DRAFT CORE Eligibility & Benefits (270/271) Data Content Rule Version EB.2.1 November 2024

Revision History for CORE Eligibility & Benefits (270/271) Data Content Rule

Version	Revision	Description	Date
1.0.0	Major	Phase I CORE 154: Eligibility and Benefits (270/271) Data Content Rule balloted and approved via the CORE Voting Process.	July 2008
2.0.0	Major	Three Phase II CORE Eligibility & Benefits Data Content Operating Rules balloted and approved via CORE Voting Process: 1. Phase II CORE 258: Eligibility and Benefits Normalizing (270/271) Patient Last Name Rule 2. Phase II CORE 259: Eligibility and Benefits (270/271) AAA Error Code Reporting Rule 3. Phase II CORE 260: Eligibility and Benefits (270/271) Data Content Rule	2009
1.1.0; 2.1.0	Minor	Adjustments to the Phase I & II CORE Eligibility and Data Content Operating Rules to support ASC X12 HIPAA-adopted v5010.	March 2011
EB.1.0	Minor	Four CORE Eligibility & Benefits Data Content Operating Rules combined into a single CORE Eligibility & Benefits Infrastructure Rule, no substantive adjustments to rule requirements: 1. Phase I CORE 154: Eligibility and Benefits (270/271) Data Content Rule 2. Phase II CORE 258: Eligibility and Benefits Normalizing (270/271) Patient Last Name Rule 3. Phase II CORE 259: Eligibility and Benefits (270/271) AAA Error Code Reporting Rule 4. Phase II CORE 260: Eligibility and Benefits (270/271) Data Content Rule • Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., eligibility, claims, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
EB.2.0	Major	Enhancements made to the Electronic Delivery of Patient Financial and Benefit Information operating rule requirements to address: • Delivery of Telemedicine Benefits • Expansion CORE-required Service Type Codes • Maximum and Remaining Coverage Benefits • Procedure Codes Requests and Responses • Authorization or Certification Determination • Communication of Tiered Benefits	April 2022
EB.2.1	Major	Expansion of: • CORE-required Service Type Codes • CORE-required Categories of Service	November 2024

		• Procedure Code Requests and Responses Additional requirements for: • Specifying Dental Benefit Limitations • Electronic Policy Access of Required Information Re-organization of Rule Contents: • Separation of Appendix into a companion document	

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Introduction

Four Phase I & II CORE Eligibility & Benefits (270/271) Data Content Operating Rules were combined in 2020 to create the CORE Eligibility & Benefits (270/271) Data Content Rule (see Revision History) as part of the CORE Eligibility & Benefit Rule Set. A single rule to support all data content operating rule requirements is consistent with all other CORE rule sets and simplifies ongoing maintenance. The rule is divided into three main sections:

1. Electronic Delivery of Patient Financial and Benefit Information
2. Normalizing Patient Last Name
3. AAA Error Code Reporting

In 2021, CORE launched a Task Group to evaluate opportunity areas for operating rule enhancement for the Electronic Delivery of Patient Financial and Benefit Information Rule.
In 2024, CORE collaborated with the National Council for Prescription Drug Plans (NCPDP) to outline how the X12 standard should be used to communicate a health plan member's drug coverage under the member's medical benefit. Additionally, partnership with the National Dental EDI Council (NDEDIC) and the American Dental Association (ADA) resulted in proposals that align communication of dental benefits with the expectations industry has for medical coverage. Outputs from work with NCPDP, NDEDIC, and the ADA were reviewed by a Task Group and are included in this rule.
For ease of reference, updated or the addition of new rule requirements are highlighted in grey.

1 Electronic Delivery of Patient Financial and Benefit Information

1.1. Issue to be Addressed and Business Requirement Justification

To electronically determine a patient's eligibility and benefits, providers need to have a robust ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271). This robust response includes the health plans providing financial information for base and remaining deductible, co-insurance, co-payment and coverage and benefit information pertaining to telemedicine, authorization or certification indication, and tiered benefits for those service types and procedure codes. HIPAA provides a foundation for the electronic exchange of eligibility and benefits information but does not go far enough to ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's current mandated data scope does not require all financial and benefit information needed by providers, and HIPAA neither addresses the standardization of data definitions nor contains business requirements by which the HIPAA-outlined data can flow. Future standards developed by ASC X12 and adopted by HIPAA may address these issues. In the meantime, businesses are seeking solutions that can be used today.
Using the available but not-required (situational) elements of the v5010 270/271, the CORE Eligibility & Benefits (270/271) Data Content Rule defines the specific business information requirements that health plans must return, and vendors, clearinghouses and providers must use if they want to be CORE-certified. As with all CORE rules, these requirements are base requirements, and it is expected many CORE-certified entities will add to these requirements as they work towards the goal of administrative interoperability.
This rule requires: the delivery of base, remaining and benefit-specific deductibles; return of co-payment and co-insurance amounts; communication of telemedicine, remaining coverage, and tiered benefits; indication if authorization or certification is required; and provides a list of CORE-required service type codes and CORE-required categories of service for procedure codes. For certain categories of service and procedure codes, requirements specify that information that supports dental plan benefits and medication coverage must also be returned if requested.
By requiring the delivery and use of this financial and benefit information via the existing v5010 270/271 HIPAA-adopted standard, the CORE Eligibility & Benefits (270/271) Data Content Rule helps provide the information that is necessary to automate electronic eligibility and benefits inquiry processes more fully and thus reduce the cost of today's more manual processes.

1.2. Scope

1.2.1. What the Rule Applies To

This CORE rule conforms with and builds upon the v5010 TR3 implementation guide and specifies the minimum content that an entity must include in the v5010 271.

1.2.2. When the Rule Applies

This rule applies when:

- The individual is located in the health plan and its agent eligibility system;

And

One of the following is true:

- A health plan and its agent receives a generic v5010 270;

Or

- A health plan and its agent receives an explicit v5010 270 for a specific service type required in §1.3.2.3 of this rule;

Or

- A health plan and its agent receives an explicit v5010 270 for a specific procedure code specified in §1.4.2.3 of this rule.

1.2.3. What the Rule Does Not Require

This rule does not require any entity to modify its use and content of:

- Other loops and data elements that may be submitted in the v5010 270 not addressed in this rule (see §1.2.4)

And

- Other loops and data elements that may be returned in the v5010 271 not addressed in this rule (see §1.2.4).

1.2.4. Applicable Loops & Data Elements

This rule covers the following specified loops, segments and data elements in the v5010 270/271 transactions:

- Segment in the v5010 270:

Loop ID and Name
Loop ID – 2100B Information Receiver Name
Data Element Segment Position, Number & Name
NM1 Information Receiver Name
REF Information Receiver Additional Identification
PRV Information Receiver Provider Information
Loop ID and Name
Loop 2110C Subscriber Eligibility or Benefit Inquiry Information
Data Element Segment Position, Number & Name
EQ Subscriber Eligibility or Benefit Inquiry Information Segment
Loop ID and Name
Loop 2110D Dependent Eligibility or Benefit Inquiry Information

- Segment in the v5010 271:

