ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (6)

RETAIL PHARMACY REIMBURSEMENT LEVELS

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

ASES
Administración de Seguros de Salud de Puerto Rico

Retail Pharmacy Reimbursement Terms

PUERTO RICO HEALTH INSURANCE ADMINISTRATION Retail Pharmacy Reimbursement Level Effective date: November 1st, 2011		
Pharmacy Type	**Ingredient Cost (AWP Discounts)**	**Dispensive Fee**
Independent:		
Brand	11%	$2.50
Bioequivalent Generics	ASES' MAC List	$2.50
Non *MAC Generics	11%	$2.50
Local Pharmacy Chains:		
Brand	11%	$2.50
Bioequivalent Generics	ASES' MAC List	$2.50
Non MAC Generics	11%	$2.50
National Pharmacy Chain:		
Brand	15%	$1.75
Generics	ASES' MAC List	$2.50
Non-MAC Generics	15%	$2.00
Diagnostic and Treatment Centers		
Brand	12%	$2.50
Generics	ASES' MAC List	$2.50
Non-MAC Generics	12%	$2.50
*MAC=Maximum Allowable Cost		Rev/06.2013

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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (7)

UNIFORM GUIDE FOR SPECIAL COVERAGE

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ASES
Administración de Seguros de Salud de Puerto Rico

Protocolo Uniforme y Mandatorio para las Condiciones Incluidas en Cubierta Especial

Inicio:

Todo médico especialista o médico primario que haya evaluado el paciente podrá realizar la solicitud de registro siempre y cuando cuente con toda la documentación requerida para la misma. La aseguradora estará obligada a realizar una determinación de aprobación o denegación de registro e informará de esta decisión mediante carta al asegurado y al médico que solicita registro. En caso de que el médico que solicita el registro no sea el médico primario del asegurado, la aseguradora enviará copia de la determinación al médico primario. La aseguradora determinará de manera final el resultado de la solicitud de registro de condición especial en un periodo de 72 horas, luego de recibir la documentación completa según requerido en este protocolo para cada condición.

Once a Provider supplies all the required information for the Contractor to process a registration and the Contractor processes such information, Special Coverage shall take effect retroactively as of the date the Provider reaches a diagnosis, including documentation of test results, for any condition included in Special Coverage. In case Information is submitted to the Contractor after the diagnosis was reached, coverage can be made retroactive up to sixty (60) Calendar Days before the date on which Provider submitted the registration request. (Contract Section 7.7.5)

Reactivación: Todo asegurado que haya perdido la elegibilidad al PSG por un periodo mayor de un año, se le requerirá una nueva certificación por parte del médico primario que evidencie el plan de tratamiento que recibe al presente para ser reactivado en la cubierta especial. Todo asegurado que pierda su elegibilidad por un periodo menor de 12 meses se volverá a registrar sin necesidad de documentos o certificaciones adicionales, a menos que para el registro específico se establezca algún otro límite.

***Asignación de Riesgo: La distribución de riesgo de la cubierta especial entre aseguradora y grupos médicos primarios está definida en la tabla siguiente. La misma puede ser modificada a solicitud de la aseguradora sujeto a previa revisión y aprobación de ASES.**

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Condición Especial	Criterios de Diagnósticos definitivos para inclusión en la cubierta	Efectividad y duración de la Cubierta Especial	Servicios incluidos en Cubierta Especial	Asignación de Riesgos*
Anemia Aplástica	I- Evaluación Hematológica: a- Contaje Absoluto de Neutrófilos <500/mm3 b- Plaquetas <20,000/mm3 c- Reticulocitos <1% d- Resultados de la aspiración y/o biopsia de Médula Ósea e- Certificación diagnóstica por Hematólogo /Oncólogo	**Efectividad** = A partir de la fecha de certificación del diagnóstico por Hematólogo/ Oncólogo o fecha de realizada la biopsia si en la lectura de esta se establece el diagnóstico definitivo. **Duración** = La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico definitivo. La cubierta especial estará vigente mientras el asegurado se mantenga elegible en el PSG	1. Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Anemia Aplástica. 2-Todo servicio médico provisto u ordenado por el Hematólogo/Oncólogo. 3-Medicamentos prescritos por el oncólogo/hematólogo y específicos para tratar la condición.	**Aseguradora –** servicios incluidos para la condición en cubierta especial o cualquier otro servicio contemplado bajo cubierta especial independientemente de esta categoría diagnóstica. GMP/PCP – recibe capitación mensual correspondiente al asegurado
Artritis Reumatoide	1-Certificacion de diagnóstico por Reumatólogo con evidencia de al menos 4 de las 7 criterios establecidos por el Colegio Americano de Reumatología; a- Entumecimiento matutino periarticular (más de una	**Efectividad** = A partir de la fecha de certificación del diagnóstico por un Reumatólogo. La evidencia de pruebas de laboratorio ESR, CRP, ANA test y radiografías pertinentes confirmando el diagnóstico, será requerida	1. Todo servicio de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Artritis Reumatoide	**Aseguradora –** servicios incluidos para la condición en cubierta especial o cualquier otro servicio contemplado bajo cubierta especial independientemente de esta categoría

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	hora de duración) por más de 6 semanas b- Hinchazón de tejidos blandos en tres o más articulaciones, por más de 6 semanas. c- Hinchazón de articulaciones en falanges proximales o metacarpo -falángicas, por más de 6 semanas. d- Artritis simétricas al menos por 6 semanas. e- Presencia de nódulos subcutáneos f- Prueba positiva de Factor reumatoide. (La aseguradora proveerá una hoja con los criterios y plan de tratamiento ser llenados por el especialista.) 2-Pruebas de laboratorios; ESR, ANA Test, CRP, RA Factor. 3- Evidencia de tratamiento con un medicamento DMARD	con la certificación de un Reumatólogo. **Duración** = mientras mantenga elegibilidad en el PSG.	1. Todo servicio médico provisto u ordenado por el reumatólogo. 2. Medicamentos prescritos por el Reumatólogo incluyendo los DMARD	diagnóstica. GMP/PCP – recibe capitación mensual correspondiente al asegurado
Autismo	1-Certificación diagnóstica de la condición por un neurólogo y siquiatra. Ambas certificaciones serán requeridas para realizar el registro. 2-Evidencia de las pruebas de M-CHAT y "Ages and Stages".	**Efectividad** = A partir de la fecha de certificación del diagnóstico por Neurólogo y Siquiatra. Se tomará la fecha de efectividad la fecha de certificación más temprana. La cubierta especial estará vigente siempre que el	1. Los servicios médicos brindados u ordenados por el siquiatra y psicólogo no requerirán referido del primario al igual que los medicamentos prescritos por el siquiatra.	Aseguradora – Todos los servicios médicos provistas por neurólogos y siquiatras incluyendo medicamentos prescritos por ellos.

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		asegurado mantenga vigente su elegibilidad al PSG hasta cumplir los 21 años de edad. Luego de los 21 años requerirá una certificación por neurólogo o siquiatra donde se establezca la necesidad de manejo y tratamiento para la condición como adulto.	Los servicios médicos brindados por el neurólogo o cualquier otro especialista recomendado para el manejo de su condición no requerirán referido del médico primario Se incluye cualquier medicamento prescrito por el neurólogo o cualquier otro especialista y específicos para tratar la condición.	**GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.
Cáncer	1-Certificacion diagnóstica con estadio, por Hematólogo/ Oncólogo, o especialista medico a cargo del manejo de la condición, con plan de tratamiento con fechas de inicio y terminación estimadas. La aseguradora proveerá un documento específico para que el especialista pueda documentar la **Certificación y Solicitud de Registro de Cáncer**. 2-Evidencia de diagnóstico en resultado de biopsia. 3-En casos donde no pueda confirmarse el diagnóstico por patología, se tomará en consideración la evidencia de	**Efectividad** = A partir de la fecha de certificación del diagnóstico por Hematólogo/ Oncólogo o fecha de realizada la biopsia si en la lectura de esta se establece el diagnóstico definitivo. **Duración** = Hasta que termine el tratamiento activo de la condición con radioterapia o quimioterapia. Todo asegurado recibirá una certificación de vigencia de registro hasta la fecha en que el asegurado cumpla con su tratamiento quirúrgico, quimioterapia y/o radioterapia. El asegurados tendrá el beneficio de cubierta para visitas a su	1. Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Cáncer. 2-Todo servicio médico provisto u ordenado por el Hematólogo/Oncólogo. 3- Medicamentos prescritos por el Oncólogo / hematólogo y específicos para tratar la condición.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.

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	estudios diagnósticos de CT, MRI, PET Scan, Sonografía, que apoyen diagnóstico o estadio.	hematólogo Oncólogo hasta un máximo de un año. Al cabo del año el Hematólogo Oncólogo realizara una solicitud de extensión de registro donde documentara el estadio de la condición y el plan de tratamiento para el próximo año. Se concederá un registro temporero hasta un máximo de 30 días para recibir la documentación en hoja de **Extensión de Registro de Cáncer**, provista por la aseguradora. De no cumplirse el proceso automáticamente el asegurado perderá su cubierta de registro. En los casos de cáncer de próstata el tratamiento con agentes de cáncer tales como Luprón, Eligard y Trelstar se considerará quimioterapia y continuarán activos en registro. Sus visitas al urólogo y las órdenes médicas y tratamiento ordenados por este especialista (Urólogo) serán cubiertas.		

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		En los casos de cáncer de mama, una vez terminado el tratamiento activo con radioterapia y quimioterapia dejarán de permanecer en el registro. Sin embargo el tratamiento con anti estrógenos (Tamoxifen) e Inhibidores de la Aromatasa (Arimidex. Aromasim y Femara) continuará siendo considerado servicio bajo la cubierta especial de cáncer.		
Cáncer de Piel Carcinoma IN SITU	- Biopsia Positiva ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15-086	**Efectividad**: Los resultados de cáncer de piel y carcinoma in situ solo se darán cubierta especial al día de la cirugía. **Duración:** el día o los días del procedimiento de remoción quirúrgica y todo servicio en ese día y cualquier otro código de radioterapia aplicada en cualquier momento.		Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.
Cáncer de Piel como Melanoma invasivo o los de Células Escamosas con Evidencia de Metástasis	- Patología o Biopsia positiva - Estudios especiales CT Scan, MRI, Sonograma - Certificación de registro llenada por dermatólogo u Oncólogo/Hematólogo	**Efectividad**: La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico. **Duración** = Hasta que termine el tratamiento activo de la condición con	1. Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Cáncer.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento.

		radioterapia o quimioterapia. Todo asegurado recibirá una certificación de vigencia de registro por un máximo de un año. Al cabo del año el Hematólogo Oncólogo realizará una solicitud de extensión de registro donde documentará el estadio de la condición y el plan de tratamiento para el próximo año. Se concederá un registro temporero hasta un máximo de 30 días para recibir la documentación en hoja de **Extensión de Registro de Cánce**r, provista por la aseguradora. De no cumplirse el proceso automáticamente el asegurado perderá su cubierta de registro.	2-Todo servicio médico provisto u ordenado por el Hematólogo/Oncólogo. 3-Medicamentos prescritos por el Oncólogo / hematólogo y específicos para tratar la condición.	**GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.
Enfermedad Renal Crónica Nivel 1 y 2	Se utiliza la razón de filtrado glomerular calculado, (GFR por sus siglas en inglés). Se requiere evidencia de resultados reciente de Creatinina en sangre, edad, sexo y raza del asegurado. **Nivel 1:** GFR mayor de 90, ICD-9-CM 585.1 **Nivel 2:** GFR mayor de 60-89, ICD-9-CM 585.2	**Nivel 1 y 2:** No se registran	**GMP/PCP**: Nivel 1 y 2 son riesgo total del GMP.	**GMP/PCP**: Nivel 1 y 2 son riesgo total del GMP.

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Nivel 3 y 4	**Nivel 3:** GFR mayor de 30-59, ICD-9-CM 585.3 **Nivel 4:** GFR mayor de 15-29, ICD-9-CM 585.4	**Nivel 3 y 4:** Requieren registro. **Duración =** mientras mantenga elegibilidad en el PSG.	**Nivel 3 y 4-** La aseguradora asume las visitas del nefrólogo (sin necesidad de referido) laboratorios renales y estudios diagnósticos ordenados por este especialista. Estudios periferovasculares para documentar el acceso de hemodiálisis y los medicamentos ordenados por el nefrólogo y relacionados a la condición y limitados a ; inmunosupresores, estimulantes de eritrocitos, Megace, antídotos renales y corticosteroides sistémicos.	**Nivel 3 y 4:** Aseguradora: Todos los servicios médicos brindados u ordenados por nefrólogo a partir de la fecha de efectividad de la cubierta. Incluyendo además: - Inserción de catéteres para diálisis - Cirugías para establecer fístulas arterio-Venosas. - Administración de agentes hematopoyéticos - Transfusiones **GMP/PCP Nivel 3 y 4;** Medico primario recibe capitación.
	Nivel 5: GFR menor de 15, ICD-9-CM 585.5 y 585.6 (ESRD)	**Duración =** mientras mantenga elegibilidad en el PSG.	**Nivel 5-**Todo tipo de servicio mientras este activo en el registro.	**Nivel 5**: Una vez se autoriza el Registro por Condición Renal Crónica el asegurado recibe una notificación por correo, indicándole los cambios en su cubierta o cambio de

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				GMP a uno de los GMP-Renales. (Centro de Diálisis). El cambio de GMP será efectivo el mes en que se efectúa la solicitud del cambio. De este momento en adelante, el GMP cesa de recibir el pago per cápita correspondiente a este asegurado. El riesgo de los servicios recibidos por el asegurado previo al cambio de GMP o registro del asegurado será a riesgo del GMP, excepto los relacionados directamente con la diálisis. Los servicios ambulatorios, no de emergencia, que se les brinde a estos asegurados en el GMP Renal tienen que coordinarse mediante referido del Nefrólogo, quien pasará a ser el médico primario de estos asegurados.

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				GMP/PCP – Nivel 5 - No recibe capitación mensual correspondiente al asegurado.
Escleroderma	1. Evidencia de resultado de ANA Test positivo > o igual a 1:80 dil 2. Resultado de biopsia de piel positiva 3. Certificación del diagnóstico por reumatólogo confirmando la condición. Para la certificación del especialista se requerirá que este establezca que el diagnóstico cumpla al menos un (1) criterio mayor ó dos (2) criterios menores (referencia el Colegio Americano de Reumatología) <u>CRITERIOS MAYORES</u>: (1) - Escleroderma proximal - Pérdida de elasticidad de la piel - Hiperpigmentación e Hipopigmentación de la piel en patrón de "sal y pimienta" (salt & pepper).	**Efectividad** = A partir de la fecha de certificación del diagnóstico por reumatólogo que establece el diagnóstico definitivo. **Duración** = mientras mantenga elegibilidad en el PSG.	1- Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Escleroderma . 2-Todo servicio médico provisto u ordenado por el reumatólogo. 3-Medicamentos prescritos por el reumatólogo y específicos para tratar la condición.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.

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	ó CRITERIOS MENORES: (2) - Esclerodactília - Pérdida de sustancia de las yemas Digitales (finger pad) - Fibrosis pulmonar en ambas bases La aseguradora o TPA diseñará una hoja para el registro de esta condición a ser llenada por el especialista que certifica la condición con los elementos requeridos para validar diagnóstico y plan de tratamiento.			
Esclerosis Múltiple y Esclerosis Lateral Amniotrofica	Criterios revisados de McDonald: El diagnóstico se confirma cuando concurren una combinación de : 1. Dos (2) episodios distintos de síntomas neurológicos verificables Por un Neurólogo. 2. Síntomas que indican daño o lesión en más de una región del Sistema Nervioso Central, MRI y laboratorios con hallazgos anormales y consistentes con MS	La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico definitivo. **Efectividad** = A partir de la fecha de certificación del diagnóstico por neurólogo que establece el diagnóstico definitivo y tratamiento. **Duración** = mientras mantenga elegibilidad en el PSG.	1- Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Esclerosis Múltiple y/o Esclerosis Lateral Amniotrofica . 2-Todo servicio médico provisto u ordenado por el neurólogo. 3-Medicamentos prescritos por el neurólogo y específicos para tratar la condición.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.

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	3. Ausencia de otra enfermedad o Condición que pueda estar causando la sintomatología o los hallazgos de laboratorio. 1. Resultado de MRI de cerebro. 2. Resultado de punción lumbar 3. Certificación del diagnóstico por neurólogo confirmando condición y tratamiento.	ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15-086		
Fibrosis Quística	1. Prueba de sudor. 2. Evidencia de tratamientos. 3. Certificación del diagnóstico por neumólogo confirmando condición.	La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico definitivo. **Efectividad** = A partir de la fecha de certificación del diagnóstico por neumólogo que establece el diagnóstico definitivo. **Duración** = mientras mantenga elegibilidad en el PSG.	Todo tipo de servicio mientras este activo en el registro.	Aseguradora – Todos los Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – No recibe capitación mensual correspondiente al asegurado.
Hemofilia – ICD-9 286-286.59	I- Evaluación de el Hematólogo: Severa: Niveles de Factor VIII <1% b- Moderada: Nivel de Factor VIII<1-5%	La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico definitivo. **Efectividad** = A partir de la fecha de certificación del diagnóstico por hematólogo	1-Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico de Hemofilia, ICD-9 286-286.59 2-Todo servicio médico provisto por el Hematólogo.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento.

	c- Leve: Nivel de Factor VIII 5-25% con manifestaciones de sangrado severo. II- Niveles de Factores de Coagulación: a- Pacientes con Hemofilia A y B severas. b- Pacientes con Hemofilia A y B severas con presencia de inhibidores. Hemofilia A y B moderadas con presencia de inhibidores 1. Resultados de niveles de coagulación. 2. Certificación del diagnóstico por hematólogo o las Clínicas de Hemofilia confirmando condición.	que establece el diagnóstico definitivo. **Duración** = mientras mantenga elegibilidad en el PSG. ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15-086	3-Medicamentos prescritos por el hematólogo específico para tratar la condición y todo factor de coagulación administrado al asegurado (Anti hemofílicos).	**GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.
Lepra – ICD-9 030-030.9	1. Evidencia de resultado de biopsia de piel 2.Cultivos positivos de infección 3. Certificación del diagnóstico por infectólogo confirmando condición.	**Efectividad** = Se inicia a partir de la fecha de certificación que establece el diagnóstico definitivo por infectólogo y termina cuando se completa el tratamiento.	1-Todo servicio médico de hospital, sala de emergencia o médico especialista, cultivos, Y biopsias de seguimiento, prestado con diagnóstico de lepra, ICD-9 030-030.9. 2-Todo servicio médico provisto por el Infectólogo.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.

			3-Medicamentos prescritos por el infectólogo	
Lupus Eritematoso Sistémico	1-Certificacion de diagnóstico por Reumatólogo con evidencia de los siguientes laboratorios; ANA Test, DS-DNA, Anti Sm y Anti Phospholipids.	**Efectividad** = A partir de la fecha de certificación del diagnóstico por reumatólogo que establece el diagnóstico definitivo. **Duración** = mientras mantenga elegibilidad en el PSG.	1- Todo servicio médico de hospital, sala de emergencia o médico especialista prestado con diagnóstico principal de Lupus Eritematoso Sistémico. 2-Todo servicio médico provisto u ordenado por el reumatólogo. 3-Medicamentos prescritos por el reumatólogo que sean dirigidos para tratar la condición de LES.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.
Niños con Necesidades Especiales de Salud.	Completar el Formulario de Registro de niños con Necesidades Especiales de Salud por parte del médico primario con evidencia de la condición médica de acuerdo a la lista de diagnósticos según en el anejo incluido por ASES en el contrato vigente titulado "**Condiciones para incluir pacientes en el Registro de Niños con necesidad Especial de salud**". La evidencia médica constará de pruebas o laboratorios pertinentes,	**Efectividad** = A partir de la fecha de certificación del diagnóstico. **Duración** = dependerá de si la condición es permanente o temporera. La manejadora de caso determinará a base del protocolo establecido por la aseguradora la duración del registro, limitado a que el asegurado no sea mayor de 21 años.	Todo tipo de servicio mientras este activo en el registro.	Referirse al listado de códigos diagnósticos de condiciones para el registro de Niños con Necesidades Especiales.

