø7- American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)	S	C	A/N	2	1672	1673	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1674	1688	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- Not Specified Only to be used when needed to conform in fixed file layout specifications. Ø2- International Classification of Diseases-1Ø Ø3- National Criteria Care Institute (NCCI) Ø4- The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED) Ø5- Common Dental Terminology (CDT) Ø7- American Psychiatric	S	C	A/N	2	1689	169Ø	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1691	17Ø5	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- Additional Drug Needed – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- Prescription Authentication – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug. AT- Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- Chronic Disease Management – The patient is participating in a coordinated health care intervention program. CH- Call Help Desk – Processor message to recommend the receiver contact the processor/plan. CS- Patient Complaint/Symptom- Code	S	C	A/N	2	17Ø6	17Ø7	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- Drug-Allergy – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- Drug-Disease (Inferred) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- Drug-Drug Interaction – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- Drug-Food Interaction – Indicates interactions between a drug and certain foods. DI- Drug Incompatibility – Indicates physical and chemical incompatibilities between two or more drugs. DL- Drug-Lab Conflict – Indicates that laboratory values							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- Apparent Drug Misuse – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- Dose Range Conflict – Code indicating that the prescription does not follow recommended medication dosage. DS- Tobacco Use – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- Patient Education/Instruction – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription. ER- Overuse – Code indicating that the current prescription refill is occurring before the days' supply of the previous filling should have been exhausted.							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			EX- Excessive Quantity – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- High Dose – Detects drug doses that fall above the standard dosing range. IC-Iatrogenic Condition – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- Ingredient Duplication – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- Low Dose – Code indicating that the submitted drug doses fall below the standard dosing range. LK- Lock In Recipient – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-Underuse – Code indicating that a prescription refill that occurred after the days' supply							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			of the previous filling should have been exhausted. MC- Drug-Disease (Reported) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-Insufficient Duration – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- Missing Information/Clarification – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- Excessive Duration – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses. NA- Drug Not Available. – Indicates the drug is not currently available from any source. NC- Non-covered Drug Purchase – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- New Disease/Diagnosis – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- Non-Formulary Drug – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- Unnecessary Drug – Code indicating that the drug is no longer needed by the patient. NP- New Patient Processing – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- Lactation/Nursing Interaction – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- Insufficient Quantity – Code indicating that the quantity of dosage units prescribed is insufficient. OH- Alcohol Conflict – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			PC- Patient Question/Concern – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- Drug-Pregnancy – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- Preventive Health Care – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems. PN- Prescriber Consultation – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- Plan Protocol – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided.							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			PR- Prior Adverse Reaction – Code identifying the patient has had a previous atypical reaction to drugs. PS- Product Selection Opportunity – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- Suspected Environmental Risk- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- Health Provider Referral – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- Suboptimal Drug/Indication – Code indicating incorrect, inappropriate, or less than							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
9-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			optimal drug prescribed for the patient's condition. SE- Side Effect – Code reporting possible major side effects of the prescribed drug. SF- Suboptimal Dosage Form – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- Suboptimal Regimen – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- Drug-Gender – Indicates the therapy is inappropriate or contraindicated in either males or females. TD- Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- Laboratory Test Needed – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- Payer/Processor Question – Code indicating that a payer or processor requested information related to the care of a patient. UD- Duplicate Drug – Code indicating that multiple prescriptions of the same drug							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			formulation are present in the patient's current medication profile.							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	Blank- No intervention. AS- Patient Assessment – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- Coordination of Care – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- Dosing Evaluation/determination – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- Dosage Evaluated – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- Formulary Enforcement – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- Generic Product Selection – The selection of a chemically	S	C	A/N	2	17Ø8	17Ø9	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. MØ- Prescriber Consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- Medication Administration – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc. MB- Overriding Benefit – Benefits of the prescribed medication outweigh the risks. MP- Patient will be Monitored – Prescriber is aware of the risk and will be monitoring the patient. MR- Medication Review – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- Previous Patient Tolerance – Patient has taken medication previously without issue. PE- Patient Education/Instruction – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			skills and competencies related to its management. PH- Patient Medication History – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- Patient Monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. PØ- Patient Consulted – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- Perform Laboratory Test – Code indicating that the pharmacist performed a clinical laboratory test on a patient. RØ- Pharmacist Consulted Other Source – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- Recommend Laboratory Test – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- Self-care Consultation – Code indicating activities performed by a pharmacist on								

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- Literature Search/review – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient. TC- Payer/processor Consulted – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- Therapeutic Product Interchange – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- Filled with Different Dosage Form – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed.	S	C	A/N	2	171Ø	1711	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			2A- Prescription Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- Not Filled, Directions Clarified – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- Recommendation Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- Recommendation Not Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- Discontinued Drug – Cognitive service involving the pharmacist's review of drug therapy that results in the							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			removal of a medication from the therapeutic regimen. 3D- Regimen Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber. 3E- Therapy Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- Therapy Changed – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- Drug Therapy Unchanged – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills							

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			the prescription as originally written. 3H- Follow-Up/Report – Code indicating that additional follow through by the pharmacist is required. 3J- Patient Referral – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- Instructions Understood – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- Compliance Aid Provided – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- Medication Administered – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- Prescribed with acknowledgements – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity	ØØ- Not Specified 11- Level 1 (Lowest) = Straightforward: Service involves minimal diagnosis or treatment options, minimal	S	C	N	2	1712	1713	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		of decision-making or resources utilized by a pharmacist to perform a professional service.	amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time. 12- Level 2 (Low Complexity) = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- Level 3 (Moderate Complexity) = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- Level 4 (High Complexity) = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 3Ø to 59 minutes of the pharmacist's time. 15- Level 5 (Highest) = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk;							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 6Ø minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC-Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR-Underuse	S	C	A/N	2	1714	1715	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			MC- Drug-Disease (Reported) MN-Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis NF- Non-Formulary Drug NN- Unnecessary Drug NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	No intervention. AS- Patient Assessment CC- Coordination of Care DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange	S	C	A/N	2	1716	1717	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- Filled with Different Dosage Form 2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements	S	C	A/N	2	1718	1719	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a	Ø- Not Specified 11- Level 1 (Lowest) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	172Ø	1721	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		professional service.								
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration	S	C	A/N	2	1722	1723	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis NF- Non-Formulary Drug NN- Unnecessary Drug NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
79-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	No intervention. AS- Patient Assessment CC- Coordination of Care DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual	S	C	A/N	2	1724	1725	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- Filled with Different Dosage Form 2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements	S	C	A/N	2	1726	1727	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	Ø- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1728	1729	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC-Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR-Underuse MC- Drug-Disease (Reported) MN-Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration	S	C	A/N	2	173Ø	1731	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis NF- Non-Formulary Drug NN- Unnecessary Drug. NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.	S	C	A/N	2	1732	1733	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- Filled with Different Dosage Form 2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements	S	C	A/N	2	1734	1735	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12-Level 2 (Low Complexity) 13-Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1736	1737	
439-E4	REASON FOR	Code identifying the type of	AD- Additional Drug Needed AN- Prescription Authentication	S	C	A/N	2	1738	1739	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	SERVICE CODE	utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AR- Adverse Drug Reaction AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			ND- New Disease/Diagnosis NF- Non-Formulary Drug NN- Unnecessary Drug NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care	S	C	A/N	2	174Ø	1741	

ADMINISTRACION DE SEGUROS DE SALUD
Contract Number
19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		when a conflict code has been identified or service has been rendered.	DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a	ØØ- Not Specified 1K- Filled with Different Dosage Form	S	C	A/N	2	1742	1743	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		conflict or the result of a pharmacist's professional service.	2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed – Cost increased acknowledged 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1744	1745	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction	S	C	A/N	2	1746	1747	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			NF- Non-Formulary Drug NN- Unnecessary Drug NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care	S	C	A/N	2	1748	1749	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		identified or service has been rendered.	DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a	ØØ- Not Specified 1K- Filled with Different Dosage Form	S	C	A/N	2	175Ø	1751	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		conflict or the result of a pharmacist's professional service.	2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed – Cost increased acknowledged 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1752	1753	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction	S	C	A/N	2	1754	1755	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			NF- Non-Formulary Drug NN- Unnecessary Drug. NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care regarding measures mitigating PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care	S	C	A/N	2	1756	1757	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		code has been identified or service has been rendered.	DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a	1K- Filled with Different Dosage Form 2A- Prescription Not Filled	S	C	A/N	2	1758	1759	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		conflict or the result of a pharmacist's professional service.	2B- Not Filled, Directions Clarified 3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed – Cost increased acknowledged 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	176Ø	1761	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction AT- Additive Toxicity	S	C	A/N	2	1762	1763	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		prescriber or the pharmacist or the reason for the pharmacist's professional service.	CD- Chronic Disease Management CH- Call Help Desk CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food Interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration MS- Missing Information/Clarification – MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis NF- Non-Formulary Drug							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			NN- Unnecessary Drug NP- New Patient Processing NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care DE- Dosing Evaluation/determination	S	C	A/N	2	1764	1765	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-0499

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		service has been rendered.	DP- Dosage Evaluated FE- Formulary Enforcement GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a	1K- Filled with Different Dosage Form 2A- Prescription Not Filled 2B- Not Filled, Directions Clarified	S	C	A/N	2	1766	1767	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato número
19-048

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		pharmacist's professional service.	3A- Recommendation Accepted 3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered 4A- Prescribed with acknowledgements							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1768	1769	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason	AD- Additional Drug Needed AN- Prescription Authentication AR- Adverse Drug Reaction AT- Additive Toxicity CD- Chronic Disease Management CH- Call Help Desk	S	C	A/N	2	177Ø	1771	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		for the pharmacist's professional service.	CS- Patient Complaint/Symptom DA- Drug-Allergy DC- Drug-Disease (Inferred) DD- Drug-Drug Interaction DF- Drug-Food interaction DI- Drug Incompatibility DL- Drug-Lab Conflict DM- Apparent Drug Misuse DR- Dose Range Conflict DS- Tobacco Use ED- Patient Education/Instruction ER- Overuse EX- Excessive Quantity HD- High Dose IC- Iatrogenic Condition ID- Ingredient Duplication LD- Low Dose LK- Lock In Recipient LR- Underuse MC- Drug-Disease (Reported) MN- Insufficient Duration MS- Missing Information/Clarification MX- Excessive Duration NA- Drug Not Available. NC- Non-covered Drug Purchase ND- New Disease/Diagnosis NF- Non-Formulary Drug NN- Unnecessary Drug NP- New Patient Processing							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			NR- Lactation/Nursing Interaction NS- Insufficient Quantity OH- Alcohol Conflict PC- Patient Question/Concern PG- Drug-Pregnancy PH- Preventive Health Care PN- Prescriber Consultation PP- Plan Protocol PR- Prior Adverse Reaction PS- Product Selection Opportunity RE- Suspected Environmental Risk RF- Health Provider Referral SC- Suboptimal Compliance SD- Suboptimal Drug/Indication SE- Side Effect SF- Suboptimal Dosage Form SR- Suboptimal Regimen SX- Drug-Gender TD- Therapeutic TN- Laboratory Test Needed TP- Payer/Processor Question UD- Duplicate Drug							
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	ØØ- No intervention. AS- Patient Assessment CC- Coordination of Care DE- Dosing Evaluation/determination DP- Dosage Evaluated FE- Formulary Enforcement	S	C	A/N	2	1772	1773	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			GP- Generic Product Selection MØ- Prescriber Consulted MA- Medication Administration MB- Overriding Benefit MP- Patient will be Monitored MR- Medication Review PA- Previous Patient Tolerance PE- Patient Education/instruction PH- Patient Medication History PM- Patient Monitoring PØ- Patient Consulted PT- Perform Laboratory Test RØ- Pharmacist Consulted Other Source RT- Recommend Laboratory Test. SC- Self-care Consultation SW- Literature Search/review TC- Payer/processor Consulted TH- Therapeutic Product Interchange ZZ- Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's	1K- Filled with Different Dosage Form 2A- Prescription Not Filled 2B- Not Filled, Directions Clarified 3A- Recommendation Accepted	S	C	A/N	2	1774	1775	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		professional service.	3B- Recommendation Not Accepted 3C- Discontinued Drug 3D- Regimen Changed 3E- Therapy Changed 3F- Therapy Changed 3G- Drug Therapy Unchanged 3H- Follow-Up/Report 3J- Patient Referral 3K- Instructions Understood 3M- Compliance Aid Provided 3N- Medication Administered. 4A- Prescribed with acknowledgements							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	ØØ- Not Specified 11- Level 1 (Lowest) 12- Level 2 (Low Complexity) 13- Level 3 (Moderate Complexity) 14- Level 4 (High Complexity) 15- Level 5 (Highest)	S	C	N	2	1776	1777	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5	S	C	A/N	2	1778	1779	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to	n/a	S	C	A/N	19	178Ø	1798	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).								
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.	Blank- Not Specified Ø- Claim Was Paid In Good Faith 1- Member Was Ineligible On Rx Date 2- Member Was Not Found On The Member Master On Rx Date 3- Claim Was Filled For A Terminated Member	S	P	A/N	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also "Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging" of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect	S	C	A/N	3	18ØØ	18Ø2	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)							
511-FB	REJECT CODE	Code indicating the error encountered.		S	C	A/N	3	18Ø3	18Ø5	
511-FB	REJECT CODE	Code indicating the error encountered.		S	C	A/N	3	18Ø6	18Ø8	
511-FB	REJECT CODE	Code indicating the error encountered.		S	C	A/N	3	18Ø9	1811	
511-FB	REJECT CODE	Code indicating the error encountered.		S	C	A/N	3	1812	1814	
SECTION DENOTES WORKERS COMPENSATION CATEGORY:										
435-DZ	CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.	n/a	S	C	A/N	3Ø	1815	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.	n/a	S	C	N	8	1845	1852	
SECTION DENOTES PRODUCT CATEGORY:										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used	1- First DataBank – A drug database company 2- Medi-Span Product Line – A drug database company 3- Micromedex/Medical Economics – A drug database company 4- Processor Developed – A proprietary drug file	S	P	A/N	1	1853	1853	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		for identifying the product.	5- Other – Different from those implied or specified 6- Redbook – A Micromedex publication of drug information 7- Multum – Drug database company							
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	3Ø	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	3Ø	1884	1913	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	15	1914	1928	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1929	1932	
	FILLER	n/a	n/a	S	P	A/N	8	1933	194Ø	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	Ø- Not Specified - When used in the Prior Authorization Transfer Standard Ø=Specific but not limited; all legend and OTC's 1- Single Source — a clinical formulation that is only available from a single distributor. 2- Authorized Generic (aka "Branded Generic") — the originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded	S	P	N	1	1941	1941	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			formulation when nearing expiration. e.g. Pfizer and its subsidiary Greenstone. 3- Generic— the pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- Over the Counter drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- Multi-source Brand— product's clinical formulation is available from multiple distributors							
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.	Blank- Not Specified Y- Maintenance Drug – Medication used to treat a chronic condition. N- Not Maintenance -- Medication used to treat an acute condition.	S	P	A/N	1	1942	1942	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with	n/a	S	P	A/N	1	1943	1943	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		a specific drug category.								
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- Not Specified 1- Schedule I Substance (no known use) 2- Schedule II Narcotic Substances 3- Schedule III Narcotic Substances 4- Schedule IV Substances 5- Schedule V Substances	S	P	A/N	1	1944	1944	
297	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (RX prescription only) or non-prescription drug (OTC).	Blank- Not Specified O- Over the counter (OTC) – prescription not required to be dispensed F- Federal/Legend (Rx Prescription Only) S- State Restricted Medication – Under federal law, the product as dispensed does not require a prescription, but is restricted to prescription sale at the state level.	S	P	A/N	1	1945	1945	
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	Ø9- Encounters	S	C	N	2	1946	1947	Use "9" – Encounters
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	Ø9- Encounters	S	C	N	2	1948	1949	
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is	Ø9- Encounters	S	C	N	2	195Ø	1951	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		clarifying the submission.								
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- Not Specified Ø- Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer 1- Drug Efficacy Study Implementation (DESI) Drug	S	P	A/N	1	1952	1952	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- Not Specified 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- Medi-Span Product Line Generic Product Identifier (GPI) – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- First DataBank GC3 – A three character alphanumeric indicator that identifies the specific therapeutic class in	S	P	A/N	1	1953	1953	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			which the active ingredient is classified. 4- Medi-Span Product Line Drug Descriptor ID (DDID) – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- First DataBank Medication Name Identifier (FDB Med Name ID) – A permanent numeric identifier that represents a unique product or generic name. 6- First DataBank Routed Medication Identifier (FDB Routed Med ID) – Represents the product or generic name and route of administration. 7- First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID) – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- Nine-digit NDC A- American Hospital Formulary Service (AHFS) Code							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			– Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- Contracting Organization (PMO) Assigned Code – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO) H- First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO) M- Manufacturer (PICO) Assigned Code – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs))							

