GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS

Hewlett Packard Enterprise

Georgia Department of Community Health (DCH)

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guide
Based on ASC X12N version: 005010X279A1

Health Care Eligibility Benefit Inquiry and Information Response (270/271)

March, 2016 005010 Version: 2.5

Disclosure Statement

The following Georgia Department of Community Health (DCH) Companion Guide is intended to serve as a companion guide to the corresponding ASC X12N/005010X279 Health Care Eligibility/Benefit Inquiry and Information Response (270/271), its related Addenda (005010X279A1) and its related Errata (005010X279E1). The companion guide further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. This companion guide supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X279 in a manner that will make its implementation by users to be out of compliance.

Note:

Type 1 TR3 Errata are substantive modifications, necessary to correct impediments to implementation, and identified with a letter 'A' in the errata document identifier. Type 1 TR3 Errata were formerly known as Implementation Guide Addenda.

Type 2 TR3 Errata are typographical modifications, and identified with a letter 'E' in the errata document identifier.

The information contained in this Companion Guide is subject to change. Electronic Data Interchange (EDI) submitters are advised to check the Georgia Web Portal site http://www.mmis.georgia.gov regularly for the latest updates.

About DCH

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable, quality health care to millions of Georgians, including some of the state's most vulnerable and underserved populations.

DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia.
http://dch.georgia.gov/

Mission Statement

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to ***A Healthy Georgia.***

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Preface

This Companion Guide to the 5010 ASC X12N Technical Report Type 3 Implementation Guides and associated errata and addenda adopted under HIPAA clarifies and specifies the data content when exchanging electronically with DCH. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that is any way exceeds the requirements or usages of data expressed in the TR3 Implementation Guides.

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1 Introduction

This section describes how TR3 Implementation Guides, also called 270/271 ASC X12N (version 005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Georgia Medicaid has information additional to the TR3 Implementation Guide. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Georgia Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Georgia Medicaid for specific segments provided by the TR3 Implementation Guides. The following is just an example of the type of information that would be spelled out or elaborated on in the Section 10: Transaction Specific Information.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
193	2100C	NM109	Subscriber Primary Identifier	00	15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Georgia Medicaid Management Information System

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						(GAMMIS).
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
241	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 270/271 Implementation Guide for the purpose of submitting eligibility and benefit inquiries electronically. This companion guide is not intended to replace the TR3 Implementation Guide. The TR3s define the national data standards, electronic format, and values for each data element with an electronic transaction. The purpose of this companion guide is to provide trading partners with a companion guide to communicate Georgia Medicaid-specific information required to successfully exchange transactions electronically with Georgia Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

Georgia Medicaid will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Georgia Medicaid-specific information, though processed, may be denied. For example, a compliant 270 Inquiry (270) created with an invalid Georgia Medicaid member identification number will be processed by Georgia Medicaid but will return an AAA03=75 (Subscriber/Insured Not Found) within the 2100C loop in the 271 Response (271).

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Refer to this companion guide first if there is a question about how Georgia Medicaid processes a HIPAA transaction. For further information, contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590. This companion guide is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with Georgia Medicaid interChange in successfully conducting EDI of administrative health care transactions. This companion guide provides instructions for enrolling as a Georgia Medicaid trading partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This companion guide does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Georgia Medicaid and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

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

This companion guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Georgia Medicaid. This companion guide supplements (but does not contradict) requirements in the ASC X12N 270/271 (version 005010X279A1) implementation guide. This information should be given to the provider's business area to ensure that eligibility responses are interpreted correctly.

This companion guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Georgia Medicaid.

This companion guide must be used in conjunction with the TR3 Implementation Guide instructions. The companion guide is intended to assist trading partners in implementing electronic 270/271 transactions that meet Georgia Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new companion guides will be posted on the GAMMIS Web Portal EDI >> Companion Guides page.

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1.3 References

The TR3 Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The TR3 Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that your IT staff, or software vendor, review this companion guide in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Georgia Medicaid.

The TR3 Implementation Guides for X12N and all other HIPAA standard transactions are available electronically at http://www.wpc-edi.com/.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a health care provider.

For all non-healthcare providers where an NPI is not assigned, the Medicaid provider number should be submitted.

Acceptable Characters

For real-time, the HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. For batch, the HIPAA transactions can contain carriage returns and line feeds, however it is recommended that the data is received in one, continuous stream without carriage return and line feeds. Georgia Medicaid accepts the extended character set. Uppercase characters are

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recommended.

Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all batch submitted files. For real-time transactions, where the 270 Inquiry (270) fails, a rejected 999 Implementation Acknowledgement, or a rejected TA1 InterChange Acknowledgment will be generated. For real-time transactions, where the 270 Inquiry (270) passes compliance and a 271 Response (271) is generated, no other acknowledgement transaction is generated.

Trading partners are responsible for retrieving acknowledgments from the GAMMIS Web Portal to determine the status of their files.

2 Getting Started

2.1 Working with Georgia Medicaid

This section describes how to interact with Hewlett Packard Enterprise' EDI Department.

Georgia Medicaid trading partners should exchange electronic health care transactions with Hewlett Packard Enterprise via the GAMMIS Web Portal, Remote Access Server (RAS), Secure File Transfer Protocol (SFTP), Network Routing Module Service (NRM), and Healthcare Transaction Services (HTS) or through a Georgia Medicaid approved Value Added Network (VAN).

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in the next section of this companion guide. After successful completion of testing, production transactions may be exchanged.

2.2 Trading Partner Registration

This section describes how to register as a trading partner with Hewlett Packard Enterprise.

All trading partners are required to complete the Georgia Medicaid trading partner agreement (TPA) form to enroll into EDI Services. Those trading partners that are using an already enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately since they are already enrolled to transmit electronically. Only one trading partner ID is assigned per submitter location. If multiple trading partner IDs are needed for the same address location, please attach a letter to the TPA explaining the need for the additional trading partner ID. Providers must use the secure GAMMIS Web Portal to delegate access to their clearinghouse, billing agent, or software vendor to allow EDI files to be downloaded on their behalf. Information on how to delegate access is found in the Web Portal User Account Management Guide on the GAMMIS Web Portal Provider Information >> Provider Manuals page.

If you are already enrolled to transmit or receive electronically and would like to make a change

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to your EDI trading partner ID profile or provider ID (ERA Only) profile, please complete the Hewlett Packard Enterprise EDI Submitter Update Form found on the GAMMIS Web Portal page EDI >> Registration Forms indicating the changes you wish to make. The following changes can be made: Trading Partner Name, Contact Information, Address, Status (Active or Inactive), Transmission Method, and Transaction Types. Trading partners cannot change their trading partner ID. This ID can simply be deactivated using the EDI Submitter Update Form and a new EDI TPA for enrollment must be submitted once the original trading partner ID has been deactivated.

Trading Partners that will be exchanging electronic health care transactions SFTP are required to complete the SFTP Setup Request Form found on the GAMMIS Web Portal page EDI >> Registration Forms. This form must be signed by an authorized agent and is necessary to transmit to and from the GAMMIS server. Failure to submit this form will cause your enrollment to be delayed, and/or returned to you as incomplete. For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

If you have already completed these forms, you will not be required to complete them again. Please contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if you have any questions about these forms.

2.3 Certification and Testing Overview

All trading partners will be certified through the completion of trading partner testing.

All trading partners that exchange electronic transactions with Georgia Medicaid must complete trading partner testing. This includes billing agents, clearinghouses or software vendors. Failure to do so will prevent successful transmissions of electronic files to the GAMMIS. Testing is not required if using the Provider Electronic Solutions (PES) software.

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Georgia Medicaid

Before exchanging production transactions with GAMMIS, each trading partner must complete testing. All trading partners who plan to exchange transactions must contact Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

For batch inbound transactions that do not have an associated response (e.g., 837, 834) testing is done through Ramp Manager which is a free interactive X12 testing website, configured to test GAMMIS X12N inbound transactions against the TR3 Implementation Guides and Georgia specific processing rules. To access Ramp Manager, visit the Georgia Health Partnership Ramp

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Management System Web site at: https://sites.edifecs.com/index.jsp?gamedicaid. A set of instructions for using the Ramp Manager site and its tools are available in the Ramp Manager User Guide, located on the EDI >> Software and Manuals page.

You will be required to have a test file that has passed compliance for each type of transaction you will be sending. The status of each transaction should show "Passed" in Ramp Manager to show that you have successfully passed compliance before Hewlett Packard Enterprise can make you an active trading partner.

For batch and real-time transactions that do have an associated response (e.g., 270/271, 276/277) Hewlett Packard Enterprise will process these transactions in a test environment to verify that the file structure and content meet HIPAA standards and Georgia Medicaid-specific data requirements and provide the associated response transaction. Once this validation is complete, the trading partner may submit production transactions to Hewlett Packard Enterprise for processing.

Hewlett Packard Enterprise does not require a specific number of test files to be sent however your test file(s) should contain as many as possible to cover each of your business scenarios.

For Eligibility Inquiry/Response, the following conditions should be addressed in one or more test files:

- The ability to perform a 270 inquiry using the Georgia Medicaid Member Identification Number.
- The ability to perform a 270 inquiry using the Georgia Medicaid Member First Name, Last Name and Social Security Number.
- The ability to perform a 270 inquiry using the Georgia Medicaid Member Social Security Number, and Date of Birth.
- The ability to perform a 270 inquiry using the Georgia Medicaid Member First Name, Last Name, Date of Birth and Gender.

Please note that if you supply data for all of the data elements, then GAMMIS will process the inquiry based on the hierarchy above. If a match is found, the 271 will return member data. If a match is not found, the 271 will return the appropriate reject code within the AAA03 data element. GAMMIS will perform multiple searches based on the data provided in the 270 request.

4 Connectivity with Georgia Medicaid / Communications

This section describes the process to submit HIPAA 270 transactions real-time or batch, along with various submission methods, security requirements, and exception handling procedures.

Georgia Medicaid supports multiple methods for exchanging electronic healthcare transactions:

- GAMMIS Web Portal
- Remote Access Server (RAS) (PES Users Only)
- Secure File Transfer Protocol (SFTP) (Batch Only)

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- Network Routing Module Service (NRM) (Real-Time Only)
- Georgia Medicaid approved Value Added Network (VAN)
- Healthcare Transaction Services (HTS) (Batch or Real-Time)

4.1 Process Flows

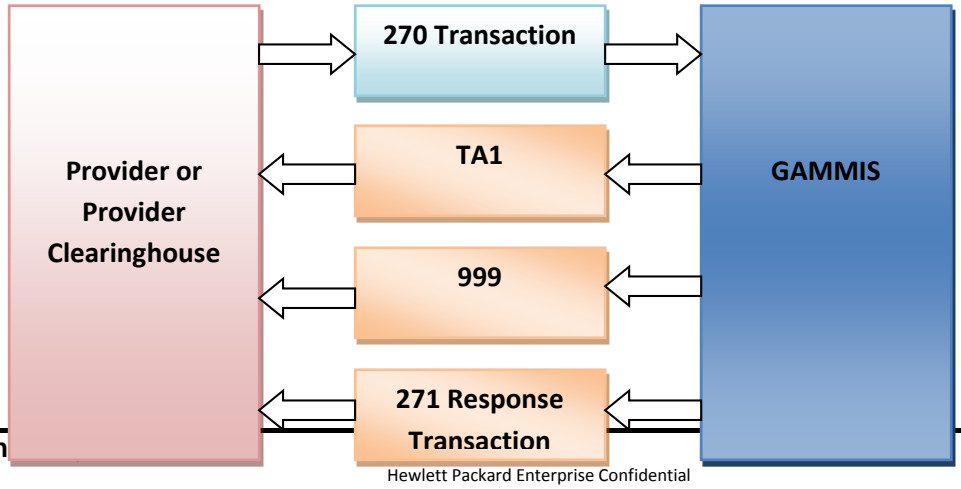
This section contains process flow diagrams and appropriate text.

