ATTACHMENT 9

INFORMATION SYSTEMS ADDENDUM 1 – 9

Vital
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GOBIERNO DE PUERTO RICO

Attachment 9 Information Systems

ADMINISTRACION DE
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Vital Plan
11-1-2018

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1. **GHP MANUAL**
2. **ADDENDUMS**

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GHP MANUAL

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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 Carriers, in accordance with the Government Health Plan (GHP) contract (Contract). This includes processes of eligibility, enrollment, premium payment, Maternity Payment, Correctional Hospital Services, STAC Payment and FMAP change (change in the FPL)- The Federal Medical Assistance Percentage, Member Race Cell/Risk Score, and Objection to Payment. The history of the services provided by the beneficiary is identified and the Carrier becomes involved when he changes Carrier. 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 Carriers shall be resolved in favor of CMS guidance and such contracts, as amended.

Previously, a Carriers was assigned to each of the ASES regions and beneficiaries in each region could not select a Carriers or change Carriers 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 Carriers. To support implementation of the GHP program, all GHP enrollees up until September 30, 2018, will be auto-enrolled by ASES in Carriers based on an algorithm that considers the existing enrollee-provider relationships and household composition, among other factors. Enrollees will be notified of the Carrier's assignment. Those enrollees, along with New Enrollees certified during October 2018 which will have the opportunity to select a Carriers of their preference, will have the opportunity to change the Carriers 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 Carriers of their preference and ninety (90) days from the certification date to opt for another selection.

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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, Carriers or Puerto Rico Puerto Rico Medicaid Office (PRMP).

4. **Auto-Enrollment Process:** The Enrollment of a Potential Enrollee in a GHP 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. The Puerto Rico Puerto Rico Medicaid Office is the only entity with the authority to cancel an enrollee's eligibility.

8. **Carrier to ASES Data Submissions**: Document provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES. **Reference Addendum 5**

9. **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).

10. **9. Certification:** A decision of the Puerto Rico Medicaid Office, where a person is eligible for services under the GHP, with Medicaid, CHIP or Commonwealth coverage.

11. **Certification date:** As provided in Section 5.1.3 of this Contract, a decision of the Puerto Rico Puerto Rico Medicaid Office where a person is eligible to receive services under the GHP, in a Medicaid, CHIP or Commonwealth coverage classification. Some public employees and retirees can enroll in GHP without first receiving a Certification

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

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

14. **COORDINATION OF BENEFITS** – COB Some people who are beneficiaries of Government Health Plan of Puerto Rico, which thrives on federal funds under certain circumstances may be eligible to receive benefits for a private plan or other health insurance funded by the Government of Puerto Rico. In accordance with applicable laws and federal guidelines, Medicaid is the payer of last resort, and the rest of the remedies must be exhausted before resorting to the services under the Medicaid funds provided. – **Reference Addendum 8**
15. **Coverage Code:** Code assigned by the Puerto Rico Puerto Rico Medicaid Office to eligible beneficiaries, according to Federal, CHIP and Commonwealth indigence criteria. Under GHP, the coverage code will coincide with the Plan Version.

16. **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.

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

18. **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.

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

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

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

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

23. **Effective Date of Eligibility:** It is the start date of an eligibility period. It is assigning by the Puerto Rico Medicaid (PRPM) according to the evaluation performed and eligibility program determined (CHIP, Medicaid, Commonwealth).

24. **Effective date of the change of Carrier:** It is the start date of the enrollment of an affiliate in a selected Carrier. For changes made in the first twenty days of the month, registration with the Carrier will become effective on the first day of the following month according to the selection of the Carrier.

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For Carriers, changes made after the first twenty days of the month, Carriers' registration will take effect on the first day of the following month (20-day rule).

25. **Enrollment Effective Date (Carrier Effective Date):** The date the eligible member is enrolled with the contracted Carrier. This date considers the effective date of eligibility or the effective date of the change in Carrier.
26. **Enrollment End Date (Carrier End Date):** The effective end date of the member's coverage period at the assigned insurance carrier. **(This change will be effective from July 31, 2022)**
27. **Enrollment Start Date:** This is the member's start date for the current period of continuous enrollment with the current insurance carrier. **(This change will be effective from July 31, 2022)**
28. **Enrollee Seed Sets:** These are GHP groups eligible by the date of execution of the automatic allocation algorithm, which are classified according to the expiration date of their eligibility and the cancellation date issued by the Puerto Rico Medicaid Office. (Cancellation date Medicaid) These groups are assigned to contracted Carriers and define the delivery packages sent to Carriers, during the self-allocation maintenance period.

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

30. **Eligible Person -** A person eligible to enroll in the GHP, as provided in Section 1.3.1 of this Contract, by virtue of being eligible for Medicaid, CHIP, or Commonwealth coverage.

31. **Enrollee:** A person who is enrolled in a Carrier's GHP, 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.

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

33. **Federal Category:** Classification established by the Puerto Rico 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.
34. **FMAP change (change in the FPL- Federal Poverty Level)** - is computed from a formula that considers the average per capita income for each State relative to the national average. Are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

35. **Foster Care Population:** Children who are in the custody of the Department of Family's ADFAN Program and enrolled in the GHP.
36. **Government Health Insurance Plan (GHP):** The government health services program (formerly called "La Reforma" or "MI Salud") offered by the government and administered by ASES, serving a mixed population of eligible for Medicaid, CHIP and Commonwealth, and emphasizes the integrated delivery of physical and behavioral health services.

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

38. **Health Insurer Code:** This is the code assigned to the Insurance Company **(this change will be effective from July 31, 2022)**

39. **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.

40. **HIPAA Transaction 834 -** The ANSI 834 EDI Enrollment Implementation Format is a standard file format for the electronic interchange of health plan enrollment data. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health plans or health insurance companies accept a standard enrollment format: ANSI 834A Version 5010. An 834 file contains an order of data, such as a subscriber's name, hire date, etc. in a data segment. The 834 is used to transfer enrollment information from the insurance coverage sponsor, benefits, or policy to a payer. The intent of this implementation guide is to meet the specific need of the health care industry for the initial enrollment and subsequent maintenance of individuals who are enrolled in insurance products. This implementation guide specifically addresses the enrollment and maintenance of healthcare products only. One or more separate flexible spending and retirement guidelines may be developed." **(This change will be effective from January 2023)**

41. **HIPAA Transaction 820 -** Health Insurance Exchange Related Payments ((**this change will be effective from January 2023)**

42. **Id Card Issue Date:** This is the member ID card issue date (**this change will be effective from December 1, 2022)**
43. **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.

44. **Initial Self-Enrollment:** The process by which an eligible person enrolled with a GHP Carrier prior to November 1, 2018, is automatically enrolled with a Carrier by ASES with an effective date of November 1, 2018.

45. **Initial Auto-Enrollment Enrollee:** Initial Auto-Enrollment Subscriber - An eligible person enrolled prior to November 1, 2018, with a GHP Carrier is automatically enrolled with a Carrier by ASES with an effective date of November 1, 2018.

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

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

48. **Maternity Payment -** Is designed to support Managed Care Organizations (MCOs) in reporting maternity deliveries for reimbursement in the Badgercare Plus – Standard program as the payment is made outside of the monthly capitation payment process

49. **Notice of Action Taken:** 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 Coverage, CHIP, or Commonwealth).

50. **New Id Card Issue Date:** It is used for the future enrollment period, populated with the member's new ID card issue date. ((**this change will be effective from December 1, 2022**

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

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

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

54. **Medicare:** Provides health insurance coverage to individuals who are age 65 and over, under age 65 with certain disabilities, and individuals of all ages with ESRD. Under Title XVIII of the Social Security Act

55. **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.

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

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

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

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

60. **Member Race Cell**: Process where the beneficiary's data is evaluated to assign them the corresponding Rate Cell monthly

61. **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.

62. **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.

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

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

65. **OTP - Objection of Payment:** This is the process for Carriers to notify ASES of objections to erroneous payments and missed payments.

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

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

68. **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 Puerto Rico Medicaid Office.

69. **PMPM Premium ("Per Member Per Month (PMPM)" Payment):** The fixed monthly amount that the Contracted Carrier 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.

70. **Potential Enrollee: Possible affiliate:** A person who has been certified by the Puerto Rico Puerto Rico Medicaid Office as eligible to enroll in the GHP (either Medicaid, CHIP or Commonwealth category coverage), but who has not yet enrolled with a contracted Carrier.

71. **Poverty Level:** As required by Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)), the Department of Health and Human Services (HHS) updates the poverty guidelines at least annually and by law these updates are applied to eligibility criteria for programs such as Medicaid and the Children's Health Insurance Program (CHIP). These annual updates increase the Census Bureau's current official poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U).

72. **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.

73. **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.

74. **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 Carrier.

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

76. **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.

77. **Puerto Rico Puerto Rico Medicaid Office (or "Medicaid Office"):** Puerto Rico Puerto Rico Medicaid Office (or "Medicaid Office"): The subdivision of the Department of Health that makes eligibility determinations and offers a Carrier selection after a favorable result of said determination under GHP for Medicaid, CHIP and Commonwealth coverage.

78. **Rate cell Process Date:** This is the process date for this transaction **(this change will be effective from December 1, 2022)**

Rate Cell Record: This is the transaction type identifier were

E - Eligible
I - Ineligible
H - History
1 - Retroactive Period (*)
2 - Retroactive Period (*)
3 - Retroactive Period (*)

(*) Correspond to record group, not to period order

Rate cell Personal ID: Member's Person Id

Race cell Rate Code: This is the member's Assigned Rate Cell

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Rate Effective Date: This is the effective start of the member's rate cell
Rate End Date: The end date of the member's rate cell.

79. **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.

80. **Redetermination:** The periodic Redetermination of eligibility of an individual for Medicaid, CHIP and Commonwealth coverage, conducted by the Puerto Rico Medicaid Office.

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

82. **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.

83. **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 Carrier comes into effect.

84. **TRANSITION OF CARE:** Historical utilization data of the beneficiary when changing Carrier

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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 if a person is eligible to receive services covered under the GHP. Members can be determined eligible to participate in the GHP as a recipient of Medicaid funded with Federal (Federal), CHIP, or Commonwealth funds. For the Medicaid and CHIP populations, the eligibility criteria are established in the State Plan and in cooperation with CMS. For state beneficiaries, eligibility requirements are set by the Medicaid Program, except for public employees and pensioners included in Other Eligible Populations, which are determined by independent ASES policies.

B. NOTICE OF DECISION

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

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

The Notice of Decision form is valid for the eligibility period identified on Form Notice of Decision and may be used for a period of thirty (30) calendar days from the date of Certification for the purpose of demonstrating eligibility. See **Addendum 1- Notice of Decision Form.**

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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 Puerto Rico Puerto Rico Medicaid Office determines eligibility. This should be the same date indicated as the eligibility period on the Form Notice of Decision.

The eligibility period specified in the Decision Notification Form may be a retroactive eligibility period, up to three (3) months before the first day of the month, in which the Potential Affiliate submits his / her application for eligibility to the Office of Puerto Rico Medicaid with Federal Medicaid and CHIP coverage where services can be covered retroactively. Retroactivity, on the effective date of eligibility, is granted when the prospective member indicates that they incurred medical expenses prior to the current eligibility period, including any services covered by Federal Medicaid or CHIP coverage, that relate to drugs or services, where pharmacy expenses are generated and have not been paid. The effective date of eligibility will be within the three (3) months prior to the month in which the prospective member submits the application. If the prospective member is eligible for Federal Medicaid or CHIP coverage in the month the service was eligible, the prospective member will receive retroactive eligibility. Retroactive benefit does not apply to Commonwealth covered beneficiaries. Retroactive eligibility is evaluated for all potential members with Federal Medicaid and CHIP coverage who notify the Puerto Rico Medicaid Office about their medical expenses and / or utilization of services during the allowed period of three (3) months. Please note that a prospective member may be classified as a Commonwealth covered member for their current eligibility period but may be classified as a federal member for any of the retroactive eligibility periods. The Puerto Rico Medicaid Office will evaluate each retroactive month separately what may result, with different coverage codes or eligibility classifications from one retroactive month to another.

When an Enrollee re-certification is filed, and the Enrollee is again eligible, as determined by the Puerto Rico 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 Puerto Rico 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 can apply for Federal Medicaid / CHIP coverage on behalf of a person who has died, during the same month they applied or up to three (3) months retroactively if the person was eligible in those months. The eligibility period will be from the first (1st) day of the application month to the date of death. This provision does not apply to Commonwealth covered beneficiaries.

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All pregnant women with federal, Commonwealth and CHIP coverage may have an eligibility period greater than twelve (12) months by 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. Commonwealth Enrollees (Commonwealth Category Beneficiaries)

The Commonwealth effective date of eligibility (see contract section 1.3.1.2.1) is the eligibility period specified on the decision notification form, and potential members are eligible to enroll as of that date. Note that a potential member may be classified as a Commonwealth covered member for their current eligibility period but may be classified as a federally covered member for any of the retroactive eligibility periods. The Puerto Rico Medicaid Office will evaluate each retroactive month separately what may result, with different coverage codes or eligibility classifications from one retroactive month to another.

Recertification for members of Commonwealth coverage, in which the member is re-eligible, the effective date of eligibility is the first (1st) day of the month after the expiration of current eligibility. The certification date for beneficiaries of coverage in Commonwealth will be when the certification is completed. If a Commonwealth coverage member's eligibility period expires prior to recertification, the Commonwealth coverage member's eligibility will be processed as a new case and the eligibility effective date will be the new eligibility effective date provided on the form. Notice of Decision. The member of Commonwealth coverage can request a Carrier at the Puerto Rico Medicaid Office for the new period of eligibility at the time of certification.

All pregnant women on Federal, CHIP and Commonwealth coverage may have an eligibility period greater than twelve (12) months by 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.

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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 Federal at the time of birth	Federally Evaluated	Federal/CHIP	Retroactive Eligibility from the date of birth or from 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 Commonwealth or Evaluated and determined to be Commonwealth 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
		Commonwealth	Eligible from the Effective Date of Eligibility as noted on Form NOTICE OF DECISION

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

In the event the mother is not currently eligible, but is assessed and found to have federal coverage at the time of the newborn's birth, the newborn's federal eligibility will be assessed and could be classified as federal, which would provide retroactive eligibility from the date of birth or three (3)

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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 ineligible or has Commonwealth or assessed coverage and is determined to be Commonwealth coverage at the time of birth, the child will be independently assessed. If the child's evaluation results in a federally covered classification, eligibility will be granted retroactive from the date of birth or for three (3) months, whichever begins later. If the result is state-funded enrollment in the program, the child will be granted eligibility as of 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 Puerto Rico 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 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 Carrier. 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		

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2. Group of Records of Retroactive Periods

Each retroactive eligibility period involves a group of records. This information is sent to the Carrier daily 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 Carriers 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 a member, two (2) or three (3) months prior to the expiration date of eligibility, the member will undergo a recertification process, for a new period of eligibility, which will be carried out by the Puerto Rico Medicaid Office. This will allow for the renewal of covered services during the next twelve (12) month period. The effective date of recertification refers to the date that the Puerto Rico Medicaid Office reevaluates the eligibility of an enrollee. This date is provided on the decision notification form. The Eligibility Expiration Date refers to the expiration date of the eligibility period granted to the member by the Puerto Rico Medicaid Office. A federal and Commonwealth covered member who is recertified will have their current eligibility period noted and will have a future Eligibility Effective Date in the Decision Notice for their next eligibility period beginning the day after the period expires. current eligibility.

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G. Termination of Eligibility (Eligibility Cancellations)

Only the Puerto Rico 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 Puerto Rico Medicaid Office and will be reflected in the ASES databases on the last day of each month.

Daily, ASES receives from Puerto Rico Medicaid Office a file with the eligibility status of the beneficiaries. In such cases, ASES will send to the Carriers 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 Puerto Rico 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. Now 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.

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H. Appeals Processes

1. Appeals Process for Re-Certification

When an enrollee does not qualify during their recertification process, they have the right to appeal the negative redetermination of their eligibility within fifteen (15) days. If a member previously eligible for Federal Medicaid or CHIP coverage appeals within fifteen (15) days of an adverse eligibility determination, the content "A" (On appeal) or "X" will be sent to the Insurance Carrier in the field. Extension flag. The member cannot be canceled during the appeals process even if the expiration date passes. When the appeal process is complete, the Puerto Rico Medicaid Office will send an update of the member's status to ASES. If the appeal is filed after the first fifteen (15) calendar days after the adverse eligibility determination, an extension will not be issued. In this case, a cancellation will be received from the Puerto Rico Medicaid Office.

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 Puerto Rico 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 Carrier 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 Puerto Rico Medicaid Office. Only Puerto Rico Medicaid Office may cancel an enrollee. The cancellation's effective date will reflect the date that Puerto Rico Medicaid Office 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 Carrier 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 Puerto Rico Medicaid Office 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 Puerto Rico Medicaid Office process. The Puerto Rico Medicaid Office will not send to ASES records of these processes unless the appeal is decided in the person's favor. For beneficiaries eligible for Federal Medicaid or CHIP coverage, a set 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 have passed, the Carrier will treat the enrollment as an emergency (special enrollment = "E"). For these cases, the Puerto Rico Medicaid Office will not send retroactive eligibility in separate transactions. In the event the person is certified as a state funded state affiliate, the date of eligibility after a favorable appeal will be prospective from the date of the favorable determination.

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I. Eligibility Extensions

When the Puerto Rico Medicaid Office grants an extension of eligibility, the date the extension expires is included in the Medicaid Cancellation Date field in the family eligibility table. For these cases, the Eligibility Expiration Date field is not updated as it encompasses the end of the original eligibility period granted by the Puerto Rico Medicaid Office prior to 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 Puerto Rico 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 Puerto Rico 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. If any additional circumstance occurs, in addition to those mentioned above in this document, that requires a determination, it will be made by the Puerto Rico Medicaid Office of the Department of Health, to extend the eligibility of the affected population. The extension of eligibility for other circumstances grants the extension period approved by CMS to the affected member. These cases will be labeled with the letter "X" in the Extension flag field. The PRMP will send ASES an update transaction on the appropriate date. The expected expiration date of the granted extension will be kept in the Medicaid Termination Date field. The effective date of eligibility and expiration date will not change due to the extension granted. An example of a circumstance in recent years is the COVID19 pandemic.

4. 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.

5. 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
X – Other circumstances extension

6. 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.

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IV. ENROLLMENT IN GHP CARRIERS

A. General Enrollment Requirements

The Carrier must coordinate with ASES, the Puerto Rico 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 Carrier must guarantee the maintenance, functionality, and reliability of all systems necessary for Enrollment and Disenrollment, pursuant to the Contract and this Manual.

B. 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 Notice of Decision set forth in Section 5.2.6 of the Contract.

The effective date of enrollment for a newborn whose mother is eligible for Federal Medicaid or CHIP coverage on the date of delivery (considered a newborn) is the date of their birth. The Effective Date of Enrollment for a newborn whose mother is an Affiliate of the Commonwealth coverage is the Effective Date of Eligibility established by the Puerto Rico Medicaid Program. A newborn will be automatically enrolled in accordance with the procedures established 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).

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C. Term of Enrollment

The Term of Enrollment with the Carrier shall be a period of twelve (12) consecutive months for all GHP Enrollees, unless a different Carrier 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 Federal Medicaid or CHIP Eligible or a member of the coverage Commonwealth, 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 Carrier until the occurrence of an event listed in Section 5.3 of the Contract (Disenrollment).

D. Carrier Notification Procedures Related to Redetermination

The Carrier must inform Enrollees who are Federal Medicaid and CHIP Eligible and coverage Commonwealth 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.

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E. Enrollment Procedures

For all Enrollees except Newborns, the Carrier 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 Carrier. The Carrier 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 Carrier 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 Carrier.

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

F. Enrollee Selection of Carrier

1. Open Enrollment Period for New Enrollees

New Enrollees to the GHP will have the opportunity to select a Carrier during the Medicaid eligibility process with the Puerto Rico Medicaid Program. If the New Enrollee does not select a Carrier, the Puerto Rico Medicaid Program will select a Carrier 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 Carrier once without cause, regardless of how the initial selection of the Carrier 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.

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2. Annual Open Enrollment Periods

Each year, the GHP offers members an annual open enrollment period. The annual open enrollment period is forty-five days from November 1 to December 15. All enrollees will have the opportunity to select a Carrier for no reason during the annual open enrollment period. If the member does not make an insurance change during the annual open enrollment period, the member will remain enrolled with their current Carrier.

During each Annual Open Enrollment Period, all enrollees will have one (1) opportunity to change Carriers for no reason during their Annual Open Enrollment Period. If a New Affiliate's Open Enrollment Period in accordance with Section 5.2.5.2 of the Agreement coincides with the Annual Open Enrollment Period, the Open Enrollment Period in Section 5.2.5.2 will prevail.

When an enrollee ceases to be part of the domestic violence or foster care population but remains an eligible individual, the enrollee can select a new Carrier during an open enrollment period.

When an enrollee is no longer eligible for Medicare Platino but remains an eligible individual, the enrollee can select a new Carrier during an open enrollment period and must follow the due process processes outlined in section 5.3.5.4 of the contract.

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Figure 1 Illustration of Initial Auto Enrollment Operations

Illustration of Initial Auto Enrollment Operations

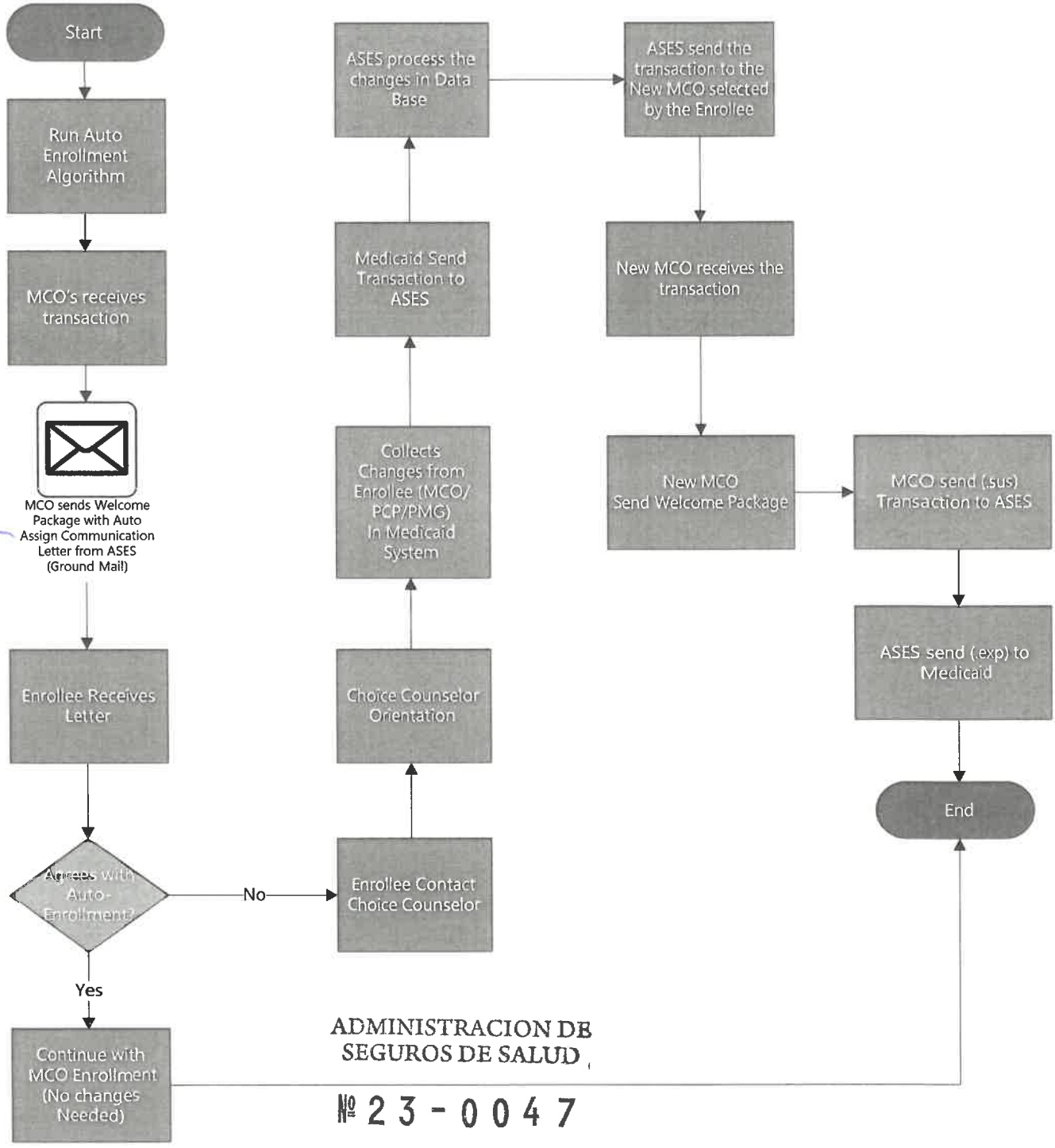

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Figure 2 Illustration of New Enrollee Enrollment Operations