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			N- Eleven-digit NDC O- UPC (OTCS) P- Product group (brand or generic name) T- First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3) U- Universal System of Classification Code (USC) – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- All products used – Represents all valid products regardless of type Z- Mutually Agreed Upon Code- A code mutually agreed upon by trading partners to identify a given data type element.							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1954	197Ø	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier	S	P	A/N	1	1971	1971	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- Nine-digit NDC A- American Hospital Formulary Service C- Contracting Organization G- First Data Bank GCN Sequence Number H- First Data Bank HICL Sequence Number M- Manufacturer (PICO) Assigned Code N- Eleven-digit NDC O- UPC P- Product group T- First Data Bank Therapeutic Class Code, Specific U- Universal System of Classification Code V- All products used Z- Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1972	1988	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in	Blank- Not Specified 1- First DataBank Formulation ID	S	P	A/N	1	1989	1989	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		the Product Code (6Ø1-	2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- Nine-digit NDC A- American Hospital Formulary Service C- Contracting Organization G- First Data Bank GCN Sequence Number H- First Data Bank HICL Sequence Number M- Manufacturer (PICO) Assigned Code N- Eleven-digit NDC O- UPC P- Product group T- First Data Bank Therapeutic Class Code, Specific U- Universal System of Classification Code V- All products used Z- Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the	n/a	S	P	A/N	17	199Ø	2ØØ6	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		product being reported.								
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- Not specified 1- Yes 2- No	S	P	A/N	1	2Ø07	2Ø07	
294	PRESCRIBED DAYS SUPPLY	Indicates the original days supply of the prescription. Applies to internal Mail Service only.	n/a	S	P	N	3	2Ø08	2Ø1Ø	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization	S	P	A/N	1	2Ø11	2Ø11	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code.							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2Ø12	2Ø28	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization	S	P	A/N	1	2Ø29	2Ø29	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2Ø3Ø	2Ø46	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Not Specified BLANK 1 First DataBank Formulation ID 2 Medi-Span Product Line Generic Product Identifier 3 First DataBank 4 Medi-Span Product Line Drug Descriptor ID 5 First DataBank Medication Name Identifier 6 First DataBank Routed Medication Identifier 7 First Databank Routed Dosage Form Medication Identifier 8 First DataBank Medication Identifier 9 First DataBank Enhanced Therapeutic Class Codes C Contracting Organization (PMO) Assigned Code D First Data Bank Therapeutic Class code, Generic	S	P	A/N	1	2Ø47	2Ø47	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			E First Data Bank Therapeutic Class code, Standard M Manufacturer (PICO) Assigned Code U Universal System of Classification Code Z Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2Ø48	2Ø64	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization D- First Data Bank Therapeutic Class code, Generic	S	P	A/N	1	2Ø65	2Ø65	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2Ø66	2Ø82	
SECTION DENOTES FORMULARY CATEGORY:										
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- Not Specified I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- Drug not on Formulary; Non-Preferred – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- Drug not on Formulary; Preferred – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- Drug not on Formulary; Neutral – The medication submitted on the claim is NOT included in the list of products in	S	P	A/N	1	2Ø83	2Ø83	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- Drug on Formulary – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- Drug not on Formulary – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- Drug on Formulary; Preferred – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- Drug on Formulary; Neutral – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- Not specified Y- Yes N- No	S	P	A/N	1	2Ø84	2Ø84	
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file	n/a	S	P	A/N	8	2Ø85	2Ø92	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		as defined by processor								
256	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.	n/a	S	P	A/N	15	2Ø93	21Ø7	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.	n/a	S	P	A/N	1	21Ø8	21Ø8	
SECTION DENOTES PRICING CATEGORY:										
5Ø6-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (5Ø9-F9)	n/a	M	C	D	8	21Ø9	2116	
5Ø7-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.	n/a	M	C	D	8	2117	2124	
894	TOTAL AMOUNT PAID BY ALL SOURCES	Total amount of the prescription regardless of party responsible for payment.	n/a	M	P	D	8	2125	2132	TOTAL AMOUNT PAID BY MCO
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to sales tax paid.	n/a	S	C	D	8	2133	214Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
5Ø5-F5	PATIENT PAY AMOUNT	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.	n/a	M	C	D	8	2141	2148	
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription coinsurance.	n/a	S	C	D	8	2149	2156	
572-4U	AMOUNT OF COINSURANCE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand product.	n/a	S	C	D	8	2157	2164	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription copay.	n/a	S	C	D	8	2165	2172	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to a periodic deductible.	n/a	S	C	D	8	2173	218Ø	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the processing fee imposed by the processor.	n/a	S	C	D	8	2181	2188	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's provider network selection.	n/a	S	C	D	8	2189	2196	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND DRUG	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Brand product.	n/a	S	C	D	8	2197	22Ø4	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Non-Preferred Formulary product.	n/a	S	C	D	8	22Ø5	2212	
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand Non-Preferred Formulary product.	n/a	S	C	D	8	2213	222Ø	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	Amount to be collected from the patient that is included in "Patient Pay	n/a	S	C	D	8	2221	2228	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		Amount" that is due to the patient being in the coverage gap (i.e. donut hole). A coverage gap is defined as the period or amount during which the previous coverage ends and before an additional coverage begins.								
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- Not Specified Y- Reduced to MAC pricing N- Not reduced to MAC pricing	S	P	A/N	1	2229	2229	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- Average Wholesale Price – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- Acquisition Cost (ACQ) – Price based on the acquisition cost for the package size dispensed. Ø3- Manufacturer Direct Price – Price the submitter paid for the drug purchased directly from the manufacturer.	S	P	A/N	2	223Ø	2231	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø4- Federal Upper Limit (FUL) – The maximum allowable cost that federal programs will reimburse. Ø5- Average Generic Price – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- Usual & Customary – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- Submitted Ingredient Cost – Ingredient cost submitted by the pharmacy on the claim Ø8- State MAC – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- Unit – The price per unit of the drug. 1Ø- Usual & Customary or Copay – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	2232	2232	
284	OUT OF POCKET APPLY AMOUNT	Amount applied to the out of pocket expense.	n/a	S	P	D	8	2233	224Ø	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19 - 07 9

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	2241	2249	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	225Ø	2258	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	2259	2267	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	2268	2276	
43Ø-DU	GROSS AMOUNT DUE	Total price claimed from all sources.	n/a	S	C	D	8	2277	2284	Amount billed to the MCO (Amount being billed by the provider to the MCO) MASK 9999999V99 zero filled, no sign
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	2285	2293	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
4Ø9-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (43Ø-DU).	n/a	S	C	D	8	2294	23Ø1	
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	n/a	S	C	D	8	23Ø2	23Ø9	
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the total Amount Paid" (5Ø9-F()	n/a	S	C	D	8	231Ø	2317	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the "Total Amount Paid" (5Ø9-F9)	n/a	S	C	D	8	2318	2325	
56Ø-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX)	n/a	S	C	D	7	2326	2332	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
561-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.	Ø2- Ingredient Cost – The dollar amount/value of the prescription submitted by the pharmacist. Does not include sales tax or dispensing fee. Ø3- Ingredient Cost + Dispensing Fee – The dollar amount/value of the prescription submitted by the pharmacist plus dispensing fee. Ø4- Professional Service Fee – The dollar amount/value for the professional service.	S	C	A/N	2	2333	2334	
521-FL	INCENTIVE AMOUNT PAID	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the "Total Amount Paid" (5Ø9-F9)	n/a	S	C	D	8	2335	2342	
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the "Total Amount Paid" (5Ø9-F9)	n/a	S	C	D	8	2343	235Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. Ø2- Shipping Cost – The amount claimed for transportation of an item. Ø3- Postage Cost – The amount claimed for the mailing of an item. Ø4- Administrative Cost – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. Ø9- Compound Preparation Cost Submitted – The amount claimed for the preparation of the compound. 11- Medication Administration – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.	S	C	A/N	2	2351	2352	
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other Amount Paid' (565- J4).		S	C	D	8	2353	236Ø	
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1- Delivery Cost Ø2- Shipping Cost Ø3- Postage Ø4- Administrative Cost	S	C	A/N	2	2361	2362	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø5- Incentive Ø6- Cognitive Service Ø7- Drug Benefit Ø8- Compound Preparation Cost Submitted Ø9- Sales Tax 1Ø- Medication Administration							
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other Amount Paid' (565- J4).		S	C	D	8	2363	237Ø	
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1- Delivery Cost Ø2- Shipping Cost Ø3- Postage Cost Ø4- Administrative Cost Ø5- Incentive Ø6- Cognitive Service Ø7- Drug Benefit Ø8- Compound Preparation Cost Submitted Ø9- Sales Tax 1Ø- Medication Administration	S	C	A/N	2	2371	2372	
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other Amount Paid' (565- J4).		S	C	D	8	2373	238Ø	
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source.	n/a	S	C	D	8	2381	2388	
351-NP	OTHER PAYER-PATIENT	Code qualifying the "Other Payer-Patient	Blank- Not Specified Ø1- Amount Applied to Periodic Deductible (517-FH) as reported	S	C	A/N	2	2389	239Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	RESPONSIBILITY AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".	by previous payer. The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3- Amount Attributed to Sales Tax (523-FN) as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			payer as the patient's responsibility. Ø7- Amount of Coinsurance (572-4U) as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9- Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø- Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12- Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13- Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.								

