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**HIPAA Eligibility Transaction System (HETS)  
Health Care Eligibility Benefit Inquiry and Response  
(270/271)  
5010 Companion Guide Supplement  
for Disproportionate Share Hospital (DSH)  
Submitters**

**FINAL**

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## 1 INTRODUCTION

CMS permits the use of the HETS 270/271 application by Medicare Disproportionate Share Hospital (DSH) Submitters and their agents (independent auditors related to DSH fraud, waste and abuse investigations) to receive a limited subset of eligibility data. This data assists DSH Submitters with the:

- Verification of CMS' determination of the hospital's Supplemental Security Income (SSI) ratio (the total number of Medicare days compared to the number of Medicare/SSI days);
- Calculation of the Medicare disproportionate patient percentage (DPP);
- Preparation for Medicare DSH audits by simulating auditor practices, such as mass eligibility checks for all hospital patients; or
- Investigation of DSH fraud, waste and abuse by independent auditors.

Sections [1.1](#) - [1.3](#) of this document are intended to replace Sections 1.1 - 1.3 of the HETS 270/271 5010 Companion Guide. Section numbering in this document corresponds to the HETS 270/271 5010 Companion Guide; any gaps in numbering are intentional.

### 1.1 SCOPE

This document is intended as a supplement for Medicare authorized DSH Submitters interested in exchanging eligibility transactions with the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application that has been modified to return limited data. It is to be used in conjunction with the ASC X12 270/271 version 005010X279A1, the ASC X12 999 version 005010X231A1 TR3s and the HETS 270/271 5010 Companion Guide. This document contains information about specific Medicare requirements for processing the DSH 270/271 transactions.

### 1.2 OVERVIEW

This supplement to the HETS 270/271 5010 Companion Guide is applicable to DSH Submitters.

The information included in the DSH 271 response is not intended to provide a complete representation of all benefits, but rather to address the status of eligibility (active or inactive) and limited patient financial responsibility for Medicare Part A.

The data included in a DSH 271 response file is to be considered true and accurate only at the particular time of the transaction. Questions regarding eligibility/benefit data for Medicare Part A should be directed to the appropriate regional Medicare Administrative Contractor (MAC). Eligibility/benefit questions

about Medicare Advantage (MA) and Medicare Secondary Payer (MSP) should be directed to the appropriate plan(s) identified in the DSH 271 response.

### 1.3 REFERENCES

- The ASC X12 270/271 version 005010X279A1 and the ASC X12 999 version 005010X231A1 TR3s can be purchased from the publisher, Washington Publishing Company, at their website: <http://store.x12.org/store/>
- HETS 270/271 5010 Companion Guide - <http://www.cms.gov/HETSHelp/downloads/HETS270271CompanionGuide5010.pdf>
- The HETS Trading Partner Agreement (TPA) form to request access to the HETS 270/271 application is available for download from the CMS HETS Help website. Use the following link to display the “How to Get Connected - HETS 270/271” page: <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html>.

## 7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

This section describes the business rules and limitations of the HETS 270/271 application for DSH transactions and is intended to replace Section 7 of the HETS 270/271 5010 Companion Guide.

All references to the ASC X12 270/271 version 005010X279A1 TR3 assume the version referenced in Section [1.1](#) of this document.

### 7.1 GENERAL STRUCTURAL NOTES

- Trading Partners should follow the ST/SE guidelines outlined in the 270 section of the ASC X12 270/271 version 005010X279A1 TR3.
- Trading Partners should follow the ISA/IEA and GS/GE guidelines for HIPAA in Appendix C of the ASC X12 270/271 version 005010X279A1 TR3 and follow the 999 and TA1 guidelines outlined in the ASC X12 version 005010X231A1 TR3.
- Trading Partners must follow the character set guidelines as defined in the Appendix of the ASC X12 270/271 version 005010X279A1 TR3.
- CMS strongly recommends that Trading Partners use the preferred 270 request transaction delimiters in Table 1. HETS will utilize these delimiters for all 271 responses (regardless of the delimiters the Trading Partner sent in the 270 request).

