Highmark

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 Implementation Guides, version 005010

March 2026

Preface

This Consolidated Companion Guide to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Highmark entities, including Highmark Inc., Highmark Senior Health Company, Highmark Blue Cross Blue Shield Delaware, Highmark Western and Northeastern New York, Highmark West Virginia and Highmark Senior Solutions Company.

Transmissions based on this companion guide, used in tandem with the v5010 ASC X12 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR’S NOTE:
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1. Introduction

1.1 Scope

This Provider EDI Companion Guide addresses how providers, or their business associates, conduct HIPAA standard electronic transactions with Highmark, including Professional Claim, Institutional Claim, Claim Acknowledgment, Claim Payment Advice, Claim Status, Eligibility, Prior Authorization Services Review, Claim attachments and Service Review attachments.

The Highmark entities supported by this guide include:

Highmark Inc. (herein referred to as Highmark or Highmark PA for clarity in this consolidated guide) covering Central, Western, Northeastern and Southeastern Pennsylvania regions

Highmark Senior Health Company

Highmark Blue Cross Blue Shield Delaware

Highmark Western and Northeastern New York

Highmark West Virginia

Highmark Senior Solutions Company

This guide also applies to the above-referenced transactions that are being transmitted to any Highmark entity by a clearinghouse.

An Electronic Data Interchange (EDI) Trading Partner is defined as any Highmark customer (Provider, Billing Service, Software Vendor, Employer Group, Financial Institution, etc.) that transmits to, or receives electronic data from, a Highmark entity.

Highmark's EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide. Highmark EDI Operations supports transactions for multiple payers; each transaction chapter lists the supported payers for that transaction, noting specific regional differences in transaction availability and processing.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Highmark. This information is organized in the sections listed below. Where regional differences exist, they are explicitly called out within the relevant sections or in dedicated regional sub-sections.

- **Getting Started**: This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

- **Testing with the Payer**: This section includes detailed transaction testing information as well as other relevant information needed to complete transaction testing with Highmark.

- **Connectivity with the Payer/Communications**: This section includes information on Highmark's transmission procedures as well as communication and security protocols, noting regional variations in supported methods (batch, real-time).

- **Contact Information**: This section includes telephone and email addresses for Highmark's EDI support, with regional specifics.

- **Control Segments/Envelopes**: This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to Highmark, detailing regional requirements for Payer IDs and message structure.

- **Payer Specific Business Rules**: This section contains information describing Highmark's business rules, with significant emphasis on detailing differences between Highmark entities.

- **Acknowledgments and Reports**: This section contains information on all transaction acknowledgments sent by Highmark. These include the TA1, Health Care Claim Acknowledgment (277CA) and the Implementation Acknowledgment for Health Care Insurance (999).

- **Trading Partner Agreements**: This section contains general information about and links to Highmark's trading partner agreements.

- **Transaction Specific Information:** This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of tables. These tables contain rows for each segment that Highmark has something additional, over and above, the information in the IGs, with regional variations highlighted.

1.3 References

Trading Partners must use the ASC X12 National Implementation Guides adopted under the HIPAA Administrative Simplification Electronic Transaction rule and Highmark's EDI Companion guidelines for development of the EDI transactions.

Trading Partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the Washington Publishing Company website:

http://www.wpc-edi.com

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice (835))
- Claim Status Category Codes and Claim Status Codes (ASC X12/005010X212 Health Care Claim Status Request and Response (276/277) and 005010X214 Health Care Claim Acknowledgment (277CA))
- Provider Taxonomy Codes (ASC X12/005010X222A1 Health Care Claim: Professional (837P) and ASC X12/005010X223A2 Health Care Claim: Institutional (837I))
- Health Care Services Decision Reason Codes (ASC X12/005010X217 (278))

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working with Highmark

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day seven days a week, except during scheduled system maintenance periods.

Provider Information Management

To obtain the status of a provider's application for participation with any Highmark provider network, or to update provider data currently on file, please contact Provider Services at the following link:

https://providers.highmark.com/contact-us

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Any Highmark entity may require access to the records at any time.

The Trading Partner's automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Trading Partner documents are acceptable. The Trading Partner, not their billing agent, is held accountable for accurate records.

The audit consists of verifying a sample of automated claim input against medical records. Retention of records may also be checked. Compliance to reporting requirements is sample checked to ensure proper coding technique is employed. Signature on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark may request, and the Trading Partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex value
!	Exclamation point	(21)
>	Greater than	(3E)
^	Caret	(5E)
|	Pipe	(7C)
~	Tilde	(7E)
*	Asterisk	(2A)
{	Left Curly Bracket	(7B)

These seven characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing and therefore would cause problems if encountered in the transaction data.

As described in the X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters shall be left

justified. Leading spaces, when they occur, are presumed to be significant characters. In the actual data stream trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality

Highmark and its Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the Highmark EDI Trading Partner Agreement.

Authorized Release of Information

When contacting EDI Operations concerning any EDI transactions, you will be asked to confirm your Trading Partner information.

2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity.

While Highmark EDI Operations will accept HIPAA compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure be established in order to secure access to data. As a result, Highmark has a process in place to establish an Electronic Trading Partner relationship. That process has two aspects:

- A Trading Partner Agreement must be submitted which establishes the legal relationship and requirements. This is separate from a participating provider agreement.
- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing Highmark's EDI system for submission or retrieval of transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner. Maintenance of the ID and password by the Trading Partner is detailed in the security section of this document.

Authorization Process

New Trading Partners wishing to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application process includes review and acceptance of the appropriate EDI Trading Partner Agreement. Submission of the EDI Transaction Application indicates compliance with specifications set forth by Highmark for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark may terminate this Agreement, without notice, if participant's account is inactive for a period of six (6) consecutive months.

Complete and accurate reporting of information will ensure that your authorization forms are processed in a timely manner. If you need assistance in completing the EDI Transaction Application, contact your company's technical support area, your software vendor, or EDI Operations.

Upon completion of the authorization process, a Logon ID and Password will be assigned to the Trading Partner. EDI Operations will authorize, in writing (via email), the Trading Partner to submit EDI transactions.

Where to Get Enrollment Forms to Request a Trading Partner ID
To receive a Trading Partner ID, you must complete an online EDI Transaction Application and agree to the terms of Highmark's EDI Trading Partner Agreement. The EDI Transaction Applications and all other EDI request forms are available through the Trading Partner Business Centers websites:

https://edi.highmark.com/edi/tpbc

Adding/Deleting a Provider to/from an Existing Trading Partner.

Trading Partners currently using electronic claim submission who wish to add or delete a provider to/from their Trading Partner Number should complete the appropriate form:

https://edi.highmark.com/edi/tpbc

Reporting Changes in Status

Trading Partners changing any other Trading Partner information must inform EDI Operations by completing the appropriate Trading Partner update form and including all information that is to be updated.

https://edi.highmark.com/edi/tpbc

Out of State Providers

Due to an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association, Highmark entities generally cannot accept electronic transactions directly from out-of-state nonparticipating/out-of-network providers for their respective members. Providers should submit all Blue Cross Blue Shield electronic claims and inquiry transactions to their local Blue Cross Blue Shield Plan. The transactions will be sent on to the Plan that holds the member's enrollment, for processing through the BlueCard or Blue Exchange programs.

Core operating hours for Blue Exchange inquiry transactions are Monday through Saturday, 12 am to 11:59 pm (CENTRAL TIME) for all entities.

2.3 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

Testing Policy

Highmark does not currently require the testing or certification of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors ensure their software complies with all current transaction requirements.

Highmark Transactional Testing

Claims Transactions
Highmark does not allow Trading Partners to send test claim or inquiry transaction files to our production environment. A TA1 will be generated for any transaction file that has “test” indicated in the ISA15 element.

Inquiry Transactions
Highmark does not allow Trading Partners to send test inquiry transaction files to production environments. A TA1 will be generated for any transaction file that has “test” indicated in the ISA15 element

Real-Time Electronic Claim Estimation Demonstration Process
Highmark’s real-time Electronic Claim Estimation process does not impact or actually update the claim adjudication system with respect to a patient’s claim history, accumulated member liability, maximums, etc. Consequently, Professional and Institutional Trading Partners that want to test real-time electronic claim capabilities will have to do so using the Electronic Claim Estimation process.

Professional and Institutional Trading Partners have the ability to validate their secure Internet connection to Highmark, as well as submit an Electronic Claim Estimation which will be edited for X12 syntax and Highmark business edits. If the Electronic Claim Estimation passes the edits, member liability will be estimated with the end results being returned in a real-time Health Care Claim Payment/Advice (835) response.

- An Implementation Acknowledgment for Health Care Insurance (999) transaction will be returned in the event that a rejection occurs at the X12 syntax editing level.

- A Health Care Claim Acknowledgment (277CA) transaction will be returned in the event that a rejection occurs as a result of Highmark business editing. The Health Care Claim Acknowledgment (277CA) transaction will return actual editing results.

- If the Electronic Claim Estimation transaction passes the X12 syntax and Highmark business level edits, a real-time Health Care Claim Payment/Advice (835) response containing the member's estimated liability and provider's estimated payment will be returned.