Loop ID and Name

Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
DTP01-374 Date/Time Qualifier
DTP02-1250 Date Time Period Format Qualifier
DTP03-1251 Date Time Period
Loop ID and Name
Loop 2110C Subscriber Eligibility or Benefit Information
Data Element Segment Position, Number & Name
EB01-1390 Eligibility or Benefit Information
EB02-1207 Coverage Level Code
EB03-1365 Service Type Code
EB05-1204 Plan Coverage Description
EB06-615 Time Period Qualifier
EB07-782 Monetary Amount
EB08-954 Percent
EB09-673 Quantity Qualifier
EB10-380 Quantity
EB11-1073 Yes/No – Authorization or Certification Indicator
EB12-1073 Yes/No – In Plan Network Indicator
EB13-C003 Composite Medical Procedure Identifier
EB13 - 1 235 Product/Service ID Qualifier
EB13 - 2 234 Product/Service ID
EB13 - 3 1339 Procedure Modifier
Data Element Segment Position, Number & Name
HSD01-673 Quantity Quantifier
HSD02-380 Quantity
HSD05-615 Time Period Qualifier
HSD06-616 Number of Periods
Data Element Segment Position, Number & Name
Msg-01 Free-Form Message Txt
Loop ID and Name
Loop 2115C Subscriber Eligibility or Benefit Additional Information
Data Element Segment Position, Number & Name
III Subscriber Eligibility or Benefit Additional Information
III01 1270 Code List Qualifier Code
III02 1271 Industry Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
DTP01-374 Date/Time Qualifier
DTP02-1250 Date Time Period Format Qualifier
DTP03-1251 Date Time Period
Loop ID and Name
Loop 2110D Dependent Eligibility or Benefit Information
Data Element Segment Position, Number & Name
EB01-1390 Eligibility or Benefit Information
EB02-1207 Coverage Level Code
EB03-1365 Service Type Code
EB06-615 Time Period Qualifier
EB07-782 Monetary Amount
EB08-954 Percent
EB09-673 Quantity Qualifier
EB10-380 Quantity

EB11-1073 Yes/No – Authorization or Certification Indicator
EB12-1073 Yes/No – In-Plan Network Indicator
EB13-C003 Composite Medical Procedure Identifier
EB13 - 1 235 Product/Service ID Qualifier
EB13 - 2 234 Product/Service ID
EB13 - 3 1339 Procedure Modifier
Data Element Segment Position, Number & Name
HSD01-673 Quantity Quantifier
HSD02-380 Quantity
HSD05-615 Time Period Qualifier
HSD06-616 Number of Periods
Data Element Segment Position, Number & Name
Msg-01 Free-Form Message Txt
Loop ID and Name
Loop 2115D Subscriber Eligibility or Benefit Additional Information
Data Element Segment Position, Number & Name
III Subscriber Eligibility or Benefit Additional Information
III01 1270 Code List Qualifier Code
III02 1271 Industry Code

1.2.5. Outside the Scope of this Rule

This rule does not require entities to internally store the data elements listed in §1.2.4 or any other data elements in conformance with this rule, but rather requires that all entities conform to this rule when conducting the v5010 270/271 transactions electronically. Entities may store data internally any way they wish but must ensure the data conform to applicable CORE rules when inserting that data into outbound transactions.

1.2.6. Assumptions

The following assumptions apply to this rule:

- This rule is a component of the larger set of CORE Eligibility & Benefits Operating Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules.
- Requirements for the use of the applicable loops and data elements apply only to the v5010 270/271.
- Health plans and their agents are able to accurately maintain benefit and eligibility data received or created in a reasonable timeframe.
- This rule is not a comprehensive companion document specifying the complete content of either the v5010 270 or v5010 271 transactions. The focus in this rule is on specifying requirements for the v5010 271 to address the CORE eligibility and benefits data content requirements for health plan benefits and services and related patient financial responsibility.

1.2.7. Abbreviations and Definitions Used in this Rule

Authorization/Certification: Provider prior authorization or certification received from the health plan to enable the provider to be aware when they need to obtain payer approval prior to performing a service, procedure, or testing on the patient to deliver more accurate patient financial responsibility.
Benefit-specific Base Deductible*:* The dollar amount of a specific covered service based on the allowed benefit that is separate and distinct from the Health Plan Base Deductible that must be paid by an individual or family before the health benefit plan begins to pay its portion of claims. The specific benefit period may be a specific date, date range, or otherwise as specified in the plan.
Explicit Inquiry: In contrast to a Generic Inquiry, an Explicit Inquiry is a v5010 270 Health Care Eligibility Benefit Inquiry that contains a Service Type Code other than and not including “30” (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, “78” (Chemotherapy). (See §1.3.2.3)
Generic Inquiry: In contrast to an Explicit Inquiry, a Generic Inquiry is a v5010 270 Health Care Eligibility Benefit Inquiry that contains only Service Type Code “30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction.

Health Plan Base Deductible: The dollar amount of covered services based on the allowed benefit that must be paid by an individual or family per benefit period before the health benefit plan begins to pay its portion of claims. The benefit period may be a specific date range of one year or other as specified in the plan.
Health Plan Coverage Date for the Individual: The effective date of health plan coverage in operation and in force for the individual.
In/Out of Network[1]: A provider network is a list of the doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members. These providers are called "network providers" or "in-network providers." A provider that isn't contracted with the plan is called an "out-of-network provider."
Patient Financial Responsibility and Benefit Information: Includes static co-pay, co-insurance information, remaining deductible, telemedicine benefits, and authorization/certification indication, etc. as outlined in §1.3.2.5 of the CORE Eligibility & Benefits Data Content Rule.
Remaining Coverage Benefits: Information corresponding to benefit limitations as outlined in the CORE Eligibility & Benefits Data Content Rule. Maximum and remaining benefits, when applicable, may include time period, monetary, and benefit quantity limitations, depending on the scenario.
Support [Supported] Service Type: Support [or Supported] means that the health plan (or information source) must have the capability to receive a v5010 270 for a specific Service Type Code and to respond in the corresponding v5010 271 in accordance with this rule.
Support [Supported] Procedure Code: Support [or Supported] means that the health plan (or information source) must have the capability to receive a v5010 270 for a specific Procedure Code and to respond in the corresponding v5010 271 in accordance with this rule. Examples referenced in this rule can include CPT, HCPCS, CDT, ICD-10-PCS, or NDC.
Telemedicine/Telehealth: When a provider delivers care for a patient without an in-person office visit, for example, online with internet access on a computer, tablet, or smartphone or via telephone.
Tiered Benefit: For the purposes of this rule a tiered benefit is when an insurance plan divides the in-network providers into multiple levels (tiers) where the benefit coverage may change based on the provider's contractual participation.

1.3. Service Type Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements

1.3.1. Basic Requirements for Submitters (Providers, Provider Vendors, and Information Receivers)

The receiver of a v5010 271 (defined in the context of this CORE rule as the system originating the v5010 270) is required to detect and extract all data elements to which this rule applies as returned by the health plan (or information source) in the v5010 271.
The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the v5010 271 data content.

1.3.2. Basic Requirements for Health Plans and Information Sources

A health plan and its agent must comply with all requirements specified in this rule when returning the v5010 271 when the individual is located in the health plan's (or information source's) system.

1.3.2.1. Health Plan Name

When the individual is located in the health plan and its agent system the health plan name must be returned (if one exists within the health plan and its agent's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor its agent is required to obtain such a health plan name from outside its own organization.

1.3.2.2. Eligibility Dates

The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with

[1] https://marketplace.cms.gov/outreach-and-education/what-you-should-know-provider-networks.pdf

code “62” Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

1.3.2.3. Requirements for a Response to an Explicit Inquiry for a CORE Required Service Type

A health plan and its agent must support an explicit v5010 270 for each of the CORE service types specified in the appendix, in *Table 1 – Eligibility & Benefits CORE Service Type Codes*, returning a v5010 271 as specified in §1.3.2.4 through §1.3.2.13.