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	2391	24ØØ	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- Not Specified Ø1- Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.. Ø2- Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3- Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4- Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5- Amount of Copay (518-FI) as reported by previous payer. Ø6- Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7- Amount of Coinsurance (572-4U) as reported by previous payer. Ø8- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9- Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer.	S	C	A/N	2	24Ø1	24Ø2	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			1Ø- Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12- Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13- Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	24Ø3	2412	
281	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.	n/a	M	P	D	8	2413	242Ø	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for	ØØ Not Specified Ø1 Ingredient Cost Paid as Submitted Ø2 Ingredient Cost Reduced to AWP Pricing	S	C	N	2	2421	2422	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		'Ingredient Cost Paid' (5Ø6-F6).	Ø3 Ingredient Cost Reduced to AWP Less X% Pricing Ø4 Usual & Customary Paid as Submitted Ø5 Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary Ø6 MAC Pricing Ingredient Cost Paid Ø7 MAC Pricing Ingredient Cost Reduced to MAC Ø8 Contract Pricing Ø9 Acquisition Pricing 1Ø ASP (Average Sales Price) 11 AMP (Average Manufacturer Price) 12 34ØB/Disproportionate Share/Public Health Service Pricing - Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. 13 WAC (Wholesale Acquisition Cost) 14 Other Payer-Patient Responsibility Amount 15 Patient Pay Amount 16 Coupon Payment							flat file created by the translator. Ø8 = 'C' which is for capitated Ø1 = 'F' which is for FFS 14 = 'T' which is TPL ØØ = 'Z' which is for Zero billed/Provider did not charge

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			17 Special Patient Reimbursement 18 Direct Price (DP) 19 State Fee Schedule (SFS) Reimbursement 2Ø National Average Drug Acquisition Cost (NADAC) 21 State Average Acquisition Cost (AAC) 22 Ingredient cost paid based on submitted Basis of Cost Free Product							
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan.	n/a	S	C	D	8	2423	243Ø	
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.	n/a	S	C	D	8	2431	2438	
514-FE	REMAINING BENEFIT AMOUNT	Amount remaining in a patient/family plan with a periodic maximum benefit.	n/a	S	C	D	8	2439	2446	
242	COST DIFFERENCE AMOUNT	Difference between client contracted amount and the pharmacy or member	n/a	S	P	D	8	2447	2454	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9 - 0 4 9

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		submitted amount.								
249	EXCESS COPAY AMOUNT	Amount of the copay that exceeds the approved amount for this claim.	n/a	S	P	D	8	2455	2462	
277	MEMBER SUBMIT AMOUNT	Ingredient cost as submitted by member (paper claims only).	n/a	S	P	D	8	2463	247Ø	
265	HOLD HARMLESS AMOUNT	Amount payable to member when paper claims amount exceeds Pharmacy Network Reimbursement.	n/a	S	P	D	8	2471	2478	
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	Amount to be collected from the patient that is included in "Patient Pay Amount" (5Ø5-F5) that is due to the patient exceeding a periodic benefit maximum.	n/a	S	C	D	8	2479	2486	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	Code indicating how the reimbursement amount was calculated for	Ø1- Quantity Dispensed – The quantity of the prescription dispensed for the patient. Ø2- Quantity Intended To Be Dispensed – Indicates that the	S	C	A/N	2	2487	2488	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		"Dispensing Fee Paid" (5Ø7-F7)	originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order. Ø3- Usual and Customary/Prorated – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated. Ø4- Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- Other							
347-HJ	BASIS OF CALCULATION – COPAY	Code indicating how the copay reimbursement amount was calculated for "Dispensing Fee Paid" (5Ø5-F5)	Ø1- Quantity Dispensed – The quantity of the prescription dispensed for the patient. Ø2- Quantity Intended To Be Dispensed – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the	S	C	A/N	2	2489	249Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			calculation of this amount even if this transaction indicates a partial filling of the order. Ø3- Usual and Customary/Prorated – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated. Ø4- Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- Other – Different from those implied or specified.							
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	Code indicating how the reimbursement amount was calculated for "Flat Sales Tax Amount Paid" (558-AW)	Blank- Not Specified ØØ- Not Specified Ø1- Quantity Dispensed – The quantity of the prescription dispensed for the patient. Ø2- Quantity Intended To Be Dispensed – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the	S	C	A/N	2	2491	2492	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			calculation of this amount even if this transaction indicates a partial filling of the order.							
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	Code indicating how the reimbursement amount was calculated for "Percentage Sales Tax Amount Paid" (559-AX)	Blank- Not Specified ØØ- Not Specified Ø1- Quantity Dispensed – The quantity of the prescription dispensed for the patient. Ø2- Quantity Intended To Be Dispensed – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	S	C	A/N	2	2493	2494	
573-4V	BASIS OF CALCULATION – COINSURANCE	Code indicating how the coinsurance reimbursement amount was calculated for "Patient Pay Amount" (559-AX)	Ø1- Quantity Dispensed – The quantity of the prescription dispensed for the patient. Ø2- Quantity Intended To Be Dispensed – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order. Ø3- Usual and Customary/Prorated – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the	S	C	A/N	2	2495	2496	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			plan copay/dispensing fee, thereby being prorated. Ø4- Waived Due To Partial Fill – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- Other – Different from those implied or specified.							
557-AV	TAX EXEMPT INDICATOR	Code indicating the payer and/or the patient is exempt from taxes.	Blank- Not Specified 1 - Payer/Plan is Tax Exempt – The Payer/Plan is not responsible for tax. The patient may be charged tax. 3- Patient is Tax Exempt – The patient cannot be charged tax. 4- Payer/Plan and Patient are Tax Exempt – Neither the payer/plan nor the patient can be charged tax.	S	C	A/N	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	2498	25Ø5	
276	MEDICARE RECOVERY INDICATOR	Field to indicate if Medicare was billed in order to recover funds for	Blank- Not Specified Ø- No Medicare Recovery – No demand for payment has been made by Medicare	S	P	A/N	1	25Ø6	25Ø6	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		current or previous claims billed to the client.	1 Prospective Billing – Demand for payment has been made before service provided 2- Retrospective Billing – Demand for payment has been made after service provided							
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.	Blank- Not Specified Ø- No reduction applied 1- Days supply reduced due to Client plan limitations 2- Days supply reduced due to Medicare Plan Limits 3- Prescribed Days Supply Dispensed based on Client Approval	S	P	A/N	1	25Ø7	25Ø7	
286	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patients spend down account (example Flexible Spending Account).	n/a	S	P	D	8	25Ø8	2515	
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	Health Care Reimbursement Account Amount Applied	n/a	S	P	D	8	2516	2523	
264	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	Client-defined benefit that provides funds to patients that can be used to offset Out of Pocket expenses.	n/a	S	P	D	8	2524	2531	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
2Ø7	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.	Blank- Not Specified A- Add to count S- Subtracts from count	S	P	A/N	1	2532	2532	
2Ø6	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.	n/a	S	P	D	4	2533	2536	
269	INVOICED AMOUNT	Amount invoiced for this transaction. Determined by Processor.	n/a	S	P	D	11	2537	2547	
	FILLER	n/a	n/a	S	P	A/N	1Ø	2548	2557	
128-UC	SPENDING ACCOUNT AMOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.	n/a	S	C	D	8	2558	2565	
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	The amount from the health plan-funded assistance account for the patient that was applied to reduce Patient Pay Amount (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits	n/a	S	C	D	8	2566	2573	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04-3

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		only. This field is always a negative amount or zero.								
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:										
461-EU	PRIOR AUTHORIZATION TYPE CODE	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	ØØ- Not Specified Ø1- Prior Authorization a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. Ø2- Medical Certification – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. Ø3- EPSDT (Early Periodic Screening Diagnosis Treatment) – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their	S	C	N	2	2574	2575	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			subsequent results and findings, immunization information, guidance and education given, and follow-up care required. Ø4- Exemption from Copay and/or Coinsurance – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. Ø5- Exemption from RX – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. Ø6- Family Planning Indicator – Code to indicate the drug prescribed is for management of reproduction. Ø7- TANF (Temporary Assistance for Needy Families) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. Ø8- Payer Defined Exemption – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			exemption not covered by one of the other type codes. Ø9- Emergency Preparedness – Code used to override claim edits during an emergency situation.							
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.	n/a	S	C	N	11	2576	2586	PRDoH will use this field to indicate the begin and the end date of an authorization. Use Julianne date.
498-PY	PRIOR AUTHORIZATION NUMBER – ASSIGNED	Unique number identifying the prior authorization assigned by the processor.	n/a	S	P	N	11	2587	2597	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	ØØ- Not Specified Ø1- Prior Authorization a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product.	S	P	N	2	2598	2599	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø2- Medical Certification – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. Ø3- EPSDT (Early Periodic Screening Diagnosis Treatment) – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. Ø4- Exemption from Copay and/or Coinsurance – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. Ø5- Exemption from RX – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. Ø6- Family Planning Indicator – Code to indicate the drug							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			prescribed is for management of reproduction. Ø7- TANF (Temporary Assistance for Needy Families) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. Ø8- Payer Defined Exemption – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes.							
SECTION DENOTES ADJUSTMENT CATEGORY:										
2Ø4	ADJUSTMENT REASON CODE	Reason for adjustment	n/a	S	P	N	3	26ØØ	26Ø2	
2Ø5	ADJUSTMENT TYPE	Type of adjustment.	Blank- Not Specified 1- Debit – An adjustment resulting in an increased payment amount. 2- Credit – An adjustment resulting in a decreased payment amount.	S	P	A/N	1	26Ø3	26Ø3	
897	TRANSACTION ID CROSS REFERENCE	For adjustments, ID associated with original claim.	n/a	S	P	A/N	3Ø	26Ø4	2633	The 18 digit transaction ID of the NCPDP encounter that is being voided by this reversal is entered here.

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:										
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.	n/a	S	P	D	8	2634	2641	
245	ELIGIBILITY COB INDICATOR	COB code as provided on Client eligibility.	Blank- Not Specified 1- Payer is Primary – Plan is first payer for patient 2- Payer is Secondary – Plan is second payer for patient 3- Payer is Tertiary – Plan is third payer for patient	S	P	A/N	1	2642	2642	
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank- Not Specified I- Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J- Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M- Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R- Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	S	P	A/N	1	2643	2643	
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	n/a	S	C/P	A/N	1Ø	2644	2653	
	FILLER	n/a	n/a	S	P	A/N	8	2654	2661	
228	COB PRIMARY PAYER	Amount paid by primary payer for	n/a	S	C/P	D	8	2662	2669	PRDoH does NOT use this field.

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	AMOUNT PAID	product or service.								
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.	n/a	S	C/P	D	8	267Ø	2677	
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.	n/a	S	C/P	D	8	2678	2685	
23Ø	COB PRIMARY PAYER COPAY	Co-pay amount according to primary payer for product or service.	n/a	S	C/P	D	8	2686	2693	
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	n/a	S	C/P	A/N	1Ø	2694	27Ø3	
	FILLER	n/a	n/a	S	P	A/N	8	27Ø4	2711	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.	n/a	S	C/P	D	8	2712	2719	
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.	n/a	S	C/P	D	8	272Ø	2727	
235	COB SECONDARY PAYER	Coinsurance amount according to	n/a	S	C/P	D	8	2728	2735	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	COINSURANCE	secondary payer for product or service.								
236	COB SECONDARY PAYER COPAY	Co-pay amount according to secondary payer for product or service.	n/a	S	C/P	D	8	2736	2743	
SECTION DENOTES REFERENCE CATEGORY:										
896	TRANSACTION ID	Internally assigned unique claim ID by the payer.	n/a	S	P	A/N	3Ø	2744	2773	Every claim in the file must contain the unique 18 digit Transaction ID assigned by MC-21 during adjudication.
5Ø3-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.	n/a	S	P	A/N	2Ø	2774	2793	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client.	n/a	S	P	A/N	5Ø	2794	2843	
396	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.	n/a	S	P	A/N	5Ø	2844	2893	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.	Y- Yes = CMS qualified facility							
SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:										
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Ø1- Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2- Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3- Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4- Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø- Not paid under Part D, paid under Part C benefit (for MA-PD plan): - This qualifier applies to MA-PD plans where the claim is	S	C	A/N	2	2895	2896	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			submitted under the Part D BIN/PCN. · The claim is NOT paid by the Part D plan benefit · The claim IS paid for by Part C benefit (MA portion of the MA-PD). · When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 6Ø- Not paid under Part D, paid as or under a supplemental benefit only: · This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided. · This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). · The claim is NOT paid by the Part D plan benefit but is								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			paid under the supplemental benefit. · When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548- 6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights". 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. Note: Non-qualified drugs are defined as no meeting the definition of a Part D drug. 61- Part D drug not paid by Part D plan benefit, paid as or								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			under a co-administered insured benefit only: · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. · When the qualifier value of 61is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62-Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. · When the qualifier value of 62 is used, the Benefit								

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Stage Count is 1 and no other benefit stage qualifier should be used. - The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug. 63- Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. •This qualifier applies to Medicare/Medicaid (MMP) plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. •The claim is NOT paid by the Part D plan benefit but is paid under the Medicaid benefit only of the Medicare/Medicaid (MMP) plan. •When the qualifier of 63 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. •The field 394-MW Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount								

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 19-04-9

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Paid, and 566-J5 Other Payer Amount Recognized) of the claim. Note: Non-qualified drugs are defined as not meeting the definition of Part D drug. 7Ø- Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non- formulary, quantity limit, etc.). · When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan- sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			8Ø- Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e. excluded drugs). · When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø- Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: · When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount							

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19 - 04 9

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			(total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2897	29Ø4	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Ø1- Deductible Ø2- Initial Benefit Ø3- Coverage Gap (donut hole) Ø4- Catastrophic Coverage 5Ø- Not paid under Part D, paid under Part C benefit (for MA-PD plan 6Ø- Not paid under Part D, paid as or under a supplemental benefit only 61- Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only 62- Non-Part D/non-qualified drug not paid by Part D plan benefit. 63- Non-Part D/non-qualified drug not paid by Part D plan benefit. 7Ø- Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing	S	C	A/N	2	29Ø5	29Ø6	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-048