- In the event the Electronic Claim Estimation cannot be finalized within the real-time process, an accepted Health Care Claim Acknowledgment (277CA) will be returned indicating the 'Estimation cannot be completed in real-time'. In order to submit a real-time Electronic Claim Estimation test transaction, the ISA15 value must be equal to a "T". For more information on HTTPS connectivity specifications for demonstration of Electronic Claim Estimation submissions, refer to the Real-Time Claim Adjudication and Estimation Connectivity Specifications. These connectivity specifications are located in the Resources section under:

  https://edi.highmark.com/edi/tpbc

3. Testing with the Payer

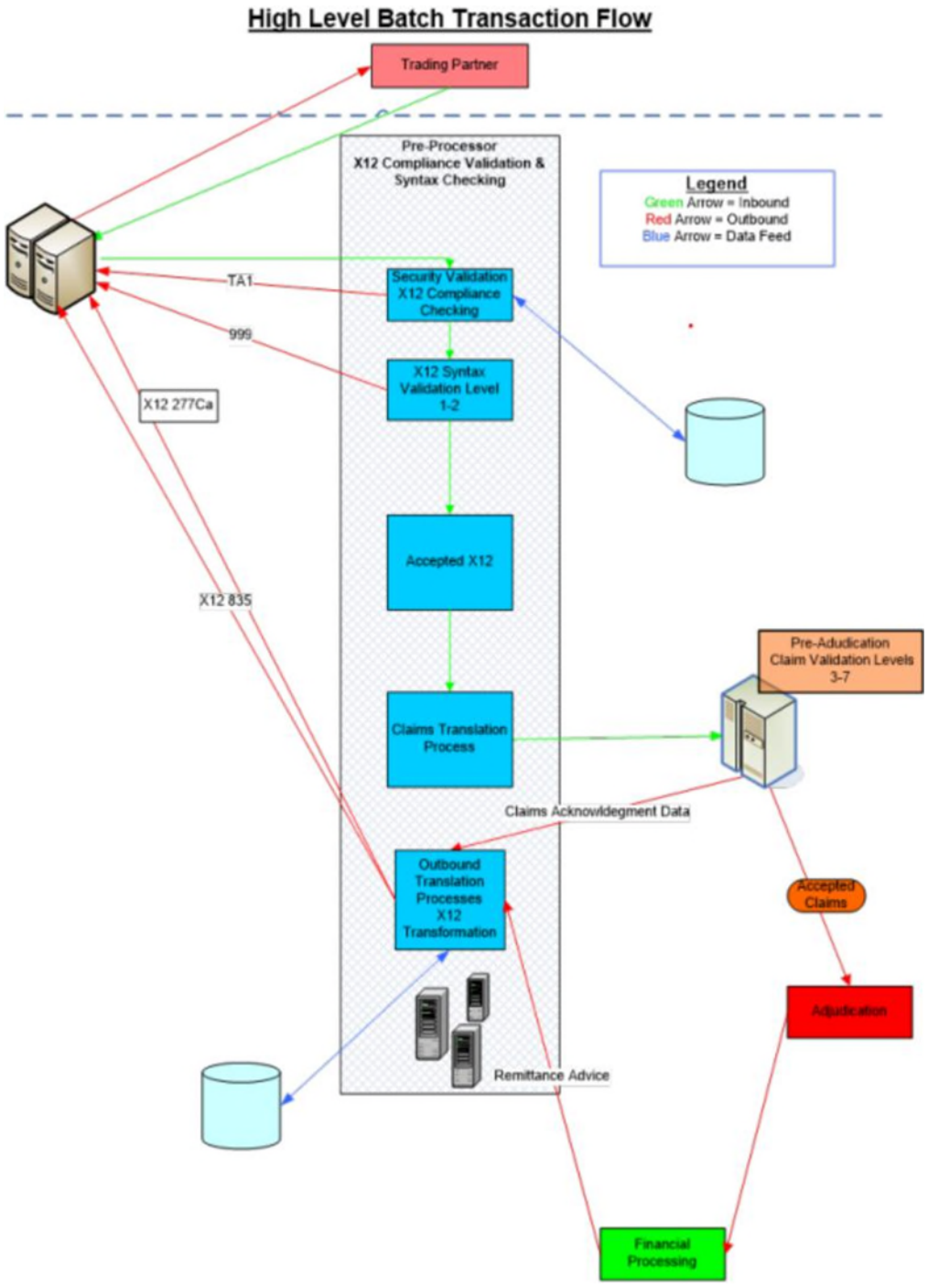
Highmark does not currently require or provide for the testing of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors test their software for HIPAA compliance on behalf of all of their clients. Any questions about the requirements contained within this Guide may be directed to EDI Operations at 1-800-992-0246 Monday through Friday 8:00am to 4:30pm, EST.

4. Connectivity with the Payer/Communications

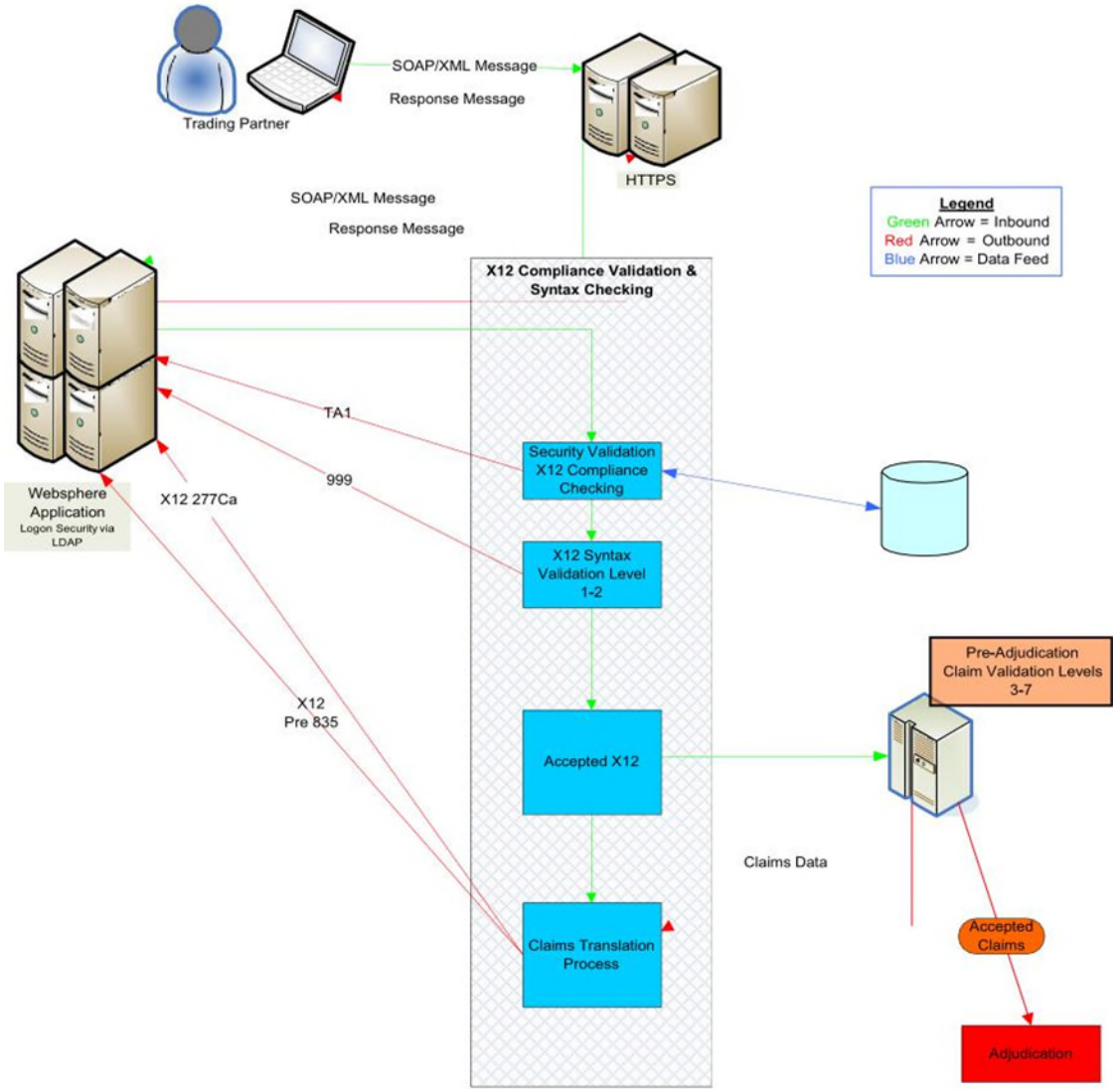
Highmark offers its Trading Partners two types of communication methods for transferring data electronically.

- Secure File Transfer Protocol (SFTP) through an Internet connection (Secure Transport) is available for transactions in batch mode.
- Hypertext Terminal Protocol Secure (HTTPS) through an Internet web service is available for transactions in real-time.

4.1 Process flows



High Level Real Time Transaction Flow



4.2 Transmission Administrative Procedures

Real-Time Technical Connectivity Specifications

Highmark entities that support real-time transactions maintain separate specifications detailing the technical internet connectivity requirements for their real-time processes. These connectivity specifications are located in the Resources section under EDI Companion Guides at:

https://edi.highmark.com/edi/tpbc

For connectivity specifications related to the Request and Response Inquiry transactions (Health Care Eligibility Benefit Inquiry and Response (270/271), Health Care Claim Status Request and Response (276/277) and Services Review Request for Review/Response (278)), see the 'Real-Time Inquiry Connectivity Specifications'.

For connectivity specifications related to Claim Adjudication and Claim Estimation processes (Electronic Claim / Health Care Claim Payment/Advice (835)), including a complete Transaction Flow diagram, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications'.

