

**834 Benefit Enrollment and Maintenance
Companion Guide
ANSI X12 834 (Version 4010)
Implementation Guide**



Simply, the right choice.
COMMUNITY HEALTH PLAN

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This Companion Guide is a work in progress. Community Health Plan reserves the right to make changes to this Companion Guide at any time without notice. When changes are made, the Change Summary on the last page of this section will identify those changes and give the date and reason for the change.

INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 834 Benefit Enrollment and Maintenance transaction implementation guide provides the standardized data requirements to be implemented for electronic enrollment submissions.

The 834 transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. Only sponsors that have been deemed “covered entities” are required to use the ANSI X12N 834 transaction.

PURPOSE

The purpose of this document is to provide the information necessary to submit enrollment information electronically to Community Health Plan. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer’s system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-di.com/hipaa/.

Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>

United States Department of Health and Human Services (HHS) – <http://aspe.hhs.gov/admsimp/>

Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>

Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

DEFINITION OF TERMS USED

Sponsor

The sponsor is the party that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association or insurance agency.

Payer/Insurer

The payer is the party that pays claims and/or administers the insurance coverage, benefit or product. A payer can be an insurance company; Health Maintenance Organization, Preferred Provider Organization, government agency or another organization contracted by one of these groups. The Payer may be referred to as the Insurer in certain sections of this document.

Third Party Administrator (TPA)

A sponsor may elect to contract with a TPA or other vendor to handle collecting insured member data if the sponsor chooses not to perform this function.

HIPAA IMPACT ON CURRENT BUSINESS PROCESSES

The 834 Benefit Enrollment and Maintenance transaction requires the employer group/sponsor to submit additional data not present in the pre-HIPAA enrollment transactions. The structure of the 834 may also enable the sponsor to relay information in a more efficient manner and may impact current business processes.

Types of Enrollment files

The 834 Benefit Enrollment and Maintenance transaction can be used in two different ways, as an update or as a full audit file. The Action Code (BGN08) identifies the use of the transaction set:

- 2 Change (update)
- 4 Verify (full audit)

An update file provides enrollment add, change and terminate requests that need to be applied to the payer's database. The transaction only contains information about changed members. A full audit file contains all current members whether involved in a change or not. The full audit file is intended to identify all active members (it may or may not include terminated members) as of a certain time period, enabling synchronization between the sponsor and payer enrollment systems. The full audit is not intended to provide a history of all previous enrollments.

Community Health Plan recommends weekly Change (update) files with quarterly Verify (full audit) files.

Termination

The 834 transaction provides the capability to terminate a member at either the Member Detail INS level (loop 2000) or at the Health Coverage HD level (loop 2300).

Member Detail Level Termination:

- Subscriber - If the termination date is passed at the INS level for the subscriber then all coverage for the subscriber and all linked dependents is terminated effective that date.
- Dependent – If the termination date is passed at the INS level for the dependent then coverage for that dependent is terminated effective that date.

Health Coverage Level Termination:

- Subscriber – If the termination date is passed at the HD level, coverage for that particular insurance product and member is terminated effective that date. If all insurance products are terminated and the subscriber has no dependents, the subscriber is terminated.
- Dependent - If the termination date is passed at the HD level, coverage for that particular insurance product and member is terminated effective that date. If all insurance products are terminated the dependent is terminated.

Termination dates are not to be sent at both levels when terminating a member. The implementation guide specifies that the use of the Benefit End Date at the Health Coverage Level should be sent when removing coverage from a member but not be used when terminating all eligibility.

A **transfer of coverage** from one insurance product to another requires the termination of the old coverage and then the addition of the new coverage. The addition of the new coverage must never be assumed to result in the automatic termination of the prior coverage. This may be a change to the sponsor's current business processes.

Terminating a Member

Community Health Plan expects the termination date to be sent in the DTP segment at the INS level when terminating a member. The date qualifier of '357' Eligibility End should be sent in element DTP01. All coverage for that member will be terminated effective that date. If the member is the subscriber and dependents are associated with his/her record, the entire family will be terminated.

