

# 270/271 HIPAA Transaction Abbreviated Companion Guide

Batch & Real Time

270 Health Care Eligibility Benefit Inquiry  
(ASC X12N 5010X279A1)

271 Health Care Eligibility Benefit Response  
(ASC X12N 5010X279A1)



## DISCLOSURE STATEMENT

While every effort has been made to ensure the accuracy and completeness of this information, Magellan Health does not warrant the accuracy or completeness of any of this information. Magellan Health assumes no legal liability or responsibility whatsoever for the accuracy or completeness of any such information contained in this guide.

This guide is intended to facilitate the implementation of HIPAA-required transactions between trading partners. If changes are required in this document, they will be made in a timely manner. The parties using these materials are responsible for ensuring that they obtain and use the most current version of this guide. Magellan Health will make reasonable efforts to communicate changes to direct trading partners.

The information contained in this Abbreviated Companion Guide does not contradict requirements defined in the ASC X12N HIPAA Implementation Guides.

## PREFACE

The Health Insurance Portability and Accountability Act (HIPAA) requires health insurance payers and covered entities in the United States to comply with the EDI standards for health care as defined in the ASC X12N Implementation Guides.

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Magellan Health.

Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA.

The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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## INTRODUCTION

### SCOPE

Covered entities (payers, health care providers, health plans and clearinghouses) must comply with the ASC X12N 270/271 (005010X279A1) for submission of eligibility and benefit inquiries to Magellan Health. The companion guide defines business rules for 270/271 data content, response times, connectivity, and system availability.

### OVERVIEW

The Companion Guide provides Magellan Health trading partners with guidelines for the 5010 version of 270 Health Care Eligibility Benefit Inquiry and Response. The Magellan Health Companion Guide documents any assumptions, conventions, or data issues that may be specific to Magellan Health business processes. As such, this Companion Guide is unique to Magellan Health and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Magellan Health. This document provides information on Magellan Health- specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at <http://store.x12.org>.

### REFERENCES

The ASC X12N 270/271 (version 005010X279A1) guide for Health Care Eligibility Benefit Inquiry and Response has been established as the standard for eligibility transactions and is available at <http://store.x12.org/store>.

Magellan Health Portal containing documentation on transactions for providers is located at [www.edi.magellanprovider.com](http://www.edi.magellanprovider.com), under Provider Resources tab.

## GENERAL EDI TERMINOLOGY

**Accumulated Amount** – The amount that the member has paid/used on deductible, out-of-pocket and benefit limits.

**Addenda** – Refers to a version of the HIPAA mandated transaction sets that corrects identified implementation issues noted in the original TR3.

**Data Segment** – Corresponds to a record in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12N). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

**Data Element** – Corresponds to a field in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length, and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal, and binary elements. Data element types are defined in Appendices B of the TR3.

**Delimiter** – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

**DOB** – An acronym for Date of Birth.

**DOS** – An acronym for Date of Service.

**EDI** – An acronym for Electronic Data Interchange.

**Electronic Data Interchange** – The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used to do EDI. They are an EDI file, a trading partner, an application file/form, translator (mapper), communications and value-added network or value-added service provider.

**Interface** – The point at which two systems connect to pass data.

**Loops** – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

**Out-of-pocket** – Patient liability.

**Routing** – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

**Static Amount** – The beginning amount for deductible, out-of-pocket and benefit limitations.

**Technical Reports Type 3 (TR3s)** – Documents that provide standardized data

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requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA TR3s on their web site: [www.wpc-edi.com](http://www.wpc-edi.com).

**Trading Partners** – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

**Translation Software** – Commercial computer software, which with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance checks standard format files and automatically creates interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

**Transaction Set** – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.

**X12N** – An Accredited Standards Committee commissioned by the American National Standards Institute to develop standards for Electronic Data Interchange. While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

## GETTING STARTED

### WORKING WITH MAGELLAN HEALTH

For technical questions or help related to 270/271 transactions, please contact:

Magellan Health EDI Support Team

E-mail: [edisupport@magellanhealth.com](mailto:edisupport@magellanhealth.com)

Magellan Health supports the 270 ASC X12N version 005010X279A1 for eligibility and benefit inquiries and responses. Providers wishing to receive the 271 must support this version.