Real-Time Claim Adjudication and Estimation
Highmark implemented real-time capability for claim adjudication and claim estimation. Both processes leverage the electronic claim and Health Care Claim Payment/Advice (835) transactions for these business functions, as well as the Health Care Claim Acknowledgment (277CA) for specific situations.

Real-Time Adjudication – allows providers to submit an electronic claim that is adjudicated in real-time and receive a response (Health Care Claim Payment/Advice (835)) at the point of service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.

Real-Time Estimation – allows providers to submit an electronic claim for a proposed service and receive a response (Health Care Claim Payment/Advice (835)) in real-time. The response Health Care Claim

Payment/Advice (835) - estimates the member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

For transaction specific information related to real-time claim adjudication and claim estimation capability, see the following sections of the Transaction Information Companion Guide:

7.1 – Health Care Claim: Professional (837P)
7.2 – Health Care Claim: Institutional (837I)
7.3 – Health Care Claim Acknowledgment (277CA)
7.4 – Health Care Claim Payment/Advice (835)

4.3 Re-transmission procedures

Highmark does not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers two methods to utilize the Internet for conducting electronic business with Highmark. The first is secured File Transfer Protocol (FTP) through Highmark's Secure File Transfer Protocol (SFTP) platform. Highmark's Secure File Transfer Protocol (SFTP) platform is available for Trading Partners who submit or receive any HIPAA-compliant EDI transactions in batch mode. The second Internet-based service offers "Real-Time" capability for the following real-time enabled transactions:

Health Care Eligibility Benefit Inquiry and Response (270/271)

Health Care Claim Status Request and Response (276/277)

Health Care Services Review Request/Response – (278/278)

Claim Adjudication or Estimation and Response – Electronic

Claim (837P/837I)

Health Care Claim Payment/Advice Pre-Adjudication/Pre-Estimation (835)

Internet File Transfer Protocol (FTP) through Highmark's Secure File Transfer Protocol (SFTP) platform

The Highmark Secure FTP platform provides an FTP service over an encrypted data session providing “on-the-wire” privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple FTP process in an encrypted and private manner.

Any state-of-the-art browser can be used to access the Highmark Secure FTP platform. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.

2. Connect to the FTP servers at: https://mft.hmhs.com

3. The server will prompt for an ID and Password. Use the ID/ Password that Highmark has provided you for accessing this service. Enter the ID, tab to password field and enter the password, then hit enter or click on OK.

4. The server will then place you in your individual file space on the FTP server. No one else can see your space and you cannot access the space of others. You will not be able to change out of your space.

5. You will need to change into the directory for the type of file you are putting or getting from the server.

6. By default, the file transfer mode will be binary, and this mode is acceptable for all data types. However, you may change between ASCII and Binary file transfer modes by clicking the “Set ASCII”/ ”Set Binary” toggle button.

7. Send Highmark a file. The following is an example of the submission of an electronic claim transaction file:

    a. Click on the “hipaa-in” folder to change into that directory.

    b. Click on the browse button to select a file from your system to send to Highmark. This will pop open a file finder box listing the files available on your system.

    c. Select the file you wish to send to Highmark and Click on OK.

d. This will return you to the browser with the file name you selected in the filename window. Now click on the “Upload File” button to transfer the file to Highmark. Once completed, the file will appear in your file list.

8. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment for Health Care Insurance (999) file:

a. Click on the “hipaa-out” directory.

b. Your browser will list all the files available to you.

c. Click on the “ack” directory.

d. Click on the file you wish to download. Your browser will download the file. If your browser displays the file instead of downloading, click the browser back button and click on the tools next to the file you wish to receive. Select application/ octet-stream. Your system may then prompt you for a “Save As” file location window. Make the selection appropriate for your system and click on Save to download the file.

4.5 Passwords

Highmark EDI Operations personnel will assign Logon IDs and Passwords to Trading Partners. EDI Transactions, submitted by unauthorized Trading Partners will not be accepted by our Highmark EDI Operations system.

Trading Partners should protect password privacy by limiting knowledge of the password to key personnel. Passwords should be changed regularly, upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the Trading Partner office, or at any time the Trading Partner deems necessary.

Password requirements include:

- Password must be 8 characters in length.
- Password must contain a combination of both numeric and alpha characters.
- Password cannot contain the Logon ID.
- Password must be changed periodically.

5. Contact Information

5.1 EDI Customer Service

Contact information for EDI Operations:

TELEPHONE NUMBER: 1-800-992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for EDI Operations:

TELEPHONE NUMBER: 1-800-992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday.

5.3 Provider Service

Inquiries pertaining to Highmark Private Business Medical/Surgical claims should be directed to the appropriate Provider Service Department listed at the link below:

https://providers.highmark.com/contact-us

5.4 Applicable websites / e-mail

EDI specifications, including this companion guide, can be accessed online at:

https://edi.highmark.com/edi/tpbc

6. Control Segments / Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the national implementation guides. Highmark's expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter of the Transaction Information Companion Guide.

Note – Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the national implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that Line Feed, hex value "0A", is not an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16

EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E
!	21
“	22
%	25
&	26
‘	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^*	5E
{	7B
}	7D
~	7E

* “^” may be used as a Data Element Separator, but will not be accepted as Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark will use the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, “!”, cannot be used in text data (type AN, Sting data element) within the transaction; reference section 2.1 of this document titled Valid Characters in Text Data.

Delimiter Type	Character Used	Hex value
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to Highmark Segment: ISA Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the national transaction implementation guides, with the clarifications listed below.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark can only support code 00 – No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark can only support code 00 – No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value “ZZ” for DE, PA and WV Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the Highmark assigned security Login ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33 ZZ	Use qualifier code value “33” for the following payers: 54771, 15460, 55204, 54828, 15459 Use qualifier code value “ZZ” for the following payers: 00570, 00070
	ISA08	Interchange Receiver ID	54771 15460 55204 54828 15459 00570 00070	Highmark PA Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional Highmark Delaware Institutional

	ISA13	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA 14	Acknowledgment Requested	1	Highmark always returns a TA1 segment when the incoming interchange is rejected due to errors at the interchange or functional group envelope
	ISA15	Usage Indicator		Highmark uses the value in this element to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from Highmark

Segment: ISA Interchange Control Header (Outgoing)

Note: Listed below are clarifications of Highmark's use of the ISA segment for outgoing interchanges.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark will send code 00 – No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark will send code 00 – No Security Information present
	ISA04	Security Information		This element must be space filled

	ISA05	Interchange ID Qualifier	33 ZZ	Use qualifier code value “33” for the following payers: 54771, 15460, 55204, 54828, 15459 Use qualifier code value “ZZ” for the following payers: 00570, 00070
	ISA06	Interchange Sender ID	54771 15460 55204 54828 15459 00570 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional Highmark Delaware Institutional
	ISA07	Interchange ID Qualifier	ZZ	Highmark will send qualifier code value “ZZ” Mutually Defined, to designate that a Highmark-assigned proprietary

Loop ID	Reference	Name	Codes	Notes/Comments
				ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The Highmark-assigned ID will be the trading partner's security login ID. This ID will be left-justified, and space filled.
	ISA 14	Acknowledgment Requested		Highmark always uses a 0 (No Interchange Acknowledgement Requested).
	ISA15	Usage Indicator		Highmark provides T or P to identify the test or production nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in sections 7 (Payer Specific Rules and Limitations) and 10 (Instruction Tables) of the Transaction Information Companion Guide.

6.3 ST-SE

Highmark has no requirements outside the national transaction implementation guides.

7. Payer Specific Business Rules and Limitations

7.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 Implementation Guide, as modified by the June 2010 Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the companion guide for submitting Health Care Claim: Professional (837P) claims.

Patient with Coverage from another Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept Health Care Claim: Professional (837P) claims when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha/numeric prefix. Highmark NAIC must be listed in the Application Receiver GS03 and in the loop 2010BB NM109 Payer ID.

Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local Highmark member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark's system, the claim would be denied for no coverage and any payment due the provider would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows Highmark to be an electronic interface for its local providers to out-of-state Plans that are licenses of the Blue Cross Blue Shield Association. Any payment to the provider will be made by Highmark.

Regional Specific BlueCard Processing (Highmark PA & Highmark Western and Northeastern New York)

For providers submitting to Highmark PA or Highmark Western and Northeastern New York, BlueCard also applies in certain situations for patients with coverage from other plans within those states.

Dental Services

Dental services that are reported with CDT dental procedure codes must be submitted as an ASC X12/005010X224A2 Health Care Claim: Dental (837) transaction to Highmark's dental associate, United Concordia Companies, Inc. (UCCI). Oral surgery services that are reported with CPT medical procedure codes must be submitted as a Health Care Claim: Professional (837P) transaction to either Highmark or UCCI according to which payer is responsible for the patient's oral surgery coverage.

Real-Time Claim Adjudication and Estimation
Highmark offers real-time claim adjudication and claims estimation processes. Real-time Electronic Claim applies the same business rules and edits as the batch Electronic Claim, with the exception of items listed below. Highmark requires that claims submitted for estimation be differentiated from claims submitted for adjudication within the SOAP of the HTTPS transmission protocol. For information on SOAP, connectivity and the related transactions for real-time claim adjudication and estimation requests, see Section 4.4.

Real-Time Adjudication: allows providers to submit an electronic claim that is adjudicated in real-time and receive a Health Care Claim Payment/Advice (835) response at the point of service. This capability allows providers to accurately identify and collect amounts that are the member's responsibility based on finalized claim adjudication results.

