Healthcare and Family Services, Bureau of Information Services

HIPAA 5010 - Health Care Eligibility Benefit Inquiry and Response: 270/271 Standard Companion Guide

Instructions related to Transactions based on ASC X12 Implementation Guide version 005010X279 and the ERRATA 005010X279A1 dated June 2010

270/271 Companion Guide Version Number: 1.0

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Preface

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

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

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

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

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

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

1.1.2 Compliance according to HIPAA

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

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

1.1.3 Compliance according to ASC X12

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

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

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with the ASC X12 version 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271) Implementation Guide and ASC X12 version 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) ERRATA dated June 2010. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X279	Health Care Eligibility Benefit Inquiry and Response (270/271)
005010X279A1	ERRATA Health Care Eligibility Benefit Inquiry and Response (270/271)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

Version 5010 HFS Unique (270) Healthcare Eligibility Benefit Inquiry items

270 – Health Care Eligibility Benefit Inquiry

Loop Id	Reference	Name	Codes	Notes/Comments
Control Segment	BHT	Beginning of Hierarchical Transaction		
Control Segment	BHT02	Transaction set purpose code	“13”	Must be “13” (Request).
2100A	NM1	Information Source Name		
2100A	NM101	Entity Identifier Code	“PR”	Must be “PR” (Payer).
2100A	NM102	Entity Type Qualifier	“2”	Must be “2” (Non-Person Entity).
2100A	NM103	Name Last or Organization Name	“ILLINOIS MEDICAID”	Must be “ILLINOIS MEDICAID”.
2100A	NM108	Identification Code Qualifier	“FI”	Must be “FI” (U.S. Federal Taxpayer’s Identification Number).
2100A	NM109	Identification Code	“37-1320188”	Must be “37-1320188”.
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	“1P”	Must be “1P” (Provider).
2100B	NM102	Entity Type Qualifier	“2”	Must be “2” (Non-Person Entity).

2100B	NM108	Identification Code Qualifier	“SV”, “XX”	Must be “SV” (Service Provider Number) or “XX” (National Provider Id Number)
2100B	NM109	Identification Code		HFS provider number for Atypical Providers or NPI
2100C	NM1	Subscriber Name		
2100C	NM108	Identification Code Qualifier	“MI”	Must be “MI” (Member Identification Number).
2100C	NM109	Identification Code		Must be the Recipient’s 9-digit number as it is shown on the MediPlan, All Kids or Senior Care Card.
2100C	REF	Subscriber Additional Information		
2100C	REF01	Reference Identification Qualifier	“SY”	Must be “SY” Social Security Number
2100C	REF02	Reference Identification		Social Security Number Format – 999999999
2110C	EQ	Subscriber Eligibility or Benefit Inquiry Information		
2110C	EQ01	Service Type Code	“30”, “32”	Must be “30” (Health Benefit Plan Coverage) or “32” (Plan Waiting Period).
2110C	DTP	Subscriber Eligibility/Benefit date		
2110C	DTP03	Date Time Period		Range of date must be a 90 day period or less. Inquiries made prior to the 20th of the current month will only have the ability to return eligibility information through the end of the current month. Inquiries made after the 20th of the current month will have the ability to return eligibility information through the end of the next subsequent month. If the DTP segment is not present, system date will be used as beginning and ending dates.

271 – Health Care Eligibility Benefit Response

Loop ID	Reference	Name	Codes	Notes/Comments
2100A	NM1	Information Source Name		
2100A	NM101	Entity Identifier Code	“PR”	Will be “PR” (Payer).
2100A	NM102	Entity Type Qualifier	“2”	Will be “2” (Non-person Entity)
2100A	NM103	Name Last or Organization Name	“ILLINOIS MEDICAID”	Will be “ILLINOIS MEDICAID”
2100A	NM108	Identification Code Qualifier	“FI”	Will be “FI” (U.S. Federal Taxpayer’s Identification Number).
2100A	NM109	Identification Code	“37-1320188”	Will be “37-1320188”.
2100A	AAA	Request Validation		
2100A	AAA01	Valid Request Indicator	“Y”	Will be “Y” – Valid but Rejected
2100A	AAA03	Reject Reason	“42”	Code will be “42” Unable to Respond at Current Time
2100A	AAA04	Follow Up Action	“P”	Code will be “P” Please Resubmit Original Transaction
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	“1P”	Will be “1P” (Provider).
2100B	NM102	Entity Type Qualifier	“2”	Will be “2” (Non-person Entity).