Changing a Member's Coverage

Depending on how the health coverage is defined in the Community Health Plan system, changing health coverage may require terminating the member in a particular group and enrolling them in a new group associated with the new benefit coverage.

- If the health coverage is directly related to a specific group number, when the member changes coverage the sponsor will send two transactions (separate INS loops) for that member. One will terminate the member in their existing group and the second will enroll the member in the new group and include the Health Coverage loop (2300) providing the details on the new coverage.
- If the health coverage is not tied to a specific group number, changing coverage will require only one transaction (INS loop) be sent for the member. This transaction will contain two iterations of the Health Coverage loop (2300). The first will terminate the existing coverage for the member. The second will add the new coverage for the member.

Coverage Information

The contract between the sponsor and payer must identify the member reporting requirements for the enrollment transaction. Much of the information in the 834 transaction is reported only if required in the contract between the sponsor and payer and not prohibited by state and federal law. The level of detail included in the 834 transaction is dependent upon these contractual relationships.

When additional information is needed by the payer to describe the exact type of coverage of its enrollees, the payer can require the sponsor to relay this information in the Plan Coverage Description (HD04) element in the Health Coverage loop (2300). The sponsor and the payer need to agree upon the actual format and content to be relayed in the loop and document this in the insurance contract.

Community Health Plan expects detail information be provided for the subscriber and each dependent. The coverage level code (HD05) is required for the subscriber record, when enrolling or changing coverage.

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 834 Benefit Enrollment and Maintenance transaction that the health plan will accept.

- 834 Benefit Enrollment and Maintenance – **ASC X12N 834(00401X095A1)**

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

- 997 Functional Acknowledgement

Field Definitions

R (Required): This field must always be included in the transmission.

S (Situational): This field is necessary in certain situations. Please review the ASC X12N Implementation Guide for instructions on when this is required.

N/U (Not Used): The shaded areas of the Companion Guide are NOT USED according to the standard and should not be included in transmissions.

Comments: This provides Community Health Plan's requirements/recommendations for some fields.

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

Community Health Plan will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Maximum Limitations

The 834 transaction is designed to transmit one or more members per subscriber contract. The hierarchy of the looping structure is Member, Health Coverage, Provider and Coordination of Benefit level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. In the 834 transaction, these limitations are explicitly stated such as:

- The Health Coverage loop (2300) is limited to 99 repetitions per member.
- The Provider Information loop (2310) is limited to 30 repetitions per Insurance product.

Although the Member Level Detail loop (2000) is defined in the implementation guide with a repetition of >1, the limitation imposed on the number of INS segments, limits the number of members that may be sent in the 834 transaction set to a maximum of 10,000. While this may not impact the size of an update transaction set, a full audit file may have to be split into multiple 834 transaction sets within a single functional group.

Community Health Plan has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). Community Health Plan requires that the Interchange Control structure is limited to one type of Functional Group, such as 834 Benefit Enrollment and Maintenance functional groups.

Community Health Plan will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.

7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Community Health Plan. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at <http://www.wedi.org/snip/public/articles/index%7E12.htm>.

Community Health Plan will provide the necessary information for clients to submit a file for testing purposes.

Trading Partner Acceptance Testing Specifications

Trading partners wishing to submit enrollment electronically to Community Health Plan, must first submit an error free test file and receive verification from Community Health Plan that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file, contact Community Health Plan's Enrollment Department at (816) 271-7380, or toll-free at 1-800-990-9247 ext. 7380.

The entire file ISA/IEA envelope will either pass (accept) or fail (reject) validation.

Helpful Hint: Create small batches of test enrollment transactions to ensure that you will not have to re-create too many enrollment transactions in the event of an error in the file. Once your files are received and verified to be error-free, you may send files of any size.

After receiving clearance to submit production enrollment files, contact the Enrollment Dept when you submit your first "live" enrollment file. Provide your submitter ID and the Community Health Plan file tracking number (if available). Information Systems will work with the enrollment department to ensure that the file uploads properly and gets all the way through the system.

