Overview
This transaction allows you to verify a patient’s eligibility status and benefits for Healthfirst of New Jersey for a single date of service.

Date of Service Restrictions
If no date is entered, the date of service defaults to the current date.

To Enter Letters
1. Press the number key on which the letter appears.
2. Press <ALPHA> once, twice, or three times, until the letter appears.
3. If needed, press to delete the last character entered.
4. Special characters are on the * key. Q, Z, and the decimal point (.) are on key 1.

Other Usage Tips
- To display help information, press <F1>.
- If your terminal has been idle, you may be prompted to enter your user ID and password.
- You can assign shortcut keys (hot keys) to frequently-used payers. When you press a shortcut key from the idle prompt, your terminal will display the Transaction Type menu for the payer assigned to that key.
- To skip an optional prompt, press .
- For instructions on setting up a list of provider IDs, see your Verifone Vx570® User Guide.
- To display a list of entries for a prompt (e.g., provider IDs), press <F2>. Select your entry, then press .

<table>
<thead>
<tr>
<th>Step</th>
<th>POS Display:</th>
<th>Enter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WELCOME TO EMDEON SWIPE CARD OR PRESS ANY KEY</td>
<td>press any key.</td>
</tr>
<tr>
<td>2</td>
<td>MEDICAL ADDRESS VERIFY FINANCIAL SETUP LEARN MORE</td>
<td>press &lt;F2&gt; for Medical (go to step 3) or press an assigned shortcut key to start the payer program (go to step 4).</td>
</tr>
<tr>
<td>3</td>
<td>SELECT PAYER:</td>
<td>select HEALTHFIRST OF NJ</td>
</tr>
<tr>
<td>4</td>
<td>SELECT TRANSACTION: Eligibility Claim Status</td>
<td>Choose transaction type: Eligibility</td>
</tr>
<tr>
<td>5</td>
<td>SELECT SEARCH TYPE: ID/DOB ID/Name</td>
<td>Choose search: ID/DOB Go to step 6. Go to step 12.</td>
</tr>
<tr>
<td>6</td>
<td>Provider ID</td>
<td>inquiring provider ID (Press &lt;F2&gt; for list.)</td>
</tr>
<tr>
<td>7</td>
<td>Prov Last/Org</td>
<td>inquiring provider’s last name or organization’s name or just to skip.</td>
</tr>
</tbody>
</table>
Step: POS Display: Enter:

<table>
<thead>
<tr>
<th>Step</th>
<th>POS Display</th>
<th>Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Prov First</td>
<td>inquiring provider’s first name or just if the provider is an organization.</td>
</tr>
<tr>
<td>9</td>
<td>Subscriber ID</td>
<td>subscriber ID</td>
</tr>
<tr>
<td>10</td>
<td>Date of Service</td>
<td>date of service (mmddyy or mmddyyyy) or just for today’s date.</td>
</tr>
<tr>
<td>11</td>
<td>Date of Birth</td>
<td>patient’s date of birth (mmddyyyy)</td>
</tr>
<tr>
<td>12</td>
<td>Provider ID</td>
<td>inquiring provider ID (Press &lt;F2&gt; for list.)</td>
</tr>
<tr>
<td>13</td>
<td>Prov Last/Org</td>
<td>inquiring provider’s last name or organization’s name or just to skip.</td>
</tr>
<tr>
<td>14</td>
<td>Prov First</td>
<td>inquiring provider’s first name or just if the provider is an organization.</td>
</tr>
<tr>
<td>15</td>
<td>Subscriber ID</td>
<td>subscriber ID</td>
</tr>
<tr>
<td>16</td>
<td>Last Name</td>
<td>patient’s last name</td>
</tr>
<tr>
<td>17</td>
<td>First Name</td>
<td>patient’s first name</td>
</tr>
</tbody>
</table>

**Response**

The following section describes each section of information that your payer can return. Individual responses can vary in content. For a detailed dictionary of response data, see the POS v5 Standard Eligibility Response Dictionary. To reprint the last response, press <Scroll Line ↑> (the key on the top far right of the keypad).

**Input Information**

The information you entered in your request.

**Healthfirst of NJ Information**

Basic information about the transaction, such as:

- The Submit ID used for tracking
- The date and time the transaction was created (generated) by the payer/fiscal intermediary.
- Benefit Indicator:
  - Y = Benefit information exists
  - N = No benefit information exists
  - P = Pending
  - Q = QMB
  - S = Spenddown
- Medicare Indicator:
  - A = Patient has Medicare Part A coverage
  - B = Patient has Medicare Part B coverage
  - A&B = Patient has Medicare Parts A and B coverage
  - NA = Unable to determine Medicare coverage
- Other Payer Indicator:
  - Y = Patient has other payer coverage
  - 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.

**Information Receiver Provider Information**

Identifies the provider’s role or type in the eligibility/benefit being inquired about and it identifies the provider’s Taxonomy Code or specialty.