**Table 1 - Preferred 270 Request Transaction Delimiters**

Character	Name	Delimiter
*	Asterisk	Data Element Separator
	Pipe	Component Element Separator
~	Tilde	Segment Terminator
^	Carat	Repetition Separator

- Each transaction must contain only one Patient Request. Each 270 request must have only one ISA/IEA, one GS/GE, one ST/SE, and a single 2100C Subscriber Loop.

## 7.2 GENERAL TRANSACTION NOTES

- The HETS 270/271 application will return benefit data if the Medicare Beneficiary is entitled to Medicare Part A.
- The HETS 270/271 application will perform X12 validation if dependent level data is sent within a 270 request but will only return a response for the subscriber level information.
- The HETS 270/271 application will always return a basic set of eligibility information regardless of the Service Type Code (STC) submitted on the 270 request.
- The HETS 270/271 application will accept multiple STCs on a 270 request transaction.
- The HETS 270/271 application may return multiple EB loops to reflect the Medicare Beneficiary’s benefit and enrollment history.
- The DSH 271 response is based upon information obtained from the CMS database at the time of inquiry and is not considered a guarantee of payment.
- The HETS 270/271 application will construct DSH 271 responses with the preferred delimiters as noted in Table 1 of this document.
- Trading Partners will receive a AAA error in the 2100A Loop with a reject reason code of AAA03 = “42” when the HETS 270/271 application is unable to process a single transaction in less than 60 seconds or when other system issues are encountered.

## 7.3 MEDICARE BENEFICIARY MATCHING RULES

- The HETS 270/271 application applies search logic that uses a combination of the following data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary’s Date of Birth (DOB), Medicare Beneficiary’s Full Last Name, and Medicare Beneficiary’s Full First Name. Trading Partners should not submit any additional Beneficiary data elements in an attempt to generate a match. Table 2 describes the necessary data elements for the required

primary and alternate search options supported by the HETS 270/271 application.

**Table 2 - HETS 270/271 Search Options**

Search	HICN	Last Name	First Name	DOB
Primary	X	X	X	X
Alternate 1	X	X		X
Alternate 2	X	X	X	

- If the Medicare Beneficiary's submitted HICN is found but is not the Medicare Beneficiary's active number, the HETS 270/271 application will cross-reference the submitted HICN to the active HICN. The DSH 271 response will include in the 2100C Loop the inactive HICN within a REF segment, the active HICN within NM109 field, and a AAA error with a reject reason code of AAA03 = "72". The submitter may then send a new 270 request with the active HICN.
- If the Trading Partner submits a Beneficiary's Middle Name or Initial in the 270 2100C NM105 or a Gender Code in the 270 2100C DMG03 then HETS will return a 999 response. Trading Partners should not submit any additional Beneficiary data elements outside of those listed above in Table 2.
- If the search criteria do not produce a match to a Medicare Beneficiary, the HETS 270/271 application will generate the appropriate AAA03 error code in the DSH 271 response. Refer to Section [8.3](#) of this document for additional information.

#### 7.4 DATE REQUEST RULES

- The HETS 270/271 application will respond with current eligibility information if no date is contained in the 270 request.
- CMS will verify that the requested date(s) on the DSH 270 request are within the HETS 270/271 application's allowable date span. The allowable date span is up to 27 months in the past and up to four months in the future, based on the date the transaction was received. If requests are outside of this range, the HETS 270/271 application will return a AAA error in the 2100C Loop with a reject reason code of AAA03 = "62".