Real-Time Estimation: allows providers to submit an electronic claim for a proposed service and receive a Health Care Claim Payment/Advice (835) response in real-time. The response estimates the amount that will be the member's responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

Real-Time Electronic Claim Submission Limitations
The following are limitations of the real-time electronic claim process:

- The real-time claim adjudication and estimation submission process is limited to a single claim (1 Loop 2300 – Claim Information) within an Interchange (ISA-IEA). Transmissions with more than a single claim will receive a rejected Implementation Acknowledgment for Health Care Insurance (999).
- Only initial claims can be submitted, not replacement, void, etc.
- Claims for FEP (Federal Employee Program) and Out-of-State Blue Cross Blue Shield may be submitted in real-time; however, they will be moved to batch processing.
- Claims submitted with the PWK Segment indicating an attachment is being sent may be submitted in real-time, however they will be moved to batch processing.

Real-time General Requirements and Best Practices

Trading Partners must account for Providers submitting both real-time and batch claims.

Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard batch method of submission or through their real-time method of submission.

NOTE: Estimates will not be accepted in batch mode, only real-time mode.

Trading Partners must ensure that claims successfully submitted through their real-time process are not included in a batch process submission, resulting in duplicate claims sent to Highmark.

Claims Resubmission

Frequency Type codes that tie to “prior claims” or “finalized claims” refer to a previous claim that has completed processing in the payer’s system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim”. An 837 is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.2 005010X223A2 Health Care Claim: Institutional (837I)

The 837 transaction is used for institutional claims. The May 2006 ASC X12 005010X223 Implementation Guide, as modified by the August 2007 and the June 2010 Type 1 Errata documents, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with the revisions in the errata; the transaction version must be identified as 005010X223A2.

Companion guides supplement the national guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction details make up the companion guide for submitting Health Care Claim: Institutional (837I) claims for patients with Highmark.

Patient with Coverage from another Out-of-State Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licenses of the Blue Cross Blue Shield Association allows Highmark entities to accept Health Care Claim: Institutional (837I) claims when the patient has coverage from an out-of-state plan.

The Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha/numeric prefix.

The appropriate Highmark entity must be listed as the payer by submitting its Payer ID in the GS03 Application Receiver's Code and the loop 2010BB NM109 Payer ID.

Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local Highmark member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark's system, the claim would be denied for no coverage and any payment due to the facility would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows Highmark to be an electronic interface for its local providers to out-of-state Plans that are licenses of the Blue Cross Blue Shield Association. Any payment to the provider will be made by Highmark.

Regional Specific BlueCard Processing (Highmark PA & Highmark Western and Northeastern New York)

For providers submitting to Highmark PA or Highmark Western and Northeastern New York, BlueCard also applies in certain situations for patients with coverage from other plans within those states.

Real-Time Claim Adjudication and Estimation Highmark offer real-time claim adjudication and claim estimation processes that leverage the electronic claim transaction. The real-time electronic claim applies the same business rules and edits as the batch electronic claim, with the exception of items listed below. Highmark requires that claims submitted for estimation be differentiated from claims submitted for adjudication within the SOAP of the HTTPS transmission protocol. For information on SOAP, connectivity and the related transactions for real-time claim adjudication and estimation requests, see Section 4.4.

Real-Time Adjudication: allows providers to submit an electronic claim that is adjudicated in real-time and receive aHealth Care Claim Payment/Advice (835) response at the point of service. This capability allows providers to accurately identify and collect amounts that are the member's responsibility based on finalized claim adjudication results.

Real-Time Estimation: allows providers to submit an electronic claim for a proposed service and receive a Health Care Claim Payment/Advice (835) response in real-time. The response estimates the amount that will be the member's responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

Real-Time Electronic Claim Submission Limitations

The following are limitations of the real-time electronic claim process:

- The real-time claim adjudication and estimation submission process is limited to a single claim (1 Loop 2300 – Claim Information) within an Interchange (ISA-IEA). Transmissions with more than a single claim will receive a rejected Implementation Acknowledgment for Health Care Insurance (999).
- Only initial claims can be submitted, not replacement, void, etc.
- Claims for FEP (Federal Employee Program) and Out-of-State Blue Cross Blue Shield may be submitted in real-time; however, they will be moved to batch processing.
- Claims submitted with the PWK Segment indicating an attachment is being sent may be submitted in real-time, however they will be moved to batch processing.
- Real-time Health Care Claim: Institutional (837I) submissions are limited to 50 lines per claim.

Real-time General Requirements and Best Practices

Trading Partners must account for Providers submitting both real-time and batch claims.

Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard batch method of submission or through their real-time method of submission.

NOTE: Estimates will not be accepted in batch mode, only real-time mode.

Trading Partners must ensure that claims successfully submitted through their real-time process are not included in a batch process submission, resulting in duplicate claims sent to Highmark.

Claims Resubmission

Frequency Type codes that tie to “prior claims” or “finalized claims” refer to a previous claim that has completed processing in the payer’s system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim”. An 837 is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.3 005010X214 Health Care Claim Acknowledgment (277CA)

The 277 Claim Acknowledgment (277CA) transaction is a business application-level acknowledgment for the Health Care Claim (837) transaction(s). This transaction acknowledges the validity and acceptability of claims for adjudication. The January 2007 ASC X12 005010X214 Implementation Guide is the primary source for definitions, data usage, and requirements.

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a Health Care Claim Acknowledgment (277CA) within twenty-four hours after Highmark receives the electronic claims, subject to processing cutoffs. The 277CA files (ISA-IEA) will be grouped by the 277CA. transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837. Each 277CA grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA – IEA) has 2 Functional Groups (GS-GE) and each Functional Group has 2 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each with a Functional Group that contains two 277CA transactions (ST-SE) that

correspond to the submitted 837 Functional Group and transactions (ST-SE).

There is a one-to-one relationship between an 837 (ST-SE) and the corresponding 277CA (ST-SE).

In the event system issues are encountered and all claims from a single 837 transaction cannot be acknowledged in a single 277CA, it may be necessary to retrieve multiple 277CA transactions related to an electronic claims transaction. See section 4.4 Communication Protocol Specifications information on retrieving the batch Health Care Claim Acknowledgment (277CA).

7.4 005010X221A1 Health Care Claim Payment/ Advice (835)

The 835 transaction is used to provide an explanation of claims payment. The April 2006 ASC X12 005010X221 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Batch Health Care Claim Payment/Advice (835) Response

Highmark Batch 835

Highmark's batch 835s are generated by PNC-ECHO Health Trust. Electronic Remittance Advices (835s) are distributed using the following ECHO Payer IDs:

- Delaware, Pennsylvania, and West Virginia: 58379
- New York: 55204

Please contact ECHO Health Inc. for assistance at 888-834-3511 or email address - edi@echohealthinc.com)

Blue Exchange (BX) Medicare Crossover 835s

Blue Exchange electronic remittance advices are only available for Medicare Crossover claims processed by BCBS Plans other than Highmark. These are also

referred to as Blue Cross and Blue Shield Secondary to Medicare claims.

Out-of-state providers should contact their local BCBS Plan for assistance. This information is for Highmark-affiliated providers who are registered with Highmark Provider Enrollment.

To receive electronic 835 remittance files for Medicare Crossover claims processed by a BCBS Plan other than Highmark, the provider's Group Billing NPI must be enrolled with Blue Exchange. Highmark EDI Operations facilitates enrollment on the provider's behalf with the Blue Cross Blue Shield Association. Interested providers should reach out to the EDI Operations Service Desk.

In order to receive the BX 835 a Trading Partner must be set up to receive the 835 transactions.

Real-Time Health Care Claim Payment/Advice (835) Response

Highmark implemented real-time capability for claim adjudication and claim estimation. A real-time Health Care Claim Payment/Advice (835) will be used as the response to a real-time claim adjudication or electronic claim1 estimation request. The real-time Health Care Claim Payment/Advice (835) response will contain the finalized results from successful claim adjudication or estimation requests. The real-time Health Care Claim Payment/Advice (835) response will be based on the ASC X12 Health Care Claim Payment/Advice (835) Transaction adopted under the HIPAA Administrative Simplification Electronic Transaction rule.
For information on connectivity and the related transactions for real-time claim adjudication and estimation, see Section 7 of the Communication/Connectivity Companion Guide.

Real-Time Health Care Claim Payment/Advice (835) for Claim Adjudication

The real-time Health Care Claim Payment/Advice (835) response for real-time claim adjudication will not contain the actual payment/check information. Actual payment for real-time adjudicated claims will continue to be generated through daily and weekly payment cycles and be subsequently reported in the respective batch payment cycles or payment Health Care Claim Payment/Advice (835).

The following table highlights some of the Health Care Claim Payment/Advice (835) data elements that have specific relevance to the reporting of real-time adjudicated claims within the Health Care Claim Payment/Advice (835).

835 Data	835 Element	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual payment is being made.
835 "Payment" Amount	BPR02= CLP04	Required elements – The Real-Time Health Care Claim Payment/Advice (835) "payment" amount (BPR02) will equal the claim "paid" amount (CLP04) since this will be a single claim Health Care Claim Payment/Advice (835).
Payment Method	BPR04= NON	Required element – Indicates

835 Data	835 Element	Comments
		"Non- Payment Data". This is an informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element –A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Data	Loops 2000, 2100 & 2110	The claims data will be reported as adjudicated with appropriate liabilities and provider 'payment' amount

Real-Time Health Care Claim Payment/Advice (835) Response for Claim Estimation

The real-time Health Care Claim Payment/Advice (835) response for a real-time claim estimation request will follow the guidelines defined in the ASC X12 Health Care Claim

Payment/Advice (835) Guide, Section 1.10.2.7 for "Predetermination of Benefits".