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			8Ø- Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing 9Ø- Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	29Ø7	2914	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	See previous 393-MV field above	S	C	A/N	2	2915	2916	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2917	2924	
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	See previous 393-MV field above.	S	C	A/N	2	2925	2926	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare	n/a	S	C	D	8	2927	2934	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		stage identified by the 'Benefit Stage Qualifier' (393-MV).								
69Ø-ZG	INVOICED DATE	The date this claim was included on an invoice.	n/a	S	P	N	8	2935	2942	
691-ZH	OUT OF POCKET REMAINING AMOUNT	Dollars remaining until patient is totally in benefit paying no out of pocket expenses.	n/a	S	P	D	8	2943	295Ø	
3Ø2-C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.	n/a	S	P	A/N	2Ø	2951	297Ø	HMO Client ID number. PRDoH does not use this field for any processing. This field's sole purpose is to tie the encounter back to something in the MCO's system. MAXIMUM 15 characters.
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic drug provided by drug compendium.	n/a	S	P	N	3	2971	2973	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-	Blank- Not Specified Ø1- UPC Ø2- HRI	S	C	A/N	2	2974	2975	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		Agent ID' (476-H6).	Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	2976	2994	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø	S	C	A/N	2	2995	2996	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		the prescribed drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID	S	C	A/N	2	3121	3122	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	2997	3Ø15	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS	S	C	A/N	2	3Ø16	3Ø17	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	3Ø18	3Ø36	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID	S	C	A/N	2	3Ø37	3Ø38	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist	n/a	S	C	A/N	19	3Ø39	3Ø57	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO	S	C	A/N	2	3Ø58	3Ø59	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	3Ø6Ø	3Ø78	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN	S	C	A/N	2	3Ø79	3Ø8Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or	n/a	S	C	A/N	19	3Ø81	3Ø99	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID	S	C	A/N	2	31ØØ	31Ø1	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04-2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	31Ø2	312Ø	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN	S	C	A/N	2	3121	3122	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with	n/a	S	C	A/N	19	3123	3141	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	3123	3141	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- Not Specified Ø1- Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.	S	C	A/N	2	3142	3143	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø3- Amount Attributed to Sales Tax (523-FN) as reported by previous payer. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- Amount of Copay (518-FI) as reported by previous payer. Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- Patient Pay Amount (5Ø5-F5) as reported by previous payer. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- Amount of Coinsurance (572-4U) as reported by previous payer. Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			current benefit status, product selection or network selection. Ø8- Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9- Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø- Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11- Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12- Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13- Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3144	3153	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility	See 351-NP above for codes.	S	C	A/N	2	3154	3155	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-043

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	AMOUNT QUALIFIER	Amount (352-NQ)".								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3156	3165	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	3166	3167	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3168	3177	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	3178	3179	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	318Ø	3189	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility	See 351-NP above for codes.	S	C	A/N	2	319Ø	3191	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	AMOUNT QUALIFIER	Amount (352-NQ)".								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3192	32Ø1	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	32Ø2	32Ø3	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	32Ø4	3213	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	3214	3215	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3216	3225	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility	See 351-NP above for codes.	S	C	A/N	2	3226	3227	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	AMOUNT QUALIFIER	Amount (352-NQ)".								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3228	3237	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	3238	3239	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	324Ø	3249	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A/N	2	325Ø	3251	
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	1Ø	3252	3261	
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty	Blank- Default 1- Specialty claim. 2- Not a specialty claim	S	P	A/N	1	3262	3262	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		pharmacy or a specialty drug.								
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3275	3277	
A39	COPAY WAIVER AMOUNT	Dollar amount funded by third party for a copay waiver program where a client funds a portion of their copay amount if they select a certain drug.	n/a	S	P	D	8	3278	3285	
A33-ZX	CMS PART D	Designation assigned by	n/a	S	P	A/N	5	3286	3290	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
	CONTRACT ID	CMS that identifies a specific Medicare Part D sponsor.								
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	Identifier assigned by CMS of a particular plan benefit package (Benefit Category) within a Medicare Part D contract.	n/a	S	P	N	3	3291	3293	
A73	MEDICARE DRUG COVERAGE CODE	Code to indicate if the claim was processed under the Part D Drug Benefit, the Part B Drug Benefit, or does not apply.	ØØ- Does Not Apply – Used when other values do not apply. Ø1- Processed Under Part D – A product that is processed under the Medicare Part D benefit which includes covered, enhanced, and OTC. Ø2- Processed Under Part B – A product that is processed under the Medicare Part B benefit	S	P	A/N	2	3294	3295	
	FILLER	n/a	n/a	M	P	A/N	423	3296	37ØØ	

3.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	CD- Post Adjudication History Compound Detail Record1	M	P	A/N	2	1	2	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/ Service Reference Number Qualifier	1- Rx Billing Transaction- A billing for a prescription or OTC drug product 2- Service Billing – Transaction is a billing for a professional service performed.	M	C	A/N	1	3	3	
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	n/a	M	C	N	12	4	15	
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	M	C	N	2	16	17	
SECTION DENOTES FIRST INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC 11- NAPPI 12- GTIN 15- GCN	M	C	A/N	2	18	19	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			28- FDB Med Name ID 29- FDB Routed Med ID 3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	M	C	A/N	19	2Ø	38	If a compound drug is being reported, this is the NDC of the FIRST component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	39	52	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient	n/a	S	C	D	8	53	6Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		Quantity' (Field 448- ED).								
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- Default Ø1- AWP (Average Wholesale Price) – A pricing benchmark for prescription drugs. Ø2- Local Wholesaler – A legitimate supplier from the surrounding area who resells drugs. Ø3- Direct – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –EAC (Estimated Acquisition Cost) – A formula- driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- Acquisition – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- MAC (Maximum Allowable Cost) – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- Usual & Customary – The pharmacy's price for the	S	C	A/N	2	61	62	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			medication for a cash paying person on the day of dispensing. Ø8- 34ØB /Disproportionate Share Pricing/Public Health Service – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- Other – Different from those implied or specified. 1Ø- ASP (Average Sales Price) – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- AMP (Average Manufacturer Price) – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- WAC (Wholesale Acquisition Cost) – A cost as defined in Title XIX, Section 1927 of the Social Security Act.							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			13- Special Patient Pricing – The cost calculated by the pharmacy for the drug for this special patient. 14- Cost basis on un-reportable quantities 15- Free product or no associated cost							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- Not specified. Y- Yes N- No	S	P	A/N	1	63	63	Indicates the NDC for the FIRST component of the compound drug is not recognized by PRDoH but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	3Ø	64	93	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	3Ø	94	123	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	1Ø	124	133	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	134	137	
532-FW	DATABASE INDICATOR	Code identifying the source of drug	1- First DataBank – A drug database company	S	P	A/N	1	138	138	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		information used for DUR processing or to define the database used for identifying the product.	2- Medi-Span Product Line – A drug database company 3- Micromedex/Medical Economics – A drug database company 4- Processor Developed – A proprietary drug file 5- Other – Different from those implied or specified 6- Redbook – A Micromedex publication of drug information 7- Multum – Drug database company							
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	ØØ- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- Authorized Generic (aka "Branded Generic") – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- Generic – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA).	S	P	N	1	139	139	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			4- Over the Counter – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription. 5- Multi-source Brand – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- Not Specified I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- Drug not on Formulary; Non-Preferred – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- Drug not on Formulary; Preferred – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- Drug not on Formulary; Neutral – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific	S	P	A/N	1	14Ø	14Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			preference as to the drug's status. P- Drug on Formulary – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- Drug not on Formulary – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- Drug on Formulary; Preferred – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- Drug on Formulary; Neutral – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	141	141	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- Not Specified 1- Schedule I Substance (no known use) 2- Schedule II Narcotic Substances 3- Schedule III Narcotic Substances 4- Schedule IV Substances 5- Schedule V Substances	S	P	A/N	1	142	142	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- Not Specified Ø- Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer 1- Drug Efficacy Study Implementation (DESI) Drug	S	P	A/N	1	143	143	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier	S	P	A/N	1	144	144	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			9- Nine-digit NDC A- American Hospital Formulary Service C- Contracting Organization G- First Data Bank GCN Sequence Number H- First Data Bank HICL Sequence Number M- Manufacturer (PICO) Assigned Code N- Eleven-digit NDC O- UPC P- Product group T- First Data Bank Therapeutic Class Code, Specific U- Universal System of Classification Code V- All products used Z- Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	145	161	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier	S	P	A/N	1	162	162	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- Nine-digit NDC A- American Hospital Formulary Service C- Contracting Organization G- First Data Bank GCN Sequence Number H- First Data Bank HICL Sequence Number M- Manufacturer (PICO) Assigned Code N- Eleven-digit NDC O- UPC P- Product group T- First Data Bank Therapeutic Class Code, Specific U- Universal System of Classification Code V- All products used Z- Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	163	179	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank	S	P	A/N	1	18Ø	18Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- Nine-digit NDC A- American Hospital Formulary Service C- Contracting Organization G- First Data Bank GCN Sequence Number H- First Data Bank HICL Sequence Number M- Manufacturer (PICO) Assigned Code N- Eleven-digit NDC O- UPC P- Product group T- First Data Bank Therapeutic Class Code, Specific U- Universal System of Classification Code V- All products used Z- Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	181	197	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- Not specified 1- Yes 2- No	S	P	A/N	1	198	198	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code	S	P	A/N	1	199	199	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2ØØ	216	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code	S	P	A/N	1	217	217	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	218	234	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code	S	P	A/N	1	235	235	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	236	252	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- Not Specified 1- First DataBank Formulation ID 2- Medi-Span Product Line Generic Product Identifier 3- First DataBank 4- Medi-Span Product Line Drug Descriptor ID 5- First DataBank Medication Name Identifier 6- First DataBank Routed Medication Identifier 7- First Databank Routed Dosage Form Medication Identifier 8- First DataBank Medication Identifier 9- First DataBank Enhanced Therapeutic Class Codes A- American Hospital Formulary Service C- Contracting Organization D- First Data Bank Therapeutic Class code, Generic E- First Data Bank Therapeutic Class code, Standard M- Manufacturer (PICO) Assigned Code U- Universal System of Classification Code Z- Mutually Agreed Upon Code	S	P	A/N	1	253	253	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	254	27Ø	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	Ø- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- Manufacturer Unit Dose – A code used to indicate a distinct dose as determined by the manufacturer. 3- Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- Pharmacy Unit Dose Patient Compliance Packaging 5- Pharmacy Multi-drug Patient Compliance Packaging 6- Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- Remote Device Multi-drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package	S	C	N	1	271	271	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
6ØØ-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- Each GM- Grams ML- Milliliters	S	C	A/N	2	272	273	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	ØØ- Not Specified Ø1- Prior Authorization Ø2- Medical Certification Ø3- EPSDT (Early Periodic Screening Diagnosis Treatment) Ø4- Exemption from Copay and/or Coinsurance Ø5- Exemption from RX Ø6- Family Planning Indicator Ø7- TANF (Temporary Assistance for Needy Families) Ø8- Payer Defined Exemption	S	P	N	2	274	275	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- Not Specified Y- Reduced to MAC pricing N- Not reduced to MAC pricing	S	P	A/N	1	276	276	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- Average Wholesale Price Ø2- Acquisition Cost (ACQ) Ø3- Manufacturer Direct Price Ø4- Federal Upper Limit (FUL) Ø5- Average Generic Price Ø6- Usual & Customary	S	P	A/N	2	277	278	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			Ø7- Submitted Ingredient Cost Ø8- State MAC Ø9- Unit 1Ø- Usual & Customary or Copay							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified Ø1- UPC Ø2- HRI Ø3- NDC Ø4- HIBCC Ø6- DUR/PPS Ø7- CPT4 Ø8- CPT5 Ø9- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 19- Truven/Micromedex Generic Master (GM) 2Ø- ICD9 21- ICD1Ø 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD1Ø-PCS 28- FDB Med Name ID 29- FDB Routed Med ID	S	C	A/N	2	279	28Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			3Ø- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 4Ø- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co- existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	281	299	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	3ØØ	3ØØ	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any.	Blank-Not Specified 1- Medicare Part B (Plan Cutback) - A reduction in a	S	P	A/N	1	3Ø1	3Ø1	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		imposed by plan.	quantity of a medical service covered by Medicare Part B 2- Medicare Part B with days' supply cutback - A reduction in the days' supply of a service/drug covered by Medicare Part B C- Net Check limit cutback - A reduction in the net amount of a check D- Days' Supply cutback – A reduction in the days' supply I- Ingredient Cost cutback - A reduction in the ingredient cost Q- Quantity cutback - A reduction in the quantity							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	3Ø2	3Ø9	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	31Ø	318	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	319	327	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as	n/a	S	P	D	9	328	336	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
79-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
		defined by processor.								
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	337	345	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	346	354	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	ØØ Not Specified Ø1 Ingredient Cost Paid as Submitted Ø2 Ingredient Cost Reduced to AWP Pricing Ø3 Ingredient Cost Reduced to AWP Less X% Pricing Ø4 Usual & Customary Paid as Submitted Ø5 Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary Ø6 MAC Pricing Ingredient Cost Paid Ø7 MAC Pricing Ingredient Cost Reduced to MAC Ø8 Contract Pricing Ø9 Acquisition Pricing 1Ø ASP (Average Sales Price) 11 AMP (Average Manufacturer Price)	S	C	N	2	355	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. Ø8 = 'C' which is for capitated Ø1 = 'F' which is for FFS 14 = 'T' which is TPL ØØ = 'Z' which is for Zero billed/Provider did not charge