Magellan Health supports both Real Time and Batch transactions for the 270/271. Real Time 270s have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed). Typical turnaround time is under 20 seconds during which the portal connection is held open.

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Batch 270s also have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed). Batch 270s can take up to 8 hours to process a response. A single 271 is created for each 270 submitted.

### TRADING PARTNER REGISTRATION

Registration for submitting files directly to Magellan Health is done in the provider testing portal at [www.edi.magellanprovider.com](http://www.edi.magellanprovider.com). Providers utilizing a clearinghouse are not required to test directly with Magellan.

## TESTING WITH MAGELLAN HEALTH

### BATCH

Magellan Health recommends that Trading Partners submit 10- 15 patients per 270 batch file and receive the associated 271 response for at least two separate files to obtain approval from Magellan Health to promote to Production. ***\*\*Active patient data must be used\*\****

### REALTIME

Providers must coordinate with Magellan Health for testing timeframes and to ensure that the necessary patient test data is available.

### CERTIFICATION AND TESTING OVERVIEW

Certification and testing for trading partners submitting directly will be done via Magellan's testing portal at [www.edi.magellanprovider.com](http://www.edi.magellanprovider.com).

Trading Partner will choose what transaction(s) will be traded with Magellan. Trading Partners will complete an EDI survey. This will allow Magellan to assess the trading partner's ability to transmit directly to Magellan.

### CERTIFICATION FOR PRODUCTION TRANSMISSION

Once the trading partner has successfully completed the testing process, the Magellan EDI Testing Specialist will give instructions on submitting production transactions.

# CONNECTIVITY WITH THE PAYER

## TRANSMISSION ADMINISTRATIVE PROCEDURES

### SCHEDULE

Test files can be submitted for review using the client's Test FTP account, or the EDI Portal.

### SYSTEM AVAILABILITY

The Magellan system is generally available 24 hours a day, 7 days a week. On occasion, there may be periods of downtime for maintenance.

### STRUCTURE REQUIREMENTS

- Real time 270 requests are limited to one inquiry, per patient, per transaction.
- Batch 270 requests are limited to 99 inquiries per file.
- Only one interchange and one functional group allowed per file.

### PUSHING/PULLING OF FILES

Magellan will work directly with each Trading Partner to determine the protocol for transmission and retrieval of file.

### RESPONSE TIMES

- A response to the real time inquiry will be provided within 20 seconds.
- A response to the batch inquiry will be provided within 8 hours after submission pending no system downtime.

## PASSWORDS

### PGP ENCRYPTION

- PGP encryption will be used for all files being transmitted.
- Keys will be shared with Trading Partner.
- Separate PGP key pairs for Test and Production.

### SFTP

Separate SFTP logon IDs and passwords for Test and Production will be issued. Trading Partner will be required to provide Magellan with IP Address. Magellan requires a unique file name to be used for each file to indicate sender, receiver, transaction type, transaction version, and date- time stamp.



## CONTACT INFORMATION

### EDI CUSTOMER SERVICE & TECHNICAL ASSISTANCE

Providers and their business associates can receive assistance by contacting Magellan Health EDI Support Team at [edisupport@magellanhealth.com](mailto:edisupport@magellanhealth.com). The support team can assist providers and vendors with EDI-related issues; that is, issues that appear to be related directly to the EDI transmission process (including front-end rejections, missing EDI files, etc.)

Magellan Health requests that trading partners, vendors and clearinghouses provide the following information for the most efficient service:

- Provider Name & TIN of the provider on whose behalf the transaction was submitted.
- Detailed description of the issue, including the error message.
- For claims, example of claim in question with the following information on the claim(s):
  - a. Name
  - b. Member ID
  - c. Date of service
  - d. Amount of Claim
- For payments, example of issue providing the following:
  - a. Payee TIN
  - b. Payment date
  - c. Payment amount
  - d. Check number
- For eligibility, claim status, and other requests, the time when the request was sent and the result.
- A contact telephone number should the EDI support staff need more information.