Batch and Real-Time Eligibility Benefit Inquiry and Response
The response to a batch and real-time eligibility transaction will consist of the following:

1. First level response: TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
2. Second level response: 999 will be generated. "Rejected" 999 when errors occur during 270 compliance validation or "Accepted" 999 if no errors are detected during the compliance validation.
3. Third level response: 271 will be generated indicating either the eligibility and benefits or AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3 Implementation Guide.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all inquiries in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Transactions that pass compliance checks, but failed to process (e.g., due to member not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the requested dates) do not generate AAA segments but will create a 271 using the information in our eligibility and benefit system.



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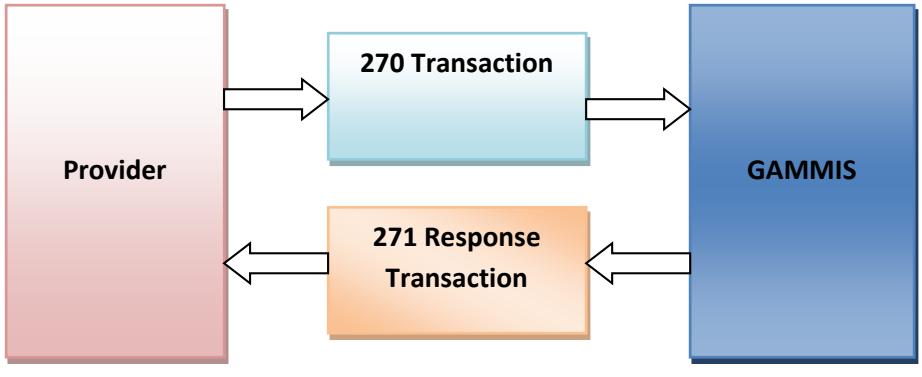
Real-Time Benefit Inquiry and Response
The response to a real-time eligibility transaction will consist of a 271 response being generated indicating the eligibility and benefits OR indicating errors using the AAA segment.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3 Implementation Guide. Transactions that pass compliance checks but fails to process (e.g., due to member not being found) will generate a real-time 271 response transaction with the appropriate AAA segment(s) indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with eligibility within the requested dates) will create a 271 using the information in our eligibility and benefit system without AAA segments.



4.2 Transmission Administrative Procedures

This section provides Georgia Medicaid's specific transmission administrative procedures. Determine if the transmission you are sending is Test or Production and is using the appropriate indicator. For details about available Georgia Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Georgia Medicaid is available only to authorized users. Submitters must be Georgia Medicaid trading partners. A submitter is authenticated using a Username and Password assigned by the trading partner.

System Availability

The system is typically available 24x7 with the exception of scheduled maintenance windows which are posted on the GAMMIS Web Portal at www.mmis.georgia.gov. Non-Routine and emergency downtime will also be posted on the GAMMIS Web Portal. The system is available on all holidays.

Transmission File Size

For Batch:

- EDI will allow no more than 100,000 requests. The definition of a request is an EQ segment within the 2100C loop.
- If the file size is 5MB or larger it must be zipped or compressed.

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For Real-Time:

- EDI will allow one (1) request per file.

Transmission Errors

When processing a real-time or batch EDI transaction that has Interchange Header errors a TA1 will be generated. If the Interchange Header is valid, but the transaction fails compliance a 999 will be generated.

Production File-naming Convention

Georgia Medicaid will only accept Windows/PC/DOS formatted files. Any file transmitted to GAMMIS must be named in accordance to standard file naming conventions, including a valid three character file extension.

- Preferred extension is: .dat, however other extensions such as .txt, .edi, .txn are allowed.

Georgia Medicaid allows for the upload and download of zipped or compressed files. Any data file contained within the zipped file must contain a valid three character file extension. Zipped files must not contain directory folders or structures and must contain only one (1) file.

4.3 Retransmission Procedure

Georgia Medicaid does not require any identification of a previous transmission of a file. All files sent should be marked as original transmissions.

4.4 Communication Protocol Specifications

This section describes Georgia Medicaid's communication protocol(s).

Georgia Medicaid Web Portal

Georgia Medicaid's Web Portal solution provides communication, data exchange, and self-service tools to the provider and member community. The Portal consists of both public and secure areas (web pages requiring a username and password). The public area contains general information, such as program awareness, notices, and forms, and allows users to respond to surveys. Providers can also apply to be a Georgia Medicaid provider online using the provider enrollment wizard, which includes the ability to track their application through the enrollment process. Once enrolled in Medicaid, providers can access their personal information using their provider number and Personal Identification Number (PIN).

The Georgia Medicaid Web Portal is designed, but not limited to support the following Internet browsers for submissions:

- Internet Explorer, version 6 or 7
- Firefox, version 3.x

Secure File Transfer Protocol (SFTP)

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Georgia Medicaid allows submitters with a file size of 2K or larger the ability to data exchange SFTP. For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

Network Routing Module Service (NRM)

Hewlett Packard Enterprise provides a Network Routing Model (NRM) which is an interactive server that is a multi-threaded windows service responsible for listening for input from a configured Value Added Network (VAN) data present port using socket connections. For more information on NRM, please contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

Remote Access Server (RAS)

Remote Access Server (RAS) enables providers to access all options of the secure Web Portal without the use of an Internet Service Provider. This option is only available to Provider Electronic Solution (PES) users who do not have an existing Internet connection. For more information on RAS, please contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

Healthcare Transaction Services (HTS)

Hewlett Packard Enterprise provides a Healthcare Transaction Service (HTS) submission method which allows trading partners to submit the 270/271 (Eligibility Inquiry and Response) and 276/277 (Claims Status Inquiry and Response) transactions from their system directly to the MMIS via a fully automated process. This system-to-system EDI web service is supported by a specific Georgia Medicaid schema and Web Services Description Language (WSDL) that are outlined in the Georgia Medicaid HTS Guide. Once trading partners develop the web service to the guide's specification they can test the web client application on the GAMMIS test servers prior to being approved for production. Interested trading partners must contact Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590 to obtain a copy of the HTS guide.

4.5 Passwords

Providers must adhere to the GAMMIS use of passwords. Providers are responsible for managing their own data. Each provider is responsible for managing access to their organization's data through the MMIS security function. Each provider must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., Granting access) only with users and entities who meet the required privacy standards. It is equally important that providers know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organizations.

For more information regarding passwords and use of passwords, contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

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5 Contact Information

Refer to this companion guide with questions, and then use the contact information below for questions not answered by this companion guide.

5.1 EDI Customer Service

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Most questions can be answered by referencing the materials posted on the GAMMIS Web Portal at https://www.mmis.georgia.gov. If you have questions related to Georgia Medicaid's Eligibility and Benefits Request and Response, contact the Hewlett Packard Enterprise EDI Team at 1-877-261-8785 or 1-770-325-9590.

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Hewlett Packard Enterprise EDI Services Team can help with connectivity issues or transaction formatting issues at 1-877-261-8785 or 1-770-325-9590 Monday through Friday 8:00 a.m. to 5:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Trading Partner ID: The Trading Partner ID is the GAMMIS key to accessing trading partner information. Trading partners should have this number available each time they contact the Hewlett Packard Enterprise EDI Services Team.

5.3 Provider Contact Center

This section contains detailed information concerning Provider Contact Center, especially contact numbers.

The Provider Contact Center should be contacted instead of the Hewlett Packard Enterprise EDI Services Team for questions regarding the details of a member's benefits, claim status information, credentialing and many other services. Provider Contact Center is available at 1-800-766-4456 or 1-770-325-9600 Monday through Friday 7:00 a.m. to 7:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Note: Have the applicable provider identifier, the NPI for health care providers or the Medicaid provider ID for atypical providers available for tracking and faster issue resolution.

The Provider Relations representative, also known as field representatives, conduct training sessions on various Georgia Medicaid topics for both large and small groups or providers and billers. In addition to provider education, field representatives are available to assist providers with complex

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billing and claims processing questions. To find or contact the appropriate Provider Relations Representative, use the Contact Us link on the GAMMIS Web Portal.

5.4 Applicable Websites

This section contains detailed information about useful Web sites.

From GAMMIS secure Portal at https://www.mmis.georgia.gov non-enrolled providers can begin the enrollment process and enrolled providers can do all of the following:

- Create Dental, Institutional, and Professional claims for submission to GAMMIS.
- Check claim status and member enrollment.
- Submit authorizations, notifications, and referrals.
- View, download, and print explanation of benefits (EOBs), and Remittance Advices.

Trading Partners can do the following:

- Create Trading Partner Profile and complete authorization testing.
- Submit batch transactions (270, 276, 834, 837D, 837I and 837P).
- Download batch transactions/acknowledgements (271, 277, 277U, TA1, 824, 834, 999, 820 and 835).
- View, download and print companion guides.

A suite of other EDI and provider tools are also available on the GAMMIS Web Portal.

Additional information is available on the following Web sites:

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

Accredited Standards Committee (ASC X12N)

- ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org

American Dental Association (ADA)

- Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classifications of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level 1 HCPCS. www.ahacentraloffice.org

American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA)

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- This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Centers for Medicare & Medicaid Services (CMS)

- CMS is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/
- This site is the resource for information related to the Health-Care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/
- This site is the resource for Medicaid HIPAA informational related to the Administrative Simplification provision. Medicaid HIPAA Administrative Simplification - Centers for Medicare & Medicaid Services

Committee on Operating Rules for Information Exchange (CORE)

- A multi-phase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. www.caqh.org/CORE_overview.php

Council for Affordable Quality Healthcare (CAQH)

- A nonprofit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Datasource (UPD), CAQH aims to reduce administrative burden for providers and health plans. www.caqh.org

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org www.caqh.org

Georgia Department of Community Health (DCH)

- This DCH Web site assists providers with HIPAA billing and policy questions, as well as enrollment support. www.mmis.georgia.gov

Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org

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Healthcare Information and Management Systems (HIMSS)

- An organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of health care. www.himss.org

National Committee on Vital and Health Statistics (NCVHS)

- The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics and national health information policy. www.ncvhs.hhs.gov

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association (AHA). It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association (AMA). It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (HHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. Health Information Privacy | HHS.gov

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction technical report type 3 implementation guides and code sets. www.wpc-edi.com

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

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6 Control Segments/Envelopes

6.1 ISA-IEA

This section describes Georgia Medicaid's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following GAMMIS specifications:

- Each trading partner is assigned a unique trading partner ID.
- All dates are in the CCYYMMDD format with the exception of the ISA09 which is YYMMDD.
- All date/times are in the CCYYMMDDHHMM format.
- GAMMIS Trading Partner ID is 77034. This value must be sent within the ISA08 for inbound transactions and will be sent within the ISA06 for outbound transactions.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Only one (1) ISA/IEA is allowed per logical file.
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.

Transactions transmitted during a session or as a batch are identified by an ISA header segment and IEA trailer segment, which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The tables below represent the interchange envelope information.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00	2	
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	'Trading Partner ID supplied by Georgia Medicaid', left justified and space filled.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.4		ISA07	InterChange ID Qualifier	ZZ	2	
C.4		ISA08	InterChange Receiver ID		15	Value = '77034' - GAMMIS Trading Partner ID, left justified and space filled.
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^, }, |		The repetition separator is a delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different from the data element separator, component element separator, and the segment terminator.
			Repetition Separator	^	1	
			Repetition Separator	}	1	
			Repetition Separator	|	1	
C.5		ISA12	InterChange Control Version Number	00501	5	
C.5		ISA13	InterChange Control Number		9	Must be identical to the associated interchange control trailer IEA01.
C.6		ISA14	Acknowledgment Requested	0, 1		
			No interchange acknowledgment requested	0	1	
			Interchange acknowledgement requested	1	1	
C.6		ISA15	Usage Indicator	T, P		
			Test data	T	1	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups. Must equal '1' for the real-time transaction to qualify for immediate response.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00	2	
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	Value = '77034' - GAMMIS Trading Partner ID, left justified and space filled.
C.4		ISA07	InterChange ID Qualifier	ZZ	2	
C.4		ISA08	InterChange Receiver ID		15	'Trading Partner ID supplied by Georgia Medicaid', left justified and space filled.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^	1	The repetition separator is a delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different from the data element separator, component element separator, and the segment terminator.
C.5		ISA12	InterChange Control Version Number	00501	5	
C.5		ISA13	InterChange Control Number		9	Identical to the associated interchange control trailer IEA01.
C.6		ISA14	Acknowledgment Requested	0	1	0 = No interchange acknowledgment requested
C.6		ISA15	Usage Indicator	T, P		
			Test data	T	1	
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups included in an interchange.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Same value as ISA13.

