834 Benefit Enrollment and Maintenance Transaction Companion Guide

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INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 834 Benefit Enrollment and Maintenance transaction implementation guide provides the standardized data requirements to be implemented for electronic enrollment submissions.

The 834 transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. Only sponsors that have been deemed "covered entities" are required to use the ANSI X12N 834 transaction.

PURPOSE

The purpose of this document is to provide the information necessary to submit enrollment information electronically to ValueOptions. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer's system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/ . Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (HHS) – http://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

DEFINITION OF TERMS USED

Sponsor

The sponsor is the party that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association or insurance agency.

Payer/Insurer

The payer is the party that pays claims and/or administers the insurance coverage, benefit or product. A payer can be an insurance company, Health Maintenance Organization, Preferred Provider Organization, government agency or another organization contracted by one of these groups. The Payer may be referred to as the Insurer in certain sections of this document.

Third Party Administrator (TPA)

A sponsor may elect to contract with a TPA or other vendor to handle collecting insured member data if the sponsor chooses not to perform this function.

HIPAA IMPACT ON CURRENT BUSINESS PROCESSES

The 834 Benefit Enrollment and Maintenance transaction requires the employer group/sponsor to submit additional data not present in the pre-HIPAA enrollment transactions. The structure of the 834 may also enable the sponsor to relay information in a more efficient manner and may impact current business processes.

Types of Enrollment files

The 834 Benefit Enrollment and Maintenance transaction can be used in two different ways, as an update or as a

full audit file. The Action Code (BGN08) identifies the use of the transaction set:

- 2 Change (Update)
- 4 Verify (full audit)

An update file provides enrollment add, change and terminate requests that need to be applied to the payer's database. The transaction only contains information about changed members. A full audit file contains all current members whether involved in a change or not. The full audit file is intended to identify all active members (it may or may not include terminated members) as of a certain time period, enabling synchronization between the sponsor and payer enrollment systems. The full audit is not intended to provide a history of all previous enrollments.

ValueOptions recommends weekly Change (update) files with quarterly Verify (full audit) files.

Termination

The 834 transaction provides the capability to terminate a member at either the Member Detail INS level (loop 2000) or at the Health Coverage HD level (loop 2300).

Member Detail Level Termination:

- Subscriber - If the termination date is passed at the INS level for the subscriber then all coverage for the subscriber and all linked dependents is terminated effective that date.
- Dependent – If the termination date is passed at the INS level for the dependent then coverage for that dependent is terminated effective that date.

Health Coverage Level Termination:

- Subscriber – If the termination date is passed at the HD level, coverage for that particular insurance product and member is terminated effective that date. If all insurance products are terminated and the subscriber has no dependents, the subscriber is terminated.
- Dependent - If the termination date is passed at the HD level, coverage for that particular insurance product and member is terminated effective that date. If all insurance products are terminated the dependent is terminated.

Termination dates are not to be sent at both levels when terminating a member. The implementation guide specifies that the use of the Benefit End Date at the Health Coverage Level should be sent when removing coverage from a member but not be used when terminating all eligibility.

A **transfer of coverage** from one insurance product to another requires the termination of the old coverage and then the addition of the new coverage. The addition of the new coverage must never be assumed to result in the automatic termination of the prior coverage. This may be a change to the sponsor's current business processes.

Terminating a Member

ValueOptions prefers the termination date to be sent in the DTP segment at the INS level when terminating a member. The date qualifier of '357' Eligibility End should be sent in element DTP01. All coverage for that member will be terminated effective that date. If the member is the subscriber and dependents are associated with his/her record, the entire family will be terminated.

ValueOptions understands many of their clients cannot send termination at the INS level and must process terminations at the coverage level. ValueOptions is able to process terminations at either level. At the Loop 2300 Health Coverage HD segment HD01 Maintenance Type Code would be '024' – Termination, the DTP01 field in the DTP segment would use the date qualifier of '349' Benefit End.