The following table highlights some of the data elements that have specific relevance to the reporting of real-time estimation responses within the Health Care Claim Payment/Advice (835). NOTE: Claim estimation will not result in claim payment. A claim will need to be submitted for adjudication after the actual services are rendered.

835 Data	835 Element/Segment	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual payment is being made.
Check Payment	BPR02=0	Required element – estimation Amount 835 Check Payment Amount will equal 0.
Payment Amount	BPR04= NON	Required element – Indicates "Non- Payment Data". This is an

835 Data	835 Element/Segment	Comments
		informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element –A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Status	CLP02	Required element – Code 25: Predetermination Pricing Only – No Payment.
Claim Paid	CLP04	Required element – The Claim Paid amount will equal 0
Service Paid	SVC03	Required element – The Service Paid amount will equal 0.

Claim/Service Adjustment	CAS	CAS Segment will report all member and provider contractual liabilities. The estimated provider paid amount will be assigned Group and Reason Code OA101. This CAS Segment adjustment will bring the claim paid amount and service paid amount to 0. CAS*OA*101*$$$$ CAS is reported at the applicable Line or Claim level.

Real-Time General Requirements and Best Practices

Trading Partners must have the ability to parse and interpret the information on the Health Care Claim Payment/Advice (835) response.

- Best Practice: Trading Partners are recommended to separate the information that will be displayed to the member from the information displayed to the provider. It is recommended that only member liability data from the real-time Health Care Claim Payment/Advice (835) claim/estimate response be presented on the screen or printed document shown to the member. Some of the provider contractual liabilities and other Health Care Claim Payment/Advice (835) data reporting on the real- time Health Care Claim Payment/Advice (835) may not be useful to the member and may cause confusion.
- Best Practice: Trading Partners are strongly recommended to have a user-friendly messaging screen that can be displayed, printed, and handed to a member to show adjudication or estimation results from the real-time Health Care Claim Payment/Advice (835). Highmark recommends the ‘Member Liability Statement’ format and data presented be modeled after the statements developed by Highmark. Example ‘Real- Time Member Liability Statements’ for both adjudicated claims and estimations are located in the Resources section under EDI Companion Guides at the following site:

  https://edi.highmark.com/edi/tpbc

- Best Practice: Trading Partners are recommended to have the dynamic statement printed on the Member Liability Statement that reads “Administered By Highmark” Note: All necessary disclaimers for the transaction will be included as one of the Remittance Advice Remark Codes passed in the real-time Health Care Claim Payment/Advice (835).

Full Accounts Receivable posting should occur from the actual “Payment Health Care Claim Payment/Advice (835)” generated from the batch payment/check cycle.

- Best Practice: Providers should post any dollar amounts received from the member as a result of the member liability reported in the real-time 835, but not post the payment or contractual obligation amounts until the batch or payment Health Care Claim Payment/Advice (835) is received.

Full Accounts Receivable posting should not be performed based on an estimation response.

- Best Practice: If services are rendered based on an estimate, the provider may post dollars received from the member based on the reported member liability from the proposed services, but not post the contractual obligation amounts until the services are rendered, the claim is submitted, adjudicated and finalized. The provider’s systems should have the capability to record member liability collected, if the feature does not already exist with the system.

Trading Partners must process and display on their screens and printed documents appropriate Remittance Advice Remark Codes that are reported in the real-time Health Care Claim Payment/Advice (835) response. Several new real-time related Remittance Advice Remark Codes have been created for standard messaging.

Trading Partner systems must be able to identify and react accordingly to both a “Real-Time Health Care Claim Payment/Advice (835)” transaction and a batch cycle “Payment Health Care Claim Payment/Advice (835)” transaction and to process both real-time and batch claims in a single system.

7.5 005010X212 Health Care Claim Status Request and Response (276/277)

The 276 transaction is used to request the status of a health care claim(s) and the 277 transaction is used to respond with information regarding the specified claim(s). The August 2006 ASC X12 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage, and requirements.

Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan

An operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept 276 request transactions and return 277 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient's Member ID must be submitted with its alpha prefix and the appropriate Highmark payer code in the GS03 Application Receiver's Code and the loop 2100A NM109 Payer ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response.

Requests per Transaction Mode

Claim status requests will be processed in real-time mode only. Claim status responses will only include information available on the payer's adjudication system. Claim data which has been purged from the system will not be available on the response. The Claim Status process for Highmark is limited to one Information Source, Information Receiver, Provider, and Patient (Subscriber or Dependent) per ST - SE transaction. If multiple requests are sent, the transaction will be rejected.

Dental Services

All status requests containing a CDT dental procedure code must be submitted directly to Highmark's dental associate, United Concordia Companies, Inc. (UCCI). Any claim status requests for oral surgery services reported with a CPT medical procedure code must be requested to either Highmark or UCCI according to which payer is responsible for the patient's oral surgery coverage.

Claim Status Search Criteria

Highmark will use the following 3 data elements to begin the initial claim search:

Provider NPI	2100C
Member ID	2100D
Service Date(s)	2200D/E or 2210D/E

If the Highmark assigned claim number is also submitted (2200D/E REF), the initial search will be limited to a claim with an exact match to that claim number and the 3 initial claim search data elements. If an exact match is not found, a second claim search will be performed using the 3 initial claim search data elements.

Highmark will use the following elements and data content to narrow down the matching criteria after searching for claims based on the 3 initial claim search data elements:

Patient Date of Birth and Gender	2000D/E
Patient Last and First Name	2100D/E
Patient Control Number	2200D/E
Claim Charge Amount	2200D/E
Line Item Control Number	2210D/E

Maximum Claim Responses per Subscriber/Patient/ Dependent

If multiple claims are found for one status request, Highmark will respond with a maximum of 30 claims. If the 30 claim maximum is met, the requestor should change the data in the 276 request and submit a new request if the claims returned do not answer the initial status request.

Corrected Subscriber and Dependent Level

Data should always be sent at the appropriate Subscriber or Dependent level, based on the patient's relationship to the Insured. If the data is at the incorrect level, but Highmark is able to identify the patient, a 277 response will be returned at the appropriate, corrected level (subscriber or dependent) based on the enrollment information on file at Highmark.

Claim Splits

Claims that were split during processing will be reported as multiple claims on the 277 Claim Status Response when a Payer Claim Control Number (2200D/E REF) was not submitted on the 276 Request. When a Payer Claim Control Number is reported for a claim that was subsequently split during processing, the 277 Response will only return the portion of the claim specific to the reported Payer Claim Control Number.

Claim vs. Line Level Status

The 276 Health Care Claim Status Request can be used to request a status at a claim level or for specific service lines. The 277 Health Care Claim Status Response will contain information for both pending and finalized claims.

Service line information and status will be returned for both professional and institutional claims. All claim service lines will be returned on a 277 Response to a 276 Request that indicated specific service lines.

Only Claim level information and status will be returned on a 277 Response where a requested claim cannot be found or a system availability issue occurs.

7.6 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

The 270 transaction is used to request the health care eligibility for a subscriber or dependent. The 271 transaction is used to respond to that request. The May 2006 ASC X12 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Patient with Coverage from another Blue Cross Blue Shield Plan

An operating arrangement among Plans that are licensees of the BlueCross Blue Shield Association allows Highmark to accept 270 request transactions and return 271 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient's Member ID must be submitted with its alpha prefix and appropriate Highmark payer should be submitted in the GS03 Application Receiver's Code and the loop 2100A NM109 Information Source ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response.

Requests Per Transaction Mode

The Eligibility Inquiry requests will be processed in real-time mode only. The inquiry process for the payers in this Reference Guide is limited to one Information Source, and Information Receiver per ST - SE transaction. If multiple requests are sent, the transaction will be rejected.

Patient Search Criteria

In addition to the Required Primary and Required Alternate Search options mandated by the 270/271 implementation guide, Highmark will search for the patient if only the following combinations of data elements are received on the 270 request:

- Subscriber ID, Patient First Name, and Patient Date of Birth
- Subscriber ID and Patient Date of Birth

7.7005010X231A1Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.) The location and reason for errors are identified in one or more of the following segments:

IK3 - segment errors
IK4 - data element errors
IK5 - transaction errors
AK9 - functional group errors

Rejection codes are contained in the ASC X12C 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA - IEA) and Functional Group (GS - GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be "005010x231A1". Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment for Health Care Insurance (999) guide.

As part of your trading partner agreement, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values supplied in the trading

partner agreement, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter. In the following example the IK404 value ‘TRADING PARTNER PROFILE’ indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

```
ISA^00^          ^00^          ^33^55204          ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
   IEA^1^035738627
```

7.8 005010X210 Additional Information to Support a Health Care Claim Attachment (275CA)

The Additional Information to Support a Health Care Claim Attachment transaction is utilized by providers and facilities to send additional information about a claim. For Highmark’s purposes the Claim Attachment version of this transaction will be referred to as 275CA. The use of this transaction is designed to assist those who are submitting unsolicited supporting information about a health care claim (837) using the 275 format. The February 2008 ASC X12 005010X210 Implementation Guide is the primary source for definitions, data usage and requirements. This section and the corresponding transaction data detail make up the companion guide for submitting Additional Information to Support a Health Care Claim Attachment (275CA) for patients with Highmark benefit plans, Federal Employees Health Benefit Plan and BlueCard Par Point of Service (POS).

