

Guide to PC-Based Transactions



Cooperative Benefit Administrators Eligibility

Subscriber v1.2
Dependent v1.2

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Overview

About the Transaction

This transaction allows you to verify a subscriber's or dependent's eligibility status and benefits for Cooperative Benefit Administrators for a single date of service.

National Provider Identifiers

In order for you to use a National Provider Identifier (NPI) as the provider ID, the following conditions must exist:

- The payer must be ready to accept NPI. Consult our payer lists at www.emdeon.com/PayerLists/payerlists.php for this payer's NPI-readiness status.
- The inquiring provider must have fulfilled all of the payer's NPI registration requirements.

Customer Support

Emdeon Customer Support

800.333.0263

customer.service@emdeon.com

Requests

Search Types

Subscriber Eligibility

ID/Date of Birth

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The **subscriber ID**.
- The subscriber's **date of birth**.
- The **service type** (optional).
- The **date of service**.

ID/Name

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The **subscriber ID**.
- The subscriber's **last name**.
- The subscriber's **first name**.
- The **service type** (optional).
- The **date of service**.

Name/Date of Birth

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The subscriber's **last name**.
- The subscriber's **first name**.
- The subscriber's **date of birth**.
- The **service type** (optional).
- The **date of service**.

Dependent Eligibility

ID/Date of Birth

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The **subscriber ID**.
- The patient's **date of birth**.
- The **service type** (optional).
- The **date of service**.

ID/Name

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The **subscriber ID**.
- The patient's **last name**.
- The patient's **first name**.
- The **service type** (optional).
- The **date of service**.

Name/Date of Birth

- The **federal tax ID** or **provider ID** of the inquiring provider.
- The patient's **last name**.
- The patient's **first name**.
- The patient's **date of birth**.
- The **service type** (optional).
- The **date of service**.

Cascade Sequence

Subscriber

1. ID/date of birth
2. ID/name
3. Name/date of birth

Dependent

1. ID/date of birth
2. ID/name
3. Name/date of birth

What is Cascading?

Cascading refers to the capability of the software to execute multiple searches automatically when a single search does not find the patient's record, or receives an error with a **Retry** status.

To enable cascading in a transaction, you must enter data for more than one search type. In this case, the software will continue to cascade until one of the following occurs:

- The patient's record is found, or a valid non-error response is received (**Closed** status)
- All available search types have been exhausted
- An error is received with an **Error** status

Input Prompts

Prompts are listed in alphabetical order.

Account

Requirement: *Optional; not sent to the payer.*

The account number you have assigned to this account, for your internal use only.

Amount

Requirement: *Optional; not sent to the payer.*

The amount applicable to this inquiry, for your internal use only.

Date of Birth

Requirement: *Required for ID/date of birth and name/date of birth searches.*

The patient's date of birth, in MMDDCCYY format.

Date of Service

Requirement: *Required.*

The date of service, in MMDDYY or MMDDCCYY format.

First Name

Requirement: *Required for ID/name and name/date of birth searches.*

The patient's first name.

Last Name

Requirement: *Required for ID/name and name/date of birth searches.*

The patient's last name.

Provider ID

Requirement: *Required.*

The inquiring provider's primary identifier. This can be the federal taxpayer's ID or the National Provider Identifier (NPI).

In order for you to use the National Provider Identifier (NPI), the payer must be ready to accept NPI. Additionally, the payer's NPI registration requirements must be fulfilled.

Service Type

Requirement: *Optional.*

The type of service relating to your request. Choose a value from the drop-down list or enter a value from "[Service Types](#)" on page 11. If you do not enter a value, service type 30 (Health Benefit Plan Coverage) will be sent.

Subscriber ID

Requirement: *Required for ID/date of birth and ID/name searches.*

The patient's subscriber ID.

Responses

About Your Responses

All of the items described in the following response explanation may not appear in every response. Payers typically return only the information that is applicable to your query.

If the payer does not return a particular piece or section of information in a specific response, the headings for that information will not print. Items will shift position to fill the vacancy.

Your username appears in the upper left corner of the response. See your product **User's Guide** for information about creating usernames.