### PROVIDER SERVICE NUMBER

For issues not directly related to EDI, the provider can contact the Provider Support Team.

**Phone: 800-450-7281**

## CONTROL SEGMENTS/ENVELOPES

Magellan requests you provide your Sender ID and qualifier information at your earliest convenience. Magellan's Payer ID is **01260**.

### CONTROL NUMBERS

ISA (ISA13) and GS (GS06) control number must be unique across all files sent. These are numeric fields. No leading zeroes beyond the minimum field length are acceptable. Other than leading zeros, the GS Control number is usually equal to the ISA control number.

Each ST transaction set control (ST02) must be unique within the GS/GE functional group.

### ISA-IEA

This section describes the use of the Interchange Control segments, ISA and IEA. These segments mark the beginning and ending of an interchange. The ISA segment has a fixed length and all the elements within this segment must be populated.

This segment includes a description of the expected sender and receiver codes and delimiters.

ISA07 = ZZ  
ISA08 = 01260  
ISA15 = "T" for test files  
ISA15 = "P" for production files.

### GS-GE

This section describes Magellan Health's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

This is a description concerning how Magellan Health expects functional groups to be sent and how Magellan Health will send functional groups. These discussions will describe how similar transaction sets will be packaged and Magellan Health's use of functional group control numbers.

GS group control number (GS06) must be unique across all files sent (This is a numeric field. Other than leading zeros, the GS Control number is usually equal to the ISA control number).

GS03 = 01260

### ST-SE

This section indicates the beginning and the ending of a transaction set and provides the count of the transmitted segments including the beginning (ST) and ending (SE) segments.

These segments also provide a Transaction Set Control Number which must be identical in each segment.

Each ST transaction set control (ST02) must be unique within the GS/GE functional group.

# MAGELLAN HEALTH BUSINESS RULES AND LIMITATIONS

## 270 REQUESTS

The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent indicating to the user, if possible, what criteria needs to be supplied to find a match.

If the necessary data elements are not sent in to satisfy one of the scenarios a 271 AAA error will be returned and a subsequent 270 request with the required additional data elements will be sent.

Magellan complies with the X12 Technical Report Type 3 guide rules regarding use of the AAA segments for errors and rejections of benefit inquiries.

## 271 RESPONSES

Magellan's 271 responses do not contain a complete list of all member benefits.

# ACKNOWLEDGEMENTS AND/OR REPORTS

## REPORT INVENTORY

270 Eligibility Requests submitted to Magellan must be HIPAA compliant.

Upon request Magellan will issue a 999 Acknowledgement for Health Care Insurance (005010X231) when a 270 is validated for batch submissions.

Magellan will issue a 271 Response Transactions for Health Care Insurance (005010X279A1) when a 270 is validated for real-time submissions.

## TRANSACTION SPECIFIC INFORMATION

A Transaction Loop is a group of related segments. Magellan specific values are required for the elements which comprise the segments for the 270 Transaction Loops. The following section identifies these loops, their segments, and their required element values:

- Loop 2100A – Information Source
- Loop 2100B – Information Receiver
- Loop 2100C – Subscriber Information
- Loop 2110C – Subscriber Benefit or Eligibility Information
- Loop 2120C – Subscriber Benefit Related Entity Information
- Loop 2100D – Dependent Information
- Loop 2110D – Dependent Benefit or Eligibility Information
- Loop 2120D – Dependent Benefit Related Entity Information

### 270 ELIGIBILITY, COVERAGE INQUIRY

#### LOOP 2100A (270) – INFORMATION SOURCE

Loop ID	Reference	Name	Codes	Notes/ Comments
2100A	NM101	Entity Identifier Code	PR	Payer
2100A	NM102	Entity Type Qualifier	2	
2100A	NM103	Name Last or Organization Name	HP Name	Magellan Health
2100A	NM108	Identification Code Qualifier	PI	PI: Payor Identifier
2100A	NM109	Identification Code	1260	Payor ID Number