Accurate reporting of Highmark’s NAIC code is critical for 275 transactions submitted to Highmark.

7.9 005010X211 Additional Information to Support a Health Care Services Review (275SR)

The Additional Information to Support a Health Care Services Review transaction is utilized by providers and facilities to send additional information about a services review/prior authorization request. For Highmark's purposes the Services Review version of this transaction will be referred to as 275SR. The use of this transaction is designed to assist those who are responding to a solicited request for additional supporting information for a service review (278) using the 275 format. The February 2008 ASC X12 005010X211 Implementation Guide is the primary source for definitions, data usage and requirements. This section and the corresponding transaction data detail make up the companion guide for submitting Additional Information to Support a Health Care Services Review (275SR) for patients with Highmark benefit plans, Federal Employees Health Benefit Plan and BlueCard Par Point of Service (POS).

Accurate reporting of the appropriate Highmark payer code is critical for 275 transactions submitted to Highmark.

7.10 005010X217 Health Care Services Review-Request for Review and Response (278)

The Health Care Services Review (278) request transaction is utilized by providers and facilities to request reviews for specialty care and admissions. The Health Care Services Review (278) response is utilized by Utilization Management Organizations (UMOs) to response with results for reviews for specialty care and admissions. The May 2006 ASC X12 005010X217 Implementation Guide is the primary source for definitions, data usage and requirements.

This section and the corresponding transaction data detail make up the companion guide for submitting and receiving Health Care Services Review (278) requests and responses for patients with Highmark benefit plans, Federal Employees Health Benefit Plan and BlueCard Par Point of Service (POS). Accurate reporting of the appropriate Highmark payer code is critical for 278 transactions submitted to Highmark.

Patients with Coverage from an Out-of-State Blue Cross Blue Shield Plan

An operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept 278 request transactions and return 278 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient's Member ID

must be submitted with its alpha prefix and Highmark must be listed as the payer by submitting Highmark's appropriate payer code in the GS03 Application Receiver's Code and the loop 2010A NM109 UMO ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response.

Requests Per Transaction Mode

The Authorization Request/Response requests will be processed in real-time mode only. The process for the payers in this Reference Guide is limited to one Utilization Management Organization (Information Source) and one Requester (Information Receiver) per ST – SE transaction. If multiple requests are sent, the transaction will be rejected

8. Acknowledgments and Reports

8.1 Report Inventory

Highmark entities have no proprietary reports beyond the standard ASC X12 acknowledgments described below.

8.2 ASC X12 Acknowledgments

Highmark provides the following standard ASC X12 acknowledgments:

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance

277 Acknowledgment Claim Acknowledgment to the Electronic Claim

Outgoing Interchange Acknowledgment TA1 Segment

Highmark returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA - IEA) must be rejected.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the guidelines in the 999 Implementation Guide. Each Highmark TA1 will have an Interchange control envelope (ISA - IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to the Implementation Acknowledgment for Health Care Insurance (999) in Sections 7.7 and 10 of this Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The Claim Acknowledgment Transaction is used to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the electronic claim transaction in batch mode. The 277CA files (ISA-IEA) will be grouped by the 277CA transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837. Each 277CA grouping (GS-GE) will be in a

separate file (ISA-IEA). For example, if an 837 file (ISA – IEA) has 2 Functional Groups (GS-GE) and each Functional Group has 2 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each

with a Functional Group that contains two 277CA transactions (STSE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

9. Trading Partner Agreements

Provider Trading Partner Agreement
For use by professionals and institutional providers.

Clearinghouse/vendor Trading Partner Agreement
For use by software vendors, billing services or clearinghouses.

TRADING PARTNERS

An EDI Trading Partner is defined as any customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits or receives electronic data.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

The Trading Partner agreements are located in the Resources section at the following site:

https://edi.highmark.com/edi/tpbc

Questions about Trading Partner Agreements should be directed to EDI Operations at 1-800-992-0246. EDI Operations personnel are available for questions from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday

10. Transaction Specific Information

This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Highmark has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements

5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Highmark

In addition to the row for each segment, one or more additional rows are used to describe Highmark's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

This lists the X12 Implementation Guides for which specific transaction instructions apply and which are included in Section 10 of this document.

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010X231A1	Implementation Acknowledgment for Health Care Insurance
005010X212	Health Care Claim Status Request and Response*
005010X279A1	Health Care Eligibility Benefit Inquiry and Response*
005010X217	Health Care Services Review-Request for Review and Response*
005010X210	Heath Care Claim Attachment
005010X211	Health Care Service Review

Highmark supports the transactions marked with an '*' in real-time only. All other listed transactions are supported in both batch and real-time.

005010X222A1 Health Care Claim: Professional (837P)

Refer to section 7.1 for Highmark Business Rules and Limitations

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros. For real-time claim adjudication or estimation, add a prefix of "R" to the Trading Partner number. For more information on how to distinguish the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' located in the 'Resources'' section under EDI Companion Guides at the following website: https://www.highmark.com/edi/tpbc

	GS03	Application Receiver's Code	54771 15460 55204 54828 15459 00570	Highmark PA Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	NM109	Receiver Primary Identifier	 54771 15460 55204 54828 15459 00570	 Highmark PA Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional Identifies the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	N3	Billing Provider Address		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		Highmark will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For Highmark claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which Highmark does not process.
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha/numeric characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BA	REF	Subscriber Secondary Identification		Highmark does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	NM109	Payer Identifier	54771 15460 55204 54828 15459 00570	Highmark PA Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional
2010BB	REF	Payer Secondary Identification		Highmark does not need secondary identification to identify the payer.
2300	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	PWK	Claim Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be found in section 6.2 of the Provider Manual at the following link: https://providers.highmark.com/resources-and-education/highmark-provider-manual 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) EL (Electronically Only) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment.
2300	CR2	Spinal Manipulation Information		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	CRC	Patient Condition Information: Vision		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	HI	Anesthesia Related procedure		Send the procedure code for the surgery or other service related to the anesthesia, if known.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2310C	N3	Service Facility Location Address		When the 2310C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.
2310C	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2400	SV1	Service Line		
	SV101-1	Product / Service ID Qualifier		1) Qualifier value HC, HCPCS, is the only value Highmark will accept in this element. 2) CDT dental codes (codes starting with a D) should be submitted in an 837-Dental transaction. Dental codes are not considered valid with an HC, HCPCS qualifier in an 837 Professional Claim transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2400	PWK	Line Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be found in section 6.2 of the Provider Manual at the following link: https://providers.highmark.com/resources-and-education/highmark-provider-manual 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic “OZ” - Support Data for Claim.
005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) EL (Electronically Only) FX (By fax)	Highmark’s business practices and policy only support the listed transmission types at this time.
2400	DTP	Last Seen Date		This date is not needed for the payer’s adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer’s adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer’s adjudication process; therefore, it is not required.
2410	LIN	Drug Identification		**1.** NDC codes are required when specified in the Provider’s agreement with Highmark. **2.** Highmark encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider’s National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider’s contractual business arrangements with Highmark
2420C	N3	Service Facility Location Address		When the 2420C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.

005010X223A2 Health Care Claim: Institutional (837I)

Refer to section 7.2 for Highmark Business Rules and Limitations

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54771C 54771W 54771S 15460 55204 54828 15459 00070	Facility in Highmark's Central Region Facility in Highmark's Western and Northeastern Regions Facility in Highmark's Southeast Region Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Institutional
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		

	NM103	Receiver Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	NM109	Receiver Primary Identifier	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Institutional Identifies the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AA	N3	Billing Provider Address		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		Highmark will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For Highmark claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which Highmark does not process.
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha/numeric characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BA	REF	Subscriber Secondary Identification		Highmark does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware

	NM109	Payer Identifier	54771C 54771W 54771S 15460 55204 54828 15459 00070	Facility in Highmark's Central Region Facility in Highmark's Western and Northeastern Regions Facility in Highmark's Southeast Region Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Institutional Identifies the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.

005010X223A2 Health Care Claim: Institutional				
oop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BB	REF	Payer Secondary Identification		Highmark does not need secondary identification to identify the payer.
2300	CLM	Claim Information		
	CLM05-1	Facility Type Code	84	Highmark considers Free Standing Birthing Center to be Outpatient when applying data edits. Note that this is a variation from the Inpatient indication in the NUBC Data Specifications Manual as of the time of this document.
2300	DTP	Discharge Hour		
	DTP03	Discharge Time		Hours (HH) are expressed as '00' for midnight', '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	DTP	Admission Date/Hour		

	DTP03	Admission Date and Hour		Hours (HH) are expressed as '00' for midnight‘, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'..

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**

	2300	PWK	Claim Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be found in section 6.2 of the Provider Manual at the following link: https://providers.highmark.com/resources-and-education/highmark-provider-manual 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic “OZ” - Support Data for

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) EL (Electronically Only) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.
2300	HI	Principle Procedure Code		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
	HI01-1	Code List Qualifier Code		Until further notification from Highmark, Advanced Billing Concepts (ABC) codes will not be accepted.
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider's National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2310E	N3	Service Facility Location Address		When the 2310E Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.
2310E	N4	Service Facility Location City/State/Zip		
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
2330B	NM1	Other Payer Name		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2400	PWK	Line Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be found in section 6.2 of the Provider Manual at the following link: https://providers.highmark.com/resources-and-education/highmark-provider-manual 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) EL (Electronically Only) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.

