Transaction Validation Worksheet
BPR – Requesting & Receiving Eligibility and Benefits Information

Health Plan: _____

Provided Information:

Is the group number supplied on the 270? YES/NO: _____ If NO, will the full set of benefit information be reported on the 271? YES/NO: _____ If 'NO', under what conditions and/or for what plans must group number be supplied?	
Are there situations under which benefits will not be available in the 271 transaction or on the eligibility/benefit web site?	
Are there any known gaps between 271 transaction and information on eligibility/benefits web site?	
What is/are the eligibility/benefits web site(s) that should be checked? (provide links)	
Is specialty care included in the EB03=30 response? YES/NO: _____ If 'NO', what service code(s) are used to designate specialty care? Is this always the case? Are there situations when this is not the case?	
When reporting co-pay and co-insurance in the EB loop • For what services do you report this information at the EB03=30 level and only at the service type level when different? • For what services do you report this information only at the service type level?	
Is telemedicine included in the EB03=30 response? YES/NO: _____ If 'NO', what service code(s) are used to designate telemedicine?	
To determine the last day of coverage, is it the day reported in the transaction or the day after the day reported in the transaction?	
When is the optimal time (day of week, time of day) to send 270 request transactions to receive the most current and complete set of benefit information?	

Validating Provider Information

Name: _____ Organization: _____

Date: _____ Email: _____

Before you begin:

1. ***Verify with the health plan*** that they have access to and saved the 270-271 combination that you selected to verify, and that
    a. The 270 was not rejected for syntactical reasons
    b. They will process and create the 271.
2. ***To the extent possible, select*** different types of patients to validate, e.g. different health plan product lines, different benefits, individual/family, subscriber/dependent, etc.
3. This validation process provides a good opportunity to ***report unresolved issues that you have encountered***

	Identify the 270 & 271 that you will be referencing	
	270	**271**
Provider Tax ID		
Provider NPI		
TRN02		
BHT03		
File Name		
Sent Date & Time		
Member ID (Loop 2100C or D, NM1 Segment, NM109)		
Member Last Name		

For more detail about any of the questions, see the corresponding BPR page #.
http://www.onehealthport.com, under Admin Simp tab select "Best Practice Recommendations', Scroll down to 'Eligibility & Benefits' Heading

I. Transaction Turnaround (BPR pg 11-12)

- If real time – was a response received within 20 sec? Yes/No/Not Applicable: _____
  What date & time did you send it? Date: _____ Time: _____
- If batch:

- Was a response received by the next business day? Yes/No/Not Applicable: ___
- Was a response received for every inquiry contained in the 270 (excluding those that are forwarded to another health plan)? Yes/No: _____

Describe Any Problem/Issue:_____

II. Availability of Benefit Information

If you received a message indicating - *Benefit information is currently unavailable, please call for information,*

Then

- Under what health plan product /group was the patient covered? _____
- If you submitted a 270 batch - For approximately how many inquiries in the batch did you receive this message: _____

Was this '*Benefit Information Unavailable'* message for the patient about which you were inquiring?

If so

Otherwise, continue completing the worksheet

III. Member Information

A. Identifying Information Presented about a Health Plan's Member (BPR pg 15) – see below for specific locations in 271.

	In Transaction (Yes, No, Can't tell)	On Web Site (Yes, No, Can't tell, Did not Check)
Is the patient the subscriber?		

If 'Can't Tell' from the transaction, does this payer/Plan use a unique Patient identifier? Yes/No/Not Sure: _____

If 'Yes' or 'Not Sure' – website may not show patient as subscriber

If 'No' - Not aligned with BPR

Was a PCP sent? Yes/No: _____

If 'No', Is a PCP required by the health plan? Yes/No/Not Sure: _____

If 'Yes' - Not aligned with BPR

If in the Subscriber relationship loop (2100C — SUBSCRIBER NAME) INS02 = 18 (Self) - respond to the following questions using the reference to Patient.