2100B	NM108	Identification Code Qualifier	“SV”, “XX”	Will be “SV” (Service Provider Number) or “XX” (National Provider Id Number).
2100B	AAA	Information Receiver Request Validation		
2100B	AAA01	Valid Request Indicator	“Y”	Will be “Y” – Valid but Rejected
2100B	AAA03	Reject Reason	“50” or “51”	50 = Provider Ineligible for Inquiries 51 = Provider Not on File
2100B	AAA04	Follow Up Action	“C”	Code will be “C” Please Correct and Resubmit
2100C	NM1	Subscriber Name		
2100C	NM108	Identification Code Qualifier	“MI”	Will be “MI” (Member Identification Number).
2100C	NM109	Identification Code		Will be the Recipient’s 9-digit number as it is shown on the MediPlan, KidCare, All Kids or Senior Care Card.
2100C	AAA	Subscriber Request Validation		
2100C	AAA01	Valid Request Indicator	“Y”	Will be “Y” – Valid but Rejected
2100C	AAA03	Reject Reason	“57”, “62”, “72”, “73”, “75” or “76”	57 = Invalid/Missing Date(s) of Service 62 = Date of Service Not Within Allowable Inquiry Period 72= Invalid/Missing Subscriber/Insured ID 73 = Invalid/Missing Subscriber/Insured Name 75 = Subscriber/Insured Not Found 76 = Duplicate Subscriber ID
2100C	AAA04	Follow Up Action	“C”	Code will be “C” Please Correct and Resubmit
2110C	EB	Subscriber Eligibility or Benefit Information		
2110C	EB01	Eligibility or Benefit Information code	“1”, “6”, “7”, “A”, “B”, “F”, “I”, “MC”, “N”, “R”, “U”, “V” or “Y”	1= Active 6 = Inactive 7 = Inactive Pending Eligibility Update A = Coinsurance B = Copayment F = Limitation I = Non-Covered MC = Managed Care Coordinator N = Services Restricted to Following Provider R = Other payer information U = Contact Following Entity V = Cannot Process Y =Spenddown

2110C	EB02	Coverage Level	"IND"	Will be "IND"
2110C	EB03	Service Type	"1", "33", "35", "47", "86", "88", "98", "AL", "MH", "UC", "2", "4'," 5","6", "7", "8","12", "13", "18", "20", "30", "40","42", "45","48", "50","51", "52", "53", "62", "65", "68","73", "76", "78", "80", "81", "82","83", "99", "AO", "A3", "A6", "A7","A8", "AD","AE", "AF", "AG", "AI", "BG", "BH", "25", "91", "92"	1 = Medical 33 = Chiropractic 35 = Dental Care 47 = Hospital 86 = Emergency 88 = Pharmacy 98 = Professional Physician AL = Vision/Optometry MH = Mental Health UC = Urgent Care 2= Surgical 4=Diagnostic X-Ray 5=Diagnostic Lab 6=Radiation Therapy 7=Anesthesia 8=Surgical Assistance 12= Durable Medical Equipment Purchase 13= Ambulatory Service Center Facility 18=Durable Medical Equipment Rental 20= Second Surgical Opinion 30= Health Benefit Plan Coverage 40=Oral Surgery 42=Home Health Care 45=Hospice 48=Hospital - Inpatient 50=Hospital - Outpatient 51=Hospital - Emergency Accident 52=Hospital - Emergency Medical 53=Hospital - Ambulatory Surgical 62=MRI/CAT Scan 65=Newborn Care 68=Well Baby Care 73=Diagnostic Medical 76=Dialysis 78=Chemotherapy 80=Immunizations 81=Routine Physical 82=Family Planning 83=Podiatry 99=Professional (Physician) Visit - Office AO=Professional (Physician) Visit - Inpatient A3=Professional (Physician) Visit - Outpatient A6=Psycho-therapy 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 25=Restorative Dental 91=Brand Name Prescription Drug 92=Generic Prescription Drug
2110C	EB04	Insurance Type	"HM", "IP", "MA", "MB", "MC", "OT" or "QM"	HM = HMO IP = Individual Policy MA = Medicare Part A MB = Medicare Part B MC = Medicaid OT = Other QM = QMB