1.3.2.4. Specifying Status of Health Benefits Coverage

For the discretionary Service Type Codes identified in the appendix, in *Table 1 – Eligibility & Benefits CORE Service Type Codes*, when the health plan is exercising its discretion to not return patient financial responsibility, the coverage status of the specific benefit (service type) must be returned regardless of whether or not that status is separate and distinct from the status of the health plan coverage.
When a service type covered by this rule is a covered benefit for in-network providers only and not a covered benefit for out-of-network providers, a health plan and its agent must indicate the non-covered status for out-of-network providers for each service type using EB12-1073 Yes/No – In Plan Network Indicator as follows:

- EB01 = I−Non-Covered
- EB03 = <Applicable Service Type Code>
- EB12 = N

1.3.2.5. Patient Financial Responsibility and Benefit Information

A health plan and its agent must return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment and benefit information pertaining to telemedicine and authorization/certification indication as specified in §1.3.2.6 through §1.3.2.13 for each of the service type codes returned. The health plan (or information source) may, at its discretion, elect not to return patient financial responsibility and benefit information (deductible, co-payment, co-insurance, telemedicine, authorization/certification) for service type codes indicated as discretionary as specified in the appendix, in *Table 1 – Eligibility & Benefits CORE Service Type Codes*.
This discretionary reporting of patient financial responsibility and benefit information does not preempt the health plan’s (or information source’s) requirement to report patient financial responsibility and benefit information for deductible, co-payment, co- insurance, telemedicine, and authorizations/certification for all other Service Type Codes as specified in the appendix, in *Table 1 – Eligibility & Benefits CORE Service Type Codes*.
Service Type Code 30−Health Benefit Plan Coverage is not included in this group of discretionary service types since this rule requires that a health plan and its agent must return base and remaining Health Plan Deductibles using Service Type Code 30.
CORE made these codes discretionary for one of three main reasons:

- A code is too general for a response to be meaningful (e.g., 1 – Medical);
- A code is typically a “carve-out” benefit (e.g., AL – Vision) where the specific benefit information is not available to the health plan or information source; Or
- A code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where privacy issues may impact a health plan or information source’s ability to return information.

See the appendix, *Table 1 – Eligibility & Benefits CORE Service Type Codes*, for a visual view of Service Type Codes and reporting requirements.
All date and date range reporting requirements for Patient Financial Responsibility are specified in §1.3.2.9.

1.3.2.6. Specifying Deductible Amounts

A health plan and its agent must return the dollar amount of the base and remaining deductible for all Service Type Codes required by §1.3.2.3 and for Service Type Code 30 (See §1.3.2.3), with consideration of §1.3.2.5 for discretionary reporting exceptions.
The deductible amount returned must be in U.S. dollars only.

1.3.2.6.1. Specifying the Health Plan Base Deductible

A health plan and its agent must return the Health Plan base deductible as defined in §1.2.7 of this rule that is the patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = 30 – Health Benefit Plan Coverage
- EB06 = <Applicable Time Period Qualifier code; see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers.>
- EB07 = Monetary amount of Health Plan base deductible

When a service type does not have a base deductible separate and distinct from the Health Plan base deductible, the Health Plan base deductible must not be returned on any EB segment where EB03≠30 − Health Benefit Plan Coverage.
When the Health Plan base deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.3.2.6.2. Specifying the Health Plan Remaining Deductible

A health plan and its agent must return the Health Plan remaining deductible, that is the patient financial responsibility, including both individual and family remaining deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = 30 – Health Benefit Plan Coverage
- EB06 = 29–Remaining
- EB07 = Monetary amount of Health Plan remaining deductible

When a service type does not have a specific remaining deductible that is separate and distinct from the Health Plan remaining deductible, the Health Plan remaining deductible must not be returned on any EB segment where EB03≠30−Health Benefit Plan Coverage.
When the Health Plan remaining deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows.

- EB12 = N or Y as applicable

The Health Plan remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no Health Plan remaining deductible is returned.

1.3.2.6.3. Specifying the Benefit-specific Base Deductible

A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 of this rule that is the patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>
- EB06 = <Applicable Time Period Qualifier code; see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers.>

- EB07 = Monetary amount of Benefit-specific base deductible

When the Benefit-specific base deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.3.2.6.4. Specifying the Benefit-specific Remaining Deductible

A health plan and its agent must return the Benefit-specific remaining deductible, that is patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>
- EB06 = 29 – Remaining
- EB07 = Monetary amount of Benefit-specific remaining deductible

When the Benefit-specific remaining deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

The benefit-specific remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no Benefit-specific remaining deductible is returned.
Returning the Benefit-specific remaining deductible is required except for those service types specified as exceptions for discretionary reporting in §1.3.2.5.

1.3.2.7. Specifying Co-Payment Amounts

A health plan and its agent must return the patient financial responsibility for co-payment for each of the Service Type Codes returned as specified as follows:

- EB01 = B–Co-Payment
- EB02 = FAM–Family or IND–Individual as appropriate
- EB07 = Monetary amount of Benefit-specific Co-payment

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

See §1.3.2.5 for discretionary reporting exceptions.

1.3.2.8. Specifying Co-Insurance Amounts

A health plan and its agent must return the patient financial responsibility for co-insurance for each of the Service Type Codes returned as follows:

- EB01 = A–Co-Insurance
- EB02 = FAM–Family or IND–Individual as appropriate
- EB08 = Percent for each Benefit-specific Co-insurance

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

See §1.3.2.5 for discretionary reporting exceptions.

1.3.2.9. Specifying the Health Plan Base Deductible Date

When the Health Plan Base Deductible date is not the same date as the Health Plan Coverage Date for the Individual a health plan and its agent must return date specifying the begin date for the base Health Plan deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03=30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

- DTP01 = 346 Plan Begin
- DTP02 = D8–Date Expressed in Format CCYYMMDD
- DTP03 = the date applicable to the time period as specified in EB06

Do not return the DTP segment when the date is the same as the Health Plan Coverage Dates for the Individual.
Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates for the base Health Plan Base deductible only in Loops 2110C/2110D where EB01 = active coverage code 1 through 5 and EB03=30–Health Plan Benefit Coverage and EB01 = C−Deductible as follows:

- DTP01 = 291–Plan
- DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- DTP03 = the range of dates applicable to the time period as specified in EB06

Do not return the DTP segment when the date range is the same as the Health Plan Coverage Dates for the Individual.

1.3.2.10. Specifying Benefit-specific Base Deductible Dates

When the Benefit-specific Base Deductible date is not the same date as the Health Plan Coverage Dates for the Individual, a health plan and its agent must return a date specifying the begin date for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

- DTP01 = 348–Benefit Begin
- DTP02 = D8–Date Expressed in Format CCYYMMDD
- DTP03 = the date applicable to the time period as specified in EB06

Do not return the DTP segment when the date is the same as the Health Plan Coverage Dates for the Individual.
Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

- DTP01 = 292–Benefit
- DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- DTP03 = the range of dates applicable to the time period as specified in EB06

Do not return the DTP segment when the date range is the same as the Health Plan Coverage Dates for the Individual.

1.3.2.11. Specifying Telemedicine Benefits

When a service type code is covered for telemedicine[2], a health plan and its agent must use the Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims Code 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home) , in Segment III[3] (SUBSCRIBER/DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION), within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for telemedicine as follows.

[2] Service type codes may have varying applicability or limitations based on a multitude of factors, such as place of service. Rule requirements specify when to send place of service codes for telemedicine specifically, when needed.

[3] Reference ASC X12N v5010X279 271/2115C/2115D III Segment

EB Segment:

- EB01 = Eligibility or Benefit Information Code used to Identify the Eligibility or Benefit Information
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = <Service Type Code that is available for Telemedicine>

III Segment:

- III01 = ZZ Place of Service Codes for CMS Professional Services
- III02 = 02 Telehealth Provided Other than in Patient's Home or 10 Telehealth Provided in Patient's Home (as appropriate)

When telemedicine benefits differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.3.2.12. Specifying Maximum and Remaining Coverage Benefits

A health plan and its agent must return maximum benefit limitations and return remaining benefits for each maximum benefit limitation for the CORE-required remaining coverage benefit service types specified in the appendix, in *Table 1 – Eligibility & Benefits CORE Service Type Codes* using two EB segment occurrences.

