

**THIS TRANSACTION SAMPLE IS INTENDED FOR REPRESENTATIONAL PURPOSES ONLY.**

**ONE OF THE FOLLOWING METHODS MAY BE USED TO REQUEST A TRANSACTION RESPONSE:**

- **Provider ID, Subscriber ID, Date of Service, Date of Birth, Last Name, First Name and Service Type**

```
01/11/07                               15:52:52
Status: CLOSED                          Id:379.1 Record: 1
```

```
BC/BS Rhode Island
Subscriber Eligibility v1.0
```

```
Benefit.....: Y
```

```
-----Input / Response Information-----
Provider ID                9876543210
Subscriber ID              1234567890123
(On File)                  1234567890123
Date Of Service           06/06/2006
Date Of Birth             01/01/2001
(On File)                 01/01/2001
Last Name                  office
(On File)                 OFFICE
First Name                 model
(On File)                 MODEL
Service Type               30
-----Transaction Information-----
Submit ID                  123456789012345678901234
Creation Date              06/06/2006
Creation Time              15:06:00
Benefit Ind                Y
-----Information Source-----
Primary ID                 00370
Name                       BCBS Rhode Island
-----Information Receiver-----
Primary ID                 9876543210
-----Subscriber-----
Trace 1                    123456789012345678901234
                              9MEDIFAX
Primary ID                 1234567890123
Last Name                  OFFICE
First Name                 MODEL
```

Date Of Birth 01/01/2001  
 Gender Male  
 123 OAK AVE  
 S ANYTOWN  
 NY  
 12345  
 Change N  
 -----Subscriber Date-----  
 Elig: 12/07/2006  
 -----Eligibility/Benefit-----  
 Actv Cvg  
 Family  
 Health Bene Plan Cvg  
 Other  
 Plan Cvg HC2C CO OPTNS  
 -----Eligibility/Benefit-----  
 Inactv  
 Dntl Care  
 Other  
 -----Eligibility/Benefit-----  
 Unlim  
 Hosp - IP  
 -----Eligibility/Benefit-----  
 Unlim  
 PC - IP  
 -----Eligibility/Benefit-----  
 Unlim  
 SA  
 -----Eligibility/Benefit-----  
 Ded  
 Individual  
 Hosp  
 Time Period Cal Yr  
 Amount \$2,000.00  
 In Network Yes  
 Deductible may not apply to some  
 services. Call BCBSRI Customer Service  
 at 1-234-456-7890  
 -----Eligibility/Benefit-----  
 Ded  
 Individual  
 Hosp  
 Time Period Cal Yr  
 Amount \$2,000.00  
 In Network No  
 -----Eligibility/Benefit-----  
 Limitations  
 Health Bene Plan Cvg  
 Age, Hi Value: 23  
 -----Eligibility/Benefit-----  
 Co-Pay  
 Hosp - Emergency Medical

Time Period	Visit
Amount	\$200.00
In Network	Yes
-----Eligibility/Benefit-----	

	Co-Pay
Professional (PHY) Visit - Office	
Time Period	Visit
Amount	\$20.00
In Network	Yes

==== Emdeon MAX Transaction Stats ====  
Query: - PASS