2110C	EB05	Plan Coverage Description		When EB04 ‘OT’; Will be ‘HFS SOCIAL SERVICES’; ‘DHS SOCIAL SERVICES’; ‘COOK COUNTY COUNTYCARE’; ‘DCFS, FULL COVERAGE’; ‘DCFS, MEDICAID ELIGIBLE, FULL COVERAGE’; ‘IDOC HOSPITAL BENEFIT PACKAGE WHILE INCARECERATED’; ‘ALL KIDS SHARE, FULL COVERAGE’; ‘ALL KIDS, FULL COVERAGE’; ‘ALL KIDS PREMIUM LEVEL 1, FULL COVERAGE’; ‘ALL KIDS PREMIUM LEVEL 2, FULL COVERAGE’; ‘VETERANS CARE, FULL COVERAGE’; 'ILLINOIS WARRIOR ASSIST, PHARMACY SERVICES ONLY'; ‘SPENDDOWN UNMET’; ‘MEDICAID, SPENDDOWN SPLIT-BILL, EMERGENCY ONLY’; ‘ELIGIBLE FOR RENAL DIALYSIS ONLY’; ‘ELIGIBLE, RENAL DIALYSIS ONLY SPENDDOWN SPLIT-BILL’; ‘MEDICAID, EMERGENCY MEDICAL CONDITION ONLY’; ‘RENAL DIALYSIS ONLY’; ‘FULL COVERAGE‘, ‘QMB ONLY‘; ‘QMB ONLY, SPENDDOWN UNMET’; ‘QMB/MEDICAID, DUAL ELIGIBLE, MEDICARE PRIMARY’; ‘QMB/MEDICAID ELIG, SPENDOWN MET,MEDICARE PRIMARY’; ‘QMB/MEDICAID ELIG, SPLIT-BILL, MEDICARE PRIMARY’; ‘QMB/MEDICAID SPENDDOWN UNMET, MEDICARE PRIMARY’; ‘QMB/MEDICAID ELIG, FULL COVERAGE, MEDICARE PRIMARY’; ‘MEDICAID ELIGIBLE, FULL COVERAGE’; ‘FULL COVERAGE SPENDDOWN MET’; ‘BCC, MEDICAID ELIGIBLE, FULL COVERAGE’; ‘FULL COVERAGE SPENDDOWN SPLIT-BILL’; ‘BCC, FULL COVERAGE’; ‘MEDICAID ELIGIBLE,FULL COVERAGE,SPENDOWN SPLITBILL’; ‘MEDICAID ELIGIBLE, FULL COVERAGE, SPENDDOWN MET’; ‘ALL KIDS, MEDICAID ELIGIBLE, FULL COVERAGE’; ‘ILLINOIS HEALTHY WOMEN ‘
2110C	EB07	Monetary Amount		Will be the Copay amount when EB01 = “B”.
2110C	EB08	Percentage		Will be the Coinsurance amount when EB01 = “A”.

2110C	EB11	Authorization or Certification Indicator	"Y"	Will be "Y" when Prior Approval Required is indicated.
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	"SY", "1L", "1W", "3H", "6P", "F6" "M7", "N6", "18", or "EJ"	SY = Social Security Number 1L = Group or Policy Number 1W = Member Identification Number 3H = Case Number 6P = Group Number F6 = Health Insurance Claim (HIC) # M7= Medical Assistance Category N6 = Plan Network Identification # 18 = Plan Name EJ = Patient Account Number
2110C	REF02	Reference Identification		Use this for the reference number as qualified by preceding data element REF01. Except following- Will be the CASE ID when REF01 = "M7" Will be Policy Number When REF01 = "18" Will be TPL Code When REF01 = "N6"
2110C	REF03	Description		Will be Policy Name When REF01 = "18"
2110C	DTP	Subscriber Eligibility/ Benefit Date		
2110C	DTP01	Date Time Qualifier	"307" or "636"	Will be "307" (Date range entered) Will be System Date, when DTP01="636"
2110C	AAA	Subscriber Request Validation		
2110C	AAA01	Valid Request Indicator	"Y"	Will be "Y" – valid but rejected
2110C	AAA03	Reject Reason Code	"15", "57", "60", "62", "63"	15 = Required application data missing 57 = Invalid/Missing Dates of Service 60 = Date of Birth Follows Date of Service 62 = Date of Service Not Within Allowable Inquiry Period 63 = Date of Service in Future
2110C	AAA04	Follow Up Action Code	"C"	Will be "C" Please Correct and Resubmit
2110C	MSG01	Copay Message		See Section 4.3 Special Messages.
2120C	NM1	Subscriber Benefit Related Entity Name		