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	evidencia de tratamiento actual, certificaciones diagnosticas por médicos especialistas consultados y otros.			
Obstetricia	Hoja de registro Obstétrico Certificación del embarazo por el Obstetra Ginecólogo	**Inicio:** Una vez se registra el caso, se enviará a la asegurada por correo una certificación de la cubierta especial. **Duración:** El registro será efectivo al día estimado de concepción según certificado por el obstetra y será efectivo hasta pasados los 56 días luego de la fecha de parto, siempre y cuando esta ocurra luego de la semana 20. Si embarazo termina en un aborto antes de la semana 20 solo se concederá 30 días luego de ocurrido el mismo.	Todos los servicios médicos, cubiertos. Mientras la asegurada esté en el registro de obstetricia, los medicamentos fuera del formulario de Obstetricia deben ser pre-certificados, completando el formulario de solicitud y enviándolo al fax determinado por la aseguradora. **Esterilizaciones:** La esterilización realizada en una admisión separada, posterior al parto o cesárea, será responsabilidad del grupo médico primario, por lo que requerirán referido del médico primario **Recién nacidos:** Los niños recién nacidos tendrán cubierta mientras tengan el contrato de la madre y hasta	Aseguradora – Todos los Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – No recibe capitación mensual correspondiente al asegurado. **Recién nacido:** Se pagará el pago per cápita del recién nacido una vez la madre salga del registro o el recién nacido sea certificado por la madre, lo que ocurra primero.

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			que termine el registro de obstetricia (56 días posteriores a la fecha de parto) bajo riesgo de la aseguradora. Bajo esta premisa, la asistencia del Pediatra durante parto por cesárea o de alto riesgo y el cuidado de rutina para el recién nacido en el hospital (*nursery room*) forman parte de la cubierta especial de obstetricia.	
Tuberculosis	**Certificación del Neumólogo** con plan de tratamiento y evidencia de; 1- Resultado de Prueba de la tuberculina 2- Radiografía de tórax (infiltrados, cavidades, consolidación, nódulos linfáticos hiliares, nódulos diseminados, miliar) 3- Muestras de esputos para AFB y cultivo para M. tuberculosis o Lavado Bronquial cuando no pueden expectorar.	**Efectividad**: La Cubierta Especial comenzará desde la fecha en que se establece el diagnóstico definitivo. **Duración**: La cubierta será variable, dependiendo de la duración del tratamiento, que puede variar de entre seis (6) meses a (1) año, dependiendo del plan de tratamiento certificado por el neumólogo. Luego del primer ano si el paciente requiere continuar tratamiento se solicitara una reevaluación del caso por el neumólogo y de acuerdo al nuevo plan de tratamiento se extenderá la cubierta.	Los servicios médicos relacionados a la condición, seguimiento, complicaciones, y/o complicaciones del procedimiento diagnóstico y/o del tratamiento serán a riesgo de la Aseguradora desde la fecha de efectividad de la Cubierta Especial. Se incluirá en la misma cualquier medicamento indicado para tratar o controlar la condición especial o condiciones que puedan surgir como parte de los estudios diagnósticos realizados, o de complicaciones propias de la enfermedad.	Aseguradora - Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP** – Recibe capitación mensual correspondiente al asegurado.

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	4- Biopsias del lugar afectado, si aplica. 5- Resultado de Prueba de VIH		. Placas de pecho de seguimiento hasta completado el tratamiento es a riesgo de la aseguradora. **El Departamento de Salud cubre :** - **Tuberculina** - **Cultivos** - **Lavado Bronquial** - **Tratamiento Médico**	
VIH-SIDA	**Certificación de registro por medico primario o medico de clínica de HIV con evidencia de ;** 1- Western Blot positivo (IFA) Inmunofluorescent Assay positivo 2- Prueba de CD 4 3- Evidencia de Enfermedades Oportunistas: - Candidiasis - Cáncer del cuello uterino (invasor) - Coccidioidomicosis, criptococosis, criptosporidiosis - Enfermedad por Citomegalovirus - Encefalopatía (relacionada con el VIH)	**Efectividad:** La efectividad de la Cubierta comenzará desde la fecha en que se establece el diagnóstico definitivo. **Duración:** La cubierta especial estará vigente mientras se mantenga la elegibilidad en el PSG ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 15-086	Todo tipo de servicio mientras este activo en el registro.	Aseguradora – Todos los Servicios médicos y medicamentos según definidos en la cubierta especial en este documento. **GMP/PCP –** No recibe capitación mensual correspondiente al asegurado.

	- Herpes simple (infección grave) - Histoplasmosis - Isosporiasis - Sarcoma de Kaposi - Linfoma (ciertos tipos) - Complejo *mycobacterium avium* - Neumonía por pneumocystis carinii/jiroveci - Neumonía (recurrente) - Leucoencefalopatía multifocal progresiva (PML) - Septicemia por salmonela (recurrente) - Toxoplasmosis del cerebro - Tuberculosis - Síndrome de Emaciación			

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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (8)

COST-SHARING

ADMINISTRACION DE SEGUROS DE SALUD
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ASES
Administración de Seguros de Salud de Puerto Rico

CO-PAYS & CO-INSURANCE*							
	Federal		CHIPs	Commonwealth Population			
SERVICES	100	110	230	300	310	320	330
HOSPITAL	HOSPITAL		HOSPITAL	HOSPITAL			
Admissions	$0	$3	$0	$3	$5	$6	$20
Nursery	$0	$0	$0	$0	$0	$0	$0
EMERGENCY ROOM (ER)	EMERGENCY ROOM (ER)		EMERGENCY ROOM (ER)	EMERGENCY ROOM (ER)			
Emergency Room (ER) Visit	$0	$0	$0	$1	$5	$10	$15
Non-emergency visit to a hospital emergency room.	$3.80	$3.80	$0	$15	$15	$15	$15
Trauma	$0	$0	$0	$0	$0	$0	$0
AMBULATORY VISITS TO	AMBULATORY VISITS TO		AMBULATORY VISITS TO	AMBULATORY VISITS TO			
Primary Care Physician (PCP)	$0	$1	$0	$0	$1	$2	$2
Specialist	$0	$1	$0	$1	$1	$3	$4
Sub-Specialist	$0	$1	$0	$1	$1	$3	$5
Pre-natal services	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES	OTHER SERVICES		OTHER SERVICES	OTHER SERVICES			
High-Tech Laboratories**	$0	50¢	$0	$1	$1	$2	$3
Clinical Laboratories**	$0	50¢	$0	$1	$1	$2	$3
X-Rays**	$0	50¢	$0	$1	$1	$2	$3
Special Diagnostic Tests**	$0	$1	$0	$1	$2	$2	$6
Therapy – Physical	$0	$1	$0	$1	$2	$2	$3
Therapy – Respiratory	$0	$1	$0	$1	$2	$2	$3
Therapy – Occupational	$0	$1	$0	$1	$2	$2	$3
Vaccines	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0
DENTAL	DENTAL		DENTAL	DENTAL			
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$0	$0	$1	$2	$3
Restorative	$0	$1	$0	$0	$1	$5	$6
PHARMACY***	PHARMACY		PHARMACY	PHARMACY			
PDL Drugs Cost:							
$0 - $10.00	$1	$1	$0	$4	$4	$4	$4
$10.01 - $25.00	$2	$2	$0	$5.50	$5.50	$5.50	$5.50
$25.01 - $50..00	$3	$3	$0	$7.50	$7.50	$7.50	$7.50
>$50.01	$4	$4	$0	$10	$10	$10	$10
Non-PDL Drugs Copayment	8%	8%	$0	20%	20%	20%	20%
	Federal		CHIPs	Commonwealth Population			
SERVICES	100	110	230	300	310	320	330

* This Attachment, Cost sharing, is subject to approval by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS").

** Apply to diagnostic tests only. Copays do not applied to tests required as part of a preventive service.

***Copays apply to each drug included in the same prescription pad. Pharmacy exception (children 0- 18) does not apply to 400 ELA employees.

****Co-pays for children 0-18 years of age are not applicable for Medicaid,Commonwealth medically indigent eligible, and for children 0-18 enrolled in the CHIP Program in group ages 0-18.

Co-pays may apply to children ages over eighteen (18) as well as to adults.

As established in 42 CFR 447.53(b) the following exceptions will be applicable for federal population under code 110:

(b) *Exclusions from cost sharing.* The plan may not provide for impositions of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals for

(1) *(Children.* Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) *Pregnant women.* Services furnished to pregnant women if such services related to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine post-partum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) Institutionalized individuals. Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §435.725, §435,733, §435.832, or §436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services as defined at section 1932(b)(2) of the Act and §438.114(a).
(5) *Family planning.* Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.
(6) *American Indians.* Items and services furnished to an American Indian directly by an American Indian health care provider or through referral under contract health services.

Pharmacy Management Program

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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (9)

INFORMATION SYSTEMS

ADMINISTRACION DE SEGUROS DE SALUD
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ASES
Administración de Seguros de Salud de Puerto Rico

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PUERTO RICO GOVERNMENT HEALTH PLAN CONTRACT

ATTACHMENT 9

INFORMATION SYSTEMS

ADMINISTRACION DE SEGUROS DE SALUD
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ASES
Administración de Seguros de Salud de Puerto Rico

Enrollment Manual

June 2011

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ASES
Enrollment Manual
June 2011

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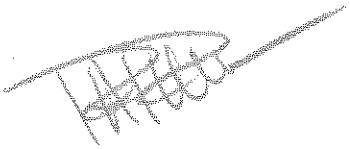
I. **Introduction** – This document is the reference manual to guide Insurance Companies and Medicare Advantage Organizations contracted by ASES in enrolling their contracted beneficiaries.

a. **Background** – Previous to January 2006 Mi Salud beneficiaries were assigned to MCO's or TPA's by region. (MCO's, TPA's and MAO's will be referred to as "carriers" in this document). Enrollment, which is the process by which the carrier sends an electronic record to ASES notifying of the subscription of a member, was done at the family level. With one record the carrier would enroll all the members of a family. At the most there could be two carriers in a region, one MCO and one TPA so conflicts were minimal. The establishment of the Medicare Platino Plans by ASES starting on January 2006 increased the complexity of identifying in the ASES database which member is covered by which organization. Once Platino was implemented the enrollment had to be done at the member level since a family could have members subscribed by different carriers. The complexity was also affected by having MAO's providing services to all the ASES regions. Therefore Platino beneficiaries had a wide choice of options which included the capacity to change carriers on a monthly basis.

b. **Basic Eligibility Concepts**



i. Eligibility for Mi Salud beneficiaries is determined by THE MEDICAID OFFICE (Programa de Asistencia Medica). Typically the beneficiaries are given eligibility for a year after which they must recertify.
ii. Those beneficiaries which do not recertify are cancelled at the eligibility expiration date. This occurs at the end of each month.
iii. Data for eligible beneficiaries is sent by THE MEDICAID OFFICE to ASES and updated in the ASES database on a daily basis.
iv. ASES sends any updates, cancellations or additions to the carriers on a daily basis.
    1. Mi Salud carriers receive data for all the members in their contracted regions.
    2. Platino carriers receive data for all their members enrolled in each contracted region.
v. Mi Salud eligible members are those which appear as eligible in the ASES database.
vi. Platino eligible members are those Mi Salud eligible members which also have Medicare A&B coverage.
    1. Medicare A&B coverage is determined by the Platino carriers by querying CMS.
    2. Platino carriers also have to query ASES to determine Mi Salud eligibility.

c. **General Enrollment Concepts** - The enrollment record (see attached) used by the carriers to notify ASES of the subscription of a member contains a series of data elements for verification of correctness and to inform ASES the particulars of the enrollment. A member can be enrolled in one of three different **Plan Types**:

   i. **01 = Mi Salud**
   ii. **02 = Platino SNP (Special Needs Plan)**
   iii. **03 = Platino MA PD (Medicare Advantage Prescription Drugs)**

   A particular carrier can offer different products under a Plan Type. These products are identified by their **Plan Version** number. ASES assigns a **Plan Version** number for each Platino product contracted. For Mi Salud enrollments the Plan Version field must equal the **coverage code** assigned to the particular beneficiaries.
   Some of the Plans contracted with ASES may require the assignment of **Primary Centers** (IPAs) and /or **PCPs** to the beneficiaries. The enrollment record includes those fields as well as the Plan Type and Version. The record also informs of the date the member was processed by the carrier and the effective date of the enrollment. (For more detail se section II.b below.)

II. Enrollment Process

a. Data Flow – The data flow for Mi Salud and Platino enrollments is similar with the principal exception of the queries that are needed in the Platino process. (see flow diagram attached)

   i. **Mi Salud** – The process starts with the receipt of the eligibility data by the carriers. Under the Auto Assign process the carriers update their database, Assign a Primary Group and PCP and issues ID Cards. These Cards are sent to the Beneficiaries by Mail. (The beneficiaries have 90 days to request a change in Primary Center or PCP.) The carrier then produces the electronic enrollment record and sends it to ASES. (The effective date of the Enrollment is the certification date of the family as received by the Carrier in the eligibility data.) These transmissions occur on a daily basis. In ASES the records are passed through an edit program. The records that pass the edits are updated to the ASES database and the beneficiaries are deemed enrolled. Those record found with error are returned to the carriers for correction. Until the records are submitted correctly the member is not enrolled in ASES and no premium payments are produced.

   ii. **Platino** – Before a Platino Plan can enroll a member it must verify Medicare coverage by querying CMS. They must also query ASES to verify if the member is eligible for Mi Salud. Once those requirements are met then the enrollment is

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submitted to ASES. In ASES the record follows the same process as described above for Mi Salud.

b. **Enrollment Record**

i. **Data Definition –** The enrollment record contains the following data elements to be complimented by the carrier:

1. RECORD_TYPE – This is always an "E" it identifies the record as an enrollment file record.

2. TRAN_ID – This is the field which identifies to the ASES system which action to take based on the data contained in the record. It can have one of several values:

   a. **E** = means that the record is a new enrollment for a member which has not been previously enrolled.

   b. **C =** Change Carrier. Used when the member has selected a different carrier than the one in which he/she is presently enrolled. It is also used for initial enrollment in Platino Plans.

   c. **P** = Changes the Plan Type. It is used when a member enrolled under a particular carrier chooses to change the product the carrier offers to one which is identified under a different Plan Type under the same carrier. Example: changing from an MA-PD Plan (Type 03) to a SNP Plan (Type 02) under the same carrier.

   d. **V** = Type Version change. It is used when a member enrolled under a particular carrier and Plan Type chooses to change the product the carrier offers to one which is identified under the same Plan Type but with a different version number under the same carrier. Example: changing from a SNP Plan (Type 02 Version 001) to a SNP Plan (Type 02 Version 002) under the same carrier. The version change value in the Tran_id is also used when a Mi Salud member changes coverage code. In this case the carrier must reissue an ID Card with the new benefits and submit a version change enrollment record to ASES where the Version number is equal to the coverage code.

   e. **I** = Ipa (Primary Center) Change. Used to record in ASES a change in the beneficiaries' selected IPA under the same carrier, Plan Type and Version.

   f. **1 = PCP1 change.** Used to record in ASES a change in the beneficiaries' selected PCP1 under the same carrier, Plan Type, Version and IPA.

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g. **2 = PCP2 change.** Used to record in ASES a change in the beneficiaries' selected PCP2 under the same carrier, Plan Type, Version and IPA.
h. **3 = PCP1 and PCP2 change.** Used to record in ASES a change in the beneficiaries' selected PCP1 and PCP2 under the same carrier, Plan Type, Version and IPA.
i. **X** = delete incorrect enrollment
j. **O** = Contract number change only
k. **D** = Disenroll. For future use.

3. PROCESS_DATE – Sign up date. Date the member contracted with the carrier. Relationship with effective date:
   a. Platino – Process date must be less than effective date.
   b. Mi Salud – process date must be equal or less than effective date.

4. REGION – Contains ASES region code. Must be the region in which the member is located in the ASES database. Platino carriers obtain this code from the ASES query response.

5. CARRIER - Two digit carrier code assigned by ASES.

6. MEMBER_PRIMARY_CENTER – Up to four digits assigned by carrier to identify their Primary centers (IPAs). Not required for some Plan Types/Versions.

7. ODSI_FAMILY_ID – Eleven digit family ID assigned by THE MEDICAID OFFICE (ODSI). This is the first part of the key for the beneficiaries in the ASES database. Platino carriers obtain this code from the ASES query response.

8. MEMBER_SSN – Social Security number of the member. It is required that this number matches with the one for the member in the ASES database.

9. MEMBER_SUFFIX – Two digit number which identifies a member within a family. Second part of the key in the ASES database.

10. EFFECTIVE_DATE – Date in which the carriers starts coverage for the member under the enrolled Plan or effective date of the change for which the enrollment

record was submitted. (For Mi Salud Enrollment the effective date id the date of certification in the MEDICAID OFFICE) . For Tran_ID's other than "E" for Mi Salud the effective date must be 1st of the month.

11. PLAN_TYPE – Plan Type code under which the member is enrolled.

12. PLAN_VERSION – Plan version under which the member is enrolled.
13. MPI – Master Patient Index. Unique number which identifies a Member in ASES and THE MEDICAID OFFICEs databases.

14. PCP1 – Fifteen digit number assigned by carriers. Use to identify the PCP1 selected by the beneficiaries.

15. PCP1_EFFECTIVE_DATE – Date in which the PCP1 assignment was effective.

16. PCP2 – Fifteen digit number assigned by carriers. Use to identify the PCP2 selected by the beneficiaries.

17. PCP2_EFFECTIVE_DATE – Date in which the PCP2 assignment was effective.

18. FAMILY_PRIMARY_CENTER – IPA assigned to all Mi Salud family members.

19. FAM_PRIMARY_CENTER_EFF_DATE – Date in which the assignment of the family IPA was effective.

20. IPA_PCP_CHANGE_REASON – Not in use.

21. MEDICARE INDICATOR – Required for Platino enrollments. (1=A&B, 3=A, 9=B)

22. HIC NUMBER – Medicare Health Insurance Claim Number. Required for Platino enrollment.

23. IPA_ESPECIAL – A "1" indicates that the member is assigned to a special IPA which is not the family IPA. Used for Mi Salud.

24. Contract Number – Contract number assigned by the carrier. It should be the number by which the member is

identified in the carriers ID card and internally in their database.

25. Special Enroll – Used to identify that the enrollment is for a newborn (N) or an emergency (E) case submitted by THE MEDICAID OFFICE or ASES. When this field is used then if the values is:
    a. N – The system allows enrollment as of the date of birth.
    b. E – The system allows enrollment as of the eligibility effective date for Federal and CHIP members (Medicaid Indicator 1 or 2).
    c. This mechanism can be utilized in cases where the **date of birth** or **certification** is on or after January 1, 2006.
26. Other data elements complimented by ASES – When the record is edited the ASES system enters the following data in the enrollment record:
    a. Reject Identifier - As a result of the edits the record could be accepted or rejected. This field contains the codes that specify that result. ("A" = Accepted; "M" = Accepted Retroactive; "R" = Rejected; "X" = Deleted)
    b. Record Key – Internal number assigned by the ASES system.
    c. Error Codes one to ten – record up to ten possible error codes.
    d. Update Date – Date to which the edit run belongs. Correspond to the date of the daily cycle the edit run was a part of.
    e. Update User – ASES internal user code.