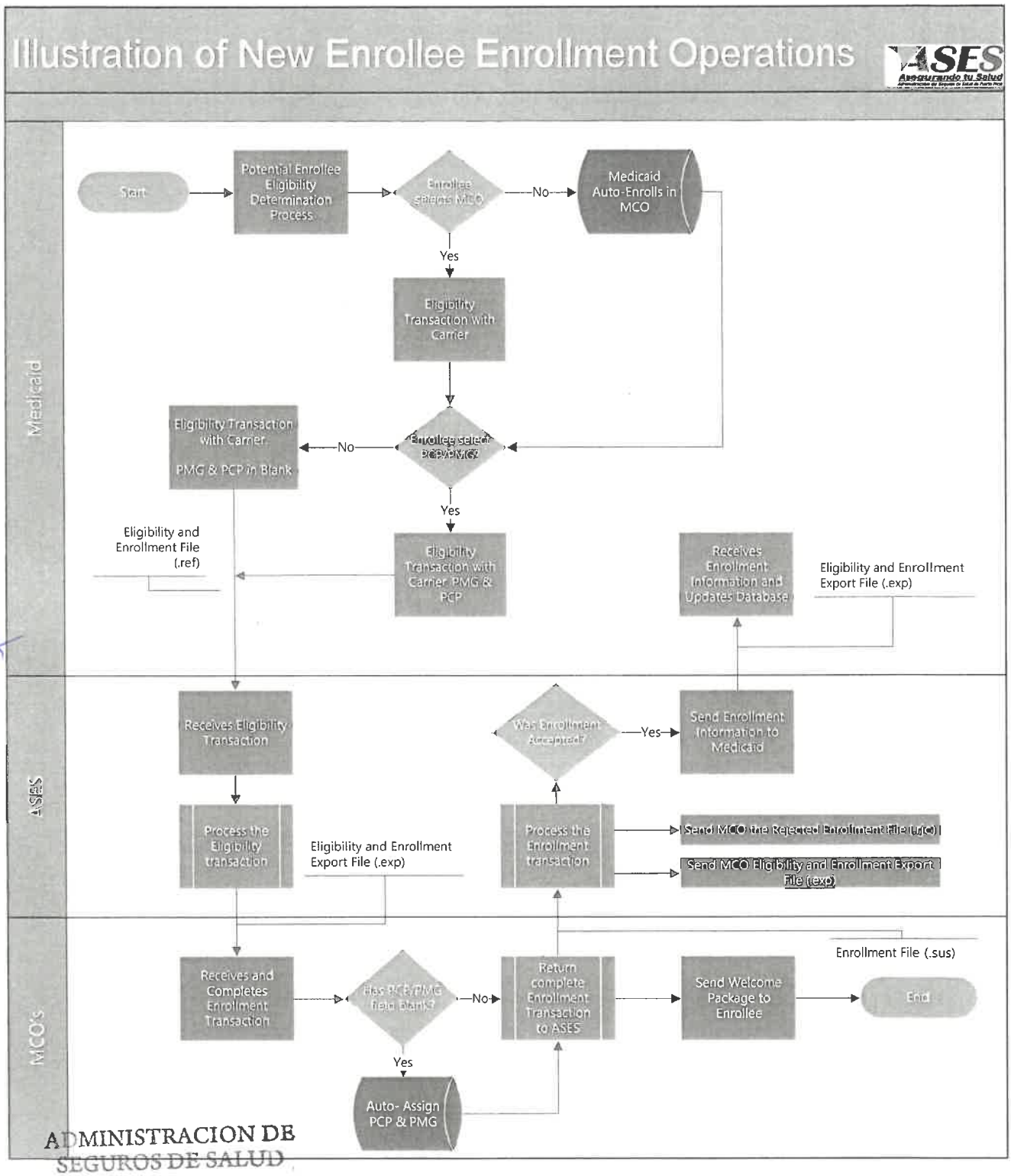

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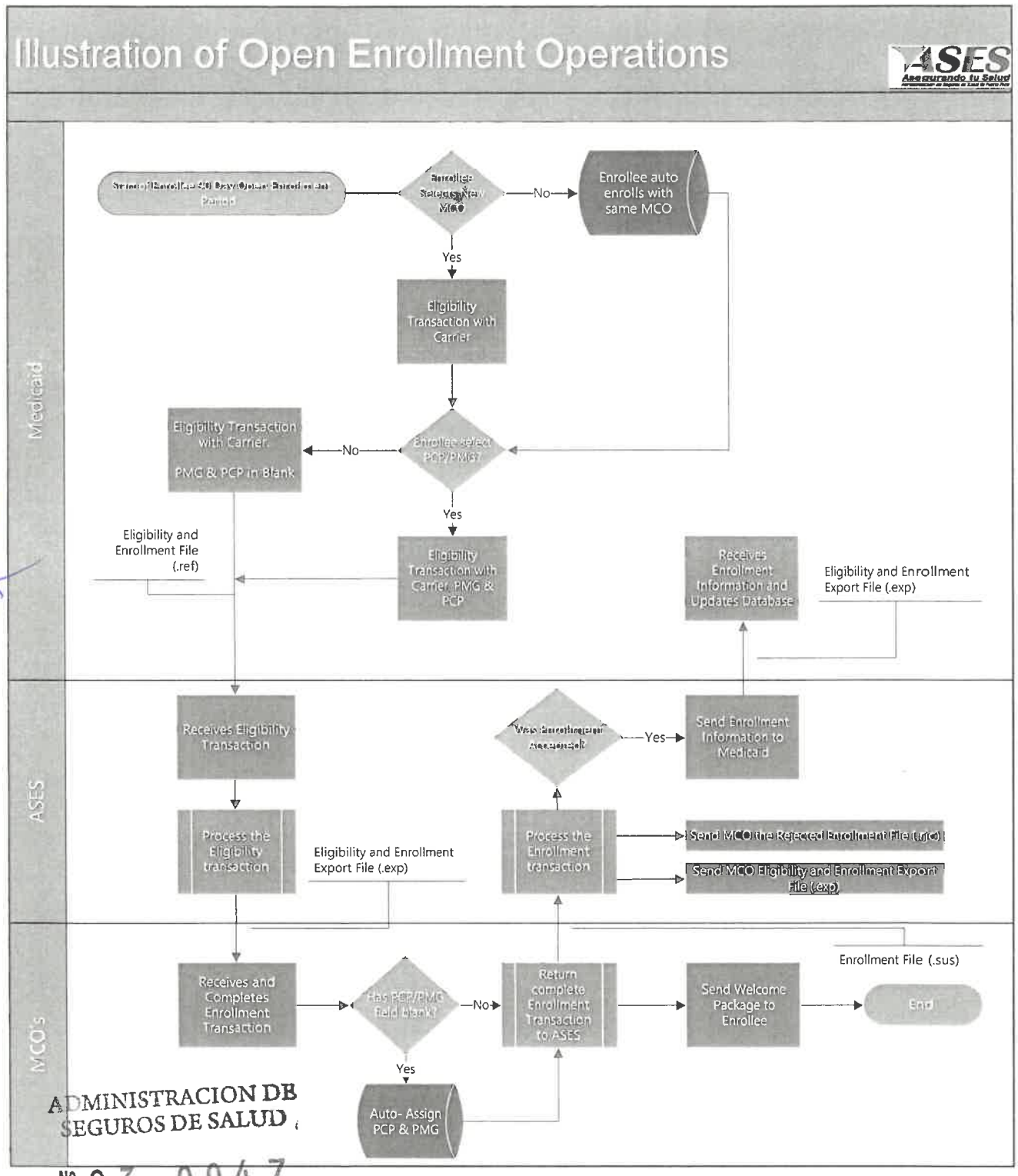
Figure 3 Illustration of Open Enrollment Operations



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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 Carrier enrollment. It is at the Enrollee's option to receive the services of the Enrollment Counselor. If any Enrollee actively selects a Carrier during the applicable Open Enrollment Period (or at point of eligibility application for New Enrollees), the Enrollment Counselor will record the selected Carrier 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 Carrier, PMG, and PCP. New Enrollees and re-certified Enrollees will be able to select a Carrier considering the availability of an enrollment spot within the capacity of each Carrier and available PCPs. The Effective Date of Enrollment of the Carrier, 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 Puerto Rico 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 Carrier, PCP and PMG.

VI. DATA EXCHANGE BETWEEN MEDICAID, ASES AND CARRIERS

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

A. Data Exchange Between Medicaid, ASES and the Carriers

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 Carrier and the Puerto Rico 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 Carrier selection or auto enrollment.

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2. ASES and the Carriers 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 Carrier data of each enrollee, ASES creates an electronic record that includes information which the Carrier can use to enroll the enrollee, such as information about the Plan Type (Federal or Commonwealth) and Plan Version (coverage code) along with their respective effective dates and other related data elements. Daily, ASES sends accepted enrollments, new eligibility, updates, and cancellations data to Carriers in a file (.exp)

Following receipt of the Carrier's file, the Carrier 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 MCO, PCP or PMG. Then, the Carrier produces the electronic registration record and sends it to ASES in a file (.sus), along with a paperwork, where it identifies the name of the file, the number of records submitted via FTP Server on or before nine o'clock. the morning (9:00 am), this accounts for the registrations to be considered. If the member's Coverage Code, PCP or PMG changes, the Carrier must send an enrollment record to ASES that reflects the change as confirmation of the issuance of a new plan identification card and its shipment to the member.

Generally, Carriers 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 Carrier is received with a different Carrier code than the one for the Carrier receiving the data, it means that the enrollee has been enrolled with a different Carrier. In this case, the previous Carrier 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 Carriers. The Tran_ID value for these transactions will be "E".

In the case that the Carrier must 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

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Enrollment indicated in the Carrier'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 Carrier with the applicable reject codes in a file (.rjc) daily. The Carrier 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 Carrier sends the corrected enrollment records within the timeframe specified no later than two (2) business days past the date on which ASES notifies the Carrier of the rejected subscriptions, after which the Carrier 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 payment process, registrations received during the month prior to the execution of the process are considered. The Carrier must make sure to complete the reconciliation of beneficiaries, every month, receiving the file and report via FTP Server where the details of the non-subscribed beneficiaries are identified.

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

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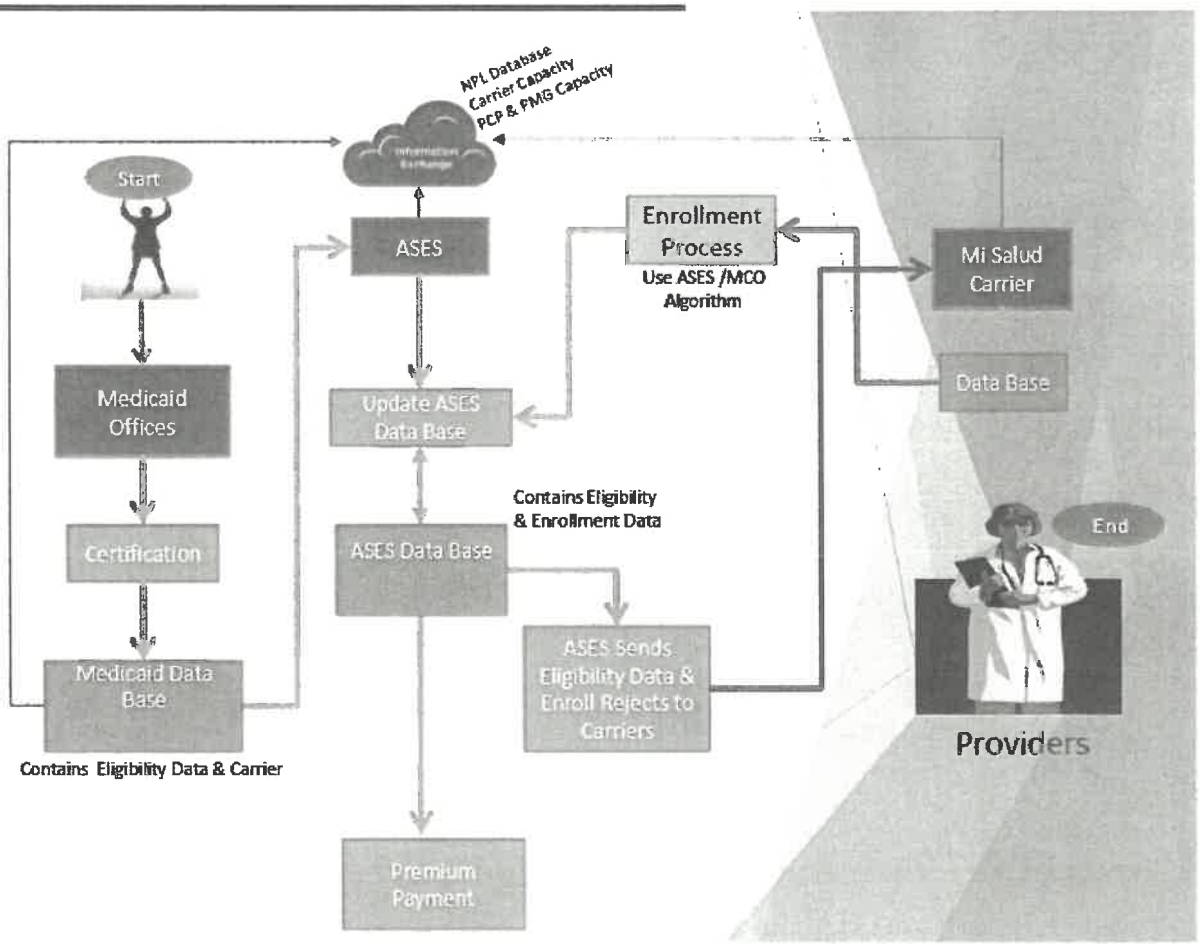
Figure 4 Medicaid/ASES/Carriers Data Flow



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B. Enrollment Files

ENROLLMENT FILE [CCYYMMDD.sus]
a. CC = Carrier 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 Carrier.
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 = Carrier 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= Carrier Code
b. YY = Year
c. MM = Month
d. DD = Day
e. rjc= Indicates that it is a file containing the records of the beneficiaries who have been rejected.
Notes: ASES will continue to run a separate edition and update cycle for each region. Enrollments are filtered through various editing and verification programs and identified as valid or rejected. This process produces a file (.rjc) that contains all the records that are rejected. See File Layout Attachment – Rejected Enrollment (.rjc) Note the (.rjc) and (.sus) share the same layout structure.

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C. GHP Enrollment

For an enrollment record to be accepted during the editing and validation processes, it is important to consider the following considerations regarding concepts related to the enrollment processes:

1. Effective Date of Enrollment

a. The Carrier 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 Carrier, the Carrier 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 Carrier and it will be responsible of indicating the PCP2 Effective Date in the enrollment record. It is under consideration if during Carrier 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.

1. 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 Carrier 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.

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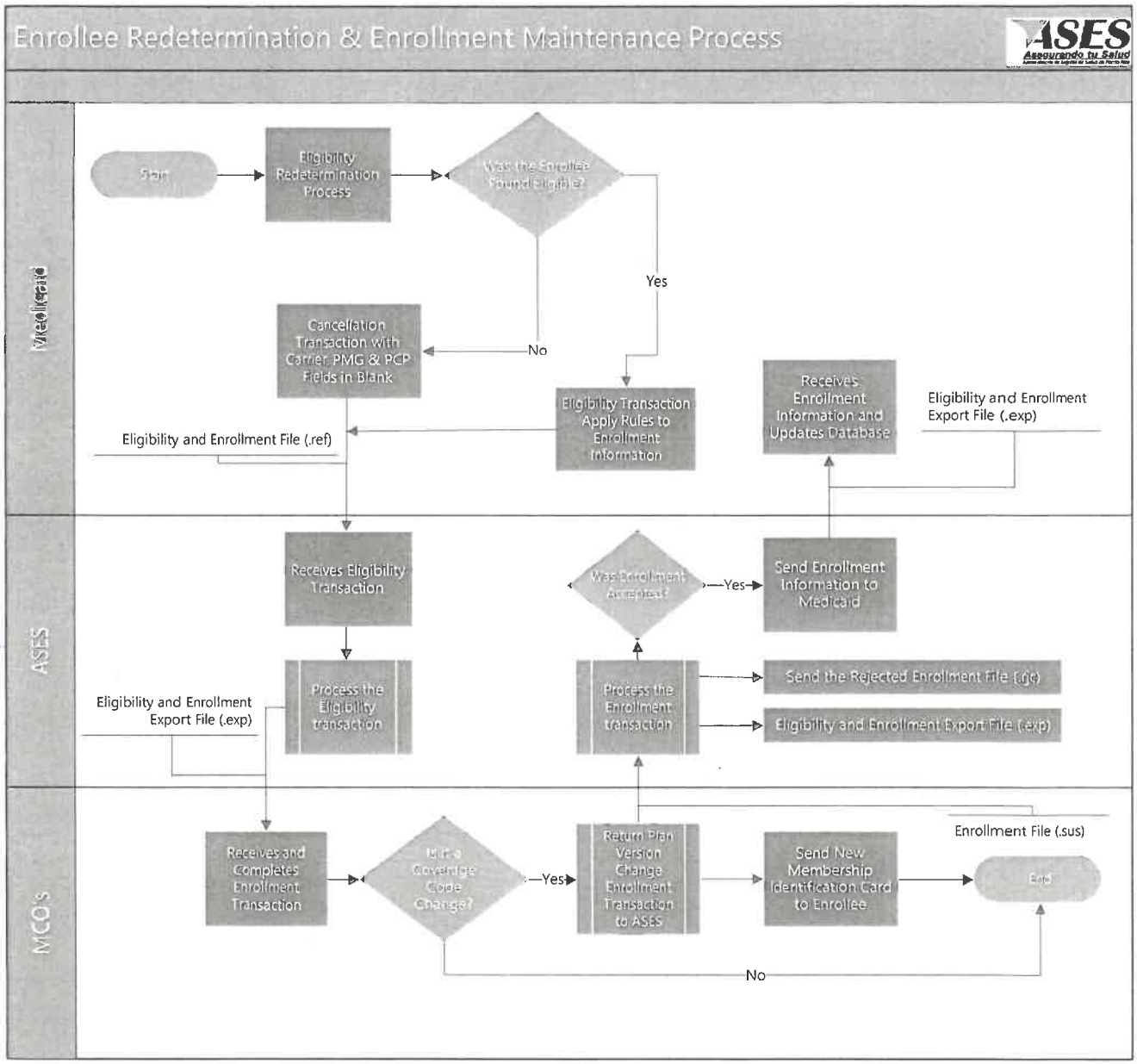
Figure 5 Enrollee Recertification & Enrollment Maintenance



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2. 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 Carrier enrollment records (.sus) corresponds to the date in which the Carrier issued the enrollee's healthcare insurance identification card.

VII. 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), must 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.

VIII. 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 Carrier'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.

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IX. Enrollment Record

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The enrollment record that is used by Carriers 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 Carrier's confirmation and guarantee that the enrollee has been successfully enrolled in the Carrier 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". Now 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.

X. Enrollment Record Fields

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

a. **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.

b.**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:

c. **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.

Plan Version Change. For MCOs, this transaction code is also used when an enrollee's coverage code in the GHP changes since at the time the coverage change is identified the beneficiary is disenrolled in ASES by blanking the *card_id_date* field. Therefore, the system identifies it as a new subscription. In these cases, the Carrier must reissue a health plan ID card showing the new benefits and submit a version change enrollment record to ASES where the version number must match the new coverage code. This transaction confirms that the new insurance card was sent to the enrollee. If such information is not sent to ASES, the enrollee will remain disenrolled from the Carrier. While in these circumstances the enrollee remains eligible to receive medical services, the Carrier will remain unable to

claim premium payment for the enrollee until the required information is submitted and accepted for validation.

b. **C** = Carrier Change. Used when the enrollee has selected a different Carrier 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 Carrier different than that arising from the ASES database or by the same Carrier if it must make a change on a previous enrollment.

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

Initially the PCP/PMG will be assigned to the enrollee by the Medicaid office, ASES or the Carrier according to the enrollee's zip code (physical address) and the enrollment capacity of the PCP/PMG. If the daily files (.exp) arrived at the Carrier without a PCP/PMG assigned the Carrier 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.

d. **1 = PCP1 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP1 under the same Carrier, 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.

e. **2 = PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP2 under the same Carrier, 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.

f. **3 = PCP1 and PCP2 change.** It is used to register, in ASES, a change in the beneficiaries' requested PCP1 and PCP2 under the same Carrier, 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.

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.

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Table 3: Hierarchy Table

TRAN ID	CARRIER	Plan Version	Primary Center	PCP1	PCP2
E -New Enrollment	Must be **the same** as in ASES DB	Y	Y	Y	O
C -Change Carrier	Must be **different** from ASES DB	Y	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

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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 PRMP. The PCP/PMG will be assigned by Contractor. 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 Carrier ("C"): The system will require registering the name of the new Carrier 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 ("E"): The plan version change is no longer used ("V"). When there is a change of coverage code, therefore of plan version, the card id date will be blanked, and the contractor will have to send a subscription as if it were a new one to be registered as a subscriber.

(D) Primary Medical Group Change ("I"): Information regarding the Carrier, 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 Carrier, 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.

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

4. **CARRIER (carrier)** –Two-digit Carrier code assigned by ASES to each of the Carriers with the purpose of identification.

5. **MEMBER_PRIMARY_CENTER** – PMG code.

6. **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 Carriers 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. "01" is used for GHP and "02" for Platino

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 Puerto Rico Medicaid Office's databases.

14. **PCP1-** NPI Number. It is used to identify the PCP1 assign or selected by the beneficiaries. If a new beneficiary, the MCO assigns the PCP and PMG. If the transaction is for a change of carrier, the new MCO must maintain the enrollee in the PCP and PMG selected in the change of carrier process with the Enrollment Counselor.

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.

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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** – This field is not currently in use.

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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** – This field is not currently 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 Carrier. It should be the number by which the member is identified in the Carriers' 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 Puerto Rico 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 Carrier 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 Carrier, 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 Carrier, 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 (Carrier, Plan Type, Plan Version, PMG, and PCP) are updated directly in the enrollee's historical record.

Identifier = "T"
It identifies a successfully processed retroactive monthly enrollment (1,2,3).

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) – See Addendum 2 Error Codes Table.**

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 Carrier.

Note:
It is up to the Carriers 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).

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XI. 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 Carriers in a file (.rjc) that includes error codes for records that have not successfully passed the validation process. Carriers 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 in **Addendum 2**.

XII. Rejected Enrollment Management

The daily process of Carriers 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 Addendum 2 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 Puerto Rico Medicaid Office determines that an enrollee is no longer eligible for GHP.

A GHP disenrollment occurs when the Puerto Rico 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 Puerto Rico Medicaid Office has expired and other reasons specified in Table 5 below:

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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 Carrier of the cancellation. Such notification shall be effectuated by means of a daily transfer of the daily process Export (.exp) files to the Carrier 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.

B. GHP Disenrollment Effective Date

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

The effective date of such cancellations will be determined by the Puerto Rico 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. CARRIER DISENROLLMENT

A. 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.

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An Enrollee wishing to make a change of carrier should contact the Enrollment Counselor. The enrollment counselor sends ASES the change notification and ASES notifies the new Carrier and the previous Carrier. This change of carrier outside of the Open Enrollment Period must be justified.

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

Transition of Care Process (TOC)

In these case in which the Enrollee changes Carriers, the Carrier that loses the Enrollee will be required to complete the Transition of Care information. It must be completed monthly. The layouts and SOP of this process that included in **Addendum 7.**

In addition, ASES will send to the new Carrier the historical claims/encounters of enrollee. El layout of historical claims is in **Addendum 7**.

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

B. 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 Puerto Rico Medicaid Office has sent a change of coverage code for an Enrollee and the Carrier has not submitted an enrollment with the new plan version related to the change of coverage. During this process the Card Issue Date field is left blank, but the enrollee keeps being eligible and enrolled with the Carrier.

Although in cases of Temporary Payment Suspension the eligibility period will continue for the beneficiaries on behalf of whom the PRMP 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. CARRIERS RESPONSIBILITIES IN THE ENROLLMENT PROCESS

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

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Table 6: Enrollment Transaction Carriers Responsibilities

Change or Modification	Action Required
1. Transfer of Daily Eligibility Files.	Daily Update of Eligibility Files in the Carrier's databases.
2. New Enrollments.	GHP Carriers 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. Carrier Change.	When an enrollee requests a Carrier change through Puerto Rico Medicaid Office, ASES or the Counselor, the ASES system will produce update record containing the new Carrier and that record will be sent to both the new and the previous Carrier. The previous Carrier should disaffiliate the member in its databases, and the new Carrier 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 Carrier'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 Carrier
5. Change in the demographic data of an enrollee. This information is received from the Puerto Rico Medicaid Office but does not cause a change in the enrollment.	The Carrier must update the enrollee's record with the new data in its database. If the enrollee informs the Carrier of an address and/or phone change, a recommendation should be made to the enrollee to notify of the change to the PRMP to keep the data up to date.
6. Rejected Records	Correct the rejected records and resend them to ASES within the time indicated by the contract in section 5.3.10
7. Cancellation of Enrollee: Only the Puerto Rico Medicaid Office may cancel the eligibility of an enrollee, having the effect that until such notice of Puerto Rico Medicaid Office is received the enrollee will remain active in the databases of both ASES and the Carriers even when the period of eligibility granted has expired.	Identify the cases of beneficiaries with canceled or denied coverage and act about these, as they are the only beneficiaries to whom services may be denied.