1.3.2.12.1. Specifying Maximum Benefit

A health plan and its agent must return maximum benefit limitations in an EB segment as follows:

- EB Segment
  - EB01 = F Limitations
  - EB03 = <Applicable CORE-required STC for Remaining Benefits>
  - EB06 = <Applicable Time Period Qualifier code; the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = M2 Maximum - Use to specify the units conveyed in EB10 (when applicable)
  - EB10 = Benefit Quantity (when applicable)

1.3.2.12.2. Specifying Remaining Benefit

A health plan and its agent must return the related remaining benefit limitation in an EB segment as follows:

- EB Segment
  - EB01 = F Limitations
  - EB03 = <Applicable CORE-required STC for Remaining Benefits>
  - EB06 = 29 Remaining
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = Quantity Qualifier (when applicable)
  - EB10 = Benefit Quantity (when applicable)

1.3.2.12.3. Remaining Benefit with Date

A health plan and its agent must return the next eligible date for a benefit when a service type has a date limitation, when applicable, using the EB and DTP Segment as follows:

- EB Segment
  - EB03 = < Applicable CORE-required STC for Remaining Benefits >

- EB06 = <Applicable Time Period Qualifier code; see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>

- DTP Segment
  - DTP01 = 348 Benefit Begin
  - DTP02 = D8 Date Expressed in Format CCYYMMDD
  - DTP03 = Next Eligible Date as applicable to the time period specified in EB06

1.3.2.13. Specifying Authorization/Certification

When a service type code covered by this rule is a covered benefit, a health plan and its agent must indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each service type as follows:

- EB11 = N or Y as applicable

If authorization or certification requirements cannot be determined for the inquired service type code and by using data sent in the v5010 270, a health plan and its agent must use EB11 with code U if authorization or certification requirements are not accessible as follows:

- EB11 = U

When authorization or certification requirements differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.4. Procedure Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements

1.4.1. Basic Requirements for Submitters (Providers, Provider Vendors and Information Receivers)

The receiver of a v5010 271 (defined in the context of this CORE rule as the system originating the v5010 270) is required to detect and extract all data elements to which this rule applies as returned by the health plan and its agent in the v5010 271.
The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the v5010 271 data content.

1.4.2. Basic Requirements for Health Plans and Information Sources

A health plan and its agent must comply with all requirements specified in this rule when returning the v5010 271 when the individual is located in the health plan's (or information source's) system.

1.4.2.1. Health Plan Name

When the individual is located in the health plan's and its agent's system the health plan name must be returned (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor the information source is required to obtain such a health plan name from outside its own organization.

1.4.2.2. Eligibility Dates

The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

1.4.2.3. Requirements for a Response to an Explicit Inquiry for a CORE Required Procedure Code

A health plan and its agent must support an explicit v5010 270 for each procedure code (CPT, HCPCS, CDT, ICD-10-PCS, or NDC) received that can be placed by the health plan into one or more of the categories of service as specified in Table 1.4.2.3 returning a v5010 271 as specified in §1.4.2.4 through §1.4.2.11.

Table 1.4.2.3

CORE-required Categories of Service for Procedure Codes (CPT, HCPCS, CDT, ICD-10-PCS, or NDC)		
Medical	*Dental*	*Medication*
Physical Therapy	Oral and Maxillofacial Surgery	Chemotherapy
Occupational Therapy	Implant Services	Injectables
Imaging	Diagnostic	Infusions
Surgery	Endodontics	Oncology
Internal Medicine	Fixed Prosthodontics	Pain Management
Primary Care	Orthodontics	Biologics
Maternal Health	Periodontics	Compound Drugs
Renal Care	Radiology	Inhalations
	Preventative	Nephrology
	Prosthodontics	Immunosuppressives
	Restorative	Antibiotics
	Specialty Procedures	Hormone Therapy
		Antiemetics

When the procedure code(s) received in the v5010 270 cannot be placed by the health plan and its agent into any of the above types of service categories, as specified in Table 1.4.2.3, the health plan and its agent should attempt to evaluate and respond appropriately to the request. Note: The health plan and its agent are strongly encouraged to evaluate and respond to all received procedure code(s).

1.4.2.4. Specifying Status of Health Benefits Coverage

When a procedure code covered by this rule is a covered benefit for in-network providers only and not a covered benefit for out-of-network providers, a health plan and its agent must indicate the non-covered status for out-of-network providers for each procedure code using EB12-1073 Yes/No – In Plan Network Indicator as follows:

- EB01 = I−Non-Covered
- EB12 = N
- EB13 = <Applicable Procedure Code>

1.4.2.5. Patient Financial Responsibility

A health plan and its agent must return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment as specified in §1.4.2.6 through §1.4.2.8. for each procedure code returned.
All date and date range reporting requirements for Patient Financial Responsibility are specified in §1.4.2.9.

1.4.2.6. Specifying Deductible Amounts

A health plan and its agent must return the dollar amount of the base and remaining deductible for all procedure codes required by §1.4.2.3.
The deductible amount returned must be in U.S. dollars only.

1.4.2.6.1. Specifying the Benefit-specific Base Deductible

A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 of this rule that is the patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.4.2.4 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB06 = < Applicable Time Period Qualifier code; see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>
- EB07 = Monetary amount of Benefit-specific base deductible
- EB13 = < the Procedure Code indicating the specific benefit to which the deductible applies>

When the Benefit-specific base deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.4.2.6.2. Specifying the Benefit-specific Remaining Deductible

A health plan and its agent must return the Benefit-specific remaining deductible, that is patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

- EB01 = C–Deductible
- EB02 = FAM–Family or IND–Individual as appropriate
- EB06 = 29 – Remaining
- EB07 = Monetary amount of Benefit-specific remaining deductible
- EB13 = <the Procedure Code indicating the specific benefit to which the deductible applies>

When the Benefit-specific remaining deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

The Benefit-specific remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no Benefit-specific remaining deductible is returned.

1.4.2.7. Specifying Co-Payment Amounts

A health plan and its agent must return the patient financial responsibility for co-payment for each Procedure Code returned as specified as follows:

- EB01 = B–Co-Payment
- EB02 = FAM–Family or IND–Individual as appropriate
- EB07 = Monetary amount of Benefit-specific Co-payment

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.4.2.8. Specifying Co-Insurance Amounts

A health plan and its agent must return the patient financial responsibility for co-insurance for each Procedure Code returned as follows:

- EB01 = A–Co-Insurance
- EB02 = FAM–Family or IND–Individual as appropriate

- EB08 = Percent for each Benefit-specific Co-insurance

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.4.2.9. Specifying Procedure Code-specific Base Deductible Dates

When the Procedure Code-specific Base Deductible date is not the same date as the Health Plan Coverage Dates for the Individual, a health plan and its agent must return a date specifying the begin date for the base Procedure Code-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

- DTP01 = 348–Benefit Begin
- DTP02 = D8–Date Expressed in Format CCYYMMDD
- DTP03 = the date applicable to the time period as specified in EB06

Do not return the DTP segment when the date is the same as the Health Plan Coverage Dates for the Individual.
Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

- DTP01 = 292–Benefit
- DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- DTP03 = the range of dates applicable to the time period as specified in EB06

Do not return the DTP segment when the date range is the same as the Health Plan Coverage Dates for the Individual.

1.4.2.10. Specifying Authorization/Certification

When a Procedure Code covered by this rule is a covered benefit, a health plan and its agent must indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each procedure code as follows:

- EB11 = N or Y as applicable

If authorization or certification requirements cannot be determined for the inquired procedure code and by using data sent in the v5010 270, a health plan and its agent must use EB11 with code U if authorization or certification requirements are not accessible as follows:

- EB11 = U

When authorization or certification requirements differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable.

1.4.2.11. Specifying Dental Benefit Limitations

When the X12 v5010 270 includes a CORE-required procedure code for a dental category of service, the information source (the health plan or contracted vendor) must return the dental benefit limitations as specified in §1.4.2.11.1 through §1.4.2.11.4.