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ii. **Uses**

1. The enrollment record can be used to trigger several actions in the ASES database. The content of the TRAN_ID field determines which action. An "E" for a Mi Salud carrier will perform the original enrollment of a member. A "C" will transfer a member from one carrier to the one submitting the enrollment or perform the original enrollment for a Platino carrier. Codes P, V, I, 1, 2, and 3 will inform the ASES system that the carrier has changed a beneficiaries Plan, Version, IPA or PCP. An "X" will delete a previously submitted record and an "O" will change a beneficiaries Contract number. In the future a "D" will produce the disenrollment of a member from its existing carrier.

iii. **Edit and update process** – Carriers can transmit enrollment files to ASES on a daily basis. They must follow the naming convention for those files which is as follows:

1. **CCYYMMDD.SUS**
1. CC = Carrier Code
2. YY = Year
3. MM = Month
4. DD = Day
5. .SUS = Identifies file as an enrollment file.

The enrollment file can contain records pertaining to any of the regions contracted by the carrier. The files received by 9:00am are entered in the ASES daily cycle. If a file is received after 9:00am it will be entered in the following day's cycle. In the cycle there are several steps which handle the enrollment records:

2. Enrollment Merge – joins the enrollment files from all carriers into a single file.

3. Enrollment Region Split – Separates the merged file into different files (one per region) based on the region code in the enrollment records. If the record sent does not have a valid region code it will go into a special error file and will not continue processing.

4. Edits - ASES run a separate edit and update cycle for each region. The enrollments are passed though the edit programs and are identified as valid or rejected.

5. Update - Valid enrollments will be used to update the beneficiaries' record in the ASES database. In this process the data in the enrollment record is entered into the beneficiaries' record. There are to types of Valid enrollments:
    a. Reject identifier = A – Identifies an accepted enrollment which is to be applied at a future effective date. The update process moves the enrollment fields (carrier, Plan, Version, Ipa and PCP) to the fields destined for new enrollments in the member's record. Until the new effective date is reached the member stays under the present enrollment condition (same carrier, Plan, Version, Ipa and PCP). At the month end cycle previous to the effective date the new field are moved to the actual fields and the enrollment becomes effective.
    b. Reject identifier = M – Indicates a retroactive enrollment. In these cases the enrollment data (carrier, Plan, Version, Ipa and PCP) is updated

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directly to the actual enrollment field in the member's record.

6. Carrier eligibility file extract – When the member's information is updated because of an enrollment being processed, a record is sent to the carrier affected in the Carrier eligibility file which is produced in every daily cycle.

c. **Carrier Responsibilities –** In order to process enrollment transactions correctly the carriers need to maintain in their particular systems the updated member eligibility data received from ASES. Such data is sent by ASES in the following files:

i. **Carrier Eligibility File (Daily & Month End)** – Produced by the ASES daily cycle. Contains all the data pertaining to the beneficiaries that have been added, updated or cancelled in the daily cycle. This includes updates caused by enrollment records being processed in that cycle. The carrier's system must identify the following situations based on the data received in these files:

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1. When a member is added.
   a. Mi Salud carriers must start the enrollment process with the member.

2. When a member changes carrier:
   a. The carrier which lost the member must identify the loss of business.

3. When any of the enrollment data changes. This includes Plan Type, Version, IPA, PCPs.
   a. The carrier system must be updated accordingly, If not this could cause the rejection of future enrollment record submissions.

4. When a Member's demographics Changes:
   a. The carrier needs to update the new data in their database.

5. When a member is cancelled:
   a. All carriers must cancel effective at the end of the month
   b. Carriers should follow up with member in case the cancellation is caused by expiration of certification.

6. When a member has a change in coverage code:
   a. Carriers must evaluate if the new coverage code requires that the member be enrolled in a different

Plan_Version and send a Version change enrollment record to ASES before the end of the month.

b. Members where the Plan_Version does not agree with the coverage code will be disenrolled in the month end cycle in ASES.
    1. Carriers must re enroll those members under the new Plan_Version that agrees with the new coverage code.

ii. **Enrollment Reject File** – Produced by the ASES daily cycle. It contains the enrollment records rejected by the validation program. The carrier must examine the rejected records and take action to correct the cause based on the error codes included. See details below about the specific error codes. The carriers system must have the capability of identifying the errors and provide the mechanisms for correction and submittal to ASES for reprocessing.

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d. **Enrollment Record Rejections**

i. **Reject Process** - Rejected enrollments are sent daily on a file which includes the error codes for the edit that failed the validation process. The carriers must correct the errors found and submit the corrected records to ASES in the next enrollment file. The file name for the reject file is:

1. **CCYYMMDD.rjc**
    a. CC = Carrier Code
    b. YY = Year
    c. MM = Month
    d. DD = Day
    e. .rjc = Identifies file as a reject file.

ii. **Error Codes** – The attached table (**Subscription Error table**) contains the error codes produced by the Validation Program. Additional descriptions and possible corrective actions have been included to assist in the correction process.

III. Premium Payment

a. **Concepts** – The new Premium Payment System works under the concept that premiums are calculated and paid for only those beneficiaries that are enrolled by the first day of the payment month. The carriers do not need to submit billing documents or files. There is one payment run per month per ASES region in which the payment for all carriers in the region is calculated.

b. **Relation to Enrollment** - Enrolled beneficiaries are those which are eligible and assigned to a particular carrier as the result of an enrollment transaction. For a particular month's run the system will consider enrolled beneficiaries in the ASES database with an enrollment date (update date in ASES) previous to the 1st day of that month. Beneficiaries enrolled after that date will be considered for payment in the next payment run after the enrollment date.

c. **Types of payment calculations** – The payment system computes several categories of payments:
   a. **Monthly payments** – For all beneficiaries enrolled at the beginning of the month for which the system is run (**Payment Month**).
   b. **Prorate Payments** – Prorate payments are calculated for Mi Salud beneficiaries that were enrolled during the previous month to the payment month. A prorated daily premium is calculated based on effective date of the enrollment.
   c. **Retroactive Payments** – Is calculated when the effective date of the enrollment is previous to the payment month. In Platino this calculation may include the previous month since no prorate is paid and because the enrollment always starts at the beginning of a month. In Mi Salud retroactive payments are always for periods two month or more before the payment month.
   d. **Retroactive prorate payments** - Retroactive prorate payments are calculated when the effective date of the enrollment falls within the first month considered for a retroactive payment
   e. **Adjustments** – Adjustments are calculated when a member changes Carrier retroactively after ASES had paid the first carrier in a previous payment run. The adjustment takes away the premium amount paid the first carrier.

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IV. SYSPREM – Enrollment in History

a. Enrollment concepts:

i. Enrollments are applied to the current eligibility data.

ii. Enrollments are allowed only in a member's current eligibility period. The **current eligibility period** is the:

1. eligibility period after a cancellation period (for a member that has been cancelled and then re-certified)
2. the current period since the initial update in ASES (as eligible) and the present time when the member has not been cancelled and remains eligible

iii. When an enrollment is not sent in time by the carrier (or a rejected record is not corrected) the eligibility data for the member will remain un-enrolled.

iv. Premiums will not be paid for un-enrolled beneficiaries when the premium payment system is run.

v. If the member is then cancelled or enrolled in a second carrier the first carrier is prevented (by the system edits) to enroll the member in a period previous to the cancellation or the enrollment.

b. SYSPREM Functionality - The SYSPREM sub-system will permit the enrollment of beneficiaries to be recorded in historic data. The main functions are:

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i. Identification of enrollment records that are candidates for processing against the history database. Rejected with error codes:

1. **107**- Effective date before current eligibility period for family
2. **108**- Effective date before current eligibility period for member
3. **280**- Family must be eligible in current eligibility period
4. **281**- Member must be eligible in current eligibility period
5. **177**- Enrolled in another carrier at or after effective date

ii. Limitations:

1. Member must be active on effective date
2. Member must not have family members with errors not acceptable by SYSPREM in the same Mi Salud enrollment batch
3. Enroll record must not have Effective Date before 01/01/2006***

iii. New Error Codes (Reject File) for **accepted** history enrollments:

1. **996** – SYSPREM record inserted in history. No action by the carrier is required.

iv. New Error Codes (Reject File) for **rejected** history enrollments:
   1. **980** - Process date in enroll record must be greater than process date of the previously enrolled Member record
   2. **981** – Member must not have family members with errors not acceptable by SYSPREM in the same enrollment batch (for Mi Salud).
   3. **982** – Enroll record must not have Effective Date before 01/01/2006***

v. Carrier Eligibility File – The daily carrier eligibility file will include the data for the members updated in history by the SYSPREM sub-system. The TRAN_ID field will contain an "H" to identify history data. The carriers must modify their systems so that the SYSPREM data is not included as actual data when processing the eligibility file.

c. Premium Payment for SYSPREM enrollments

i. Monthly Premium Payment run will include all SYSPREM records processed during the previous month.

ii. Payment will be calculated for months from the effective date of the SYSPREM enrollment up to:
   1. The month in which the member is enrolled in a different carrier
   2. The month in which the Member is cancelled
   3. Actual Billing date

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d. SYSPREM in summary:

i. SYSPREM will enroll beneficiaries in history for cases where the enrollment can not be applied to actual data.

ii. Some members will not be enrolled in history because they are:
   1. Not eligible at the effective date
   2. Enrolled in a different carrier

iii. Carriers need to evaluate cases rejected by SYSPREM in order to determine:
   1. Errors in the effective date assigned
   2. Correctness of the beneficiaries' data included in the enrollment record

V. Addendums

e. Enrollment Record Layout
f. Consistency Hierarchy Table
g. Error Code Table
h. Flow Diagrams

ENROLLMENT AND CARRIER IPA/PCP CHANGE FILE

November 1, 2007

This file is received by ASES from the insurance companies and TPO's on a daily basis. It contains data pertinent to **new enrollment** and families which have selected to **change their enrollment** to the organization producing the file. **Modified for Medicare Plans Enrollment on September 2005. Concept change form one record per family enrolled to one record per member. Modify to include special enroll field on novembre 2007** Modified on April 2013 to include Trailer record for the Migracion Project.

Member Record

Record Fields	Position	Size	Notes
RECORD_TYPE	1	1	"E" for Enrollment Record (Constant)
TRAN_ID	2	1	E=new enrollment, P=Plan Type change, C=Carrier change, V= Version change, I=IPA change, 1=PCP1 change, 2=PCP2 change, 3=PCP1 and PCP2 change, X= Delete incorrect enrollment, O=Contract Number Change only
PROCESS_DATE	3	8	MMDDYYYY - Date Enrolled in Carrier
REGION	11	1	Region code
CARRIER	12	2	Carrier code
MEMBER_PRIMARY_CENTER	14	4	IPA or PHO code
ODSI_FAMILY_ID	18	11	
MEMBER_SSN	29	9	
MEMBER_SUFFIX	38	2	
EFFECTIVE_DATE	40	8	MMDDYYYY- Card issue date for new Reforma enrollment (Trans_ID= E) or Effective date (1st day of month) for other Trans_ID's
PLAN_TYPE	48	2	See Plan Type Table
PLAN_VERSION	50	3	Used to identify version of Plan within PLAN_TYPE (if needed)
MPI	53	13	Alpha-numeric ej.-"0080012345678"
PCP1	66	15	Text
PCP1_EFFECTIVE_DATE	81	8	MMDDYYYY

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PCP2	89	15	Text
PCP2_EFFECTIVE_DATE	104	8	MMDDYYYY
FAMILY_PRIMARY_CENTER	112	4	IPA or PHO code
FAM_PRIMARY_CENTER_EFF_DATE	116	8	MMDDYYYY
IPA_PCP_CHANGE_REASON	124	2	Code Table to be supplied
MEDICARE INDICATOR	126	1	1=A&B, 3=A, 9=B
HIC NUMBER	127	12	
Reject Identifier	139	1	"A" = Accepted; "M" = MA Retroactive; "R" = Rejected; "X" = Deleted
Record Key	140	14	YYYYMMDD999999
Error Code 1	154	3	Indicates error (see error code table)
Error Code 2	157	3	Indicates error (see error code table)
Error Code 3	160	3	Indicates error (see error code table)
Error Code 4	163	3	Indicates error (see error code table)
Error Code 5	166	3	Indicates error (see error code table)
Error Code 6	169	3	Indicates error (see error code table)
Error Code 7	172	3	Indicates error (see error code table)
Error Code 8	175	3	Indicates error (see error code table)
Error Code 9	178	3	Indicates error (see error code table)
Error Code 10	181	3	Indicates error (see error code table)
Update Date	184	8	YYYYMMDD
Update User	192	8	"SYSTUPD "
IPA_ESPECIAL	200	1	1 = IPA Especial
Contract Number	201	13	Character left justified
Special Enroll	214	1	E = Emergency N = New Born
Filler	215	15	
	230		

TRAILER Record			
Record Fields	Position	Size	Notes

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RECORD_TYPE	1	7	**"TRAILER"** for Record (Constant)
FILLER	8	10	SPACES
NUMBER OF RECORDS	18	8	99999999 Numeric - right justified - zero filled
Filler	26	10	SPACES
Filler	36	3	"230" (Numeric Constant)
Filler	39	191	SPACES
	230		

*** **NUMBER OF RECORDS** FIELD CONTAINS THE SUM OF THE NUMBER OF RECORDS IN THE FILE **NOT INCLUDING THE TRAILER.**

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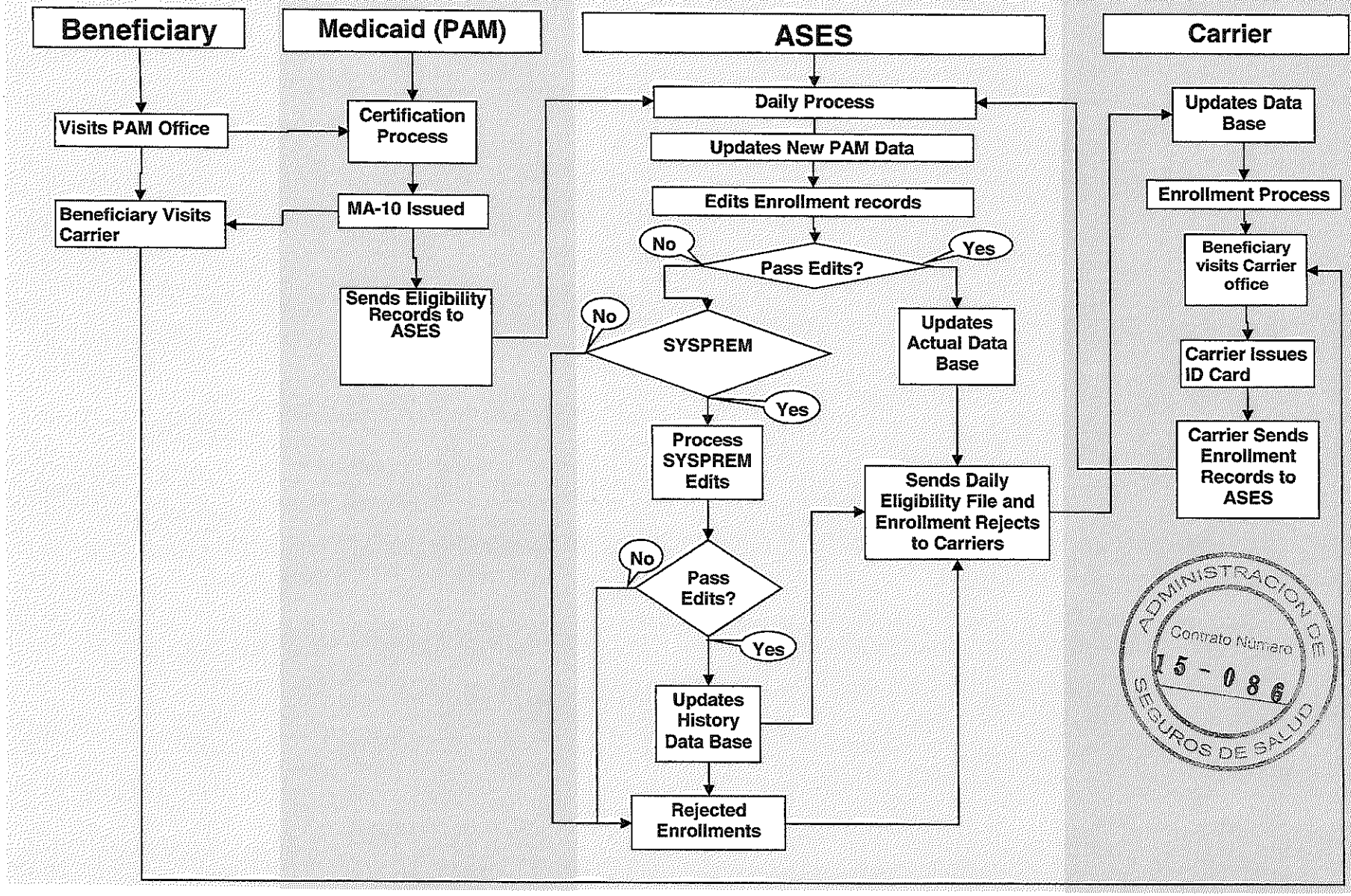
ASES
Information Flow - SYSPREM



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Carrier to ASES Data Submissions

New File Layouts

Version 2.0

October 30, 2013

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Version Changes

Version 2.0

CLAIMS Input File Layout - Removed

Removed

SERVICES Input File Layout - Removed

Removed

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CLAIMSERVICES Input File Layout - Added

New layout that combines claims and services into one file.
New fields added to the layout.

Filename Change

Filenames for all data files have been changed to change 1 digit year to 2 digit year and to remove the region from the filename.

Data Validation Change

Files will no longer be tested individual field validations. Data submitted must reconcile to control totals provided by carriers and will undergo a data audit to test for data quality issues. Monthly files that do not pass the reconciliation process and the data audit process will be rejected.

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Carrier to ASES Data Submissions
File Layouts

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NOTES

ASES new file layouts for submission by Carriers for data generated from April, 2013 forward.

CLAIMS AND SERVICES FILES –

In the previous version of the layouts, a CLAIMS file and a detailed SERVICE file were used to represent claims. In version 2.0 of the layouts, only one file exists for both the header and detail portions of the claim, now referred to as the CLAIMSERVICES file. Records in the CLAIMSERVICES file have both the header and detail portions of the claim.

In addition to the merging of CLAIMS and SERVICES, a number of changes to the claims data layout have occurred, including the transaction processing methodology and the addition of several fields. Read carefully the section below on transaction handling for claims data.

CLAIMS TRANSACTION HANDLING –

The previous method of handling claim adjustments and reversals used a transaction code to completely replace a claim with a new claim. This method has been changed in this version of the layouts to more closely match existing claims processing systems and allow for adjustments to occur on different dates. All adjustments of an adjudicated claim line are now accepted in the CLAIMSERVICES file. Do not send claims that are in an open status, such as pended claims, held, rejected, or pre-adjudicated claims. Claims reversals and adjustments happen as follows:

Paid or Denied FFS Claims

Individual service lines are adjusted at the line level with additional adjustment services marked with a claim line status code of 'A', while the original claim has a status code of 'P' for paid, 'D' for denied claims, or 'E' for encounter claims. The adjustment service may have the same claim ID and line number, may have the same claim ID and a different line number, or may be provided with a different claim ID and different line number.

Encounter Claims

Claims representing encounters have no allowed or paid amounts and are therefore not able to be adjusted monetarily. If an encounter needs to be updated to change any of the fields of the encounter, the adjusting claim must have a claim status code of 'E' and the claim ID and service line number must be the same as the encounter being adjusted. Our process will remove the original encounter so that duplicate encounters will not be counted in the data.

PROVIDER IDS –

ASES is requesting that provider NPIs are populated in the NPI field on provider records to assist in provider attribution and reporting across all Carriers. ASES will still accept the carrier's own provider id as the provider ID for medical claims, but the additional field NPI should be populated.