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8. Temporary Suspension	Carriers should identify when a record received has a different coverage code than is recorded in their databases. In these cases, Carriers 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 suspended from premium payments (blanks will be included in the Card Issue Date field) until corrected, subject to Section 5.3.10.

Check addendum 2, the changes to be considered as of December 1, 2022, and January 2023

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 Carriers is calculated using the Member Assigned Rate Cell ID as described in Addendum 4 below according to the beneficiaries that are enrolled in the ASES databases.

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.

As a result of actuarial studies, each rate cell has a premium assigned to it.

Premium payments will be made on the first day of the month following the acceptance of the enrollment record by ASES. The premium to pay is based on rate cell assign. 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:

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A. Types of Payments

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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 coverage the first premium payment is effectuated for the entire month in which the enrollee is eligible.

However, prorated payments are generated for all the beneficiaries that Puerto Rico Medicaid Office 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 Puerto Rico Medicaid Office. Also, newborns that are not classified as deemed newborns and that are evaluated as any other federal coverage will have prorated payments for the first month from the date of birth.

Other reason for prorate payment is 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 Carrier's cancellation of a previous enrollment or Carrier change.

Premiums are paid retroactively when a Carrier 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 PRMP. 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 Puerto Rico 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 Carrier in the enrollment record with the letter 'E' in the special_enroll field.

Correction of Enrollment Errors: these are the cases in which the Carriers must 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

Prorated retroactive payments are calculated considering the cases in which the Enrollment Effective Date falls in the first month considered for a retroactive payment. These are partial payments for the first month of the beneficiaries' eligibility period. These types of payments are used for beneficiaries with Commonwealth coverage funded by the GHP, considered newborns.

5. Adjustments

A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a Carrier 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 affected under a Carrier change or Plan Version change. The adjustments are calculated for those cases where an enrollee changes Carrier and the Carrier executed a late enrollment after ASES had disbursed payment to the first Carrier in a previous payment transaction. In these cases, an adjustment of premium paid to the first Carrier is made.

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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. Other adjustments that can be made as part of the premium payment process are changes of rate cells and process reconciliation (**See Objection of Payment Process (OTP) on Addendum 4**). The adjustment codes are included in the 820 files.

Table 8: Adjustment type Table

Adjustment Code	Adjustment Description
1	Duplicate Pay
2	Deceased
4	COB
5	Rate Adjustment
6	Reverse Adjustment
7	Fix Rate
8	Full Month Adjustment
9	Newborn
10	Ineligible
11	Special Reconciliation
12	Rate Cell
13	Maternity Kick Payment
14	Reconciliation Vital

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B. ASES Reasons for not Executing a Premium Payment

A premium payment will not be executed in favor of a Carrier 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 Carrier 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 Carrier.
(4) If for late enrollment.

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C. EDI 820 Payment File

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The reconciliation process carried out between ASES and the Carriers in relation to the payment of premiums must consider the content of the EDI 820 files. This file is produced monthly by region, Carrier, and Plan Type. It includes details of the types of payment that correspond to each of the beneficiaries assigned to the Carriers contracted for the month in question. Refer to **Addendum 3, *.820 Premium Payment 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 Carrier. The file name is described below.

Maternity Payments are included in this file.

Premium Payment Transactions [PCC0YYMM0000.820]
a. P = Identify Premium Payment
b. CC = Carrier code
c. 99 = plan type (Reform 01, Platino 02)
d. YY = Year
e. MM = Month
f. 0000 = IPA Direct Contract
g. .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 Puerto Rico Medicaid Office.

At any time, the status of the Enrollee may change. If the Enrollee's status changes before a Carrier 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 since the payment system does not make premium payments for beneficiaries who are not enrolled now 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 Carrier, the first

Carrier will be prevented, during the validation phase of the system, from enrolling the enrollee in a period before the cancellation or the enrollment from the second Carrier. 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

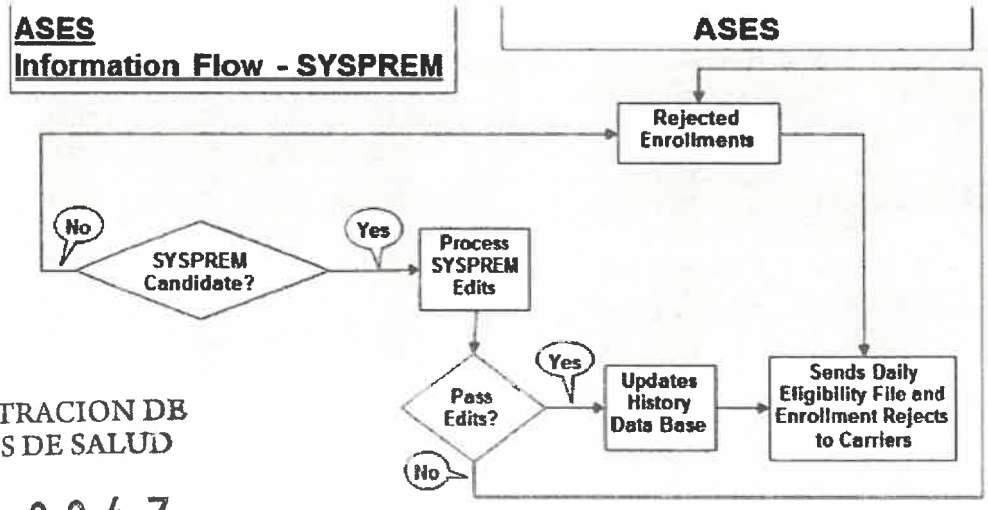
Among the main functions of this system is the identification of enrollment records that are candidates for processing in historical data because they are enrollments that do not correspond to a current period of eligibility or current status.

B. Carriers Eligibility File

The Carrier'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. Carriers 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 Carrier 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



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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 Carrier,
(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

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

Table 9: Secondary Error Codes for SYSPREM

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

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 Carrier 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 Carrier. Carriers need to evaluate the cases rejected by SYSPREM in

order to identify errors in the assigned Effective Date and the correctness of the beneficiaries' data included in the enrollment record.

Check addendum 2 the changes to be considered as of December 1, 2022, and January 2023

ADDENDUM

1. Notice of Decision
2. Enrollment Record File
3. *.820 Premium Payment File Layout
4. MCO Objection of Payments
5. CARRIER to ASES ver 4.1C_rev.20220912
6. Coordination Of Benefits (COB)
7. Transition Of Care
8. EFT Folder Organization Insurance Carrier

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XIII. APPROVALS

Revision Sheet

Date: 12/01/2022

Winda J. Lorenzo González
Oficial Principal de Informática, Interina

ADDENDUM 1

Notice of Decision

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GOBIERNO DE PUERTO RICO
Departamento de Salud
Programa Medicaid

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

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

Jerry Rosas Mcquire
737 Main Street
San Juan, PR 00901

Notificación de Decisión - Solicitud de Beneficios Médicos

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

Resumen de Decisiones de Elegibilidad

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

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

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

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

Cómo Tomamos Nuestras Decisiones de Elegibilidad

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

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

Uso de Su Cubierta de Beneficios Médicos

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

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

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

Servicios y Costos de Salud

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

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

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

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

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

Debe Reportar Cambios

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

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

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

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

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

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

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

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

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

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

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

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

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

Siempre mantendremos su información segura y privada.

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ADDENDUM 2

Enrollment Record File

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Service Type	Service	Cost Sharing By Coverage Code											Effective Period	
		100	110	120	130	220	230	300	310	320	330	400	Start *****	End
Hospital	Admissions	$0	$4	$5	$8	$0	$0	$15	$15	$15	$20	$50	2016/07/01	
Hospital	Nursery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Emergency Room	Emergency Room (ER) Visit	$0	$0	$0	$0	$0	$0	$2	$10	$15	$20	$20	2016/07/01	
Emergency Room	Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)	$0	$4	$5	$8	$0	$0	$20	$20	$25	$30	$20	2016/07/01	
Emergency Room	Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)	$0	$2	$3	$4	$0	$0	$20	$20	$25	$30	$20	2016/07/01	
Emergency Room	Trauma	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Ambulatory	Primary Care Physician (PCP) (per visit)	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$3	2016/07/01	
Ambulatory	Specialist (per visit)	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$7	2016/07/01	
Ambulatory	Sub-Specialist (per visit)	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$10	2016/07/01	
Ambulatory	Pre-natal services (per visit)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Other Services	High-Tech Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%	2016/07/01	
Other Services	Clinical Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%	2016/07/01	
Other Services	X-Rays**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%	2016/07/01	
Other Services	Special Diagnostic Tests**	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	40%	2016/07/01	
Other Services	Therapy – Physical	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5	2016/07/01	
Other Services	Therapy – Respiratory	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5	2016/07/01	
Other Services	Therapy – Occupational	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5	2016/07/01	
Other Services	Vaccines	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Other Services	Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Dental	Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	2016/07/01	
Dental	Preventive (Adult)	$0	$1	$1.50	$2	$0	$0	$2	$2	$3	$5	$3	2016/07/01	
Dental	Restorative	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	$10	2016/07/01	
Pharmacy	Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5	2016/07/01	
Pharmacy	Preferred (Adult)****	$0	$1	$2	$3	N/A	N/A	$3	$3	$5	$5	$5	2016/07/01	
Pharmacy	Non-Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10	2016/07/01	
Pharmacy	Non-Preferred (Adult)****	$0	$3	$4	$6	N/A	N/A	$8	$8	$10	$10	$10	2016/07/01	

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Reason Code	Reason for Disenrollment	Effective Date of Disenrollment
03	Death of Enrollee	First day of the month after death
04	CMS rejected Medicare Advantage Enrollment (Platino)	There are conditions in particular that CMS may reject a subscription submitted by the MAO. In this case, ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO.
05	Member enrollment was found to be an error	If the subscriber is not the correct person, the date of effectiveness is not correct and other possible errors then ASES will take the following action: If the member was in an MCO, it will be returned to the same MCO. If the member was subscribed to another MAO, the previous MAO must resubmit the subscription that corresponds to the effective date of the subscription of the MAO is disenrollment from.
06	Platino Enrollee lost Medicare Part A and/or Part B	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO and assign an MCO with the round robin method.
07	Member voluntary request terminatino (Platino)	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO.
08	Carrier requested termination (following contract prodecures)	
09	Incarceration	First day of the month after incarceration
10	Enrollee enters or stated in a residential institution under circumstances which rendered the individual ineligible for enrollment in Medicare Advantage, including when an Enrollee is admitted to the hospital that 1) is certified by Medicare as a long-term care hospital and 2) has a average stay for all patients greater than ninety-five (95) days.	First day of the month after following entry or first day of the month following classification of the stay as permanent, subsequent to entry.
11	Individual enrolled while ineligible for enrollment	Effective Date of Enrollment in the Contractor's Plan.
12	(PR) – Enrollee moved outside of Puerto Rico	First day of the month after the update of the system with the new address. ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO. PRMP must proceed to cancel the member.
13	Change to another MAO	ASES will proceed to disenroll the member and stop premium payments as of the effective date indicated by the reporting MAO. The new MAO must submit the subscription as soon as possible and by the appropriate effective date.

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

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

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

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E	19	PMG Effective Date	1	№ 23-0047 Contrato Número		Effective start date of the PMG assigned to the insured member. For Platino carriers, fill with blanks if no PMG has been assigned to the member. Format: MMDDCCYY CCYY - Century and Year MM - Month DD - day This is optional for Platino carriers	
E	20	Primary Care Change Reason	124	2	14,22,46,A4,AB,AC, AD,AE,AF,AG,AH,AI, AJ	14 - Voluntary Withdrawal 22 - Plan Change 46 - Current Customer Information File in Error A4 - Dissatisfaction with Office Staff AB - Dissatisfaction with Medical Care/Services Rendered AC - Inconvenient Office Location AD - Dissatisfaction with Office Hours AE - Unable to Schedule Appointments in a Timely Manner AF - Dissatisfaction with Physician's Referral Policy AG - Less Respect and Attention Time Given thatn to other Patients AH - Patiente Move to a New Location AI - No Reason Given AJ - Appointment Times not Met in a Timely Manner If None of the specific Maintenance reasons apply, send 'AI' No Reason Given	Change Reasons Added
E	21	FILLER	126	1		Filler	Change to filler as it is submitted in the Insurance Record
E	22	MBI	127	12		Member's current Medicare Beneficiary Identifier (MBI) Fill with blanks if member is not known to have Medicare coverage	
E	23	FILLER	139	1		Fill with blanks	
E	24	PCP Authorization Token	140	14		Fill with blanks For future use: Token received by the Carrier from ASES authorizing the PCP assignment to the insured member. This is used to maintain PCP's cap for assigned members The PCP Confirmation Code is obtained using a reservation system impemented as a webservice by ASES. It also validates the PCP NPI number is valid. Format: YYYYMMDD999999, ASES provided value	
E	25	FILLER	154	3		Fill with blanks	
E	26	FILLER	157	3		Fill with blanks	
E	27	FILLER	160	3		Fill with blanks	
E	28	FILLER	163	3		Fill with blanks	
E	29	FILLER	166	3		Fill with blanks	
E	30	FILLER	169	3		Fill with blanks	
E	31	FILLER	172	3		Fill with blanks	
E	32	FILLER	175	3		Fill with blanks	
E	33	FILLER	178	3		Fill with blanks	
E	34	FILLER	181	3		Fill with blanks	
E	35	FILLER	184	8		Fill with blanks	
E	36	Policy Number	192	13		Member's Policy Number (also known as Contract Number) assigned by the Insurance carrier	Change Field Id and Position

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

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

ADMINISTRACION DE
SEGUROS DE SALUD

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Contrato Número

Municipality Code	Municipality Name	Region Code
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B
0096	Corozal	B
0100	Culebra	F
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S

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Contrato Número

0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F
0188	Manati	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayaguez	Z
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z

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Contrato Número

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 Jose	J
0276	San Lorenzo	E
0280	San Sebastian	Z
0284	Santa Isabel	G
0288	Toa Alta	B
0292	Toa Baja	B
0296	Trujillo Alto	F
0300	Utuado	A
0304	Vega Alta	B
0308	Vega Baja	A
0312	Vieques	F
0316	Villalba	G
0320	Yabucoa	E
0324	Yauco	S
0666	Outside Puerto Rico	

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Contrato Número

Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
F		**Member (First Segment)**					
F	1	Record Type	1	1	F	F - Member (First Segment)	
F	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) The number correspond to the record group, not to the period order	
F	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	4	Social Security Number	11	9		Social Security Number of the insured member	
F	5	FILLER	20	2		filled with '00'	
F	6	FILLER	22	14		filled with blanks	
F	7	Person Id	36	11		Member's Person Id This Identifier is assigned to beneficiaries and related contact and household persons in the Eligibility Determination process.	
F	8	Contact Last Name	47	15		Last Name of the member's contact person	
F	9	Contact Second Last Name	62	15		Second Last Name of the member's contact person	
F	10	Contact First Name	77	20		First Name of the member's contact person	
F	11	Region	97	1	A, B, E, F, G, J, S, Z, P	Region code assigned to the insured member A - Norte B - Metro Norte E - Este F - Noreste G - Sureste J - San Juan S - Suroeste Z - Oeste P - Virtual	
F	12	Municipality	98	4	See Appendix Municipality Codes	Municipality Code Format: Zero fill, right justify.	
F	13	Facility	102	4		Facility Code Zero fill, right justify.	
F	14	FILLER	106	1		filled with blanks	
F	15	FILLER	107	1		filled with blanks	
F	16	Eligibility Effective Date	108	8		Effective start date of the eligibility period	
F	17	FILLER	116	1		filled with blanks	
F	18	FILLER	117	2		filled with blanks	
F	19	Expiration Date	119	8		Re-certification cutoff date for the member's eligibility period. Changes to Re Certification Date are submitted in the "Cancellation / Extension Date"	
F	20	FILLER	127	1		filled with blanks	
F	21	Mailing Address 1	128	75		Address line of the current mailing address of the insured member	
F	22	Mailing Address 2	203	75		Second address line of the current mailing address of the insured member	
F	23	Mailing City	278	16		City name of the member's mailing address	
F	24	Mailing ZIP	294	5		First 5 digits of the zip code of the member's mailing address Format: Zero fill, right justify.	

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
F	25	Mailing ZIP4	299	4		Last 4 digits of the zip code of the member's mailing address Format: Zero fill, right justify.	
F	26	Residence Address 1	303	75		Address line of the current residential address of the insured member	
F	27	Residence Address 2	378	75		Second Address line of the current residential address of the insured member	
F	28	Residence City	453	16		City name of the member's residential address	
F	29	Residence Zip	469	5		First 5 digits of the Zip code of the member's residential address Format: Zero fill, right justify.	
F	30	Residence Zip4	474	4		Last 4 digits of the Zip code of the member's residential address Format: Zero fill, right justify.	
F	31	Communication Number	478	10		Member's communication number. Filled with a qualified phone number including the area code	
F	32	FILLER	488	2		filled with blanks	
F	33	FILLER	490	20		filled with blanks	
F	34	FILLER	510	2		filled with blanks	
F	35	FILLER	512	20		filled with blanks	
F	36	FILLER	532	2		filled with blanks	
F	37	FILLER	534	20		filled with blanks	
F	38	FILLER	554	2		filled with blanks	
F	39	FILLER	556	2		filled with blanks	
F	40	FILLER	558	6		filled with blanks	
F	41	FILLER	564	8		filled with blanks	
F	42	FILLER	572	3		filled with blanks	
F	43	FILLER	575	1		filled with blanks	
F	44	Eligible Members	576	2		Count of eligible members in the household of the insured member	
F	45	Cancellation or Termination Code	578	2	06,07,08,09,10,13,30,31	Eligibility determination reason code for member's cancellation or termination 06 - Change in Family Composition 07 - Income Changes 08 - Death of the enrollee 09 - Moving Out of State 10 - Incarceration of the enrollee 13 - Enrollee Found Not Eligible 30 - Other Reasons 31 - Voluntary Closing Filled with blanks when member has not received a cancellation or termination	ADMINISTRACION DE SEGUROS DE SALUD № 23-0047 Contrato Número
F	46	Carrier Code	580	2		Code of insurance carrier asigned to the member.	
F	47	Carrier Effective Date	582	8		Effective Start Date for the member's coverage period in the assigned Insurance Carrier Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	48	Carrier End Date	590	8		Effective End Date for the member's coverage period in the assigned Insurance Carrier Only for Transation Id = (H)istory or when thre is a carrier change in the future to a different carrier, otherwise filled with blanks Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	

Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
F	49	FILLER	598	3		Filled with blanks	
F	50	FILLER	601	3		Filled with blanks	
F	51	PMG Federal Tax Id	604	9		Federal Tax Id for the member's Primary Medical Group (PMG)	
F	52	New Carrier	613	2		New carrier code	
F	53	New PMG Federal Tax Id	615	9		Federal Tax Id for the PMG assigned to the insured member	
F	54	New PMG Effective Date	624	8		Effective start date for the new PMG assigned to the insured member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	55	Policy Number	632	13		Member's Policy Number (also known as Contract Number) assigned by the Insurance Carrier MCO contract number	
F	56	FILLER	645	1		Filled with blanks	
F	57	New Carrier Effective Date	646	8		Effective date for the carrier assigned to the member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	58	PMG Effective Date	654	8		Effective date for the PMG assigned to the insured member Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	59	Certification Date	662	8		Member's certification date for the eligibility period Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
F	60	PCP Change Reason	670	2		Code of member's reason for changing PCP	
F	61	FILLER	672	1		Filled with blanks	
F	62	FILLER	673	8		Filled with blanks	
F	63	FILLER	681	11		Filled with blanks	
F	64	Case Number	692	10		Member's case number assigned by the Department of Health / Medicaid Program	
F	65	Extension or Cancellation Date	702	8		This field is used depending on the member's eligibility status in Record M, Field 38 (Eligibility Indicator) (1) Extension Date When the record Transation Id not valued 'I' this is the member's Extension date for the cutoff Recertification Date (2) Cancellation Date When the record Transation Id is valued 'I' this is the member's Termination or Cancellation date Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	ADMINISTRACION DE SEGUROS DE SALUD № 23-0047 Contrato Número
F	66	FILLER	710	8		Filled with blanks	
F	67	FILLER	718	2		Filled with blanks	

Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
F	68	Gender	720	1	1,2,3	Gender identity of the insured member 1 - Male 2 - Female 3 - Unnkown	
F	69	New Id Card Issue Date	721	8		For future enrollment period, filled with the member's new Identification Card Issue Date. This field is filled with blanks when the insurance carrier has to submit an enrollment effectuation due to the addition of a subscriber or a change in the coverage code. Format: MMDDCCYY	
F	70	Member Start Date	729	8		Member's start date for the current period of continuous enrollment in current insurance carrier. Format: MMDDCCYY	
F	71	FILLER	737	3		Filled with blanks	
M		**Member (Second Segment)**					ADMINISTRACION DE SEGUROS DE SALUD
M	1	Record Type	1	1	M	M - Member Second Segment	
M	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	№ 23-0047 Contrato Número
M	3	Process Date	3	8		Process Date for this transaction Format: MMDDYYYY	
M	4	Social Security Number	11	9		Member's social security number	
M	5	FILLER	20	2		filled with '00'	
M	6	FILLER	22	1		Filled with blanks	
M	7	FILLER	23	9		Filled with blanks	
M	8	FILLER	32	2		Filled with '01'	
M	9	Contact Person Id	34	11		Person Id assigned to the member's contact	
M	10	FILLER	45	3		filled with blanks	
M	11	Last Name	48	15		Member's Last Name	
M	12	Second Last Name	63	15		Member's Second Last Name	
M	13	First Name	78	20		Member's First Name	
M	14	Middle Initial	98	1		Member's Middle Initial	
M	15	FILLER	99	1		Filled with '0'	
M	16	Date Of Birth	100	8		Member's date of birth Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
M	17	FILLER	108	1		Filled with '0'	
M	18	Sex	109	1	1,2,3	Member's sex at birth 1 - Male 2 - Female 3 - Unknown	
M	19	FILLER	110	1		Filled with '0'	
M	20	FILLER	111	1		Filled with '0'	
M	21	FILLER	112	1		Filled with '0'	

Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
M	22	FILLER	113	1		Filled with blanks	
M	23	Social Security Benefits	114	1	1,2	Code to identify if the member receives social security benefits 1 - Yes 2 - No	
M	24	FILLER	115	1		Filled with blanks	
M	25	FILLER	116	2		Filled with '00'	
M	26	FILLER	118	1		Filled with '0'	
M	27	FILLER	119	1		Filled with '0'	
M	28	FILLER	120	1		Filled with '0'	
M	29	FILLER	121	1		Filled with '0'	
M	30	Marital Status Code	122	1	1,2,3,4,5	Code of the member's marital status 1 - Single 2 - Married 3 - Divorced 4 - Widowed 5 - Other	
M	31	FILLER	123	9		Filled with blanks	
M	32	Pregnancy Indicator	132	1	1,2	Member's pregnancy indicator at the moment of the eligibility evaluation 1 - Member is not pregnant 2 - Member is pregnant	
M	33	FILLER	133	1		filled with blanks	
M	34	MBI	134	11		Member's current Medicare Beneficiary Identifier filled with blanks if member does not have Medicare coverage	
M	35	FILLER	145	1		Filled with '0'	
M	36	FILLER	146	1		Filled with '0'	
M	37	FILLER	147	1		Filled with '0'	
M	38	Eligibility Indicator	148	1	Y,N	Member's eligibility indicator for this transaction Y - Yes, Member is Eligible N - No, Member is not Eligible	
M	39	Cancellation Code	149	2		Duplicated Field for Record F, Field 45 Filled with value in Record F, Field 45	
M	40	FILLER	151	2		Filled with blanks	
M	41	PMG NPI	153	10		PMG NPI Optional for Carrier Platino Filled with blanks if no PMG on record	
M	42	New PMG NPI	163	10		New PMG NPI Optional for Carrier Platino Filled with blanks if no PMG on record	
M	43	PMG Medicaid Id	173	9		This is the PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Added