1.4.2.11.1. Specifying Frequency Limitations

A health plan and its agent must return frequency limitations for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB and HSD Segment as follows:

- EB Segment:
  - EB01 = F-Limitations
  - EB13 = <the Procedure Code the frequency limitation applies to>
- HSD Segment[4]:
  - HSD01 = <Applicable Quantity Qualifier>
  - HSD02 = Quantity
  - HSD05 = <Applicable Time Period Qualifier, see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>
  - HSD06 = Number of Periods

1.4.2.11.2. Specifying Waiting Periods

A health plan and its agent must return waiting periods for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB Segment as follows:

- EB Segment:
  - EB01 = F Limitation
  - EB09 = <Applicable Quantity Qualifier for Waiting Period; see appendix, *Table 3 – CORE Recommended Quantity Qualifier Codes* for recommended qualifiers>
  - EB10 = Quantity (numeric value of waiting period)
  - EB13 = <the Procedure Code where the waiting period applies>

1.4.2.11.3. Specifying Age Limitations

A health plan and its agent must return age limitations for procedure codes that align with CORE-required dental categories of service, when applicable, using the EB Segment as follows:

- EB Segment:
  - EB01 = F Limitation
  - EB09 = <Applicable Quantity Qualifier for Age Limitations: S7 – Age, High Value or S8 – Age, Low Value; see appendix, *Table 3 – CORE Recommended Quantity Qualifier Codes* for recommended qualifiers>
  - EB10 = Quantity (numeric value of age limit)
  - EB13 = <the Procedure Code where the age limit applies>

1.4.2.11.4. Specifying Maximum and Remaining Coverage Benefits

A health plan and its agent must return maximum benefit limitations and return remaining benefits for each maximum benefit limitation for procedure codes that align with CORE-required dental categories of service, when applicable, using two EB segment occurrences.

1.4.2.11.4.1. Specifying Maximum Benefit

A health plan and its agent must return maximum benefit limitations in an EB segment as follows:

- EB Segment
  - EB01 = F Limitations
  - EB06 = <Applicable Time Period Qualifier code; the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = M2 Maximum - Use to specify the units conveyed in EB10 (when applicable)
  - EB10 = Benefit Quantity (when applicable)

[4] When applicable, include HSD03= Unit or Basis for Measurement and HSD04= Sample Selection Modulus

- EB13 = <the Procedure Code where maximum benefit applies>

1.4.2.11.4.2. Specifying Remaining Benefit

A health plan and its agent must return the related remaining benefit limitation in an EB segment as follows:

- EB Segment
  - EB01 = F Limitations
  - EB06 = 29 Remaining
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = Quantity Qualifier (when applicable)
  - EB10 = Benefit Quantity (when applicable)
  - EB13 = <the Procedure Code where remaining benefit applies>

1.4.2.11.4.3. Remaining Benefit with Date

A health plan and its agent must return the next eligible date for a benefit when a service type has a date limitation, when applicable, using the EB and DTP Segment as follows:

- EB Segment
  - EB06 = <Applicable Time Period Qualifier code; see the appendix, *Table 2 – CORE Recommended Time Period Qualifier Codes* for recommended qualifiers>
  - EB13 = < the Procedure Code where remaining benefit applies >
- DTP Segment
  - DTP01 = 348 Benefit Begin
  - DTP02 = D8 Date Expressed in Format CCYYMMDD
  - DTP03 = Next Eligible Date as applicable to the time period specified in EB06

1.5. Tiered Benefits

1.5.1. Member Tiered Benefit Coverage

When the v5010 270 includes a CORE-required service type or procedure code, as specified in §1.3.2 and §1.4.2, and it is determined to be a tiered benefit for the ***patient identified***, the v5010 271 must include the following data in EB Loops 2110C/2110D for each applicable tiered benefit. Each EB loop must also include an MSG segment identifying the benefit tier and the MSG segment content must begin with “MSG*BenefitTier…”.

- Coverage Status of Benefit
- Benefit-Specific Base Deductible
- Benefit-Specific Remaining Deductible
- Co-Pay Amount
- Co-Insurance Amount
- Coverage Level
- Benefit-specific Base Deductible Dates
- Remaining Benefit Coverage
- Authorization or Certification Indication
- In/Out of Network Indication

When a specific tiered benefit cannot be determined, all tiers must be returned along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to

them and the MSG segment content must begin with "MSG*Benefit Tier cannot be determined…".

1.5.2. Provider Tiered Benefit Reimbursement

When the health plan and its agent can appropriately identify the provider specified in Loop 2100B NM1/REF/PRV segments the v5010 271 must return the following:

- The tiered network status of in-network, out-of-network, or exclusive/preferred for the inquiring provider.

AND

- Benefit information only for the patient tier that applies to the inquiring provider if determination can be made.

When a patient benefit tier cannot be determined for the provider specified in Loop 2100B, information for all benefit tiers applicable to the patient must be returned in EB Loops 2110C/2110D along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to them.

1.6. Electronic Policy Access of Required Information

Health plans and their agents must make data requirements for this transaction easily accessible to submitters of an eligibility and benefits inquiry, either on the plan website or in the transaction-specific companion guide.

2 Normalizing Patient Last Name

2.1. Issue to be Addressed and Business Requirement Justification

Healthcare providers and health plans have a requirement to uniquely identify patients (aka subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for health plan benefits. At a high level, this identification requirement consists of accurately matching:
Individuals with records and information that relate to them and to no one else; and
Disparate records and information held in various organizations' computer systems about the same individuals.
For health plans, this identification requirement currently is met by uniquely numbering the individuals whereby each person (or a subscriber and dependents) is assigned an identifier by the health plan covering the individual, i.e., a subscriber, member or beneficiary ID. This ID is combined with other demographic data about the individual (e.g., first name, last name, date of birth, gender, etc.) and then used in healthcare transactions, such as eligibility inquiries, claims submissions, etc. Healthcare providers obtain this unique identifier from patients, combine it with other demographic data, and then subsequently use it when conducting electronic transactions with health plans, such as insurance verification and claims submissions. The health plans then use this combination of ID and demographic data to attempt to uniquely locate the individual within their systems.
However, oftentimes, while the ID may be valid and correct, the other demographic data submitted by the healthcare provider does not match similar demographic data held by the health plans' systems, and such transactions are then rejected or denied.

2.2. Scope

2.2.1. What the Rule Applies To

This CORE rule for normalizing patient last name applies to the HIPAA-adopted v5010 270/271 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 rule applies only to certain characters in a person's last name including:

- Punctuation values as specified in §2.3.2.3
- Upper case letters
- Special characters as specified in §2.3.2.3
- Name suffixes and prefixes specified as character strings in §2.3.2.2

2.2.2. When the Rule Applies

This CORE rule for normalizing patient last name applies only when:

- The trading partners are using the ASC X12 Basic Character Set (see §2.2.7 below for explanation).
  And
- A member ID (MID) is submitted in Loop 2100C of the v5010 270 inquiry transaction.
  And
- A Last Name (LN) is submitted in Loops 2100C/2100D of the v5010 270 inquiry transaction.
  And
- The Last Name (LN) is used in the health plan's (or information source's) search and match logic.

2.2.3. When the Rule Does Not Apply

This CORE rule for normalizing patient last name does not apply when:

- Trading partners have agreed to use the ASC X12 Extended

  Character Set.

  Or

- The Last Name (LN) is not used in the health plan's (or information source's) search and match logic.

2.2.4. Recommendation for Validation of Last Name in Other Transactions

Health plans are encouraged to employ a no-more-restrictive name validation logic in other HIPAA administrative transactions than what is employed for the v5010 270/271 transactions.