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6.2 GS-GE

This section describes Georgia Medicaid's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how GAMMIS expects functional groups to be sent and how GAMMIS will send functional groups. These discussions will describe how similar transaction sets will be packaged and Georgia Medicaid's use of functional group control numbers. The tables below represent the functional group information.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HS	2	
C.7		GS02	Application Sender's Code		2/15	'Trading Partner ID supplied by Georgia Medicaid'. This will equal the value in ISA06.
C.7		GS03	Application Receiver's Code		5	Value = '77034' - GAMMIS Trading Partner ID. This will equal the value in ISA08.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Must be identical to the value in GE02.
C.8		GS07	Responsible Agency Code	X	1	
C.8		GS08	Version/Release/ Industry ID Code		12	005010X279A1

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Number of included Transaction Sets. Must equal '1' for the real-time transaction to qualify for immediate response.
C.9		GE02	Group Control Number		1/9	The functional group control number. Same value as GS06.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HB	2	
C.7		GS02	Application Sender's Code		5	Value = '77034' - GAMMIS Trading Partner ID. This will equal the value in ISA08.
C.7		GS03	Application Receiver's Code		2/15	'Trading Partner ID supplied by Georgia Medicaid'. This will equal the value in ISA06.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Identical to the value in

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						GE02.
C.8		GS07	Responsible Agency Code	X	1	
C.8		GS08	Version/Release/ Industry ID Code		12	005010X279A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Total number of transaction sets included in the functional group.
C.9		GE02	Group Control Number		1/9	The functional group control number. Same value as GS06.

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6.3 ST-SE

This section describes Georgia Medicaid's use of transaction set control numbers.

Georgia Medicaid recommends that trading partners follow the guidelines set forth in the TR3 Implementation Guide – start the first ST02 in the first file with 000000001 and increment from there. The TR3 Implementation Guides should be reviewed for how to create compliant transactions set control segments.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
61		ST	Transaction Set Header			
61		ST01	Transaction Set Identifier Code	270	3	
62		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.
63		ST03	Implementation Convention Reference		12	005010X279A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
200		SE	Transaction Set Trailer			
200		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
200		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
209		ST	Transaction Set Header			

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
209		ST01	Transaction Set Identifier Code	271	3	
210		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.
211		ST03	Implementation Convention Reference		12	005010X279A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
450		SE	Transaction Set Trailer			
450		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
450		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

6.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

6.5 File Delimiters

Georgia Medicaid requests that submitters use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Contact the Hewlett Packard Enterprise EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if there is a need to use a delimiter other than the following:

Data Element: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommend data element delimiter is an asterisk (*).

Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommend repetition separator is a caret (^).

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Component-Element: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Data Segment: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

7 Georgia Medicaid Specific Business Rules and Limitations

This section describes Georgia Medicaid's business rules, for example:

- Communicating payer specific edits
- Billing for specific services

Before submitting electronic claims to GAMMIS, please review the appropriate HIPAA Technical Report Type 3 (TR3) Implementation Guide and Georgia Medicaid companion guide. In addition, Georgia Medicaid recommends that you review the Georgia Medicaid billing guides. These guides provide additional billing instructions for specific provider types. They are available on the GAMMIS Web Portal Provider Information >> Provider Manuals page.

The following sections outline recommendations, instructions, and conditional data requirements for transactions submitted to GAMMIS. This information is designed to help trading partners construct transactions in a manner that will allow the GAMMIS to efficiently process transactions.

7.1 Additional Information for Member Name

The member name segment accepts and returns 60 characters for the last name and 35 characters for the first name as required in the TR3 Implementation Guide. However, if a value is submitted on a transaction that is greater than what is stored in the Georgia Medicaid member database, on the return transaction the following would occur.

- If a match is found on the database, the value stored on the database table is returned.
- If no match is found on the database, the value stored on the original incoming transaction will be returned.

Example:
A provider submits an eligibility verification check (270) with a last name that is 22 characters long, but the database currently stores only 20 of those characters. On the return transaction (271), the provider will receive only the first 20 characters of the last name submitted, if a match is found on the database. If for some reason, the member name submitted is not a Georgia Medicaid member, and is not stored on the database (no match found), on the return transaction (271) the last, first and middle names would be returned exactly as they were originally submitted. The following scenarios must be addressed in one or more test files:

- Inquiry by 12-digit member identification (ID) number;
- Inquiry by member's first name, last name and social security number (SSN);
- Inquiry by SSN and Date of Birth (DOB); and
- Inquiry by member's first name, last name, DOB and Gender.

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Georgia Medicaid requires testing of the 270 transaction prior to accepting production 270 inquiries. Inquiries will be processed in a test environment to validate that the file structure and content meet HIPAA standards, and Georgia Medicaid-specific data requirements. Once this validation is complete, the trading partner may submit production 270 inquiries to GAMMIS for eligibility responses.

7.2 Logical File Structure

a. For real-time 270/271 transactions, there can be only one interchange (ISA/IEA), one functional group (GS/GE) and one transaction (ST/SE) per logical file. Within the transaction (ST/SE) there can only be one request. This has been defined as the Eligibility or Benefit Inquiry (EQ) segment within Loop 2110C.

b. For Batch 270/271 transactions, there can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

c. For Real-Time and Batch 270/271 transactions, there can only be one information source loop (2000A) and one information receiver loop (2000B) within a transaction (ST/SE). This is a new requirement documented within the TR3 Implementation Guide notes section on the HL segment within the 2000A and 2000B loops.

7.3 Compliance Checking

Inbound 270 transactions are validated through SNIP Level 4. All other levels will be validated within the GAMMIS.

7.4 Multiple Birth Situations

The GAMMIS does not store birth sequence identifiers. The system will use the member's first name and member's last name submitted when searching for eligibility information to distinguish between individuals in a multiple birth situation.

7.5 Information Receiver (Provider Information 2100B Loop)

All covered entities must use their NPI within the 2100B-NM109 on the 270 request. If, the Georgia Medicaid Provider ID is received, and the GAMMIS determines that an NPI should have been present, the 271 response will contain an AAA03=51 (Provider Not on File).

- Non-covered entities will use their Georgia Medicaid Provider ID within the 2100B-NM109.

7.6 Subscriber Date (Subscriber Information 2100C Loop)

If the 2100C DTP segment is not received within each inquiry, the day the transaction was processed will be considered the date of service.

Inquiries can span months up to a year (12) months up to the last day of the current month. (e.g., DTP*291*RD8*20110201-20120228). If, the inquiry exceeds the allowed span, the 271

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response will contain an AAA03=57 (Invalid/Missing Dates(s) of Service).

7.7 Qualifiers for ICD-9 / ICD-10 Diagnosis Codes and Principal Procedure Codes

Georgia Medicaid requirements for the use of ICD-9 / ICD-10 Diagnosis Codes and Qualifiers and ICD-9 / ICD-10 Principal Procedure Codes and Qualifiers:

For X12 837P 5010A1:

- Where the From Date of Service is prior to October 1, 2015, ICD-9 Diagnosis Codes / Qualifiers are required.
- Where the From Date of Service is on or after October 1, 2015, ICD-10 Diagnosis Codes / Qualifiers are required.

For X12 837I 5010A1:

- For all Outpatient Services, where the From Date of Service is prior to October 1, 2015, ICD-9 Diagnosis Codes / Qualifiers are required. For claims that contain Principal Procedure Code or Other Procedure Codes ICD-9 procedure codes and qualifiers must be used.
- For all Outpatient Services, where the From Date of Service is on or after October 1, 2015, ICD-10 Diagnosis Codes / Qualifiers are required. For claims that contain Principal Procedure Code or Other Procedure Codes ICD-10 procedure codes and qualifiers must be used.
- For all Inpatient Services, where the Through Date of Service is prior to October 1, 2015, ICD-9 Diagnosis Codes / Qualifiers are required. For claims that contain Principal Procedure Code or Other Procedure Codes ICD-9 procedure codes and qualifiers must be used.
- For all Inpatient Services, where the Through Date of Service is on or after October 1, 2015, ICD-10 Diagnosis Codes / Qualifiers are required. For claims that contain Principal Procedure Code or Other Procedure Codes ICD-10 procedure codes and qualifiers must be used.

	837P (ICD-9)	**837P (ICD-10)**	**837I (ICD-9)**	**837I (ICD-10)**
Principal Diagnosis Code	BK	ABK	BK	ABK
Other Diagnosis Code	BF	ABF	BF	ABF
Admitting Diagnosis Code			BJ	ABJ
Patients Reason for Visit			PR	APR
E-Code			BN	ABN
Principal Procedure Code			BR	BBR
Other Procedure Code			BQ	BBQ

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7.8 Name Normalization (CORE Standard)

In an effort to further simplify the eligibility inquiry and response transaction, and reduce the number of non-matches, Georgia Medicaid, in collaboration with the Healthcare Administrative Simplification Collaborative, which consists of a number of health plans across the state of Georgia, has adopted the Name Normalization standard developed by the Council for Affordable Quality Healthcare (CAQH).

More specifically, Georgia Medicaid has adopted the CORE 258: Phase II Normalizing Patient Last Name Rule, where CORE stands for Committee on Operating Rules for Exchange. This applies to the HIPAA adopted X12N 270/271 eligibility inquiry and response transactions and specifies the requirements for a CORE-certified health plan (or information source), to normalize a person's last name during any name validation or matching process by the health plan (or information source). This CORE rule applies only to certain characters in a person's last name including:

- Punctuation values;
- Uppercase letters;
- Special characters; and
- Name suffixes and prefixes.

Georgia Medicaid applies these normalization rules to both the patient's first name and last name. For additional information on CORE 258, refer to http://www.caqh.org/pdf/CLEAN5010/258-v5010.pdf.

Please Note: The delimiters that may be used in the Patient Last Name according to the CORE standard are limited to space, comma, and forward slash. Any other non-alphabetic delimiter will be viewed as a special character. Valid examples include:

- SMITH SR;
- SMITH, SR; and
- SMITH/SR

7.9 Data Content and Eligibility & Benefits Data Content (CORE Standard)

Georgia Medicaid has adopted the CORE 154: Data Content Rule and CORE 260: Eligibility & Benefits Data Content (270/271) Rule. CORE Rule 154 primarily outlines a set of requirements for health plans to return base financial responsibility related to the deductible, co-pay and co-insurance for a set of 12 services type codes within the 270/271 transactions. CORE rule 260 extends and enhances CORE Rule 154 by requiring the provision of remaining deductible amounts for the 12 service type codes and an additional set of 39 other Service Type Codes.

Georgia Medicaid will support a generic inquiry within the 270-2110C-EQ01:

- 30 = Health Benefit Plan Coverage

For the generic inquiry '30' (Health Benefit Plan Coverage) the following service types will be reported on the 271 response where the 2110C-EB03 equals:

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30 = Health Benefit Plan Coverage
1 = Medical Care

33 = Chiropractic
35 = Dental Care
47 = Hospital
48 = Hospital – Inpatient
50 = Hospital – Outpatient
86 = Emergency Services
88 = Pharmacy
98 = Professional (Physician) Visit – Office
AL = Vision (Optometry)
MH = Mental Health
UC = Urgent Care

Georgia Medicaid also supports the following explicit service type inquiries along with the service types listed above. When the 270 contains an explicit service type within the 270-2110C-EQ01, the 271 response will contain information for service type '30' Health Benefit Plan Coverage and the explicit service type requested within the 271-2110C-EB03.

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
40 = Oral Surgery
42 = Home Health Care
45 = Hospice
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
93 = Podiatry
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
BG = Cardiac Rehabilitation
BH = Pediatric

For additional information on CORE 154, refer to www.caqh.org/pdf/CLEAN5010/154-v5010.pdf for additional information on CORE 260, refer to www.caqh.org/pdf/CLEAN5010/260-v5010.pdf.