005010X214 Health Care Claim Acknowledgment (277CA)

Refer to section 7.3 for Highmark Business Rules and Limitations

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		This will match the payer id in the GS03 of the claim transaction
			54771 54771C	Highmark Facility in Highmark's Central Region
			54771W	Facility in Highmark's Western and Northeastern Regions
			54771S	Facility in Highmark's Southeast Region
			15460	Highmark Senior Health Company
			55204	Highmark Western and Northeastern New York
			54828	Highmark West Virginia
			15459	Highmark Senior Solutions Company
			00570	Highmark Delaware Professional
			00070	Highmark Delaware Institutional

	GS03	Application Receiver's Code		This will always be the Highmark assigned Trading Partner Number for the entity receiving this transaction.
2100A	NM1	Information Source Name		
	NM109	Information Source Identifier	 54771 54771C 54771W 54771S 15460 55204 54828 15459 00570 00070	This will match the payer id in the GS03 of the claim transaction Highmark Facility in Highmark's Central Region Facility in Highmark's Western and Northeastern Regions Facility in Highmark's Southeast Region Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware Professional Highmark Delaware Institutional
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number for the entity that submitted the original 837 transaction.
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge receipt of the claim transaction by the payer. It does not mean all of the claims have been accepted for processing. We will not report rejected claims at this level.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
	STC01-2	Health Care Claim Status Code	19	Default value for this status level.
	STC01-3	Entity Identifier Code	PR	Default value for this status level.
	STC03	Action Code	WQ	This element will always be set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
	STC04	Total Submitted Charges		In most instances this will be the sum of all claim dollars (CLM02) from the 837 being acknowledged. In instances where the claim dollars do not match, an exception process occurred. See Section 7.3 about the exception process.
2200C		Provider of Service Information Trace Identifier		The 2200C loop will not be used. Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Relational edits between claim and line level data will be reported at the service level
	STC01-2	Health Care Claim Status Code	247	Health Care Claim Status Code '247 - Line Information' will be used at the claim level when the reason for the rejection is line specific.
2200D	DTP	Claim Level Service Date		
	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used.
	DTP03	Claim Service Period		The earliest and latest service line dates will be used as the claim level range date for professional claims. When the service line is a single date of service, the same date will be used for the range date.
2220D	STC	Service Line Level Status Information		Relational edits between claim and line level data will be reported at the service level
2220D	DTP	Service Line Date		.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used
	DTP03	Service Line Date		When the service line date is a single date of service the same date will be used for the range date

005010X212 Health Care Claim Status Request and Response (276/277)

Refer to section 7.5 for Highmark Business Rules and Limitations

005010X212 Health Care Claim Status Request				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group		
	GS02	Application Sender's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zero's
	GS03	Application Receiver's Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2100A	NM1	Payer Name		
	NM103	Payer Name		Highmark will not use the payer name as part of their search criteria.
	NM108	Identification Code Qualifier	PI	

005010X212 Health Care Claim Status Request				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Payer Identifier	 54771 15460 55204 54828 15459 00070	This must be the same number as identified in GS03. Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number. This must be the same Trading Partner number as identified in GS02. The submitted value must not include leading zero's.
2100C	NM1	Provider Name		This will always be the Billing Provider NPI.
	NM103	Provider Last or Organization Name		Highmark will not use the Provider Name when searching for claims.
	NM108	Identification Code Qualifier	XX	
	NM109	Provider Identifier		This will always be the Billing Provider NPI.
2100D	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Highmark will not use the subscriber name to search for claims unless the subscriber is the patient and the name is needed to narrow the search criteria.
	NM104	Subscriber First Name		Highmark will not use the subscriber name to search for claims unless the subscriber is the patient and the name is needed to narrow the search criteria.
	NM108	Identification Code Qualifier	MI	

	NM109	Subscriber Identifier		This is the identifier from the member's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.

005010X212 Health Care Claim Status Request				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2200D	REF	Payer Claim Control		
	REF02	Payer Claim Control Number		When the Payer Claim Control Number is provided, the payer will initially limit the search to an exact match of that control number. If an exact match is not found, a second search will be performed using other data submitted on the claim status request. See Section 7.5 Claim Status Search Criteria for more information.
2210D	SVC	Service Line Information		Highmark will not use the service line procedure code information reported in the SVC when searching for claims.
2000E	REF	Payer Claim Control		
	REF02	Payer Claim Control Number		When the Payer Claim Control Number is provided, the payer will initially limit the search to an exact match of that control number. If an exact match is not found, a second search will be performed using other data submitted on the claim status request. See Section 7.5 Claim Status Search Criteria for more information.
2210E	SVC	Service Line Information		Highmark will not use the service line procedure code information reported in the SVC when searching for claims.

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group		
	GS02	Application Sender's Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating it is real-time response.

2100A	NM1	Payer Name		
	NM109	Payer Identifier	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number.
2200B	TRN	Information Receiver Trace Identifier		Highmark will not be returning status at the 2200B level.
2100C	NM1	Provider Name		
	NM108	Identification Code	XX	
	NM109	Provider Identifier		This will always be the Billing Provider NPI.
2200C	TRN	Provider of Service Trace Identifier		Highmark will not be returning status at the 2200C level.
2100D	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	MI	
	NM109	Subscriber Identifier		This will be the same member identification number that was submitted on the 276.
2200D	STC	Claim Level Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment

2220D	SVC	Service Line Information		Highmark will return service line information when a finalized or pended claim is
2220D	STC	Service Line Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
2200E	STC	Claim Level Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
2220E	SVC	Service Line Information		Highmark will return service line information when a finalized or pended claim is found.
2220E	STC	Service Line Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.

005010279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Refer to section 7.6 for Highmark Business Rules and Limitations

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zero's
	GS03	Application Receiver's Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use this code to indicate that Highmark is a payer
	NM103	Information Source Last or Organization Name		The information in this element will not be captured and used in the processing
	NM108	Identification Code Qualifier	NI	Use this code to indicate the NAIC value is being sent in NM109
	NM109	Information Source Primary Identifier	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2100B	NM1	Information Receiver Name		

	NM101	Entity Identifier Code	2B 36 P5	Highmark business practices do not allow for eligibility inquiries from Third Party Administrators, Employers or Plan Sponsors.
	NM108	Identification Code Qualifier	XX PI	Provider Request Payer Request
2100B	REF	Information Receiver Additional Identification		The information in this segment will not be captured and used in the processing.
2100B	N3	Information Receiver Address		The information in this segment will not be captured and used in the processing.
2100B	N4	Information Receiver City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		Enter the full Unique Member ID including the alpha prefix found on the patient's healthcare ID card.
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help Highmark identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100C	N3	Subscriber Address		The information in this segment will not be captured and used in the processing.
2100C	N4	Subscriber City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	PRV	Provider Information		Highmark does not use the information in this segment except as noted below.
	PRV02	Reference Identification Qualifier	9K	This is the only qualifier Highmark processes.
2100C	HI	Subscriber Health Care Diagnosis Code		Highmark does not process eligibility responses as the Diagnosis level. Do not send.

2100C	DTP	Subscriber Date		
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	EQ01	Service Type Code		Highmark will accept this as a repeating element when applicable
	EQ01	Service Type Code	35	Dental inquiries must be submitted to UCCI. Oral Surgery inquiries must be submitted to both Highmark for Medical coverage and UCCI for Dental coverage.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BE,BJ, BK, BL, BM, BP, BN, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	Highmark does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, Highmark will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, 98 (MSG "Specialist"), BZ and MH.
	EQ02	Composite Medical Procedure Identifier		Highmark does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01
	EQ03	Coverage Level Code	FAM	Highmark does not process inquiries at the contract, or family, level. The 271 response will include only subscriber eligibility information
2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		Highmark does not consider the information in the III segment for processing.
2110C	DTP	Subscriber Eligibility/Benefit Date		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2100D	REF	Dependent Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help Highmark identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100D	N3	Dependent Address		The information in this segment will not be captured and used in the processing.
2100D	N4	Dependent City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100D	PRV	Provider Information		Highmark does not use the information in this segment except as noted below.
	PRV02	Reference Identification Qualifier	9K	This is the only qualifier Highmark processes.
2100D	HI	Dependent Health Care Diagnosis Code		Highmark does not process eligibility responses as the Diagnosis level. Do not send.
2100D	DTP	Dependent Date		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2110D	EQ	Dependent Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Highmark will accept this as a repeating element when applicable
	EQ01	Service Type Code	35	Dental inquiries must be submitted to UCCI. Oral Surgery inquiries must be submitted to both Highmark for Medical coverage and UCCI for Dental coverage.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BE, BJ, BK, BL, BM, BP, BN, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	Highmark does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, Highmark will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, 98 (MSG "Specialist"), BZ and MH.
	EQ02	Composite Medical Procedure Identifier		Highmark does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110D	III	Dependent Eligibility or Benefit Additional Inquiry Information		Highmark does not consider the information in the III segment for processing.
2110D	DTP	Dependent Eligibility/Benefit Date		
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group		
	GS02	Application Sender's Code	54771 15460 55204 54828 15459 00070	This will match the payer id in the GS03 of the 270 transaction Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware

	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
2100C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Highmark will accept up to 60 characters on the 270 Inquiry. However, only the first 35 characters will be returned on the 271 response
	NM104	Subscriber First Name		Highmark will accept up to 35 characters on the 270 Inquiry. However, only the first 25 characters will be returned on the 271 response

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM108	Identification Code Qualifier	MI	This is the only qualifier Highmark will return on the 271 Response
	NM109	Subscriber Primary Identifier		If a contract ID that is not an Unique Member ID (UMI) is submitted, Highmark will return the corrected UMI in this element. The submitted ID will be returned in an REF segment with a Q4 qualifier.
2110C	EB	Subscriber Eligibility or Benefit Information		
	EB03	Eligibility or Benefit Information		Highmark will return this as a repeating element when applicable
2110C	DTP	Subscriber Eligibility/Benefit Date		
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re-certification date	Highmark will return the Coordination of Benefits eligibility, effective, cancel or certification dates, if applicable
2110C	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".
2100D	NM1	Dependent Name		
	NM103	Dependent Last Name		Highmark will accept up to 60 characters on the 270 Inquiry. However, only the first 35 characters will be returned on the 271 response
	NM104	Dependent First Name		Highmark will accept up to 35 characters on the 270 Inquiry. However, only the first 25 characters will be returned on the 271 response

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110D	EB	Dependent Eligibility or Benefit Information		
	EB03	Eligibility or Benefit Information		Highmark will return this as a repeating element when applicable
2110D	DTP	Dependent Eligibility/Benefit Date		
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re=certification date	Highmark will return the Coordination of Benefits eligibility, effective, cancel or certification dates, if applicable
2110D	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".