Additional Reference Documents

More information about your response can be found in the following documents:

- **PC-Standard-Eligibility-Response-Dictionary.pdf** - gives a more detailed description of data fields returned in the standard Emdeon response.
- **Dictionary-of-Transaction-Error-Messages.pdf** – a complete dictionary of error messages.
- **Common Response Abbreviations.pdf** – common abbreviations used in the standard Emdeon response, along with their full description.

These documents are available on your installation CD, and on the Web at:

http://www.emdeon.com/support/document_library.php

Note: The above documents are in Portable Document Format (.pdf). You must have the Adobe® Acrobat® Reader to view this document. If you do not have the Reader, you can download it for free at www.adobe.com.

Status

Closed

The patient is eligible or is on file. Read the response for clarification.

Retry

The patient is ineligible or is not on file, or you entered invalid information, or Emdeon did not receive a valid standard response. Read the message in the response for clarification.

Error

A communications-related error or error of greater severity occurred. Read the message in the response for clarification.

Indicators

This information appears on the top of the report. The indicators show the following:

Benefit

Indicates the presence or type of benefit information in the response.

Y = Benefit information exists

N = No benefit information exists

P = Pending

Other Payer

Indicates the patient's Other Payer coverage.

NA = Unable to determine if Other/Additional Payer information is present in the response from the payer.

Medicare

Indicates the patient's Medicare coverage.

NA = Unable to determine if Medicare information is present in the response from the payer.

Input and Response Information

The input area shows the data you sent in the request. For some of the input fields, the response area displays what the payer actually has on file. This arrangement enables you to verify what you entered against what is on file.

Depending on your software product and report settings, response information fields can appear in one of two locations:

- They can appear in a column to the right of the input fields.
- They can appear beneath the input fields, with the heading (On File).

An asterisk to the left of an input field indicates that the mirrored response data did not match your input data.

The following response fields are displayed:

- The subscriber's Cooperative Benefit Administrators subscriber ID.
- The patient's date of birth.
- The patient's last name.
- The patient's first name.

Transaction Information

The Transaction Information section returns reference information for this particular transaction, such as:

- The Submit ID used for tracking.
- The date and time when the transaction was created.
- Benefit Indicator:

Y = Benefit information exists.
N = No benefit information exists.
P = Pending.

- Medicare Indicator:
 - NA** = Unable to determine Medicare coverage.
- Other Payer Indicator:
 - NA** = Unable to determine other payer coverage.

Information Source

Information about the payer, such as primary ID and name.

Information Source Contact

Payer contact information.

Information Receiver

Information about the requesting provider, such as primary ID and name.

Subscriber

Information about the subscriber, or the patient, when the patient is the subscriber. Includes:

- The subscriber's primary ID.
- Demographic information, such as:
 - Last, first, middle name
 - Prefix and suffix
 - Date of birth
 - Gender
 - Address
 - Student status
 - Handicap indicator
 - Birth sequence
- Whether any identifying elements for the subscriber have changed from those submitted in the request (**Change**).
- Additional identification numbers other than the primary ID.
- Eligibility or benefit dates. Dates can also appear in the Eligibility/Benefit section.

Patient

Information about the patient, when the patient is a dependent. Includes:

- The dependent's primary ID.
- Demographic information, such as:
 - Last, first, middle name
 - Prefix and suffix
 - Date of birth

Gender
Address
Student status
Handicap indicator
Birth sequence
Relationship to subscriber

- Whether any identifying elements for the dependent have changed from those submitted in the request (**Change**).
- Additional identification numbers other than the primary ID.
- Eligibility or benefit dates. Dates can also appear in the Eligibility/Benefit section.

Eligibility/Benefit

Each Eligibility/Benefit section gives details about the patient's eligibility status and other types of benefits. There can be several Eligibility/Benefit sections. Information includes:

- Eligibility Type: Identifies the type of information to which this section applies:
 - Active Coverage
 - Benefit Disclaimer
 - Cannot Process.
 - Co-Insurance
 - Deductible
 - Inactive Coverage
 - Non-Covered
- Coverage type.
- Service type (see "[Service Types](#)" on page 11).
- Applicable dollar amount or percentage.
- Insurance type (see "[Insurance Types](#)" on page 12).
- Plan coverage information.
- Benefit period.
- Benefit quantity.
- Authorization or certification required.
- In-network indicator.
- Product or service ID.
- Procedure Modifiers.
- Health care service delivery details.
- Additional identifiers.
- Benefit-specific eligibility dates.
- Limitations.
- Information used to determine eligibility.
- Benefit-related entity and entity contact information.