7.10 AAA Error Code Reporting (CORE Standard)

Georgia Medicaid has adopted the CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule. CORE Rule 259 outlines a set of requirements for health plans to return consistent and specific member identification validation error reporting.

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Based on the data received on the 270 transaction, various values could be reported within the 2100C-AAA03. It is possible that multiple AAA segments could be returned based on the data received. Examples where the AAA segment is returned:

- 2100C-AAA03 = 72 (Invalid/Missing Subscriber ID)
  - No valid member search criteria received
  - No Member ID, Last Name or SSN received. Gender, First Name and DOB received.
  - No Member ID, First Name or SSN received. Gender, Last Name and DOB received.
  - No Member ID, SSN or DOB received. Gender, First and Last Name received.
  - No Member ID, SSN or Gender received. First Name, Last Name and DOB received.
  - Incorrect Member ID, No SSN or DOB received. First Name, Last Name and Gender received.
  - Valid SSN, Invalid DOB, No Member ID received. Gender, First Name, and Last Name received.

- 2100C-AAA03 = 73 (Invalid /Missing Subscriber Name)
  - Invalid SSN, No Member ID, DOB or Gender received. First Name and Last Name received.
  - Valid SSN and First Name, Invalid Last Name, No Member ID, DOB or Gender received.
  - Valid DOB, Gender and First Name received. Invalid Last Name, No Member ID or SSN received.
  - Valid DOB, First and Last Name, Invalid Gender, No Member ID or SSN received.
  - SSN, First and Last Name received. Multiple member matches on GAMMIS database is found.
  - DOB, Gender, First and Last Name received. Multiple member matches on GAMMIS database is found.

- 2100C-AAA03 = 76 (Duplicate Subscriber ID)
  - Valid SSN and DOB received. Multiple member matches on GAMMIS database found.

- Two (2) occurrences of the 2100C-AAA, where AAA03 = 58 (Invalid/Missing Date-Of-Birth) AND 72 (Invalid/Missing Subscriber ID)
  - Valid SSN, Invalid DOB, No Member ID, Gender, First or Last Name received.

- Two (2) occurrences of the 2100C-AAA, where AAA03 = 72 (Invalid/Missing Subscriber ID) AND 73 (Invalid /Missing Subscriber Name)
  - Invalid Member ID, SSN, Last Name and DOB received. Valid Gender and First Name received.

- Three (3) occurrences of the 2100C-AAA, where AAA03 = 58 (Invalid/Missing Date-Of-Birth) AND AAA03 = 72 (Invalid/Missing Subscriber ID) AND 73 (Invalid /Missing

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Subscriber Name)

- Invalid Member ID, SSN, Last Name and DOB received. Valid Gender and First Name received.

7.11 Multiple Service Types with Multiple Date Ranges within the same Request

If multiple Service Type Codes within multiple 2110C-EQ segments are received. And the date ranges (2110C-DTP) vary within each of the 2110C loops GAMMIS will provide eligibility information for all service types requested from the oldest date to the latest date received within a year span up to the end of the current month. Example of 2110C Received:

```
EQ*30~
DTP*RD8*20130301-20130331~
EQ*42~
DTP*RD8*20130201-20130228~
EQ*51~
DTP*RD8*20130101-20130131~
```

Response will contain information for Service Type Code '30', Service Type Codes 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, UC which are required based on CORE rule 154 and 260 if Service Type Code 30 is received. It will also contain information for Service Type Codes 42 and 51. The date range will be 01012013 through 03312013.

8 Acknowledgements and/or Reports

8.1 The TA1 Interchange Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

For batch and real-time if ISA or GS errors were encountered then the generated TA1 report with the Interchange Header errors will be returned for pickup.

What to look for in the TA1

The TA1 segment indicates whether or not the submitted interchange control structure passed the HIPAA compliance check.

If TA104 is "R" then the transmitted interchange control structure header and trailer were rejected because of errors. The submitter will need to correct the errors and resubmit the corrected file to GAMMIS.

Example:

- TA1*900000001*090721*1700*R*006~

The data elements in the TA1 segment are defined as follows:

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TA101 contains the Interchange Control Number (ISA13) from the file to which this TA1 is responding (“900000001” in the example above).

TA102 contains the Interchange Date (“090721” in the example above).

TA103 contains the Interchange Time (“1700” in the example above).

TA104 code indicates the status of the interchange control structure (“R” in the example above). The definition of the code is as follows;

> “R” – The transmitted interchange control structure header and trailer are rejected because of errors.

TA105 code indicates the error found while processing the interchange control structure (“006” in the example above). The definitions of the codes are as follows:

Code	Description
000	No Error
001	The InterChange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid InterChange ID Qualifier for Sender
006	Invalid InterChange Sender ID
007	Invalid InterChange ID Qualifier for Receiver
008	Invalid InterChange Receiver ID
009	Unknown InterChange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid InterChange Date Value
015	Invalid InterChange Time Value
016	Invalid InterChange Standards Identifier Value
017	Invalid InterChange Version ID Value
018	Invalid InterChange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid InterChange Content (e.g., Invalid GS Segment)
025	Duplicate InterChange Control Number
026	Invalid Data Element Separator

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Code	Description
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

The TA1 segment will be sent within its own interchange (i.e., ISA-TA1-IEA)

Example of a TA1 within its own interchange

```
ISA*00*          *00*          *ZZ*77034          *ZZ*RECEIVER
*110721*1701*^*00501*000000001*0*P*:~TA1*900000001*110720*1245*R*006~IEA*0*000
000001~
```

For additional information, consult the Interchange Control Structures, X12.5 Guide. TR3 Implementation Guides may be obtained by logging on to www.wpc-edi.com and following the links to 'EDI Publications' and '5010 Technical Reports.'

8.2 The 999 Implementation Acknowledgement

For batch each time a 5010 X12 file is submitted to GAMMIS, a 999 acknowledgement is sent to the submitter within one business day. For real-time a 999 acknowledgement is generated only if the 270 eligibility request fails compliance. A 999 does not guarantee processing of the transaction. It only signifies that GAMMIS received the Functional Group. The following sections explain how to read the 999 to find out whether a file is accepted or rejected. If a Functional Group is accepted, no action is required by the submitter. If the Functional Group is rejected, the submitter must correct the errors and submit the corrected file to GAMMIS.

What to look for in the 999

Locate every AK9 segment. These segments indicate whether or not the submitted Functional Group passed the HIPAA compliance check. If each AK9 segment appears as AK9*A, this means the entire Functional Group was accepted for processing. The transaction will process.

If any AK9 segment begins with AK9*R (Rejected), or AK9*P (Partially Accepted – At least one transaction set was rejected), you should review the IK5 segments for any and all IK5*R values. This segment displays which transaction set or sets have been rejected.

Example of the 999 Acknowledgment

```
ST*999*0001*005010X231~
AK1*HC*6454*005010X231~
AK2*837*0001~
IK5*A~
AK2*837*0002~
```


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IK3*CLM*22*22**8~
CTX*CLM01:123456789~
IK4*2*782*1~
IK5*R*5~
AK9*P*2*2*1~
SE*8*0001~

AK1: This segment refers to the (GS) group set level of the original file sent to GAMMIS.

- AK101 is equal to GS01 from the original file (e.g., the AK101 of an 837 claims file would be "HC"; the AK101 of a 270 Eligibility Inquiry file would be "HS").
- AK102 is equal to GS06 from the original file (Group Control Number).
- AK103 is equal to GS08 from the original file (EDI Implementation Version).

AK2: This segment refers to the (ST) Transaction set level of the original file sent to GAMMIS.

- AK201 is equal to ST01 from the original file (e.g., the AK201 of an 837 claims file would be "837"; the AK201 of a 270 Eligibility Inquiry file would be "270").
- AK202 is equal to ST02 from the original file (Transaction Set Control Number).
- AK203 is equal to ST03 from the original file (EDI Implementation Version).

IK3: This segment reports errors in a data segment.

Example: IK3*CLM*22**8~

- IK301 contains the segment name that has the error. In the example above, the segment name is "CLM".
- IK302 contains the numerical count position of this data segment from the start of the transaction set (a "line count"). The erroneous "CLM" segment in the example above is the 22nd segment line in the Transaction Set. Transaction Sets start with the "ST" segment. Therefore, the erroneous segment in the example is the 24th line from the beginning of the file because the first two segments in the file, ISA and GS, are not part of the transaction set.
- IK303 may contain the loop ID where the error occurred.
- IK304 contains the error code and it states the specific error. In the example above, the code '8' states 'Segment Has Data Element Errors.'

Code	Description
1	Unrecognized segment ID
2	Unexpected segment
3	Required segment missing
4	Loop occurs over maximum times
5	Segment Exceeds Maximum Use
6	Segment not in defined transaction set
7	Segment not in proper sequence

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Code	Description
8	Segment has data element errors
I4	Implementation "Not Used" segment present
I6	Implementation Dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation Dependent "Not Used" segment present

CTX: This segment describes the Context/Business Unit. The CTX segment is used to identify the data that triggered the situational requirement in the IK3.

Example:

IK3*CLM*22**8~
CTX*CLM01:123456789~

IK4: This segment reports errors in a data element.

Example:

IK4*2*782*1~

- IK401 contains the data element position in the segment that is in error. "2" in the example above represents the second data element in the segment.
- IK402 contains the data element reference number as found in the appropriate TR3 Implementation Guide. "782" in the example above represents the CLM02 data element from the 837P.
- IK403 contains the error code and states the specific error. "1" in the example above represents "Required Data Element Missing."

Code	Description
1	Required data element missing
2	Conditional required data element missing
3	Too many data elements
4	Data element too short
5	Data element too long
6	Invalid character in data element
7	Invalid code value
8	Invalid date
9	Invalid time
10	Exclusion condition violated
12	Too many repetitions
13	Too many components
I6	Code value not used in implementation
I9	Implementation dependent data element missing
I10	Implementation "Not Used" data element present
I11	Implementation too few repetitions
I12	Implementation pattern match failure

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Code	Description
I13	Implementation Dependent "Not Used" element present

- IK404: May contain a copy of the bad data element

IK5: This segment reports errors in a transaction set.

Example: IK5*R*5~

- IK501 indicates whether the transaction set is:
  - A = Accepted
  - R = Rejected

  Other codes such as M, W, or X are for security decryption purposes but are rarely used.

  "R" in the example above means the transaction set was rejected due to errors.

- IK502 indicates the implementation transaction set syntax error. "5" in the example above indicates "One or More Segments in Error."

  Below is a sample of IK502 error codes. Please refer to the 999 TR3 Implementation Guide for a complete list of these error codes.

Code	Description
1	Transaction Set not supported
2	Transaction Set trailer missing
3	Transaction Set Control Number in Header/Trailer do not match
5	One or more segments in error

AK9: This segment reports the functional group compliance status.

Example: AK9*P*2*2*1~

- AK901 indicates whether the entire functional group is:

  - A = Accepted
  - P = Partially Accepted, at least one transaction set was rejected. The rejected transaction set within the functional group needs to be corrected and resubmitted.
  - R = Rejected, the functional group was rejected and was NOT forwarded for further processing. The file will need to be corrected and resubmitted.

  Other codes such as M, W, or X are for security decryption purposes but are rarely used.

  "P" in the example above means the functional group was partially accepted and at least one transaction set was rejected.

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- AK902 contains the total number of transaction sets. In the example above, two transaction sets were submitted.
- AK903 contains the number of received transaction sets. In the example above, two transaction sets were received.
- AK904 contains the number of accepted transaction sets in a Functional Group. In the example above, one transaction set was accepted.
- AK905 contains the Functional Group Syntax Error Code.

Below is a sample of AK905 error codes. Please refer to the 999 TR3 Implementation Guide for a complete list of error codes.