Table 3 illustrates the allowable request date ranges:

**Table 3 - Request Date Calendar**

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	October, 3 years ago	May of the current year
February	November, 3 years ago	June of the current year
March	December, 3 years ago	July of the current year
April	January, 2 years ago	August of the current year
May	February, 2 years ago	September of the current year

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
June	March, 2 years ago	October of the current year
July	April, 2 years ago	November of the current year
August	May, 2 years ago	December of the current year
September	June, 2 years ago	January of the following year
October	July, 2 years ago	February of the following year
November	August, 2 years ago	March of the following year
December	September, 2 years ago	April of the following year

**Example:** If an eligibility request is sent on February 1, 2016, requests from November 1, 2013 through June 1, 2016 will be accepted.

## 7.5 MEDICARE PART A & PART B ELIGIBILITY BUSINESS RULES

- The HETS 270/271 application will not return Medicare Part B eligibility data within a DSH 271 response.
- Trading Partners should review the entire DSH 271 eligibility response to determine the appropriate eligibility status for the Medicare Beneficiary.
- To indicate periods of Medicare Part A entitlement, the HETS 270/271 application will return a 2110C Loop with element EB01 = “1” along with the DTP03 where DTP01 = “291” with beginning and end dates, where appropriate, for each applicable entitlement period.
- The HETS 270/271 application will return a 2110C Loop with element EB01= “6” for Part A without the DTP segments for either of the following reasons:
  - The Medicare Beneficiary’s Part A entitlement had not yet begun as of the requested date(s) of service.
  - The Medicare Beneficiary’s Part A entitlement has terminated prior to the requested date(s) of service.
- The HETS 270/271 application will return a 2110C Loop with element EB01= “6” and no additional data, when the Medicare Beneficiary is deceased and the Date of Death is prior to the requested date(s) of service.
- If a Medicare Beneficiary has died, but the requested date(s) of service are prior to the Date of Death, their Medicare Part A entitlement date(s) and other applicable eligibility data will be returned along with a separate DTP segment containing the Date of Death.
- EB04 will be omitted when periods of ineligibility apply to Medicare Part A.
- Multiple periods of a Medicare Beneficiary’s inactive Medicare enrollment may be returned in a DSH 271 response if they occur during the requested date(s) of service.
- Example segments returned in a DSH 271 response:

- Part A Entitlement
  - EB\*1\*\*30\*MA~
  - DTP\*291\*RD8\*CCYYMMDD-CCYYMMDD~ (DTP03 = Entitlement and Termination Dates where applicable)
- Inactive Due to Date of Death
  - DTP\*442\*D8\*CCYYMMDD~ (DTP03 = Date of Death)
  - EB\*6\*\*30~
- For additional information, refer to Table 11.

## 7.6 MA PLAN ENROLLMENT BUSINESS RULES

- All Medicare Beneficiary MA plans with enrollment periods that overlap the requested date(s) of service will be returned within the DSH 271 response.
- The HETS 270/271 application will return one of the following qualifiers within Loop 2110C, element EB04, for each MA enrollment:
  - HM for Health Maintenance Organization (HMO) Medicare Non-Risk
  - HN for HMO Medicare Risk
  - IN for Indemnity
  - PR for Preferred Provider Organization (PPO)
  - PS for Point of Service (POS)

The HETS 270/271 application will return only the most recent plan designation (HMO, PPO, POS, Indemnity) for an MA contract, even if the contract's plan designation has changed since the Medicare Beneficiary originally enrolled in the contract.

- MCO Bill Option Code will be returned only for Insurance Type Code values "HM", "HN", "IN", "PR" and "PS". The MCO Bill Option Codes returned by the HETS 270/271 application are:

### **Beneficiary "locked in" to MCO**

"A" - Fiscal Intermediary should process all claims

"B" - MCO should process only in-plan Part A claims and in-area Part B claims

"C" - MCO should process all claims

### **Beneficiary NOT "locked in" to MCO**

"1" - Fiscal Intermediary should process all claims

"2" - MCO should process only in-plan Part A claims and in-area Part B claims

- Trading Partners are advised to contact the plans if there are any questions about the plan terms and conditions. In addition, indication of coverage does

not imply or guarantee payment by the plan. Trading Partners should contact the plan for full benefit and billing information.