For pharmacy claims only

For pharmacy providers, only the NCPDP/NABP number is accepted. Carriers must include pharmacy providers in their provider files sent to ASES and the IDs must be consistent within the carriers claims. In other words, a pharmacy should have one NCPDP/NABP number and that number should as the billing provider be used for all claims from that pharmacy. When claims are validated, the Billing Provider on the claim record will be validated against the Provider file and will be matched even if the provider is unique for the carrier.

PROVIDER TELEPHONE NUMBERS –

Provider Telephone remains a required field on the Provider Input Layout. In the event, and as an exception, if the carrier does not have the actual provider's telephone number they should insert their own (Carrier's) telephone number. This also applies to the IPA Work Phone field in the same way.

Note that all telephone number fields must be filled using only numbers. No spaces or () characters should be included. For example, the telephone number (939) 123-4567 will be coded in the data field as 9391234567.

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CAPITATION AMOUNT –

The amount to be reported on capitation records must be a net amount that represents any costs associated with providing services which are not reported in claims and encounters. This may come from formal contracts with providers such as HCO/PCPs, or any other financial arrangement or allocation of costs.

The number should represent a calculation which includes the earned capitation for the period less claims paid amounts, if any, chargeable against the provider risk. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

CAPITATION ADJUSTMENTS –

There may be circumstances in which capitation payments which have already been reported, need in a later month to be adjusted or even reversed. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record for the provider / member / experience date with an amount to be added or subtracted from the previously reported amount. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date and a Capitation Amount of -$10.00. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

Note that, as Capitation net amounts for any particular record may be negative, a reversal in such a case would be a positive amount.

DATA VALIDATION PROCESS –

All files will pass through a validation process. Validation will check the basic structure of the file and its records and may result in a file being rejected. Such rejections may be caused for example, by file names which fail to follow the naming convention, a file containing wrong length records or other basic tests.

All files which are rejected will be notified to the carrier with an explanation of why the file is rejected. No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next months files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMS AND CAPITATION LAG REPORTS –

Carriers are required to submit claims and capitation payment reports, called lag reports, on a monthly basis. These reports will be used to reconcile the data submitted. Data that does not match the lag reports on paid amount within a reasonable percentage will be deemed invalid and must be corrected. The lag reports submitted by the carrier will be considered to be financially accurate and may be used for other purposes, including negotiations or other financial analyses. Therefore, it is in the carrier's best interests to produce lag reports that are either from another source that the actual files that are submitted, or to verify that the lag reports tie to financial reports.

The required claims lag reports need to be an excel file with the following characteristics:

1. Claims paid amounts by region, incurred month, paid month, and claim type (medical, pharmacy and dental) for claims.
2. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.

An example of how the claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Paid Amount
Medical	East	201101	201101	50,823.43
Medical	South	201101	201102	45,534.00
Medical	North	201101	201103	986,796.36
Pharmacy	East	201101	201101	686.89
Pharmacy	South	201101	201102	2,342.22
Dental	North	201101	201103	780,989.16
...	...	...	...	...

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The required capitation lag reports need to be an excel file with the following characteristics:

1. Capitation paid amounts by region, capitation experience month, paid month
2. The report must include at least all paid and experience months going back 2 full years prior to the month the report is run.

An example of how the capitation lag report data should look for claims is as follows:

Region	Incurred Month	Paid Month	Capitation Paid Amount
East	201101	201101	5,023.43
South	201101	201102	4,534.00
North	201101	201103	98,796.36
East	201101	201101	66.89
South	201101	201102	242.22
North	201101	201103	70,989.16
...	...	...	...

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PRIMARY CARRIER ID –

A field for the Primary Carrier ID has been added to the Claims Input Layout to recognize the MCO or TPA which enrolls the member and assigns IPA and PCP Provider IDs. The Carrier ID filed will carry the ID of the carrier generating the Claims Input File. These files will contain the same value when the reporting carrier is an MCO or TPA. When the reporting carrier is an MBHO or PBM the Carrier ID will contain the code of the MBHO or PBM and the Primary Carrier ID will contain the code of the MCO or TPA of the member.

IPA CODES AND PROVIDER CODES –

The Primary Carrier ID field has been added to be able to distinguish the validation of IPA and Provider codes by carrier. The Primary Carrier ID will carry the code of the MCO or TPA which contracts the members IPA and PCP Provider. In Claims records the codes for IPA and PCP Provider will be those created by the MCO/TPA and delivered to the MBHOs and PBMs in eligibility/enrollment data exchanges.

ATTENDING PROVIDER –

The validation rules for Attending Provider have been changes to remove the requirement that the value match a valid provider (i.e. a provider code reported by the carrier in its Provider file. The field is still required.

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MUNICIPALITY SERVICE –

Recognizing that claims may be processed for services outside of Puerto Rico, code 0666 is included in the list of Municipality Codes. This value is valid only for use in the field Municipality Service on the Claims Input File. This value should be used only when services are paid for outside of Puerto Rico.

General Notes on data layout requirements

Date Fields - All date fields in the following data layout are defined to the same size and format as YYYYMMDD. An 8 byte field where YYYY = 4 digit year, MM = 2 digit month and DD = 2 digit day. 1 digit month and day values must always have the leading zero (0). Date fields must contain a valid date with months between 01 and 12 and days between 01 and maximum day in month. July 1, 2006 will be coded as 20060701.

Amount Fields – All amount fields representing money must be numeric and are defined as 9 bytes in the format 9(7)v99 where v represents and implied decimal point. This allows a maximum of 7 digits for dollars plus the last two digits for cents. These numbers are always right justified and zero filled to the left. As examples:

$1.23 will be coded as	000000123
$100.00 will be coded as	000010000

All amount fields are positive and follow the above definition unless clearly specified otherwise.
End of Record Filler – All file layouts have been designed to end with a filler field of 1 byte which must always be coded as an "*" character. This is done to avoid issues between different systems when generating and transferring ASCII files in which ending field may be empty. The fixed End of Record Filler guarantees that all records in a file can be constructed to the fixed length format as defined in the layouts.

Justification and filling of Fields – The layouts have all been specified to provide fixed length fields and fixed length records. While other methods can be used, it is felt that this provides the best common ground for working with multiple entities each of which uses varying systems. To be sure everyone understands the same about the comments on justification and filling the following examples are given to help keep this concept clear.

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically numeric field are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a 9(7)v99 where v represents an implied decimal the following examples illustrate how data will look in the field:

Value	Field
12.50	000001250
101	000010100
1,234.56	000123456
1,000,000	100000000

All alphanumeric fields must be filled completely. If the value of data in the field is less than the width of the field then care must be taken to ensure that the field is filled with blanks. Allowing "NULLS" or other special characters through may cause unexpected results and make reading, loading and validation of the data difficult. Typically alphanumeric field are left justified and filled to the right with blanks to complete the field. In a field specified as alphanumeric such a X(20) the following examples illustrate how data will look in the field where the [ ] characters represent the start and end of the field –

Value	Field
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]
(Metro-North Region)	[(Metro-North Region)]

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References to CMS 1500 and UB-92 – All references to CMS 1500 or UB-92 in this document are for convenience and correspond equally to equivalent electronic formats and will apply equally to the next version of CMS 1500 or the UB-04 when implemented.

MPI Number fields – In all files in which MPI Number is required, carriers should code all 9s if the MPI is unknown. This should not be true for any current beneficiary. This exception will continue until such time as ASES determines that the issue of MPI being unavailable has disappeared from historical data. For Government Employee MPI should be filled with Contract Number.

File Naming Convention

All files to be delivered to ASES by the carriers must follow the naming conventions below. Files which do not fit the naming convention will be ignored and the carrier deemed to have failed in delivery of such a file.

File names must adhere strictly to this naming convention as the structure includes information for identification of the carrier, dates and file type. If not named correctly the file cannot be processed properly.

The general format of file names will be –

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Dccyymms.fff

Where:

Character 1	Always "**D**"		
Characters 2-3	**cc**	=	Carrier Code (See attachment II)
Character 4-5	**yy**=	Last two digits of year	
Characters 6-7	**mm**	=	Month
Character 8	**s**	=	sequence number of file submission.

All submission start with s = 0 and continue in numeric if files are re-submitted to 9
If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …

Character 9	Always "."
Characters 10-11	Extension code identifying type of file

CLM	for	CLAIMSERVICES
PRV	for	PROVIDERS
IPA	for	IPA
CAP	for	CAPITATIONS

Files are always dated for the month being reported. For example, when sending claims paid in September 2013 the **yymm** part of the file name will be **1309** while the file will be sent to ASES in October.

Examples of completing this naming convention are –

For imaginary carrier 96 in the files for ClaimServices and payments in April 2013 will be named as follows –

ClaimServices	D9613040.CLM
Providers	D9613040.PRV
IPA	D9613040.IPA
Capitation	D9613040.CAP

When the Capitation file is rejected, the corrected file will be re-submitted as
D9612041.CAP

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	region_code	varchar(1)	**Region Code**	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions	**X**	Required Must be valid ASES Region code
3	plan_type	varchar(2)	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD	**XX**	Required Must equal "01", "02" , "03","04","05"or "06" Value "01' must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				04 = State Agency 05 = Municipality 06 = Public Corporation		Values of "04", "05" or "06" must correspond to government employees carrier ID.
4	plan_version	varchar(3)	**Plan Version**	Plan Version to distinguish multiple plans within Plan Type. Always three numeric characters, e.g. 001 For government employee claims indicates contract type: 001 = Family 002 = Couple 003 = Individual 004 = Optional Dependent	**XXX**	Required Must be a 3 digit Plan Version Code Carrier ID, Plan Type and Plan Version must validate with a plan definition contracted with ASES
5	claim_id	varchar(20)	**Claim ID**	Unique Identification number within Carrier with the addition of the claim_parent. May be Carrier's Internal Claim Identification number. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
7	Sv_line	varchar(5)	**Service Line Number**	Number identifying individual service within a given claim.	**XXXXX**	Required Must be a maximum of 5 digits. ID of the Service Line within the Claim ID. Duplicates within Claim ID and Service Line Number on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier).
8	bill_type	varchar(1)	**Bill Type**	Originating bill type – U=UB-92 / Institutional H=HCFA/CMS1500 / Individual / Professional, P=Pharmacy Claim, D=Dental Claim.	**X**	Required Must equal "U", "H", "P" or "D"

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
9	claim_type	varchar(1)	**Claim Type**	Claim Type: I=Inpatient O=Outpatient P=Professional	X	Required Must equal "I", "O" or "P"
10	sv_stat	varchar(1)	**Claim Line Status**	Indicates payment action on the service represented by this record. P= Paid D=Denied A=Adjustment R=Reversal E=Encounter	X	Required Must equal "P", "D", "A", "R" or "E" If value is "E", service will have zero Paid Amount.
11	adm_date	datetime()	**Admit Date**	For UB-92 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	YYYYMMDD	Required Must be a valid date
12	dis_date	datetime()	**Discharge Date**	For UB-92 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	YYYYMMDD	Required Must be a valid date Must be equal or later than Admit Date
13	from_date	datetime()	**Service From Date**	Begin date of the treatment.	YYYYMMDD	Required Must be a valid date.
14	to_date	datetime()	**Service To Date**	End date of the treatment.	YYYYMMDD	Required Must be a valid date Must be on or after Service From Date
15	paid_date	datetime()	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	YYYYMMDD	Required Must be a valid date

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						Must be on or after Service To Date
16	rec_date	datetime()	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Discharge Date
17	entry_date	datetime()	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Received Date
18	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
19	mpi	Varchar(13)	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
20	primary_center	varchar(10)	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Must be present on all claims of Plan Type 01 May be present on claims of other Plan Types When present it indicates the Primary center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Primary Carrier ID and IPA
21	ssn_mainh	varchar(9)	**HOH Social Security**	Social Security number of Head of Household (HOH) of family.	**9(9)**	Required

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				This is available from the Family record in ASES eligibility data sent to carriers.		Must be all numeric Must be a full 9 digits
22	ssn	varchar(9)	**Patient Social Security**	Social Security Number of member	**9(9)**	Required Must be all numeric Must be a full 9 digits
23	member_suffix	varchar(2)	**ASES Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	**99**	Required Must be ASES Assigned member suffix All numeric value 01 to 99
24	patient_name	varchar(30)	**Patient Name**	Member Name	**X(30)**	Required Must be left justified, blank filled to the right
25	family_id	varchar(11)	**ASES Family ID**	Family ID as supplied in ASES Eligibility data.	**X(11)**	Required ASES / ODSI Family ID Alphanumeric full 11 characters For government employee use SSN Main Holder. Must be left justified, blank filled to the right
26	sex	varchar(1)	**Sex Code**	Gender of member M = Male F = Female	**X**	Required Must equal "M" or "F"
27	birth_date	datetime()	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Cannot be in the future compared to Extract Date Cannot be greater than 150 years ago compared to Extract Date Must be equal or earlier than Admit Date
28	municipality_res	varchar(4)	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						All numeric, right justified, zero filled Must correspond to a municipality within Region Code
29	municipality_code	varchar(4)	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I	XXXX	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled
30	drg_code	varchar(4)	**DRG Code**	Diagnosis Related Group Code	XXXX	Must be a valid DRG Code
31	drg_type	varchar(1)	**DRG Type Code**	DRG Type Code, when DRG is provided. Must be one of the following: 1= MS DRG 2= CMS DRG 3= AP DRG 4= APR DRG	X	Must equal, 1, 2, 3, or 4.
32	proc_code	varchar(15)	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	X(15)	For claims from CMS1500 / UB92, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code For Pharmacy claims this must be all blanks
33	cpt_mod_1	varchar(2)	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code
34	cpt_mod_2	varchar(2)	**Procedure Modifier Code 2**	Modifier code valid for the Procedure Code	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
35	cpt_mod_3	varchar(2)	**Procedure Modifier Code 3**	Modifier code valid for the Procedure Code	XX	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code
36	rev_code	varchar(5)	**Revenue Code**	For UB92 Claims NUBC Revenue Code	X(5)	For UB92 claims. When present it must be a valid Revenue code. Must be left justified, blank filled to the right
37	rx_ndc	varchar(11)	**National Drug Code**	For Pharmacy only. National Drug Code value for prescribed drug in 5 4 2 format	X(11)	Required on Pharmacy claims Must be a valid NDC code in 5 4 2 format filling all 11 bytes For non-Pharmacy claims must be blank
38	tooth_code	varchar(3)	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	XXX	Must be present on Dental claims when Procedure code requires Tooth Code Must be a valid Tooth Code when present Must be left justified and blank filled to complete the field For non-Dental claims must be blank
39	surface_code	varchar(7)	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	X(7)	Must be present on Dental claims when procedure code requires Surface Code Must be a valid Surface Code Must be left justified and blank filled to complete the field

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						For non-Dental claims must be blank
40	icd9_diag_01	varchar(8)	**Primary ICD9 Diagnosis code**	Non-Pharmacy/Dental Principal diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Required field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
41	icd9_diag_02	varchar(8)	**Second ICD9 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
42	icd9_diag_03	varchar(8)	**Third ICD9 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
43	icd9_diag_04	varchar(8)	**Fourth ICD9 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
44	icd9_diag_05	varchar(8)	**Fifth ICD9 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
45	icd9_diag_06	varchar(8)	**Sixth ICD9 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
46	icd10_diag_01	varchar(8)	**Primary ICD10 Diagnosis code**	Non-Pharmacy/Dental Principal diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	X(8)	Not required for Pharmacy and Dental claims Required field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
47	icd10_diag_02	varchar(8)	**Second ICD10 Diagnosis code**	Non-Pharmacy/Dental	X(8)	

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.		Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
48	icd10_diag_03	varchar(8)	**Third ICD10 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
49	icd10_diag_04	varchar(8)	**Fourth ICD10 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
50	icd10_diag_05	varchar(8)	**Fifth ICD10 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
51	icd10_diag_06	varchar(8)	**Sixth ICD10 Diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code
52	icd9_proc_01	varchar(10)	**Primary ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Required field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
53	icd9_proc_02	varchar(10)	**Second ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
54	icd9_proc_03	varchar(10)	**Third ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
55	icd9_proc_04	varchar(10)	**Fourth ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						Allowed field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
56	icd9_proc_05	varchar(10)	**Fifth ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
57	icd9_proc_06	varchar(10)	**Sixth ICD9 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD9-CM procedure code
58	icd10_proc_01	varchar(10)	**Primary ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Required field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
59	icd10_proc_02	varchar(10)	**Second ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
60	icd10_proc_03	varchar(10)	**Third ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						Allowed field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
61	icd10_proc_04	varchar(10)	**Fourth ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
62	icd10_proc_05	varchar(10)	**Fifth ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
63	icd10_proc_06	varchar(10)	**Sixth ICD10 Procedure code**	Non-Pharmacy/Dental ICD-9 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD10-CM procedure code
64	pcp_prov	varchar(10)	**PCP Provider**	Provider ID of member's PCP. Where possible, use the NPI as the ID. Defined by Primary Carrier. MBHOs and PBMs use data supplied on eligibility/enrollment data from MCO/TPA	**X(10)**	Required for Plan Type "01" claims Must be found on the Provider table matched by Primary Carrier ID and Provider ID
65	att_prov	varchar(10)	**Attending Provider**	Provider ID of the provider delivering the service.	**X(10)**	Required

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician		Must be filled with a value
66	bill_prov	varchar(10)	**Billing Provider**	Provider ID of Provider billing services On pharmacy claims this is the dispensing pharmacy and number may be NCPDP/NABP	X(10)	Required Must be a valid Provider ID
67	network_affiliation	Varchar(1)	**Network Affiliation**	Indicates if the service provider is in the preferred provider network or not. Y = Yes N = No	X	Must be "Y" or "N"
68	primary_carrier_id	varchar(2)	**Primary Carrier ID**	Value that identifies the primary carrier – MCO or TPA. Must be a valid code. See Carrier Code List in Attachment II	XX	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES
69	pos_code	varchar(2)	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	XX	Required Must be a valid Place of service Code
70	cob_code	varchar(1)	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise	X	Required Must be "Y" or "N"
71	amt_billed	money()	**Billed Amount**	For non-Pharmacy Cost of service as billed by the provider.	9(7)v99	Required for non-Pharmacy claims. Must be a number on all non-pharmacy records Cannot be left blank for non-pharmacy
72	amt_allowed	money()	**Allowed Amount**	For non-Pharmacy Amount allowed for the service by the carrier	9(7)v99	Required for non-Pharmacy claims. Must be a number on all records

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						Cannot be left blank For pmt_stat "P" (Payment Status = "paid") this must be greater than zero.
73	Deduct	money()	**Deductible**	Amount paid by member before payments by the carrier begin for this service	**9(7)v99**	Required Must be a number on all records Cannot be left blank
74	Copay	money()	**Co-Pay**	Amount paid by member as dollar co-payment for this service	**9(7)v99**	Required Must be a number on all records Cannot be left blank
75	Cob	money()	**COB Amount**	Amount paid by other Health Insurance attributable to this service.	**9(7)v99**	Required Must be a number on all records Cannot be left blank
76	Coins	money()	**Coinsurance Amount**	Amount paid by member as percentage of cost for this service	**9(7)v99**	Required Must be a number on all records Cannot be left blank
77	amt_paid	money()	**Paid Amount**	Amount paid by carrier for this service	**9(7)v99**	Required Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with pmt_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – <u>For non-Pharmacy:</u> amt_paid = amt_allowed - deduct - copay - cob - coins <u>For Pharmacy:</u>