General Eligibility Coverage Information (**Bold** indicates must be present for all patients)	**Impact High or Med**	**Found in transaction** Y or N	**Is the transaction and web site information Same or Different?** Same, Different, Did not check
Subscriber Name	High		
Patient Name	High		
Patient's Relationship	High		
Patient Date of Birth	High		
Patient Gender	Med		
Patient Member Number	High		
Coverage Date	High		
Eligibility Status	High		
Group Number	High		
Group Name	Med		
Other Coverage	High		
Primary Care Physician	High		
Plan Type	Med		
Washington State Balance Billing Message	High		

If information on the transaction is DIFFERENT than the information on the web site, please take a screen shot of the web site and submit with this worksheet.

For Coverage Date, is the DTP segment value in the 2100C/D loop either 291 or 346?
Yes/No/Not Sure: _____ (BPR pg 12)

Was Patient Account Number[*1] in 270? (Loop 2100C/D, REF01= 'EJ', REF02) Y or N	**If Yes, Was it returned on 271?** Y or N

[*1] – *Patient Account Number in the 270 transaction is called Patient Control Number in the 835 transaction*

Describe Any Problem/Issue:_____

B. Plan/Contract Information - EB03=30 (BPR pgs 16-20)

In-Network Coverage (EB12 = 'Y' or 'W'): What was the value of EB12? _____

Individual Coverage EB02=IND:

Record the AMOUNTS reported in the transaction and on the web site		**Individual Coverage (EB02=IND)**		**Web Site**
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271?** Y or N	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Co-Insurance (EB01=A)				
Co-Pay (EB01=B)				
Deductibles (EB01=C)				
Out of Pocket Max (EB01=G)				
Spend Down (EB01=Y) (Medicaid)				

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet.

Family Coverage EB02=FAM:

Record the AMOUNTS reported in the transaction and on the web site		**Individual Coverage (EB02=FAM)**		**Web Site**
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271?** Y or N	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Co-Insurance (EB01=A)				
Co-Pay (EB01=B)				
Deductibles (EB01=C)				
Out of Pocket Max (EB01=G)				

Record the AMOUNTS reported in the transaction and on the web site		Individual Coverage (EB02=FAM)		Web Site
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271? Y or N**	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Spend Down (EB01=Y) (Medicaid)				

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet

Out-of-Network Coverage:

Was there an EB segment with EB03=30 and EB12 = 'N'? Yes/No? _____

If there wasn't an EB12='N', was there Out-of-Network coverage on the web site? Yes/No? _____

If there was an EB12='N', complete the below

Individual Coverage EB02=IND:

Record the AMOUNTS reported in the transaction and on the web site		Individual Coverage (EB02=IND)			Web Site
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271? Y or N**	**Is there also an EB03 with this EB01 & with EB12 = 'W'? Yes or No**	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Co-Insurance (EB01=A)					
Co-Pay (EB01=B)					
Deductibles (EB01=C)					
Out of Pocket Max (EB01=G)					
Spend Down (EB01=Y) (Medicaid)					

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet.

Family Coverage EB02=FAM:

Record the AMOUNTS reported in the transaction and on the web site		Individual Coverage (EB02=FAM)			Web Site
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271? Y or N**	**Is there also an EB03 with this EB01 & with EB12 = 'W'? Yes or No**	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Co-Insurance (EB01=A)					

Record the AMOUNTS reported in the transaction and on the web site			Individual Coverage (EB02=FAM)			Web Site
Contract Level Limits (EB segment EB03=30)	**Is this segment in 271? Y or N**		**Is there also an EB03 with this EB01 & with EB12 = 'W'? Yes or No**	**Benefit Limit Amount EB07**	**Benefit Amount Remain EB07**	**Benefit Limit Amount EB07**
Co-Pay (EB01=B)						
Deductibles (EB01=C)						
Out of Pocket Max (EB01=G)						
Spend Down (EB01=Y) (Medicaid)						

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet

IV. Service Type Request/Response

- 270
  - Were you able to enter multiple EQ01 - services types? Yes/No? _____
  - What is the value(s) for EQ01: _____, _____, _____, _____, _____, _____
- 271
  - Was there an EB*1 segment (EB01='1')? Yes/No? _____