- For information on how to contact plans go to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html> and choose “MA Plan Directory”.
- Example segments returned in a DSH 271 response:

- MA

```
EB*R**30*HN~ (EB04 = Plan Type)
REF*18*12345 001~ (REF02 = Contract Number followed by Plan
Number)
DTP*290*D8*CCYYMMDD~ (DTP03 = MA Enrollment Date)
MSG*MCO Bill Option Code - C~
LS*2120~
NM1*PRP*2*ABC HEALTHCARE~ (NM103 = Contract Name)
N3*PO BOX 123~ (N301 = Contract Street Address)
N4*ANYTOWN*MD*999999999~ (N401 = Contract City, N402 =
Contract
State, N403 = Contract Zip)
PER*IC**TE*8001234567*UR*www.plan.com~ (PER04 = Plan
Telephone Number, PER06 = Contract Website Address)
LE*2120~
```

- For additional information, refer to Table 12.

## 7.7 MEDICARE SECONDARY PAYER (MSP) ENROLLMENT BUSINESS RULES

- All Medicare Beneficiary insurance coverage policies that are primary to Medicare coverage will be returned within the DSH 271 response, provided that the enrollment period overlaps the requested date(s) of service.
- Example segments returned in a DSH 271 response:

- MSP

```
EB*R**30*12~ (EB04 = MSP Insurance Type Code)
REF*IG*123456789~ (REF02 = Insurance Policy Number)
DTP*290*D8*CCYYMMDD~ (DTP03 = MSP Effective Date(s))
LS*2120~
NM1*PRP*2*ABC HEALTHPLAN~ (NM103 = MSP Name)
N3*123 MAIN ST~ (N301 = MSP Street Address)
N4*ANYTOWN*MD*999999999~ (N401 = MSP City, N402=MSP
State, N403=MSP Zip)
LE*2120~
```

- For additional information, refer to Table 13.

## 8 ACKNOWLEDGEMENTS, ERROR CODES AND/OR REPORTS

Section [8.3](#) of this document replaces Section 8.3 of the HETS 270/271 5010 Companion Guide.

### 8.3 DSH 271

When the 270 request complies with the X12 standard syntax requirements and all additional formatting rules as specified by this document, then a DSH 271 response transaction is returned to the Submitter. If no error exists, the Medicare Beneficiary eligibility data will be returned within the DSH 271 response. Refer to Section [10.2](#) of this document for more information.

The AAA error segment is utilized within the DSH 271 response to communicate error conditions based on CMS business rules. The HETS 270/271 application will return the invalid or non-matching data element(s) from the 270 request for 2100C Loop AAA error codes 58, 62, 71, 72, and 73. The AAA error codes applicable to DSH Submitters are specified in Table 4.

In the 2nd column of Table 4, AAA01 Yes Condition means that the request is valid, but the transaction was rejected and AAA01 No Condition means that the request or an element in the request is not valid. In the 4th column of Table 4, AAA04 Follow-up Action code R means “Resubmission Allowed” and AAA04 Follow-up Action code C means “Please Correct and Resubmit”.

**Table 4 - AAA Error Codes**

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100A	No	04 - When multiple Medicare Beneficiaries are included on a single 270 request.	C
2100A	Yes	42 - When the system is unable to respond as a result of being unavailable or when a HIPAA compliant 271 cannot be formatted.	R
2100A	No	79 - When 2100A NM103 or NM109 Source identification is other than “CMS”.	C
2100A	No	T4 - When 270 2100A NM103 or NM109 is missing.	C
2100B	No	41 - When the National Provider Identifier (NPI) located at 2100B NM109 is a valid FFS Medicare NPI and exists in HDT, but there is no current, valid relationship between the NPI and the provided HETS Submitter ID. Ensure that there is a relationship between your Submitter ID and the NPI in HDT.	C
2100B	No	43 - When the 2100B NM101 is not equal to “1P”, “FA” or “80” or when the NPI located at 2100B NM109 has an invalid Medicare Provider status. If you believe that the NPI is a valid FFS Medicare provider or supplier, contact your MAC for verification.	C