For a complete description of the abbreviations appearing in this section, see **Common Response Abbreviations.pdf** on your installation CD and on the Web at

http://www.emdeon.com/support/document_library.php

Error Messages

Transaction-related error messages begin with CL, HT, RH, or another alphabetic prefix, followed by a number and a line or so of text.

For a comprehensive description of all error messages, see the document **Dictionary of Transaction Error Messages**.

This document is available on your installation CD, and on the Web at:

http://www.emdeon.com/support/document_library.php

Values

Service Types

Code	Input Drop-Down Abbreviations	Response Abbreviations	Full Description
1	Medical Care	Med Care	Medical Care
30	Hlth Bene Plan Cvg	Health Bene Plan Cvg	Health Benefit Plan Coverage
33	Chiropractic	Chiropractic	Chiropractic
35	Dntl Care	Dntl Care	Dental Care
48	Hosp-IP	Hosp – IP	Hospital – Inpatient
50	Hosp-OP	Hosp – OP	Hospital – Outpatient
86	Emergency Services	Emergency Svcs	Emergency Services
88	Pharmacy	Pharm	Pharmacy
98	Prof PHY Vist-Offc	Prof PHY Vist-Office	Professional (Physician) Visit – Office
AL	Vision (Optometry)	Vision (Optometry)	Vision (Optometry)

Insurance Types

The payer can return any of the values listed below.

Value in Response	Description
Mcare 2ndary Working Aged Beneficiary or Spouse with EGHP	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
Mcare 2ndary ESRD Beneficiary in the 12 mo coordination period with an EGHP	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer group health plan
Mcare 2ndary, No-fault Ins including Auto is Primary	Medicare Secondary, No-fault Insurance including Auto is Primary
Mcare 2ndary Work Comp	Medicare Secondary Workers Compensation
Mcare 2ndary PHS or Other Federal Agency	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
Mcare 2ndary Black Lung	Medicare Secondary Black Lung
Mcare 2ndary Vets Admin	Medicare Secondary Veterans Administration
Mcare 2ndary Disabled Beneficiary Under Age 65 with LGHP	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
Mcare 2ndary, Other Liability Ins is Primary	Medicare Secondary, Other Liability Insurance is Primary
Auto Ins Pol	Auto Insurance Policy
Comm	Commercial
COBRA	Consolidated Omnibus Budget Reconciliation Act (COBRA)
Mcare Conditionally Primary	Medicare Conditionally Primary
Disability	Disability
Disability Benes	Disability Benefits
Exclusive Provider Organization	Exclusive Provider Organization
Fam or Friends	Family or Friends
Grp Pol	Group Policy
HMO	Health Maintenance Organization (HMO)
HMO – Mcare Risk	Health Maintenance Organization (HMO) – Medicare Risk
Spcl Low Income Medicare Beneficiary	Special Low Income Medicare Beneficiary
Indemnity	Indemnity
Indiv Pol	Individual Policy
LTC	Long Term Care
Long Term Pol	Long Term Policy
Life Ins	Life Insurance
Litigation	Litigation
Mcare A	Medicare Part A
Mcare B	Medicare Part B
Mcaid	Medicaid
Mgap A	Medigap Part A
Mgap B	Medigap Part B

Value in Response	Description
Mcare Primary	Medicare Primary
Other	Other
Property Ins – Personal	Property Insurance – Personal
Personal	Personal
Personal Payment (Cash - No Ins)	Personal Payment (Cash - No Insurance)
PPO	Preferred Provider Organization (PPO)
POS	Point of Service (POS)
QMB	Qualified Medicare Beneficiary
Property Ins – Real	Property Insurance – Real
Supplemental Pol	Supplemental Policy
TEFRA	Tax Equity Fiscal Responsibility Act (TEFRA)
Work Comp	Workers Compensation
Wrap Up Pol	Wrap Up Policy