Changing a Member's Coverage

Depending on how the health coverage is defined in the ValueOptions system, changing health coverage may require terminating the member in a particular group and enrolling them in a new group associated with the new

benefit coverage.

- If the health coverage is directly related to a specific group number, when the member changes coverage the sponsor will send two transactions (separate INS loops) for that member. One will terminate the member in their existing group and the second will enroll the member in the new group and include the Health Coverage loop (2300) providing the details on the new coverage.
- If the health coverage is not tied to a specific group number, changing coverage will require only one transaction (INS loop) be sent for the member. This transaction will contain two iterations of the Health Coverage loop (2300). The first will terminate the existing coverage for the member. The second will add the new coverage for the member.

Coverage information

The contract between the sponsor and payer must identify the member reporting requirements for the enrollment transaction. Much of the information in the 834 transaction is reported only if required in the contract between the sponsor and payer and not prohibited by state and federal law. The level of detail included in the 834 transaction is dependant upon these contractual relationships.

When additional information is needed by the payer to describe the exact type of coverage of its enrollees, the payer can require the sponsor to relay this information in the Plan Coverage Description (HD04) element in the Health Coverage loop (2300). The sponsor and the payer need to agree upon the actual format and content to be relayed in the loop and document this in the insurance contract.

ValueOptions expects detail information be provided for the subscriber and each dependent. The coverage level code (HD05) is required for the subscriber record, when enrolling or changing coverage.

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 834 Benefit Enrollment and Maintenance transaction that the health plan will accept.

- 834 Benefit Enrollment and Maintenance - **ASC X12N 834 (004010X095A1)** ☒

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

- TA1 Interchange Acknowledgement ☒
- 997 Functional Acknowledgement ☒

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

ValueOptions will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Maximum Limitations

The 834 transaction is designed to transmit one or more members per subscriber contract. The hierarchy of the looping structure is Member, Health Coverage, Provider and Coordination of Benefit level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. In the 834 transaction, these limitations are explicitly stated such as:

- The Health Coverage loop (2300) is limited to 99 repetitions per member.
- The Provider Information loop (2310) is limited to 30 repetitions per Insurance product.

Although the Member Level Detail loop (2000) is defined in the implementation guide with a repetition of >1, the limitation imposed on the number of INS segments, limits the number of members that may be sent in the 834 transaction set to a maximum of 10,000. While this may not impact the size of an update transaction set, a full audit file may have to be split into multiple 834 transaction sets within a single functional group.

ValueOptions has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). ValueOptions requires that the Interchange Control structure is limited to one type of Functional Group, such as 834 Benefit Enrollment and Maintenance functional groups.

ValueOptions will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Telecommunication Specifications

To submit an enrollment electronically to ValueOptions you must obtain a Submitter ID/Password from the ValueOptions EDI help desk. Please contact them via e-mail at e-supportservices@valueoptions.com or by calling 888-247-9311.

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at http://www.wedi.org/snip/public/articles/index.shtml . ValueOptions will provide the necessary mechanism for clients to submit a file for testing purposes. This process will be further discussed during the implementation meetings between ValueOptions and client.

Trading Partner Acceptance Testing Specifications

Trading partners wishing to submit enrollment electronically to ValueOptions, must first submit an error free test file and receive verification from ValueOptions that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file you must obtain a Test ID/Password from the ValueOptions EDI help desk. Please contact them via e-mail at e-supportservices@valueoptions.com or by calling 888-247-9311.

The entire file ISA/IEA envelope will either pass (accept) or fail (reject) validation.

Helpful Hint: Create small batches of test enrollment transactions to ensure that you will not have to re-create too many enrollment transactions in the event of an error in the file. Once your files are received and verified to be error-free, you may send files of any size.

After receiving clearance to submit production enrollment files, contact the EDI Help Desk when you submit your first “live” enrollment file. Provide your submitter ID and the ValueOptions file tracking number (if available). EDI services will work with the enrollment department to ensure that the file uploads properly and gets all the way through the system.