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee For Plan Type "02" or "03" only - amt_paid may be zero if the appropriate calculation above results in 0.00. For Plan Type "01" the amt_paid must be greater than zero.
78	rx_disc	money()	**Drug Discount**	For Pharmacy only Amount Discounted at the Pharmacy This is the discount given from AWP to get the Ingredient Cost When drug is paid from a MAC list the discount amount will be Zero (0) This field does not form part of the calculation to get Amount Paid but can be used with Ingredient Cost to work back to AWP.	**9(7)v99**	Required on Pharmacy claims On non-Pharmacy claims must be blank
79	rx_ingr_cost	money()	**Ingredient Cost**	For Pharmacy only Cost of ingredient(s) dispensed for this Service	**9(7)v99**	Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank
80	rx_disp_fee	money()	**Dispensing Fee**	For Pharmacy only Dispensing fee charged by pharmacy	**9(7)v99**	Required on Pharmacy claims Must be a number On non-Pharmacy claims must be blank
81	rx_total_disp	Float()	**Total Quantity Dispensed**	For Pharmacy only Total quantity of drug dispensed by pharmacy.	**9(7)v99**	Required on Pharmacy claims Must be a number, right justified, zero filled

#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
						On non-Pharmacy claims must be blank
82	rx_days_supply	smallint()	**Prescription Days**	For Pharmacy only Number of days prescribed and dispensed	999	Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank
83	rx_drug_type	varchar(2)	**Drug Type Code**	For Pharmacy only Code identifying type of drug on pharmacy claims Valid codes are - 01=Generic 02=SSB 03=MSB	XX	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank
84	rx_daw	varchar(6)	**Dispensed As Written**	For Pharmacy only Code indicating "Dispense as written" status of the prescription on pharmacy claims Valid Codes are – 0 - NO DISPENSE AS WRITTEN (Substitution Allowed) (or no product selection indicated) 1 - PHYSICIAN writes DISPENSE AS WRITTEN 2 - PATIENT REQUESTED 3 - PHARMACIST SELECTED BRAND 4 - GENERIC NOT IN STOCK 5 - BRAND DISPENSED, PRICED AS GENERIC 6 - OVERRIDE 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW 8 - GENERIC NOT AVAILABLE	X(6)	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				9 - OTHER		
85	rx_refill_cnt	varchar(6)	**Refill Count**	For Pharmacy only The number of refills specified by the physician writing the prescription on pharmacy claims	9(6)	Required on Pharmacy claims When present must be a number On non-Pharmacy claims must be blank
86	rx_par	varchar(7)	**Participating Pharmacy Flag**	For Pharmacy only Indicates whether prescription was dispensed by a participating pharmacy on pharmacy claims Valid values – "Y" = participating pharmacy "N" = non-participating pharmacy	X(7)	Required on Pharmacy claims Left justified, blank filled Must be "Y" or "N" On non-Pharmacy claims must be blank
87	dis_stat	varchar(2)	**Discharge Status Code**	On UB-92 claims, Patient Status Code at discharge.	XX	Required for UB-92 claims When present, it must not contain blanks
88	risk_type	varchar(3)	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	XXX	Required Must be filled Must be "PCP" or "CAR" For PBM only value can be "UNK"
89	stop_loss_flag	Varchar(1)	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member	X	Required Must be filled ""Y" or "N"

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				Otherwise "N". When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"		
90	applied_cost	varchar(1)	**Cost Applied To**	For Medicare Platino, defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	X	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled and be a valid value Not Required for Plan Type "01"
91	ases_split_amt	money()	**ASES Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to ASES coverage.	9(7)v99	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 1 or 3 Not Required for Plan Type "01"
92	cms_split_amt	money()	**CMS Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to CMS (MA) coverage.	9(7)v99	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 2 or 3 Not Required for Plan Type "01"
93	off_island	varchar(1)	**Off Island Flag**	Indicator for whether service was located off of the islands of Puerto Rico, Culebra, and Vieques. Y=Off Island N=On Island	X	Required
94	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	X	Required Must be = "*"

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#	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
				RECORD LENGTH	655	

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PROVIDERS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	prov_carrier	varchar(2)	**Prov Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	prov_id	varchar(20)	**Prov ID**	Provider ID as assigned by carrier *SEE NOTES – Changes and Additions in Data File Layouts: PHARMACY PROVIDER IDs*	**X(20)**	Required Must be left justified and blank filled to the right
3	prov_lname	varchar(50)	**Prov Lname**	For an individual, Last Names (Apellidos) For an entity (other than an individual), the entity name	**X(50)**	Required Must be left justified, blank filled to the right
4	prov_fname	varchar(30)	**Prov Fname**	For an individual, First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
5	prov_mname	varchar(30)	**Prov Mname**	For an individual, Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
6	prov_addr1	varchar(45)	**Prov Addr1**	First line of provider's address	**X(45)**	Required Must be left justified, blank filled to the right
7	prov_addr2	varchar(45)	**Prov Addr2**	Second line of provider's address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
8	prov_addr3	varchar(45)	**Prov Addr3**	Third Line of provider's address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
9	prov_city	varchar(45)	**Prov City**	Provider's city	**X(45)**	Required Must be left justified, blank filled to the right
10	prov_state	varchar(45)	**Prov State**	Provider's state	**X(45)**	Required Must be left justified, blank filled to the right
11	prov_zip	varchar(9)	**Prov Zip**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
12	prov_country	varchar(45)	**Prov Country**	Provider's country	**X(45)**	Required Must be left justified, blank filled to the right
13	Prov_tel	Varchar(20)	**Prov Telephone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
14	prov_ext	varchar(20)	**Prov Ext**	Provider's telephone extension	**X(20)**	Optional Must be left justified, blank filled to the right

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
15	prov_email	varchar(40)	**Prov Email**	Provider's e-mail address	X(40)	Optional If supplied it must fit e-mail address format rules Must be left justified, blank filled to the right
16	prov_contact	varchar(50)	**Prov Contact**	Name of contact person if provider is not an individual	X(50)	Optional Must be left justified, blank filled to the right
17	prov_type	varchar(20)	**Prov Type**	Type of provider. See Provider Type Codes in Attachment VI	X(20)	Required Must be left justified, blank filled to the right Must be a valid Provider Type Code
18	spec1	varchar(20)	**Spec1**	Provider Specialty (first). See Specialty Code in Attachment III	X(20)	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
19	spec2	varchar(20)	**Spec2**	Provider Specialty (second). See Specialty Code in Attachment III	X(20)	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
20	spec3	varchar(20)	**Spec3**	Provider Specialty (third). See Specialty Code in Attachment III	X(20)	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
21	spec4	varchar(20)	**Spec4**	Provider Specialty (fourth). See Specialty Code in Attachment III	X(20)	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
22	network_specialist	Varchar(01)	**Preferred Network Specialist**	Indicates if the service provider is a participating specialist of the preferred network in the PMG	X	Required Must be "Y" or "N"
23	filler_23	n/a	**Filler**		X(20)	
24	federal_tax_id	varchar(20)	**Federal Tax ID**	SSN for individuals, EIN for entities.	X(20)	Required Left justified, blank filled to the right Must be 9 digits in significant positions
25	licence_number	varchar(15)	**License Number**	State License Number	X(15)	Optional Should be supplied when available Must be left justified, blank filled to the right
26	NPI	varchar(15)	**NPI**	National Provider Identifier	X(10)	Required Left justified, blank filled to the right
27	dea_number	varchar(20)	**DEA Number**	DEA number	X(20)	Optional Should be supplied when available Must be left justified, blank filled to the right
28	medicare_number	varchar(20)	**Medicare Number**		X(20)	Optional Must be left justified, blank filled to the right

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	medicaid_number	varchar(20)	**Medicaid Number**		**X(20)**	Optional Must be left justified, blank filled to the right
30	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Provider Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
31	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**781**	

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IPA INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	ipa	varchar(4)	**IPA Code**	Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters.	**X(4)**	Required IPA/HCO code assigned by Carrier Must be left justified, blank filled to the right
3	ipa_desc	varchar(80)	**IPA Description**	Name of IPA/HCO	**X(80)**	Required Must be left justified, blank filled to the right
4	ipa_addr1	varchar(45)	**IPA Addr1**	IPA/HCO's first line of address	**X(45)**	Required Must be left justified, blank filled to the right
5	ipa_addr2	varchar(45)	**IPA Addr2**	IPA/HCO's second line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
6	ipa_addr3	varchar(45)	**IPA Addr3**	IPA/HCO's third line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
7	ipa_city	varchar(45)	**IPA City**	IPA/HCO's city	**X(45)**	Required Must be left justified, blank filled to the right
8	ipa_state	varchar(45)	**IPA State**	IPA/HCO's state	**X(45)**	Required Must be left justified, blank filled to the right
9	ipa_zip	varchar(9)	**IPA Zip**	IPA/HCO's zip code. Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric. Must be 5 or 9 digits in length.
10	ipa_country	varchar(45)	**IPA Country**	IPA/HCO's country	**X(45)**	Required Must be left justified, blank filled to the right
11	ipa_home_phone	varchar(20)	**IPA Home Phone**	Home telephone number of contact person for IPA/HCO	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
12	ipa_work_phone	varchar(20)	**IPA Work Phone**	Principal work telephone number of IPA/HCO.	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
13	ipa_ext	varchar(20)	**IPA Ext**	Telephone extension at IPA Work Phone for contact person	**X(20)**	Optional Must be left justified, blank filled to the right
14	federal_tax_id	varchar20)	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**454**	

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ADMINISTRACIÓN DE SEGUROS DE SALUD
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CAPITATION INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digit s (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	varchar(20)	**Capitation ID**	Capitation payment ID must be a unique ID within carrier.	**X(20)**	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	varchar(1)	**Capitation Type**	Capitation type code defined as: "P"=PCP "S"=specialty "F"=Fixed Payment	**X**	Required Must be "P", "S" or "F"
4	cap_date	datetime	**Capitation Date**	Date capitation paid.	**YYYYMMDD**	Required Must be a valid date
5	expr_date	datetime	**Experience Date**	Experience date of capitation payment. This is the date for which the capitation payment applies.	**YYYYMMDD**	Required Must be a valid date
6	prov	varchar(20)	**Provider ID**	Carrier assigned Provider ID of the provider to which the capitation payment is made.	**X(20)**	Required Must be a valid Provider ID
7	ipa	varchar(10)	**IPA ID**	Carrier assigned ID of IPA/HCO. This must be filled when Capitation type is PCP and IPA/HCO is involved (Must always be filled for Plan Type 01 by MCOs/TPAs when capitation payment is for PCP services)	**X(10)**	Required If Capitation Type is "P" and Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier
8	region_code	varchar(1)	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL	**X**	Required Must be valid ASES Region code
9	municipality_code	varchar(4)	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
10	member_ssn	varchar(9)	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric)

CAPITATION INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
11	family_id	varchar(11)	**ASES Family ID**	Family ID as supplied in ASES Eligibility data.	**X(11)**	Required ASES / ODSI Family ID Alphanumeric full 11 characters
12	member_suffix	varchar(2)	**Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	**99**	Required Must be 2 digits (numeric)
13	cap_amt	money	**Capitation Amount**	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
14	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
15	mpi	Varchar(13)	**MPI Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data	**X(13)**	Required Must be a valid MPI number
16	filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**128**	

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ATTACHMENTS

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ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Adjuntas	S	0004
Aguada	Z	0008
Aguadilla	Z	0012
Aguas Buenas	E	0016
Aibonito	G	0020
Añasco	Z	0024
Arecibo	A	0028
Arroyo	G	0032
Barceloneta	A	0036
Barranquitas	G	0040
Bayamón	B	0044
Cabo Rojo	Z	0048
Caguas	E	0052
Camuy	A	0056
Canovanas	F	0060
Carolina	F	0064
Cataño	B	0068
Cayey	E	0072
Ceiba	F	0076
Ciales	A	0080
Cidra	E	0084
Coamo	G	0088
Comerio	B	0092

Ordered By Code		
CODE	MUNICIPALITY	REGION
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Corozal	B	0096
Culebra	F	0100
Dorado	B	0104
Fajardo	F	0108
Florida	A	0112
Guanica	S	0116
Guayama	G	0120
Guayanilla	S	0124
Guaynabo	B	0128
Gurabo	E	0132
Hatillo	A	0136
Hormigueros	Z	0140
Humacao	E	0144
Isabela	Z	0148
Jayuya	S	0152
Juana Diaz	G	0156
Juncos	E	0160
Lajas	Z	0164
Lares	A	0168
Las Marias	Z	0172
Las Piedras	E	0176
Loiza	F	0180
Luquillo	F	0184

Ordered By Code		
CODE	MUNICIPALITY	REGION
0096	Corozal	B
0100	Culebra	F
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S
0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Manatí	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200
Moca	Z	0204
Morovis	A	0208
Naguabo	E	0212
Naranjito	B	0216
Orocovis	G	0220
Patillas	G	0224
Peñuelas	S	0228
Ponce	S	0232
Puerta de Tierra	J	0264
Puerto Nuevo	J	0270
Quebradillas	A	0236
Rincon	Z	0240
Rio Grande	F	0244
Rio Piedras	J	0272
Sabana Grande	Z	0248
Salinas	G	0252
San German	Z	0256
San José	J	0274
San Juan	J	0266

Ordered By Code		
CODE	MUNICIPALITY	REGION
0188	Manatí	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z
0252	Salinas	G
0256	San German	Z
0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San José	J

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality				Ordered By Code		
MUNICIPALITY	REGION	CODE		CODE	MUNICIPALITY	REGION
San Lorenzo	E	0276		0276	San Lorenzo	E
San Sebastian	Z	0280		0280	San Sebastian	Z
Santa Isabel	G	0284		0284	Santa Isabel	G
Toa Alta	B	0288		0288	Toa Alta	B
Toa Baja	B	0292		0292	Toa Baja	B
Trujillo Alto	F	0296		0296	Trujillo Alto	F
Utuado	A	0300		0300	Utuado	A
Vega Alta	B	0304		0304	Vega Alta	B
Vega Baja	A	0308		0308	Vega Baja	A
Vieques	F	0312		0312	Vieques	F
Villalba	G	0316		0316	Villalba	G
Yabucoa	E	0320		0320	Yabucoa	E
Yauco	S	0324		0324	Yauco	S
Outside Puerto Rico	–	0666	*	0666	Outside Puerto Rico	--

* 0666 is valid only for use with Municipality Service on Claims Input File

NOTE: Any municipality code may appear in region SPECIAL.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
01	Triple S	MCO
03	(discontinued)	MCO
02	Humana	MCO
17	MCS	MCO
25	(discontinued)	MCO
27	MCS Life	Medicare Platino
28	Red Medica	Medicare Platino
29	Medicare y Mucho Mas	Medicare Platino
31	Triple S	Medicare Platino
33	Preferred Medicare Choice	Medicare Platino
34	MCS Advantage	Medicare Platino
35	COSVIMed	Medicare Platino
37	Salud Dorada con Medicare	Medicare Platino
39	MAPFRE	Medicare Platino
41	Health Medicare Ultra	Medicare Platino
42	Humana	Medicare Platino
44	Auxilio Platino	Medicare Platino
47	American Health	Medicare Platino
49	FirstPlus	Medicare Platino
51	Triple S	TPA – Direct Contract
52	Humana	TPA – Direct Contract
53	MCS	TPA – Direct Contract

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
54	Triple S	TPA – Direct Contract
55	COSVI	TPA – Direct Contract
60	Caremark	PBM
64	MC-21	PBM
70	ASSMCA	Mental Health Pilot
71	Plan de Salud Hospital Menonita	Government Employee
72	MMM Healthcare,INC	Government Employee
73	National Life Insurance Company	Government Employee
74	Ryder Health Plan, Inc.	Government Employee
75	Triple-S Salud Inc.	Government Employee
76	(discontinued)	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	Humana Insurance of Puerto Rico,Inc.	Government Employee
79	MCS Advantage,Inc.	Government Employee
80	MCS Life Insurance Company	Government Employee
81	Asociacion de Maestros de Puerto Rico	Government Employee
82	First Medical Health Plan, Inc.	Government Employee
83	APS	MBHO
95	FHC	MBHO

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics / Gynecology
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
26	Psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)
44	Infectious Disease
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapy
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
DD	Dentist
EN	Endodontist
HE	Health Educator
HN	Home Health Nurse
PE	Periodontist
RT	Respiratory Therapist
ST	Speech Therapist
BB	Blood Bank
CV	Cardiac Catheterization Facility
DF	Dialysis Facility
EC	Emergency Care Facility
HV	HIV Ambulatory Antibiotic Facility
HO	Hospice

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
NI	Neonatal ICU
OP	Optical
PC	Clinic – Primary Level
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
SH	State Hospital
SP	State Psychiatric Hospital
XR	X-ray Facility
Z4	Cardiovascular Surgery Program
O1	Occupational Medicine
P1	Perinatology
N1	Neonatolgy
G1	Geneticist
P2	Pediatric Surgery

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-08

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan		
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

ADMINISTRACION DE SEGUROS DE SALUD
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15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

ADMINISTRACION DE SEGUROS DE SALUD
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15-086

ATTACHMENT V - PROVIDER TYPE CODES

CODE	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
AM	Ambulance
AS	Ambulatory Surgical Center
BB	Blood Bank
CL	Clinical Facility
DE	Dentist
DM	Durable Medical Equipment (DME)
EM	Emergency Facility
HH	Home Health Agency
HO	Hospital
HS	Hospice
LA	Laboratory
MD	Medical Doctor (Physician)
RX	Pharmacy
SN	Skilled Nursing Facility (SNF)
UF	Urgent Care facility
XR	Radiology Facility
ZZ	Other

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-08

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

INFORMATION SYSTEMS

ENROLL RELATIONSHIP REQUIREMENTS

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

ASES
Administración de Seguros de Salud de Puerto Rico

Enroll Relationship Requirements

ENROLLMENT RECORD DATA -- BASIC FIELD RELATIONSHIP

TRANS_ID	CARRIER	Plan_TYPE	VERSION	Primary_Center	PCP1	PCP2
E - New Enrollment	Y	Y	Y	Y	Y	O
C - Change Carrier	Must be **different** to ASES DB	Y	Y	Y	Y	O
P - Plan Change	Must be **the same** as in ASES DB	Must be **different** to ASES DB	Y	Y	Y	O
V - Version Change	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** to ASES DB	Y	Y	O
I - Change Primary Center	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **different** to ASES DB	Y	O
1 - Change PCP1	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Y	N
2 - Change PCP2	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	N	Y
3 - Change PCP1 & PCP3	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Must be **the same** as in ASES DB	Y	Y

Y = Field must have data
N = The field must be Blank
O = Use of the field is Optional

Notes:

1. If the Plan Detail Table indicares that a a Primary Center or PCP is **required** the enrollment record **must include** data in those fields.

2. If the Plan Detail Table indicares that a a Primary Center or PCP is **not required** the enrollment record **must not include** data in those fields.

3. Retroactive Enrollment -- For Plan_Type other than "01" (Reforma) any changes (Trans_ID not "E") after the effective date will be treated as Retroactive Enrollments (Trans_ID = "E"). Actual fields will be populated instead of new fields.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

CARRIER ELIGIBLITY OUTPUT FILE - Insurance Record

This file is created by the HCRE export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. This **Insurance Record** is adeded for the Meditis Implementation on Febrary 2011.

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"I" for Insurance
2	TRAN-ID	2	1	E=eligible
3	PROCESS-DATE	3	8	MMDDYYYY
4	ODSI-FAMILY-ID	11	11	
5	Member Suffix	22	2	
6	Health Insurer Code	24	3	Code identifies Insurance Company
7	Policy Number	27	20	
8	Policy-EXPIRATION-DATE	47	8	MMDDYYYY
9	Covered Services	55	40	20 coverage code fields (2 character each).
10	***FILLER***	95	***445***	
		540		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
75-086

CARRIER ELIGIBLITY OUTPUT FILE

This file is created by the HCRE export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. **Modified on May 2003 for the direct contracting pilot project. See entries in bold. Modified on March 2004 for Smartcard project. See entries in bold and highlighted.** Modified on Sept. 2005 for Medicare Project. Modified August 2006 to add Coverage Fiels for new PSG contrating. Modified on January 2008 to add tran_id = H for sysprem records. Modified for Mediti on January 2011.