2.2.5. Applicable Data Elements & Loops

This rule for normalizing patient last name covers the following specified data element and loops in the v5010 270 and v5010 271 transactions:

Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
AAA03-901 Reject Reason Code
INS03-875 Maintenance Type Code
INS04-1203 Maintenance Reason Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
AAA03-901 Reject Reason Code
INS03-875 Maintenance Type Code
INS04-1203 Maintenance Reason Code

2.2.6. Outside the Scope of this Rule

This rule for normalizing patient last name does not:

- Require CORE-certified entities to internally store these and other data elements in conformance with this rule, but rather requires that all parties conform to this rule when conducting the HIPAA- adopted v5010 270/271 transactions electronically.
- Require conversion of letter case and/or special characters by any party for subsequent processing of the data through internal systems.
- Specify whether or not a health plan (or information source) must validate the full last name or may validate only a portion of the last name.
- Specify the search criteria used by a health plan (or information source) to identify a patient.

2.2.7. Approved Basic Character Set

The X12 Basic Character Set consists of:

- Upper case letters from A to Z
- Digits from 0 to 9
- Special characters:

! “ & ' ( ) * + , - . / : ; ? =

- The space character

Note: Special characters are removed from this category when used as delimiters.

2.2.8. Use of Extended Character Set

The ASC X12 Extended Character Set as specified in X12.6 Application Control Architecture §3.3.2 is outside the scope of this rule and may be used only by agreement between trading partners. The ASC X12 Extended Character set includes the lowercase letters, other special characters, national characters and select language characters.

2.2.9. Assumptions

The following assumptions apply to this rule:

- This rule is a component of the larger set of CORE Eligibility & Benefits Operating Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules;
- Requirements for the use of the applicable loops and data elements apply only to the HIPAA-adopted v5010 270/271;
- Health plans (and information sources) are able, in a reasonable timeframe, to maintain the relevancy, accuracy, and timeliness of data returned in the v5010 271;
- This rule is not a comprehensive companion document specifying the complete content of either the v5010 270 or v5010 271 transactions. The focus in this rule is on specifying requirements for the v5010 271 to address the Last Name Normalization requirements;
- The submitter of the v5010 270 knows which data elements and values were submitted in the v5010 270 (i.e., member identifier, first name, last name, date of birth).

2.3. Normalizing Patient Last Name Rule Requirements

2.3.1. Basic Recommendations for Submitters of the v5010 270

2.3.1.1. When Name Suffix is Stored Separately

When the submitter’s system enables the capture and storage of a person’s name suffix in a separate data field, the person’s name suffix should be submitted in the NM107-1039 Name Suffix data element in Loops 2100C/2100D.

2.3.1.2. When Name Suffix is Not Stored Separately

When the person’s name suffix is stored internally as part of a person’s last name, the submitter’s system must attempt to identify and parse the last name data element to extract the name suffix such that it will be transmitted in the NM107-1039 Name Suffix data element in Loops 2100C/2100D.

When a name suffix or prefix cannot be stored separately, it should be separated from the last name by a space, a comma or a forward slash (see §2.3.2.3) when storing it.

2.3.2. Basic Requirements for Health Plans & Information Sources

2.3.2.1. Normalizing Last Name

A health plan (or information source) must:

- Normalize the last name as submitted in the v5010 270 inquiry

  And

- Normalize the last name as stored in the health plan's (or information source's) eligibility system prior to using the submitted last name and the stored last name.

To normalize the submitted and stored last name:

- Remove all of the character strings specified in §2.3.2.2 when they are preceded by one of the punctuation values specified in §2.3.2.3 and followed by a space or when they are preceded by one of the punctuation values specified in §2.3.2.3 and are at the end of the data element

  And

- Remove the special characters specified in §2.2.7 in the name element.

If the normalized last name is successfully matched or validated, the health plan (or information source) must return the complete v5010 271 as required in §1 of this rule.
If the normalized last name is not successfully matched or validated, the health plan (or information source) must return a v5010 271 response with a AAA segment using the appropriate error code as specified in §3 of this rule regarding errors in Subscriber/Patient Identifiers and Names.

2.3.2.2. Character Strings to be Removed During Name Normalization

The following character strings represent the complete set of character strings to be removed when normalizing a last name as specified in §2.3.3. Any other character strings not included in this section are not covered by this rule. This requirement is in addition to other requirements specified §3 of this rule regarding errors in Subscriber/Patient Identifiers & Names.

- JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

2.3.2.3. Punctuation Values Used as Delimiters in Last Name

The following punctuation values represent the recommended set of punctuation values to be used to delimit (separate) a last name from a name suffix or prefix when a name suffix, prefix or a title cannot be stored separately in internal systems.

- space, comma, forward slash

2.3.3. Required Response for Name Validation

If the name validation is successful, the health plan must return the complete v5010 271 as required by §1 of this rule.
If the un-normalized stored last name does not match the un-normalized submitted last name, the v5010 271 must include:

- The last name as stored prior to normalization in the health plan's (or information source's) eligibility system in the NM103-1035 Last Name data element in either Loop 2100C or Loop 2100D as appropriate

  And

- The INS segment with the appropriate codes as specified in Table 2.3.3 Last Name Validation 271 INS Segment Reporting Requirements below.

Table 2.3.3 Last Name Validation v5010 271 INS Segment Reporting Requirements

Validation Results	Patient is Subscriber	Patient is Dependent	INS Segment Returned	Code	NM1 Segment Returned
Valid Last Name	Yes	No	2100C	INS03 = 001 Change INS04 = 25 Change in Identifying Data elements	NM103 = Last Name of Subscriber As Stored in Health Plan's Eligibility System
Valid Last Name	No	Yes	2100D	INS03 = 001 Change INS04 = 25 Change in Identifying Data elements	NM103 = Last Name of Patient As Stored in Health Plan's Eligibility System

If the name validation fails, the appropriate AAA error code and other data elements as required by §3.3.5 of the AAA Error Codes Reporting Rule regarding errors in Subscriber/Patient Identifiers & Names rule must be returned.

2.3.4. Basic Requirements for Receivers of the v5010 271

The receiver of a v5010 271 (defined in the context of this CORE rule as the system originating the v5010 270) is required to comply with §3.3.2 of the AAA Error Codes Reporting Rule regarding Subscriber/Patient Identifiers & Names.

3 AAA Error Code Reporting

3.1. Issue to be Addressed and Business Requirement Justification

Healthcare providers and health plans have a requirement to uniquely identify patients (aka subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for health plan benefits. At a high level, this identification requirement consists of accurately matching:

- Individuals with records and information that relate to them and to no one else; and
- Disparate records and information held in various organizations' computer systems about the same individuals.

For health plans, this identification requirement currently is met by uniquely delineating the individuals whereby each person (or a subscriber and dependents) is assigned an identifier by the health plan covering the individual, i.e., a subscriber, member or beneficiary ID. This ID is combined with other demographic data about the individual (e.g., first name, last name, date of birth, gender, etc.) and then used in healthcare transactions, such as eligibility inquiries, claims submissions, etc.
Healthcare providers obtain this unique identifier from patients, combine it with other demographic data, and then subsequently use it when conducting electronic transactions with health plans, such as insurance verification and claims submissions. The health plans (or information sources) then use this combination of ID and demographic data to attempt to uniquely locate the individual within their systems. However, oftentimes, the ID may not be valid and correct, the other demographic data submitted by the healthcare provider does not match similar demographic data held by the health plans' systems, or some of the data elements required by the health plan are missing; therefore such transactions are then rejected or denied.
The v5010 270 transaction submitted by healthcare providers may contain some or all of the four data elements in the v5010 270/271 and agreed to in the trading partner agreements. §1.4.8 and §1.4.8.1 of the v5010 270/271 TR3 define a "maximum data set that an information source may require and identifies further elements the information source may use if they are provided. §1.4.8.2 defines four alternate search options that an Information Source is required to support in addition to the Primary Search Option. If an Information Source is unable to identify a unique individual in their system (more than one individual matches the information from the Required Alternate Search Option), the Information Source is required to reject the transaction and identify in the 2100C or 2100D AAA segment the additional information from the Primary Search Option that is needed to identify a unique individual in the Information Source's system."