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
M	44	New PMG Medicaid Id	182	9		This is the New PMG's Medicaid Id associated with the the PMG's Service Location where this member is assigned. This is the same value used in the PRMMIS Provider Group Links Interface This is optional for Platino carriers. Fill with blanks if not required	Added
M	45	FILLER	191	26		Filled with blanks	
M	46	Government Group	217	2	See Appendix Government Group Codes	Group identifier related to other federal and local government entities associated with the insured member	
M	47	Person Id	219	11		Member's Person Identifier This Identifier is assigned to beneficiaries and related contact and household persons by the Department of Health	
M	48	FILLER	230	10		Filled with blanks	
M	49	FILLER	240	5		Filled with blanks	
M	50	MPI	245	13		Member's master patient index (MPI) number	
M	51	Certification Date	258	8		Duplicate Field on Record F Field 59 Filled with value in Record F, Field 59	
M	52	Policy Number	266	13		Duplicate Field on Record F Field 55 Filled with value in Record F, Field 55	
M	53	PMG Code	279	4		Code of PMG assigned to the insured member. PMG code must be submittd to ASES in Report 12 by the Insurance Carrier in a weekly basis.	
M	54	PMG Effective Date	283	8		Effective Start Date of the member's assignment to the PMG Format: MMDDCCYY	
M	55	New PMG Code	291	4		Code of the PMG assigned to the insured member PMG Code must be provided by the Insurance Carrier in a weekly basis in Report 12.	
M	56	New PMG Effective Date	295	8		Effective Start Date of the PMG assigned to the insured member Format: MMDDCCYY	
M	57	PCP	303	15		NPI of the PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	58	PCP Effective Date	318	8		Effective start date for the PCP assigned to the insured member Format: MMDDCCYY	
M	59	Second PCP	326	15		NPI of the Second PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	60	Second PCP Effective Date	341	8		Effective start date for the second PCP assigned to the insured member Format: MMDDCCYY	
M	61	New PCP	349	15		NPI of the New PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	62	New PCP Effective Date	364	8		Effective start date for the New PCP assigned to the insured member Format: MMDDCCYY	
M	63	New Second PCP	372	15		NPI of the New Second PCP assigned to the insured member Format: Left filled with blanks, use 10 digit valid NPI number	
M	64	New Second PCP Effective Date	387	8		Effective start date for the New Second PCP assigned to the insured member Format: MMDDCCYY	
M	65	FILLER	395	15		Filled with blanks	

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
M	66	Id Card Issue Date	410	8		Member's Identification Card Issue Date This field is filled with blanks when the insurance carrier has to submit an enrollment effectuation due to the addition of a subscriber or a change in the coverage code. Format: MMDDCCYY	
M	67	FILLER	418	1		Filled with blanks	
M	68	Primary Care Change Reason	419	2		Code use by the carrier for identifying the reason of the member's primary care change (primary care includes: PMG,PCP, Second PCP) This is an informative field that may be used for audit purposes. Fill with blanks if no PMG, PCP or Second PCP changes.	
M	69	Program	421	1	1,2,3	Member's Affordability Insurance Program 1 - Medicaid 2 - CHIP 3 - Commonwealth	
M	70	FILLER	422	1		Filler	Change to filler as it is submitted in the Insurance Record
M	71	Carrier	423	2		Duplicate Field on Record F Field 46 Filled with value in Record F, Field 46	
M	72	Carrier Effective Date	425	8		Duplicate Field on Record F Field 47 Filled with value in Record F, Field 47	
M	73	New Carrier	433	2		Code of the insurance new carrier assigned to the member	
M	74	New Carrier Effective Date	435	8		Effective start date of the new carrier assigned to the insured member Format: MMDDCCYY	
M	75	Plan Type	443	2	01,02	Code of the Plan Type assigned to the insured member 01 - Vital 02 - Platino	
M	76	Plan Type Effective Date	445	8		Effective start date of the Plan Type assigned to the insured member Format: MMDDCCYY	
M	77	Plan Version	453	3		Code of the insurance carrier's product matching member's health coverage entitlement	
M	78	Plan Version Effective Date	456	8		Effective start date of the Plan Version assigned to the insured member Format: MMDDCCYY	
M	79	New Plan Type	464	2		Code of New Plan Type assigned to the insured member 01 - Vital 02 - Platino bb - Not assigned	
M	80	New Plan Type Effective Date	466	8		Effective start date of the new Plan Type assigned to the insured member Format: MMDDCCYY	
M	81	New Plan Version	474	3		Code of the new insurance product the carrier assigned to the member matching the requested Health Coverage	
M	82	New Plan Version Effective Date	477	8		Effective start date of the new Plan Version assigned to the insured member Format: MMDDCCYY	
M	83	FILLER	485	1		Filled with blanks	
M	84	FILLER	486	12		Filled with blanks	
M	85	FILLER	498	1		Filled with blanks	
M	86	FILLER	499	8		Filled with blanks	

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
M	87	Confined Coverage Code	507	3	See Appendix Coverage Codes	Federal Coverage Code for Hospitalization coverage entitlement when the beneficiary has Government Group Code in (03, 04, 97) representing a confined population. If not applicable leave blank This information will be shared if available	Added
M	88	Coverage Code	510	3	See Appendix Coverage Codes	Code for the member's health coverage entitlement A beneficairy with Government Group Code in (97) only has a Confined Coverage Code. If not aplicable leave blank	Changed Field Id, includes rule for Incarcerated population.
M	89	New Policy Number	513	13		Member's Policy Number (Contract Number) assigned by the Insurance Carrier.	Changed Field Id
M	90	Special Enroll	526	1	T, E, N	T - Retroactive Period E - Late Eligibility (used in new enrollments when a retro eligibility with more than 3 months is received) N = Deemed Newborn Filled with blanks if no special enroll period	Changed Field Id
M	91	Cost Sharing Exception Code	527	1	N,C,P,A,I,H	N - No exception C - Child P - Pregnant A - American Indian I - Institutionalized H - Hospice	Changed Field Id
M	92	Co-Payment Maximum	528	5		Maximum co-payment amount for the member's household. Format: filled with number, includes two decimal positions.	Changed Field Id
M	93	Extension Flag	533	1	N,A,U,P,X,H	N - No extension A - Pending Appeal U - Appeal closed P - Pregnancy X - Other extension H - Natural Disaster	Changed Field Id
M	94	Spend Down Indicator	534	1	N,S	Fill with blanks For future use: N - No spend-down involved S - Spend-down satisfied (If S, required at least one spend-down record on recod group)	Changed Field Id
M	95	Eligibility Group	535	3	See Appendix Eligibility Group Codes	Member's eligibility Group Code	Changed Field Id
M	96	Date of Death	538	8		Member's date of death as reported by the Department of Health Format: MMDDCCYY	Changed Field Id
M	97	Custom Property 1	546	8		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	98	Custom Property 2	554	8		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	99	Custom Property 3	562	15		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id
M	100	Custom Property 4	577	15		This field is defined to be used in response to an emergency or special situation where information exchanged is required and not yet available in any other field - For current use see reference table "Custom Properties"	Changed Field Id

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
M	101	Language Spoken	592	3	See Appendix Language Codes	Language Spoken is shared if available	Changed Field Id
M	102	Language Written	595	3	See Appendix Language Codes	Language Written is shared if available	Changed Field Id
M	103	Race	598	2	See Appendix Race and Ethinicity Codes	Race is shared if available	Changed Field Id
M	104	Ethnicity	600	2	See Appendix Race and Ethinicity Codes	Ethnicity is shared if available	Changed Field Id
M	105	FILLER	602	138		Filled with blanks	
O		**Household**					
O	1	Record Type	1	1		O - Household Record	
O	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	
O	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDYYYY	
O	4	Person Id	11	11		Member's Person Id	
O	5	Household Person 1	22	11		Person Id for member's household person 1	
O	6	Household Person 2	33	11		Person Id for member's household person 2	
O	7	Household Person 3	44	11		Person Id for member's household person 3	
O	8	Household Person 4	55	11		Person Id for member's household person 4	
O	9	Household Person 5	66	11		Person Id for member's household person 5	
O	10	Household Person 6	77	11		Person Id for member's household person 6	
O	11	Household Person 7	88	11		Person Id for member's household person 7	
O	12	Household Person 8	99	11		Person Id for member's household person 8	
O	13	Household Person 9	110	11		Person Id for member's household person 9	
O	14	Household Person 10	121	11		Person Id for member's household person 10	
O	15	Household Person 11	132	11		Person Id for member's household person 11	
O	16	Household Person 12	143	11		Person Id for member's household person 12	
O	17	Household Person 13	154	11		Person Id for member's household person 13	
O	18	Household Person 14	165	11		Person Id for member's household person 14	
O	19	Household Person 15	176	11		Person Id for member's household person 15	
O	20	Household Person 16	187	11		Person Id for member's household person 16	
O	21	Household Person 17	198	11		Person Id for member's household person 17	
O	22	Household Person 18	209	11		Person Id for member's household person 18	
O	23	FILLER	220	520		Fill with empty spaces.	
I		**Insurance (COB)**					
I	1	Record Type	1	1	I	I - Insurance (COB) Record	
I	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
I	3	Proces Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
I	4	Person Id	11	11		Member's Person Id	
I	5	FILLER	22	2		filled with '01'	
I	6	Health Insurer Code	24	3	See Appendix ASES Insurer Codes	Code assigned to the Insurance Company by ASES	
I	7	Policy Number	27	20		Policy number assigned by the Insurance Company to the member. If it is Medicare, it will be filled with the MBI number	
I	8	Policy End Date	47	8			
I	9	Covered Services	55	40		20 coverage code fields (2 character each).	
I	10	Policy Effective Date	95	8		Effective Date for policy (Medicare benefits or private plans)	
I	11	FILLER	103	637			
R		**Rate Cell and Risk Score**					
R	1	Record Type	1	1	R	R - Rate Cell and Risk Score Record	
R	2	Transaction Id	2	1	E,I,H,1,2,3	Transaction type identifier E - Eligible I - Ineligible H - History 1 - Retroactive Period (*) 2 - Retroactive Period (*) 3 - Retroactive Period (*) (*) Correspond to record group, not to period order	
R	3	Process Date	3	8		ASES Process Date for this transaction Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	
R	4	Person Id	11	11		Member's Person Id	
R	5	FILLER	22	14		Filled with blanks	
R	6	Rate Code	36	3		Member's adjudicated rate cell code. **Left justified, fill with blanks when rate code is less than 3 characters.**	Change Size from 2 to 3 characters
R	7	Risk Score	39	8		Member's adjudicated Risk Score Factor used to calculate capitation payments. This Risk Score is adjusted for Budget Neutrality. Format uses up to 3 digits NON Decimal and up to 4 decimal digits, **Examples:** **- 001.0000** **- 123.4567** **- 001.1200**	Added
R	8	Risk Score Indicator	47	1		Risk Score Indicator 0 = Risk Score is using a Default Value 1 = Risk Score is evaluated by using CDPS+RX Risk adjustment module including budget neutrality.	Added

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Record	Field	Field Name	Pos	Size	Codes	Notes/Comments	Version Changes
R	9	Raw Risk Score	48	8		Risk Score Factor generated by the CDPS+RX Risk adjustment module Format uses same format as the Risk Score field If Risk Score indicator is 0 then this field will be filled with blanks.	Added
R	10	Effective Date	56	8		Member's rate cell and risk score effective start Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	Change position and now includes changes to the adjudicated risk score
R	11	End Date	64	8		Member's rate cell and risk score effective end. Filled with blanks when effective period ends with the end of the eligibility period If the member has a carrier change in the future, the rate cell end date will be populated. Format: MMDDCCYY MM - Month DD - Day CCYY - Century and Year	Change position and now includes changes to the adjudicated risk score
R	12	FILLER	72	668	740	Filled with blanks	

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

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	Español	English	Government Entity
43	Empleado Municipal Arecibo	Employee of Arecibo Municipality	Arecibo
44	Empleado Municipal Barceloneta	Employee of Barceloneta Municipality	Barceloneta
45	Empleado Municipal Camuy	Employee of Camuy Municipality	Camuy
46	Empleado Municipal Ciales	Employee of Ciales Municipality	Ciales
47	Empleado Municipal Florida	Employee of Florida Municipality	Florida
48	Empleado Municipal Hatillo	Employee of Hatillo Municipality	Hatillo
49	Empleado Municipal Lares	Employee of Lares Municipality	Lares
50	Empleado Municipal Manatí	Employee of Manatí Municipality	Manatí
51	Empleado Municipal Morovis	Employee of Morovis Municipality	Morovis
52	Empleado Municipal Quebradillas	Employee of Quebradillas Municipality	Quebradillas
53	Empleado Municipal Utuado	Employee of Utuado Municipality	Utuado
54	Empleado Municipal Vega Baja	Employee of Vega Baja Municipality	Vega Baja
55	Empleado Municipal Aguas Buenas	Employee of Aguas Buenas Municipality	Aguas Buenas
56	Empleado Municipal Aibonito	Employee of Aibonito Municipality	Aibonito
57	Empleado Municipal Caguas	Employee of Caguas Municipality	Caguas
58	Empleado Municipal Cayey	Employee of Cayey Municipality	Cayey
59	Empleado Municipal Cidra	Employee of Cidra Municipality	Cidra
60	Empleado Municipal Gurabo	Employee of Gurabo Municipality	Gurabo
61	Empleado Municipal Humacao	Employee of Humacao Municipality	Humacao
62	Empleado Municipal Juncos	Employee of Juncos Municipality	Juncos
63	Empleado Municipal Las Piedras	Employee of Las Piedras Municipality	Las Piedras
64	Empleado Municipal Maunabo	Employee of Maunabo Municipality	Maunabo
65	Empleado Municipal Naguabo	Employee of Naguabo Municipality	Naguabo
66	Empleado Municipal San Lorenzo	Employee of San Lorenzo Municipality	San Lorenzo
67	Empleado Municipal Yabucoa	Employee of Yabucoa Municipality	Yabucoa
68	Empleado Municipal Cabo Rojo	Employee of Cabo Rojo Municipality	Cabo Rojo
69	Empleado Municipal Hormigueros	Employee of Hormigueros Municipality	Hormigueros
70	Empleado Municipal Lajas	Employee of Lajas Municipality	Lajas
71	Empleado Municipal Las Marías	Employee of Las Marías Municipality	Las Marías
72	Empleado Municipal Mayagüez	Employee of Mayagüez Municipality	Mayagüez
73	Empleado Municipal Rincón	Employee of Rincón Municipality	Rincón
74	Empleado Municipal Sabana Grande	Employee of Sabana Grande Municipality	Sabana Grande
75	Empleado Municipal San Germán	Employee of San Germán Municipality	San Germán
76	Empleado Municipal Maricao	Employee of Maricao Municipality	Maricao
77	Empleado Municipal Adjuntas	Employee of Adjuntas Municipality	Adjuntas
78	Empleado Municipal Arroyo	Employee of Arroyo Municipality	Arroyo
79	Empleado Municipal Coamo	Employee of Coamo Municipality	Coamo
80	Empleado Municipal Guánica	Employee of Guánica Municipality	Guánica
81	Empleado Municipal Guayama	Employee of Guayama Municipality	Guayama
82	Empleado Municipal Guayanilla	Employee of Guayanilla Municipality	Guayanilla
83	Empleado Municipal Jayuya	Employee of Jayuya Municipality	Jayuya
84	Empleado Municipal Juana Díaz	Employee of Juana Díaz Municipality	Juana Díaz
85	Empleado Municipal Patillas	Employee of Patillas Municipality	Patillas

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	Español	English	Government Entity
86	Empleado Municipal Peñuelas	Employee of Peñuelas Municipality	Peñuelas
87	Empleado Municipal Ponce	Employee of Ponce Municipality	Ponce
88	Empleado Municipal Salinas	Employee of Salinas Municipality	Salinas
89	Empleado Municipal Santa Isabel	Employee of Santa Isabel Municipality	Santa Isabel
90	Empleado Municipal Villalba	Employee of Villalba Municipality	Villalba
91	Empleado Municipal Yauco	Employee of Yauco Municipality	Yauco
92	Empleado Municipal Añasco	Employee of Añasco Municipality	Añasco
93	Empleado Universidad de PR y sus Recintos	University of Puerto Rico	University of Puerto Rico
94	Empleado de Corporaciones Públicas	Government Corporation	Government Corporation
95	Program MEDIMED	Beneficiary	MEDIMED Program
97	Encarcelados	Incarcerated	Department Of Correction And Rehabilitation
96	Adfan Título IV - Asistencia para Adopción	Title IV-E federal adoption assistance	Administration for Childen and Families
99	Ninguno	None	None

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

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

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ASES Insurer Code	Insurer Name
001	MEDICARE HOSP.Y AMBULATORIO - Parte A B
002	MMM
003	MEDICARE HOSP. - Parte A
004	PREFERRED MEDICARE CHOICE
005	MCS CLASSICARE
006	TRIPLE-S MEDICARE OPTIMO
007	LA CRUZ AZUL DE PUERTO RICO
008	TRIPLE-S
009	MEDICARE AMBULATORIO - Parte B
010	FIRST MEDICAL
011	ASOCIACION DE MAESTROS
012	HUMANA ADVANTAGE
013	COSVI DE P.R.
014	MCS
015	HOSPITAL DE LA CONCEPCIÓN
016	HUMANA
017	SERVICIOS DE SALUD BELLA VISTA
018	AUXILIO MUTUO
019	UNION TRABAJADORES DE MUELLES
020	GOLDEN CROSS HEALTH PLAN
021	MENONITA DE P. R.
022	AETNA LIFE INS. CO.
023	AMERICAN CENTRAL INVESTOR LIFE
024	AMERICAN FAMILY LIFE INSURANCE
025	AMERICAN HOME ASSURANCE
026	ALLSTATES INSURANCE CO.
027	AMERICAN HARDWARE LIFE INS.
028	AMERICAN NATIONAL INS. CO.
029	ATLANTIC SOUTHERN INS. CO.
030	AMERICAN CENTRAL INVESTOR INS. CO.
031	ARGONAUT INS. CO.

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ASES Insurer Code	Insurer Name
032	CONFEDERATION LIFE INS. CO.
033	COMBINED INS. CO.
034	CROWN LIFE INSURANCE CO.
035	CONNECTICUT GENERAL LIFE INS. CO.
036	COOPERATIVA SEGUROS MULTIPLES
037	COMMUWEALTH INS. CO.
038	CONTINENTAL ASSURANCE CO.
039	CHAMPURS, BLUE SHIELD OF CALIFORNIA
040	CONFEDERATION LIFE GROUP HEALTH CLAIMS
041	GENERAL ACCIDENT AND INSURANCE CORP.
042	INTERCONTINENTAL LADIES GARMENT WORKERS
043	JOHN HANCOCK
044	LINCOLN NATIONAL LIFE INS. CO.
045	LA ATLANTICA
046	LINCOLN INCOME LIFE INS. CO.
047	MUTUAL LIFE INC.
048	MUTUAL LIFE INC.
049	MASSACHUSSETS MUTUAL LIFE INS. CO.
050	METROPOLITAN LIFE INS.
051	MONEY MUTUAL LIFE INS. OF N. Y.
052	NATIONAL LIFE INS. CO.
053	N.M.U. PENSION AND WELFARE PLAN
054	NEW ENGLAND MUTUAL LIFE INS. CO.
055	NORTH AMERICAN CO. LIFE INS. CO.
056	NATIONAL HOME LIFE INS.
057	NEW YORK LIFE INS. CO.
058	OCCIDENTAL LIFE INS.
059	PROVIDENT LIFE AND ACCIDENT INS. CO.
060	PRUDENTIAL LIFE INS. CO.
061	PACIFIC MUTUAL LIFE INS. CO.

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ASES Insurer Code	Insurer Name
062	MAPFRE - PRAICO
063	PLAN UNION MARINOS MERCANTES
064	PILOT LIFE INS. CO.
065	PAN AMERICAN LIFE INS. CO.
066	PLAN DE SALUD U.I.A.
067	REPUBLIC NATIONAL LIFE INS. CO.
068	SEAFARES WELFARE MEDICAL PLAN
069	SUN LIFE ASSURANCE CO.
070	SALUD PREVENTIVA, INC.
071	SECURITY NATIONAL LIFE INS. CO.
072	STATE MUTUAL LIFE INS. CO. OF AMERICA
073	THE PRUDENTIAL INS. CO.
074	TRANS OCEANIC LIFE INS.
075	TRANS WORLD INS. CO.
076	THE BANKERS LIFE
077	THE CARBORUNDUM CO. OF P.R.
078	THE NEW YORK LIFE INS. CO.
079	THE HERFORD INS. CO.
080	THE MUTUAL LIFE INS. CO. OF NEW YORK
081	THE GUARDIAN LIFE INS. CO.
082	THE EQUITABLE LIFE ASSURANCE
083	THE TRAVELERS INS. CO.
084	THE MONEY MUTUAL LIFE INS. CO.
085	UNITED BENEFITS LIFE INS. CO.
086	UNITED OF OMAHA
087	UNITED LIFE INS. CO.
088	SERVI MEDICAL
089	PLAN DE LA POLICIA
090	FIRST MEDICAL ADVANTAGE
091	AUXILIO MUTUO ADVANTAGE

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ASES Insurer Code	Insurer Name
092	RYDERS HEALTH PLAN
093	CIGNA
094	COSVI ADVANTAGE
095	MAPFRE ADVANTAGE
096	AMERICAN HEALTH MEDICARE
097	SALUD DORADA ADVANTAGE
098	MEDICARE PLATINO
099	OTRAS COMPANIAS ASEGURADORAS
100	ACCA
101	COVEL
102	FONDO DEL SEGURO DEL ESTADO
103	TRICARE
104	CIGNA PREFERED
105	CIGNA EXCLUSIVE
106	CANADA LIFE
107	CHAMPUS/CHAMPVA
108	MEDPLUS
109	COLVER
110	GLOBAL HEALTH PLAN
111	HOFFA
112	INTEGRATE COMMUNITY HEALTH
113	PROSALUD
114	INTERNATIONAL MANAGED CARE
115	MMM
116	NIÑOS LISIADOS (DEPT DE SALUD)
117	OPTIONS
118	VOID Old PALIC
119	PROSAM
120	UTM
121	UTI

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ASES Insurer Code	Insurer Name
122	UIA
123	UNITED HEALTH CARE INS. CO.
124	SDM HEALTH MANAGEMENT, INC.
125	PHARMACY INSURANCE CORPORATION OF AMERICA
126	MCS ADVANTAGE, INC.
127	PROSALUD HMO, CORP.
128	FEDERACION DE MAESTROS DE PUERTO RICO
129	First Plus
130	Delta Dental
131	Constelation Health
132	Molina Health
133	ENVISION RX
134	CORRECTIONAL HEALTH SERVICES CORP.
135	OPTIMA HEALTH PR
136	MEDICARE FARMACIA - PARTE D
137	PLATINO - CONSTELLATION HEALTH
138	PLATINO - HUMANA ADVANTAGE
139	PLATINO - MCS CLASSICARE
140	PLATINO - MEDICARE Y MUCHO MAS (MMM)
141	PLATINO - PREFERRED MEDICARE CHOICE (PMC)
142	PLATINO - TRIPLE-S ADVANTAGE

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Error Code	Response Type	Focus Field(s)	Special Enroll	Data Source
011	Invalid Content Error	Record Type	Any	Any
021	Blank Field Error	Tran Id	Any	Any
022	Conditionally Invalid Content	Tran Id	Any	MO MA IC CO
025	Conditionally Invalid Content	Tran Id	T	Any
031	Invalid Content Error	Process Date	Any	Any
032	Relative Invalid Content	Process Date	Any	Any
033	Conditionally Invalid Content	Process Date, Effective Date, PMG Tax Id Effe	Any	IC CO
034	Conditionally Invalid Content	Process Date	Not T	MO IC CO
035	Conditionally Invalid Content	Process Date, Effective Date	Not T T	MA
036	Relative Invalid Content	Process Date, PCP1 Effective Date	Any	Any
037	Relative Invalid Content	Process Date, PCP2 Effective Date	Any	Any
038	Relative Invalid Content	Process Date, PMG Tax Id Effective Date	Any	Any
041	Blank Field Error	Region	Any	Any
042	Relative Invalid Content	Region	Any	Any
043	Conditionally Invalid Content	Region	Any	MO MA IC CO
051	Blank Field Error	Carrier	Any	Any
052	Invalid Content Error	Carrier	Any	Any
053	Contextual Applicability Issue	Carrier, Effective Date	T Not T	MO MA CO
054	Contextual Applicability Issue	Carrier, PMG Tax Id, PCP1	Not T	MO IC CO
055	Contextual Applicability Issue	Carrier, Effective Date	Not T T	Any
056	Conditionally Invalid Content	Carrier, Region	Any	Any
057	Contextual Applicability Issue	Carrier, PMG Tax Id, PMG Tax Id Effective D	Not T	MO
061	Conditionally Invalid Content	PMG Tax Id	Any	Any
062	Contextual Applicability Issue	PMG Tax Id, Tran Id	Not T	Any
063	Contextual Applicability Issue	PMG Tax Id, Tran Id	Not T	Any
071	Blank Field Error	Family Id	Any	Any
072	Invalid Content Error	Family Id	Any	Any
073	Contextual Applicability Issue	Family Id, Region	Not T	Any
081	Blank Field Error	Member SSN	Any	Any
082	Invalid Content Error	Member SSN	Any	Any
091	Blank Field Error	Member Suffix	Any	Any
092	Invalid Content Error	Member Suffix	Any	Any
093	Contextual Applicability Issue	Member Suffix, Family Id, Region	Not T	Any
101	Invalid Content Error	Effective Date	Any	Any
102	Relative Invalid Content	Effective Date	Any	Any
103	Conditionally Invalid Content	Effective Date	Any	MO
104	Conditionally Invalid Content	Effective Date	Not T	MO IC CO
105	Conditionally Invalid Content	Effective Date	Any	MA
107	Contextual Applicability Issue	Effective Date	Not T	MO MA
109	Contextual Applicability Issue	Effective Date	Not T	Any
10A	Contextual Applicability Issue	Special Enroll	E	MO
10B	Contextual Applicability Issue	Effective Date, Special Enroll	N	MO
10D	Conditionally Invalid Content	Special Enroll	E	Any
111	Blank Field Error	Plan Type	Any	Any
112	Conditionally Invalid Content	Plan Type	Any	MA