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"M" for member
2	TRAN-ID	2	1	E=eligible, I=ineligible, R=reject, H= SYSPREM (history)
3	PROCESS-DATE	3	8	MMDDYYYY
4	FAMILY-SSN	11	9	SSN of Head-of-Household
5	FAMILY-SUFFIX	20	2	Zero fill, right justify.
6	FILLER	22	1	
7	MEMBER-SSN	23	9	
8	MEMBER-SUFFIX	32	2	
9	FILLER	34	14	
10	1ST-LAST-NAME	48	15	
11	2ND-LAST-NAME	63	15	
12	FIRST-NAME	78	20	
13	MIDDLE-INITIAL	98	1	
14	RELATIONSHIP	99	1	
15	DATE-OF-BIRTH	100	8	MMDDYYYY
16	PLACE-OF-BIRTH	108	1	
17	SEX	109	1	
18	CATEGORY	110	1	
19	CATEGORY-2	111	1	
20	CONDITION	112	1	
21	SOURCE-CODE	113	1	
22	RECEIVE-SS	114	1	
23	MED-INS-CODE	115	1	Zero fill, right justify.
24	POLICY	116	2	
25	CLASS	118	1	
26	CLASS-2	119	1	
27	DENIAL-CAT	120	1	
28	DENIAL-CAT-2	121	1	
29	MARITAL-STATUS	122	1	
30	SSN	123	9	
31	PREG-IND	132	1	
32	ABSENT-PARENT	133	1	
33	HICN	134	11	
34	PILOT-CAT	145	1	
35	PILOT-CLASS	146	1	
36	PILOT-DENIAL	147	1	
37	HCRE-ELIGIBILITY-IND	148	1	
38	HCRE-DENIAL-CODE	149	2	Zero fill, right justify.
39	OTHER-INSURER1	151	2	Insurance co. code NOT USED
40	OTH_POLICY1	153	20	Policy number NOT USED
41	OTHER-INSURER2	173	2	Insurance co. code NOT USED
42	OTH_POLICY2	175	20	Policy number NOT USED
43	OTHER-INSURER3	195	2	Insurance co. code NOT USED
44	OTH_POLICY3	197	20	Policy number NOT USED
45	GROUP-IDENT	217	2	"06" - ELA, "02" - Veteran, "22" - Small Bus. Zero fill, right justify.
46	ODSI-FAMILY-NO	219	11	"Gx"+HOH SSN for ELA (x=0,1,2 ... by subscription period)
47	ELA-ERRORS	230	10	5 2-digit error codes for ELA-SB-Vet
48	AGENCY	240	5	Agency # for ELA / Group Num for SB. Zero fill, right justify.
49	***MASTER PATIENT INDEX (MPI)***	***245***	***13***	
50	***MEMBER CERTIFICATION DATE***	***258***	***8***	***MMDDYYYY***
51	***CONTRACT NUMBER***	***266***	***13***	***Include Suffix.***
52	***MEMBER PRIMARY CENTER***	***279***	***4***	
53	***MEMBER PRIMARY CENTER EFFECTIVE DATE***	***283***	***8***	***MMDDYYYY***
54	***MEMBER NEW PRIMARY CENTER***	***291***	***4***	
55	***MEMBER NEW PRIMARY CENTER EFFECTIVE DATE***	***295***	***8***	***MMDDYYYY***
56	***PCP1***	***303***	***15***	
57	***PCP1 EFFECTIVE DATE***	***318***	***8***	***MMDDYYYY***
58	***PCP2***	***326***	***15***	
59	***PCP2 EFFECTIVE DATE***	***341***	***8***	***MMDDYYYY***
60	***NEW PCP1***	***349***	***15***	
61	***NEW PCP1 EFFECTIVE DATE***	***364***	***8***	***MMDDYYYY***
62	***NEW PCP2***	***372***	***15***	
63	***NEW PCP2 EFFECTIVE DATE***	***387***	***8***	***MMDDYYYY***
64	***CARD ID NUMBER***	***395***	***15***	
65	***CARD ID DATE***	***410***	***8***	***MMDDYYYY***
66	***ELA INDICATOR***	***418***	***1***	***1=NO PREMIUM 2=PREMIUM Spaces when not ELA.***
67	***PRIMARY CENTER PCP CHANGE REASON***	***419***	***2***	***Basado en tabla de Código de Razón.***

ADMINISTRACIÓN DE SEGUROS DE SALUD
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15 - 086

68	MEDICAID INDICATOR	421	1	1=Medicaid Federal, 2=SCHIPS 3=Estatal 4= Estatal otros
69	MEDICARE INDICATOR	422	1	1=A&B, 3=A, 9=B
70	CARRIER	423	2	
71	CARRIER_EFF_DATE	425	8	MMDDYYYY
72	NEW_CARRIER	433	2	
73	NEW_CARRIER_EFF_DATE	435	8	MMDDYYYY
74	PLAN_TYPE	443	2	"bb"=elegible no suscrito, Ver tabla Plan Type
75	PLAN_TYPE_EFF_DATE	445	8	MMDDYYYY
76	PLAN_VERSION	453	3	Version del plan MA suscrito
77	PLAN_VERSION_EFF_DATE	456	8	MMDDYYYY
78	NEW_PLAN_TYPE	464	2	
79	NEW_PLAN_TYPE_EFF_DATE	466	8	MMDDYYYY
80	NEW_PLAN_VERSION	474	3	
81	NEW_PLAN_VERSION_EFF_DATE	477	8	MMDDYYYY
82	INSTITUTIONAL_STATUS	485	1	Y or N
83	HIC NUMBER MA	486	12	
84	AUTO_ENROLL_INDICATOR	498	1	0 = Not Auto; >0 = Auto Enroll
85	AUTO_ENROLL_DATE	499	8	MMDDYYYY
86	IPA_ESPECIAL	507	1	1 = IPA Especial
87	CMS_Cert_Status	508	2	Status de Certificación en CMS
88	Coverage_Code	510	3	
89	New Contract Number	513	13	
	Special_Enroll	526	1	E = Emergency N = New Born
90	FILLER	527	13	
		540		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

CARRIER ELIGIBLITY OUTPUT FILE

This file is created by the HCRE export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. **Modified on May 2003 for the direct contracting pilot project. See entries in bold. Modified on March 2004 for Smartcard project. See entries in bold and highlighted.** Modified on July 2005 for Medicare Project. Modified on January 2008 to add tran_id = H for sysprem records. Modified for Mediti on January 2011.

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"F" for family
2	TRAN-ID	2	1	E=eligible, I=ineligible, R=reject, H= SYSPREM (history)
3	PROCESS-DATE	3	8	MMDDYYYY
4	FAMILY-SSN	11	9	SSN of Head-of-Household(HOH)
5	FAMILY-SUFFIX	20	2	"00"
6	FILLER	22	14	
7	ODSI-FAMILY-ID	36	11	"Gx"+HOH SSN for ELA (x=0,1,2 ... by subscription period)
8	HOH-1ST-LAST-NAME	47	15	
9	HOH-2ND-LAST-NAME	62	15	
10	HOH-FIRST-NAME	77	20	
11	REGION	97	1	
12	MUNICIPALITY	98	4	Zero fill, right justify.
13	FACILITY	102	4	
14	INVESTIGATION-IND	106	1	
15	TRANSACTION-TYPE	107	1	
16	EFFECTIVE-DATE	108	8	Start date of eligibility MMDDYYYY
17	FINANCIAL-RESP-PCT	116	1	
18	CERTIFIER-NUMBER	117	2	
19	EXPIRATION-DATE	119	8	End date of eligibility MMDDYYYY
20	COND-ELIG-IND	127	1	
21	MAILING-ADDRESS1	128	25	
22	MAILING-ADDRESS2	153	25	
23	MAILING-CITY	178	16	
24	MAILING-ZIP	194	5	
25	MAILING-ZIP4	199	4	
26	RESIDENCE-ADDRESS1	203	25	
27	RESIDENCE-ADDRESS2	228	25	
28	RESIDENCE-CITY	253	16	
29	RESIDENCE-ZIP	269	5	
30	RESIDENCE-ZIP4	274	4	
31	PHONE	278	7	
32	OTHER-INSURER1	285	2	**Insurance co. code NOT USED**
33	OTH-POLICY1	287	20	**Policy number NOT USED**
34	OTHER-INSURER2	307	2	**Insurance co. code NOT USED**
35	OTH-POLICY2	309	20	**Policy number NOT USED**
36	OTHER-INSURER3	329	2	**Insurance co. code NOT USED**
37	OTH-POLICY3	331	20	**Policy number NOT USED**
38	MEMBERS	351	2	# members in family
39	ODSI-MEMBERS-ELIGIBLE	353	2	# members eligible ODSI / optionals ELA-SB-Vet
40	USER-CODE	355	6	
41	ENTRY-DATE	361	8	MMDDYYYY
42	PCT-OF-POVERTY-LEVEL	369	3	
43	DEDUCTIBLE-LEVEL-CODE	372	1	
44	HCRE-MEMBERS-ELIGIBLE	373	2	# members eligible by ASES. Zero fill, right justify.
45	HCRE-DENIAL-CODE	375	2	Zero fill, right justify.
46	CARRIER-CODE	377	2	
47	EFFECTIVE-CARRIER-DATE	379	8	For Family Carrier . MMDDYYYY
48	ELA-ERRORS	387	10	5 2-digit error codes for ELA-SB-Vet
49	MANCOMUNADO	397	1	Y / N (ELA Only)
50	FILLER	398	3	
51	**Family-PRIMARY-CENTER**	401	4	**IPA or PHO**
52	**NEW-CARRIER**	405	2	**New carrier code**
53	**NEW-Family-PRIMARY-CENTER**	407	4	**new IPA or PHO for families changing carrier**
54	**NEW-Family-PRIMARY CENTER EFFECTIVE DATE**	411	8	**MMDDYYYY - effective date of IPA/PHO change**
55	***CONTRACT NUMBER***	***419***	***13***	***Parte común del contrato***
56	***REGION ASES***	***432***	***1***	
58	***NEW CARRIER EFFECTIVE DATE***	***433***	***8***	***New Carrier MMDDYYYY***
59	***FAMILY PRIMARY CENTER EFFECTIVE DATE***	***441***	***8***	***MMDDYYYY***
60	***CERTIFICATION DATE***	***449***	***8***	***MMDDYYYY***
61	***PRIMARY CENTER PCP CHANGE REASON***	***457***	***2***	***Basado en tabla de Código de Razón.***
62	**AUTO_ENROLL_INDICATOR**	***459***	***1***	***0 = Not Auto; >0 = Auto Enroll***
63	**AUTO_ENROLL_DATE**	***460***	***8***	***MMDDYYYY***
64	**PAM NEW FAMILY_ID**	***468***	***11***	***New Family_id assigned by PAM for Meditis. Use as a reference only.***
65	***FILLER***	***479***	***61***	

ADMINISTRACION DE SEGUROS DE SALUD
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15 - 080

*** All are Text Fields

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

INFORMATION SYSTEMS

QUERY RESPONSE FILE LAYOUT

ASES
Administración de Seguros de Salud de Puerto Rico

QUERY RESPONSE FILE LAYOUT

October 20, 2008

This file is sent by ASES to Carriers as a response to query records. The Response Record informs if a Beneficiary is elegible for GHIP (Reform) coverage. It provides the key data elements which the Carrier will use to notify enrollment to ASES once approved by CMS.

Query Response Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"R" for Response
2	CARRIER_PROCESS_DATE	2	8	YYYYMMDD
3	**BENEFICARY SSN**	10	9	
4	CARRIER_1ST_LAST_NAME	19	15	
5	CARRIER_2ND_LAST_NAME	34	15	
6	CARRIER_FIRST_NAME	49	20	
7	CARRIER_SEX	69	1	1 = Male, 2 = Female
8	CARRIER_DATE OF BIRTH	70	8	YYYYMMDD
9	CARRIER_REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	ASES_1ST_LAST_NAME	81	15	
12	ASES_2ND_LAST_NAME	96	15	
13	ASES_FIRST_NAME	111	20	
14	ASES_SEX	131	1	1 = Male, 2 = Female
15	ASES_DATE OF BIRTH	132	8	YYYYMMDD
16	**ASES_REGION**	140	1	
17	ELEGIBILITY_INDICATOR	141	1	**Y or N**
18	**ODSI_FAMILY_ID**	142	11	
19	**MEMBER_SUFFIX**	153	2	
20	**MPI**	155	13	Alpha-numeric ej.-"0080012345678"
21	MEDICAID_INDICATOR	168	1	**1 = Federal Medicaid**
22	ELEGIBILITY_EFFECTIVE_DATE	169	8	YYYYMMDD
23	ELEGIBILITY_EXPIRATION_DATE	177	8	YYYYMMDD
24	ASES_PROCESS_DATE	185	8	YYYYMMDD
25	MESSAGE_CODE	193	6	Spaces= no errors, 01=SSN no match, 02=Sex no match, 03=DOB no match, 04=Region no match, 05=Miembro de municipio no contratado por Carrier, 06=Empleado ELA, 07=SSN no match (history records)
26	ASES_DEDUCTIBLE_LEVEL	199	1	
27	MUNICIPIO	200	4	Código Municipio en ASES
28	FECHA DE EFECTIVIDAD	204	8	Para uso en queries historicos. Formato YYYYMMDD.
29	CODIGO DE CUBIERTA	212	3	Código de Cubierta (Coverage Code)
30	FILLER	215	5	
		220		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

ELIGIBILITY QUERY FILE LAYOUT

August 1, 2008

This file is produced by MA Carriers and sent to ASES to verify the elegibility of Medicare Beneficiaries in the GHIP (Reforma).

Query Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"Q" for Query
2	PROCESS_DATE	2	8	YYYYMMDD
3	BENEFICARY SSN	10	9	
4	1ST_LAST_NAME	19	15	
5	2ND_LAST_NAME	34	15	
6	FIRST_NAME	49	20	
7	SEX	69	1	1 = Male, 2 = Female
8	DATE OF BIRTH	70	8	YYYYMMDD
9	REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	FECHA DE EFECTIVIDAD	81	8	Para uso en queries historicos. Entrar fecha en que comienza la suscripcion del Beneficiario. Formato YYYYMMDD. El dia debe ser primero de mes. Si el query no es historico se deja en blanco.
12	FILLER	89	11	
		100		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15 - 08

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

INFORMATION SYSTEMS

SUBSCRIPTION FILE ERROR DESCRIPTION

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
5-086

ASES
Administración de Seguros de Salud de Puerto Rico

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
011	Invalid Record Type		Must be "E"
021	Spaces in Trans ID.		
022	Invalid Trans ID.		
031	Spaces in Process Date.		
032	Invalid Process Date.		
033	Except for newborns enrollments, Process Date should be less or equal than Effective Date and greater or equal than three months before Effective Date (Mi Salud)	For Mi Salud (Plan Type = 01) the Process Date must be **equal or less** that the Effective Date. Effective Date has to be within 2 months of the Process Date.	Verify process date versus effective date.
034	If Tran_Id = "E" and Mi Salud and Process_Date >= 11/16/2006, then Effective_Date cannot be 11/01/2006	Special edit for coverage conversion of Nov.2006.	
035	Process Date should be less than Effective Date and greater or equal than three months before Effective Date (Platino)	For **Platino** (Plan Type = 02 or 03) the Process Date must be **less** that the Effective Date. Effective Date has to be within 2 months of the Process Date.	Verify process date versus effective date.
036	Process Date should be greater or equal than three months before PCP1_EFFECTIVE_DATE	PCP1_EFFECTIVE_DATE can not be more than 3 month greater that the process date.	
037	Process Date should be greater or equal than three months before PCP2_EFFECTIVE_DATE	PCP2_EFFECTIVE_DATE can not be more than 3 month greater that the process date.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
038	Process Date should be greater or equal than three months before FAM_PRIMARY_CENTER_EFF_DATE	FAM_PRIMARY_CENTER_EFF_DATE can not be more than 3 month greater that the process date.	
041	Spaces in Region		
042	Invalid Region		
051	Spaces in Carrier		
052	Invalid Carrier		
053	Carrier equal to actual Carrier and Tran_ID = C is a requesting to carrier change.	The enrollment has a C (carrier change) in the Tran_ID and the carrier is the same as the carrier in the member record in ASES.	Verify if the record should have been send with another Tran_ID (like V or I). If not the member is already enrolled and no further
054	If plan type=01 and effective_date is future should be 1st of the month	Enrollments for future dates must have effective dates for the 1st of the month.	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
055	Carrier not contracted in the municipality or region at the enrollment effective date.	Match Carriers_contracted table by Carrier and region. The effective date of the enrollment has to be within the effective and expiration dates of the selected carriers_contracted table record for that carrier and Region. Carrier must be contracted at the effective date of the enrollment. The enrollment record plan_type has to be 01 if the Reforma column is "Y". Else the plan in the enrollment has to be "02" or "03". The Plan_Type must match the carriers_contracted table record for the effective date of the enrollment. If the "Todos_Municipios" column is "N" then the municipality code in the member_eligibility record for the member in the enrollment record has to match one of the municipality codes in the selected table record. If some municipalities are contracted in a region then the municipality code must match.	Carrier should review member's address an insure that the municipality in included in the ASES contract.
056	Plan type = 01 and effective date is 20101001 at enrollment, and new_plan_type = 02 and new_carrier_eff_date is 20101001 at member_eligibility	This is a temporary error code to be operating during the month of September 2010 related to the October 1, 2010 conversion.	
057	Plan type = 01 and effective date is 20101001 at enrollment, and plan_type = 02 at member_eligibility	This is a temporary error code to be operating during the month of September 2010 related to the October 1, 2010 conversion.	