Code	Description
1	Functional group not supported
2	Functional group version not supported
3	Functional group trailer missing
4	Group Control Number in the functional group Header and Trailer do not agree
5	Number of included transaction sets does not match actual count
6	Group Control Number violates syntax
17	Incorrect message length (Encryption only)
18	Message authentication code failed
19	Functional Group Control Number not unique within interchange

For additional information, consult the Implementation Acknowledgment for Health Care Insurance (999) Guide. TR3 Implementation Guides may be obtained by logging onto www.wpc-edi.com and following the links to “HIPAA” and “HIPAA Guides.”

8.3 Report Inventory

There are no acknowledgement reports at this time.

9 Trading Partner Agreements

Providers who intend to conduct electronic transactions with Georgia Medicaid must sign the Georgia Medicaid Trading Partner Agreements. A copy of the agreement is available on the GAMMIS Web Portal page EDI >> Registration Forms.

Trading Partners

An Electronic Data Interchange (EDI) Trading Partner is defined as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with Georgia Medicaid. The Trading Partner and Georgia Medicaid acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each part agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated there under.

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Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

10 Transaction Specific Information

This section describes how ASC X12N Technical Report Type 3 (TR3) Implementation Guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Georgia Medicaid has something additional, over and above, the information in the TR3s. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3s internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Georgia Medicaid

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

10.1 270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
63		BHT	Beginning of Hierarchical Transaction			
64		BHT02	Transaction Set Purpose Code	13	2	13 = 'Request'
64		BHT03	Reference Identification		50	Required when the transaction is used in real-time. In 270 batch, may be provided at the sender's discretion. In 271 real-time value received on the 270 will be returned on the 271.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
66	2000A	HL	Information Source Level			Per HIPAA requirement there can only be one (1) 2000A Loop within a transaction (ST/SE).
69	2100A	NM1	Information Source Name			
69-70	2100A	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
70	2100A	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
70	2100A	NM103	Name Last or Organization Name		26	Value = 'GEORGIA HEALTH PARTNERSHIP'
71	2100A	NM108	Identification Code Qualifier	PI	2	PI = 'Payor Identification'
71	2100A	NM109	Identification Code		5	Value = '77034' GAMMIS Payer ID.
72	2000B	HL	Information Receiver Level			Per HIPAA requirement there can only be (1) 2000 Loop within a transaction (ST/SE).
75	2100B	NM1	Information Receiver Name			Information received within the 2100B NM1 segment will be echoed back on the 271 response.
75-76	2100B	NM101	Entity Identifier Code	1P	2	1P = 'Provider'
77	2100B	NM108	Identification Code Qualifier	SV, XX		
			Service Provider	SV	2	
			National Provider Identifier (NPI)	XX	2	
78	2100B	NM109	Identification Code			
			Georgia Medicaid Service Provider		10	NM108='SV'
			National Provider Identifier (NPI)		10	NM108='XX'
82	2100B	N4	Information Receiver City, State, Zip Code			
83	2100B	N403	Postal Code		9	Provider's Zip Code. Zip code must equal a length of 5 or 9. Used in processing the request if the 2100A-NM108=XX (NPI).

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
84	2100B	PRV	Information Receiver Provider Information			
85	2100B	PRV03	Provider Specialty Code		1/50	Provider Taxonomy Code. Used in processing the request if the 2100A-NM108=XX (NPI).
86-57	2000C	HL	Subscriber Level			
89	2000C	HL04	Hierarchical Child Code	0	1	0 = 'No Subordinate HL Segment in This Hierarchical Structure' For Georgia Medicaid the Member is the Subscriber so there should never be a Dependent Level.
90	2000C	TRN	Subscriber Trace Number			
91	2000C	TRN02	Reference Identification		50	Trace Number. Value received on the 270 will be returned on the 271.
91	2000C	TRN03	Originating Company Identifier		10	Value received on the 270 will be returned on the 271. Per HIPAA, the first position must be: '1' if an EIN is used. '3' if a DUNS is used. '9' if a user-assigned identifier is used.
91	2000C	TRN04	Reference Identification		50	Additional Trace Number. Value received on the 270 will be returned on the 271.
97	2100C	REF	Subscriber Additional Identification			If the Patient Account Number is on the 270 request, it will be returned on the 271 response.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
98-99	2100C	REF01	Reference Identification Qualifier	EJ	2	EJ = 'Patient Account Number'
99	2100C	REF02	Reference Identification		38	Georgia Member Patient Account Number.
122	2100C	DTP	Subscriber Date			
123	2100C	DTP01	Date/Time Qualifier	291	3	291 = 'Plan'
123	2100C	DTP02	Date Time Period Format Qualifier	D8, RD8		
			Date Format = CCYYMMDD	D8	2	
			Date Format = CCYYMMDD-CCYYMMDD	RD8	3	
123	2100C	DTP03	Date Time Period		16	To date of service if DTP02=D8 Format CCYYMMDD. From/To date of service if DTP02=RD8 Format CCYYMMDD-CCYYMMDD.

Georgia Medicaid supports multiple search criteria for an eligibility inquiry. An inquiry may be submitted using:

- Georgia Medicaid Member ID;
- Member First Name, Last Name and Social Security Number;
- Member Social Security Number and Date of Birth;
- Member First Name, Last Name, Date of Birth and Gender;

Inquiry by Member ID

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			
95	2100C	NM108	Identification Code Qualifier	MI	2	MI = 'Member Identification Number'
96		NM109	Identification Code		12	12-digit Georgia Member Medicaid ID. If member is not found, information received on this NM1 will be echoed back on

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						the 271.

Inquiry by Member First Name, Last Name and Social Security Number

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			If a member is not found based on this search criteria submitted, information received will be echoed back on the 271.
93	2100C	NM103	Name Last or Organization Name		60	A maximum of 20 characters will be used for the search.
93	2100C	NM104	Name First		35	A maximum of 15 characters will be used for the search.
97	2100C	REF	Subscriber Additional Identification			
98-99	2100C	REF01	Reference Identification Qualifier	SY	2	SY = 'Social Security Number'
99	2100C	REF02	Reference Identification		9	9-digit Georgia Member Social Security Number.

Inquiry by Member Social Security Number and Date of Birth

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
97	2100C	REF	Subscriber Additional Identification			If a member is not found based on this search criteria submitted, information received will be echoed back on the 271.
98-99	2100C	REF01	Reference Identification Qualifier	SY	2	SY = 'Social Security Number'
99	2100C	REF02	Reference Identification		9	9-digit Georgia Member Social Security Number.
107	2100C	DMG	Subscriber Demographic Information			
108	2100C	DMG01	Date Time Period Format	D8	2	'D8' Format = CCYYMMDD

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
109	2100C	DMG02	Date Time Period		8	Member Date of Birth. Format: CCYYMMDD

Inquiry by Member First Name, Last Name, Date of Birth and Gender

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			If a member is not found based on this search criteria submitted, information received will be echoed back on the 271.
93	2100C	NM103	Name Last or Organization Name		60	A maximum of 20 characters will be used for the search.
93	2100C	NM104	Name First		35	A maximum of 15 characters will be used for the search.
107	2100C	DMG	Subscriber Demographic Information			
108	2100C	DMG01	Date Time Period Format	D8	2	'D8' Format = CCYYMMDD
109	2100C	DMG02	Date Time Period		8	Member Date of Birth. Format: CCYYMMDD
110	2100C	DMG03	Gender Code	M, F	1	Member Gender. M = 'Male' F = 'Female'
TR3 Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/Comments**
124-125	2110C	EQ	Subscriber Eligibility or Benefit Inquiry			
125-128	2110C	EQ01	Service Type Code			
			Health Benefit Plan Coverage	30	2	
			Medical Care	1	1	
			Surgical	2	1	
			Diagnostic X-Ray	4	1	
			Diagnostic Lab	5	1	
			Radiation Therapy	6	1	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Anesthesia	7	1	
			Surgical Assistance	8	1	
			Durable Medical Equipment Purchase	12	2	
			Ambulatory Service Center Facility	13	2	
			Durable Medical Equipment Rental	18	2	
			Second Surgical Opinion	20	2	
			Chiropractic	33	2	
			Dental Care	35	2	
			Oral Surgery	40	2	
			Home Health Care	42	2	
			Hospice	45	2	
			Hospital	47	2	
			Hospital – Inpatient	48	2	
			Hospital – Outpatient	50	2	
			Hospital - Emergency Accident	51	2	
			Hospital - Emergency Medical	52	2	
			Hospital - Ambulatory Surgical	53	2	
			MRI/CAT Scan	62	2	
			Newborn Care	65	2	
			Well Baby Care	68	2	
			Diagnostic Medical	73	2	
			Dialysis	76	2	
			Chemotherapy	78	2	
			Immunizations	80	2	
			Routine Physical	81	2	
			Family Planning	82	2	
			Emergency Services	86	2	
			Pharmacy	88	2	
			Podiatry	93	2	
			Professional (Physician) Visit – Office	98	2	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Professional (Physician) Visit - Inpatient	99	2	
			Professional (Physician) Visit - Outpatient	A0	2	
			Professional (Physician) Visit - Home	A3	2	
			Psychotherapy	A6	2	
			Psychiatric - Inpatient	A7	2	
			Psychiatric - Outpatient	A8	2	
			Occupational Therapy	AD	2	
			Physical Medicine	AE	2	
			Speech Therapy	AF	2	
			Skilled Nursing Care	AG	2	
			Substance Abuse	AI	2	
			Vision (Optometry)	AL	2	
			Cardiac Rehabilitation	BG	2	
			Pediatric	BH	2	
			Mental Health	MH	2	
			Urgent Care	UC	2	

10.2 271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
215	2000A	AAA	Request Validation			
215	2000A	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
216	2000A	AAA03	Reject Reason Code	42	2	42 = 'Unable to Respond at Current Time'
218	2100A	NM1	Information Source Name			
218-219	2100A	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
219	2100A	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
219	2100A	NM103	Name Last or Organization Name		26	Value = 'GEORGIA HEALTH PARTNERSHIP'
220	2100A	NM108	Identification Code Qualifier	PI	2	PI = 'Payor Identification'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
220	2100A	NM109	Identification Code		5	Value = '77034' GAMMIS Payer ID.
221	2100A	PER	Information Source Contact Information			
222	2100A	PER02	Name		17	'EDI SERVICES TEAM'
222-223	2100A	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone Number'
223	2100A	PER04	Communication Number		10	'8772618785'
223-224	2100A	PER05	Communication Number Qualifier	TE	2	TE = 'Telephone Number'
224	2100A	PER06	Communication Number		10	'7703259590'
232	2100B	NM1	Information Receiver Name			2100B NM1 segment will contain the information that was received on the 270.
238	2100B	AAA	Request Validation			
238-239	2100B	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
239	2100B	AAA03	Reject Reason Code	50, 51		
			Provider Ineligible for Inquiries	50	2	
			Provider Not on File	51	2	
243	2000C	HL	Subscriber Level			
245	2000C	HL04	Hierarchical Child Code	0	1	0 = 'No Subordinate HL Segment in This Hierarchical Structure'
246	2000C	TRN	Subscriber Trace Number			1st Repetition of TRN Segment: Echo Trace Number received on the 270.
247-248	2000C	TRN01	Trace Type Code	2	1	2 = 'Referenced Transaction Trace Numbers'
248	2000C	TRN02	Reference Identification		50	Value received on the 270: 2000C-TRN02.
248	2000C	TRN03	Originating Company Identifier		10	Value received on the 270: 2000C-TRN03.
248	2000C	TRN04	Reference Identification		50	Value received on the 270:

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						2000C-TRN04.
246	2000C	TRN	Subscriber Trace Number			2nd Repetition of TRN Segment: Sender Assigned Trace Information.
247-248	2000C	TRN01	Trace Type Code	1	1	1 = 'Current Transaction Trace Numbers'
248	2000C	TRN02	Reference Identification		50	Sender Assigned Trace Number.
248	2000C	TRN03	Originating Company Identifier		10	'9 77034' (9 followed by four spaces then 77034).
249	2100C	NM1	Subscriber Name			
250	2100C	NM103	Name Last or Organization Name		60	Member Last Name. A maximum of 20 characters will be used for the search. If not found, the value submitted on the 270 will be returned on the 271.
250	2100C	NM104	Name First		35	Member First Name. A Maximum of 15 characters will be used for the search. If not found, the value submitted on the 270 will be returned on the 271.
250	2100C	NM105	Name Middle		25	Member Middle Name. A maximum of one character will be returned if member is found. If not found, the value submitted on the 270 will be returned on the 271.
251	2100C	NM108	Identification Code Qualifier	MI	2	MI = 'Member Identification Number'
252	2100C	NM109	Identification Code		12	12-digit Georgia Member Medicaid ID. If not found, the value submitted on the 270 will be returned on the 271.