**Subscriber**

Information about the subscriber. Includes:

- The transaction audit (trace) numbers and origins
- The subscriber’s primary ID
Demographic information, such as name, date of birth, gender, and address are returned when the subscriber is the patient. Birth sequence number assigned to each family member who is born with the same birth date. Indicates whether any identifying elements for the subscriber have changed from those submitted in the request.

**Subscriber Additional ID**
Subscriber identification numbers other than the primary ID, such as the Medicare HIC number. The type of ID number is also described. This section can appear up to nine times.

**Subscriber Provider Information**
Identifies the subscriber's provider's role or type, an additional identification qualifier, and provider ID or Taxonomy Code.

**Subscriber Diagnosis Code**
The subscriber's principal diagnosis code, description, and code source and up to eight additional diagnosis codes, descriptions, and code sources.

**Subscriber Date**
A date or range of dates relating to the subscriber's eligibility/benefits. The type of date and/or time is also described. If the type of date returned in this section is **Eligibility**, **Eligibility Begin**, **Eligibility End**, **Admission**, or **Service**, it is implied that the date applies to all Eligibility/Benefit sections that follow unless there is a specific date in the Eligibility/Benefit section.

**Subscriber Military Personnel Information**
Information about the subscriber's military service, if applicable. This information is returned if the transaction is processed by the Department of Defense or CHAMPUS/TRICARE. Includes:
- The status of the subscriber's military personnel information (e.g., Current, Latest, Oldest, etc.).
- The subscriber's general employment status (e.g., Active Military, Honorably discharged, etc.).
- The subscriber's government service affiliation (e.g., Army, Air Force, Coast Guard, etc.).
- A free-form description that further identifies the subscriber's exact military unit.

The subscriber's current or most recent military rank.
The beginning date or date span of the subscriber's military service.

**Eligibility or Benefit Details**
The eligibility and benefit sections give details about the patient’s eligibility status and other types of benefits. There can be several eligibility and benefit sections. Each section header describes the eligibility status or benefit type to which the section applies. See **Eligibility/Benefit Types** for a list of possible sections.

**Note:** A row of all dashes designates the beginning of another section of data of the same eligibility/benefit type as the preceding section.

Information for each type of eligibility status or benefit section can include:
- Coverage type
- Service types¹
- Applicable dollar amount or percentage
- Insurance type²
- Plan coverage information
- Benefit period
- Benefit amount
- Benefit percent
- Benefit quantity
- Authorization or certification required
- In-network indicator
- Product or service ID
- Procedure Modifiers
- Primary diagnosis code pointer and up to three pointers corresponding to additional diagnosis codes in the order of importance to the service
- Additional product or service ID
- Benefit quantity
- Benefit frequency
- Benefit period
- Delivery frequency and time
- Additional ID types, ID numbers, and descriptions for the entity
- Up to 20 additional dates and/or times and types related to the benefit
- Messages relating to the benefit
- Additional information about the patient's injury
- The type of servicing facility
- Service limitations
- Benefit-related entity and entity contact information

¹see **Service Types**
²see **Insurance Types**
Eligibility/Benefit Types

<table>
<thead>
<tr>
<th>Eligibility Types</th>
<th>Benefit Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actv Cvg</td>
<td>Cost Containment</td>
</tr>
<tr>
<td>Actv – Full Risk Capitation</td>
<td>Rsv (Reserve)</td>
</tr>
<tr>
<td>Actv – Srvcs Capitated</td>
<td>PCP</td>
</tr>
<tr>
<td>Actv – Srvcs Capitated to PCP</td>
<td>Pre-existing Cond</td>
</tr>
<tr>
<td>Actv – Pend Investigation</td>
<td>MC Coord (Managed Care Coordinator)</td>
</tr>
<tr>
<td>Inactv</td>
<td>Svcs Restricted to Following</td>
</tr>
<tr>
<td>Inactv – Pend Elig Updte</td>
<td>Not Deemed a Med Necessity</td>
</tr>
<tr>
<td>Inactv – Pend Investigation</td>
<td>Benef Disclmr</td>
</tr>
<tr>
<td>Co-Ins</td>
<td>2nd Surg Opinion Reqd</td>
</tr>
<tr>
<td>Co-Pay</td>
<td>Other/Addl Payer</td>
</tr>
<tr>
<td>Deductible</td>
<td>Prior Year(s) History</td>
</tr>
<tr>
<td>Cvg Basis</td>
<td>Card(s) Rptd Lost/Stolen</td>
</tr>
<tr>
<td>Bene Descrip</td>
<td>Contact Following for Elig/Bene</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Cannot Process</td>
</tr>
<tr>
<td>Limitations</td>
<td>Other Sce of Data</td>
</tr>
<tr>
<td>Out of Pckt (Stop Loss)</td>
<td>Health Care Facility</td>
</tr>
<tr>
<td>Unlim</td>
<td>Spend Down</td>
</tr>
<tr>
<td>Non-Cvd</td>
<td></td>
</tr>
</tbody>
</table>

Error Messages

Transaction-related error messages begin with CL, HT, or RH, 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.