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100B	No	50 - When the NPI located at 2100B NM109 is a valid, FFS Medicare provider or supplier but is not currently eligible to verify Medicare eligibility in HETS. Contact MCARE for further information.	C
2100B	No	51 - When the NPI located at 2100B NM109 is not on file with HETS. Verify that the NPI is a valid FFS Medicare Provider and ensure that the NPI is added to your Submitter ID via HDT. An overnight update may be required before the NPI can be used with HETS.	C
2100C	No	58 - When the 270 2100C DMG02 element and NM104 element are both missing.	C
2100C	No	62 - When the 270 2100C DTP03 element request date is more than 27 months in the past, or more than 4 months in the future.	C
2100C	No	71 - When the 270 2100C DMG02 element does not match the Medicare Beneficiary DOB on the database.	C
2100C	No	72 - When the 270 2100C NM109 element is either: <ul style="list-style-type: none"> <li>• An invalid length or cannot be matched to any HICN on the database, or</li> <li>• Missing. When the NM109 element is missing, the 271 AAA response will also return the value "MISSING" in the 271 2100C NM109, or</li> <li>• Inactive. When the NM109 is inactive, the 271 AAA response will also return the active HICN in the 271 2100C NM109 along with the requested HICN in the 2100C REF segment.</li> </ul>	C
2100C	No	73 - When the 270 2100C NM103 element is missing, or the matching algorithm of the Medicare Beneficiary Last Name on the 270 request does not satisfy the matching algorithm of the Medicare Beneficiary Last Name in the database, or the last name is too long (41-60 characters in length).	C
2100C	No	73 - When the 270 2100C NM104 element does not satisfy the matching algorithm of the Medicare Beneficiary First Name in the database or the first name is too long (31-35 characters in length).	C

## 10 TRANSACTION SPECIFIC INFORMATION

Section [10](#) of this document is intended to replace Section 10 of the HETS 270/271 5010 Companion Guide.

This section defines specific requirements that CMS requires over and above the standard information in the ASC X12 270/271 version 005010X279A1 TR3 referenced in Section [1.1](#) of this document.

## 10.1 270 ELIGIBILITY REQUEST TRANSACTION

This section describes the values required by CMS in the 270 request. Any segments or elements not referenced in the following tables should be submitted on the 270 request as per the ASC X12 270/271 version 005010X279A1 TR3.

### 10.1.1 Information Source Level Structures

CMS will be the Information Source for all Medicare Eligibility Transactions. Table 5 defines specific requirements for the Header and Information Source data.

**Table 5 - Header and Information Source**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	HETS does not support cancellations.
2100A	NM1	Information Source Name		
2100A	NM102	Entity Type Qualifier	2	
2100A	NM103	Information Source Last or Organization Name		HETS always expects "CMS".
2100A	NM109	Information Source Primary Identifier		HETS always expects "CMS".

### 10.1.2 Information Receiver Level Structures

Clearinghouses that submit transactions on behalf of the Provider must ensure that the correct, valid, and active Medicare Provider identification is submitted as the Information Receiver. Only National Provider Identifier (NPI) numbers are accepted. Table 6 defines specific requirements for the Information Receiver data.

**Table 6 - Information Receiver**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	HETS only sends responses for providers, hospitals and facilities.
2100B	NM109	Information Receiver Identification Number		The Medicare Enrolled Provider's NPI number.

### 10.1.3 Subscriber Level Structures

Trading Partners must ensure that only one Medicare Beneficiary request is submitted in the Subscriber Level for each transaction. Table 7 defines specific requirements for the Subscriber Level data.