CHP - 834 Transaction Matrix

ASC X12N Version 004010X095

LOOP ID	Page #(s)	SEG ID	ELEMENT ID	ELEMENT VALUES	ELEMENT DESCRIPTION	REQ (R/S)
	B.3	ISA	Interchange Control Header			R
			01 – Authorization Info Qualifier	00 = No authorization information present	Relates to no meaningful information in ISA02	R
	B.3	ISA	02 – not used	Insert asterisk		R
	B.4	ISA	03 – Security Information Qualifier	00 = No security information present	Relates to no meaningful information in ISA04	R
	B.4	ISA	04 – Security Info	Insert 00		R
	B.4	ISA	05 – Interchange ID Qualifier	ZZ = Mutually Defined		R
	B.4- B.6	ISA	06 – Interchange Sender ID	ID code determined by sender	This is a unique ID number (i.e. Federal Tax ID.) Field length = 15.	R
	B.5	ISA	07 – Interchange ID Qualifier	ZZ = Mutually Defined	This ID qualifies the receiver in ISA08	R
	B.5	ISA	08 – Interchange Receiver ID	ID=GroupNumber		R
	B.5	ISA	09 – Interchange Date	YYMMDD		R
	B.5	ISA	10 – Interchange Time	HHMM		R
	B.5	ISA	11 – Interchange Control Standards Identifier	U		R
	B.5	ISA	12 – Interchange Control Version Number	00401		R
	B.5	ISA	13 – Interchange Control Number		This number must be identical to the associated Interchange Trailer IEA02	R
	B.6	ISA	14 – Acknowledgement Requested	1 = Interchange acknowledgement requested	All senders will receive a 997 code upon successful receipt of file transfer.	R
	B.6	ISA	15 – Usage Indicator	P = Production Data T = Test Data		R
	B.6	ISA	16 – Component Element Terminator	CHP recommends using “>” as the segment terminator and using the “~”, tilde, as the segment separator.	Note: This value must be different than the data element separator and the segment terminator	R
ISA ELEMENT EXAMPLE:						
ISA*00*.....*01*Password..*ZZ*Submitter.ID..*ZZ*Receiver.ID.....*030101*1200*U*00401*123456789*1*T*>~						
Note: The ISA segment is a fixed format. Spaces in the example are presented by “.” for clarity.						
	B.8	GS	01 - Functional Group Header	BE = Benefit enrollment and maintenance		R
	B.8	GS	02 – Senders ID Code	Insert senders ID	Same ID number as ISA06	R
	B.8	GS	03 – Receivers ID Code	Insert receiver ID	Same ID number as ISA08	R
	B.8	GS	04 – Date of functional group creation date	CCYYMMDD		R
	B.8	GS	05 – Time of creation	HHMM		R
	B.9	GS	06 – Group Control Number		This number must match the data element in the associated functional group trailer in GE02	R
	B.9	GS	07 – Responsible Agency Code Identifier	X = Accredited Standards Committee X12		R
	B.9	GS	08 – Version Release/Industry Identifier Code	004010X095 or 004010X095A1	Must use full code	R