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
061	Trans ID in ("E","C","P","V","I") and is required then Member Primary Center had spaces	Member Primary center is required when the enrollment has a Tran_ID of "E","C","P","V","I" in Reforma or if the Platino Plan is identified as requiring Primary Center.	
062	Trans ID in ("1","2","3") and Member Primary Center is different from actual subscribed Primary Center.	The enrollment is for a PCP change but has a Primary Center different from the one in the member record in ASES.	PCP changes are accepted if the record has the same carrier, Plan Type, Version and IPA as the ASES database for the member. Check if the intention is to change both the IPA and the PCP and submit a IPA change (Tran_ID = I) with the new IPA and PCPs.
063	Primary Center equal to actual Primary Center	IPA change when the IPA in the ASES database for the member is the same.	Verify if the record should have been send with another Tran_ID. If not the member is already enrolled in the IPA and no further action should be required.
064	if Tran_ID="D" should be space		
065	For the Special region. Invalid Member Primary Center for Direct Contract Carrier. A record in our tables was not found for the given region, carrier, member_primary_center and effective_date.	Incorrect IPA in the enrollment record.	Verify and correct.
066	For any region other than Special. Invalid Member Primary Center for Direct Contract Carrier. A record in our tables was not found for the given region, carrier, member_primary_center and effective_date.	Incorrect IPA in the enrollment record.	Verify and correct.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
15 - 086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
071	Spaces in Family ID		
072	Length of Family ID not equal 11		
073	Family ID Not Found	Family_Id not found in the region indicated in the enrollment record.	Verify if the family ID used is correct. Verify if the region code is the correct one for the member.
081	Spaces Member SSN		
082	Length of Member SSN not equal 9		
083	Member SSN Not Found		Verify if the Member SSN used is correct. Verify if the region code is the correct one for the member.
091	Spaces in Member Suffix		
092	Length of Member Suffix not equal 2		
093	Family_id and Member Suffix Not Found in ASES Eligibility	No record for the member found in the ASES database.	Verify that the assignment of the Suffix in the carrier database coincides with ASES. If the family_id or the Member SSN is also in error this code will appear.
101	Spaces in Effective Date		
102	Invalid Effective Date		
103	In Enroll and Reforma, effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify dates and correct.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
104	Other than Enroll and Reforma, effective date should be 1st of the month.	For Reforma (Plan Type = 01) where the Tran_ID is not E the effective date must be greater than the run date and 1st of the month.	Verify dates and correct.
105	For Platino, the effective date should be 1st of the month.		
106	if TRAN_ID IN ("D") then effective date should be 1st of the month		
107	Effective date should be during the last active period for the family	The family to which the member belongs was cancelled after the effective date in the enrollment record.	This cases will be submitted to be enrolled in history under the new version of the enrollment
108	Effective date should be during the last active period for the member	The the member was cancelled after the effective vdate in the enrollment record.	This cases will be submitted to be enrolled in history under the new version of the enrollment system (SYSPREM).
10A	If Emergency (special_enroll = 'E') then if before Auto Assign (certification_dt @ family_eligibility < 2011-07-01) or federal (medicaid indicator is in '1' or '2') then if before Mi Salud (eligibility_effective_date < 2010-10-01) then cannot subscribe earlier than the certification date, else if during Mi Salud (eligibility_effective_date >= 2010-10-01) then cannot subscribe earlier than the eligibility effective date. Else if during Auto Assign (certification_dt @ family_eligibility >= 2011-07-01) and statal (medicaid indicator is in '3' or '4') then cannot subscribe earlier than the certification date.	For emergencies the effective date can not be less that the family eligibility effective date.	Verify and correct.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
10B	If special_enroll = 'N', effective date should be at least as recent as member birth date and effective date should not be more than a year forward from the birth date	For new borns the effective date can not be less than the birth date or a year after the birth date.	Verify and correct.
10D	If special_enroll = 'E' , then plan type should be reform	Not exist enrollments with emergencies to Platino members	Verify and correct.
111	Spaces in Plan Type		
112	Length of Plan Type not equal 2		
113	Invalid Plan Type,Carrier and Plan Version	Enrollment records have to match the Plan Type and Plan Version contracted by the carrier with ASES.	Verify and correct.
114	if Trans_ID="D" should be "01"		
115	"02" and not Medicare Part A & B in ASES data		
121	Spaces in Plan Version		
122	Length of Plan Version not equal 3		
123	Invalid Plan Version		Verify that the Plan, Version in the enrollment is the Plan
124	if Trans_ID="D" should be "001"		
131	Length of MPI Number not equal 13		
132	MPI Number Not Found in ASES Eligibility		Verify that the correct MPI was used. Verify if the region code is the correct one for the
141	Spaces in PCP1 when Tran ID <> "2" <>"D" is required.	For enrollments where the PCP1 is required the PCP1 Field must not be in spaces.	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
15 0 8 6

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
142	PCP1 should be spaces when Tran ID = "2" ="D"	For changes in PCP2 the PCP1 field must be spaces.	
151	Spaces in PCP1 Effective Date when Tran ID <> "2" <>"D" is required.	Spaces or invalid date was entered in PCP1 Effective Date in enrollments where PCP1 is required.	Verify and correct.
152	Invalid PCP1 Effective Date when Tran ID <> "2" <> "D" is required.		
153	PCP1 Effective Date whitout spaces when Tran ID <> "2" <> "D" is not required.	PCP1 effective date must be in spaces when the enrollment is not for a PCP2 change and PCP1 is not required.	Verify and correct.
154	PCP1 Effective Date should be spaces when Tran ID = "2"	PCP1 effective date must be in spaces when the enrollment is for a PCP2 change.	Verify and correct.
155	In Enroll, PCP1 effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the PCP1 Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify and correct.
156	Other than Enroll, PCP1 effective date should be 1st of the month.		
157	if PCP1 not null PCP1_effective_Date should be not null and viceversa	When there is data in the PCP1 field there should be a valid date in the PCP1 Effective Date field and vice versa.	Verify and correct.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
158	if new enroll, carrier change or ipa change, and PCP1 not null, PCP1_effective_Date should be same as Effective_Date. if plan type change, plan version change, pcp1 change or pcp1 and pcp2 change, and PCP1 not null, PCP1_effective_Date should be greater or equal than Effective_Date in member_eligibility.		Verify and correct.
161	Spaces in PCP2 when If Trans_ID in ("2", "3")	Tran_ID 2 and 3 require data in PCP2 field.	Verify and correct.
162	PCP2 should be spaces when If Trans_ID not in ("2", "3")		
171	Spaces in PCP2 Effective Date when If Trans_ID in ("2", "3")	Tran_ID 2 and 3 require date in PCP2 effective Date field field.	Verify and correct.
172	Invalid PCP2 Effective Date when Tran ID <> "2"	Invalid data in PCP2 Effective Data	
173	In Enroll, PCP2 effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the PCP2 Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify and correct.
174	Other than Enroll, PCP2 effective date should be 1st of the month.		
175	if PCP2 not null PCP2_effective_Date should be not null and viceversa	When there is data in the PCP2 field there should be a valid date in the PCP2 Effective Date field an dvice versa.	
176	if Tran_ID="D" should be null		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
177	Enrolled in other carrier at or after enrollment Effective Date	The member was enrolled in another carrier after the effective date in the enrollment record	
178	if new enroll, carrier change or ipa change, and PCP2 not null, PCP2_effective_Date should be same as Effective_Date. if plan type change, plan version change, pcp2 change or pcp1 and pcp2 change, and PCP2 not null, PCP2_effective_Date should be greater or equal than Effective_Date in member_eligibility.		Verify and correct.
179	Future subscription already set for another carrier at enrollment future Effective Date		
181	Is required then Family Primary Center had spaces	family Primary Center required for Reforma	
182	Is not required and Family Primary Center didn't had spaces.		
183	if Tran_ID = "D" should be space		
191	Is required and Family Primary Center Effective Date have spaces		
192	Incorrect Family Primary Center Effective Date		
193	Is not required and Family Primary Center Effective Date did not have		
194	if Tran_ID="D" should be null		
200	if Tran_ID = "D" should be space		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
5-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
211	Incorrect Plan and Version: Members is not Federal Medicaid	The Plan Type and Version contracted by the carrier require that the member be Federal Medicare and the ASES database indicates the member is not Federal Medicare.	
221	Duplicate Enrollment	Two enrollment records entered in the same daily run for the same member as defined by Family_ID and Suffix.	
222	Already Enroll in the Same Carrier	When the Tran_ID is E and the ASES database has the member as enrolled in the same carrier	Verify if the record should have been send with another Tran_ID (like V or I). If not the member is already enrolled and no further action should be required.
223	Already Enroll in Other Carrier	When the Tran_ID is E and the ASES database has the member as enrolled in another carrier.	Verify if the record should have been send with a carrier change Tran_ID (E).
224	Member Not Eligible At Carrier Effective Date		
225	Incorrect SSN		
226	Incorrect MPI		
227	Trans ID = "P" and Carrier is different from actual subscribed Carrier.	Only the current carrier in the ASES database can submit a Plan Change enrollment record. The Member is enrolled under a different carrier in the ASES database.	Verify if the record should have been send with another Tran_ID.
228	Trans ID = "V" and Carrier or Plan Type are different as the actual data.	Version changes are allowed under the same carrier and Plan Type. Only the current carrier in the ASES database can submit a Version Change enrollment record. The Member is enrolled under a different carrier or Plan Type in the ASES database.	Verify if the record should have been send with another Tran_ID

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 15-08

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
229	Trans ID = "I" and Carrier or Plan Type or Version are different as the actual data.	Ipa changes are allowed under the same carrier, Plan Type and Version. Only the current carrier in the ASES database can submit a IPA Change enrollment record. The Member is enrolled under a different carrier or Plan Type or Version in the ASES database.	Verify if the record should have been send with another Tran_ID
22A	Trans ID in ("1", "2", "3") and Carrier orPlan Type or Version or Primary Center are different as the actual data.	PCP changes are allowed under the same carrier, Plan Type, Version and IPA. Only the current carrier in the ASES database can submit a PCP Change enrollment record. The Member is enrolled under a different carrier or Plan Type or version or IPA in the ASES database.	Verify if the record should have been send with another Tran_ID
22B	if TransID=3 , PCP1 and PCP2 both effective dates must be future or		
22C	Member in the same family should be in the same carrier,plan_type,version,primary center,	For Reforma members in a family.	
22D	Invalid new field date values	Effective date can not be greater than run date by more than 4 months	
22E	if PLAN_TYPE="01" then PLAN_VERSION should be the same as the COVERAGE_CODE	In Enrollment record for Reform (Plan Type 01) beneficiaries the Version field must match the coverage code field in the ASES database for the member being enrolled.	Verify and correct.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 15-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
22F	if PLAN_TYPE="01" and exists an Error_code in one family_id all member are rejected	When and enrollment record for one family member has errors, all the family members are given the 22F error code. This Keeps all the enrollment record for a family together and avoids partial processing of the family members in the same run.	Correct the errors other than 22F in all family Members.
22G	if PLAN_TYPE="02" or "03" (Platino) then PLAN_VERSION in the Enrollment record should match the PLAN_VERSION with the same COVERAGE_CODE assigned in the Plan Detail table.	For Platino enrollments: The member Coverage Code is assigned a specific Version in the Plan Detail Table. If a different Version is used this error will be produced. For members with Coverage Code 012 or 013 the Version for Coverage Code 011 must be used.	Correct Version and submitt Enrollment again.
241	When Plan Type =1 and new enrollment		
242	carrier change to plan type =1 and alredy exist in Member eligibility table		
250	if Tran_ID = "D" should be space		
260	if Tran_ID = "D" should be space		
270	if Tran_ID="D" should be null		
280	Family should be elegible		
281	Member should be eligible		
980	Record already enrolled in history has higher or equal process date.		
981	Rejected family member has errors not accepted by SYSPREM.		
982	Effective Date before '01/01/2006'		

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 15-08

ELIGIBILITY QUERY FILE LAYOUT

August 1, 2008

This file is produced by MA Carriers and sent to ASES to verify the elegibility of Medicare Beneficiaries in the GHIP (Reforma). .

Query Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"Q" for Query
2	PROCESS_DATE	2	8	YYYYMMDD
3	BENEFICARY SSN	10	9	
4	1ST_LAST_NAME	19	15	
5	2ND_LAST_NAME	34	15	
6	FIRST_NAME	49	20	
7	SEX	69	1	1 = Male, 2 = Female
8	DATE OF BIRTH	70	8	YYYYMMDD
9	REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	FECHA DE EFECTIVIDAD	81	8	Para uso en queries historicos. Entrar fecha en que comienza la suscripcion del Beneficiario. Formato YYYYMMDD. El dia debe ser primero de mes. Si el query no es historico se deja en blanco.
12	FILLER	89	11	
		100		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 16-086

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
983	Already subscribed in the same Carrier at the specified Effective Date.		
984	Tran_Id = 'E', Effective Date is not 1st of the month and member is already subscribed in another Carrier.		Must be resubmitted as a carrier change (tran_id = "C". Effective date must be 1st of the following month.
985	If special_enroll = 'E', effective date should be at least as recent as member certification date at the specified Effective Date.		
986	For SYSPREM processing, the Effective Date should be before the Effective Date of the current record at Member Eligibility.		Verify Effective Date.
995	Had 22F but was re-evaluated because the records with errors in its family were processed by SYSPREM.		
996	Processed by SYSPREM	Not an Error	No Action Should be taken.
998	Spaces in Record Key.	Not an Error	No Action Should be taken.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 15 - 08

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

rror Cod	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
999	New Case with a Record Key.	Not an Error	No Action Should be taken.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-086

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

INFORMATION SYSTEMS

ASES 820 (HIPAA COMPLIANCE PREMIUM OR FEE PAYMENT FILE)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
15-08

ASES
Administración de Seguros de Salud de Puerto Rico

ASES 820

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	4010A1 - 5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
ISA	**Interchange Control Header**	**R**					**Interchange Control Header**							
ISA01	Authorization Information Qualifier	R	ID	2 / 2			Authorization Information Qualifier	R	ID	2 / 2				00
ISA02	Authorization Information	R	AN	10 / 10			Authorization Information	R	AN	10 / 10				SPACES(10)
ISA03	Security Information Qualifier	R	ID	2 / 2			Security Information Qualifier	R	ID	2 / 2				00
ISA04	Security Information	R	AN	10 / 10			Security Information	R	AN	10 / 10				SPACES(10)
ISA05	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA06	Interchange Sender ID	R	AN	15 / 15			Interchange Sender ID	R	AN	15 / 15				ASES+SPACES(11)
ISA07	Interchange ID Qualifier	R	ID	2 / 2			Interchange ID Qualifier	R	ID	2 / 2				ZZ
ISA08	Interchange Receiver ID	R	AN	15 / 15			Interchange Receiver ID	R	AN	15 / 15				(CARRIER_NAME)+SPACES(VAR)
ISA09	Interchange Date	R	DT	6 / 6			Interchange Date	R	DT	6 / 6				SYSTEM DATE (YYMMDD)
ISA10	Interchange Time	R	TM	4 / 4			Interchange Time	R	TM	4 / 4				SYSTEM TIME (HHMM)
ISA11	Interchange Control Standards Identifier	R	ID	1 / 1		U	Repetition Separator	R	ID	1 / 1		^	Usage	^
ISA12	Interchange Control Version Number	R	ID	5 / 5		00401	Interchange Control Version Number	R	ID	5 / 5		00501	Values	00501
ISA13	Interchange Control Number	R	NO	9 / 9			Interchange Control Number	R	NO	9 / 9				SYSTEM DATE (YYMMDD)+001
ISA14	Acknowledgment Requested	R	ID	1 / 1			Acknowledgment Requested	R	ID	1 / 1				0
ISA15	Production Data	R	ID	1 / 1		P, T	Production Data	R	ID	1 / 1		P, T		P
ISA16	Component Element Separator	R	ID	1 / 1		|	Component Element Separator	R	ID	1 / 1		|		|
GS	**Functional Group Header**	**R**					**Functional Group Header**							
GS01	Functional Identifier Code	R	ID	2 / 2		PO, RA	Functional Identifier Code	R	ID	2 / 2				RA
GS02	Application Sender's Code	R	AN	2 / 15			Application Sender's Code	R	AN	2 / 15				ASES
GS03	Application Receiver's Code	R	AN	2 / 15			Application Receiver's Code	R	AN	2 / 15				(CARRIER_NAME)+SPACES(VAR)
GS04	Date	R	DT	8 / 8			Date	R	DT	8 / 8				SYSTEM DATE (YYYYMMDD)

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GS05	Time	R	TM	4 / 8			Time	R	TM	4 / 8				SYSTEM TIME (HHMM)
GS06	Group Control Number	R	NO	1 / 9			Group Control Number	R	NO	1 / 9				1+SYSTEM DATE (YYMMDD)
GS07	Responsible Agency Code	R	ID	1 / 2			Responsible Agency Code	R	ID	1 / 2				X
GS08	Version / Release / Industry Identifier Code	R	AN	1 / 12		004010X061A1	Version / Release / Industry Identifier Code	R	AN	1 / 12		005010X218	Values	005010X218
ST	**Transaction Set Header**	**R**					**Transaction Set Header**	**R**						
ST01	Transaction Set Identifier Code	R	R	3 / 3		820	Transaction Set Identifier Code	R	R	3 / 3		820		820
ST02	Transaction Set Control Number	R	ID	4 / 9			Transaction Set Control Number	R	ID	4 / 9				YYMM+CARRIER_ID+REGION+PLAN_TYPE
ST03							Implementation Convention Reference	R	AN	1 / 35		005010X218	New	005010X218
BPR	**Financial Information**	**R**					**Financial Information**	**R**						
BPR01	Transaction Handling Code	R	ID	1 / 2		C,D,U,I,P,U,X	Transaction Handling Code	R	ID	1 / 2		C,D,U,I,P,U,X		I
BPR02	Total Premium Payment Amount	R	R	1 / 18			Total Premium Payment Amount	R	R	1 / 18				Sum of CALC_AMOUNT for Carrier/Region/Plan_Type
BPR03	Credit or Debit Flag Code	R	ID	1 / 1		C,D	Credit or Debit Flag Code	R	ID	1 / 1		C,D		C
BPR04	Payment Method Code	R	ID	3 / 3		ACH,BOP,CHK,FWT,SWT	Payment Method Code	R	ID	3 / 3		ACH,BOP,CHK,FWT,NON,SWT	Values	CHK
BPR05	Payment Format Code	S	ID	1 / 10		CCP,CTX	Payment Format Code	S	ID	1 / 10		CCP,CTX		
BPR06	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,04	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,02,04	Values	
BPR07	Originating Depository Financial Institution (DFI) Identifier	S	AN	3 / 12			Originating Depository Financial Institution (DFI) Identifier	S	AN	3 / 12				
BPR08	Account Number Qualifier	S	ID	1 / 3		ALC,DA	Account Number Qualifier	S	ID	1 / 3		ALC,DA		
BPR09	Sender Bank Account Number	S	AN	1 / 35			Sender Bank Account Number	S	AN	1 / 35				

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Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	4010A1 - 5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
BPR10	Originating Company Identifier	S	AN	10 / 10			Originating Company Identifier	R	AN	10 / 10			Usage Req.	ASES_FEDERAL_TAX ID
BPR11	Originating Company Supplemental Code	S	AN	9 / 9			Originating Company Supplemental Code	S	AN	9 / 9				[redacted]
BPR12	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,04	Depository Financial Institution (DFI) ID Number Qualifier	S	ID	2 / 2		01,02,04	Values	[redacted]
BPR13	Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12			Receiving Depository Financial Institution (DFI) Identifier	S	AN	3 / 12				[redacted]
BPR14	Account Number Qualifier	S	ID	1 / 3		DA,SG	Account Number Qualifier	S	ID	1 / 3		DA,SG		[redacted]
BPR15	Receiver Bank Account Number	S	AN	1 / 35			Receiver Bank Account Number	S	AN	1 / 35				[redacted]
BPR16	Check Issue or EFT Effective Date	R	DT	8 / 8			Check Issue or EFT Effective Date	R	DT	8 / 8				Check Date
TRN	**Reassociation Key**	**R**					**Reassociation Trace Number**	**R**					**Desc.**	
TRN01	Trace Type Code	R	ID	1 / 2		1,3	Trace Type Code	R	ID	1 / 2		1,3		3
TRN02	Check or EFT Trace Number	R	AN	1 / 30			Check or EFT Trace Number	R	AN	1 / 50			Max	Check Number
TRN03	Originating Company Identifier	S	AN	10 / 10			Originating Company Identifier	S	AN	10 / 10				[redacted]
TRN04	Originating Company Supplemental Code	S	AN	1 / 30			Originating Company Supplemental Code	S	AN	1 / 50			Max	[redacted]
CUR	**Non-US Dollars Currency**	**S**					**Foreign Currency Information**	**S**						
CUR01	Entity Identifier Code	R	ID	2 / 3		2B,PR	Entity Identifier Code	R	ID	2 / 3		2B,PR		[redacted]
CUR02	Currency Code	R	ID	3 / 3		MXP,CAD, USD	Currency Code	R	ID	3 / 3		MXP,CAD	Values	[redacted]
CUR03	Exchange Rate	S	R	4 / 10			[redacted]						Usage Req.	[redacted]
REF	**Premium Receiver Identification Key**	**S**					**Premium Receiver Identification Key**	**S**						
REF01	Reference Identification Qualifier	R	ID	2 / 3		14,18,2F,38 ,72	Reference Identification Qualifier	R	ID	2 / 3		14,17,18,2F ,38,72,LB	Values	14
REF02	Premium Receiver Reference Identifier	R	AN	1 / 30			Premium Receiver Reference Identifier	R	AN	1 / 50			Max	CARRIER+REGION_ID +PRIMARY_CENTER
DTM	**Process Date**	**S**					**Process Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		[redacted]

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DTM02	Payer Process Date	R	DT	8 / 8			Payer Process Date	R	DT	8 / 8				
DTM	**Delivery Date**	**S**					**Delivery Date**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		009	Date Time Qualifier	R	ID	3 / 3		009		
DTM02	Premium Delivery Date	R	DT	8 / 8			Premium Delivery Date	R	DT	8 / 8				
DTM	**Coverage Period**	**S**					**Coverage Period**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3		582	Date Time Qualifier	R	ID	3 / 3		582		
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3			Date Time Period Format Qualifier	R	ID	2 / 3				
DTM06	Coverage Period	R	AN	1 / 35			Coverage Period	R	AN	1 / 35				
DTM							**Creation Date**	**S**					**New**	
DTM01							Date Time Qualifier	R	ID	3 / 3		097	New	
DTM02							Creation Date	R	DT	8 / 8			New	
N1	**Premium Receiver's Name**	**R**			**1000A**		**Premium Receiver's Name**	**R**			**1000A**			
N101	Entity Identifier Code	R	ID	2 / 3	1000A	PE	Entity Identifier Code	R	ID	2 / 3	1000A	PE		PE
N102	Information Receiver Last or Organization Name	R	AN	1 / 60	1000A		Information Receiver Last or Organization Name	R	AN	1 / 60	1000A			CARRIER_NAME
N103	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	Identification Code Qualifier	R	ID	1 / 2	1000A	1,9,EQ,FI,XV	N/U w/N102	FI
N104	Receiver Identifier	R	AN	2 / 80	1000A		Receiver Identifier	R	AN	2 / 80	1000A		N/U w/N102	CARRIER_FEDERAL_TAX_ID
N2	**Premium Receiver's Additional Name**	**S**					**Premium Receiver's Additional Name**	**S**						
N201	Receiver Additional Name	R	AN	1 / 60	1000A		Receiver Additional Name	R	AN	1 / 60	1000A			
N3	**Premium Receiver's Address**	**S**					**Premium Receiver's Address**	**S**						
N301	Receiver Address Line	R	AN	1 / 55	1000A		Receiver Address Line	R	AN	1 / 55	1000A			
N302	Receiver Address Line	S	AN	1 / 55	1000A		Receiver Address Line	S	AN	1 / 55	1000A			
N4	**Premium Receiver's City, State, Zip**	**S**					**Premium Receiver's City, State, Zip Code**	**S**					**Desc.**	
N401	Information Receiver City Name	R	AN	2 / 30	1000A		Information Receiver City Name	R	AN	2 / 30	1000A			
N402	Information Receiver State Code	R	ID	2 / 2	1000A		Information Receiver State Code	S	ID	2 / 2	1000A		Usage Req.	
N403	Information Receiver Postal Zone or ZIP Code	R	ID	3 / 15	1000A		Information Receiver Postal Zone or ZIP Code	S	ID	3 / 15	1000A		Usage Req.	