#### LOOP 2100B (270) – INFORMATION RECEIVER

Loop ID	Reference	Name	Codes	Notes/ Comments
2100B	NM101	Entity Identifier Code	1P	Provider
2100B	NM108	Identification Code Qualifier	FI SV XX	FI: Federal Taxpayer ID SV: Service Provider Number XX: NPI
2100B	NM109	Identification Code		ID Code

#### LOOP 2100C (270) – SUBSCRIBER INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2100C	NM101	Entity Identifier Code	IL	IL: Insured or Subscriber
2100C	NM102	Entity Type Qualifier	1	1:Person
2100C	NM108	Identification Code Qualifier	MI	Member Identification Code
2100C	NM109	Subscriber Identification Code		Unique Member Identifier or SSN

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Loop ID	Reference	Name	Codes	Notes/ Comments
2100C	DMG01	Date Time Period Format Qualifier	D8	D8: Date Format: CCYYMMDD
2100C	DMG02	Subscriber Birth Date		Date Format: CCYYMMDD
2100C	HI	Subscriber Healthcare Diagnosis Code		Required when limits are being requested on the 271 responses. Otherwise not required.

### LOOP 2110C (270) – SUBSCRIBER ELIGIBILITY & BENEFIT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2110C	EQ			Magellan supports only one occurrences of the EQ segment per transaction.
2110C	EQ01	Service Type Code	MH 30	MH – Mental Health 30 – Medical

### LOOP 2100D (270) - DEPENDENT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2010AA	NM102	Entity Type Qualifier	1 2	1: Person 2: Non – Person Entity
2010AA	NM103	Name Last		Magellan processes all alpha characters, dashes, or spaces. No other special characters are allowed.
2010AA	NM104	Name First		If NM102 = '2' then this element should be blank.
2010AA	NM108	Identification Code Qualifier	XX	XX: National Provider Identifier
2010AA	NM109	Identification Code		Provider's HIPAA National Provider Identifier (NPI) Number required by Magellan.
2010AA	N301	Address Information		Required by Magellan. Must be Physical Address, PO Box or Lock Box not
2010AA	N401	City Name		Required by Magellan.
2010AA	N402	State or Province Code		Required by Magellan.
2010AA	N403	Postal Code		Required by Magellan.
2010AA	REF01	Reference Identification Qualifier	EI	EI: Employer's Identification Number
2010AA	REF02	Reference Identification		Employer's Identification Number is required by Magellan.

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### LOOP 2100D (270) – DEPENDENT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2110D	EQ			Magellan supports only one occurrences of the EQ segment per transaction.
2110D	EQ01	Service Type Code	MH 30	MH – Mental Health 30 – Medical (MCC – Magellan Complete Care)

### 271 ELIGIBILITY, COVERAGE RESPONSE

#### LOOP 2100A (271) – INFORMATION SOURCE

Loop ID	Reference	Name	Codes	Notes/ Comments
2100A	NM101	Entity Identifier Code	PR	Payer
2100A	NM102	Information Source Name	2	Non-Person Entity
2100A	NM108	Identification Code Qualifier	FI SV XX	FI: Federal Taxpayer ID SV: Service Provider Number XX: NPI

#### LOOP 2100B (271) – INFORMATION RECEIVER

Loop ID	Reference	Name	Codes	Notes/ Comments
2100B	NM109	Identification Code		Information on 270 transactions sent back on 271 transactions.

#### LOOP 2100C (271) – SUBSCRIBER INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2100C	AAA01	Response Code	Y N	Y: Valid but rejected. N: Not Valid.
2100C	AAA03	Rejection Reason Code	57 58 60 71 72 73 75 76	57: Invalid/Missing Date(s) of Service 58: Invalid/Missing Date of Birth 60: DOB Follows DOS 71: DOB Does Not Match 72: Invalid/Missing ID 73: Invalid/Missing Name 75: Subscriber/Insured Not Found 76: Duplicate Subscriber/Insured ID
2100C	AAA04	Follow-Up Action Code	C	C: Please correct and resubmit.
2100C	INS01	Subscriber Relationship Response Code	Y N	Y: Yes N: No
2100C	INS02	Relationship Code	18	18: Self

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Loop ID	Reference	Name	Codes	Notes/Comments
2100C	INS03	Type Code	001	001: Change indicates a correction in the data sent has been returned.
2100C	INS04	Maintenance Reason Code	25	25: Change in Identifying Data Elements.