    If Yes – What service type codes were listed in EB03? ___, ___, ___, ___, ___, ___,___, ___, ___,___, ___, ___,___, ___, ___,___, ___, ___,___, ___
  - Was there an EB*I segment (EB01='I')? Yes/No? _____

    If Yes – What service type codes were listed in EB03? ___, ___, ___, ___,
  - Was there an EB*U segment (EB01='U')? Yes/No? _____

    If Yes – What service type codes were listed in EB03? ___, ___, ___, ___,

Determining whether section V &/or VI should be completed … Answer all 3 questions

Looking at the value(s) of EQ01 in the 270 … and the response(s) in the 271	**Yes or No**	**If Yes, Then**
Did you request a '30'?		Complete Section V
Did you request something other than '30' and no information was returned for that service(s)?		Complete Section V
Did you request something other than '30' and information was returned for those services?		Complete Section VI

V. Standard Set of Services - Transaction Information Content (BPR pgs 21-28)

Only complete this section if one of the EQ01 values = '30' OR if the 271 did not contain specific benefit information for one of the valid, non-30 service type codes in EQ01.

Note: If EQ01 contains a service type code and no specific benefit information is reported in the 271, the health plan should provide information as if EQ01=30.

For each individual service type (EB03=HIPAA code) reported in the transaction (each service type in the transaction should be reported on its own line below)

		Co-Pay EB01=B		Co-Insurance EB01=A		Deductible EB01=C		
Standard Service Types (EB03 = what HIPAA Code?)	**EB02 (IND or FAM)**	**EB 07 Amt**	**EB 12 = Y,N,W?**	**EB08 %**	**EB 12 = Y,N,W?**	**EB 07 0 or Amt**	**EB 12 = Y,N, W?**	**Same as on website or Cust Service? Y, No, Did not check**

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet

Describe Any Problem/Issue:_____

Can differences in member financial responsibility, e.g. co-pay between primary care and specialty care, be identified? (though use of service types, message lines etc.) _____

For each individual service type (EB03=HIPAA code) reported in the transaction (each service type in the transaction should be reported on its own line below)

	Max Benefit Limit (dollar) EB01=F			Max Benefit Limit EB01=F Mark type of Limit: Days ___ Visits___				
Standard Service Types (EB03 = HIPAA Code)	**EB07 Limit Amt**	**EB07 Amt Remain**	**EB12 = Y,N,W?**	**EB10 Limit Amt**	**EB10 Amt Remain**	**EB12 = Y,N,W?**	**Service Delivery Limits HSD Seg. Y, N, NA**	**Same as on website or Cust Service? Y, No, Did not check**

If amount on transaction does not match the amount on the web site, please take a screen shot of the web site and submit with this worksheet

Describe Any Problem/Issue:_____

VI. Explicitly Specified Services - Transaction Information Content (BPR pgs 29-34)

Only complete this section for EQ01 values other than 30 where individual Service Type Benefit Info is provided in the 271,

For each individual service type (EB03=HIPAA code) reported in the transaction (each service type in the transaction should be reported on its own line below)

		Co-Pay EB01=B		Co-Insurance EB01=A		Deductible EB01=C		
Explicitly Specified Service Types (EB01 = HIPAA Code)	**EB02 ? (IND or FAM**	**EB07 Amt**	**EB12 = Y,N,W?**	**EB08 %**	**EB12 = Y,N,W?**	**EB07 0 or Amt**	**EB12 = Y,N,W?**	**If N, did patient have that benefit? Y, No, Did not check**

Describe Any Problem/Issue:_____

Can differences in member financial responsibility, e.g. co-pay between primary care and specialty care, be identified? (though use of service types, message lines etc.) _____

	Max Benefit Limit (dollar) EB01=F			Max Benefit Limit (days/visits) EB01=F			
Individually Specified Service Types (EB01 = HIPAA Code)	**EB07 Limit Amt**	**EB07 Amt Remain**	**EB12 = Y,N, W?**	**EB10 Limit Amt**	**EB10 Amt Remain**	**EB12 = Y,N,W?**	**Service Delivery Limits HSD Seg. Y, N, NA**