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N404	Country Code	S	ID	2 / 3	1000A		Country Code	S	ID	2 / 3	1000A			
N407							Country Subdivision Code	S	ID	1 / 3	1000A		New	
RDM							**Premium Receiver's Remittance Delivery Method**	**S**					**New**	
RDM01							Report Transmission Code	R	ID	1 / 2	1000A	BM,EM,FT, FX,IA,OL	New	
RDM02							Name	S	AN	1 / 60	1000A		New	
RDM03							Communication Number	S	AN	1 / 256	1000A		New	
N1	**Premium Payer's Name**	**R**			**1000B**		**Premium Payer's Name**	**R**			**1000B**			
N101	Entity Identifier Code	R	ID	2 / 3	1000B	PR	Entity Identifier Code	R	ID	2 / 3	1000B	PR		PR
N102	Premium Payer Name	S	AN	1 / 60	1000B		Premium Payer Name	S	AN	1 / 60	1000B			ASES_NAME
N103	Identification Code Qualifier	S	ID	1 / 2	1000B	1,9,24,75,EQ,FI,PI	Identification Code Qualifier	S	ID	1 / 2	1000B	1,9,24,75,EQ,FI,PI	N/U w/N102	FI
N104	Premium Payer Identifier	S	AN	2 / 80	1000B		Premium Payer Identifier	S	AN	2 / 80	1000B		N/U w/N102	ASES_FEDERAL_TAX ID
N2	**Premium Payer's Additional Name**	**S**					**Premium Payer's Additional Name**	**S**						
N201	Premium Payer Additional Name	R	AN	1 / 60	1000B		Premium Payer Additional Name	R	AN	1 / 60	1000B			
N3	**Premium Payer's Address**	**S**					**Premium Payer's Address**	**S**						
N301	Premium Payer Address Line	R	AN	1 / 55	1000B		Premium Payer Address Line	R	AN	1 / 55	1000B			
N302	Premium Payer Address Line	S	AN	1 / 55	1000B		Premium Payer Address Line	S	AN	1 / 55	1000B			
N4	**Premium Payer's City State Zip**	**S**					**Premium Receiver's City, State, Zip Code**	**S**					**Desc.**	
N401	Premium Payer City Name	R	AN	2 / 30	1000B		Premium Payer City Name	R	AN	2 / 30	1000B			
N402	Premium Payer State Code	R	ID	2 / 2	1000B		Premium Payer State Code	S	ID	2 / 2	1000B		Usage Req.	
N403	Premium Payer Postal Zone or ZIP Code	R	ID	3 / 15	1000B		Premium Payer Postal Zone or ZIP Code	S	ID	3 / 15	1000B		Usage Req.	
N404	Country Code	S	ID	2 / 3	1000B		Country Code	S	ID	2 / 3	1000B			
N407							Country Subdivision Code	S	ID	1 / 3	1000B		New	

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PER	**Premium Payer's Administrative Contact**	S					**Premium Payer's Administrative Contact**	S						
PER01	Contact Function Code	R	ID	2 / 2	1000B	IC	Contact Function Code	R	ID	2 / 2	1000B	IC		
PER02	Premium Payer Contact Name	R	AN	1 / 60	1000B		Premium Payer Contact Name	R	AN	1 / 60	1000B			
PER03	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,FX,TE	Communication Number Qualifier	R	ID	2 / 2	1000B	EM,FX,TE	Usage Req.	
PER04	Communication Number	S	AN	1 / 80	1000B		Communication Number	R	AN	1 / 256	1000B		U. Req./Max	
PER05	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE		
PER06	Communication Number	S	AN	1 / 80	1000B		Communication Number	S	AN	1 / 256	1000B		Max	
PER07	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE	Communication Number Qualifier	S	ID	2 / 2	1000B	EM,EX,FX,TE		
PER08	Communication Number	S	AN	1 / 80	1000B		Communication Number	S	AN	1 / 256	1000B		Max	
N1							**Intermediary Bank Information**	S			**1000C**		**New**	
N101							Entity Identifier Code	R	ID	2 / 3	1000C	04,0B,8W,AK,BE,BK,C1,C2,IAT,MJ,RB,Z6,ZB,ZL	New	
N102							Name	S	AN	1 / 60	1000C		New	
N103							Identification Code Qualifier	S	ID	1 / 2	1000C	31,57,94,A3,A4,A6,CF,G,PA	New	
N104							Identification Code	S	AN	2 / 80	1000C		New	
N2							**Intermediary Bank Additional Name**	S					**New**	
N201							Name	R	AN	1 / 60	1000C		New	
N3							**Intermediary Bank's Address**	S					**New**	
N301							Address Information	R	AN	1 / 55	1000C		New	
N302							Address Information	S	AN	1 / 55	1000C		New	
N4							**Intermediary Bank's City, State, Zip Code**	S					**New**	
N401							City Name	R	AN	2 / 30	1000C		New	

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N402							State or Province Code	S	ID	2 / 2	1000C		New	
N403							Postal Code	S	ID	3 / 15	1000C		New	
N404							Country Code	S	ID	2 / 3	1000C		New	
N407							Country Subdivision Code	S	ID	1 / 3	1000C		New	
PER							**Intermediary Bank's Administrative Contact**	**S**					**New**	
PER01							Contact Function Code	R	ID	2 / 2	1000C	IC	New	
PER02							Name	R	AN	1 / 60	1000C		New	
PER03							Communication Number Qualifier	R	ID	2 / 2	1000C	EM,FX,TE	New	
PER04							Communication Number	R	AN	1 / 256	1000C		New	
PER05							Communication Number Qualifier	S	ID	2 / 2	1000C	EM,EX,FX,TE	New	
PER06							Communication Number	S	AN	1 / 256	1000C		New	
PER07							Communication Number Qualifier	S	ID	2 / 2	1000C	EM,EX,FX,TE	New	
PER08							Communication Number	S	AN	1 / 256	1000C		New	
ENT	**Organization Summary Remittance**	**S**			**2000A**		**Organization Summary Remittance**	**S**			**2000A**			
ENT01	Assigned Number	R	NO	1 / 6	2000A		Assigned Number	R	NO	1 / 6	2000A			
ENT02	Entity Identifier Code	R	ID	2 / 3	2000A	2L	Entity Identifier Code	R	ID	2 / 3	2000A	2L,AG,NH,RGA,UN	Values	
ENT03	Identification Code Qualifier	S	ID	1 / 2	2000A	1,9,FI	Identification Code Qualifier	R	ID	1 / 2	2000A	1,9,24,FI	U. Req./Values	
ENT04	Organization Identification Code	S	AN	2 / 80	2000A		Organization Identification Code	R	AN	2 / 80	2000A		Usage Req.	
ADX							**Organization Summary Remittance Level Adjustment for Previous Payment**	**S**			**2200A**		**New**	
ADX01							Premium Payment Adjustment Amount	R	R	1 / 18	2200A		New	

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ADX02							Premium Payment Adjustment Reason	R	ID	2 / 2	2200A	52,53,80,81,86,BJ,H1,H6,RU,WO,WW	New	
RMR	**Organization Summary Remittance Detail**	**R**			**2300**		**Organization Summary Remittance Detail**	**R**			**2300**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300	11,1L,CT,IK	Reference Identification Qualifier	R	ID	2 / 3	2300	11,1L,CT,IK		
RMR02	Contract, Invoice, Account, Group, or Policy Number	R	AN	1 / 30	2300		Contract, Invoice, Account, Group, or Policy Number	R	AN	1 / 50	2300		Max	
RMR03	Payment Action Code	S	ID	2 / 3	2300	PA,PI,PO,PP	Payment Action Code	S	ID	2 / 2	2300	PA,PI,PO,PP	Max	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300		Detail Premium Payment Amount	R	R	1 / 18	2300			
RMR05	Billed Premium Amount	S	R	1 / 18	2300		Billed Premium Amount	S	R	1 / 18	2300			
REF							**Premium Receivers Identification Key**	**S**			**2300A**		**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300A	14,17,18,2F,38,E9,LB,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300A		New	
DTM							**Organizational Coverage Period**	**S**			**2300A**		**New**	
DTM01							Date Time Qualifier	R	ID	3 / 3	2300A	582,AAG	New	
DTM02							Date	S	DT	8 / 8	2300A		New	
DTM05							Date Time Period Format Qualifier	S	ID	2 / 3	2300A	RD8	New	
DTM06							Date Time Period	S	AN	1 / 35	2300A		New	
IT1	**Summary Line Item**	**S**			**2310A**		**Summary Line Item**	**S**			**2310A**			
IT101	Line Item Control Number	R	AN	1 / 20	2310A		Line Item Control Number	R	AN	1 / 20	2310A			
SAC							Service, Promotion, Allowance or Charge Information	S			2312A		New	
SAC01							Allowance or Charge Indicator	R	ID	1 / 1	2312A	C	New	

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SAC02							Service, Promotion, Allowance or Charge Code	R	ID	4 / 4	2312A	A172,B680, D940,G740	New	
SAC05							Amount	R	ID	1 / 15	2312A		New	
SLN	**Member Count**	**S**			**2315A**		**Member Count**	**S**			**2315A**			
SLN01	Line Item Control Number	R	AN	1 / 20	2315A		Line Item Control Number	R	AN	1 / 20	2315A			
SLN03	Information Only Indicator	R	ID	1 / 1	2315A	O	Information Only Indicator	R	ID	1 / 1	2315A	O		
SLN04	Head Count	R	R	1 / 15	2315A		Head Count	R	R	1 / 15	2315A			
SLN05	Unit or Basis for Measurement Code	R	ID	2 / 2	2315A	10,IE,PR	Unit or Basis for Measurement Code	R	ID	2 / 2	2315A	10,IE,PR		
ADX	**Organization Summary Remittance Level Adj.**	**S**			**2320A**		**Organization Summary Remittance Level Adj.**	**S**			**2320A**			
ADX01	Adjustment Amount	R	R	1 / 18	2320A		Adjustment Amount	R	R	1 / 18	2320A			
ADX02	Adjustment Reason Code	R	ID	2 / 2	2320A	20,52,53,A A,H1,H6,IA, J3	Adjustment Reason Code	R	ID	2 / 2	2320A	20,52,53,A A,H1,H6,IA, J3		
ENT	**Individual Remittance**	**S**			**2000B**		**Individual Remittance**	**S**			**2000B**			
ENT01	Assigned Number	R	NO	1 / 6	2000B		Assigned Number	R	NO	1 / 6	2000B			AUTONUMBER(+1) RESET TO 1 AT NEXT ST
ENT02	Entity Identifier Code	R	ID	2 / 3	2000B	2J	Entity Identifier Code	R	ID	2 / 3	2000B	2J		2J
ENT03	Identification Code Qualifier	R	ID	1 / 2	2000B	34,EI,ZZ	Identification Code Qualifier	R	ID	1 / 2	2000B	34,EI,II	Values	34
ENT04	Receiver's Individual Identifier	R	AN	2 / 80	2000B		Receiver's Individual Identifier	R	AN	2 / 80	2000B			MEMBER Social Security Number
NM1	**Individual Name**	**S**			**2100B**		**Individual Name**	**S**			**2100B**			
NM101	Entity Identifier Code	R	ID	2 / 3	2100B	EY,QE	Entity Identifier Code	R	ID	2 / 3	2100B	DO,EY,IL,Q E	Values	QE
NM102	Entity Type Qualifier	R	ID	1 / 1	2100B	1	Entity Type Qualifier	R	ID	1 / 1	2100B	1		1
NM103	Individual Last Name	S	AN	1 / 35	2100B		Individual Last Name	S	AN	1 / 60	2100B		Max	MEMBER_LAST_NAM E_1
NM104	Individual First Name	S	AN	1 / 25	2100B		Individual First Name	S	AN	1 / 35	2100B		Max	
NM105	Individual Middle Name	S	AN	1 / 25	2100B		Individual Middle Name	S	AN	1 / 25	2100B			
NM106	Individual Name Prefix	S	AN	1 / 10	2100B		Individual Name Prefix	S	AN	1 / 10	2100B			

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NM107	Individual Name Suffix	S	AN	1 / 10	2100B		Individual Name Suffix	S	AN	1 / 10	2100B			
NM108	Identification Code Qualifier	S	ID	1 / 2	2100B	34,EI,N	Identification Code Qualifier	S	ID	1 / 2	2100B	34,EI,N		
NM109	Individual Identifier	S	AN	2 / 80	2100B		Individual Identifier	S	AN	2 / 80	2100B			
ADX							**Individual Premium Adjustment for Previous Payment**	**S**			**2200B**		**New**	
ADX01							Premium Payment Adjustment Amount	R	R	1 / 18	2200B		New	
ADX02							Adjustment Reason Code	R	ID	2 / 2	2200B	52,53,80,81,86,BJ,H1,H6,RU,WO	New	
RMR -1	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		11
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	FAMILY_ID+Member_Suffix+MPI+Municipio
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			
REF - 1							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
DTM - 1	**Individual Coverage Period**	**S**					**Individual Coverage Period**	**S**						
DTM01	Date Time Qualifier	R	ID	3 / 3	2300B	582	Date Time Qualifier	R	ID	3 / 3	2300B	582,AAG	Values	582
DTM02							Date	S	DT	8 / 8	2300B		Usage Req.	
DTM05	Date Time Period Format Qualifier	R	ID	2 / 3	2300B	RD8	Date Time Period Format Qualifier	S	ID	2 / 3	2300B	RD8	Usage Req.	RD8

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ASES 820

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	4010A1 - 5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
DTM06	Coverage Period	R	AN	1 / 35	2300B		Coverage Period	S	AN	1 / 35	2300B		Usage Req.	Coverage Start Dt-Coverage End Dt based upon CALC_DAYS. Use Accounting Dt for retro and adjustments. (YYYYMMDD)
RMR - 2	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		IK
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	CARRIER_ID+REGION+BILLING_DATE(YYMM)
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			CALC_AMOUNT
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			BILLED_AMOUNT
REF - 2							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
ADX - 2	**Individual Premium Adjustment**	**S**			**2320B**		**Individual Premium Adjustment**	**S**			**2320B**			
ADX01	Adjustment Amount	R	R	1 / 18	2320B		Adjustment Amount	R	R	1 / 18	2320B			(CALC_AMMOUNT minus BILLED_AMOUNT)+adjustment_carrier_code
ADX02	Adjustment Reason Code	R	ID	2 / 2	2320B	20,52,53,AA,AX,H1,H6,IA,J3	Adjustment Reason Code	R	ID	2 / 2	2320B	20,52,53,AA,AX,H1,H6,IA,J3		IA
RMR - 3	**Individual Premium Remittance Detail**	**S**			**2300B**		**Individual Premium Remittance Detail**	**S**			**2300B**			
RMR01	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW	Reference Identification Qualifier	R	ID	2 / 3	2300B	11,9J,AZ,B7,CT,ID,IG,IK,KW		KW
RMR02	Insurance Remittance Reference Number	R	AN	1 / 30	2300B		Insurance Remittance Reference Number	R	AN	1 / 50	2300B		Max	ERROR_CODES

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ASES 820

Element	4010A1 Identifier Description	Usage Req.	Type	Min/Max	Loop	Req./Rec. Values	4010A1 - 5010 SIDE BY SIDE Identifier Description	Usage Req.	Type	Min-Max	Loop	Req./Rec. Values	Notes Changes	Notes ASES
RMR03	Payment Action Code	S	ID	2 / 2	2300B	PI,PP							Usage Req.	
RMR04	Detail Premium Payment Amount	R	R	1 / 18	2300B		Detail Premium Payment Amount	R	R	1 / 18	2300B			0
RMR05	Billed Premium Amount	S	R	1 / 18	2300B		Billed Premium Amount	S	R	1 / 18	2300B			
REF - 3							**Reference Information**	**S**					**New**	
REF01							Reference Identification Qualifier	R	ID	2 / 3	2300B	14,18,2F,38,E9,LU,ZZ	New	
REF02							Reference Identification	R	AN	1 / 50	2300B		New	
SE	**Transaction Set Trailer**	**R**					**Transaction Set Trailer**	**R**						
SE01	Transaction Segment Count	R	NO	1 / 10			Transaction Segment Count	R	NO	1 / 10				Count of segments including ST and SE
SE02	Transaction Set Control Number	R	AN	4 / 9			Transaction Set Control Number	R	AN	4 / 9				YYMM+CARRIER_ID+REGION+PLAN_TYPE
GE	**Functional Group Trailer**	**R**					**Functional Group Trailer**	**R**						
GE01	Number of Transaction Sets Included	R	NO	1 / 6			Number of Transaction Sets Included	R	NO	1 / 6				1
GE02	Group Control Number	R	NO	1 / 9			Group Control Number	R	NO	1 / 9				1+SYSTEM DATE(YYMMDD)
IEA	**Interchange Control Trailer**	**R**					**Interchange Control Trailer**	**R**						
IEA01	Number of Included Functional Groups	R	NO	1 / 5			Number of Included Functional Groups	R	NO	1 / 5				1
IEA02	Interchange Control Number	R	NO	9 / 9			Interchange Control Number	R	NO	9 / 9				SYSTEM DATE (YYMMDD)+001

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