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
			12 34ØB/Disproportionate Share/Public Health Service Pricing 13 WAC (Wholesale Acquisition Cost) 14 Other Payer-Patient Responsibility Amount 15 Patient Pay Amount 16 Coupon Payment 17 Special Patient Reimbursement 18 Direct Price (DP) 19 State Fee Schedule (SFS) Reimbursement 2Ø National Average Drug Acquisition Cost (NADAC) 21 State Average Acquisition Cost (AAC) 22 Ingredient cost paid based on submitted Basis of Cost Free Product							
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	357	364	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19 - 049

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
SECTION DENOTES SECOND INGREDIENT: SAME AS THE FIRST INGREDIENT										
SECTION DENOTES THIRD INGREDIENT:										
SECTION DENOTES FOURTH INGREDIENT:										
SECTION DENOTES FIFTH INGREDIENT:										
SECTION DENOTES SIXTH INGREDIENT:										
SECTION DENOTES SEVENTH INGREDIENT:										
SECTION DENOTES EIGHTH INGREDIENT:										

3.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
PRDoH only accepts Compound Detail Record1. DO NOT SEND Compound Detail Record2										
SECTION DENOTES NINTH INGREDIENT:										
SECTION DENOTES TENTH INGREDIENT:										
SECTION DENOTES ELEVENTH INGREDIENT:										
SECTION DENOTES TWELVTH INGREDIENT:										
SECTION DENOTES THIRTEENTH INGREDIENT:										
SECTION DENOTES FOURTEENTH INGREDIENT:										
SECTION DENOTES FIFTEENTH INGREDIENT:										

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

3.3 POST ADJUDICATION HISTORY TRAILER RECORD

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRDoH Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PT- Post Adjudication History Trailer Record	M	P	A/N	2	1	2	
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.	n/a	M	P	N	1Ø	3	12	
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).	n/a	M	P	D	12	13	24	
693	TOTAL GROSS AMOUNT DUE	Total sum of the gross amount due fields on the claim level.	n/a	S	P	D	12	25	36	
694	TOTAL PATIENT PAY AMOUNT	Total sum of the patient pay amount fields on the claim level.	n/a	M	P	D	12	37	48	
	FILLER	n/a								

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

Appendix A: Frequently Asked Questions

To be updated as questions come in.

Appendix B: Change Summary

Version	Issue Date	Modified By	Comments / Reason
1.Ø	Ø2/16/2Ø17	Wil Joslyn	Original document with formatting updates

Version	Issue Date	Modified By	Comments / Reason
2.Ø	06/30/2017	Wil Joslyn	On page 159 add the following text to field "Transaction Id Cross Reference" - The 18 digit transaction ID of the NCPDP encounter that is being voided by this reversal is entered here.
			On page 162 Remove the text for Field #896 and replace with 'Every claim in the file must contain the unique 18 digit Transaction ID assigned by MC-21 during adjudication".
			On page 193 remove field "Original Transaction Id";
			On page 193 remove "Voided Transaction Identifier" row.
			On page 193 change the following values for Filler: (1) Change length to 423 (2) Change start position from 3314 to 3296

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X224A2 Dental Health Care Claim/Encounter (837D)

Companion Guide Version Number: 5.0

December 2017

For Module One Implementation

Puerto Rico Medicaid Management Information System Services Project

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04-9

Disclosure Statement

Companion guides 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 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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 the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Dental Claim/Encounter ASC X12N version 005010X224A2 (837D), 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.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Disclaimer: The information contained in this Companion Guide is subject to change.

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Contents

1 INTRODUCTION

This section describes how TR3, also called 837D ASC X12N (version 005010X224A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health 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 6: 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 Puerto Rico Department of Health.
			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.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837D (referred to as Dental Claim/Encounter in the rest of this document) for the purpose of submitting 837D 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 Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. 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 Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837D Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for 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, Puerto Rico Department of Health 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.

This guide is designed to help those responsible for testing and setting up electronic Dental Claim/Encounter 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 Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837D (version 005010X224A2) Implementation Guide. 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 Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837D transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837D Health Care Claim/Encounter (version 005010X224A2) 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 Puerto Rico Department of Health.

Provider taxonomy code set can be obtained from www.wpc-edi.com/reference.

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.

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.

All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health 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. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

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.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- 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).

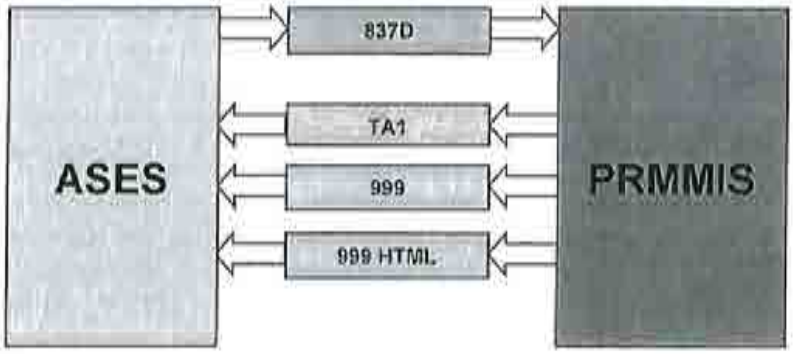
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837D transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837D complies with the 005010X224A2 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. Transactions that pass this compliance check will generate an "Accepted" 999 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 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks, but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid".



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health'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 (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

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

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s). The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own Internet connection to access the Web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

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

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a trading partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- 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 999 claims/encounters per Transaction Set (ST-SE).
- 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. The table below represents only those fields in which Puerto Rico Department of Health 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.

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: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER - '03' - Additional Data Identification.
C.4		ISA02	Authorization Information		ENCOUNTER - MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present.
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined.
C.4		ISA06	Interchange Sender ID		Trading Partner ID' supplied by Puerto Rico Department of Health, left justified and space filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined.
C.5		ISA08	Interchange Receiver ID	PRMMIS	PRMMIS - left justified and space filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
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 = No interchange acknowledgment requested (TA1).
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 Separator	:	A colon ":" is recommended.

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

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

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

Functional Group Header (GS)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

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

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Dental Claim/Encounter (837D)
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
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	005010X224A2	Version/ Release/ Industry Identifier Code

Functional Group Trailer (GE)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

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

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health 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	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
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	005010X224A2	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	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

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.

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator 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 Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

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

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN, in the MCO's system, of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF - PAYER CLAIM CONTROL NUMBER
REF01 = F8 - Original Reference Number
REF02 = The TCN, in the MCO's system, of the encounter being voided

5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837D 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. Puerto Rico Department of Health 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 837D will need to be corrected and resubmitted.

6 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 Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X224A2 — 837D Health Care Claim/Encounter

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable. RP = Encounters — Reporting.
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		Required if different than the name contained in the Submitter Name (Loop 1000A, NM1 segment)
71	1000A	PER03	Communication Number Qualifier	EM, FX,TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)
74	2100A	NM1	Receiver Name		

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	'PUERTO RICO DEPARTMENT OF HEALTH'
80	1000B	NM108	Identification Code Qualifier	46	"46" - Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
78	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER - When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (see 2010AA below).
78	2000A	PRV03	Reference Identification		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
82	2010AA	NM1	Billing Provider Name		*Note:* Puerto Rico Department of Health only accepts the use of NPIs as identification for dental providers.
83	2010AA	NM102	Entity Type Qualifier	1, 2	Enter the "1" value to indicate that the biller is a person. Enter the "2" value to indicate that the biller is a non-person entity.
86	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
87	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health.
96	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
101	2010AC	NM1	Pay-to Plan Name		This loop will only be used for subrogation.
114	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
115	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
115	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
115	2010BA	NM104	Subscriber First Name		Enter the member's first name.
115	2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" for member identification number.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-04

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
116	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
124	2010BB	NM1	Payer Name		
125	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter the value "PUERTO RICO DEPARTMENT OF HEALTH".
125	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
125	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
145	2300	CLM	Claim Information		
146	2300	CLM01	Patient Control Number		*Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. ENCOUNTER: MCO should send the original PCN from the provider's original claim.
147	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-3	Claim Frequency Code	1, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
					claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER: Use "1" as a frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the internal control number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
148	2300	CLM19	Predetermination of Benefits Code		*Note:* Puerto Rico Department of Health does not support predetermination of benefits.
154	2300	DTP	Service Date		
154	2300	DTP01	Date / Time Qualifier	472	"472" – Service
154	2300	DTP02	Date Time Period Format Qualifier	D8, RD8	"D8" – Date Expressed in Format CCYYMMDD "RD8" – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD (including dash)
154	2300	DTP03	Service Date		Service Date

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
166	2300	REF	Service Authorization Exception Code		*Note:* If all services were not the result of emergency care, submit multiple claims/encounters.
156	2300	DN1	Orthodontic Total Months of Treatment		
156	2300	DN101	Orthodontic Treatment Months Count		The estimated number of treatment months.
156	2300	DN102	Orthodontic Treatment Months Remaining Count		The number of treatment months remaining.
159	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
162	2300	CN1	Contract Information		ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
162	2300	CN101	Contract Type Code		ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
162	2300	CN102	Contract Amount		ENCOUNTER - Required If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
168	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
168	2300	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number
168	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
171	2300	REF	Prior Authorization		
172	2300	REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
9-049

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
172	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received. This number must be entered with the qualifier "G1" (Prior Authorization Number).
190	2310A	NM1	Referring Provider Name		
191	2310A	NM101	Entity Identifier Code	DN, P3	DN = Referring Provider Use on the first iteration of this loop. Use if loop is used only once. P3 = Primary Care Provider Use only if loop is used twice. Use only on second iteration of this loop.
192	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
192	2310A	NM109	Referring Provider Identifier		
193	2310A	PRV	Referring Provider Specialty Information		
193	2310A	PRV01	Provider Code	RF	"RF" – Referring
193	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
193	2310A	PRV03	Provider Taxonomy Code		Referring Provider Taxonomy Code. Used for claims submitted with NPI.
194	2310A	REF	Referring Provider Secondary Identification		
194	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non- healthcare providers.
196	2310B	NM1	Rendering Provider Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop: 2310C N403.
197	2310B	NM101	Entity Identifier Code	82	82 = Rendering Provider
198	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
198	2310B	NM109	Rendering Provider Identifier		
199	2310B	PRV	Rendering Provider Specialty Information		
199	2310B	PRV01	Provider Code	PE	PE = Performing
199	2310B	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Taxonomy Code
199	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code. Used for claims submitted with NPI.
200	2310B	REF	Rendering Provider Secondary Identification		

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
200	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non- healthcare providers.
202	2310C	NM1	Service Facility Name		*Note:* Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop, 2310C N403.
203	2310C	NM101	Entity Identifier Code	77	77 = Service Location
203	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
204	2310C	NM109	Laboratory or Facility Primary Identifier		
205	2310C	N3	Service Facility Location Address		
205	2310C	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
206	2310C	N4	Service Facility Location City, State, Zip Code		
206	2310C	N401	Laboratory or Facility City Name		Service Facility Location City
207	2310C	N402	Laboratory or Facility State or Province Code		Service Facility Location State
207	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location 9-digit Zip Code
221	2320	SBR	Other Subscriber Information		ENCOUNTER - Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
224	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER: When the MCO is the payer the value should be "HM" NOTE: All valid values will be accepted for other payer loops.
225	2320	CAS	Claim Level Adjustments		
227	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" – MCO denied claim
227	2320	CAS03	Adjustment Amount		
231	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
231	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
231	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL or MCO)
246	2330B	NM1	Other Payer Name		ENCOUNTER - Loop 2330B (Other Payer Name) is required on all encounter claims. *Note*: For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
247	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures third party payment amount(s) from the service line(s) in 2430-SVD02. *Note*: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned trading partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted
281	2400	LX	Service Line Number		
281	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
282	2400	SV3	Dental Service		
282	2400	SV304-1	Oral Cavity Designation Code		Enter the appropriate Mouth Quadrant code for each procedure. Only the first value listed for each procedure is used to process the claim. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both. See Appendix A.

ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 19-049

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
288	2400	TOO	Tooth Information		
288	2400	TOO01	Code List Qualifier Code	JP	"JP" – Universal National Tooth Designation System
288	2400	TOO02	Tooth Code		Enter the appropriate 2-digit Tooth Number on the detail line for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
289	2400	TOO03-1	Tooth Surface Code		Enter the appropriate Tooth Surface code for each procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
290	2400	DTP	Service Date		
290	2400	DTP01	Date/ Time Qualifier	472	"472" – Service This DTP Segment is Required if Dates of Service are different than those submitted within the 2300-DTP03, where DTP01=472.
290	2400	DTP02	Date Time Period Format Qualifier	D8	"D8" – Date Expressed in Format CCYYMMDD
290	2400	DTP03	Service Date		
296	2400	CN1	Contract Information		ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
296	2400	CN101	Contract Type Code		ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
296	2400	CN102	Contract Amount		ENCOUNTER - Required If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-04

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
					Note: The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount the health plan paid the provider for this detail.
316	2420A	NM1	Rendering Provider Name		*Note*: Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-to Provider (2010AA\AB).
318	2420A	NM108	Identification Code Qualifier	XX	"XX" – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
318	2420A	NM109	Rendering Provider Identifier		National Provider Identification (NPI)
319	2420A	PRV	Rendering Provider Specialty Information		Used for claims submitted with NPI.
319	2420A	PRV01	Provider Code	PE	PE = Performing
319	2420A	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Taxonomy Code
319	2420A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code.
320	2420A	REF	Rendering Provider Secondary Identification		
320	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number Non-healthcare providers must send this REF segment where REF01= "G2".
333	2420D	NM1	Service Facility Name		*Note*: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
334	2420D	NM101	Entity Identifier Code	77	77 = Service Location
334	2420D	NM102	Entity Type Qualifier	2	2 = Non-Person Entity
334	2420D	NM102	Laboratory or Facility Name		
334	2420D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
334	2420D	NM109	Laboratory or Facility Primary Identifier		
336	2420D	N3	Service Facility Location Address		
336	2420D	N301	Laboratory or Facility Address Line		
337	2420D	N4	Service Facility Location City, State, Zip Code		

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
337	2420D	N401	Laboratory or Facility City Name		
338	2420D	N402	Laboratory or Facility State or Province Code		
338	2420D	N403	Laboratory or Facility Postal Zone or ZIP Code		Must be 9 digits
339	2420D	REF	Service Facility Location Secondary Identification		
339	2420D	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note*: The "G2" qualifier should only be used for non-healthcare providers.
340	2420D	REF02	Service Facility Location Secondary Identifier		
341	2430	SVD	Line Adjudication Information		ENCOUNTER -Loop 2430 Required on all encounter claims. *Note*: Other payer payment amounts are required to be entered at the detail level.
341	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B- NM109 Identifying Other Payer.
342	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
345	2430	CAS	Line Adjustment		
346	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" – MCO denied claim
346	2430	CAS03	Adjustment Amount		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-04

A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

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

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	16		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	23	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	23	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	29	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	29	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

A.3 Change History

Version 3.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6.
2300	20	CLM02	Total Claim Charge Amount		Remove Note: *"Note:* Puerto Rico Department of Health interChange will process claims/encounters submitted with a negative billed amount as if the provider submitted a zero billed amount."
2300	22	PWK06	Attachment Control Number		Remove text: Please see page 16, "Hard Copy Attachments."
2300	23	CN101	Contract Type Code	05,09	Replace text with: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	23	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	CN103	Contract Percentage		Remove row.
2300	24	HI	Health Care Diagnosis Code		Remove segment.
2310A	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

					Note: The "G2" qualifier must be used for non-healthcare providers.
2310B	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310C	25	NM1	Service Facility Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2330B	27	NM1	Other Payer Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2420D	30	REF04-1	Reference Identification Qualifier		Remove row.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-041

A.4 Change History

Version 3.1 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text in third paragraph: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation
Section 1.4	9		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: 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

					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt 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)
Section 1.4	9		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flow		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify test: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Modify Text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file
Section 4.6	16		Procedures for Voiding Encounters		Modify text: When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
2010AB	19	NM1	Pay-To Address Name		Modify text:

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

					This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	20	CLM01	Patient Control Number		Modify Note/Comment: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Encounters: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify Note/Comment: "1" — Indicates that this is the first claim/encounter submitted to the PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Encounter: Paper submissions/requests will not be supported for encounter processing. Remove Note/Comment: Electronic adjustments are subject to the same requirements as paper adjustments and therefore

					may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	22	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2300	22	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	PWK	Claim Supplemental Information		Modify Note/Comment: Puerto Rico Department of Health PRMMIS does not use this field for processing of the claim/encounter
2300	22	PWK01 thru PWK05			Delete rows.
2300	23	REF	Payer Claim Control Number		Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-019

2300	25	REF02	Payer Claim Control Number		Add Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2310A	25	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2310B	24	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	25	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2320	25	CAS05 thru CAS17	Adjustment Reason Code		Delete rows.
2400	26	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2430	28	SVD	Line Adjudication Information		Change name of segment and remove (name loop) from Notes/Comments
2430	28	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	28	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	29	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2430	29	CAS05 thru	Adjustment Reason Code &		Delete rows.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
19-049

		CAS18	Adjustment Amount		
N/A	34		Section 7 – Appendix A		Remove Section 7

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	24	SBR09	Claim Filing Indicator Code	16, CI,HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	25	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2300	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2330B	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	27	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

2400	27	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2400	27	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

A.6 Change History

Version 5.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	22	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	22	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. And no other value applies. "09" – FFS
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	23	NTE	Claim Notes		Remove Segment
2300	23	NTE01	Note Reference Code	ADD	Remove line
2300	23	NTE02	Claim Note Text		Remove line
2320	25	SBR09	Claim Filing Indicator Code		Modify the text: ENCOUNTER: When the MCO is the payer the value should be "HM" *Note:* All valid values will be accepted for other payer loops.
2330B	25	DTP	Claim Check or Remittance Date		Remove Segment
2330B	25	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	25	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD

2330B	25	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	27	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan
2400	27	CN101	Contract Type Code	05, 09	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	27	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X223A2 Institutional Health Care Claim/Encounter (837I)

Companion Guide Version Number: 5.0

December 2017

For Module One Implementation

Puerto Rico Medicaid Management Information System Services Project

Disclosure Statement

Companion guides 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 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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 the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Institutional Claim/Encounter ASC X12N version 005010X223A2 (837I), 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.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Disclaimer: The information contained in this Companion Guide is subject to change.

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Table of Contents

INTRODUCTION

This section describes how TR3, also called 837I ASC X12N (version 005010X223A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health 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 0: 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 Puerto Rico Department of Health.
			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.

Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837I (referred to as Institutional Claim/Encounter in the rest of this document) for the purpose of submitting 837I 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 Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. 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 Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837I Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for 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.

Overview

Per HIPAA requirements, Puerto Rico Department of Health 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.

This guide is designed to help those responsible for testing and setting up electronic Institutional Claim/Encounter 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 Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837I (version 005010X223A2) Implementation Guide. 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 Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837I transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837I Health Care Claim/Encounter (version 005010X223A2) 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 Puerto Rico Department of Health.

Provider taxonomy code set can be obtained from www.wpc-edi.com/reference.

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.

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.

All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-012

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

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.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- 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).

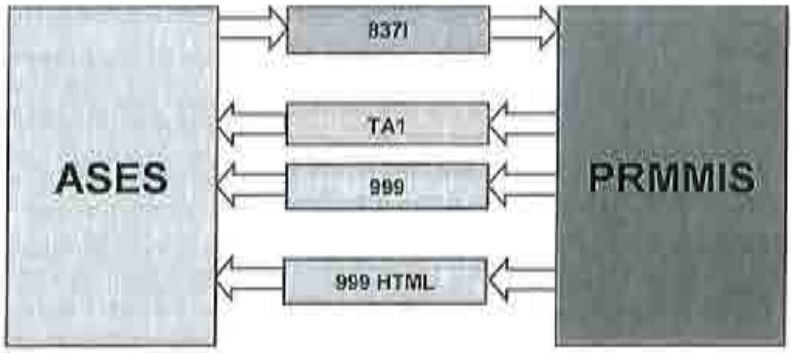
CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837I transactions, along with various submission methods, security requirements, and exception handling procedures.

Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837I complies with the 005010X223A2 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. Transactions that pass this compliance check will generate an "Accepted" 999 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 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks, but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid".



Transmission Administrative Procedures

This section provides Puerto Rico Department of Health'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 (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

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

Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own Internet connection to access the Web application.

CONTROL SEGMENTS / ENVELOPES

ISA-IEA

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

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a trading partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- 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 999 claims/encounters per Transaction Set (ST-SE).
- 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. The table below represents only those fields in which Puerto Rico Department of Health 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.

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: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" - Additional Data Identification.
C.4		ISA02	Authorization Information		ENCOUNTER - MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present.
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined.
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left justified and space filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined.
C.5		ISA08	Interchange Receiver ID	PRMMIS	PRMMIS - left justified and space filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
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 = No interchange acknowledgment requested (TA1).
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 Separator	:	A colon ":" is recommended.

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

GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

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

Functional Group Header (GS)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

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

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Institutional Claim/Encounter (837I)
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
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	005010X223A2	Version/ Release/ Industry Identifier Code

Functional Group Trailer (GE)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

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

ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health 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	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
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	005010X223A2	This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero
10-049

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

Control Segment Notes

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.

File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator 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 Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

Terminology

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

Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN, in the MCO's system, of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF - PAYER CLAIM CONTROL NUMBER
REF01 = F8 - Original Reference Number
REF02 = The TCN, in the MCO's system, of the encounter being voided

ACKNOWLEDGEMENTS AND/OR REPORTS

Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837I 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. Puerto Rico Department of Health 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 837I will need to be corrected and resubmitted.

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 Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

005010X223A2 — 837I Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable. RP = Encounters — Reporting.
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		Required if different than the name contained in the Submitter Name (Loop 1000A, NM1 segment)
71	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)
74	2100A	NM1	Receiver Name		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	'PUERTO RICO DEPARTMENT OF HEALTH'
75	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
80	2000A	PRV	Billing Provider Specialty Information		*Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
80	2000A	PRV01	Provider Code	BI	"BI" – Billing
80	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
80	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
84	2010AA	NM1	Billing Provider Name		ENCOUNTER - This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, see ISA01 and ISA02.
85	2010AA	NM102	Entity Identifier Code	85	85 = Billing Provider
86	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
86	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
87	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
88	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health.
90	2010AA	REF	Billing Provider Tax Identification		
90	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID (EIN)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
90	2010AA	REF02	Billing Provider Tax Identification Number		Valid 9-digit Employer ID number
94	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
107	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
108	2000B	HL03	Hierarchical Level Code	22	22 = Subscriber
108	2000B	HL04	Hierarchical Child Code	0	0 = No Subordinate HL Segment in This Hierarchical Structure.
109	2000B	SBR	Subscriber Information		
109	2000B	SBR01	Payer Responsibility Sequence Number Code		The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code.
110	2000B	SBR09	Claim Filing Indicator Code		See Comment on 2000B-SBR01.
112	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
113	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
113	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
113	2010BA	NM104	Subscriber First Name		Enter the member's first name.
113	2010BA	NM108	Identification Code Qualifier	MI	MI = Member identification number.
114	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
116	2010BA	N4	Subscriber City, State, Zip Code		
116	2010BA	N401	Subscriber City Name		Subscriber City
116	2010BA	N402	Subscriber State Code		Subscriber State

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-019

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
117	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code
121	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
122	2010BB	NM1	Payer Name		
122	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
123	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
123	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
129	2010BB	REF	Billing Provider Secondary Identification		
129	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* The "G2" qualifier must be used for non-healthcare providers.
130	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
143	2300	CLM	Claim Information		
144	2300	CLM01	Patient Control Number		*Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. ENCOUNTER: MCO should send the original PCN from the provider's original claim.
145	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-1	Facility Type Code		Value received is the 1st two positions of the Type of Bill (TOB).
147	2300	CLM05-2	Facility Code Qualifier	A	"A" – Uniform Billing Claim Form Bill Type
147	2300	CLM05-3	Claim Frequency Code	1, 3, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					adjudicated and "paid" claim/encounter. "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER: Use "1" as a frequency code when resubmitting a denied claim. Note: The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
149	2300	DTP	Discharge Hour		
149	2300	DTP01	Date / Time Qualifier	096	"096" – Discharge

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
149	2300	DTP02	Date Time Period Format Qualifier	TM	"TM" – Time (HHMM)
149	2300	DTP03	Discharge Time		Bill the Discharge Hour on all claims involving final services rendered. When a Discharge Hour is submitted, the Discharge Date is populated with the Statement Last Date of Service. This field only applies for nursing home patients discharged prior to the end of the month.
150	2300	DTP	Statement Dates		
150	2300	DTP01	Date/ Time Qualifier	434	"434" – Statement
150	2300	DTP02	Date Time Period Format Qualifier	RD8	"RD8" – Range of Dates Expressed in Format: CCYYMMDD-CCYYMMDD
153	2300	CL1	Institutional Claim Code		
153	2300	CL103	Patient Status Code		*Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
154	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
158	2300	CN1	Contract Information		ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
158	2300	CN101	Contract Type Code		ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
158	2300	CN102	Contract Amount		ENCOUNTER - Required If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
163	2300	REF	Referral Number		
163	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
163	2300	REF02	Referral Number		
164	2300	REF	Prior Authorization		
164	2300	REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number
164	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received. This number must be entered with the qualifier "G1" (Prior Authorization Number).
166	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
166	2300	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number
166	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
258	2300	HI	Occurrence Information		For those HI Segments Page 184 through Page 304 within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment are captured and stored within the MMIS.
258	2300	HI01-1	Code List Qualifier Code	BH	"BH" – Occurrence
269	2300	HI12-1	Code List Qualifier Code	BH	"BH" – Occurrence
319	2310A	NM1	Attending Provider Name		Required for Inpatient Services
319	2310A	NM101	Entity Identifier Code	71	"71" – Attending Provider
321	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
321	2310A	NM109	Attending Provider Primary Identifier		HIPAA National Provider Identifier
322	2310A	PRV	Attending Provider Specialty Information		
322	2310A	PRV01	Provider Code	AT	"AT" – Attending
322	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
322	2310A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code. Used for claims submitted with NPI.
324	2310A	REF	Attending Provider Secondary Identification		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
324	2310A	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non- healthcare providers.
336	2310D	NM1	Rendering Provider Name		*Note:* Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim.
337	2310D	NM101	Entity Identifier Code	82	82 = Rendering Provider
338	2310D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
338	2310D	NM109	Rendering Provider Identifier		HIPAA National Provider Identifier
339	2310D	REF	Rendering Provider Secondary Identification		
339	2310D	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non- healthcare providers.
341	2310E	NM1	Service Facility Name		*Note:* Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
342	2310E	NM101	Entity Identifier Code	77	77 = Service Location
342	2310E	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
342	2310E	NM109	Laboratory or Facility Primary Identifier		HIPAA National Provider Identifier
344	2310E	N3	Service Facility Location Address		
344	2310E	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
345	2310E	N4	Service Facility Location City, State, Zip Code		
345	2310E	N401	Laboratory or Facility City Name		Service Facility Location City
346	2310E	N402	Laboratory or Facility State or Province Code		Service Facility Location State
346	2310E	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location 9-digit Zip Code
339	2310E	REF	Rendering Provider Secondary Identification		
339	2310E	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier should only be used for non- healthcare providers.
349	2310F	NM1	Referring Provider Name		*Note:* Required on an outpatient claim when the Referring Provider is different than the Attending Provider.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
350	2310F	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
351	2310F	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
351	2310F	NM109	Referring Provider Identifier		HIPAA National Provider Identifier
352	2310F	REF	Referring Provider Secondary Identification		
352	2310F	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
354	2320	SBR	Other Subscriber Information		ENCOUNTER - Loop 2320 (Other Subscriber Information) is required on all encounter claims *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
355	2320	SBR01	Payer Responsibility Sequence Number Code		Enter the appropriate standard code. The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code.
356	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER: When the MCO is the payer the value should be "HM" NOTE: All valid values will be accepted for other payer loops.
358	2320	CAS	Claim Level Adjustments		
360	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" – MCO Denied Claim
360	2320	CAS03	Adjustment Amount		
364	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
364	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
364	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL or MCO)
364	2320	AMT	Remaining Patient Liability		
364	2320	AMT01	Amount Qualifier Code	EAF	"EAF" – Amount Owed