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
253	2100C	REF	Subscriber Additional Identification			
254-255	2100C	REF01	Reference Identification Qualifier	EJ, SY, NQ		
			Georgia Member Patient Account Number	EJ	2	
			Social Security Number	SY	9	
			Medicaid Member Identification Number	NQ	12	
256	2100C	REF02	Reference Identification			
			Georgia Member Patient Account Number		38	If the Patient Account Number is on the 270 request, it will be returned on the 271 response.
			Georgia Member Social Security Number.		9	If the Social Security Number is on the 270 request, it will be returned on the 271 response.
			12-digit Georgia Member Medicaid ID		12	As it was on the 270 request.
257	2100C	N3	Subscriber Address			Address Information will be returned if no AAA segment is present within this loop.
257	2100C	N301	Address Information		55	Georgia Medicaid Member Address 1.
258	2100C	N302	Address Information		55	Georgia Medicaid Member Residential County Code if applicable.
259	2100C	N4	Subscriber Address			Address Information will be returned if no AAA segment is present within this loop.
260	2100C	N401	City Name		30	Georgia Medicaid Member City.
260	2100C	N402	State		2	Georgia Medicaid Member State.
260	2100C	N403	Postal Code		9	Georgia Medicaid Member Zip Code.
262	2100C	AAA	Request Validation			
262	2100C	AAA01	Yes/No Condition or	N	1	N = 'No'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Response Code			
263	2100C	AAA03	Reject Reason Code	57, 58, 62, 63, 72, 73, 75, 76		
			Invalid/Missing Date(s) of Service	57	2	
			Invalid/Missing Date-of-Birth	58	2	
			Date of Service Not Within allowable Inquiry Period	62	2	
			Date of Service in Future	63	2	
			Invalid/Missing Subscriber/Insured ID	72	2	
			Invalid/Missing Subscriber Name	73	2	
			Subscriber/Insured Not Found	75	2	
			Duplicate Subscriber/Insured ID Number	76	2	
268	2100C	DMG	Subscriber Demographic Information			
269	2100C	DMG01	Date Time Period Format Qualifier	D8		'D8' Format = CCYYMMDD
269	2100C	DMG02	Date Time Period		8	If member found, Georgia Medicaid date of birth is returned. If not found, the value submitted on the 270 will be returned on the 271.
269	2100C	DMG03	Gender Code		1	If member found, Georgia Medicaid gender is returned. If not found, the value submitted on the 270 will be returned on the 271.
271	2100C	INS	Subscriber Relationship			This segment will only be returned if the Georgia Member Information

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						returned on the 271 is different than the information submitted on the 270. If a match is found on the Georgia Member Medicaid ID received, and the other Georgia Member information received on the 270 is different than that stored on the GAMMIS database, the information from the GAMMIS database is returned.
271	2100C	INS01	Yes/No Condition or Response Code	Y	1	' Yes' (Insured Indicator)
272	2100C	INS02	Individual Relationship Code	18	2	'Self'
272	2100C	INS03	Maintenance Type Code	001	3	'Change'
272	2100C	INS04	Maintenance Reason Code	25	2	'Change in Identifying Data Elements'
283	2100C	DTP	Subscriber Date			
283	2100C	DTP01	Date/Time Qualifier	152, 291, 356, 357		
			Update Date (Retro Eligibility)	152	3	
			Plan	291	3	
			Begin Date (Retro Eligibility)	356	3	
			End Date (Retro Eligibility)	357	3	
123	2100C	DTP02	Date Time Period Format Qualifier	D8	2	'D8' Format = CCYYMMDD
123	2100C	DTP03	Date Time Period			

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Update Date (Retro Eligibility)		8	DTP01=152
			Plan		8	DTP01=291
			Begin Date (Retro Eligibility)		8	DTP01=356
			End Date (Retro Eligibility)		8	DTP01=357

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10.2.1 Various repetitions of 2110C (Subscriber Eligibility or Benefit Information Responses)

Medicaid and Waiver

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	1, 6		
			Active	1	1	
			Inactive	6	1	
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	Aid category and Aid category description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		264	"MEDICAID" Aid category 865 – "This is presumptive eligible member. Inpatient hospital and delivery procedures are

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						not covered”. Aid categories 280, 281, 282, 289, 290 and 291 with no hospice lock-in – “This is a hospice patient”. Aid category 177 – “Eligible for family planning services only”. Only one message will be returned, messages will not be concatenated in this data element.

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QMB

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	1, 6		
			Active	1	1	
			Inactive	6	1	
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	Aid category and Aid category description.
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		264	Aid categories 660 and 460 – "Qualified Medicare beneficiary – eligible for Medicare coinsurance and deductible reimbursement only".

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Only one message will be returned, messages will not be concatenated in this data element.

Medicare Part A

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	2	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	MA	2	MA = 'Medicare Part A'
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	F6	2	F6 = 'HIC Number'
316	2100C	REF02	Reference Identification		50	Medicare ID
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		15	'Medicare Part A'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

Medicare Part B

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage
298	2110C	EB04	Insurance Type Code	MB	2	MB = 'Medicare Part B'
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	F6	2	F6 = 'HIC Number'
316	2100C	REF02	Reference Identification		50	Medicare ID
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		15	'Medicare Part B'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

Medicare Part C

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
299	2110C	EB05	Plan Coverage Description		50	Medicare Plan Name
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	F6	2	F6 = 'HIC Number'
316	2100C	REF02	Reference Identification		50	Medicare ID
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		60	'Medicare Part C'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

Medicare Part D: Member has Medicare Part D Coverage

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
299	2110C	EB05	Plan Coverage Description		50	Medicare Plan Name
315	2110C	REF	Subscriber Additional Identification			

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
315-316	2110C	REF01	Reference Identification Qualifier	F6	2	F6 = 'HIC Number'
316	2100C	REF02	Reference Identification		50	Medicare ID
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	From Date: 1st day of the month of Part D eligibility based on the request date submitted or from date of service submitted on 270 transaction whichever is greater. To Date: 99991231 or to date of service submitted on 270 transaction, whichever is smaller. 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		264	This member is enrolled in a Medicare Part D prescription plan. The member does not have Medicaid prescription coverage. This members Medicare Part D prescription

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						plan is Contract Number and/or Plan ID
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		15	'Medicare Part D'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
341	2120C	PER02	Name		60	Medicare Plan Name
342	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
342	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Medicare Part D: Member has DECLINED Medicare Part D Coverage

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		264	Member refused Part D coverage. This member has no prescription coverage and has declined coverage under the Medicare Part D prescription coverage.

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Third Party Liability (TPL)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
292-293	2110C	EB02	Coverage Level Code	IND	3	IND = 'Individual'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
299	2110C	EB05	Plan Coverage Description		50	Coverage Description
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	IG, 6P		
			Insurance Policy Number	IG	2	
			Group Number	6P	2	
316	2100C	REF02	Reference Identification			
			Insurance Policy Number		50	REF01=IG
			Group Number		50	REF01=6P
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		60	'Carrier Name'
332-333	2120C	NM108	Identification Code Qualifier	PI	2	PI = 'Payor Identification'
333	2120C	NM109	Identification Code		80	'Carrier Code'
336	2120C	N4	Subscriber Benefit Related Entity City, State, Zip Code			
336	2120C	N401	City Name		30	'City'
337	2120C	N402	State or Province Code		2	'State'
337	2120C	N403	Postal Code		9	'Zip Code'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Lock-In

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	1, 6		
			Active	1	1	
			Inactive	6	1	
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
299	2110C	EB05	Plan Coverage Description		50	Program Code and Description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		60	'Carrier Name'
332-333	2120C	NM108	Identification Code Qualifier	SV	2	SV = 'Service Provider Number

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
333	2120C	NM109	Identification Code		10	Unique value based on Provider Service Location
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
340	2120C	PER02	Name		60	Lock-in Provider
341	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
341	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Diagnostic Lab, Diagnostic Dental, Health Benefit Plan Coverage, Dental Care, Prosthodontics, Routine (Preventive) Dental, Home Health Visits, Family Planning, Podiatry-Office Visits, Podiatry-Nursing Home Visits, Physician Visit-Office, Physician Visit=Nursing Home, Psychiatric, Vision

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	F	1	F = 'Limitations'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
299	2110C	EB05	Plan Coverage Description		50	Description of Limitations
301-302	2110C	EB09	Quantity Qualifier	QA, 99		
			Quantity Approved	QA	2	
			Quantity Used	99	2	
302	2110C	EB10	Quantity		10	If EB09=QA (Quantity Approved) If EB09=99 (Quantity Used)
309	2110C	HSD	Health Care Services Delivery			
311	2110C	HSD05	Time Period Qualifier	22, 23, 32		
			Service Year	22	2	
			Calendar Year	23	2	
			Life Time	32	2	
311	2110C	HSD06	Number of Periods		3	Frequency of Benefits

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Dental X-Ray

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	F	1	F = 'Limitations'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
299	2110C	EB05	Plan Coverage Description		50	'Dental X-Rays'
301-302	2110C	EB07	Monetary Amount		10	'Amount Approved or Used'
309	2110C	HSD	Health Care Services Delivery			
311	2110C	HSD05	Time Period Qualifier	22, 23, 32		
			Service Year	22	2	
			Calendar Year	23	2	
			Life Time	32	2	
311	2110C	HSD06	Number of Periods		3	Frequency of Benefits

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Managed Care

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	MC	1	MC = 'Managed Care Coordinator'
293-298	2110C	EB03	Service Type Code	96	2	96 = 'Professional (Physician)
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	Managed Care Program Description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
331	2120C	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
			Non-Person Entity	2	1	
331	2120C	NM103	Name Last or Organization Name		60	'Managed Care Provider Organization Name or Last

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Name'
331	2120C	NM104	Name First		35	'Managed Care Provider First Name'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
341	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
341	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Long Term Care (LTC)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	CB	1	CB = 'Coverage Basis'
293-298	2110C	EB03	Service Type Code	54	2	54 = 'Long Term Care'
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	Level of Care Code and Description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	1P	2	1P = 'Provider'
331	2120C	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
			Non-Person Entity	2	1	
331	2120C	NM103	Name Last or Organization Name		60	'Provider Organization Name or Last Name'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
331	2120C	NM104	Name First		35	'Provider First Name'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
341	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
341	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Hospice

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	CB	1	CB = 'Coverage Basis'
293-298	2110C	EB03	Service Type Code	45	2	45 = 'Hospice'
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	Program Code and Description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	1P	2	1P = 'Provider'
331	2120C	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
			Non-Person Entity	2	1	
331	2120C	NM103	Name Last or Organization Name		60	'Provider Organization Name or Last Name'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
331	2120C	NM104	Name First		35	'Provider First Name'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
341	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
341	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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Patient Liability

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	G	1	G = 'Out of Pocket' (Stop Loss)
293-298	2110C	EB03	Service Type Code	54	2	54 = 'Long Term Care'
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
299	2110C	EB05	Plan Coverage Description		50	'Patient Liability'
299-300	2110C	EB06	Timer Period Qualifier	31, 34		
			Patient Liability Paid	31	2	
			Patient Liability Amount for Month	34	2	
301-302	2110C	EB07	Monetary Amount		10	If EB06=31 'Patient Liability Paid' If EB06=34 'Patient Liability Amount for Month'
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307, 348		
			Eligibility	307	3	
			Benefit Begin	348	3	
318	2110C	DTP02	Date Time Period Format Qualifier	D8, RD8		
			Date Format CCYYMMDD	D8	2	
			Date Format CCYYMMDD-CCYYMMDD	RD8	3	
318	2110C	DTP03	Date Time Period			
			Eligibility		17	'CCYYMMDD-CCYYMMDD'
			Benefit Begin		8	'CCYYMMDD'
319	2110C	AAA	Request Validation			

