Overview
This transaction allows you to verify a subscriber’s or dependent’s eligibility status and benefits for United Healthcare Shared Services for a span of service dates.

Date of Service Restrictions
• Any date on file.
• If no date is entered, the date of service will default to the current date.

Special Considerations
• This payer permits use of the inquiring provider’s National Provider Identifier (NPI) or taxpayer ID.
• If you do not enter a Service Type, Service Type 30 – Health Benefit Plan Coverage will be sent with your request.

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 or Service Types), press <F2>. Select your entry, then press ←. For more information, see your Verifone Vx570® User Guide.

Request

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<thead>
<tr>
<th>Step</th>
<th>POS Display:</th>
<th>Enter:</th>
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<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 UNITED HEALTH SHARED SVCS</td>
</tr>
<tr>
<td>4</td>
<td>SELECT TRANSACTION: Sub Eligibility Dep Eligibility</td>
<td>Choose transaction type: Sub Eligibility Dep Eligibility</td>
</tr>
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### Step: POS Display: Enter:

<table>
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<tr>
<th>Step</th>
<th>POS Display:</th>
<th>Enter:</th>
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<tbody>
<tr>
<td>5</td>
<td><strong>SELECT SEARCH TYPE:</strong> ID/DOB ID/NAME SSN/DOB NAME/DOB</td>
<td>Choose search:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ID/DOB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ID/NAME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SSN/DOB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NAME/DOB</td>
</tr>
</tbody>
</table>

**ID – date of birth search:**

| 6    | **Provider ID** | inquiring provider ID or taxpayer ID (Press <F2> for list.) |
| 7    | **Prov Last/Org** | inquiring provider’s last name or organization’s name  |
| 8    | **Prov First** | inquiring provider’s first name or just if the provider is an organization. |
| 9    | **Subscriber ID** | subscriber ID  |
| 10   | **Begin DOS** | beginning date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 11   | **End DOS** | ending date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 12   | **Date of Birth** | date of birth (mmddyyyy)  |
| 13   | **Service Type** | Service Type or just to send Service Type 30 — Health Benefit Plan Coverage. (Press <F2> for list.) |

**ID – name search:**

| 14   | **Provider ID** | inquiring provider ID or taxpayer ID (Press <F2> for list.) |
| 15   | **Prov Last/Org** | inquiring provider’s last name or organization’s name  |
| 16   | **Prov First** | inquiring provider’s first name or just if the provider is an organization. |

**Social Security number – date of birth search:**

| 17   | **Subscriber ID** | subscriber ID  |
| 18   | **Begin DOS** | beginning date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 19   | **End DOS** | ending date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 20   | **Last Name** | last name  |
| 21   | **First Name** | first name  |
| 22   | **Service Type** | Service Type or just to send Service Type 30 — Health Benefit Plan Coverage. (Press <F2> for list.) |
| 23   | **Provider ID** | inquiring provider ID or taxpayer ID (Press <F2> for list.) |
| 24   | **Prov Last/Org** | inquiring provider’s last name or organization’s name  |
| 25   | **Prov First** | inquiring provider’s first name or just if the provider is an organization. |
| 26   | **Begin DOS** | beginning date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 27   | **End DOS** | ending date of service (mmddyy or mmddyyyy) or just for today’s date. |
| 28   | **SSN** | Social Security number, no dashes  |
| 29   | **Date of Birth** | date of birth (mmddyyyy)  |
| 30   | **Service Type** | Service Type or just to send Service Type 30 — Health Benefit Plan Coverage. (Press <F2> for list.) |
### Step: POS Display: Enter:

**Name – date of birth search:**

1. **Provider ID**
   - Inquiring provider ID or taxpayer ID (Press **<F2>** for list.)

2. **Prov Last/Org**
   - Inquiring provider’s last name or organization’s name

3. **Prov First**
   - Inquiring provider’s first name or just if the provider is an organization.

4. **Begin DOS**
   - Beginning date of service (mmddyy or mmddyyyy) or just for today’s date.

5. **End DOS**
   - Ending date of service (mmddyy or mmddyyyy) or just for today’s date.

6. **Date of Birth**
   - Date of birth (mmddyyyy)

7. **Last Name**
   - Last name

8. **First Name**
   - First name

9. **Service Type**
   - Service Type to send Service Type 30 – Health Benefit Plan Coverage. (Press **<F2>** for list.)

### United Healthcare Shared Services Information

**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.

**United Healthcare Shared Services 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 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.

**Patient**
Information about the patient, when the patient is a dependent. Includes:
- The transaction audit (trace) numbers and origins
- Demographic information, such as name, date of birth, gender, and address
- Relationship of patient to subscriber
- Birth sequence number assigned to each family member who is born with the same birth date
- Indicates whether any identifying elements for the patient have changed from those submitted in the request

**Patient 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 is returned when the patient is not the subscriber (for example, a spouse or dependent).

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

**Patient Date**
A date or range of dates relating to the patient'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.

**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 types
- Applicable dollar amount or percentage
- Insurance type
- 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>Actv Cvg</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactv</td>
<td>Limitations</td>
</tr>
<tr>
<td>Co-Ins</td>
<td>Out of Pckt (Stop Loss)</td>
</tr>
<tr>
<td>Co-Pay</td>
<td>Non-Cvd</td>
</tr>
<tr>
<td>Deductible</td>
<td>Contact Following for Elig/Bene</td>
</tr>
<tr>
<td>Bene Descrip</td>
<td>Cannot Process</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. Most messages are self-explanatory.
For a comprehensive description of all error messages, see the document Dictionary of
Transaction Error Messages.