GS ELEMENT EXAMPLE: GS*BE*SENDER CODE*CHP777777*20030101*1200*1*X*004010X095~

GS ELEMENT EXAMPLE: GS*BE*SENDER CODE*CHP777777*20030101*1200*1*X*004010X095A1~

LOOP ID	Page #(s)	SEG ID	ELEMENT ID	ELEMENT VALUES	ELEMENT DESCRIPTION	REQ (R/S)
	27	ST	01 – Transaction Set Identifier Code	834		R
	27	ST	02 - Transaction Set Control Number		Group Specific Control Number to identify transaction set. Must match number in SE02	R
ST ELEMENT EXAMPLE: ST*834*0001~						
	28-31	BGN	01- Transaction Set Purpose Code	00 = Original		R
	28-31	BGN	02- Reference Identification	Group Number	Sender Organization Name	R
	28-31	BGN	03- Date		Date 834 created CCYYMMDD	R
	28-31	BGN	04-Time		Date 834 created HHMM	R
	28-31	BGN	08- Action Code	2 = Change (Update) 4 = Verify	2 = Change Only 4 = Full Population Audit (including term records)	R
BGN ELEMENT EXAMPLE: BGN*00*11227*20030301*1200*ES***2~						
1000A	35-36	N1	01-Entity Identifier Code	P5 = Plan Sponsor		R
	35-36	N1	02-Name		Group Name	R
	35-36	N1	03- Identification Code Qualifier	FI = Federal Tax ID		R
	35-36	N1	04- Identification Code		Group Federal Tax ID	R
1000A N1 ELEMENT EXAMPLE: N1*P5*ABC GROUP*FI*123456786~						
1000B	37-38	N1	01- Entity Identifier Code	IN = Insurer		R
	37-38	N1	02- Name	COMMUNITY HEALTH PLAN		R
	37-38	N1	03- Identification Code Indicator	FI = Federal Tax ID		R
	37-38	N1	04- Identification Code	CHP Federal Tax ID 431690582		R
1000B N1 ELEMENT EXAMPLE: N1*IN*COMMUNITY HEALTH PLAN*FI*431690582~						
1000C	39-40	N1	01- TPA/Broker Identifier Code BO = Broker or Sales Office TV = Third Party Admin (TPA)		Note: Loop 1000C is only used if the Broker/TPA is receiving commissions from CHP on the group listed in 1000A	S
	39-40	N1	02- Broker/TPA Name			R (if 1000C is used)
	39-40	N1	03- Identification Code Qualifier	94 = Broker/TPA Number indicator		R (if 1000C is used)
	39-40	N1	04- TPA/Broker Identification Code	CHP Number Assigned to TPA/Broker		R (if 1000C is used)
1000C ELEMENT EXAMPLE: N1*BO*AAA FINANCIAL*94*555555~						
2000	43	INS	01- Yes/No Condition	Y = Yes N = No	Y = Subscriber N = Dependent	R
	44-45	INS	02 – Individual Relationship Code	01 = Spouse 18 = Self 19 = Child Step Child, Ward, Adopted Child, Misc. Child Values 53 = Life Partner/SS Domestic Partner	Relationship to Subscriber	R

LOOP ID	Page #(s)	SEG ID	ELEMENT ID	ELEMENT VALUES	ELEMENT DESCRIPTION	REQ (R/S)
2000	45-47	INS	03 – Maintenance Type Code	001 = Change 021 = Addition 024 = Cancellation or Term 030 = Audit or Compare	001 = Change to existing coverage 021 = Add a Subscriber or Dependent 024 = Cancel or termination of Sub. or Dependent 030 = Full Population Audit, including term records	R
	46-47	INS	04 – Maintenance Reason Code	Please refer to value options on pages 46 and 47 of the ASC X12N 834 Implementation Guide for valid code(s)		R
	47-48	INS	05 – Benefit Status Code	A = Active C = COBRA S = Surviving Insured	Benefit Status Code	R
	48	INS	06 – Medicare Plan Code	A = Medicare Part A B = Medicare Part B C = Medicare Part A & B D = Medicare Eligible	Medicare Eligible	S
	49	INS	08 – Employment Status Code	FT = Full Time L1 = Leave of Absence PT = Part time RT = Retired TE = Termination	Employee Status Code	S
	49	INS	09- Student Status Code	F = Full time	Student Status Code	R
	49	INS	10- Handicap Indicator	Y = Yes N = No	Used to reference dependents only.	R
INS ELEMENT EXAMPLE: INS*Y*18*021*28*A*C**FT~ INS*Y*18*(MAINT TYPE)*(MAINT REASON)*(BENEFIT STATUS CODE)*(MEDICARE PLANCODE)**(EMPLOYMENT STATUS CODE)~						
2000	51	REF	01- Reference Number Qualifier	0F =Subscriber Number indicator		R
	52	REF	02 – Subscriber Number	Subscriber SSN or Other	DO NOT USE HYPHENS	R
REF ELEMENT EXAMPLE: REF*0F*920399398~ REF*0F*(SSN)~						
2000	55	REF	01a - Group Number	1L	This is a CHP required element on all transactions	R
	56	REF	02a - Group Reference ID	Insert CHP assigned Group Number	Group Number	R
REF ELEMENT EXAMPLE: REF*1L*19300~ REF*1L*(ASSIGNED GROUP NUMBER)~						
2000	55	REF	01b - Subgroup Number	DX = Reference Identifier	This is a CHP required element on all transactions	R
	56	REF	02b - Subgroup Reference ID	Insert CHP Assigned Subgroup Number	Subgroup Number	R
REF ELEMENT EXAMPLE: REF*17*0001~ REF*DX*(ASSIGNED SUBGROUP NUMBER)~						