Describe Any Problem/Issue:_____

VII. Other Information

A. Messages (BPR pg 36)

1. Are Messages within the transaction ONLY used to convey information that is a) critical for the provider to know and b) cannot be conveyed using standard codes in EB01. Yes/No: _____

   If No: what message was used inappropriately? _____

2. Is the information in the MSG segment understandable? Yes/No: _____

   If No: is there a link to clarifying information? Yes/No: _____

   If No: what message contained confusing information? _____

3. What worked and what didn't work about the message segments? _____

B. AAA Segments (BPR pg 37-44)

Are AAA Segments Used appropriately? Yes/No/NA: _____

If No,

When should a AAA segment have been used and wasn't? _____

_____

When should a different AAA segment been used? _____

_____

When should a AAA segment been used differently? _____

_____

C. Other Known Issues not reflected on this work sheet?

_____

_____

General Eligibility Coverage Information in 271
Cheat Sheet

	Location in 271 Transaction	
Data Element	**For patient as subscriber**	**For patient as dependent**
Subscriber Name	Loop 2100C, NM1 Segment	
Patient Name	Same as Subscriber Name above	Loop 2100D, NM1 Segment, NM101-NM105
Patient's Relationship to Subscriber	Loop 2100C, INS Segment, INS01-INS02, INS01='Y', INS02: See TR3 for full list of values	Loop 2100D INS Segment, INS01= N, INS02: See TR3 for full list of values
Patient Date of Birth	Loop 2100C, DMG Segment, DMG02	Loop 2100D, DMG Segment, DMG02
Patient Gender	Loop 2100C, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown	Loop 2100D, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown
Patient Member Number	Loop 2100C, NM1 Segment, NM109	Loop 2100D, NM1 Segment, NM109
Group Number	Loop 2100C, REF Segment, REF01-02, REF01 = '6P' - Group Number	Loop 2100D, REF Segment, REF01-02, REF01 = '6P' -Group Number
Coverage Date (aka Policy Effective Date) [*2]	Loop 2100C, DTP Segment, DTP01-DTP03	Loop 2100D, DTP Segment, DTP01-DTP03
Transaction Reference Number	TRN02 (that matches to the respective 270 transaction)	
Eligibility Status	EB Segment = EB*1**30*	
Group Name	Loop 2100C, REF Segment, REF03	Loop 2100D, REF Segment, REF03
Plan Type	Loop 2110C, EB Segment, EB04-EB05	Loop 2110D, EB Segment, EB04-EB05
Other Coverage[*1]	Loop 2120C, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)	Loop 2120D, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)
Primary Care Physician (PCP) [*1]	Loop 2120C, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).	Loop 2120D, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).

[*1] - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

[*2] - See section 1.4.7.1 of the TR3 for specific values to be used depending upon coverage conditions.

Codes Called out in the Eligibility & Benefits Data Content Operating Rule

1 Medical Care
2 Surgical
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
12 Durable Medical Equipment Purchase
13 Ambulatory Service Center Facility
18 Durable Medical Equipment Rental
20 Second Surgical Opinion
33 Chiropractic
35 Dental Care
40 Oral Surgery
42 Home Health Care
45 Hospice
47 Hospital
48 Hospital - Inpatient
50 Hospital - Outpatient
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
62 MRI/CAT Scan
65 Newborn Care
68 Well Baby Care
73 Diagnostic Medical
76 Dialysis
78 Chemotherapy
80 Immunizations
81 Routine Physical
82 Family Planning
86 Emergency Services
88 Pharmacy
93 Podiatry
98 Professional (Physician) Visit - Office
99 Professional (Physician) Visit - Inpatient
A0 Professional (Physician) Visit - Outpatient
A3 Professional (Physician) Visit - Home
A6 Psychotherapy
A7 Psychiatric – Inpatient
A8 Psychiatric - Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
AI Substance Abuse
AL Vision (Optometry)
BG Cardiac Rehabilitation
BH Pediatric
MH Mental Health
UC Urgent Care

Legend:
* **Bold** indicates, per CORE, the health plan has discretion in returning deductible, co-pay & coinsurance
* *Italics* indicates, per CORE, EB03=30 included service types 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, UC