2120C	NM101	Entity Identifier Code	“13”, “1P”, “P3”, “PRP”, “X3”	13 = Contracted Service Provider 1P = Provider P3 = Primary Care Provider PRP = Primary Payer X3 = Utilization Management Organization
2120C	NM108	Identification Code Qualifier	“MI”,”PI”	MI = Member Identification Number PI = Payer Identification
2120C	PER	Subscriber Benefit Related Entity Contact Information		
2120C	PER03	Communication Number Qualifier	“TE”	TE = Telephone

4 TI Additional Information

Questions, comments, or suggestions regarding this information should be directed to hfswebmaster@illinois.gov

4.1 Business Scenarios

How to submit Recipient Eligibility Inquiry

The Department offers the ability to perform Direct Data Entry (DDE), real-time, and batch eligibility inquiries. Inquiries can be performed using the Medical Electronic Data Interchange (MEDI), or the Recipient Eligibility Verification (REV) system.

The MEDI web site, http://www.myhfs.com/ allows enrolled providers and their agents the ability to use DDE or to submit a 270 transaction to inquire upon eligibility information.

The REV system allows authorized vendors a means to submit 270 transactions on behalf of providers. More information on the REV system and the REV vendors is available at http://www.hfs.illinois.gov/rev/

The MEDI and the REV systems are available 24 hours a day, 7 days a week.

Grouping and Processing

The REV and MEDI systems offer a mechanism by which a single Recipient Eligibility Inquiry request can be processed and returned in a real-time mode. Under normal conditions, the response to any real-time inquiry will return in a matter of seconds. A single Recipient Eligibility Inquiry request, also referred to as a real-time request, is defined as a single transaction. For real-time, if additional transactions are sent, HFS will process only the first transaction and ignore all others. Additionally, the MEDI IEC system will offer a mechanism whereby 270 X12 formatted transactions will be processed in a batch mode. For batch, multiple transactions are acceptable. Batch transactions will be accumulated throughout the day and under normal conditions, the response will occur within 24 hours.

Eligibility Information

The Department's MediPlan Card, KidCare Card, All Kids Card or SeniorCare Cards contain the Recipient Identification Number (RIN) for each participant. If the participant has their card or if the RIN is known, it should be submitted for all transactions.

If the participant's RIN is not known or is not available, providers may use any combination of the following two sources of identification to inquire on a participant's eligibility: Participant's Name (First and Last Name), Social Security Number and/or Date of Birth.

4.2 Payer Specific Business Rules and Limitations

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

The Department will continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing. The Department will also support a Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet.

EDI Information

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

Listed below are guidelines to follow when transmitting real time information to the Department.

1. A transmission (ISA/IEA) must contain only one functional group (GS/GE) with only one transaction set (ST/SE). Any loop occurrences over one will be ignored.

2. The Department will only process the first occurrence of the following loops.

Any loop occurrences over one will be ignored.

"HL" (Information Source Level) segment for Loop 2000A

"HL" (Information Receiver Level) segment for Loop 2000B

"HL" (Subscriber Level) segment for Loop 2000C

"EQ" (Subscriber Eligibility or Benefit Inquiry Information) for Loop 2110C

"DTP" (Subscriber Eligibility/Benefit Date) for Loop 2110C

3. For purposes of 270/271 processing, HFS considers the subscriber to always be the patient. HFS will only use subscriber level information in its processing. All dependent level data that pass translator edits will be ignored.

4.3 Special Messages

This section contains information relating to copayment messages found in Loop 2110C MSG segment on page 13.

1	OTC Presc drugs copay, $2. NonEmerg ER visit copay, $3.90.Family Planning related medical services require a copay for office visits.
2	State Funded Copay for Emergency Room visit for Non- Emergent service is $50.00/visit. Non-Emergency Transportation services, LTC services, including Supportive Living Facility services and OTC Drugs are not covered.
3	State Funded Non-Emergency Transportation services, LTC services, including Supportive Living Facility services and OTC Drugs are not covered.
4	Organ Transplant Service services are not covered.
5	State Funded Coverage is limited to IL Department of Human Services Programs. Services under this coverage are billed directly to HFS. If you have any questions about DHS Social Services cases, please call the RIN help desk at 1-800-385-0872
6	Title XIX Coverage limited to services provided by Cook County CountyCare. Questions should be directed to www.CountyCare.com or 312-864-8200.
7	State Funded Pharmacy services only
8	State Funded Coverage includes inpatient and limited outpatient hospital services only.
9	Title XIX Coverage limited to services provided by Cook County Health and Hospital Systems. Please see www.countycare.com/providers/coveragestart for more information.
10	Title XIX
11	Title XXI
12	State Funded
13	Title XXI Copayment for Over the Counter Prescription Drugs is $2.00. No copayment for Well-Child Immunizations, Preventive Services, Diagnostic Services or Family Planning. Family Planning related medical services require a copayment for office visits.
14	State Funded. Copayment for Over the Counter Prescription Drugs is $2.00. No copayment for Well-Child Immunizations, Preventive Services, Diagnostic Services or Family Planning. Family Planning related medical services require a copayment for office visits.