005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Refer to section 7.7 for Highmark Business Rules and Limitations

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment, therefore, when there are errors in the submitted GS, “TRADING PARTNER PROFILE” will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time

005010X210 Additional Information to Support a Healthcare Claim attachment (275CA)

Refer to section 7.8 for Highmark Business Rules and Limitations

005010X210 Additional Information to Support a Healthcare Claim Attachment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		The receiver's Highmark-assigned Trading Partner Number will be used.
	GS03	Application Receiver's Code	54771 15460 55204 54828 15459 00070	To support Highmark's routing process, all claims in a functional group should be for the same payer. Submit the NAIC code for the payer identified in the claim. Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	BGN			
	BGN01	Transaction Set Purpose Code	02	Used when submitting an unsolicited attachment to an 837
1000A	NM1	Payer Name Information		
	NM101	Entity Identifier Code	PR	Payer
	NM102	Entity Type Qualifier	2	Non-Person
	NM103	Organization Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware

	NM108	Identification Code Qualifier	PI	Payer Identifier
	NM109	Identification Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2000A	TRN	Attachment Control Number		
	TRN02	Reference Identification		This value should be the Payer Claim Control Number

005010X211 Additional Information to Support a Healthcare Services Review (275SR)

Refer to section 7.9 for Highmark Business Rules and Limitations

005010X211 Additional Information to Support a Healthcare Services Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		**T**he receiver's Highmark-assigned Trading Partner Number will be used.
	GS03	Application Receiver's Code	 54771 15460 55204 54828 15459 00070	To support Highmark's routing process, all authorization requests in a functional group should be for the same UMO. Submit the NAIC code for the UMO identified as the source of the decision/response. Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	BGN			
	BGN01	Transaction Set Purpose Code	11 02	Use when submitting a solicited 275 as a request for additional information. *An unsolicited 275 is not supported at this time
1000B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	PR	

	NM102	Entity Type Qualifier	2	Non-Person
	NM103	Organization Name		Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
	NM108	Identification Code Qualifier	PI	Payor Identifier
	NM109	Identification Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2000A	TRN	Attachment Control Number		
	TRN02	Reference Identification		This value should be the Payer Assigned Authorization number. NOTE: If this 275 solicited is in response to a 278 then the Payer Assigned Auth number would be found in Loop 2000E and 2000F (if applicable), REF02 (REF01 Qualifier = NT).

005010X217 Health Care Services Review- Request for Review and Response (278)

Refer to section 7.10 for Highmark Business Rules and Limitations

5010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code		To support Highmark's routing process, all authorization requests in a functional group should be for the same UMO. Submit the NAIC code for the UMO identified as the source of the decision/response in loop 2010A of the 278 transaction.

			54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2010A	NM1	Utilization Management Organization (UMO) Name		
2010A	NM108	Identification Code Qualifier	PI	Payor Identifier
	NM109	Identification Code	54771 15460 55204 54828 15459 00070	Highmark Highmark Senior Health Company Highmark Western and Northeastern New York Highmark West Virginia Highmark Senior Solutions Company Highmark Delaware
2010B	N3	Requester Address		Due to Highmark's business practices, this information is needed to identify the requester's Practice, Physician, Supplier, or Institution office location. If Highmark is unable to identify the location, the default will be the main location on the Highmark system.

2010B	N4	Requester City, State, Zip Code		Due to Highmark's business practices, this information is needed to identify the requester's Practice, Physician, Supplier, or Institution office location. If Highmark is unable to identify the location, the default will be the main location on the Highmark system.
2010B	PER	Requester Contact Information		
	PER02	Name		Due to Highmark's business practices, this information is needed to process authorizations.
	PER03	Communication Number Qualifier	TE	Telephone

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER04	Communication Number		Always include an area code with the telephone number.
2010C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM104	Subscriber First Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM105	Subscriber Middle Name		Due to Highmark's business practices, this information is needed to process authorizations.
2010C	DMG	Subscriber Demographic Information		
2010C	DMG02	Subscriber Birth Date		The subscriber's birth date is needed when the subscriber is the patient.
2010D	NM1	Dependent Name		
	NM103	Dependent Last Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM104	Dependent First Name		Due to Highmark's business practices, this information is needed to process authorizations.

	NM105	Dependent Middle Name		Due to Highmark's business practices, this information is needed to process authorizations..
2010D	DMG	Dependent Demographic Information		
	DMG02	Dependent Birth Date		The dependent's birth date is needed when the dependent is the patient.
2000E	UM	Health Care Services Review Information		
	UM01	Request Category Code	AR	Use this value if this authorization is for inpatient place of service
	UM03	Service Type Code		Due to Highmark's business practices, this information is needed to process authorizations.
	UM04-1	Facility Type Code		Due to Highmark's business practices, this information is needed to process authorizations.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	UM04-2	Facility Code Qualifier	B	Enter code value for Place of Service code from the Centers for Medicare and Medicaid Services.
2000E	DTP	Admission Date		
DTP01		Date Time Qualifier	435	Use this value if this authorization is for inpatient place of service
2000E	HI	Patient Diagnosis		Due to Highmark's business practices, this information is needed to process authorizations.
2000E	PWK			
	PWK02	Report Transmission Code	AA BM FX	Due to Highmark's business systems, these values are the only methods by which additional information can be received.
2010EA		Patient Event Provider Name		Due to Highmark's business practices, for Facility requests, one iteration of the Patient Event Provider Name Loop is needed to process authorization requests.
2010EA	N3	Patient Event Provider Address		Due to Highmark's business practices, this information is needed to process authorizations.
2010EA	N4	Patient Event Provider City, State, Zip Code		Due to Highmark's business practices, this information is needed to process authorizations.
2010EA	PER	Patient Event Provider Contact Information		

	PER02	Name		Please enter the name of the person Highmark should contact for additional information. If there is no specific person assigned to answer 278 Transaction inquiries, there must be a value in PER04 so Highmark can contact the provider.
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Always include an area code with the telephone number.
2000F	UM	Health Care Services Review Information		If different than the information located in the UM segment at the Patient Event Level, the following UM values are needed to process authorizations.
	UM03	Service Type Code		Due to Highmark's business practices, this information is needed to process authorizations.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	UM04-1	Facility Type Code		Due to Highmark's business practices, this information is needed to process authorizations..
	UM04-2	Facility Code Qualifier	B	Due to Highmark's business practices, this information is needed to process authorizations..
2000F	DTP	Service Date		Due to Highmark's business practices, this information is needed to process authorizations. Enter the proposed or actual date of the procedure.
2000F	SV1	Professional Service		
	SV101-1	Product/Service ID Qualifier	HC	For professional services, Highmark will only accept the codes from the Health Care Financing Administration Common Procedural Coding System external code list.
	SV202-1	Product/Service ID Qualifier	HC	For institutional services, Highmark will only accept the codes from the Health Care Financing Administration Common Procedural Coding System external code list.
2010F				

		Service Provider Name		Due to Highmark's business practices, for Professional requests, one iteration of the Service Provider Name Loop is needed to process authorization requests.
2010F	N3	Service Provider Address		Due to Highmark's business practices, this information is needed to process authorizations.
2010F	N4	Service Provider City, State, Zip Code		Due to Highmark's business practices, this information is needed to process authorizations.
2010F	PER	Service Provider Contact Information		
	PER02	Name		Please enter the name of the person Highmark should contact for additional information. If there is no specific person assigned to answer 278 Transaction inquiries, there must be a value in PER04 so Highmark can contact the provider.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Always include an area code with the telephone number.

005010X217 Health Care Services Review- Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Highmark will send the NAIC code for the Utilization Management Organization (UMO) that is sending this response.
			54771	Highmark
			15460	Highmark Senior Health Company
			55204	Highmark Western and Northeastern New York
			54828	Highmark West Virginia
			15459	Highmark Senior Solutions Company
			00070	Highmark Delaware
	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
	GS06	Group Control Number		Highmark will send a unique control number for each functional group.

Appendices

1. Implementation Checklist

Highmark does not have an Implementation Checklist.

2. Business Scenarios

No Business Scenarios at this time.

3. Transmission Examples

No examples at this time.

4. Frequently Asked Questions

No FAQs at this time

5. Change Summary

The items below were revised from the January 2026 version to this March 2026 version of the Provider Companion Guide.

Page	Section	Description
Multiple	Combined all the section to one	