### LOOP 2110C (271) – SUBSCRIBER ELIGIBILITY & BENEFIT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2110C	EB01	Eligibility or Benefit Information	1 5 6 A B C F G H I L N R	1: Active Coverage 5: Active – Pending Investigation 6: Inactive A: Co-Insurance B: Co-Payment C: Deductible F: Limitations G: Out of Pocket (Stop Loss) H: Unlimited I: Non-Covered L: Primary Care Provider N: Services Restricted to Following Provider R: Other or Additional Payer
2110C	EB03	Service Type Code		Returned from 270
2110C	EB05	Plan Coverage Description		Plan Description
2110C	EB07	Monetary Amount		Qualifier based on EB01. EB01 = A, B, C, G
2110C	REF01	Reference Identification Qualifier	18 6P	18 – Plan Number 6P – Group Number
2110C	REF02	Reference ID		Plan Identifier
2110C	REF03	Description		Description of the Plan
2110C	DTP01	Date/Time Qualifier	356 357	356 – Eligibility Begin Date 357 – Eligibility End Date
2110C	DTP03	Date Time Period		Dates associated with DTP01 qualifier

### LOOP 2100D (271) - DEPENDENT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2100D	AAA01	Response Code	Y N	Y N Y: Valid but rejected. N: Not Valid.
2100D	AAA03	Rejection Reason Code	58 60 64 65 67 68	58: Invalid/Missing Date of Birth 60: DOB Follows DOS 64: Invalid/Missing Patient ID 65: Invalid/Missing Patient Name 67: Patient Not Found 68: Duplicate Patient ID

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			71 77	71: DOB does not match 77: Subscriber Found; Patient Not Found
2100D	AAA04	Follow-Up Action Code	C	C: Please correct and resubmit.
2100D	INS01	Subscriber Relationship Response Code	Y N	Y: Represents the Insured is Subscriber N: Represents the Insured is Dependent
2100D	INS02	Relationship Code	01 19 20 21 53 G8	01: Spouse 19: Child 20: Employee 21: Unknown 53: Life Partner G8: Other Relationship
2100D	INS03	Type Code	001	001: Change indicates a correction in the data sent has been returned.
2100D	INS04	Maintenance Reason Code	25	25: Change in Identifying Data Elements.

### LOOP 2110D (271) – DEPENDENT ELIGIBILITY & BENEFIT INFORMATION

Loop ID	Reference	Name	Codes	Notes/ Comments
2110D	EB01	Eligibility or Benefit Information	1 5 6 A B C F G H I L N R	1: Active Coverage 5: Active – Pending Investigation 6: Inactive A: Co-Insurance B: Co-Payment C: Deductible F: Limitations G: Out of Pocket (Stop Loss) H: Unlimited I: Non-Covered L: Primary Care Provider N: Services Restricted to Following Provider R: Other or Additional Payer
2110D	EB03	Service Type Code		Returned from 270
2110D	DTP01	Date/Time Qualifier	356 357	356 – Eligibility Begin Date 357 – Eligibility End Date
2110D	DTP03	Date Time Period		Dates associated with DTP01 qualifier



## APPENDIX

### REVISION HISTORY

Revision Number	Date	Section	Notes
1.2	10/2014	ALL	Updated format. NLC
1.3	1/2017	Transaction Specifications	Updated EQ 30 to Medical (MCC) NLL
1.4	9/2023	ALL	Update format and content. NLL
1.5	3/2025	ISA.07 Qualifier 270 Transaction Specification	Removed 33 as MGLN is not listed on NAIC. Removed MCC reference. NLL