15 Title XXI
OTC Presc Drugs copay , $3. NonEmerg ER visit copay, $25. Family Planning related medical services require a copay for office visit.

16 State Funded
OTC Presc Drugs copay , $3. NonEmerg ER visit copay, $25. Family Planning related medical services require a copay for office visit.

17 Title XXI
Not Eligible for Non-Emergency Transportation.

18 Title XXI
NonEmerg ER visit copay, $30. Family Planning related medical services require a copay for office visits. Not Eligible for Non-Emergency Transportation.

19 State Funded
Not Eligible for Non-Emergency Transportation.

20 State Funded
NonEmerg ER visit copay, $30. Family Planning related medical services require a copay for office visits. Not Eligible for Non-Emergency Transportation.

21 Title XXI
Copays do not apply as the Annual Copayment Maximum has been met.

22 State Funded
Copays do not apply as the Annual Copayment Maximum has been met.

23 Title XXI
Copays do not apply as the Annual Copayment Maximum has been met. Not eligible for Non-Emergency Transportation

24 State Funded
Copays do not apply as the Annual Copayment Maximum has been met. Not eligible for Non-Emergency Transportation

25 State Funded
Coverage limited to family planning related exams, mammograms and diagnostic tests and treatment of STIs (except HIV) found at a family planning visit. Refer to www.illinoishealthywomen.com for more information.

26 State Funded
Coverage limited to family planning related exams, mammograms and diagnostic tests and treatment of STIs (except HIV) found at a family planning visit. OTC Presc drugs copay, $2. Refer to www.illinoishealthywomen.com for more information.

27 Title XIX
Coverage limited to family planning related exams, mammograms and diagnostic tests and treatment of STIs (except HIV) found at a family planning visit. Refer to www.illinoishealthywomen.com for more information.

28 Title XIX
Coverage limited to family planning related exams, mammograms and diagnostic tests and treatment of STIs (except HIV) found at a family planning visit. OTC Presc drugs copay, $2. Refer to www.illinoishealthywomen.com for more information.

29 Title XIX
Medicaid Presumptive Eligibility
Inpatient and LTC services are not covered

30 Title XIX
Hospital Presumptive Eligibility
Inpatient and LTC services are not covered

31 State Funded
Medicaid Presumptive Eligibility
Inpatient and LTC services are not covered

32 Title XIX
Organ Transplant Service services are not covered.

33 Title XIX
OTC Presc drugs copay, $2. NonEmerg ER visit copay, $3.90.Family Planning related medical services require a copay for office visits.

34 Title XIX
Childrens Presumptive Eligibility

35 TITLE XIX
Medicaid Presumptive Eligibility

36 Title XIX
Hospital Presumptive Eligibility

37 State Funded
OTC Presc drugs copay, $2. NonEmerg ER visit copay, $3.90.Family Planning related medical services require a copay for office visits.

38 Title XIX
OTC Presc drugs copay, $2. NonEmerg ER visit copay, $3.90.Family Planning related medical services require a copay for office visits.

39 Title XXI
OTC Presc drugs copay, $2. NonEmerg ER visit copay, $3.90.Family Planning related medical services require a copay for office visits.

40 Title XXI
Hospital Presumptive Eligibility

41 Title XXI
Childrens Presumptive Eligibility

5 TI Change Summary

Revision Date: **08/12/2013**	**Revision Description: Clarified Codes and added information to 2110C REF03. Added 4.3 Special Messages under 2110C MSG01**
Revision Date: **01/22/2014**	**Revision Description: Updated EB03 Service Type Codes returned in 271. Updated EB05 Plan Coverage Description with current description. Updated 4.3 Special Messages to include 2 new messages.**
Revision Date: **01/27/2015**	**Revision Description:** Updated the EB03 codes column to include all of the Service Type Codes that we currently return. Updated the EB05 Plan Coverage Description to currently utilized descriptions and removed duplicate messages. Updated 4.3 Special Messages section by removing all 14 messages and replacing them with the 41 messages now needed to accommodate returning funding source and presumptive eligibility information in the message.
Revision Date:	**Revision Description:**
Revision Date:	**Revision Description:**

Revision Date:	Revision Description: