

THIS TRANSACTION SAMPLE IS INTENDED FOR REPRESENTATIONAL PURPOSES ONLY.

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

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

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09/08/06                               10:39:14
Status: CLOSED                          Id:5.35 Record: 35

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Michigan
Eligibility v1.8

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Medicaid.....: Y
Other Payer....: Y
Medicare.....: Y

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-----Input / Response Information-----

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Provider ID                5171323
MI Prov Type                40
Recipient ID                12345678
(On File)                   12345678
Begin DOS                   01/29/2003
End DOS                     01/29/2003
Date Of Birth
(On File)                   06/15/1920
Last Name
(On File)                   OFFICE
First Name
(On File)                   MODEL

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-----Medicaid Information-----

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Gender                      M
Deductible                  N
Medicare HIC #              123456789A
Worker Load #               00001234

```

-----Eligibility-----

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Begin Date                  05/01/2004
End Date                    05/01/2004

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Residence County Code 41
 Kent
 DHS County Code 41
 Kent
 DHS County Office Phone 616-247-6000
 Scope-Cvg 2F
 Medicaid-Nursing Home Services
 PAMA Program M
 Medicaid for the aged.
 Case # A1234567A
 -----Level Of Care-----
 Begin Date 05/01/2004
 End Date 05/01/2004
 Level Of Care 02
 Recipient is receiving nursing home
 services.
 Provider ID 1234567
 Patient Pay \$800
 -----Dental-----
 Begin Date 05/01/2004
 End Date 05/01/2004
 Fee For Service Dental (If 21 or
 older: Emergency Dental Only)
 -----Third Party Liability-----
 Other Ins 95
 Recipient qualifies for or is enrolled
 in Medicare Part A and B and has other
 medical insurance.
 -----Third Party Liability-----
 Begin Date 03/01/2003
 End Date 12/31/2099
 Control # 1234567890
 Carrier ID 00123456
 Carrier Name AETNA US HEALTHCARE
 Contact CLAIM DEPT EMPLOYEE BENEFITS
 PO BOX 981107
 EL PASO
 TX
 799981107
 Policy # 607517 11 002
 Policyholder MODEL OFFICE
 Contract # 295050964
 Service Code 295050964
 Other Ins 01
 Aetna.
 -----Third Party Liability-----
 Begin Date 06/01/2003
 End Date 12/31/2099
 Control # 4042569015
 Carrier ID 14679010
 Carrier Name BC BS OF MI-VISION
 Contact VISION CLAIMS

600 LAFAYETTE
DETROIT
MI
48226

Policy # 12345678
Policyholder OFFICE MODEL
Contract # 123456789
Service Code 123456789
Other Ins 86

Vision Only Plans.

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