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
364	2320	AMT02	Remaining Patient Liability		
384	2330B	NM1	Other Payer Name		ENCOUNTER - Loop 2330B (Other Payer Name) is required on all encounter claims *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
385	2330B	NM108	Identification Code Qualifier	PI, XV	"PI" – Payer Identification "XV" – Centers for Medicare and Medicaid Services Plan ID
385	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures third party payment amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned trading partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted
423	2400	LX	Service Line Number		
423	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA allowed 999 detail lines per claim.
424	2400	SV2	Institutional Service Line		
424	2400	SV201	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
425	2400	SV202-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
428	2400	SV205	Service Unit Count		Enter the number of days spent in hospital or at home. Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units

ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 19-049

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					entered on the transaction 3.75 are processed as 3 units.
459	2410	LIN	Drug Identification		
451	2410	LIN02	Service ID Qualifier	N4	"N4" – National Drug Code
451	2410	LIN03	Drug Identification		Enter National Drug Code in 5-4-2 Format
451	2410	CTP	Drug Quantity		
452	2410	CTP04	National Drug Unit Count		National Drug Unit Count
452	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
476	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 Required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
476	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 identifying Other Payer.
477	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line item level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
481	2430	CAS	Line Adjustment		
482	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" – MCO Denied line item
482	2430	CAS03	Adjustment Amount		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

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

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	17		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	27	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	27	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	34	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	34	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2300	22	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	24	CL103	Patient Status Code		Changed the title of Section 9 to Nursing Home Termination Codes to Patient Status Codes Crosswalk.
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	25	CN104	Contract Code		REMOVED THIS ROW
2310A	27	REF01	Reference Identification Qualifier	0B, G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

					Note: The "G2" qualifier must be used for non-healthcare providers.
2310A	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310D	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2320	30	CAS03	Adjustment Amount		Remove Comment.
2320	30	CAS06	Adjustment Amount		Remove Comment.
2320	30	CAS09	Adjustment Amount		Remove Comment.
2320	30	CAS12	Adjustment Amount		Remove Comment.
2320	30	CAS15	Adjustment Amount		Remove Comment.
2320	31	CAS18	Adjustment Amount		Remove Comment.
2320	34	CAS03	Adjustment Amount		Remove Comment.
2320	34	CAS06	Adjustment Amount		Remove Comment.
2320	34	CAS09	Adjustment Amount		Remove Comment.
2320	34	CAS12	Adjustment Amount		Remove Comment.
2320	35	CAS15	Adjustment Amount		Remove Comment.
2320	35	CAS18	Adjustment Amount		Remove Comment.

A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	7		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions.
Section 1.2	7		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider NPI		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: 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 File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt 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)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file.
Section 4.6	16		Procedures for Voiding Encounters		Modify text:

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-0469

					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
2010AB	20	NM1	Pay-To Address Name		Modify text: This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2000B	20	SBR01	Payer Responsibility Sequence Number Code		The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	21	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text:

					Note: Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify text: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Remove text: Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Modify text: ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. Add text: ENCOUNTER: MCOs are required to send their claim

					ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length.
2300	23	PWK01 thru PWK05			Remove rows.
2300	23				Modify text: Puerto Rico Department of Health's PRMMIS does not use this field for processing of the claim/encounter
2300	23	CL103	Patient Status Code		Remove text: The X12N 837I does not support the use of the Nursing Home Termination Codes currently billed on Nursing Home claims. Remove Text: The Termination Code is derived from the Patient Status Code. Remove Text: See Section 9 - Nursing Home Termination Codes to

					Patient Status Codes Crosswalk. Add text: *Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
2300	24	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	24	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	26	HI01-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2300	26	HI12-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2310F	26	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	27	SBR01	Payer Responsibility Sequence Number Code		Modify Notes/Comments: The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing

					Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2320	27	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2320	27 thru 28	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	SV201	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
2430	30	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	30	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	30	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line item level only.

					This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	31	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2430	31 thru 32	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
N/A	36		Section 7 – Appendix A		Remove Section 7
N/A	36		Section 8 – Appendix B		Remove Section 8
N/A	36		Section 9 – Appendix C		Remove Section 9
N/A	37		Section 10 – Appendix D		Remove Section 10

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: Negative Dollar Amounts Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	26	SBR09	Claim Filing Indicator Code	16 CI, HM MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	27	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	27	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

A.6 Change History

Version 6.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code		Modify the text: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	26	SBR09	Claim Filing Indicator Code		Modify the text: ENCOUNTER: When the MCO is the payer the value should be "HM" *Note:* All valid values will be accepted for other payer loops.
2330B	27	DTP	Claim Check or Remittance Date		Remove Segment
2330B	27	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	27	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	27	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)


ADMINISTRACION DE
Contrato Numero
19 - 04
SEGUROS DE SALUD

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X222A1 Professional Health Care Claim/Encounter (837P)

Companion Guide Version Number: 5.0

December 2017

For Module One Implementation

Puerto Rico Medicaid Management Information System Services Project

Disclosure Statement

Companion guides 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 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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 the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Professional Claim/Encounter ASC X12N version 005010X222A1 (837P), 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.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Disclaimer: The information contained in this Companion Guide is subject to change.

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Contents

1 INTRODUCTION

This section describes how TR3, also called 837P ASC X12N (version 005010X222A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health 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 6: 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 Puerto Rico Department of Health.
			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.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837P (referred to as Professional Claim/Encounter in the rest of this document) for the purpose of submitting 837P 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 Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. 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 Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837P Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for 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, Puerto Rico Department of Health 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.

This guide is designed to help those responsible for testing and setting up electronic Professional Claim/Encounter 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 Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837P (version 005010X222A1) Implementation Guide. 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 Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837P transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837P Health Care Claim/Encounter (version 005010X222A1) 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 Puerto Rico Department of Health.

Provider taxonomy code set can be obtained from www.wpc-edi.com/reference.

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.

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.

All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

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.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- 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).

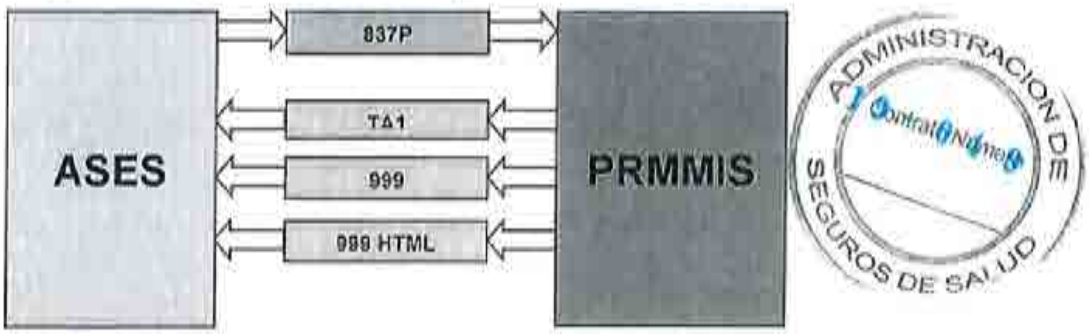
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837P transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837P complies with the 005010X222A1 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. Transactions that pass this compliance check will generate an "Accepted" 999 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 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks, but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid".



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health'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 (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

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

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own Internet connection to access the Web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

This section describes Puerto Rico Department of Health's use of the Interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a trading partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- 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 999 claims/encounters per Transaction Set (ST-SE).
- 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. The table below represents only those fields in which Puerto Rico Department of Health 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.

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: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" - Additional Data Identification.
C.4		ISA02	Authorization Information		ENCOUNTER - MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present.
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined.
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left justified and space filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined.
C.5		ISA08	Interchange Receiver ID	PRMMIS	PRMMIS - left justified and space filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
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 = No interchange acknowledgment requested (TA1).
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 Separator	:	A colon ":" is recommended.

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

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

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

Functional Group Header (GS)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.
Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Professional Claim/Encounter (837P)
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
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	005010X222A1	Version/ Release/ Industry Identifier Code

Functional Group Trailer (GE)

In the table below fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

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

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health 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	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
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	005010X222A1	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	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

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.

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator 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 Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

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

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN, in the MCO's system, of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF - PAYER CLAIM CONTROL NUMBER
REF01 = F8 - Original Reference Number
REF02 = The TCN, in the MCO's system, of the encounter being voided

5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health 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 837P 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. Puerto Rico Department of Health 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 837P will need to be corrected and resubmitted.

6 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 Puerto Rico Department of Health 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 Puerto Rico Department of Health.

