

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

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

- Provider ID, Social Security Number, Date of Birth, Beginning Date of Service and Ending Date of Service
- Provider ID, Social Security Number, Last Name, First Name, Beginning Date of Service and Ending Date of Service
- Provider ID, Last Name, First Name, Date of Birth, Beginning Date of Service and Ending Date of Service

08/23/06 09:57:25  
Status: CLOSED Id:4.33 Record: 33

Michigan MICHild  
Eligibility v1.1

MICHild.....: Y

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-----Input / Response Information-----
Provider ID                1234567
MI Prov Type                30
SSN                        123456789
Begin DOS                   04/01/2004
End DOS                     04/01/2004
Date Of Birth
(On File)                   01/01/1985
Last Name                   OFFICE
(On File)                   OFFICE
First Name                  MODEL
(On File)                  MODEL
-----MICHILD Information-----
MI                           R
SSN                          123-45-6789
Gender                       M
Elig Ind                     Y
-----Eligibility-----
Begin Date                   04/01/2004
End Date                     04/01/2004
County Code                  63
                             Oakland
                             MICHild Eligible
Medical Plan                 Blue Cross & Blue
                             Shield

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Medical Phone	800-543-7765
Dental Plan	Delta Dental
Dental Phone	800-482-8915

==== Emdeon MAX Transaction Stats ====  
Query: SSN/Name - PASS