**Table 7 - Subscriber**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		Last Name is required for Medicare Beneficiary Identification using the Primary or Alternate Search options. Maximum length allowable is 40 characters.
2100C	NM104	Subscriber First Name		First name is required for Medicare Beneficiary Identification only when the Beneficiary's date of birth is not submitted. Maximum length allowable is 30 characters.
2100C	NM107	Subscriber Name Suffix		When the suffix is part of the Medicare Beneficiary's Last Name on the Medicare card, the suffix is required for Last Name matching. For convenience, the Subscriber Name Suffix can also be appended to the Subscriber Last Name field to meet matching constraints.
2100C	NM109	Subscriber Primary Identifier		HICN is required for all Medicare Beneficiary Search options. This element must exactly match the ID on the patient's Medicare card.
2100C	DMG	Subscriber Demographic Information		
2100C	DMG02	Subscriber Birth Date		Date of Birth is required for Medicare Beneficiary Identification only when the Beneficiary's first name is not submitted.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	291	
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
2110C	EQ01	Service Type Code		HETS will accept all X12 STC codes; however, only those codes specified by the HETS 5010 Companion Guide will return explicit benefit information. All other X12 codes will return only the basic set of eligibility data as defined in Section 7.2 of the HETS 5010 Companion Guide.
2110C	EQ02	Composite Medical Procedure Identifier		HETS will accept all valid Procedure codes; however, only those codes specified by this Companion Guide will return explicit benefit information. All other valid Procedure codes will return only the basic set of eligibility data.

**10.2 DSH 271 ELIGIBILITY RESPONSE TRANSACTION**

This section describes the values returned by CMS in the DSH 271 eligibility response transaction. The following tables describe the CMS utilization of segments and elements when there is a type of uniqueness or restriction. All other values comply with the ASC X12 270/271 version 005010X279A1 TR3.

**Table 8 - Header and Information Source**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100A	NM1	Information Source Name		
2100A	NM101	Entity Identifier Code	PR	
2100A	NM108	Identification Code Qualifier	PI	
2100A	NM109	Information Source Primary Identifier		HETS always returns "CMS".
2100A	PER	Information Source Contact Information		
2100A	PER03	Communication Number Qualifier	UR	
2100A	PER04	Information Source Communication Number		HETS always returns the Payer URL "http://www.cms.gov/HETSHelp/".
2100A	PER05	Communication Number Qualifier	UR	
2100A	PER06	Information Source Communication Number		HETS always returns the Payer URL "http://www.cms.gov/center/provider.asp".

**Table 9 - Information Receiver**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	
2100B	NM109	Information Receiver Identification Number		The Provider's assigned NPI number as submitted on the 270 request.

**Table 10 - Subscriber Demographic Data**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2000C	TRN	Subscriber Trace Number		
2000C	TRN01	Trace Type Code	2	
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM104	Subscriber First Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM107	Subscriber Name Suffix		

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	NM109	Subscriber Primary Identifier		HETS returns the HICN submitted on the 270 request or the active cross-referenced HICN when an inactive HICN is submitted. If a HICN was not submitted on the 270 request, a value of "MISSING" will be returned.
2100C	REF	Subscriber Additional Identification		A REF segment in the 2100C Loop is returned containing the HICN submitted on the 270 when an active/cross-referenced HICN is found and returned in the NM109.
2100C	REF01	Reference Identification Qualifier	Q4	This element is used to communicate the submitted HICN from the 270 request when a cross-referenced HICN is located.
2100C	REF02	Subscriber Supplemental Identifier		This element is used to communicate the submitted HICN from the 270 request when a cross-referenced HICN is located.
2100C	N3	Subscriber Address		
2100C	N301	Subscriber Address Line		Medicare Beneficiary Address Line 1 or "Unknown" if any address lines are missing or invalid on the database.
2100C	N4	Subscriber City State Zip		
2100C	N401	Subscriber City Name		Medicare Beneficiary City Name or "Unknown" if any address lines are missing or invalid on the database.
2100C	N402	Subscriber State Code		Medicare Beneficiary State Code or "MD" if any address lines are missing or invalid on the database.
2100C	N403	Subscriber Postal Zone or Zip Code		Medicare Beneficiary Postal ZIP Code or "21244" if any address lines are missing or invalid on the database.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	307 or 442	