INTERCHANGE CONTROL HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
			HEADER		
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: '00' No Authorization Information Present '03' Additional Data Identification	Use '03' Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for additional identification or authorization.	Use the ValueOptions submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	Use '01' Password to indicate that a password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender	Use the ValueOptions submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Refer to the implementation fuide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use '30' Federal Tax ID Number.
	ISA08	Interchange Receiver ID	R		Use '54-1414194' ValueOptions' EIN Number
	ISA09	Interchange Date	R	Date format YYMMDD.	The date (ISA09) is expected to be no more than seven days before the file received. Any date that does not meet this criterion may cause the file to be rejected.
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specification.
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' U.S. EDI Community of ASC X12	This value is defined by the sender's system. If the sender does not wish to define a unique identifier, zero fill this element.
	ISA12	Interchange Control Version Number	R	Valid value:	Use the current standard approved for the

Seg	Data Element	Name	Usage	Comments	Expected Value
				'00401' Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997.	ISA/IEA envelope. Other standards will not be accepted.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier, zero fill this element.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowlegement Requested	Use '0' No Acknowledgement Requested. ValueOptions will not be generating the TA1 Interchange Acknowledgement or the 997 Functional Acknowlegdement.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	The Usage Indicator should be set appropriately. The value in this element will be verified against the accounts "test" status in ETS and rejected if they do not match.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the daya included in the transaction set. This element contains the delimiter that will be used to separate compinent data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	ValueOptions will accept any delimiter specified by the sender. This uniqueness of each delimiter will be verified.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
				TRAILER	
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups	R	Count of the number of functional groups in the interchange.	Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e. functional identifier code 'BE' Benefit Enrollment and Maintenance (834).
	IEA02	Interchange Control Number	R	The interchange control number in IEA02 must be identicalto the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

FUNCTIONAL GROUP HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
			HEADER		
GS		**Functional Group Header**	**R**		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'BE' Benefit Enrollment and Maintenance (834)	Use the value specified in the implementation guide.
	GS02	Application Sender's Code	R		Use the ValueOptions supplied Client Code.
	GS03	Application Receiver's Code	R		This field will identify how the file is received by ValueOptions. Use 'EDI' for electronic transfer, 'MAGMEDIA' for magnetic media such as tape or diskette.
	GS04	Date	R	Date format YCCYMMDD.	Refer to the implementation guide specifications.
	GS05	Time	R	Time format HHMM.	Refer to implementation guide specifications.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	This value is defined by the sender's system. If ValueOptions eventually implements the 997, this number will be used to identify the functional group being acknowledged.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' Accredited Standards Committee X12	Use the value specified in the implementation guide.
	GS08	Version/Release Industry ID Code	R	Valid value: '004010X095A1' Benefit Enrollment and Maintenance Addenda Approved for Publication by ASC X12.	Use the current standard approved for publication by ASC X12. Other standards will not be accepted.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group. Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated interchange header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
BGN		**Beginning Segment**	**R**		
	BNG01	Transaction Set Purpose Code	R	Valid values: '00' Original '15' 15' Re-submission (corrected transmission when original has not yet been processed) '22' Information Copy (when original was lost or not processed).	Use '00' Original.
REF		**Transaction Set Policy Number**	**S**	**This segment can be used if a unique ID Number for a group applies to the entire transaction set. The issuer of the policy, the Payer/Plan Administrator, determines the definition of the Master Policy Number. The Master Policy Number may be used to meet various business needs such as indicating the line of business under which the policy is defined.** **This segment is REQUIRED when the contract or trading partner agreement identify a Master Policy Number for use with electronic enrollment.**	**The ValueOptions contract does not identify a Master Policy Number. The Group Number should be sent in the Member Policy Number segment of loop 2000.**
REF		**Effective Date**	**S**	**To be sent when required by contract terms.**	**The ValueOptions contract does not require this segment.**
LOOP ID – 1000B PAYER					
N1		**Payer**	**R**		
	N103	Identification Code Qualifier	R	Valid values: 'FI' Federal Taxpayer's Identification Number 'XV' HCFA National PlanID Specify the identification code qualifier to be submitted by the sender.	Use 'FI' Federal Taxpayer's ID.
	N104	Insurer Identification Code	R	Specify the insurer identification code to be submitted by the sender.	Use '54-1414194' the ValueOptions EIN number.
LOOP ID – 1000C TPA/BROKER NAME					
N1		**TPA/Broker Name**	**S**		
	N103	Identification Code	R	Valid values:	Use 'FI' Federal Taxpayer's ID.