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			
330	2120C	NM101	Entity Identifier Code	1P	2	1P = 'Provider'
331	2120C	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
			Non-Person Entity	2	1	
331	2120C	NM103	Name Last or Organization Name		60	'Provider Organization Name or Last Name'
331	2120C	NM104	Name First		35	'Provider First Name'
332-333	2120C	NM108	Identification Code Qualifier	SV	2	
333	2120C	NM109	Identification Code		10	'Unique value based on Provider Service Location'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	IC = 'Information Contact'
341	2120C	PER03	Communication Number Qualifier	TE	2	TE = 'Telephone'
341	2120C	PER04	Communication Number		10	'Contact Telephone Number'
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

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PeachCare

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	1, 6		
			Active	1	1	
			Inactive	6	1	
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
299	2110C	EB05	Plan Coverage Description		50	Aid Category and Aid Category Description
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		264	'PeachCare'

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Co-Pay Amount

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information			
			Co-Payment	B	1	
			Non-Covered	I	1	
292-293	2110C	EB02	Coverage Level Code	IND	3	IND = 'Individual'
293-298	2110C	EB03	Service Type Code			
			Medical Care	1	1	
			Chiropractic	33	2	
			Dental Care	35	2	
			Hospital	47	2	
			Hospital – Inpatient	48	2	
			Hospital – Outpatient	50	2	
			Emergency Services	86	2	
			Pharmacy	88	2	
			Professional (Physician) Visit – Office	98	2	
			Vision (Optometry)	AL	2	
			Mental Health	MH	2	
			Urgent Care	UC	2	
298	2110C	EB04	Insurance Type Code			
			Medicaid	MC	2	
			Other	OT	2	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
299	2110C	EB05	Plan Coverage Description		50	Coverage Description
299-300	2110C	EB06	Timer Period Qualifier	27	2	27 = 'Visit'
301-302	2110C	EB07	Monetary Amount		10	If EB06=27 'Co-Pay Amount'
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	
322	2110C	MSG	Message Text			
323	2110C	MSG01	Free-form Message Text		1/264	'The co-payment amount for the service may vary. Please check the Medicaid / PeachCare for Kids Policy Manual for the exact co-payment amount.

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Co-Insurance

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information			
			Co-Insurance	A	1	
			Non-Covered	I	1	
292-293	2110C	EB02	Coverage Level Code	IND	3	IND = 'Individual'
293-298	2110C	EB03	Service Type Code			
			Medical Care	1	1	
			Chiropractic	33	2	
			Dental Care	35	2	
			Hospital	47	2	
			Hospital – Inpatient	48	2	
			Hospital – Outpatient	50	2	
			Emergency Services	86	2	
			Pharmacy	88	2	
			Professional (Physician) Visit – Office	98	2	
			Vision (Optometry)	AL	2	
			Mental Health	MH	2	
			Urgent Care	UC	2	
298	2110C	EB04	Insurance Type Code			
			Medicaid	MC	2	
			Other	OT	2	

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
299	2110C	EB05	Plan Coverage Description		50	Coverage Description
301	2110C	EB08	Percentage as Decimal		1/10	Amount represents the Member's portion of responsibility.
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	307	3	307 = 'Eligibility'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	

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Health Benefit Plan Deductible

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	C		C = 'Deductible'
292-293	2110C	EB02	Coverage Level Code	IND	3	IND = 'Individual'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code			
			Medicaid	MC	2	
			Other	OT	2	
299	2110C	EB05	Plan Coverage Description		50	Coverage Description
299-300	2110C	EB06	Timer Period Qualifier			
			Contract	25	2	
			Remaining	29	2	
301-302	2110C	EB07	Monetary Amount		10	If EB06=25 'Contract Deductible' If EBO06=29 'Remaining Deductible'
315	2110C	DTP	Subscriber Eligibility/Benefit Date			
317-318	2110C	DTP01	Date/Time Qualifier	291	3	291 = 'Plan'
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	'RD8' Format = CCYYMMDD-CCYYMMDD
318	2110C	DTP03	Date Time Period		17	Eligibility Date = 'CCYYMMDD-CCYYMMDD'
319	2110C	AAA	Request Validation			
319-320	2110C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'

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TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
320-321	2110C	AAA03	Reject Reason Code			
			Invalid/Missing Date(s) of Service.	57	2	
			Date of Service Not Within allowable Inquiry Period.	62	2	

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11 Appendices

11.1 Implementation Checklist

This appendix contains all necessary steps for going live with Georgia Medicaid.

1. Call the Hewlett Packard Enterprise EDI Services Team with any questions at the Toll Free Number.
2. Check the Georgia Web Portal http://www.mmis.georgia.gov regularly for the latest updates.
3. Confirm you have completed your TPA Agreement and been assigned a Trading Partner ID.
4. Make the appropriate changes to your systems/business processes to support the updated companion guides:
    - If you use third party software, work with your software vendor to have the appropriate software installed.
    - If testing system-to-system (Real-Time) interface the Trading Partner or provider must work with your software vendor to have the appropriate software installed at their sites(s) prior to performing testing with Georgia Medicaid.
5. Identify the transactions you will be testing:
    - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
    - Health Care Claim Status Request and Response (276/277)
    - Health Care Premium Payment (820)
    - Health Care Benefit Enrollment and Maintenance (834)
    - Health Care Payment/Advice (835)
    - Health Care Claim: Dental (837D)
    - Health Care Claim: Institutional (837D)
    - Health Care Claim: Professional (837P)
6. Confirm you have reported all the NPIs you will be using for testing by validating them with Georgia Medicaid. Make sure your claim(s) successfully pay to your correct Provider ID, if you have associated multiple Georgia Medicaid provider IDs to one NPI and/or taxonomy code.
    - If the entity testing is a billing intermediary or software vendor, they should use the provider's identifiers on the test transaction.
7. When submitting test files, make sure the members/claims you submit are representative of the type of service(s) you provide to Georgia Medicaid members.
8. Schedule a tentative week for the initial test.
9. Confirm the email/phone number of the testing contact and confirm that the person you are speaking with is the primary contact for testing purposes.

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11.2 Business Scenarios

This section contains typical business scenarios. The actual data streams linked to these scenarios are included in Section 11.3.

1. 5010 Georgia Medicaid 270 transaction inquiring with Georgia Medicaid Member Number:

   SUBMITTER: PEACHTREE CLINIC
   NPI#: 1111111112
   MEMBER ID: 121212121213
   MEMBER NAME: LNAME, FNAME
   MEMBER DOB: 08-27-1934
   MEMBER GENDER: FEMALE
   MEMBER SSN: 123001234

2. 5010 Georgia Medicaid 270 transaction inquiring with Georgia Medicaid Member First Name, Last Name and Social Security Number:

3. 5010 Georgia Medicaid 270 transaction inquiry with Georgia Medicaid Member Social Security Number and Date of Birth:

11.3 Transmission Examples

This section contains actual data streams. The business scenarios linked to the data streams are included in section 11.2.

Real-Time Transaction Examples:

1. **Georgia Medicaid 270 transaction (Georgia Medicaid Member ID Inquiry):**

```
ISA*00*          *00*          *ZZ*TPID          *ZZ*77034          *130207*0800*^*00501*505043666*0
*T*:~
GS*HS*TPID*77034*20130207*0800*43666*X*005010X279A1~
ST*270*0001*005010X279A1~
BHT*0022*13*TEST01*20130207*1200~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*1*TRACE-NUMBER1*1    77034~
NM1*IL*1******MI*121212121213~
DTP*291*RD8*20130101-20130115~
EQ*30~
SE*12*0001~
GE*1*43666~
IEA*1*505043666~
```


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Georgia Medicaid Response 271 transaction for inquiry with Georgia Medicaid Member ID:

```
ISA*00*          *00*          *ZZ*77034      *ZZ*TPID       *130207*0801*^*00501*000000001*0
*T*:~
GS*HB*77034* TPID *20130207*0801*00002*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*TEST01*20130207*0801~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
PER*IC*EDI SERVICES TEAM*TE*8772618785*TE*7703259590~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*2*TRACE-NUMBER1*1    77034~
TRN*1*1111111112*1    77034~
NM1*IL*1*MLAST*MFIRST****MI*121212121213~
N3*ADDRESS1*ADDRESS2~
N4*CITY*GA*305573494~
DMG*D8*19340824*F~
DTP*291*RD8*20130101-20130115~
EB*1**30*MC*259 - Community Care Waiver~
DTP*307*RD8*20130101-20130115~
MSG*MEDICAID~
EB*D~
DTP*307*RD8*20130101-20130115~
MSG*COPAY|REQUIRED;
EB*R**30*MA~
REF*F6*987654~
DTP*307*RD8*20130101-20130115~
LS*2120~
NM1*PR*2*Medicare Part A~
LE*2120~
SE*28*0001~
GE*1*00002~
IEA*1*000000001~
```

2. **Georgia Medicaid 270 transaction (Georgia Medicaid Member First/Last Name and Social Security Number Inquiry)**

```
ISA*00*          *00*          *ZZ*TPID       *ZZ*77034      *130207*0800*^*00501*505043666*0
*T*:~
GS*HS*TPID*77034*20130207*0800*43666*X*005010X279A1~
ST*270*0002*005010X279A1~
BHT*0022*13*TEST02*20130207*1200~
HL*1**20*1~
```


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```
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*1*TRACE-NUMBER2*1    77034~
NM1*IL*1*MLAST*MFIRST~
REF*SY*123001234~
DTP*291*RD8*20130101-20130115~
EQ*30~
SE*13*0002~
GE*1*43666~
IEA*1*505043666~
```

Georgia Medicaid Response 271 transaction for inquiry with Georgia Medicaid Member First/Last Name and Social Security Number:

```
ISA*00*          *00*          *ZZ*77034      *ZZ*TPID       *130207*0801*^*00501*000000001*0
*T*:~
GS*HB*77034* TPID *20130207*0801*00002*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*TEST02*20130207*0801~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
PER*IC*EDI SERVICES TEAM*TE*8772618785*TE*7703259590~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*2*TRACE-NUMBER2*1    77034~
TRN*1*1111111112*1    77034~
NM1*IL*1*MLAST*MFIRST****MI*121212121213~
REF*SY*123001234~
N3*ADDRESS1*ADDRESS2~
N4*CITY*GA*305573494~
DMG*D8*19340824*F~
DTP*291*RD8*20130101-20130115~
EB*1**30*MC*259 - Community Care Waiver~
DTP*307*RD8*20130101-20130115~
MSG*MEDICAID~
EB*D~
DTP*307*RD8*20130101-20130115~
MSG*COPAY|REQUIRED;
EB*R**30*MA~
REF*F6*987654~
DTP*307*RD8*20130101-20130115~
LS*2120~
NM1*PR*2*Medicare Part A~
```


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```
LE*2120~
SE*29*0001~
GE*1*00002~
IEA*1*000000001~
```

3. **Georgia Medicaid 270 transaction (Georgia Medicaid Member Social Security Number and Date of Birth Inquiry)**

```
ISA*00*          *00*          *ZZ*TPID          *ZZ*77034          *130207*0800*^*00501*505043666*0
*T*:~
GS*HS*TPID*77034*20130207*0800*43666*X*005010X279A1~
ST*270*0003*005010X279A1~
BHT*0022*13*TEST03*20130207*1200~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*1*TRACE-NUMBER3*1    77034~
NM1*IL*1 ~
REF*SY*123001234~
DMG*D8*19340824*F~
DTP*291*RD8*20130101-20130115~
EQ*30~
SE*14*0003~
GE*1*43666~
IEA*1*505043666~
```

Georgia Medicaid Response 271 transaction for inquiry with Georgia Medicaid Member Social Security Number and Date of Birth:

```
ISA*00*          *00*          *ZZ*77034          *ZZ*TPID          *130207*0801*^*00501*000000001*0
*T*:~
GS*HB*77034* TPID *20130207*0801*00002*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*TEST03*20130207*0801~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
PER*IC*EDI SERVICES TEAM*TE*8772618785*TE*7703259590~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*2*TRACE-NUMBER3*1    77034~
TRN*1*1111111112*1    77034~
NM1*IL*1*MLAST*MFIRST****MI*121212121213~
```


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```
REF*SY*123001234~
N3*ADDRESS1*ADDRESS2~
N4*CITY*GA*305573494~
DMG*D8*19340824*F~
DTP*291*RD8*20130101-20130115~
EB*1**30*MC*259 - Community Care Waiver~
DTP*307*RD8*20130101-20130115~
MSG*MEDICAID~
EB*D~
DTP*307*RD8*20130101-20130115~
MSG*COPAY|REQUIRED;
EB*R**30*MA~
REF*F6*987654~
DTP*307*RD8*20130101-20130115~
LS*2120~
NM1*PR*2*Medicare Part A~
LE*2120~
SE*29*0001~
GE*1*00002~
IEA*1*000000001~
```

Batch Transaction Example:

This is an example of a batch file containing three inquires, two within the first transaction for the same provider, different members, and one within the second transaction. For Georgia Medicaid batch files have the ability to loop at the functional group, transaction and hierarchical levels. Each functional group within an interchange has to be the same transaction type.