**Table 11 - Medicare Part A Plan Level Eligibility**

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	1 or 6	
2110C	EB04	Insurance Type Code	MA	EB04 will be omitted when requested dates are after a Medicare Beneficiary's Date of Death. When requested dates are during a period of Incarceration, Deportation or Alien Status, EB04 will be omitted only from the EB segment pertaining to the period of inactivity or ineligibility.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP	Subscriber Eligibility/Benefit Date		If multiple entitlement periods exist, HETS returns them in descending order - future, current, past. For inactive periods, the DTP segment will only be included for a specific date range.
2110C	DTP01	Date Time Qualifier	291	N/A

**Table 12 - Medicare Advantage (MA) Enrollment Data**

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	MA Loop Information in this table will be returned on the 271 response when STC "30" is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	R	
2110C	EB04	Insurance Type Code	HM, HN, IN, PR, or PS	
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	18	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		HETS returns the Contract Number and Plan Number, separated by a space. If a Plan Number is unavailable, HETS returns only the Contract Number.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	N/A
2110C	MSG	Message Text		
2110C	MSG01	Free Form Message Text		HETS returns "MCO Bill Option Code - [code value]". Code values returned are: A, B, C, 1 or 2.
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR or PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the MA Insurer Name.
2120C	N301	Benefit Related Entity Address Line		Medicare Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Medicare Insurer Address Line 2 if valid, otherwise not sent.

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2120C	N401	Benefit Related Entity City Name		Medicare Insurer City Name or "Baltimore" if any address lines are missing or invalid on the database.
2120C	N402	Benefit Related Entity State Code		Medicare Insurer State Code or "MD" if any address lines are missing or invalid on the database.
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Medicare Insurer Postal ZIP Code or "21244" if any address lines are missing or invalid on the database.
2120C	PER	Benefit Related Entity Contact Information		HETS returns the telephone number or website address in the PER03 and PER04 elements when the MA plan has only a telephone number or only a website address. If neither exists, then HETS does not return the PER segment.

**Table 13 - MSP Enrollment Data**

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	MSP Loop Information in this table will be returned on the 271 response when STC "30" is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	R	
2110C	EB04	Insurance Type Code		HETS returns codes: 12, 13, 14, 15, 16, 41, 42, 43, 47, or WC
2110C	REF	Subscriber Additional Identification	REF	
2110C	REF01	Reference Identification Qualifier	IG	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		HETS returns the MSP Policy Number.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the Primary Insurer Name.
2120C	N3	Benefit Related Entity Address	N3	Beginning of segment
2120C	N301	Benefit Related Entity Address Line		Primary Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Primary Insurer Address Line 2 if valid, otherwise not sent.

<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>X12 Codes</b>	<b>Notes/ Comments</b>
2120C	N4	Benefit Related Entity City State Zip		
2120C	N401	Benefit Related Entity City Name		Primary Insurer City if valid, otherwise not sent.
2120C	N402	Benefit Related Entity State Code		Primary Insurer State Code
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Primary Insurer ZIP Code

## APPENDIX A - SAMPLE DSH 270 ELIGIBILITY REQUEST TRANSACTION

```
□0000000441□
ISA*00*      *00*      *ZZ*C123X456*ZZ*CMS
*160116*0734**^*00501*000005014*1*P*|~
GS*HS*D000000011*CMS*20160116*073411*5014*X*005010X279A1~
ST*270*000000001*005010X279A1~
BHT*0022*13*ALL*20160116*073411~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*80*2*TEST*****XX*2223334444~
HL*3*2*22*0~
NM1*IL*1*SMITH*MARY****MI*123456789A~
DMG*D8*19240901~
DTP*291*RD8*20150101-20160330~
EQ*1~
SE*12*000000001~
GE*1*5014~
IEA*1*000005014~
□
```