Research conducted by CORE Participants indicated that improved specificity and standardized use of the AAA codes would give providers better feedback to understand what information is missing or incorrect in order to obtain a valid match.

3.2. Scope

3.2.1. What the Rule Applies To

This AAA error code reporting rule applies only to certain data elements used to identify a person in loops and data segments in the v5010 270/271 TR3 as specified in §3.2.4 of this rule.
This rule defines a standard way to report errors that cause a health plan (or information source) not to be able to respond with a v5010 271 showing eligibility information for the requested patient or subscriber. The goal is to use a unique error code wherever possible for a given error condition so that the re-use of the same error code is minimized. Where this is not possible, the goal (when re-using an error code) is to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements such that the provider will be able to determine as precisely as possible what data elements are in error and take the appropriate corrective action.

3.2.2. When the Rule Applies

This AAA error code reporting rule applies only when a health plan (or information source) is processing the data elements identifying an individual in a v5010 270 received from a submitter and:

- The health plan (or information source) performs pre-query evaluation against one or more of the HIPAA-maximum required data elements[5] identifying an individual in a v5010 270 received from a submitter.

  Or

- The health plan (or information source) performs post-query evaluation against one or more of the HIPAA-maximum required data elements identifying an individual in a v5010 270 from a submitter.

In the context of this AAA error code reporting rule the following definitions will apply:

- Pre-query evaluation is the logic of one or more checks of the following done by a health plan's (or information source's) system prior to a database look-up to determine if:
  - The data elements it requires to identify an individual are present in the v5010 270

    Or

  - The data elements it requires to identify an individual satisfy formatting requirements as defined in §3.3.3.2 of this rule.

    Or

  - The date-of-birth (DOB) for either the subscriber or dependent is a valid date as defined in §3.3.3.2 of this rule.

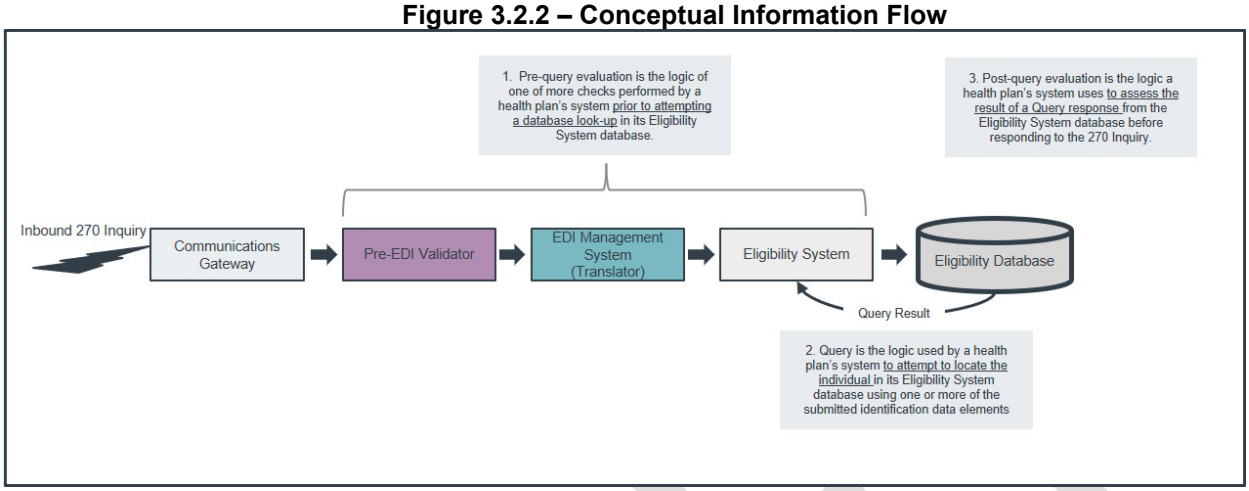
Query is the logic used by a health plan's (or information source's) system to attempt to locate the individual in its eligibility system using one or more of the submitted identification data elements.

Post-query evaluation is the logic a health plan's (or information source's) eligibility system uses to assess the results of a Query attempt before responding to the v5010 270.

[5] HIPAA-adopted v5010 270/271 TR3 §1.3.8 through §1.4.8.1 specifies the following: "If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are: Patient's Member ID, Patient's First Name, Patient's Last Name, Patient's Date of Birth. If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are: Loop 2100C Subscriber's Member ID, Loop 2100D Patient's First Name, Patient's Last Name, Patient's Date of Birth."

Figure 3.2.2 below is a graphical representation of a conceptual system information flow showing where such pre-query, query and post-query evaluations may take place. This diagram does not represent all systems but is a conceptual approach solely to illustrate these concepts.

Figure 3.2.2 – Conceptual Information Flow



3.2.3. What the Rule Does Not Require

This AAA error code reporting rule does not require a health plan (or information source):

- to use any specific search and match criteria or logic
- to use any specific combination of submitted identification data elements
- to perform a pre-query evaluation
- to perform DOB validation
- to reject the v5010 270 upon detecting an error condition addressed by this rule, but only requires the health plan to return the AAA record when the health plan does reject the v5010 270.

3.2.4. Applicable Data Elements & Loops

This rule covers the following specified data element and loops in the v5010 270/271 transactions:

Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
NM108-66 ID Code Qualifier
NM109-67 ID Code
DMG02-1251 Subscriber Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
DMG02-1251 Dependent Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code

3.2.5. Assumptions

- The v5010 270 and v5010 271 are compliant with v5010 270/271 TR3.
- The submitter of the v5010 270 knows which data elements were submitted in the v5010 270 (i.e., member identifier, first name, last name, date of birth).
- A last or first name is considered invalid only when it does not match a last or first name in the health plan's (or information source's) eligibility system.

3.2.6. Abbreviations Used in this Rule

- MID = member identifier
- FN = first name
- LN = last name
- DOB = date of birth

3.2.7. Outside the of Scope of this Rule

This rule does not specify whether or not a health plan (or information source) must use the full last or first name or may use only a portion of the last or first name when performing a Pre-Query, Query, or Post-Query process (refer to §2 for use of special characters and letter case in subscriber/patient names).

3.3. AAA Error Code Reporting Rule Requirements

3.3.1. Basic Requirements for Health Plans and Information Sources

A health plan (or information source) is required:

- To return a AAA segment for each error condition (as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table in §3.3.5) that it detects as specified in §3.3.3 – 3.3.5

And

- To return code "N" in the AAA01 Valid Request Indicator data element

And

- To return the specified Reject Reason Code in AAA03 as specified in §3.3.3 – 3.3.5 for the specific error condition described

And

- To return code "C" in the AAA04 Follow-up Action Code data element

And

- To return data elements submitted and used as specified in §3.3.5.

This may result in multiple AAA segments being returned in the v5010 271 response such as a AAA segment specifying an error in the LN data element and another AAA segment specifying an error in the MID data element in the same NM1 segment. Examples of such AAA segments include (error conditions and required error codes are specified in subsequent sections of this rule):

AAA*N73*C~**	Indicates LN missing & required or LN does not match LN in eligibility system
AAA*N73*C~**	Indicates FN missing & required or FN does not match FN in eligibility system
AAA*N72*C~**	Indicates MID missing & required or MID does not match MID in eligibility system

3.3.2. Basic Requirements for Receivers of the v5010 271

The receiver of a v5010 271 (defined in the context of this rule as the system originating the v5010 270) is required:

- To detect all combinations of error conditions from the AAA segments in the v5010 271 as defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements Table in §3.3.5

And

- To detect all data elements to which this rule applies as returned by the health plan in the v5010 271

And

- To display to the end user text that uniquely describes the specific error condition(s) and data elements returned by the health plan in the v5010 271

And

- Ensure that the actual wording of the text displayed accurately represents the AAA03 error code and the corresponding "Error Condition Description" specified in the Error Reporting Codes & Requirements Table in §3.3.3 – 3.3.5 without changing the meaning and intent of the error condition description.