```
ISA*00*          *00*          *ZZ*TPID          *ZZ*77034          *130207*0800*^*00501*505043666*0
*T*:~
GS*HS*TPID*77034*20130207*0800*43666*X*005010X279A1~
ST*270*0001*005010X279A1~
BHT*0022*13*TEST03*20130207*1200~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*1*TRACE-NUMBER1*1    77034~
NM1*IL*1*LNAME*FNAME*M***MI*123456789012~
DMG*D8*19340824*F~
DTP*291*RD8*20130101-20130115~
EQ*30~
```


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```
HL*4*2*22*0~
TRN*1*TRACE-NUMBER2*1    77034~
NM1*IL*1~
REF*SY*123001234~
DMG*D8*19350828*M~
DTP*291*D8*20130101~
EQ*30~
SE*20*0001~
ST*270*0002*005010X279A1~
BHT*0022*13*TEST04*20130207*1200~
HL*1**20*1~
NM1*PR*2*GEORGIA HEALTH PARTNERSHIP*****PI*77034~
HL*2*1*21*1~
NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~
HL*3*2*22*0~
TRN*1*TRACE*1    77034~
NM1*IL*1*MLAST*MFIRST~
REF*SY*555555555~
DTP*291*RD8*20130201-20130205~
EQ*30~
SE*13*0002~
GE*2*43666~
IEA*1*505043666~
```


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11.4 Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Georgia Medicaid and its providers.

Q: As a trading partner or clearinghouse, who should I contact if I have questions about testing, specifications, trading partner enrollment or if I need technical assistance with electronic submission?

A: EDI testing and trading partner enrollment support is available Monday through Friday 8a.m.-5p.m. by calling toll-free at (877) 261-8785 or locally at (770) 325-9590.

Q: Who should I contact if I have questions pertaining to billing or to check on the status of a submitted claim?

A: Providers should contact the Provider Contact Center for any non-EDI related questions or GAMMIS Web Portal assistance by calling the Interactive Voice Response System (IVRS) toll-free at (800) 766-4456 or locally at (770) 325-9600.

Q: After I submit my EDI Trading Partner Agreement Form, when should I expect to receive my Trading Partner ID?

A: Once we receive your EDI enrollment in the mail and process it, which takes 1-5 days, you should receive your trading partner Web Portal logon credentials by e-mail immediately. You will also receive your EDI Welcome Letter by mail within 5-7 business days of your application being approved. If your trading partner logon credentials were not received, contact EDI Services Monday-Friday 8a.m.-5p.m. EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with your Trading Partner Name, Trading Partner ID assigned, and Mailing Address.

Q: What are the steps that Providers need to take to begin sending EDI Transactions and testing with Hewlett Packard Enterprise?

A: All providers must already be enrolled with Georgia Medicaid to apply for EDI Enrollment, unless using a clearinghouse, software vendor, or billing agent. However, providers may also enroll as direct electronic submitters using the EDI Trading Partner Agreement. A copy of the EDI Agreement can be downloaded from the GAMMIS Web Portal on the EDI >> Registration Forms page. Once approved to send EDI transactions, all providers/submitters (except those using an enrolled clearinghouse, software vendor, or billing agent) will be required to go through testing using their chosen EDI software, clearinghouse, or vendor. Testing is not required for use of the PES software. Providers can contact EDI Services toll-free at (877) 261-8785 or locally at (770) 325-9590 for additional details regarding EDI transactions, testing, and PES training. Providers can begin testing files in Ramp Manager immediately. Once testing is passed, providers should

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submit the necessary EDI trading partner agreement (if enrolling for the first time) or the EDI Update form (if making a change to their transaction) to be made active in Production.

Q: How do I access Ramp Manager to test my transactions?

A: You can access Ramp Manager online by visiting the Georgia Health Partnership Ramp Management System at https://sites.edifecs.com/index.jsp?gamedicaid.

Q: Is there a certain number of test files that need to be sent through Ramp Manager?

A: No; however, Hewlett Packard Enterprise requires a test file to pass compliance for each transaction type and trading partner that will be sending files. The status of each transaction should show "PASS" in Ramp Manager to show that you have successfully passed compliance before Hewlett Packard Enterprise can make you active.

Q: I am a provider. How do I enroll to receive my Remittance Advice electronically (835-ERA)?

A: Providers must complete and submit an Hewlett Packard Enterprise Submitter Update Form indicating that they would like to receive an ERA835 for the payee ID. If you wish to delegate access to these 835 ERAs (Electronic Remittance Advice) so that your clearinghouse, software vendor, or billing agent can access these on your behalf, you must provide them access to your file downloads. Contact your clearinghouse, software vendor, or billing agent to get the e-mail address and username that you should grant access to, then follow the instructions in the GAMMIS Web Portal User Account Management Guide on the Provider Information >> Provider Manuals page. Refer to section 3.2, titled "Providers or Trading Partners Delegating Access to a Billing Agent or Trading Partner Account" for detailed instructions. You will need to grant the "Trade Files Download" role for a user to have access to your 835 ERA file.

Q: After I submit my provider enrollment application, when should I expect to receive my PIN letter in the mail?

A: You should receive your PIN letter within 5-7 business days of your Provider Enrollment application being approved. If you do not receive your PIN letter within this timeframe, please contact EDI Services Monday-Friday 8am-5pm EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with the provider's account information: provider's Name, provider ID, Tax ID/SSN, and the Mailing Address.

Q: Where is my PIN letter being sent?

A: PIN letters are sent to the provider's mailing address on file. If the mailing address shown on file is incorrect, providers must submit the Medicaid Change of Information form (as shown on the GAMMIS Web Portal under the Provider Information >> Provider Manuals page) to ensure the address is up–to-date before the PIN letter reissue request can be processed.

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Q: How do I request and submit EDI files through the Web Portal?

A: Establish an internet connection to the provider secure Web Portal using your trading partner account logon credentials. Select the Trade Files menu in order to download and/or upload EDI files.

- **File Upload**
  The File Upload page allows the user to select a file from a local hard drive and upload it to the Georgia MMIS. The file extension should end in .txt. Users of the feature include clearinghouses, software vendors, third party agents, and providers that wish to upload batch EDI transactions directly, including claim and encounter submissions. To use the batch upload option, providers must use HIPAA-compliant software or vendors that can create required data in HIPAA-compliant ANSI X12 Addenda format.

- **File Download**
  The File Download page allows the user to select a file from the secure GAMMIS Web Portal and download it to their system. The download process begins when the download option is checked and the user selects the download button.

Q: How long are ERA835, 277U, 824 and/or 999's available for download on the GAMMIS Web Portal?

A: All outbound EDI transactions will be made available for download on the provider portal for six weeks from the date of creation. Providers and trading partners are encouraged to download the documents as soon as they are available.

Q: What types of acknowledgment reports will Hewlett Packard Enterprise return following EDI submission?

A: A TA1 will be generated when errors occur within the interchange envelope ISA/IEA. If no TA1 is generated, by default an 824 Acknowledgment is returned to the trading partner for all 837P, 837I, and 837D claim transaction types. A 999 acknowledgement will be returned on batch 270 (Eligibility) and 276 (Claim Status) and failed 270 Real-Time (Eligibility Requests) and 276 Real-Time (Claim Status) transaction types. For those real-time 270 and 276 transactions that pass compliance, the respective 271 and 277 transactions will be generated. The 835 (ERA) will be returned to the payee provider or trading partner delegated by the provider if the claims were accepted electronically and forwarded for claims adjudication. The 277U (Unsolicited Claim Status Report) is returned if there was a problem with the claims that prevented the claims adjudication system from processing the claims (for example, Invalid NPI or Provider Not on File).

Q: Will electronic remittances (835) be returned in one file for all providers or a separate file for each provider?

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A: There will be separate files for each provider.

Q: Will our trading partner number or submitter ID, as shown in the ISA06, be returned in the remittance advice 835 file?

A: No, the ISA08 and GS03 within the remittance advice 835 will contain the Payee Provider ID.

Q: What filename will be used for the 835 files?

A: As documented in the 835 companion guides, the filename will be in this format: BatchID_TransactionType_FileName_ProviderNumber_Sequence Number_ProcessDate.out.dat.

Q: Will Hewlett Packard Enterprise continue to send paper EOBs for providers that are receiving the Electronic Remittance Advice (ERA)?

A: No, unless specifically requested by the provider to receive both. Providers can notify EDI Services or the Provider Enrollment Unit if they wish to receive both the paper EOB and the ERA.

Q: Where can we find the Georgia Medicaid/PeachCare for Kids® HIPAA Companion Guides?

A: The companion guides are available on the Web Portal on the EDI >> Companion Guides page.

Q: Where can I find a copy of the HIPAA ANSI TR3 Implementation Guides?

A: The TR3 Implementation Guides must be purchased from the Washington Publishing Company at www.wpc-edi.com.

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12 Change Summary

This section describes the differences between the current Companion Guide and previous guides(s).

Version	Date	Section/Pages	Descriptions
1.7	03/01/2013	Entire document	Complete revision to comply with CAQH® (Council for Affordable Quality Healthcare) CORE™ (Committee on Operating Rules for Information Exchange) v5010 Master Companion Guide Template. Transaction specific data elements, and their values, were not changed. All previous versions are obsolete.
2.0	05/03/2013	Logo on Cover Page Entire Document	Changed Logo on Cover Page to be the new branding logo. Changed any reference to TR3 to be TR3 Implementation Guide or Implementation Guides. Changed references to companion guide that were listed as 'document' to 'companion guide'.
2.0	05/03/2013	Sections 3, 7 and 10	Section 3: Modified last paragraph. Section 7.9 – 7.11: Added. Section 10.1: Added 2110C-EQ. Section 10.2: Modified 2100C-AAA03. Section 10.2: Removed Co-Pay Section 10.2: Added Co-Pay Amount, Co-Insurance and Deductible.
2.1	07/15/2014	Section 10.2.1	Modified MSG01 comments within the 'Medicare Part D Member had Declined coverage' occurrence. Modified MSG01 comments within the 'Medicare Part D Member has coverage' occurrence.
2.2	10/09/2014	Section 10.2	Page 51 (N3/N4): Modified Notes/Comments.

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Version	Date	Section/Pages	Descriptions
2.3	04/07/2015	Section 10.2	Page 9: Corrected hyperlink. Page 15: Removed "Medicaid HIPAA Compliant Concept Model (MHCCM)". Page 29: Revised ICD-10 implementation date. Page 84 (DTP): Changed DTP01 to '291'.
2.4	11/01/2015	Entire document	Modified Cover page and footer due to change in Hewlett Packard Enterprise documentation standards.
		Section 7.7	Modified entire section pertaining to ICD-10.
2.5	03/17/2016	Section 5.4	Modified links that were not working. Revised year in footer

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