2000	59-60	DTP	01- Date/Time Qualifier	336 = Employment Begin	Hire Date	R
	60	DTP	02- Date/Time Format Qualifier	D8		R
	60	DTP	03- Date/Time Period	CCYYMMDD		R
DTP ELEMENT EXAMPLE: DTP*336*D8*20020101~ DTP*336 employment begin date						
LOOP ID	Page #(s)	SEG ID	ELEMENT ID	ELEMENT VALUES	ELEMENT DESCRIPTION	REQ (R/S)
2100A	61-63	NM1	01 - Member Identify Information	IL = Insured or Subscriber 74 = Corrected Insured SSN	IL = Enrolling a new member or making a change to their record (other than a SSN change). 74 = Correcting SSN	R
	61-63	NM1	02- Entity Type Qualifier	1 = Person	To clarify to the system to look for person(s), instead of Entity(s).	R
	61-63	NM1	03- Name Last		Last Name	R
	61-63	NM1	04- Name First		First Name	R
	61-63	NM1	05- Name Middle		Middle Name or Initial	S
	61-63	NM1	07- Name Suffix		Name Suffix	S
	61-63	NM1	08- Identification Code Qualifier	34 = SSN		R
	61-63	NM1	09- Identification Code		Member's SSN	R
NM1 ELEMENT EXAMPLE: NM1*IL*1*SMITH*JOHN*L*SR**34*920399398~ NM1*IL*1*SMITH*JOHN*L*SR**34*(SSN)~ note: using the SSN indicator "34" and adding the SSN in this segment is only applicable if the group obtains the dependents SSN. If not populating this info, the segment should appear: NM1*IL*SMITH*JOHN*L*SR~						
2100A	67	N3	01- Address Line	Subscriber Address – free form allowed	Dependent address not required unless not living with Subscriber	R
	67	N3	02- Address Line 2			S
NM3 ELEMENT EXAMPLE: N3*50 BAY STREET APT 5~ N3*(ADDRESS1 & ADDRESS2)~ note: N3 & N4 should only be present on dependents records if the address is different than the Sub's address						
2100A	68	N4	01- City		City	R
	68	N4	02- State		State	R
	68	N4	03- Zip		Zip + 4 (do not use hyphens)	R
NM4 ELEMENT EXAMPLE: N4*BAY CITY*FL*112230000~ N4*(CITY)*(ST)*(ZIP)~						
2100A	70-72	DMG	01- Date/Time Format Qualifier	D8 = CCYYMMDD		R
	70-72	DMG	02- Date/Time Period	CCYYMMDD	Date of Birth	R
	70-72	DMG	03- Gender Code	M = Male F = Female	Gender	R
DMG ELEMENT EXAMPLE: DMG*D8*19560205*F~ DMG*D8*(DOB)*(GENDER)~						