Seg	Data Element	Name	Usage	Comments	Expected Value
		Qualifier		'FI' Federal Taxpayer's Identification Number '94' Code assigned by the organization that is the ultimate destination of the transaction set 'XV' HCFA National PlanID	
	N104	TPA/Broker Identification Code	R		Use Federal Tax ID of the TPA.
LOOP ID – 2000 MEMBER LEVEL DETAIL					
INS		**Member Level Detail**	**R**		
	INS03	Maintenance Type Code	R	Valid values: '001' Change '021' Addition '024' Cancellation or Termination '025' Reinstatement '030' Audit or Compare	The '030' Audit or Compare code is to be sent only when the file is a Full Audit file (specified by BGN08 = '4' Verify).
	INS04	Maintenance Reason Code	S	Recommended: To be sent unless the trading partner agreement between the sponsor and payer allow this data element to not be sent.	ValueOptions expects the Maintenance Reason Code to be included in the transaction.
REF		**Subscriber Number**	**R**		
	REF02	Subscriber Identifier	R		Use the ValueOptions Subscriber ID.
REF		**Member Policy Number**	**S**	This segment should be used if the policy or group number applies to all coverage data (all 2300 loops) that apply for this member. This segment is required unless the policy number is sent in the REF segment, loop 2300 position 290.	**ValueOptions expects the Group Number to be sent in this segment.**
	REF01	Reference Identifier Qualifier	R	Valid values: '1L' Group or Policy Number	Use 'IL' Group or Policy Number.
	REF02	Insured Group or Policy Number	S		Use the ValueOptions Group Number.
DTP		**Member Level Dates**	**S**	**Required when enrolling a member or when the sponsor is informed of any change to those dates. Only those dates that apply to the particular insurance contract need to be sent.**	
	DTP01	Date/Time Qualifier	R	Valid values: '286' Retirement '296' Return to work '300' Date last worked '301' COBRA Qualifying Event '303' Maintenance Effective '336' Employment Begin '337' Employment End '338' Medicare Begin	Use '336' Employment Begin '383' Adjusted Hire '394' Rehire to transmit the hire date of the employee. Use '297' Date Last Worked '337' Employment End

Seg	Data Element	Name	Usage	Comments	Expected Value
				'349' Medicare End '340' COBRA Begin '341' COBRA End '350' Education Begin '351' Education End '356' Eligibility Begin This is used to convey the beginning date when a member could elect to enroll or begin benefits in any health care plan through the employer. This is not the actual begin date, which is conveyed in the DTP segment at position 270. '357' Eligibility End '383' Adjusted Hire '393' Plan Participation Suspension '394' Rehire '473' Medicaid Begin '474' Medicaid End	to transmit the employee termination date. Use '357' Eligibility End to terminate a member in a group. Use '340' COBRA Begin to transmit the member's enrollment in COBRA. Use '341' COBRA End to transmit the COBRA benefit's end date.
LOOP ID – 2100A MEMBER NAME					
NM1		**Member Name**	**R**		
	NM108	Identification Code Qualifier	S	Valid values: '34' Social Security Number The social security number may not be used for any Federally administered programs such as Medicare or CHAMPUS. 'ZZ' Mutually Defined Value is required if National Individual Identifier is mandated for use	Use '34' Social Security Number.
	NM109	Identifier Code	S	Until the HIPAA Individual Identifier is available the SSN is to be sent when available and allowed under confidentiality regulations.	Use member's SSN.
N4		**Member Residence City, State ZipCode**	**S**	**Required when enrolling subscriber, when enrolling a dependent and the dependent's address is different from the subscriber and when changing a member's address.**	
	N405	Location Qualifier	S	Valid values: '60' Area. The area code indicates that N406 will contain an out-of-area indicator for this member. The meaning of that indicator is defined in the trading partner agreement. 'CY' County/Parish	Use 'CY' County/Parish.
	N406	Location Identification Code	S	This element is ONLY USED when the member identified in the related INS segment is the subscriber.	Use subscriber's county code if available.