**APPENDIX B - SAMPLE DSH 271 ELIGIBILITY RESPONSE TRANSACTION**

0000000951  
 ISA\*00\* \*00\* \*ZZ\*CMS \*ZZ\*C123X456  
 \*160116\*0734\*\*^\*00501\*000025349\*0\*T\*|~  
 GS\*HB\*CMS\*C123X456\*20160116\*07340000\*1\*X\*005010X279A1~  
 ST\*271\*0001\*005010X279A1~  
 BHT\*0022\*11\*5010 MSP DATE SPECIFIC 002\*20160116\*07345830~  
 HL\*1\*\*20\*1~  
 NM1\*PR\*2\*CMS\*\*\*\*\*PI\*CMS~  
 PER\*IC\*\*UR\*http://www.cms.gov/HETSHelp/\*UR\*http://www.cms.gov/center/provider  
 .asp~  
 HL\*2\*1\*21\*1~  
 NM1\*1P\*2\*MEIC\*\*\*\*\*XX\*1234567893~  
 HL\*3\*2\*22\*0~  
 NM1\*IL\*1\*SMITH\*MARY\*\*\*\*MI\*123456789A~  
 N3\*123 MAIN ST~  
 N4\*ANYTOWN\*MD\*999999999~  
 DMG\*D8\*19240901\*F~  
 DTP\*307\*D8\*20160116~  
 EB\*1\*\*30\*MA~  
 DTP\*291\*D8\*19931101~  
 EB\*R\*\*30\*HN~  
 REF\*18\*H3952 008~  
 DTP\*290\*RD8\*20070101-20151231~  
 MSG\*MCO Bill Option Code - C~  
 LS\*2120~  
 NM1\*PRP\*2\*ABC HEALTH PLAN~  
 N3\*123 MAIN ST~  
 N4\*ANYTOWN\*MD\*999999999~  
 PER\*IC\*\*TE\*9999999999\*UR\*www.abchealthplan.com~  
 LE\*2120~  
 EB\*R\*\*30\*12~  
 REF\*IG\*999999999~  
 DTP\*290\*D8\*19931101~  
 LS\*2120~  
 NM1\*PRP\*2\*ABC INSURANCE COMPANY~  
 N3\*123 MAIN ST~  
 N4\*ANYTOWN\*MD\*999999999~  
 LE\*2120~  
 SE\*34\*0001~  
 GE\*1\*1~  
 IEA\*1\*000025349~

**APPENDIX C - REVISION HISTORY**

Table 14 provides a summary of changes made to this document.

**Table 14 - Document Revision History**

Version	Date	Description of Changes
3-3	03/17/2016	<ul style="list-style-type: none"> <li>● Section 7.1 - Updated section to include references to current X12 documentation and versioning.</li> <li>● Section 7.1 - 7.5 - Minor updates to language to ensure consistency with HETS 270/271 Companion Guide.</li> <li>● Section 7.3 - Added notes stressing that Trading Partners should not submit non-required data elements of the Medicare Beneficiary, including Middle Name/Initial and/or Gender Code. Sending non-required data elements may result in a 999 response.</li> <li>● Section 8.3 - Updated Table 4 with current list of 271 AAA responses.</li> <li>● Section 10 - Minor updates to language to ensure consistency with HETS 270/271 Companion Guide. All Tables updated to match style/format of HETS 270/271 Companion Guide.</li> <li>● Minor formatting and grammatical changes throughout the document.</li> </ul>
3-2	03/22/2013	Table 10 - Updated address elements for missing data.
3-1	02/19/2013	Section 8.3 - Removed text reference to AAA code 74 since it was removed from the table in a previous release.