The actual wording of the text displayed is at the discretion of the receiver.

3.3.3. Pre-Query Error Conditions and Reporting Requirements

Pre-query errors may occur when a health plan (or information source) performs various evaluations against the data elements in the v5010 270 used to identify an individual. There are two types of pre-query evaluations that may be performed as specified in §3.3.3.1 and §3.3.3.2.
A health plan (or information source) is not required by this rule to perform any pre-query evaluations.
When a health plan (or information source) performs a pre-query evaluation, it must return a AAA segment for each error condition detected along with the data elements submitted and used as specified in §3.3.3.1 and §3.3.3.2.

3.3.3.1. Missing & Required Data Element

This error condition may occur when a health plan (or information source) checks to determine that one or more of the data elements it requires to attempt a database look-up in its eligibility system are present in the submitted v5010 270.
When a health plan (or information source) checks for missing and required data elements and errors are found, the health plan (or information source) is required to return a v5010 271 as specified in §3.3.5 of this rule.
This rule does not require a health plan (or information source) to check for missing and required data elements.
The maximum data elements that may be required by a health plan (or information source) are specified in §1.4.8 Search Options of the v5010 270/271 TR3.

3.3.3.2. Invalid MID or DOB

An invalid MID error condition may occur when a health plan (or information source) has specific requirements for the minimum or maximum length or datatype (e.g., all numeric) of a member identifier.
This rule does not require a health plan (or information source) to validate a MID for any formatting requirements.
The MID is invalid if it does not meet either the length, formatting or data type requirements of the health plan. When a health plan (or information source) checks the format of the MID and the MID is invalid, the health plan (or information source) must return a v5010 271 as specified in §3.3.5 of this rule.
An invalid DOB error condition may occur when a health plan (or information source) validates a DOB.
This rule does not require a health plan (or information source) to validate a DOB.
A DOB is invalid when it does not represent a valid date as determined by the health plan (or information source).
When a health plan (or information source) validates a DOB and errors are found, the health plan (or information source) is required to return a v5010 271 as specified in §3.3.5 of this rule.

3.3.3.3. Pre-Query Error Reporting

When a pre-query error is detected the health plan (or information source) must

- Return a AAA segment for each error detected using the appropriate Reject Reason Code for each Pre-Query Error Condition listed in §3.3.5 of this rule

And

- Return the data elements indicated in §3.3.5 of this rule.

3.3.4. Post-Query Error Conditions and Reporting Requirements

Post-query errors may occur when a health plan (or information source) attempts a database look-up in its eligibility system and is not able to locate a unique record. The following types of post-query errors that may occur include:

- Look-up attempted, no record found
- Look-up attempted, single record found
- Look-up attempted, multiple records found

The error conditions and error codes reporting requirements tables specified in §3.3.5 of this rule are designed to apply regardless of a health plan's (or information source's) specific search and match logic. As such, the codes are applicable to any health plan's (or information source's) search and match logic. A health plan (or information source) is not required by this rule to use any specific combination of submitted individual identification data elements nor any specific search and match logic. When a health plan (or information source) detects any of the specified error conditions, it must

- Return a AAA segment for each error detected using the appropriate Reject Reason Code for each Post-Query Error Condition as specified in §3.3.5 of this rule

And

- Return the data elements as specified in §3.3.5 of this rule.

3.3.5. Error Reporting Codes & Requirements Table

The Error Reporting Codes and Requirements Table below describes each error condition and the corresponding AAA03 error code that must be used to identify the error in the v5010 271. Errors may occur in either the Subscriber Loop or the Dependent Loop or both. The error code that must be used for each defined error condition is marked with an X. The data elements submitted in the v5010 270 that must be returned if used are also specified. Multiple error conditions are possible.

Table 3.3.5: Error Reporting Codes & Requirements Table

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
Pre-Query - No Look-up Attempted Missing & Required Data											
1	Health plan (or information source) requires MID MID was not submitted in the v5010 270			X			None				

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	Health plan (or information source) does not attempt look-up										
2	Health plan requires LN LN was not submitted in the v5010 270 Health plan does not attempt look-up				X		None		X		None
3	Health plan (or information source) requires FN FN was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up				X		None		X		None
4	Health plan (or information source) requires DOB DOB was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up	X					None	X			None

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
Pre-Query – No Look-up Attempted Formatting Errors											
5	MID submitted in the v5010 270 does not satisfy health plan (or information source) formatting requirements Health plan (or information source) does not attempt look-up			X			MID submitted				
6	DOB submitted is not valid Health plan (or information source) does not attempt look-up	X					Subscriber DOB submitted	X			DOB submitted at either Subscriber or Dependent Level or both depending on which DOB is in error
Post-Query – Look-up Attempted No Record Found											
7	MID submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses MID to search			X			Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
8	LN submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses LN to search				X		Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
Post-Query – Look-up Attempted Single Record Found											
9	MID submitted in the v5010 270 in Subscriber loop does not match MID in eligibility system when health plan (or information source) uses LN to search and a single record is returned			X			Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
10	LN submitted in the v5010 270 in Subscriber or Dependent loop does not match LN in eligibility system when health plan (or information source) uses MID to search and a single record is returned				X		Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used		X		None
11	FN submitted in the v5010				X		Subscriber FN submitted		X		Dependent FN submitted

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	270 in either Subscriber or Dependent loop does not match FN in eligibility system when health plan (or information source) uses either MID or LN to search and a single record is returned						Other data elements submitted & used and any AAA error codes associated with these data elements				Other data elements submitted & used and any AAA error codes associated with these data elements
12	DOB submitted in the v5010 270 in either Subscriber or Dependent loop does not match DOB in eligibility system when health plan (or information source) uses either MID or LN to search and a single record is returned		X				Subscriber DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements			X	Dependent DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements

Error Reporting Codes & Requirements Table												
		Subscriber Loop						Dependent Loop				
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
13	LN and/or FN submitted in the v5010 270 in Dependent loop does not match LN and/or FN in eligibility system when health plan (or information source) uses MID to search and a single record is returned *Note: This may be an unlikely condition that could occur, e.g., a MID only submitted in Subscriber loop and Dependent LN submitted*								X		Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements
Post-Query Look-up Multiple Records Found												
14	Multiple records returned when only a MID submitted in the v5010 270 in Subscriber loop (MID search)					X	Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
15	Multiple records returned for LN when only LN/FN was submitted in the v5010 270				X		Subscriber LN submitted Other data elements submitted & used and any AAA				

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	in Subscriber loop (name search)						error codes associated with these data elements				
16	LN submitted in the v5010 270 in Subscriber loop does not match LN in eligibility system when only LN/MID was submitted and health plan (or information source) uses MID to search and multiple records are returned				X		Subscriber LN submitted Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
17	FN submitted in the v5010 270 in Subscriber loop does not match FN in eligibility system when only FN/ LN/MID was submitted and health plan (or information source) uses either MID or LN to search and multiple records are returned				X		Subscriber FN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				

4 Conformance Requirements

Conformance with this CORE Operating Rule can be voluntarily demonstrated and certified through successful completion of the Eligibility & Benefits CAQH Certification Test Suite with a third party CORE-authorized Testing Vendor, followed by the entity's successful application for a CORE Certification Seal.

A CORE Certification Seal demonstrates that an entity has successfully tested for conformity with all the CORE Eligibility & Benefits Operating Rules, and the entity or its product has fulfilled all relevant conformance.