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				IC
				CO
				MO
				Any
113	Contextual Applicability Issue	Plan Type, Carrier, Plan Version, Effective Date	Any	Any
121	Blank Field Error	Plan Version	Any	Any
122	Invalid Content Error	Plan Version	Any	Any
123	Contextual Applicability Issue	Plan Version, Effective Date	Any	Any
131	Invalid Content Error	MPI Number	Any	Any
132	Contextual Applicability Issue	MPI Number	Not T	Any
141	Conditionally Invalid Content	PCP1	Any	Any
142	Conditionally Invalid Content	PCP1	Not T	Any
151	Conditionally Invalid Content	PCP1 Effective Date	Any	Any
152	Conditionally Invalid Content	PCP1 Effective Date	Any	Any
153	Conditionally Invalid Content	PCP1 Effective Date	Any	Any
154	Conditionally Invalid Content	PCP1 Effective Date	Not T	Any
155	Conditionally Invalid Content	PCP1 Effective Date	Any	Any
156	Conditionally Invalid Content	PCP1 Effective Date	Any	Any
157	Conditionally Invalid Content	PCP1 Effective Date, PCP1	Any	Any
158	Contextual Applicability Issue	PCP1 Effective Date, PCP1, Effective Date	Any	Any
			Not T	
161	Conditionally Invalid Content	PCP2	Not T	Any
162	Conditionally Invalid Content	PCP2	Not T	Any
171	Conditionally Invalid Content	PCP2 Effective Date	Not T	Any
172	Relative Invalid Content	PCP2 Effective Date	Any	Any
173	Conditionally Invalid Content	PCP2 Effective Date, PCP2	Any	Any
174	Conditionally Invalid Content	PCP2 Effective Date	Any	Any
175	Conditionally Invalid Content	PCP2 Effective Date, PCP2	Any	Any
177	Contextual Applicability Issue	Effective Date, Process Date	Not T	MA
				MO
			T	
178	Contextual Applicability Issue	PCP2 Effective Date, PCP2, Effective Date	Any	
			Not T	
179	Contextual Applicability Issue	Process Date, Effective Date	Not T	MA
181	Conditionally Invalid Content	PMG Tax Id	Any	Any
191	Conditionally Invalid Content	PMG Tax Id Effective Date	Any	Any
192	Relative Invalid Content	PMG Tax Id Effective Date	Any	Any
211	Contextual Applicability Issue	PMG Tax Id Effective Date	Not T	Any
			T	MO
221	Duplicate Records	Region, Family Id, Data Source	Not T	Any
			T	
			Not T	MO
				MA
222	Contextual Applicability Issue	Carrier	T	Any
223	Contextual Applicability Issue	Carrier	Not T	MO
				MA
			T	Any
			Not T	MO
				MA
224	Contextual Applicability Issue	Effective Date, Special Enroll	T	MO
				MA
225	Contextual Applicability Issue	Member SSN	Not T	MO
				MA
				IC
				CO
			T	MO
226	Contextual Applicability Issue	MPI Number	Not T	Any
			T	
228	Contextual Applicability Issue	Carrier, Data Source	Not T	MA
				MO
				IC
				CO
229	Contextual Applicability Issue	Carrier, Plan Type, Plan Version	Not T	Any
22A	Contextual Applicability Issue	Carrier, Plan Type, Plan Version, PMG Tax Id	Not T	Any
22B	Conditionally Invalid Content	PCP1 Effective Date, PCP2 Effective Date	Not T	Any
22D	Conditionally Invalid Content	Effective Date, PMG Tax Id Effective Date, P	Any	Any
22E	Contextual Applicability Issue	Plan Version, Effective Date	Not T	MO
			T	
22G	Contextual Applicability Issue	Plan Version, Effective Date	Not T	MA
			T	
230	Blank Field Error	Data Source	Any	Any
231	Invalid Content Error	Data Source	Any	Any

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232	Conditionally Invalid Content	Data Source	Any	MO IC CO
233	Conditionally Invalid Content	Data Source	Any	MA
251	Conditionally Invalid Content	HIC Number, Plan Type	Any	MA
280	Contextual Applicability Issue	Region, Family Id	Not T	Any
281	Contextual Applicability Issue	Region, Family Id	Not T	Any
980	Contextual Applicability Issue	Effective Date	Not T	MO MA
982	Contextual Applicability Issue	Effective Date	Not T	MA MO
983	Contextual Applicability Issue	Carrier, Plan Type, Plan Version	Not T	MO MA
984	Contextual Applicability Issue	Carrier, Effective Date	Not T	MO MA
985	Contextual Applicability Issue	Special Enroll	E	MO
986	Contextual Applicability Issue	Effective Date	Not T	MO MA MA
987	Contextual Applicability Issue	Member SSN	Not T	MO MA
988	Contextual Applicability Issue	N/A	Not T	MO MA
989	Contextual Applicability Issue	Special Enroll, Effective Date	N	MO
996	ACK	N/A	Not T	MA MO

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Contrato Número

Validation Response Issues/Scenarios
Invalid content for the Record Type.
The Tran Id field is blank.
The Tran Id should be E, C, I, 1, 2 or 3.
Invalid content for the Tran Id.
The Tran Id should be C.
The Tran Id should be E or C.
Invalid Process Date.
The enrollment Process Date is before 1/1/2010.
The enrollment Effective Date, PCP1 Effective Date and PMG Tax Id Effective Date should follow the carrier enrollment change's twenty days rule using the enrollment change Process Date as reference.
The enrollment Process Date should be on or before the ASES process date.
The enrollment Process Date should be before the enrollment Effective Date.
The enrollment Process Date should be on or after three months before the enrollment Effective Date.
The enrollment Process Date should be on or after the first day of the month following the enrollment Effective Date.
The enrollment Process Date is more than three months before the PCP1 Effective Date.
The enrollment Process Date is more than three months before the PCP2 Effective Date.
The enrollment Process Date is more than three months before the PMG Tax Id Effective Date.
The Region field is blank.
The Region is different from the ASES process region. This is put in place to prevent a silent enrollment rejection.
If the Tran Id is C, then the Region should not be P.
The Region should not be P.
The Carrier field is blank.
Invalid content for the Carrier code.
The Tran Id is C, but the currently enrolled carrier found at ASES member data for the retroactive eligibility period corresponding to the enrollment Effective Date matches the Carrier field.
The Tran Id is C, but the currently enrolled carrier found at ASES member data matches the Carrier field.
The Tran Id is E, but the current enrollment information (carrier, PMG tax id or PCP1) found at ASES member data does not match the Carrier, PMG Tax Id or PCP1 fields.
~~The Tran Id is C, but the prospective enrollment information (carrier, PMG tax id or PCP1) found at ASES member data does not match the Carrier, PMG Tax Id or PCP1 fields.~~
The Tran Id is C, but the prospective enrollment carrier found at ASES member data matches the Carrier field.
The contract information, corresponding to the enrollment Carrier and Effective Date, indicates that it does not cover the municipality found at ASES member data.
The contract information, corresponding to the enrollment Carrier and Effective Date, indicates that it does not cover the municipality found at ASES member data for the retroactive eligibility period corresponding to the curre
The Region is P then Data Source should be MO and the Carrier should be 09.
The Tran Id is I, the PMG Tax Id Effective Date is after the ASES process date and the Carrier is the same as the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ▶ The prospe
The Tran Id is I, the PMG Tax Id Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ▶ The pro
The Tran Id is I, the PMG Tax Id Effective Date is on or before the ASES process date, but at least one of the following situations occur: ▶ The Carrier is different from the currently enrolled carrier at ASES member data. ▶
The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date and the Carrier and PMG are the same as the currently enrolled carrier and PMG at ASES member data, but at least one of the following situations o
The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ▶ The prospe
The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date, the Carrier is the same as the currently enrolled carrier at ASES member data and the PMG is different from the currently enrolled PMG at ASES m
The Tran Id is 1 or 3, the PCP1 Effective Date on or before the ASES process date, but at least one of the following situations occur: ▶ The Carrier is different from the currently enrolled carrier at ASES member data. ▶ The
The Tran Id is 2, the PCP2 Effective Date is after the ASES process date and the Carrier and PMG are the same as the currently enrolled carrier and PMG at ASES member data, but at least one of the following situations occur:
The Tran Id is 2, the PCP2 Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur: ▶ The prospective
The Tran Id is 2, the PCP2 Effective Date is after the ASES process date, the Carrier is the same as the currently enrolled carrier at ASES member data and the PMG is different from the currently enrolled PMG at ASES memb
The Tran Id is 2, the PCP2 Effective Date is on or before the ASES process date but at least one of the following situations occur: ▶ The Carrier is different from the currently enrolled carrier. ▶ The PMG is different from th
If the Tran Id is E, C, V or I and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PMG then the PMG Tax Id should not be blank.
The Tran Id is 1, 2, or 3 and the PMG Tax Id is not blank but the PMG is different from the currently enrolled PMG in ASES member data.
The Tran Id is I and PMG is required for the plan (Carrier, Plan Version) by the given enrollment Effective Date but the PMG is the same as the currently enrolled PMG in ASES member data.
The Family Id field is blank.
The content for the field is not 11 characters long and hence is invalid.
The member (Region, Family Id) was not found in ASES data.
The Member SSN field is blank.
The content for the field is not 9 characters long and hence is invalid.
The Member Suffix field is blank.
Invalid content for the Member Suffix.
The member (Region, Family Id, Member Suffix) was not found in ASES data.
Invalid enrollment Effective Date.
The enrollment Effective Date is before 1/1/2010.
If the Tran Id is E then the Effective Date should be before the ASES process date.
If the Tran Id is E then the enrollment Effective Date should be before the ASES process date.
If the Tran Id is C then the enrollment Effective Date should be on or after the first day of the month following the ASES process date.
If the Tran Id is not 1, 2 or 3 then the enrollment Effective Date should be a first day of the month.
The member (Region, Family Id) had an interruption of eligibility after the enrollment Effective Date.
The Effective Date is within a retroactive eligibility period for the member.
The Tran Id is E, but the ASES member data does not indicate Medicaid federal program membership and thus Late Eligibility enrollment does not apply.
The Tran Id is E, but the enrollment Effective Date occurs before the member birth date found at ASES member data.
The Tran Id is E, but the Effective Date occurs more than a year after the member birth date found at ASES member data.
The Tran Id is E, but ASES member data does not indicate Medicaid Deemed Newborn classification.
The Plan Type should be 01 and the Data Source should be MO.
The Plan Type field is blank.
The Plan Type should be 02.

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The Plan Type should be 01.
The content for the field is not 2 characters long and hence is invalid.
A match for the Carrier and Plan Version according to the given enrollment Effective Date was not found in ASES data.
The Plan Version field is blank.
The content for the field is not 3 characters long and hence is invalid.
A match for the Plan Version according to the given enrollment Effective Date was not found in ASES data.
The content for the field is not 13 characters long and hence is invalid.
The member (Region, MPI Number) was not found at ASES member data.
If the Tran Id is not 2 and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1, then the PCP1 should not be blank.
If the Tran Id is 2, then the PCP1 should be blank.
If the Tran Id is not 2 and the plan (carrier, plan version) contract corresponding to the Effective Date requires a PCP1, then the PCP1 Effective Date should contain a valid date.
If the Tran Id is not V and the PCP1 Effective Date is populated, then the PCP1 Effective Date should be on or after 2015-01-01 and the plan (Carrier, Plan Version) contract corresponding to the enrollment Effective Date sh
If Tran Id is not 2 and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date does not require a PCP1 then PCP1 Effective Date should be blank.
If the Tran Id is 2 then, the PCP1 Effective Date should be blank.
If the Tran Id is E and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 then the PCP1 Effective Date should be on or before the ASES process date.
If the Tran Id is C, the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 and the PCP1 Effective Date is on or before the month of the ASES process date, then the PCP1 Effective D
If the PCP1 Effective Date is blank, then the PCP1 should be blank.
If the PCP1 Effective Date is not blank, then the PCP1 should not be blank.
The PCP1 is not blank and the Tran Id is E, C or I, but the PCP1 Effective Date is different from the enrollment Effective Date.
The PCP1 is not blank and the Tran Id is V, 1 or 3, but the PCP1 Effective Date is earlier than the current enrollment effective date at ASES member data.
If the Tran Id is 2, then PCP2 should not be blank.
If the Tran Id is 1, then the PCP2 should be blank.
If the Tran Id is 2 or 3, then pcp2 effective date should contain a valid date.
The PCP2 Efective Date is before 1/1/2010.
If Tran Id is E and PCP2 is not blank then PCP2 Effective Date should be on or before the ASES process date.
If the Tran Id is C and the PCP2 Effective Date is on or before the month of the ASES process date, then the PCP2 Effective Date should be a first day of the month.
If the PCP2 Effective Date is blank, then the PCP2 should be blank.
If the PCP2 Effective Date is not blank, then the PCP2 should not be blank.
The Tran Id is E or C, the enrollment Effective Date is on or before the ASES process date, but for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is befor
The Tran Id is E or C, the current enrollment carrier is populated at ASES member data, the enrollment Effective Date is on or before the ASES process date and on or before the current enrollment effective date at ASES mem
The Tran Id is C, the prospective enrollment carrier is populated at ASES member data, the Carrier is different from the prospective enrollment carrier at ASES member data, the Effective Date is after the ASES process date an
The Tran Id is E or C, the current enrollment carrier is populated at ASES member data, for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is the same as t
The Tran Id is E, the current enrollment carrier is populated at ASES member data, the enrollment Effective Date is on or before the ASES process date, but it is also on or before the current enrollment effective date at ASES
The Tran Id is E or C, the enrollment Effective Date is on or before the ASES process date, but for a historical enrollment period at ASES member data the carrier is populated and the enrollment record Effective Date is befor
The Tran Id is E, the enrollment Effective Date is on or before the ASES process date, but the current enrollment carrier is not populated at ASES member data.
The Tran Id is E or C, there is a previous retroactive eligibility enrollment at ASES member data for the period implicated by the enrollment Effective Date and the enrollment Effective Date is on or after the previous retroactiv
The PCP2 is not blank and the Tran Id is E, C or I, but the PCP2 Effective Date is different from the enrollment Effective Date.
The PCP2 is not blank and the Tran Id is V, 1 or 3, but the PCP2 Effective Date is earlier than the current enrollment effective date at ASES member data.
The Tran Id is E or C, the prospective enrollment carrier and effective date are populated at ASES member data, the enrollment Effective Date is the same as the prospective enrollment effective date at ASES member data and
If the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a family PMG then PMG Tax Id should not be blank.
If the plan (Carrier, Plan version) contract corresponding to the Effective Date requires a PMG then the PMG Tax Id Effective Date should contain a valid date.
The PMG Tax Id Effective Date should be on or after 1/1/2010.
The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date, but a record identifying the member as Federal Medicaid was not found at ASES member data a
The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date but a retroactive eligibility record identifying the member as Federal Medicaid was not found at A
Only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions is allowed.
Only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch is allowed.
The Tran Id is E but the Carrier is the same as the currently enrolled carrier at ASES member data and the card id date at ASES member data is populated.
The Tran Id is E but the Carrier and Plan Version are the same as the currently enrolled for the corresponding retroactive eligibility period at ASES member data and the card id date at ASES member data is populated.
The Tran Id is E but the Carrier is different from the currently enrolled carrier at ASES member data.
The Tran Id is E but the Carrier is different from the currently enrolled for the corresponding retroactive eligibility period at ASES member data.
The member is not eligible by the enrollment Effective Date at ASES member data.
The member is not eligible at ASES member data by (i.e. there was no retroactive eligibility period corresponding to) the enrollment Effective Date.
The Member SSN is not the same as the one found at ASES member data.
The Member SSN is not the same as the one found at ASES member historical data.
The Member SSN is not the same as the one from the corresponding retroactive eligibility record at ASES member data.
The MPI Number is not the same as the one from ASES member data.
The MPI Number is not the same as the one from the corresponding retroactive eligibility record at ASES member data.
Tran Id is V but the Carrier is different from the currently enrolled at ASES member data.
Tran Id is V.
Tran Id is I but the Carrier or Plan Version are different from the currently enrolled at ASES member data.
Tran Id is 1, 2 or 3, but the Carrier, Plan Version or PMG Tax Id are different from the currently enrolled at ASES member data.
If Tran Id is 3 then the PCP1 Effective Date and the PCP2 Effective Date should both be prospective or both be immediate relative to the ASES process date.
The Effective Date, PCP1 Effective Date, PCP2 Effective Date and PMG Tax Id Effective Date should not be later than 4 months after the ASES process date.
The Plan Version is different from the coverage code found at ASES member data according to the enrollment Effective Date.
The Plan Version is different from the coverage code found at ASES member data for the retroactive eligibility record according to the enrollment Effective Date.
The Plan Version does not correspond with the coverage code found at ASES member data according to the enrollment Effective Date.
The Plan Version does not correspond with the coverage code found at ASES member data for the retroactive eligibility record according to the enrollment Effective Date.
The Data Source field is blank.
Invalid content.

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Plan Type should be 01.
The Plan Type should be 02.
The content for the field is not 11 characters long and hence is invalid.
The member (Region, Family id) was found in ASES data but is not currently eligible.
The member (Region, Family id) was not found in ASES data.
The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data, but there is a later assignment or enrollment to another carrier that is effective during the sa
The enrollment is a Platino SYSPREM candidate but, at ases member historical data, there is a later assignment or enrollment to another carrier that is effective on the same date or later during the same month and the process d
The enrollment is a Platino SYSPREM candidate, but the Effective Date is before 2015- 01-01.
The enrollment is a VITAL SYSPREM candidate, but the Effective Date is before 2018- 01-01.
The enrollment is a VITAL SYSPREM candidate and the Effective Date is on or after 2018-01-01, but there is not an eligible record in ASES member historical data containing an enrollment carrier and effective date which ma
The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data but the period implicated by the Effective Date is already enrolled under the same enrollmen
The enrollment is a Platino SYSPREM candidate, but the period implicated by the Effective Date is already enrolled under the same enrollment information (Carrier, Plan Version) at ASES member historical data.
The enrollment is a VITAL SYSPREM candidate and there is a match for the enrollment assignment at ASES member historical data but the period implicated by the Effective Date is already enrolled under another carrier at A
The enrollment is an Platino SYSPREM candidate and the Tran Id is E but the period implicated by the Effective Date is already enrolled under another carrier at ASES member historical data.
The enrollment is a Late Enrollment (Special Enroll "E") SYSPREM candidate, but the group code from determined sysprem base record at ASES member historical data does not identify the member as a federal program bene
The enrollment is a SYSPREM candidate and the member is currently eligible, but the Effective Date is on or after the enrollment effective date at ASES member data.
The enrollment is a SYSPREM candidate and the member is currently not eligible but the Effective Date is on or after the eligibility cancellation date at ASES member data.
The enrollment is a SYSPREM candidate but the Member SSN was not found at ASES member historical data.
A SYSPREM base record could not be determined and, hence, the SYSPREM enrollment failed. This is a catchall to prevent a silent enrollment failure.
The enrollment is a Newborn Enrollment (Special Enroll "N") SYSPREM candidate, but a record containing a group code identifying the member as Deemed Newborn was not found at ASES member historical data.
The enrollment was successfully processed as a historical enrollment (SYSPREM).

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Possible Action(s)
Valid content for Record Type is: E = Enrollment.
Insert valid content.
Change the Tran Id to E, C, I, 1, 2 or 3. Otherwise, check the Data Source.
Insert valid content.
Change the Tran Id to C. Otherwise, check the Data Source.
Change the Tran Id to E or C. Otherwise check the Special Enroll.
Insert a valid date.
Insert a date on or after 1/1/2010.
Check the enrollment Process Date. Otherwise, check the Effective Date, PCP1 Effective Date or PMG Tax Id Effective Date.
Check the enrollment Process Date. Otherwise, check the Data Source.
Check that the enrollment Process Date is set appropriately. Otherwise, check the enrollment Effective Date.
Check that the enrollment Process Date is on or after the first day of the month following the enrollment Effective Date. Otherwise, check the enrollment Effective Date.
Check that the enrollment Process Date is set appropriately. Otherwise, check the PCP1 Effective Date.
Check that the enrollment Process Date is set appropriately. Otherwise, check the PCP2 Effective Date.
Check that the enrollment Process Date is set appropriately. Otherwise, check the PMG Tax Id Effective Date.
Insert valid content.
Contact ASES to initiate a case review.
Check the Tran Id. Otherwise, check the Region.
Check the Region. Otherwise, check the Data Source.
Insert valid content.
Insert valid content.
Check the Carrier. Otherwise, check the Tran Id or if an enrollment is needed.
Check the Tran Id. Otherwise, check member data sent by ASES and if the enrollment still applies.
Check if the enrollment transaction is needed.
Check the enrollment Effective Date. Otherwise, check the Carrier.
Check that the Data Source is MO and the Carrier is 09. Otherwise, check the Region.
Check the Tran Id and the enrollment information against ASES data and make adjustments accordingly. Otherwise, check if the enrollment still applies.
ctively enrolled carrier at ASES member data is different from the Carrier. ▶ The prospectively enrolled PMG at ASES member data is different from the PMG. ▶ The prospective enrollment card id date at ASES member data is not populated. ▶ The prospective enrollment effective date at ASES
▶ The prospectively enrolled carrier and PMG at ASES member data are neither blank nor the same as the Carrier and PMG. ▶ The card id date at ASES member data is not populated. ▶ The prospective enrollment effective date at ASES member data is not the same as the PCP2 Effective Date. ly enrolled carrier at ASES member data is different from the Carrier ▶ The prospectively enrolled PMG at ASES member data is different from the PMG. ▶ The prospective enrollment card id date at ASES member data is not populated. ▶ The prospective enrollment effective date at ASES mem
Insert a PMG Tax Id. Otherwise check the Carrier, Plan Version, Effective Date or Tran Id.
Change the PMG Tax Id accordingly. Otherwise check the Tran Id.
Check the PMG Tax Id. Otherwise, check if the change is still needed.
Insert valid content.
Insert content that is 11 characters long.
Check the Family Id and Region.
Insert valid content.
Insert content that is 9 characters long.
Insert valid content.
Valid content for Member Suffix is 01.
Check that the Member Suffix is 01. Otherwise check the Family Id and Region.
Insert a valid date.
Insert a date on or after 1/1/2010.
Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.
Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.
Change the enrollment Effective Date to be a first day of the month. Otherwise, check the Tran Id.
Change the enrollment Effective Date appropriately.
Change the enrollment Effective Date appropriately.
Change the Special Enroll field content. Otherwise, check the enrollment Effective Date.
Change the enrollment Effective Date appropriately. Otherwise, check the Tran Id.
Change the Special Enroll appropriately. Otherwise, check the enrollment Effective Date, Tran Id.
Check the Plan Type, Data Source or Special Enroll.
Insert valid content.
Check that the Plan Type is 02.

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Check that the Plan Type is 01.
Insert content that is 2 characters long.
Check the Carrier and Plan Version. Otherwise, check the enrollment Effective Date.
Insert valid content.
Insert content that is 3 characters long.
Check the Plan Versio. Otherwise, check the Effective Date.
Insert content that is 13 characters long.
Check the MPI Number. Otherwise check the Region.
Insert a PCP1. Otherwise check the Carrier, Plan Version, Effective Date or Tran Id.
Clear the PCP1 field. Otherwise, check the Tran Id.
Insert a valid date. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
Insert a valid date if appropriate. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
Clear the PCP1 Effective Date field. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
Clear the PCP1 Effective Date field. Otherwise, check the Tran Id.
Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
Clear the PCP1 field. Otherwise, check the PCP1 Effective Date.
Insert a PCP1. Otherwise, clear the PCP1 Effective Date field.
Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id or Effective Date.
Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id.
Insert a PCP2. Otherwise, check the Tran Id.
Clear the PCP2 field. Otherwise, check the Tran Id.
Insert a valid date. Otherwise, check the Tran Id.
Insert a date on or after 1/1/2010.
Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id or PCP2.
Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id.
Clear the PCP2 field. Otherwise, check the PCP2 Effective Date.
Insert a PCP2. Otherwise, clear the PCP2 Effective Date field.
Check the Effective Date. Otherwise, check if the enrollment still applies.
Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.
Check the Effective Date. Otherwise, check if the enrollment still applies.
Check if the enrollment still applies.
Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.
Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id or Effective Date.
Change the PCP2 Effective Date appropriately. Otherwise, check the Tran Id.
Check the Process Date or Effective Date. Otherwise, check if the enrollment still applies.
Insert a PMG Tax Id. Otherwise check the Carrier, Plan Version or Effective Date.
Insert a valid date. Otherwise, check the Effective Date, Carrier and Plan Version.
Insert a date on or after 1/1/2010.
Insert a valid PMG Tax Id Effective Date. Otherwise, check the Effective Date, Carrier and Plan Version.
Include only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions.
Include only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch.
Check if an enrollment is needed. Otherwise, check the Tran Id or Carrier.
Check if an enrollment is needed. Otherwise, check the Tran Id, Carrier or Plan Version.
Check if an enrollment still applies. Otherwise, check the Tran Id or Carrier.
Check the Effective Date.
Check the Member SSN.
Check the MPI Number.
Check the Carrier. Otherwise, check the Tran Id.
Check the Tran Id. Otherwise, check the Data Source.
Check the Carrier or Plan Version. Otherwise, check the Tran Id.
Check the Carrier, Plan Version or PMG Tax Id. Otherwise, check the Tran Id.
Check the PCP1 Effective Date or PCP2 Effective Date. Otherwise, check the Tran Id.
Check the Effective Date, PCP1 Effective Date, PCP2 Effective Date or PMG Tax Id Effective Date.
Check the Plan Version. Otherwise, check the Effective Date.
Check the Plan Version. Otherwise, check the Effective Date.
Insert valid content.
Insert valid content.

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Change the Plan Type to 01. Otherwise, check the Data Source.
Change the Plan Type to 02. Otherwise, check the Data Source.
Insert content that is 11 characters long.
Check Region, Family Id and Effective Date.
Check Region and Family Id.
Check the Effective Date.
Check the Process Date. Otherwise, check the Effective Date.
Check the Effective Date.
Check the Carrier or Effective Date.
Check the Carrier or Plan Version. Otherwise, check the Effective Date or if the enrollment is still needed.
Check the Effective Date. Otherwise, check the Carrier or if the enrollment still applies.
Check the Effective Date. Otherwise, check the Tran Id, Carrier or if the enrollment still applies.
Check the Special Enroll. Otherwise, check if the enrollment still applies.
Check the Effective Date.
Check the Member SSN.
Check if enrollment still applies. Contact ASES to continue a joint investigation.
Check the Special Enroll. Otherwise, check if the enrollment still applies.
Confirm enrollment through the member data received from ASES on the same ASES process date.

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

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R	21 Program	168	1 1,2,3	Affordability Insurance Program 1 - Medicaid 2 - CHIP 3 - Commonwealth	Previous Version: Field: MEDICAID_INDICATOR Notes/Comments:	No changes required
R	22 Eligibility Effective Date	169	8	YYYYMMDD	Previous Version: Field: ELEGIBILITY_EFFECTIVE_DATE Notes/Comments: YYYYMMDD	No changes required
R	23 Eligibility Expiration Date	177	8	YYYYMMDD	Previous Version: Field: ELEGIBILITY_EXPIRATION_DATE Notes/Comments: YYYYMMDD	No changes required
R	24 Process Date	185	8	Response Process Date Format: CCYYMMDD	Previous Version: Field: ASES_PROCESS_DATE Notes/Comments: YYYYMMDD	No changes required
R	25 Message Code	193	6	Spaces= no errors, 01=MPI no match, 02=Sex no match, 03=DOB no match, 04=Region no match, 05=Miembro de municipio no contratado por Carrier, 06=Empleado ELA, 07=SSN no match (history records)	Previous Version: Field: MESSAGE_CODE Notes/Comments: Spaces= no errors, 01=MPI no match, 02=Sex no match, 03=DOB no match, 04=Region no match, 05=Miembro de municipio no contratado por Carrier, 06=Empleado ELA, 07=SSN no match (history records)	No changes required
R	26 Deductible Level	199	1		Previous Version: Field: ASES_DEDUCTIBLE_LEVEL Notes/Comments:	No changes required
R	27 Municipality	200	4 See Ref table	Municipality Code Format: Zero fill, right justify.	Previous Version: Field: MUNICIPIO Notes/Comments: Código Municipio en	No changes required
R	28 Inquiry's Effective Date	204	8	Filled with same value received from the insurance carrier inquiry.	Previous Version: Field: FECHA DE EFECTIVIDAD Notes/Comments: Para uso en queries historicos. Formato YYYYMMDD.	No changes required
R	29 Health Coverage	212	3 See Ref table		Previous Version: Field: CODIGO DE CUBIERTA Notes/Comments: Código de Cubierta (Coverage Code)	No changes required
R	30 FILLER	215	5		Previous Version: Field: FILLER Notes/Comments:	No changes required

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

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ENROLLMENT AND CARRIER IPA/PCP CHANGE FILE

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

Member Record

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

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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=MCO, MA=Platino, CO=Counselor
Filler	226	4	**R**	
	230			

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

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

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

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

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

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

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

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The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date and the Carrier is different from the currently enrolled carrier at ASES member data, but at least one of the following situations occur:

- ►The prospectively enrolled carrier at ASES member data is different from the Carrier.
- ►The prospectively enrolled PMG at ASES member data is different from the PMG.
- ►The prospective enrollment card id date at ASES member data is not populated.
- ►The prospective enrollment effective date at ASES member data is not populated.
- ►The prospective enrollment effective date at ASES member data is not the same as the PCP1 Effective Date.

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The Tran Id is 1 or 3, the PCP1 Effective Date is after the ASES process date, the Carrier is the same as the currently enrolled carrier at ASES member data and the PMG is different from the currently enrolled PMG at ASES member data, but at least one of the following situations occur:

- ▶The prospectively enrolled carrier at ASES member data is different from the Carrier.
- ▶The prospectively enrolled PMG at ASES member data is different from the PMG.
- ▶The prospective enrollment card id date at ASES member data is not populated.
- ▶The prospective enrollment effective date at ASES member data is not populated.
- ▶The prospective enrollment effective date at ASES member data is not the same as the PCP1 Effective Date.

The Tran Id is 1 or 3, the PCP1 Effective Date on or before the ASES process date, but at least one of the following situations occur:

- ▶The Carrier is different from the currently enrolled carrier at ASES member data.
- ▶The PMG is different from the currently enrolled PMG at ASES member data.
- ▶The card id date at ASES member data is not populated.

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The Tran Id is 2, the PCP2 Effective Date is after the ASES process date and the Carrier and PMG are the same as the currently enrolled carrier and PMG at ASES member data, but at least one of the following situations occur:

- ▶The prospectively enrolled carrier and PMG at ASES member data are neither blank nor the same as the Carrier and PMG.
- ▶The card id date at ASES member data is not populated.
- ▶The prospective enrollment effective date at ASES member data is not the same as the PCP2 Effective Date.

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

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

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

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061	CIC	№ 23-0047 PMG Tax Id Contrato Número	Any	Any	If the Tran Id is E, C, V or I and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PMG then the PMG Tax Id should not be blank.	Insert a PMG Tax Id. Otherwise check the Carrier, Plan Version, Effective Date or Tran Id.
062	CAI	PMG Tax Id, Tran Id	Not T	Any	The Tran Id is 1, 2, or 3 and the PMG Tax Id is not blank but the PMG is different from the currently enrolled PMG in ASES member data.	Change the PMG Tax Id accordingly. Otherwise check the Tran Id.
063	CAI	PMG Tax Id, Tran Id	Not T	Any	The Tran Id is I and PMG is required for the plan (Carrier, Plan Version) by the given enrollment Effective Date but the PMG is the same as the currently enrolled PMG in ASES member data.	Check the PMG Tax Id. Otherwise, check if the change is still needed.
071	BF	Family Id	Any	Any	The Family Id field is blank.	Insert valid content.
072	IC	Family Id	Any	Any	The content for the field is not 11 characters long and hence is invalid.	Insert content that is 11 characters long.
073	CAI	Family Id, Region	Not T	Any	The member (Region, Family Id) was not found in ASES data.	Check the Family Id and Region.
081	BF	Member SSN	Any	Any	The Member SSN field is blank.	Insert valid content.
082	IC	Member SSN	Any	Any	The content for the field is not 9 characters long and hence is invalid.	Insert content that is 9 characters long.
091	BF	Member Suffix	Any	Any	The Member Suffix field is blank.	Insert valid content.
092	IC	Member Suffix	Any	Any	Invalid content for the Member Suffix.	Valid content for Member Suffix is 01.
093	CAI	Member Suffix, Family Id, Region	Not T	Any	The member (Region, Family Id, Member Suffix) was not found in ASES data.	Check that the Member Suffix is 01. Otherwise check the Family Id and Region.
101	IC	Effective Date	Any	Any	Invalid enrollment Effective Date.	Insert a valid date.

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

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

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

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155	CIC	PCP1 Effective Date ADMINISTRACION DE SEGUROS DE SALUD	Any	Any	If the Tran Id is E and the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 then the PCP1 Effective Date should be on or before the ASES process date.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
156	CIC	№23-0047 Contrato Número PCP1 Effective Date	Any	Any	If the Tran Id is C, the plan (Carrier, Plan Version) corresponding to the enrollment Effective Date requires a PCP1 and the PCP1 Effective Date is on or before the month of the ASES process date, then the PCP1 Effective Date should be a first day of the month.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id, Effective Date, Carrier or Plan Version.
157	CIC	PCP1 Effective Date, PCP1	Any	Any	If the PCP1 Effective Date is blank, then the PCP1 should be blank.	Clear the PCP1 field. Otherwise, check the PCP1 Effective Date.
					If the PCP1 Effective Date is not blank, then the PCP1 should not be blank.	Insert a PCP1. Otherwise, clear the PCP1 Effective Date field.
158	CAI	PCP1 Effective Date, PCP1, Effective Date	Any	Any	The PCP1 is not blank and the Tran Id is E, C or I, but the PCP1 Effective Date is different from the enrollment Effective Date.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id or Effective Date.
			Not T		The PCP1 is not blank and the Tran Id is V, 1 or 3, but the PCP1 Effective Date is earlier than the current enrollment effective date at ASES member data.	Change the PCP1 Effective Date appropriately. Otherwise, check the Tran Id.
161	CIC	PCP2	Not T	Any	If the Tran Id is 2, then PCP2 should not be blank.	Insert a PCP2. Otherwise, check the Tran Id.
162	CIC	PCP2	Not T	Any	If the Tran Id is 1, then the PCP2 should be blank.	Clear the PCP2 field. Otherwise, check the Tran Id.

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

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

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

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

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211	CAI	PMG Tax Id Effective Date ADMINISTRACION DE SEGUROS DE SALUD № 23-0047 Contrato Número	Not T	Any	The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date, but a record identifying the member as Federal Medicaid was not found at ASES member data and the PMG Tax Id Effective Date is not populated.	Insert a valid PMG Tax Id Effective Date. Otherwise, check the Effective Date, Carrier and Plan Version.
			T	MO	The plan (Carrier, Plan Version) requires the member to be classified as Federal Medicaid by the given enrollment Effective Date but a retroactive eligibility record identifying the member as Federal Medicaid was not found at ASES member data and the PMG Tax Id Effective Date is not populated.	
221	DR	Region, Family Id, Data Source	Not T	Any	Only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions is allowed.	Include only a single record per member (Region, Family Id) per batch among those that are not retroactive eligibility enrollment transactions.
			T		Only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch is allowed.	Include only a single record per member retroactive eligibility period (Region, Family Id, Effective Date year-month) per batch.
			Not T	MO	The Tran Id is E but the Carrier is the same as the currently enrolled carrier at ASES member data and the card id date at ASES member data is populated.	Check if an enrollment is needed. Otherwise, check the Tran Id or Carrier.
				MA		

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

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

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

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

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

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

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

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

Any
MO, JC, CO

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

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

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

Any
Not T

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

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

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

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

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NOSUS File Layout				
This file include members do not enrolled by carrier.				
#Field	**Record fields**	**Position**	**Size**	**Notes**
1	REGION ID	1	1	
2	CERTIFICATION DATE	2	19	
3	FAMILY ID	21	11	
4	MPI NUMBER	32	13	
5	MEMBER SUFFIX	45	2	
6	COVERAGE CODE	47	3	
7	UPDATE DATE	50	19	
8	ELEGIBILITY DATE	69	19	
Record Length		88		Plus commas for csv format (94)

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Field	Name	Position	Size	Notes	Version Change	Version Change Category
1	Region Id	1	1	Filled with value in enrollment export file for field F.11 Region	Previous Version: Field: REGION ID Notes:	No change Required
2	Certification Date	2	19	Filled with value in enrollment export file for field F.59 Certification Date	Previous Version: Field: CERTIFICATION DATE Notes:	No change Required
3	Person Id	21	11	Filled with value in enrollment export file for field F.7 Person Id	Previous Version: Field: FAMILY ID Notes:	No change Required
4	MPI	32	13	Filled with value in enrollment export file for field M.50 MPI	Previous Version: Field: MPI NUMBER Notes:	No change Required
5	FILLER	45	2	filled with '00'	Previous Version: Field: MEMBER SUFFIX Notes:	No change Required
6	Coverage Code	47	3	Filled with value in enrollment export file for field M.89 Coverage Code	Previous Version: Field: COVERAGE CODE Notes:	No change Required
7	Process Date	50	19	Filled with value in enrollment export file for field F.3 Process Date	Previous Version: Field: UPDATE DATE Notes:	No change Required
8	Eligibility Effective Date	69	19	Filled with value in enrollment export file for field F.16 Eligibility Effective Date	Previous Version: Field: ELEGIBILITY DATE Notes:	No change Required

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ADDENDUM 3

*.820 Premium Payment File Layout

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GOVERNMENT OF PUERTO RICO
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
ASES

ASES/ES
ASES ENTERPRISE SYSTEMS

Puerto Rico Medicaid Enterprise - Health Insurance Plans

820 Payroll Deducted and Other Group Premium Payment for Insurance Products Companion Guide

Instructions related to the ASC X12 Payroll Deducted and Other Group Premium Payment For Insurance Products (820) transaction, based on the 005010X218 Implementation Guide for the Issuers of the Government Health Plan (GHP) known as *Plan Vital*, as established by the Puerto Rico Health Insurance Administration (ASES) Act No. 72

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Version 1.0
January 01, 2023

I. Document Information

Required Information	Description
Owner:	ASES
Date:	10/31/2022
Approved by:	Edna Y. Matin Ramos, MA Executive Director of ASES Winda J. Lorenzo González Acting Director IT

II. Document Revision History

Version number	Date	Description
v 1.0	10/28/2022	First version published for review.

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3 Preface

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

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Express permission to use X12 copyrighted materials has been granted.

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4 Table of Contents

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5 General Information

3.1 Overview of HIPAA Legislation

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

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

3.2 Compliance according to HIPAA

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

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

3.3 Compliance according to ASC X12

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

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

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3.4 Intended Use

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

3.5 Updates

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

3.6 Contacts

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

3.7 Conventions

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

a) Convention Example

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

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b) Convention Fields

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

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

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6.1 Control Segments

6.1.1 Header

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

Contrato Número

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

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

6.1.2 Trailer

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

Contrato Número

6.2 Transaction Segments

6.2.1 Header

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

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

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

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6.2.2 Detail

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

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

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Page	Min/Max	Loop	Reference	Name	Codes	Notes/Comments
						The field will be populated with multiple fields separated by "|". The fields are: - Transaction Type (size = 3) - Internal Control Number (ICN) (size = 18) - Payment Category (size = 4) - Payment Reason (size = 3) - Rate Cell Code (size = 3) - Risk Score Factor (size = up to 8) Notes: - The ICN for a Reverse Transaction will be the original transaction ICN - Risk Score Factor is only submitted for Plan Vital Capitation Payments (Payment Category = CP01)
114	1/50		REF02	Reference Identification		
115			DTM	Individual Coverage Period		Required when the premium payer is not paying from an invoice, but paying on account for a coveraged period. If not required by this implementation guide do not send.
115	3/3		DTM01	Date/Time Qualifier	582	582 - Report Period
76	2/3		DTM05	Date Time Period Format Qualifier	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD
76	1/35		DTM06	Date Time Period		Value = Coverage Period
117			ADX	Individual Premium Adjustment for Current		Required when the paid amount differs from the billed amount (RMR05 is present) in the related RMR

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

6.2.3 Trailer

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

7 Appendixes

7.1 Transaction Types

Code	*Description*
PAY	Payment
REV	Reversal

7.2 Payment Categories

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

7.3 Payment Reasons

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

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7.4 Rate Cell Codes

7.4.1 Capitation Payment

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

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

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

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

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

Code	Rate Cell
V01	Medicaid - Age 18 and under
V02	Medicaid Age 19+
V03	Medicaid Aged, Blind, Disabled
V04	CHIP All Ages

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Code	Rate Cell
V05	Commonwealth - Age 18 and under
V06	Commonwealth - Age 19+
V11	Dual A
V12	Dual AB
V13	Foster or Domestic Abuse

7.4.2 Capitation Payment - Medicaid Wraparound

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

Code	Rate Cell
38	Medicaid Platino
40	CW Platino

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

Code	Rate Cell
P01	Medicaid Platino
P02	CW Platino

7.4.3 Case Rate Payments

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

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

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

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

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7.5 File Naming Convention

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

Premium Payment Transactions: [PYYYYMM_CCPT_SS.820]

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

Example: P202301_0101_00.820

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

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7.6 Examples

7.6.1 Scenario One

Plan Vital Original Payment Example

ST*820*230019901*005010X218
BPR*I*80000000.00*C*NON******660500678******20230101~
TRN*3*20230101*660500678*~
REF*14*09~
DTM01*009*20230105~
N1*PE*PLAN VITAL INSURANCE CARRIER NAME*FI*699999999~
N1*PR*ASES*FI*660500678~
ENT*1*2J*34*599999999~
NM1*IL*1*LASTNAME1|LASTNAME2*FIRSTNAME*I*80099999999~
RMR*AZ*0080099999999|9999999999|999999999*203.98*~
REF*ZZ*REV|CP01|000|V02|1.0000|0000000000000000001~
DTM*582**RD8*20230101-20230131~**
SE*1*230019901~

7.6.2 Scenario Two

Plan Vital Adjustment Payment Example.

ST*820*230019901*005010X218
BPR*I*80000000.00*C*NON******660500678******20230101~
TRN*3*20230101*660500678*~
REF*14*09~
DTM01*009*20230105~
N1*PE*PLAN VITAL INSURANCE CARRIER NAME*FI*699999999~
N1*PR*ASES*FI*660500678~
ENT*1*2J*34*599999999~
NM1*IL*1*LASTNAME1|LASTNAME2*FIRSTNAME*I*80099999999~
RMR*AZ*0080099999999|9999999999|999999999*-203.98*~
REF*ZZ*REV|0000000000000000001|CP01|002|V02|1.0000~
DTM*582**RD8*20230101-20230131~**
RMR*AZ*0080099999999|9999999999|999999999*373.18*~
REF*ZZ*PAY|0000000000000000002|CP01|002|V11|1.0000~
DTM*582**RD8*20230101-20230131~**
SE*1*230019901~

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7.6.1 Scenario Three

Medicare Platino Original Payment Example

ST*820*230019901*005010X218
BPR*I*1000000.00*C*NON******660500678******20230101~
TRN*3*20230101*660500678*~
REF*14*09~
DTM01*009*20230105~
N1*PE*MEDICARE PLATINO INSURANCE CARRIER NAME*FI*699999999~
N1*PR*ASES*FI*660500678~
ENT*1*2J*34*599999999~
NM1*IL*1*LASTNAME1|LASTNAME2*FIRSTNAME*I*80099999999~
RMR*AZ*0080099999999*20*~
REF*ZZ*PAY|000000000000000001|CP02|000|P01~
DTM*582**RD8*20230101-20230131~**
SE*1*230019901~

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ADDENDUM 4

MCO
Objection of Payments

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Government of Puerto Rico
Puerto Rico Health Insurance Administration

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ASES
ADMINISTRACION DE SEGUROS DE SALUD DE PUERTO RICO

Objection To Payment (OTP) Interface

File Layout

Version 1.3
May, 2021

GOVERNMENT OF PUERTO RICO ASES

ADMINISTRACION DE SEGUROS DE SALUD

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General Information

This document describes the file layout required to be submitted in case of an Objection to Payment.

The information on this document is subject to continuous revisions and modifications that will be made available to all parts involved.

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Objection To Payment - Request File Layout

File Naming Convention

File Naming Convention	Part	Meaning
otp_request_cc_yyyymm_ss.txt	otp_request	Static text for interface identifier
	cc	Carrier code
	yy	Billing date year
	mm	Billing date month
	ss	Version Sequence

Notes:

Versioning
The first file submitted for a billing cycle should use *Version Sequence* equal to "00".
If a submitted file presents errors or requires adjustments, the Contractor may submit a second version incrementing by one the Version Sequence. Nonetheless, a new version can only be submitted within the 30 Calendar Days period after the payment is made.