Seg	Data Element	Name	Usage	Comments	Expected Value
DMG		**Member Demographics**	**S**	**Required when enrolling a new member or when changing a member's demographic information.**	
	DMG04	Marital Status Code	S	This data should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer. This element is ONLY USED when the member identified in the related INS segment is the subscriber.	The ValueOptions contract requires the Marital Status Code be sent for the Subscriber. Refer to the implementation guide for the list of valid marital status codes.
	DMG05	Race or Ethnicity Code	S	This data should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer. This element is ONLY USED when the member identified in the related INS segment is the subscriber.	The ValueOptions contract requires the Race or Ethnicity Code be sent for the Subscriber. Refer to the implementation guide for the list of valid race codes.
	DMG06	Citizenship Status Code	S	This data should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer. This element is ONLY USED when the member identified in the related INS segment is the subscriber.	The ValueOptions contract does not require the Citizenship Status Code.
ICM		**Member Income**	**S**	**This segment should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer.**	**The ValueOptions contract does not require this segment.**
AMT		**Member Policy Amounts**	**S**	**This segment should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer.**	**The ValueOptions contract does not require this segment.**
LUI		**Member Language**	**S**	**This segment should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. This element is ONLY USED when the member identified in the related INS segment is the subscriber.**	**The ValueOptions contract requires this segment be sent for the Subscriber if the information is available.**
LOOP ID – 2100B INCORRECT MEMBER NAME					
NM1		**Incorrect Member Name**	**S**	**This segment is only used if a corrected name is sent in loop 2100A or if the previously supplied demographics are being changed.**	
	NM108	Identification Code Qualifier	S	Valid values: '34' Social Security Number The social security number may not be used for any Federally administered programs such as Medicare or CHAMPUS. 'ZZ' Mutually Defined	Use '34' Social Security Number.

Seg	Data Element	Name	Usage	Comments	Expected Value
				Value is required if National Individual Identifier is mandated for use	
	NM109	Identifier Code	S		Use the incorrect SSN that was previously sent for the member.
				LOOP ID – 2100D MEMBER EMPLOYER	
NM1		**Member Employer**	**S**	**This loop is to be sent when someone other than the sponsor employs the member and the insurance contract requires the payer be notified of such employment. An example is the employment of a dependent.**	**The ValueOptions contract does not require this segment.**
				LOOP ID – 2100E MEMBER SCHOOL	
NM1		**Member School**	**S**	**This loop is to be sent when the member is enrolled in school and the payer is required to be notified under the insurance contract between the sponsor and the payer.**	**The ValueOptions contract does not require this segment.**
				LOOP ID – 2100G RESPONSIBLE PERSON	
NM1		**Responsible Person**	**S**	**This loop is used to identify the person responsible for the member, if other than the subscriber.**	**The ValueOptions contract does not require this segment.**
				LOOP ID – 2300 HEALTH COVERAGE	
HD		**Health Coverage**	**S**	**This segment is required when enrolling a new member or when adding, updating or removing coverage from an existing member.**	
	HD03	Insurance Line Code	R		Use 'AK' Mental Health.
	HD04	Plan Coverage Description	S	Use this element when additional information is needed by the insurer to describe the exact type of coverage being provided. If required by an insurer, this information must be included. The insurer establishes the content of this element in the contract.	Use the ValueOptions benefit package code. This 4-character alpha-numeric code will be supplied by ValueOptions. It is required to properly identify the ValueOptions benefit package.
	HD05	Coverage Level Code	S	This data should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. This element is ONLY USED when the member identified in the related INS segment is the subscriber.	The ValueOptions contract requires the Coverage Level Code be sent for the Subscriber.
AMT		**Health Coverage Policy**	**S**	**This data should only be transmitted when such transmission is required under the insurance contract between the sponsor and payer.**	**The ValueOptions contract does not require this segment.**

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Health Coverage Policy Number**	**S**	**This segment should be used to identify a policy or group number for a particular insurance product if it has not already been identified in REF02, position 1-030 or REF02, position 2-020. This is necessary when not all coverage types have the same group or policy number.**	**The ValueOptions expects the Group Number to be sent in this segment when multiple Group Numbers are involved in a contract.**
IDC		**Identification Card**	**S**	**This segment is used to request the production of an identification card.**	**ValueOptions does not generate Member ID cards. The Medical Carrier's ID card identifies the Mental Health Carrier.**
LOOP ID – 2310 PROVIDER INFORMATION					
NM1		**Provider Name**	**S**	**Use this loop to provide information about primary care or capitated physicians and pharmacies chosen by the enrollee in a managed care plan when that selection is made through the sponsor.**	
	NM101	Entity Identifier Code	R	Valid values: '3D' Obstetrics and Gynecology Facility 'OD' Doctor of Optometry 'P3' Primary Care Provider 'QA' Pharmacy 'QN' Dentist 'Y2' Managed Care Organization	Use 'P3' Primary Care Provider
	NM108	Identification Code Qualifier	S	The National Provider ID should be passed in NM109. Until that ID is available the Federal Tax ID should be used. Valid values: '34' Social Security Number 'FI' Federal Taxpayer's Identification Number 'SV' Service Provider Number (addendum) This is a number assigned by the payer used to identify a provider. 'XX' HCFA National Provider Identifier	Use either '34' or 'FI' as the identification code qualifier.
	NM109	Provider Identifier	S		Use the Tax ID/SSN of the provider.
N4		**Provider City, State, Zip Code**	**S**	**To be sent when required in the insurance contract between the sponsor and payer.**	**The ValueOptions contract does not require this segment.**
PLA		**PCP Change Reason**	**S**	**This segment should be used to report the reason and the effective date that a member changes primary care provider.**	**ValueOptions expects the PCP Effective Date.**
LOOP ID – 2320 COORDINATION OF BENEFITS					

Seg	Data Element	Name	Usage	Comments	Expected Value
COB		**Coordination of Benefits**	**S**	**Use this loop whenever an individual has another insurance plan with benefits similar to those covered by the insurance product specified in the HD segment. Send this data when such transmission is required under the insurance contract between the sponsor and the payer.**	**The ValueOptions contract requires COB information be sent if present.**
	COB02	Insured Group or Policy Number	S	Always supply the policy number when it is available.	Use the Other Insurance Group Number.
REF		**Additional Coordination of Benefits Identifiers**	**S**	**Use this segment if additional data on COB exists.**	
	REF01	Reference Identification Qualifier	R	Valid values: '60' Account Suffix Code '6P' Group Number 'A6' Employee Identification Number 'SY' Social Security Number 'ZZ' Mutually Defined. (National ID Number when mandated)	Use either 'SY' or 'A6' as the reference identifier qualifier.
	REF02	Reference Identification	R		Use the SSN or Employee ID of the other insured.
N1		**Other Insurance Company Name**	**S**	**Use this segment to send the name of the insurance company when provided to the sponsor.**	
	N102	Insurer Name	S	Send the insurance company name if no standard identifier is available to pass.	Use the Other Insurer Carrier Name.
DTP		**COB Eligibility Dates**	**S**	**This segment contains the dates for which coordination of benefits is in effect. Send the eligibility date when provided to the sponsor.**	**ValueOptions expects the Other Insurance Effective Dates when available.**