In addition to the row for each segment, one or more additional rows are used to describe Puerto Rico Department of Health'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 Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X222A1 — 837P Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
71	None	BHT	Beginning of Hierarchical Transaction		
71	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
71	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable. RP = Encounters — Reporting.
74	1000A	NM1	Submitter Name		
75	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
76	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
77	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
77	1000A	PER02	Submitter Contact Name		Required if different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
77	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM"– Electronic Mail "FX" – Fax "TE" – Telephone
77	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)
79	1000B	NM1	Receiver Name		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
80	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	'PUERTO RICO DEPARTMENT OF HEALTH'
80	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
80	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
83	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER - When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (see 2010AA below).
83	2000A	PRV01	Provider Code	BI	"BI" – Billing
83	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code *Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
83	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing. *Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with Puerto Rico Department of Health.
88	2010AA	NM1	Billing Provider Name		ENCOUNTER - This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, see ISA01 and ISA02.
88	2010AA	NM102	Entity Identifier Code	85	85 = Billing Provider
89	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
89	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
91	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department Of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
92	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department Of Health.
94	2010AA	REF	Billing Provider Tax Identification		
94	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID (EIN)
94	2010AA	REF02	Billing Provider Tax Identification Number		Valid 9-digit Employer ID number
101	2010AB	NM1	Pay-To Address Name		*Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
114	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
115	2000B	HL03	Hierarchical Level Code	22	22 = Subscriber
115	2000B	HL04	Hierarchical Child Code	0	0 = No Subordinate HL Segment in this Hierarchical Structure.
116	2000B	SBR	Subscriber Information		
116	2000B	SBR01	Payer Responsibility Sequence Number Code		Refer to the 837 Professional Implementation Guide for valid values (pg. 296).
118	2000B	SBR09	Claim Filing Indicator Code	MC	"MC" – Medicaid
121	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
122	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
122	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
122	2010BA	NM104	Subscriber First Name		Enter the member's first name.
122	2010BA	NM108	Identification Code Qualifier	MI	MI = Member identification number.
123	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
125	2010BA	N4	Subscriber City, State, Zip Code		
125	2010BA	N401	Subscriber City Name		Subscriber City
125	2010BA	N402	Subscriber State Code		Subscriber State
126	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code
130	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department Of Health.
133	2010BB	NM1	Payer Name		
134	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
134	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
134	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
136	2010BB	N4	Payer City, State, Zip Code		
136	2010BB	N401	City Name	SAN JUAN	
137	2010BB	N402	Payer State Code	PR	
137	2010BB	N403	Payer Postal Zone or ZIP Code	00922	
140	2010BB	REF	Billing Provider Secondary Identification		*Note:* Non-healthcare (Atypical) providers are required to submit this segment.
140	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* This qualifier may only be used by non-healthcare providers who do not possess an NPI ID (i.e., Med waivers).
141	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
157	2300	CLM	Claim Information		
158	2300	CLM01	Patient Control Number		*Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. ENCOUNTER: MCO should send the original PCN from the provider's original claim.
159	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
159	2300	CLM05-1	Facility Type Code		Value received is the 1st two positions of the Type of Bill (TOB). Enter the two-digit Place of Service Code at the claim header. Enter Place of Service code '99' for public transportation claims.
159	2300	CLM05-2	Facility Code Qualifier	B	"B" – Place of Service Codes for Professional or Dental Services
159	2300	CLM05-3	Claim Frequency Code	1, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" – Original Claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER: Use "1" as a Frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the internal control number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					ENCOUNTER: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
161	2300	CLM11-1	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two - character injury codes listed above in each Data Element if they apply. Otherwise, this field may be left blank.
161	2300	CLM11-2	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two character injury codes listed above in each Data Element, if they apply. Otherwise, this field may be left blank.
182	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
186	2300	CN1	Contract Information		ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
186	2300	CN101	Contract Type Code		ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
186	2300	CN102	Contract Amount		ENCOUNTER - Required If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
193	2300	REF	Referral Number		
193	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
193	2300	REF02	Referral Number		
194	2300	REF	Prior Authorization		
194	2300	REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number
195	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received. This number must be entered with the qualifier "G1" (Prior Authorization Number).
196	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
196	2300	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number
196	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
211	2300	CR1	Ambulance Transport Information		
212	2300	CR104	Ambulance Transport Reason Code		Enter the Ambulance Transport Reason Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
212	2300	CR105	Unit or Basis for Measurement Code	DH	"DH" – Miles
213	2300	CR106	Transport Distance		Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units entered on the transaction 3.75 are processed as 3 units.
213	2300	CR109	Round Trip Purpose Description		Description / clarification of the Purpose of the ambulatory trip. *Note:* Only used on round-trip ambulatory claims.
214	2300	CR2	Spinal Manipulation Service Information		
215	2300	CR208	Patient Condition Code		Enter the corresponding Condition Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
216	2300	CRC	EPSDT Referral		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
216	2300	CRC01	Code Category	07, ZZ	"07" – Ambulance Certification "ZZ" – Mutually Defined Enter this for Child Health Check-Up Screening Referral Information.
217	2300	CRC02	Certification Condition Indicator	Y, N	"Y" – Yes "N" – No For Child Health Check-Up screenings enter a "Y" if the patient is referred to another provider as a result of the screening. Enter "N" if no referral is made. If "N" is entered here, enter "NU".
217	2300	CRC03	Condition Code	AV, NU, S2, ST	Enter one of the following valid values. For Child Health Check- Up Exam Result: "AV" – Patient Refused Referral "NU" – Not Used (Patient Not Referred) "S2" – Under Treatment "ST" – New Services Requested
257	2310A	NM1	Referring Provider Name		
258	2310A	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
258	2310A	NM102	Entity Type Qualifier	1	"1" – Person
259	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
259	2310A	NM109	Referring Provider Identifier		
260	2310A	REF	Referring Provider Secondary Identification		
260	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
262	2310B	NM1	Rendering Provider Name		*Note:* Required when the Rendering Provider is different than the Billing Provider reported in Loop 2010AA. *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403
263	2310B	NM101	Entity Identifier Code	82	82 = Rendering Provider
264	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
264	2310B	NM109	Rendering Provider Identifier		
265	2310B	PRV	Rendering Provider Specialty Information		
265	2310B	PRV01	Provider Code	PE	"PE" – Performing

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
265	2310B	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
265	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code. Used for claims submitted with NPI.
267	2310B	REF	Rendering Provider Secondary Identification		
267	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non- healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
269	2310C	NM1	Service Facility Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
270	2310C	NM101	Entity Identifier Code	77	77 = Service Location
270	2310A	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
270	2310A	NM103	Laboratory or Facility Name		
271	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
271	2310C	NM109	Laboratory or Facility Primary Identifier		
272	2310C	N3	Service Facility Location Address		
272	2310C	N301	Laboratory or Facility Address Line		
273	2310C	N4	Service Facility Location City, State, Zip Code		
273	2310C	N401	Laboratory or Facility City Name		
273	2310C	N402	Laboratory or Facility State or Province Code		
273	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location 9-digit Zip Code
275	2310C	REF	Service Facility Location Secondary Information		
275	2310C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
276	2310C	REF02	Laboratory or Facility Secondary Identifier		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
285	2310E	NM1	Ambulance Pick-Up Location		*Note:* For Ambulatory claims only.
285	2310E	NM101	Entity Identifier Code	PW	"PW" – Pickup Address
286	2310E	NM102	Identification Code Qualifier	2	"2" – Non-Person Entity
287	2310E	N3	Ambulance Pick-Up Location Address		
287	2310E	N301	Ambulance Pick-up Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate
288	2310E	N4	Ambulance Pick-Up Location City, State, Zip Code		
288	2310E	N401	Ambulance Pick-up City Name		
289	2310E	N402	Ambulance Pick-up State or Province Code		
289	2310E	N403	Ambulance Pick-up Postal Zone or ZIP Code		
290	2310F	NM1	Ambulance Drop-Off Location		*Note:* For Ambulatory Claims Only
290	2310F	NM101	Entity Identifier Code	45	"45" – Drop-Off Location
291	2310F	NM102	Identification Code Qualifier	2	"2" – Non- Person Entity
292	2310F	N3	Ambulance Drop-Off Location Address		
292	2310F	N301	Ambulance Drop-off Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate.
293	2310F	N4	Ambulance Drop-Off Location City, State and Zip Code		
293	2310F	N401	Ambulance Drop-off City Name		
294	2310F	N402	Ambulance Drop-off State or Province Code		
294	2310F	N403	Ambulance Drop-off Postal Zone or ZIP Code		
295	2320	SBR	Other Subscriber Information		ENCOUNTER - Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Numero 19-049

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
298	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER: When the MCO is the payer the value should be "HM" *Note*: All valid values will be accepted for other payer loops.
299	2320	CAS	Claim Level Adjustments		
301	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" – MCO denied claim
305	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
305	2320	AMT01	Amount Qualifier Code	D	"D" - Payer Amount Paid
305	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL or MCO)
320	2330B	NM1	Other Payer Name		ENCOUNTER - Loop 2330B (Other Payer Name) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is TPL, the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
321	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures third party payment amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned trading partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted.
350	2400	LX	Service Line Number		
350	2400	LX01	Assigned Number		SV101

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
351	2400	SV1	Professional Service		
351	2400	SV101	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
352	2400	SV101-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
353	2400	SV101-2	Procedure Code		Enter the procedure code for this Service line. For Child Health Checkup (CHCUP) claims, enter the screening procedure code on the first service line. Enter procedure code "99998" for Public Transportation Claims.
355	2400	SV104	Service Unit Count		
357	2400	SV109	Emergency Indicator	Y	"Y" – Yes Enter 'Y' if the services are known to be an emergency.
357	2400	SV111	EPSDT Indicator	Y	"Y" – Yes Enter 'Y' when the recipient was referred for services as the result of a Child Health Check-up screening.
357	2400	SV112	Family Planning Indicator	Y	"Y" – Yes Enter 'Y' if the services relate to pregnancy or if the services were for Family Planning.
373	2400	CRC	Ambulance Certification		
374	2400	CRC03	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if Condition Code applies to entire claim. Used only for Ambulance claims.
375	2400	CRC07	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if Condition Code applies to entire claim. Used only for Ambulance claims.
395	2400	CN1	Contract Information		ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
395	2400	CN101	Contract Type Code		ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 19-049

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					FFS encounter claims should indicate the appropriate value as listed in the TR3.
395	2400	CN102	Contract Amount		ENCOUNTER - Required If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. Note: The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount the health plan paid the provider for this detail.
423	2410	LIN	Drug Identification		
425	2410	LIN02	Product or Service ID Qualifier	N4	"N4" – National Drug Code
425	2410	LIN03	National Drug Code		Enter National Drug Code in 5-4-2 Format
426	2410	CTP	Drug Quantity		
426	2410	CTP04	National Drug Unit Count		
427	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
430	2420A	NM1	Rendering Provider Name		*Note:* Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering Provider information is different than the Billing Provider (2010 AA). If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop: 2310C N403.
432	2420A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
432	2420A	NM109	Rendering Provider Identifier		
433	2420A	PRV	Rendering Provider Specialty Information		
433	2420A	PRV01	Provider Code	PE	"PE" – Performing
433	2420A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
433	2420A	PRV03	Provider Taxonomy Code		Detail Level Rendering Provider Taxonomy Code

ADMINISTRACION DE SEGUROS DE SALUD
Certificate number 13 - 04 - 9

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
434	2420A	REF	Rendering Provider Secondary Identification		
434	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* Non-healthcare providers must send this REF segment where REF01 = G2.
435	2420A	REF02	Rendering Provider Secondary Identifier		Enter PR Medicaid Provider ID.
441	2420C	NM1	Service Facility Name		If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
442	2420C	NM101	Entity Identifier Code	77	77 = Service Location
442	2420C	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
442	2420C	NM103	Laboratory or Facility Name		
442	2420C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
442	2420C	NM109	Laboratory or Facility Primary Identifier		
444	2420C	N3	Service Facility Location Address		
444	2420C	N301	Laboratory or Facility Address Line		
445	2420C	N4	Service Facility Location City, State, Zip Code		
445	2420C	N401	Laboratory or Facility City Name		
446	2420C	N402	Laboratory or Facility State or Province Code		
446	2420C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location 9-digit Zip Code
447	2420C	REF	Service Facility Location Secondary Information		
447	2420C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
448	2420C	REF02	Laboratory or Facility Secondary Identifier		
480	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 Required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
480	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 identifying Other Payer.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
480	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
484	2430	CAS	Line Adjustment		
486	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER: "A1" - MCO Denied detail
486	2430	CAS03	Adjustment Amount		
490	2430	DTP	Line Check or Remittance Date		ENCOUNTER – Claim will be denied if all the dates at the detail level are not the same date.

A. APPENDIX A

A.1 Change Summary

Version 1.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

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

A.2 Change Summary

Version 2.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310B	24	NM1	Rendering Provider Name		*Note:* Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim. *Note:* If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C. **Changed to:** *Note:* Required when the Rendering Provider is different than the Billing Provider reported in Loop 2010AA.

A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	3		Introduction		The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.
2300	19	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required If CN101 = 05, then amount is zero.

					If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	REF02	Value Added Network Trace Number		Modify text: Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credited/voided).
2310A	23	REF01	Reference Identification Qualifier	0B, G2	*Note:* The "G2" qualifier must be used for non-healthcare providers.
2310B	24	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
2310C	25	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
2400	28	SV101-1	Product/Service ID Qualifier	HC	Element changed from SV102-1 to SV101-1.
2400	28	SV101-2	Procedure Code		Element changed from SV102-2 to SV101-2.
2400	29	CRC	Ambulance Certification		Loop corrected from 2410 to 2400
2400	29	CRC03	Condition Code		Loop corrected from 2410 to 2400
2400	29	CRC07	Condition Code		Loop corrected from 2410 to 2400
2420C	31	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number

					Note: The "G2" qualifier must be used for non-healthcare providers.

A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: 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

					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt 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)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: Claim - [space fill]
N/A	12	ISA02	Authorization Information		Remove text: "00" – No Authorization Information Present.
N/A	14	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles
Section 4.2	16		Testing		Modify text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including the Transaction ST segment and Transaction SE segment.
Section 4.6	16		Procedures for voiding encounters		Modify text:

					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
1000B	18	NM1	Receiver Name		Correct the Loop number.
2010AB	20	NM1	Pay-to-Address		Modify text: *Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	22	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	23	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text: *Note:* Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	23	CLM05-1	Facility Type Code		Remove text: *Note:* See the Medicaid Provider Reimbursement Handbook for a list of all of the valid values.
2300	23	CLM05-3	Claim Frequency Code		Remove text: Valid values are as follows: Modify text: The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of

					a previously adjudicated and "paid" claim/encounter: "1" – Original claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety.
2300		CN1			
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Remove text: ENCOUNTER - Attachments are not permitted for Encounter Claims Modify text: Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.

2300	23	PWK01 thru PWK05			Delete rows.
2300	24	REF02	Referral Number		Remove text: Enter DS Waiver Coordinator Number with the REF01 = '9F'
2300	25	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	26	REF01	Reference Identification Qualifier		Remove code and text: "0B" – State License Number
2310B	26	REF01	Reference Identification Qualifier		Remove text: *Note:*This is not required for nursing homes.
2320	28	CAS02	Adjustment Reason Code	A1	Remove text: All values from code source 139 are allowed.
2320	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2400	30	SV101	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the

					Puerto Rico Medicaid program.
2430	33	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	34	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	34	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	33	CAS02	Adjustment Reason Code		Remove code & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" = Medicare Blood Deductible. Remove text: Other external code source values from code source 139 are allowed.
2430	33	CAS03	Adjustment Amount		Remove codes & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" enter the Medicare Blood Deductible. ENCOUNTER: "A1" - MCO Denied detail Other external code source values from code source 139 are allowed.
2430	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	28	SBR09	Claim Filing Indicator Code	16, CI, HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	28	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	28	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	30	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

2400	30	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" - FFS
2400	30	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

A.6 Change History

Version 5.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-16-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	28	SBR09	Claim Filing Indicator Code		Modify the text: ENCOUNTER: When the MCO is the payer the value should be "HM" *Note:* All valid values will be accepted for other payer loops.
2330B	29	DTP	Claim Check or Remittance Date		Remove Segment
2330B	29	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	29	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD

2330B	29	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	30	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
2400	30	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	30	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..