File Content

Field#	Field Name	Description	Position	Size	Data Type	Validation Rules
1	Incurred Month	Incurred Month on the Health Plan being subject to an objection of payment	1	8	YYYYMM01	Required
2	Incurred Start Date	Start Date within the Incurred Month. This is for subperiods within a month, otherwise use first day of the month	9	8	YYYYMMDD	Required
3	Incurred End Date	End Date within the Incurred Month. This is for subperiods within a month, otherwise use last day of the month	17	8	YYYYMMDD	Required
4	MPI	Master Patient Index. (Medicaid Member Id)	25	13	X(13)	Required
5	Application Number	Medicaid Application Number	38	10	X(10)	Required
6	Eligibility Start Date	Eligibility Start Date for the Incurred Period in the Health Plan	48	8	YYYYMMDD	Required
7	Carrier	Carrier Code	56	2	X(2)	Required
8	Carrier Effective Date	Carrier Effective Date	58	8	YYYYMMDD	Required
9	Coverage Code	Coverage Code	66	3	X(3)	Required
10	DOB	Date Of Birth	69	8	YYYYMMDD	Required
11	Sex	1=Masculine, 2=Femenine	77	1	X(1)	Required
12	Group Ident	Group Identification (Government Group Code)	78	3	X(3)	Required
12.1	Group Code	Group Code (Eligibility Group Code)	81	3	X(3)	Required
13	Dual Member	Identifies if is a dual member using the following values: N=No Dual; A=Medicare Part A Only AB=Medicare Part A and Medicare Part B	84	2	X(2)	Required This information is obtained from the Insurance Records, field *Health Insurer Code*: - 003 for Part A - 009 for Part B

Field#	Field Name	Description	Position	Size	Data Type	Validation Rules
14.1	Enrollment Notification	Carrier Eligibility File Name (.EXP) where the subscription process is accepted by ASES enabling the enrollment of this member for payments. If a proper enrollment process is not yet accepted by ASES use the file name for the .EXP with the notification of the assignment for this member.	86	14	X(14)	Required if payment is expected
14.2	Enrollment Confirmation By Carrier	Enrollment Confirmation File Name (.SUS)	100	14	X(14)	Required if payment is expected and a proper enrollment has been rejected by ASES.
14.3	Enrollment Acceptance	Indicate if the subscription process is accepted by ASES using: Y: YES N: NO	114	2	X(2)	Required if payment is expected and a proper enrollment has been rejected by ASES.
15.1	HCHN Category	HCHN Category	116	20	X(20)	Required if Expected Rate Cell is HCHN
16.1	HCHN Notification	File Name for the *Report 8 - High Cost High Need (HCHN)* where the notification for this category was sent.	136	30	X(30)	Required if Expected Rate Cell is HCHN
17.1	Encounter Carrier Id	Carrier Reporting the Encounter. This is the Carrier reported on the .CLM file	166	2	X(2)	Required when: - Expected Rate Cell is MDKP - HCHN exceeding 6 months in the registry
18.1	Encounter Claim Id	Encounter Identifier. This is the Claim Id reported on the .CLM file	168	30	X(30)	Required when: - Expected Rate Cell is MDKP - HCHN exceeding 6 months in the registry

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Field#	Field Name	Description	Position	Size	Data Type	Validation Rules
19.1	Encounter Service Date	Encounter Service Date. This is the From Date associated to the Claim Id reported in the .CLM File.	198	8	YYYYMMDD	Required when: - Expected Rate Cell is MDKP - HCHN exceeding 6 months in the registry
20.1	Encounter Notification	.CLM File Name containing the Encounter that sustains the adjudication of the HCHN rate cell	206	30	X(30)	Required when: - Expected Rate Cell is MDKP - HCHN exceeding 6 months in the registry
21.1	Billing Date	Billing Date	236	8	YYYYMMDD	Required if a Payment was received
22.1	Rate Cell	Received Rate Cell	244	3	X(3)	Required if a Payment was received
22.2	Risk Score	Received Risk Score	247	6	X(6)	Required if a Payment was received (Example 1.0000)
23.1	Premium Amount	Received Premium Amount	247	7	S9(5)v99	Required if a Payment was received
24.1	Payment Objection Id	Unique Id for each transaction associated to an Objection of Payment. All responses for the objections of payment will reference this Identifier.	254	30	X(30)	Required
25.1	Objection Type	PP=Premium Payment (Capitation Payment) MDKP=Maternity Delivery Kick Payment	284	4	X(4)	Required
26.1	Expected Rate Cell	Expected Rate Cell	288	2	X(2)	Required
27.1	Expected Premium Amount	Expected Premium Amount	290	7	S9(5)v99	Required
28.1	Comments	Additional Comments explaining the objection of payment	297	200	X(200)	Required
29	End of Record	End of Record Filler	497	1	*	Required

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Objection To Payment - Error File Layout

File Naming Convention

File Naming Convention	Part	Meaning
otp_response_cc_yyyymm_ss.err	otp_response	Static text for interface identifier
	cc	Carrier code
	yy	Billing date year
	mm	Billing date month
	ss	Version Sequence

File Content

The error file to the objection of payment will contain the Objection Payment Id and the following fields

Field#	Field Name	Description	Position	Size	Data Type
1	Rec_file	Record Line	1	6	Number
2	payment_objection_id	Objection of Payment Id received from the carrier.	7	30	Varchar(30)
3	err_code	Error Code	37	5	Varchar(5)
4	field_name	Fields that affect the rule	42	150	Varchar(150)
5	description	Description	192	100	Varchar(100)
6	Filler	End of Record Filler (*)	292	1	*

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Objection To Payment - Response File Layout

File Naming Convention

File Naming Convention	Part	Meaning
otp_response_cc_yyyymm_ss.txt	otp_response	Static text for interface identifier
	cc	Carrier code
	yy	Billing date year
	mm	Billing date month
	ss	Version Sequence

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File Content

The response file to the objection of payment will contain the Objection Payment Id and the following fields

Field#	Field Name	Description	Position	Size	Data Type	Validation Rules
1	Payment Objection Id	Objection of Payment Id received from the carrier.	1	30	X(30)	Required
2	Evaluation Result	Accepted, Rejected, InProcess	31	9	Varchar(9)	Required
3	Evaluation Explanation	If the Evaluation Result is Rejected then an explanation is provided.	40	100	Varchar(100)	Required if Rejected
4	End of Record	End of Record Filler	140	1	*	Required

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ADDENDUM 5

CARRIER to ASES ver 4.1C_rev.20220912

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Carrier to ASES Data Submissions

New File Layouts

Version 4.1C

September 12, 2022

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Version Changes

Version 3.0A

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

CAPITATION Input File Layout

CAPITATION TYPE field was modified.

PROVIDER Input File Layout

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

CLAIMSERVICES Input File Layout - Added

New fields added to the layout.

Data Validation and Auditing Change

New section regarding data validation and auditing added.

Version 3.0A rev3

Provider, Network, and IPA Files Layout

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

CLAIMSERVICES Input File Layout

PLAN TYPE field and PLAN VERSION LIST were modified.

Version 3.0A rev4

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

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Version 3.0A rev5

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

Version 4.0B

Additional Provider and Network files content requirements were added, for required fields that are unavailable for "Out of Network" providers.
New descriptions and/or validation rules were added to the CLAIMSERVICES Input File Layout, applicable to GHIP and Government Employee Carriers.
CARRIER CODES, PLAN VERSION LIST and Place of Service Codes were modified.

Version 4.0C

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

Version 4.1C

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

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

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

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Introduction

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

Claims Transaction Handling

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

Paid or Denied FFS Claims

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

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

Encounter Claims

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

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

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

Provider, IPA and Network Files

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

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

The Provider and Network files must include:

- all "In Network" providers directly contracted or sub-contracted with the carrier,
- any "Out of Network" providers included on the CLM file,
- all providers included on the CAP file (only applicable for the Provider File and excluding PMGs).

For "Out of Network" provider records, the carrier's will report as much information as available on their systems. The carrier shall submit "Out of Network" provider records with a contract effective date equal to '99991231'. For any required fields for which the carrier does not have valid information, the fields must be left blank.

ASES is requesting that provider NPIs are to always be used as the PROV_ID in order to assist in provider attribution and reporting across all Carriers. ASES will not accept the carrier's own provider id as the provider ID for medical claim, unless the carrier presents a valid reason for not using NPI's. Consequently, for providers that don't qualify to obtain an NPI by the nature of its business, the carrier may submit the Tax Id of the provider as the PROV_ID to which the capitation payment is made. The carrier will have to present an official notification to ASES of every provider that was reported with a Tax Id in lieu of an NPI.

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For pharmacy claims only

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

Capitation Files

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

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

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

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

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

Capitation Adjustments

There may be circumstances in which capitation payments which have already been reported, need to be adjusted or reversed in a later month. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record

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for the provider / member / experience date with the amount(s) to be added or subtracted from the previously reported amount(s), specifically for the following fields: Capitation Amount, Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date, a Capitation Amount of -$10.00, and the corresponding adjustments to the Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent fields as well. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

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

Data Validation and Audit Process

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

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

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

Claims, Capitation and Encounter Lag Reports

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

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The claims and capitation lag reports submitted by the carrier will be considered to be financially accurate and may be used for other purposes, including negotiations or other financial analyses. Therefore, it is in the carrier's best interests to produce lag reports that are either from another source that the actual files that are submitted, or to verify that the lag reports tie to financial reports.

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

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

CLAIMLAG_ccyymms.xls(x)

Where:

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

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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
…	…	…	…

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

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

ENCOUNTERLAG_ccyymms.xls(x)

Where:

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

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

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

Primary Carrier ID

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

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

General Notes on Field Level Requirements

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

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

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

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

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

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

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

- `S` - Leading sign
- `9(7)` - 7 decimal digits
- `V` - Implied decimal point
- `99` - 2 digits after the implied decimal point

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

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

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

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

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

Data File Naming Conventions

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

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

The general format of file names will be –

Dccyymms.fff.zip

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

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Character 4-5	**yy**	=	Last two digits of year
Characters 6-7	**mm**	=	Month
Character 8	**s**	=	sequence number of file submission.

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

Character 9 Always "."

Characters 10-12 Extension code identifying type of file

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

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

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

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

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

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

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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 "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05", "06" and "09" value must be "X".**

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
3	plan_type	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD 04 = Law 95 Commercial 05 = Law 95 Advantage 06 = Law 95 ELA-GHP **07 = Commercial non-Law 95** **08 = Advantage non-Law 95** **09= LAW 95 Pensioned Police**	**XX**	Required **Must equal "01", "02", "03", "04", "05", "06", "09"** Value "01" must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID. Values of "04" or "05" must correspond to Government Employee Carrier ID. Value "06" must correspond to Government Employee Carrier ID for ELA-GHP ("ELA Puros"). **Values of "07" or "08" must correspond to carrier, which is not plan type "01"-"06" or "09".** **Value "09" must correspond to government employee carrier ID for Pensioned Police.**
4	contract_type	**Contract Type**	Contract type to distinguish multiple plans within Plan Type. For government employee claims indicates contract type: 1 = Family 2 = Couple 3 = Individual 4 = Optional Dependent	**X**	**Required for Plan Type "04", "05", "06" and "09" (Government Employee)** Not required for Plan Type "01", "02", or "03".
5	claim_id	**Claim ID**	Unique Identification number within Carrier for the claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.

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CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
6	sv_line	**Service Line Number**	Number identifying individual service within a given claim.	**XXXXX**	Required Must be a maximum of 5 digits. ID of the Service Line within the Claim ID. Duplicates within Claim ID and Service Line Number on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier).
7	bill_type	**Bill Type**	Originating bill type – U=UB-04 / Institutional H=HCFA/CMS1500 / Individual / Professional P=Pharmacy Claim D=Dental Claim	**X**	Required Must equal "U", "H", "P" or "D".
8	ub_bill_type	**UB Type of Bill**	Type of Bill on the UB claim form. The type of bill encodes facility type, bill classification, and description.	**XXX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard three digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
9	sv_stat	**Claim Line Status**	Indicates payment action on the service represented by this record. P= Paid D=Denied A=Adjustment R=Reversal E=Encounter	**X**	Required Must equal "P", "D", "A", "R" or "E" If value is "E", service will have zero Paid Amount.

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CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
10	adj_code	**Adjustment Reason Code**	Adjustment reason code explaining why a claim payment was adjusted. Codes used are the X12 code list maintained by CMS and NUCC. The code set can be found at the following site: http://www.x12.org/codes/claim-adjustment-reason-codes/	**XXX**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A". Right justified. For claims without adjustment, this field must be left blank.
11	forced_claim_ind	**Forced Claim Indicator**	This code indicates if the claim was processed by forcing it through a manual override process.	**X**	'Y'- Yes 'N' - No
12	adm_date	**Admit Date**	For UB-04 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	**YYYYMMDD**	Required Must be a valid date.
13	dis_date	**Discharge Date**	For UB-04 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	**YYYYMMDD**	Required Must be a valid date Must be equal or later than Admit Date
14	from_date	**Service From Date**	Begin date of the treatment.	**YYYYMMDD**	Required Must be a valid date.
15	to_date	**Service To Date**	End date of the treatment.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service From Date
16	paid_date	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service To Date

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	rec_date	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Discharge Date
18	entry_date	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Received Date
19	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
20	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
21	primary_center	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Must be present on all claims of Plan Type "01", except on claims from plan version 970. May be present on claims of other Plan Types When present it indicates the Primary Care Center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Carrier ID and IPA.
22	ssn_mainh	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
23	ssn	**Patient Social Security**	Social Security Number of member	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
24	member_suffix	**ASES Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be ASES Assigned member suffix. All numeric value 01 to 99.
25	patient_name	**Patient Name**	Member Name	**X(30)**	Required Must be left justified, blank filled to the right.
26	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
27	sex	**Sex Code**	Gender of member M = Male F = Female	**X**	Required Must equal "M" or "F"
28	birth_date	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date. Must be equal or earlier than Admit Date.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	municipality_res	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
30	municipality_code	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled. For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
31	drg_code	**DRG Code**	Diagnosis Related Group Code	**XXXX**	Must be a valid DRG Code
32	drg_type	**DRG Type Code**	DRG Type Code, representing the type of DRG Code submitted on the claim.	**X**	Required when DRG is provided. Must be one of the following: 1= MS DRG 2= CMS DRG 3= AP DRG 4= APR DRG
33	drg_outlier_amt	**DRG Outlier Amount**	Additional amount paid by carrier on a claim that is associated with either a cost outlier or length of stay outlier.	**S9(7)v99**	For claims submitted on Uniform Bill (UB) claim form. Must be zero for encounters. Must be zero for Services with Payment Status of "D". On non-UB claims must be blank.
34	drg_rel_weight	**Relative DRG Weight**	Indicates the relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year.	**X(6)**	If populated, must be a valid weight without any decimal points. Left justified, blank filled. A DRG weight of 2.397 should be reported as 2397.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
35	pre_auth_num	**Pre-Authorization Number**	The number identifying pre-authorization. An unique identification number, that indicates the services provided on this claim have been authorized by the carrier (Also called Prior Authorization)	**X(20)**	Should be supplied when available. Left justified, blank filled to 20 characters if value is less than 20 characters.
36	proc_code	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	**X(15)**	For claims from CMS1500 / UB-04, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code. For Pharmacy claims this must be all blanks.
37	cpt_mod_1	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code.
38	cpt_mod_2	**Procedure Modifier Code 2**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code Must be left blank for encounters
39	cpt_mod_3	**Procedure Modifier Code 3**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
40	cpt_mod_4	**Procedure Modifier Code 4**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
41	cpt_mod_5	**Procedure Modifier Code 5**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
42	cpt_mod_6	**Procedure Modifier Code 6**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
43	rev_code	**Revenue Code**	For UB-04 Claims NUBC Revenue Code	X(4)	Required for UB-04 claims. When present it must be a valid Revenue code. Must be zero filled to the left.
44	rx_ndc	**National Drug Code**	For Pharmacy only. National Drug Code value for prescribed drug in 5 4 2 format	X(11)	Required on Pharmacy claims. Must be a valid NDC code in 5 4 2 format filling all 11 bytes. For non-Pharmacy claims must be blank.
45	tooth_code	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	XXX	Must be present on Dental claims when Procedure code requires Tooth Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.
46	surface_code	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	X(7)	Must be present on Dental claims when procedure code requires Surface Code. Must be a valid Surface Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.

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

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
51	Icd_diag_05	**Fifth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
52	Icd_diag_06	**Sixth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
53	Icd_diag_07	**Seventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
54	Icd_diag_08	**Eighth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
55	Icd_diag_09	**Ninth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
56	Icd_diag_10	**Tenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
57	Icd_diag_11	**Eleventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
58	Icd_diag_12	**Twelfth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
59	icd_proc_01	**Primary ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
60	icd_proc_02	**Second ICD10 Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
61	icd_proc_03	**Third ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
62	icd_proc_04	**Fourth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
63	icd_proc_05	**Fifth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
64	icd_proc_06	**Sixth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
65	pcp_prov_id	**PCP Provider**	National Provider Identifier (NPI) of the member's PCP.	**X(20)**	Required for Plan Type "01" claims Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
66	att_prov_id	**Attending Provider**	National Provider Identifier (NPI) of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
67	att_taxonomy	**Attending Provider Taxonomy**	Indicates the corresponding provider taxonomy of billing entity/provider, to define provider's type, classification, and area of specialization. The taxonomy code for the institution billing/caring for the beneficiary.	**X(12)**	Required Left justified, blank field to the right.
68	ref_prov_id	**Referring Provider**	National Provider Identifier (NPI) of referring provider, when applicable.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.
69	ref_prov_taxonomy	**Referring Provider Taxonomy**	Indicates the corresponding provider taxonomy of referring provider, to define provider's type, classification, and area of specialization.	**X(12)**	Left justified, blank field to the right.
70	bill_prov_id	**Billing Provider**	National Provider Identifier (NPI) of the provider billing for the service.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
71	network_affiliation	**Network Affiliation**	Indicates if the service provider is in the preferred provider network or not. Y = Yes N = No	**X**	Required Must be "Y" or "N".

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#	Field	Name	Description	Deliverable Data Format	Validation Rules
72	primary_carrier_id	**Primary Carrier ID**	Value that identifies the primary carrier providing service to the patient. May be the same as the carrier_id field or another carrier as a sub-contractor – a MBHO, Vision, or Dental plan. See Carrier ID List in Attachment II	**XX**	Required Must be two (2) digits (alpha-numeric). Must equal a valid Carrier ID as assigned by ASES if one has been assigned. If sub-contracted entity does not have a carrier code assigned by ASES, the following default codes may be used to represent the type of sub-contracted entity is the primary carrier: MB – Mental Health VS – Vision DN – Dental OT – Other/Unknown Carrier Type
73	pos_code	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	**XX**	Required Must be a valid Place of service Code.
74	cob_code	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise.	**X**	Required Must be "Y" or "N"
75	amt_billed	**Billed Amount**	For non-Pharmacy Cost of service as billed by the provider.	**S9(7)v99**	Required for non-Pharmacy claims. Must be a number on all non-pharmacy records. Cannot be left blank for non-pharmacy.

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

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
81	amt_paid	**Paid Amount**	Amount paid by carrier for this service	**S9(7)v99**	Required Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with sv_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – For non-Pharmacy: amt_paid = amt_allowed - deduct - copay - cob - coins For Pharmacy: amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee **For Plan Type "02", "03", "04", "05", "06", "09" only - amt_paid may be zero if the appropriate calculation above results in 0.00.** For Plan Type "01" the amt_paid must be greater than zero.
82	enc_proxy_price	**Encounter Proxy Price**	This field shows the amount that would have been paid for this exact same service if it had been processed as a Fee For Service claim. It does not represent an actual dollar disbursement.	**S9(7)v99**	Required on Encounter claims. On non-encounter claims, it must be blank.

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

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

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

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

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
99	ub_dis_stat	**UB Discharge Status Code**	On UB-04 claims, Patient Status Code at discharge.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard two digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
100	risk_type	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Shared risk agreement should be identified as "SHR" Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM only value can be "UNK"
101	stop_loss_flag	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member Otherwise "N". When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"	**X**	Required Must be filled ""Y" or "N"
102	applied_cost	**Cost Applied To**	For Medicare Platino, defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	**X**	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled and be a valid value. **Not Required for Plan Type "01", "04", "05", "06","09"**

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#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
103	ases_split_amt	**ASES Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to ASES coverage.	**S9(7)v99**	Must be filled if Cost Applied To = "1" or "3" **Not Required for Plan Type "01", "04", "05" , "06" or "09".**
104	cms_split_amt	**CMS Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to CMS (MA) coverage.	**S9(7)v99**	Required for Plan Type "02" and "03" (Medicare Platino) **Must be filled if Cost Applied To = 2 or 3** **Not Required for Plan Type "01", "04", "05", "06" or "09"**
105	off_island	**Off Island Flag**	Indicator for whether service was located off of the islands of Puerto Rico, Culebra, and Vieques.	**X**	Required Y=Off Island N=On Island
106	plan_version	**Plan Version**	Plan Version to distinguish multiple plans within the Plan Type. Always three numeric characters, e.g. 001 See Plan Version List in Attachment VI	**XXX**	Required Must be a 3 digit Plan Version Code Carrier ID, Plan Type, and Plan Version must validate with a plan definition contracted with ASES. **Required for Plan Type "02", "03" (Medicare Platino), "04", "05", "06" and "09"** Not Required for Plan Type "01"
107	sv_units	**Units of Service**	Number of occurrences of service	**9(10)**	When present must be a number.
108	claim_type	**Claim Type**	Claim Type: I=Inpatient O=Outpatient P=Professional	**X**	Required for all medical claims. For Rx and Dental claims, this field can be left blank. Must equal "I", "O" or "P" if populated.

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

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

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

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

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

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

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

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

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

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

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

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

RECORD LENGTH	**977**

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PROVIDERS INPUT FILE LAYOUT

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

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PROVIDERS INPUT FILE LAYOUT

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

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

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

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

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PROVIDERS INPUT FILE LAYOUT

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

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PROVIDERS INPUT FILE LAYOUT

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

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IPA INPUT FILE LAYOUT

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

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IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	federal_tax_id	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	ipa_npi	**IPA NPI**	National Provider Identifier (NPI) of the IPA., where possible.	**X(10)**	Required Left justified, blank field to the right.
17	ipa_adm_lname	**IPA Administrator Lname**	IPA/HCO Administrator Last Names (Apellidos)	**X(50)**	Required Must be left justified, blank filled to the right
18	Ipa_adm_fname	**IPA Administrator Fname**	IPA/HCO Administrator First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
19	prov_mname	**IPA Administrator Mname**	IPA/HCO Administrator Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
20	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**580**

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CAPITATION INPUT FILE LAYOUT

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

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CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	region_code	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05" "06" and "09", value must be "X".**
10	municipality_code	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
11	member_ssn	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric) Right justified, zero filled
12	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.

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CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
13	member_suffix	**Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be 2 digits (numeric)
14	cap_amt	**Capitation Amount**	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
15	gross_cap_amt	**Gross Capitation Amount**	Gross Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
16	net_cap_amt	**Net Capitation Amount**	Net Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

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CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	risk_type	**MPI Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" If the risk is shared then the value =' SHR' Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR".	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM the only value should be "UNK"
18	tier	**Member capitation tier**	Member capitation tier 0001 Medicare A&B Male 0002 Medicare A Male 0006 Medicare A&B Female 0007 Medicare A Female 0008 0-11 Months 0009 12-23 Months 0010 24 Months - 10 Years 0011 11 - 18 Years 0024 19 - 35 Female 0025 19 - 35 Male 0026 36 - 54 Female 0027 36 - 54 Male 0028 55 - 64 Female 0029 55 - 64 Male 0031 65 + Female 0032 65 + Male	**X(4)**	Required
19	days	**Capitation days**	Number of days included in capitation amount.	**S99**	Required Must be a number 3 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 2 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

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CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
20	mem_percent	**Capitation percentage**	Percentage (days / month days)	**S999**	Required Must be a number 4 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 3 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
21	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
22	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
23	Federal_Tax_ID	**Federal Tax ID (SSN or EIN)**	The federal identification number of the provider to which the capitation payment is made. If the provider does not have a federal identification number, enter '999999999' in this column. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
24	filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**193**

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NETWORK INPUT FILE LAYOUT

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

ADMINISTRACION DE SEGUROS DE SALUD
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NETWORK INPUT FILE LAYOUT

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

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NETWORK INPUT FILE LAYOUT

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

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NETWORK INPUT FILE LAYOUT

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENTS

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

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

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

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

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

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

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

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

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

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

NOTE: Any municipality code may appear in region SPECIAL.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

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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)
44	Infectious Disease

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

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

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ATTACHMENT III - SPECIALTY CODES

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
BB	Blood Bank
CV	Cardiac Catheterization Facility
DC	Detox Center
DD	Dentist
DF	Dialysis Facility
EC	Emergency Care Facility
EN	Endodontist

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
G1	Geneticist
HE	Health Educator
HN	Home Health Nurse
HV	HIV Ambulatory Antibiotic Facility
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
N1	Neonatology
NI	Neonatal ICU
O1	Occupational Medicine
OP	Optical
P1	Perinatology
P2	Pediatric Surgery
PC	Clinic – Primary Level
PE	Periodontist
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
RT	Respiratory Therapist
SH	State Hospital
SP	State Psychiatric Hospital
ST	Short Term Intervention Center (Behavioral Health-Stabilization Unit)
XR	X-ray Facility

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ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Z4	Cardiovascular Surgery Program

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

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

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

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

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment- Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus- Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

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ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	**Non-residential Opioid Treatment Facility**	**A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).**
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A

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ATTACHMENT IV - PLACE OF SERVICE CODES

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

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ATTACHMENT V - PROVIDER TYPE CODES

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

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ATTACHMENT VI – PLAN VERSION LIST

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

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

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

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

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

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

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05	79	510	ELA TE AYUDA OSS-PDS	Regular	HMO	
05	79	511	ELA MAXIMO OSS-PDS	Regular	HMO	
04	80	401	Oro	Regular	MCO	
04	80	402	Plata	Regular	MCO	
04	80	403	Bronce	Regular	MCO	
04	80	404	Rubi	Regular	MCO	
04	80	405	Diamante	Regular	MCO	
04	80	406	Complementaria de Medicare	Regular	MCO	
04	80	407	Mandatoria	Regular	MCO	
04	80	408	Alterno 1	Regular	MCO	
04	80	409	Alterno 2	Regular	MCO	
04	80	410	Mandatorio ULTRA	Regular	MCO	
04	80	411	Alternativa 1 MAX	Regular	MCO	
04	80	412	Alternativa 2 FIT	Regular	MCO	
04	82	403	Bronce	Regular	MCO	
04	82	404	Alternativa 1 Premium ELA RUBI	Regular	MCO	
04	82	405	Diamante	Regular	MCO	
04	82	406	Complementaria de Medicare	Regular	MCO	
04	82	407	Alternativa 2 Classic ELA RUBI	Regular	MCO	
04	82	408	Alterno 1	Regular	MCO	
04	82	409	Alterno 2	Regular	MCO	
06	82	400	Coverage 400 (ELA)	Regular	HMO	
09	82	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	87	501	Oro	Regular	HMO	
05	87	502	Plata	Regular	HMO	
05	87	503	Bronce	Regular	PPO	
05	87	504	Rubi	Regular	HMO	
05	87	505	ELA Royal	Auto-Enrollment	HMO	
05	87	506	ELA Óptimo	Auto-Enrollment	HMO	
05	87	507	ELA Royal Plus	Auto-Enrollment	HMO	
05	87	508	ELA Titán	Auto-Enrollment	HMO	
05	87	509	ELA Óptimo Plus	Auto-Enrollment	HMO	

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05	88	501	MMM ELA Advantage	Regular	PPO	
05	88	502	Plata	Regular	PPO	
05	88	503	Bronce	Regular	PPO	
05	88	504	Rubi	Regular	PPO	
05	88	505	Premium	Auto-Enrollment	PPO	
05	88	506	Premium 2	Auto-Enrollment	PPO	
05	88	507	Plus	Auto-Enrollment	PPO	
06	91	400	Coverage 400 (ELA)	Regular	HMO	
09	91	400	Coverage 400 (ELA)	Retired Policemen	HMO	

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ATTACHMENT VII – CAPITATION TYPE LIST

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

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ATTACHMENT VIII - HOUR CODES

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

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ADDENDUM 6

Coordination of Benefits (COB)

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Puerto Rico Medicaid Enterprise - Health Insurance Plans

ASES COB Data Submissions (Third Party Liability)

Interface Control Document

Version 1.8.3
January 01, 2023

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I. Document Information

Required Information	Description
Owner:	ASES
Date:	10/31/2022
Approved by:	Edna Y. Marin Ramos, MA Executive Director of ASES Winda J Lorenzo Gonzalez Acting Director IT

II. Document Revision History

Version number	Date	Description
v 1.0	10/28/2022	First version published for review.