2100G	115	NM1	01- Entity Identifier Code	E1 - Person or Other Entity Legally Responsible for a Child	This code should be used when a Qualified Medical Child Support Order (QMSCO) is present. To be used with version 004010X095A1	R
	116	NM1	02- Entity Type Qualifier	1 = Person		R
	116	NM1	03- Name Last or Organization			R
	116	NM1	04- Name First			R
NM1 ELEMENT EXAMPLE: NM1*E1*1*DOE*JOHN~						
2300	128-131	HD	01- Maintenance Type Code	001 = Change 021 = Add 024 = Cancellation/Term 030 = Audit or Compare, Including Terms	Maintenance Type Code	R
	128-131	HD	03- Insurance Line Code	DEN = Dental HLT = Health VIS = Vision HMO = HMO PPO = Preferred Provider Option	Insurance Line Code	R
	128-131	HD	04- Plan Coverage Description		Plan Description(Free Form)	S
	128-131	HD	05- Coverage Level Code	EMP = Individual FAM = Family E1D = Employee + 1 ECH = Emp + Child(ren) ESP = Emp + Spouse	Coverage Type Code	R
LOOP ID	Page #(s)	SEG ID	ELEMENT ID	ELEMENT VALUES	ELEMENT DESCRIPTION	REQ (R/S)
HD ELEMENT EXAMPLE: HD*021**HLT*PLAN B*FAM~ HD*(ACTION CODE)**(PLAN TYPE)*(PLAN NAME)*(TOC CODE)~						
2300	132-133	DTP	01- Date/Time Qualifier	303 = Maintenance Effective 348 = Benefit Begin 349 = Benefit End	303 = Change Effective Date 348 = Coverage Begin Date 349 = Coverage End Date	R
	132-133	DTP	02- Date/Time Format Qualifier	D8		R
	132-133	DTP	03 -Date/Time Period THIS IS A PERTINENT ELEMENT FOR ALL TRANSACTIONS WITH CHP	CCYYMMDD		R
DTP ELEMENT EXAMPLE: DTP*348*D8*20020101~ DTP*303 (effective date of action/maintenance) Note: Only one action code to be passed per record. Example: Do not pass maintenance effective date AND term effective date.						
2300	135-136	REF	01 – Group Reference Qualifier	1L = CHP assigned Group Number	This is a CHP required element on all transactions	R
	135-136	REF	02 – Group Reference Number	Insert Group Specific Policy number	This is a CHP required element on all transactions	R
REF ELEMENT EXAMPLE: REF*1L*1234567~) REF*1L (group number)						
2300	135-136	REF	01 – Client Reporting Category Qualifier	17 = Reference Identifier	This is a CHP required element on all transactions	R
	135-136	REF	02 – Plan Reference Number	Insert Plan Specific Section, Package, POS Indicator Number	This is a CHP required element on all transactions	R

REF ELEMENT EXAMPLE: REF*17*00010020~ REF*17 (section/package code/POS indicator)						
2310	139	LX	01- Assigned Number	1	Sequential number for LX loops	S
LX ELEMENT EXAMPLE: LX*1~ Note: Required element for HMO Plans						
2310	140-141	NM1	01- Entity Identifier Code	P3 = Primary Care Physician		S
	141	NM1	02- Entity Type Qualifier	1 = Person		S
	142	NM1	08- Provider Number Identifier Qualifier	XX = CHP Provider Identifier qualifier SV = Service Provider Number	SV to be used with version 004010X095A1	S
	142	NM1	09 – Provider Identification Code	Insert CHP provider identifier number		S
	142	NM1	10- Entity Relationship Code	25= Established Patient 26 = Not Established Patient 72 = Unknown		S
NM1 ELEMENT EXAMPLE: NM1*P3*1*****XX*22512345*25~ NM1*(Entity Type Qualifier)***** (ID Code Qualifier)*(ID Code)*(Entity Relationship Code)~						
	158	SE	01 – Number of included segments			R
	158	SE	02 – Transaction set control number		This data element must be identical to ST02	R
SE ELEMENT EXAMPLE: SE*39*0001~						
	B.10	GE	01 – Number of transaction sets included			R
	B.10	GE	02 – Group control number		This data element must be identical to GS06	R
GE ELEMENT EXAMPLE: GE*1*123456~						
	B.7	IEA	01 – Number of included functional groups			R
	B.7	IEA	02 – Interchange control number		This data element must be identical to ISA13	R
IEA ELEMENT EXAMPLE: IEA*1*123456~						