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Change History

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

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Preface

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

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

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

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

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

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

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

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1 Introduction

1.1 Coordination of Benefits (COB)

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

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

1.2 Data Validation Process

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

All files which are rejected will be notified to the Insurer with an explanation of why the file is rejected. No records from such a file will be retained in the system and the Insurer will be required to resubmit the rejected file in its entirety before the next month's files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

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1.3 General Notes on data layout requirements

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

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

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

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

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

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically numeric field are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a 9(7)v99 where v represents an implied decimal the following examples illustrate how data will look in the field:

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

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

Value	**Field**
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]

2 File Naming Convention

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

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

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

Where:	Character 1-3	ccc	=	Insurer Code (See attachment I)
	Character 4-5	yy	=	Last two digits of year
	Characters 6-7	mm	=	Month
	Character 8	s	=	sequence number of file submission.

All submission start with s = 0 and continue in numeric if files are re-submitted to 9

If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …

Character 9	Always "."
Characters 10-12	Extension code identifying type of file

COB for COORDINATION OF SERVICES

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

Examples of completing this naming convention are –

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

Coordination of Services 09613040.COB

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

09612041.COB

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

09612041.ERR

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

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

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

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

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

XLS for MS EXCEL FILE FORMAT

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Examples of completing this naming convention are –

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

Transmittal Sheet 0961304230-tr.XLS

Data File Text Format

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

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3 File Layout - Insurer COB File - COB Record

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

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11	INSURANCE_COVERAGE	Insurance Coverage	79	20	(See Appendix II) Include all coverage codes with Insurance for covered individual.Concatenate all codes.	Required. For Medicare coverage Plans use letter C,F or G only. DO NOT USE COMMAS TO SEPARATE CODES.

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

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

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

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4 File Layout - Error COB File

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

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5 Appendixes

Appendix 1 - Insurer Codes

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

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

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

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

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

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Appendix 2 -Insurance Coverage

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

Appendix 3 - Services Type Codes

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

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

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Appendix 4 - Error Codes

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

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

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Appendix 3 - Transmittal Sheet

NOMBRE DE ASEGURADORA
HOJA DE TRAMITE ARCHIVOS COB
ENVIO DE ARCHIVOS

FECHA DE ENVIO:

ENVIADO A: ASES_COB@asespr.org

ENVIADO POR:

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

PARA USO DE ASES	
RECIBIDO EN ASES POR:	FECHA: / /

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

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

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ADDENDUM 7

Transition of Care

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Transition of Care File

Case Management

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item num	Record Fields	Description	Position	Size	Data Type	Required/Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	PCP_Name	PCP Name	272	30	Varchar	R	
16	PCP_NPI	PCP NPI	302	10	Numeric	R	
17	Servicing_NPI	Servicing Provider NPI	312	10	Numeric	R	
18	Servicing_Specialty	Servicing Provider Specialty type	322	2	Varchar	R	
19	Servicing_Name	Servicing provider Name	324	30	Varchar	R	
20	Servicing_Phone	Servicing provider phone number	354	10	Numeric	R	9999999999
21	Care_Ma_Prog	Care Management Program	364	500	Varchar	R	
22	Prog_Start_Date	Program Start Date	864	8	Numeric	R	YYYYMMDD
23	Prog_End_Date	Program End Date	872	8	Numeric	R	YYYYMMDD (for open period use 20990101)
24	Diag_Code1	Primary Diagnostic Code	880	8	Varchar	R	
25	Diag_Code2	Diagnosis Code	888	8	Varchar	R	
26	Diag_Code3	Diagnosis Code	896	8	Varchar	R	
27	Diag_Code4	Diagnosis Code	904	8	Varchar	R	
28	Diag_Code5	Diagnosis Code	912	8	Varchar	R	
29	Problem	Problems/Situations	920	500	Varchar	R	situations
30	Intervention	Interventions (ongoing and Pending)	1420	500	Varchar	R	Include one or more inverventions
			1920				

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Code	Code Description
HIV	HIV CATASTROPHIC DIAGNOSIS
NEPH	NEPHROLOGY - ESRD V
OBGY	OBGYN DIAGNOSIS
ONCO	ONCOLOGY CATASTROPHIC DIAGNOSIS
TRAN	ORGAN TRANSPLANT
PNEP	CHRONIC RENAL DISEASE III & IV
GANAP	APLASTIC ANEMIA
ARRE	REHUMATOID ARTHRITIS
UTIP	AUTISM
SCLE	SCLERODERM
MSCL	SCLEROSIS MULTIPLE
CYFI	CYSTIC FIBROSIS
HEMO	HEMOFILIA
LEPR	LEPRA
LUPU	LUPUS
TUBE	TUBERCULOSIS
CSN	CHILDREN WITH SPECIAL NEEDS
ADHD	ADHD Diagnosis
CMH	Chronic Mental Health Patient
SBUP	Buprenorphine Patient
DIAB	Diabetes Type 1
MOB	Morbid Obesity
PKU	Phenylketonuria (PKU)
PH	Pulmonary Hypertension
PCC	Palliative Care in Cancer (PCC)
ZIKA	Children in ZIKA care & following

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Transition of Care File
Disease Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	Servicing_NPI	Servicing Provider NPI	272	10	Numeric	R	
16	Servicing_Specialty	type	282	2	Varchar	R	
17	Servicing_Name	Servicing provider Name	284	30	Varchar	R	
18	Servicing_Phone	number	314	10	Numeric	R	
19	Diag_code1	Diagnosic Code	324	8	Varchar	R	ICD 10
20	Diag_code2	Diagnosic Code	332	8	Varchar	R	ICD 10
21	Diag_code3	Diagnosic Code	340	8	Varchar	R	ICD 10
22	Diag_code4	Diagnosic Code	348	8	Varchar	R	ICD 10
23	Diag_code5	Diagnosic Code	356	8	Varchar	R	ICD 10
24	Condition_for_program	Condition	364	8	Varchar	R	ICD 10
25	Severity	Severity	372	10	Varchar	R	Low, Medium, High
			382				

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Transition of Care File

Hospital Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/Optional	Notes
1	Carrier_source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	Adm_date	Admision Date	272	8	Numeric	R	YYYYMMDD
16	Dis_date	Actual Discharge Date	280	8	Numeric	R	YYYYMMDD
17	Hosp_NPI	Hospital NPI	288	10	Numeric	R	
18	Hosp_Name	Hospital Name	298	30	Varchar	R	
19	Adm_Diag1	Admission Diagnosis	328	8	Varchar	R	ICD 10
20	Adm_Diag2	Admission Diagnosis	336	8	Varchar	R	ICD 10
21	Adm_Diag3	Admission Diagnosis	344	8	Varchar	R	ICD 10
22	Adm_Diag4	Admission Diagnosis	352	8	Varchar	R	ICD 10
23	Adm_Diag5	Admission Diagnosis	360	8	Varchar	R	ICD 10
24	Adm_type	Admission type	368	2	Varchar	R	**PH**=Physical, **ME**=Mental, **MP**=Mental Partial, **SN**=skill nursing facility
25	Dis_diag1	Discharge Diagnostic	370	7	Varchar	R	ICD 10
26	Dis_diag2	Discharge Diagnostic	377	7	Varchar	R	ICD 10
27	Dis_diag3	Discharge Diagnostic	384	7	Varchar	R	ICD 10
28	Dis_diag4	Discharge Diagnostic	391	7	Varchar	R	ICD 10
29	Dis_diag5	Discharge Diagnostic	398	7	Varchar	R	ICD 10
30	Authorization_number	For references	405	15	Varchar	R	
			420				

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Transition of Care File
Life Support Case Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	Servicing_NPI	Servicing Provider NPI	272	10	Numeric	R	
16	Servicing_Specialty	Servicing Provider Specialty type	282	2	Numeric	R	
17	Servicing_Name	Servicing provider Name	284	30	Varchar	R	
18	Servicing_Phone	Servicing provider phone number	314	10	Numeric	R	9999999999
19	Req_NPI	Requesting Provider NPI	324	10	Numeric	R	
20	Req_Specialty	Requesting Provider Specialty type	334	10	Numeric	R	
21	Req_Name	Requesting provider Name	344	30	Varchar	R	
22	Req_Phone	Requesting provider phone number	374	10	Numeric	R	9999999999
23	Service_Pla_Trans	Services In place to be transitioned	384	10	Varchar	R	
24	Service_Code1	Service codes	394	10	Varchar	R	CPT, No decimal period
25	Service_Code2	Service codes	404	10	Varchar	R	CPT, No decimal period
26	Service_Code3	Service codes	414	10	Varchar	R	CPT, No decimal period
27	Service_Code4	Service codes	424	10	Varchar	R	CPT, No decimal period
28	Service_Code5	Service codes	434	10	Varchar	R	CPT, No decimal period
29	Resquest_date	Authorization request date	444	8		R	YYYYMMDD
30	Approved_date	Approved date	452	8	Numeric	R	YYYYMMDD
31	Place_of_Service	Place of Services	460	10	Numeric	R	See Place of Service TAG (Source Milliman Layout)

Todos los procedimientos incluidos en una misma transacción debe ser aprobados en la misma fecha. La fecha de comienzo y/o terminación de aplicar deben coincidir, de lo contrario, se requiere emitir otra transacción.

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32	Service_Start_Period	Period Start Date	470	8	Numeric	R	YYYYMMDD
33	Service_Expected_End	Expected Period End Date	478	8	Numeric	R	YYYYMMDD
34	Diag_code1	Diagnosis Code	486	6	Varchar	R	ICD 10
35	Diag_code2	Diagnosis Code	492	6	Varchar	R	ICD 10
36	Diag_code3	Diagnosis Code	498	6	Varchar	R	ICD 10
37	Diag_code4	Diagnosis Code	504	6	Varchar	R	ICD 10
38	Diag_code5	Diagnosis Code	510	6	Varchar	R	ICD 10
			516				

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Transition of Care File

OBGYN Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item num	Record Fields	Description	Position	Size	Data Type	Required/Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	PCP_Name	PCP Name	272	30	Varchar	R	
16	PCP_NPI	PCP NPI	302	10	Numeric	R	
17	Req_NPI	Requesting Provider NPI	312	10	Numeric	R	
18	Req_Specialty	Requesting Provider Specialty type	322	10	Numeric	R	
19	Req_Name	Requesting provider Name	332	30	Varchar	R	
20	Req_Phone	Requesting provider phone number	362	10	Numeric	R	
21	OB_NPI	OBGYN NPI	372	10	Numeric	R	
22	OB_Group	OBGYN -PMG	382	20	Varchar	R	If apply
23	OB_Name	OBGYN Physician Name	402	30	Varchar	R	
24	OB_Phone	OBGYN phone number	432	10	Numeric	R	9999999999
25	Program	Program	442	20	Varchar	R	
26	Preg_Trim_Reg	Pregnant Woman Trimester at Registry	462	1	Numeric	R	
27	Est_Date_Deli	Estmated Date of Delivery	463	8	Numeric	R	YYYYMMDD
28	Preg_High_Risk	Pregnant Woman is a High Risk YES/NO?	471	1	Varchar	R	Y/N
29	Prog_Start_Date	Registry Program Start Date	472	8	Numeric	R	YYYYMMDD
30	Prog_End_Date	Registry Program End Date	480	8	Numeric	R	YYYYMMDD (for open period use 20990101)
31	Diag_Code	Primary Diagnostic Code	488	8	Numeric	R	ICD 10
32	Diag_Code	Diagnosis Code	496	8	Numeric	R	ICD 10
33	Diag_Code	Diagnosis Code	504	8	Numeric	R	ICD 10
34	Diag_Code	Diagnosis Code	512	8	Numeric	R	ICD 10
35	Diag_Code	Diagnosis Code	520	8	Numeric	R	ICD 10
36	Last_men_date	last menstruation date	528	8	Numeric	R	YYYYMMDD
37	Problems	Problems	536	500	Varchar	R	Care Plan Problems. One or more situations
38	Intervention	Interventions (ongoing and Pending)	1036	500	Varchar	R	Include one or more inverventions
			1536				

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Transition of Care File
PA Denied Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/ Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	O	9999999999
15	Req_NPI	Requesting Provider NPI	272	10	Numeric	R	
16	Req_Specialty_code	Requesting Provider Specialty type	282	2	Numeric	R	
17	Req_Name	Requesting provider Name	284	30	Varchar	R	
18	Req_Phone	Requesting provider phone number	314	10	Numeric	R	9999999999
19	Service_Denied1	Procedure code denied	324	6	Numeric	R	CPT, No decimal period
20	Service_Denied2	Procedure code denied	330	6	Numeric	R	CPT, No decimal period
21	Service_Denied3	Procedure code denied	336	6	Numeric	R	CPT, No decimal period
22	Service_Denied4	Procedure code denied	342	6	Numeric	R	CPT, No decimal period
23	Service_Denied5	Procedure code denied	348	6	Numeric	R	CPT, No decimal period
24	Request_date	Authorization request date	354	8	Numeric	R	
25	PA_Denial_Determ_Date	PA Denial Determination Date	362	8	Numeric	R	YYYYMMDD - Considered up to 60 days to summit the appeal
26	Total_Units_Denied	Total Units Denied	370	3	Numeric	R	
27	Diag_Code1	Primary Diagnostic Code	373	8	Numeric	R	ICD 10
28	Diag_Code2	Diagnosis Code	381	8	Numeric	R	ICD 10
29	Diag_Code3	Diagnosis Code	389	8	Numeric	R	ICD 10
30	Diag_Code4	Diagnosis Code	397	8	Numeric	R	ICD 10
31	Diag_Code5	Diagnosis Code	405	8	Numeric	R	ICD 10
			413				

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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
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.

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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.
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
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.

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		• 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.
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.
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.

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Transition of Care File

Pre Authorization Layout

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/ Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	PCP_Name	PCP Name	272	30	Varchar	R	
16	PCP_NPI	PCP NPI	302	10	Numeric	R	
17	Servicing_NPI	Servicing Provider NPI	312	10	Numeric	R	
18	Servicing_Specialty	Servicing Provider Specialty type	322	2	varchar	R	
19	Servicing_Name	Servicing provider Name	324	30	Varchar	R	
20	Servicing_Phone	Servicing provider phone number	354	10	Numeric	R	9999999999
21	Req_Prov_NPI	Requesting provider NPI	364	10	Numeric	R	
22	Req_Prov_Specialty	Requesting provider Speciallty Type	374	2	Varchar	R	
23	Req_Prov_Name	Requesting provider Name	376	30	Varchar	R	
24	Req_Prov_Phone	Requesting provider Phone Number	406	10	Numeric	R	9999999999
25	Diag_code1	Primary Diagnostic Code	416	8	Varchar	R	
26	Diag_code2	Diagnostic Code	424	8	Varchar	R	Include all related diagnoses
27	Diag_code3	Diagnostic Code	432	8	Varchar	R	
28	Diag_code4	Diagnostic Code	440	8	Varchar	R	
29	Diag_code5	Diagnostic Code	448	8	Varchar	R	
30	Service_units	Units or quantity services	456	4	Numeric	R	
31	Authorization_date	Service Authorization date	460	8	Numeric	R	YYYYMMDD
32	Service_code1	Service code/Procedure (S)	468	6	Varchar	R	CPT, No decimal period
33	Service_code2	Service code/Procedure (S)	474	6	Varchar	R	CPT, No decimal period
34	Service_code3	Service code/Procedure (S)	480	6	Varchar	R	CPT, No decimal period
35	Service_code4	Service code/Procedure (S)	486	6	Varchar	R	CPT, No decimal period
36	Service_code5	Service code/Procedure (S)	492	6	Varchar	R	CPT, No decimal period
37	Hospice	Hospice	498	1	Varchar	R	Y=Yes, N=No
38	Authorization number	For references only	499	15	Varchar	R	
39	Serv_Start_Date	Service start date	514	8	Numeric	R	YYYYMMDD
40	Serv_End_Date	Service end date	522	8	Numeric	R	YYYYMMDD (for open period use 20990101)

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Transition of Care File

Serious Mental Illness Patients (SMI)

This file is received by ASES from the insurance companies and on a monthly basis. It contains data pertinent to the transition of care of

Item num	Record Fields	Description	Position	Size	Data Type	Required/ Optional	Notes
1	Carrier_Source	Source Carrier Code	1	2	Numeric	R	Carrier Code Given by ASES
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculibo, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Addr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	PCP_Name	PCP Name	272	30	Varchar	R	
16	PCP_NPI	PCP NPI	302	10	Numeric	R	
17	Servicing_NPI	Servicing Provider NPI	312	10	Numeric	R	
18	Servicing_Specialty	Servicing Provider Specialty type	322	2	Varchar	R	
19	Servicing_Name	Servicing provider Name	324	30	Varchar	R	
20	Servicing_Phone	Servicing provider phone number	354	10	Numeric	R	9999999999
21	Care_Ma_Prog	Care Management Program	364	500	Varchar	R	
22	Prog_Start_Date	Program Start Date	864	8	Numeric	R	YYYYMMDD
23	Prog_End_Date	Program End Date	872	8	Numeric	R	YYYYMMDD
24	Diag_Code1	Primary Diagnostic Code	880	8	Varchar	R	
25	Diag_Code2	Diagnosis Code	888	8	Varchar	R	
26	Diag_Code3	Diagnosis Code	896	8	Varchar	R	
27	Diag_Code4	Diagnosis Code	904	8	Varchar	R	
28	Diag_Code5	Diagnosis Code	912	8	Varchar	R	
29	Problem	Problems/Situations	920	500	Varchar	R	Care Plan Problems. One or more situations
30	Intervention	Interventions (ongoing and Pending)	1420	500	Varchar	R	Include one or more inverventions
			1920				

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Transition of Care File
Special Coverage Layout

This file is received by ASES from the insurance companies and monthly basis. It contains data pertinent to the transition of care of the patient

Item Num	Record Fields	Description	Position	Size	Data Type	Required/ Optional	Notes
1	Carrier_source	Source Carrier code	1	2	Numeric	R	
2	MPI	Member MPI	3	13	Numeric	R	
3	Last_Name1	Member Last Name	16	30	Varchar	R	
4	Last_Name2	Member Last Name 2	46	30	Varchar	O	
5	First_Name	Member First Name	76	30	Varchar	R	
6	Initial	Initial	106	1	Varchar	O	
7	DOB	Enrollee DOB	107	8	Numeric	R	YYYYMMDD
8	Gender	Member Gender	115	1	Numeric	R	1=Masculino, 2=Femenino
9	Addr1	Member Address1	116	45	Varchar	R	
10	Adrr2	Member Address2	161	45	Varchar	O	
11	City	Member City	206	45	Varchar	R	
12	State	Member State	251	2	Varchar	R	
13	Zip	Member Zip	253	9	Numeric	R	999999999
14	Phone	Member Phone	262	10	Numeric	R	9999999999
15	Servicing_NPI	Servicing Provider NPI	272	10	Numeric	R	
16	Servicing_Specialty	Servicing Provider Specialty type	282	2	Numeric	R	
17	Servicing_Name	Servicing provider Name	284	30	Varchar	R	
18	Servicing_Phone	Requesting provider phone number	314	10	Numeric	R	9999999999
19	Program	Program	324	6	Varchar	R	
20	Prog_Start_Date	Registry Program Start Date	330	8	Numeric	R	YYYYMMDD
21	Prog_End_Date	Registry Program End Date	338	8	Numeric	R	YYYYMMDD (for open period use 20990101)
22	Condition	Condition	346	8	Varchar	R	**See Condition Table TAG**
23	Diag_Code1	Primary Diagnostic Code	354	8	Varchar	R	ICD 10
24	Diag_Code2	Diagnostic Code	362	8	Varchar	R	ICD 10
25	Diag_Code3	Diagnostic Code	370	8	Varchar	R	ICD 10
26	Diag_Code4	Diagnostic Code	378	8	Varchar	R	ICD 10
27	Diag_Code5	Diagnostic Code	386	8	Varchar	R	ICD 10
28	Problems	Problem	394	500	Varchar	R	Care Plan Problems. One or more situations
29	Intervention	Interventions (ongoing and Pending)	894	500	Varchar	R	Include one or more inverventions
			1394				

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ADDENDUM 8

EFT Folder Organization
Insurance Carrier

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GOVERNMENT OF PUERTO RICO
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
ASES

ASES/ES
ASES ENTERPRISE SYSTEMS

Folder Organization
EFT Enterprise File Transfer

Insurance Carrier

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Approvals

By signing here each individual acknowledges that they have reviewed this document and agree that based on his/her knowledge and area of expertise:

- The approach is consistent with ASES expectations and is achievable.
- The design will address known concerns and issues.
- The document contains appropriate information describing the intended use of the system, approaches, and its operational conditions.
- It includes all features required.

Role	Person	Date	Signature
IT Director	Rafael Vazquez	11/1/2022	
Assistant Director	Winda Lorenzo	11/01/2022	
Information Security Administrator (SA)	Ramiro Rodriguez	11/1/2022	

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Change History

Version	Date	Author	Description of Change
1.0	10/01/2023	ASES	Initial Folder Structure

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Preface

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

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

Location for ASES Secure FTP

https://asessecurevdr.sharefile.com/

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Reporting Guidelines

The reporting guidelines are located in the following folder within *ASES Secure FTP*

Reporting_Guidelines

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File Transfer Organization

Here is how the files are organized for Insurance Carriers.

Legend

- Regular Folder
- ASES/ES Folder (Automated Processing Folder)

General Use Folder

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - General Use
      - Submit to ASES
      - Received from ASES

Benefit Enrollment and Maintenance Folder

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - Enrollment
      - Submit to ASES
      - Received from ASES

Premium Payment Folder

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - Premium Payment
      - Submit to ASES
      - Received from ASES

Reporting Package Folders

- **FTP_ASES**

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Reporting Package Folders

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - Compliance
      - 1-Weekly
        - Submit to ASES
        - Received from ASES
      - 1.5-Bi-Weekly
        - Submit to ASES
        - Received from ASES
      - 2-Monthly
        - Submit to ASES
        - Received from ASES
      - 3-Quarterly
        - Submit to ASES
        - Received from ASES
      - 4-Semi annually
        - Submit to ASES
        - Received from ASES
      - 5-Annually
        - Submit to ASES
        - Received from ASES
      - 6-AD Hoc
        - Submit to ASES
        - Received from ASES
    - Customer Service
      - [Note: Same as Compliance]
    - Finance
      - [Note: Same as Compliance]
    - Legal
      - [Note: Same as Compliance]
    - Clinical Operations Area
      - [Note: Same as Compliance]
    - Systems
      - [Note: Same as Compliance]
    - Program Integrity
      - [Note: Same as Compliance]

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Encounter Data Folder

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - Encounter Data (Report 12)
      - CLM
        - Submit to ASES
        - Received from ASES
      - CAP
        - Submit to ASES
        - Received from ASES
      - PRV
        - Submit to ASES
        - Received from ASES
      - NET
        - Submit to ASES
        - Received from ASES
      - IPA
        - Submit to ASES
        - Received from ASES

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Example for Carrier submission (MCOs/MAOs):
SSS quarterly submission for report 03 "Fraud, Waste and Abuse": RP_13_03_2022030.xml.

AS-IS	TO-BE
Directorio para Reportes SSS Compliance 3-Quarterly *RP_13_03_2022030.xml*	FTP_ASES FTP_TRIPLE_S Compliance 3-Quarterly Submit to ASES *RP_13_03_2022030.xml*

Example ASES Response file for MCOs/MAOs
ASES response file to SSS for report 03 "Fraud, Waste and Abuse"

AS-IS	TO-BE
FTP_ASES FTP_TRIPLE_S Receive from ASES *RP_13_03_2022030-FWA.xlsx*	FTP_ASES FTP_TRIPLE_S Compliance 3-Quarterly Received from ASES *RP_13_03_2022030-FWA.xlsx*

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Other Guidelines

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

- For Test environments the folder structure will be the same as the Production Environment, except that the root folder will be as follows:
  - For QA Tests that required the use of production data or PHI data
    - FTP_ASES_TEST
  - For other Required Tests that do not using production data nor PHI data, an specific structure can be created using a number after the word TEST, example
    - FTP_ASES_TEST01
    - FTP_ASES_TEST02

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