Availity

Availity® Health Information Network

Batch Electronic Data Interchange (EDI) Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Where healthcare **connects.**

Disclosure Statement

Availity provides the information in this document for education and awareness use only. While Availity believes all information in this document to be correct at the time of writing, this document is intended for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by Availity.

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Preface

Rules for format, content, and data element values are listed in the HIPAA Technical Reports Type 3 (TR3s) for submitting 5010 HIPAA transactions. These guides are available on the Washington Publishing Company website.

This Availity EDI Companion Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the transactions specified in this guide as related to Availity. This guide also provides specific information for data elements and values required by Availity.

Important: As defined in the HIPAA TR3s, documents like this Availity EDI Companion Guide are intended to supplement, not replace, the standard HIPAA TR3 for each transaction set. Information in this guide is not intended to modify the definition, data condition, or use of any data element or segment in the standard TR3s. It is also not intended to add any additional data elements or segments to the defined data set. This guide does not utilize any code or data values that are not valid in the standard TR3s. It also does not change the meaning or intent of any implementation specifications in the standard TR3s.

Note:

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Table of contents

Introduction

Scope

The purpose of the Availity Health Information Network EDI Guide (Availity EDI Guide, for short) is to communicate Availity-specific requirements and other information that supplements requirements and information already provided in standard EDI and HIPAA communications.

Overview

Availity, LLC., a leader in EDI healthcare technology, offers a full suite of EDI health information exchange services through a single web connection to the Availity® Health Information Network. In addition to offering an extensive array of real-time EDI transactions, we also provide near real-time processing of batch EDI transactions. The Availity® Health Information Network is your one stop on the web for secure connectivity and electronic access to an extensive list of commercial insurance payers.

The Availity® Health Information Network is operationally HIPAA compliant, accepting and processing in a secure environment all American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA). Availity edits batches of transactions for X12N syntax compliance, and then splits the batches into the lowest transaction level possible before applying HIPAA-semantic validation rules. Depending on the payer, Availity might also apply payer-specific edits to transactions that pass HIPAA syntax validation before routing the transactions to the designated payer.

Using the Availity® Health Information Network file transfer features, users can send all files and retrieve responses through one interface.

Benefits

As an Availity user, you will realize the following benefits:

- Electronic access to commercial and government insurance payers
- The ability to submit transactions destined for multiple payers in a single batch
- Reduced administrative work and expense
- Reduced postage and material expense
- Ability to submit transactions twenty-four hours a day, seven days a week (except during scheduled maintenance times)
- Acknowledgement of receipt for each transmitted file
- Increased accuracy of data and reduced risk of duplication
- Increased productivity
- Improved payment cycle and reduced appeals
- Compliance with HIPAA mandates for electronic transactions

Supported EDI transactions

Availity is operationally HIPAA compliant, securely accepting and processing a number of X12N transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA). The table below provides information about the ANSI ASC X12N health care electronic transactions adopted for use by the HIPAA regulations, and supported by the Availity Health Information Network.

Supported transaction formats

Format	Version supported	Transaction type	Optimal batch file
ASC X12N 837	005010X223A2	Institutional Claims	5,000 claims or 4 megabytes
ASC X12N 837	005010X222A1	Professional Claims	5,000 claims or 4 megabytes
ASC X12N 837	005010X224A2	Dental Claims	5,000 claims or 4 megabytes
ASC X12N 270/271	005010X279A1	Health Care Benefit Inquiry/Response (Eligibility and Benefits)	4 megabytes
ASC X12N 276/277	005010X212	Health Care Claim Status Request/ Response	4 megabytes
ASC X12N 278	005010X217	Health Care Services Request (Authorization and Referral) for Review/Response	4 megabytes
ASC X12N 278	005010X216	Health Care Services Review Notification and Acknowledgement	4 megabytes
ASC X12N 835	005010X221A1	Health Care Claim Payment/Advice (ERA)	4 megabytes
ASC X12N 275	005010X210	Additional Information to Support a Health Care Claim or Encounter (275)	40 megabytes max per attachment and 80 megabytes max per batch

Note: For the ASC X12N 835 format, files over 12 megabytes with large checks might not be validated.

The Availity HIPAA validation is based on the HIPAA-mandated implementation guides. For information about HIPAA edits, please refer to the appropriate *HIPAA Implementation Guide* for the transaction you are submitting.

- For a cost, you can obtain the appropriate *HIPAA Implementation Guide* from the publisher, Washington Publishing Company (WPC) (http://www.wpc-edi.com/). WPC offers implementation guides for each transaction type (claims, authorizations and referrals, and so on) in a regular version and a combined version, which contains the addenda. Choose the implementation guide that best suits your business needs.
- You might want to validate or certify your transactions prior to submitting them to Availity. This service is offered over the Internet by various vendors.

  Tip: Search on `free HIPAA validator`, in a search engine, for a list of sites that might be offering HIPAA validators.

Additional Availity EDI Companion Guides and resources

For Availity-specific information about ASC X12N 275 (005010X210) transactions, see the Availity EDI 275 Companion Guide.

For an introduction to submitting batch EDI transactions to Availity, see the EDI Connection Guide.

Getting started

Trading Partner Registration

To start submitting transactions to the Availity Health Information Network, the Availity administrator for your organization must first register the organization with Availity by following these steps:

1. Go to www.availity.com and click **REGISTER**.

   Note: The registration must be completed by someone from your business with the authority to authorize the Availity Organization Agreement.

2. Complete the online registration for your type of organization. The process involves providing demographic information about your organization and choosing a user ID for the administrator. At the end of the registration process, you will electronically agree to the Organization Access Agreement, which you can print for your records.

   Learn More: Learn about Availity Essentials registration

When we have processed the application, we send a confirmation by email to the administrator. The first time you log in to Availity Essentials, the system prompts you to agree to the disclaimer, set up your security questions, change your password, and verify your email.

Once the administrator is able to log in to Availity Essentials, they can set up authorized personnel in the office as Availity Essentials users. Each user must have a unique user ID and password. Availity does not allow users to share login credentials.

Connectivity with the payer/communications

EDI file submission methods

Availity provides the following modes for submitting batch files of EDI transactions.

Submit transaction files through FTP

If you work with a practice management system, health information system, or other automated system that supports an FTP connection, you can securely upload batch files of X12 EDI transactions to the Availity FTP site where they are automatically picked up by Availity and submitted to the appropriate health plans.

Submit transaction files through Availity Essentials

If you have batch files of X12 EDI transactions that you need to process and you don't have access to an FTP connection, you can manually upload the batch files through Availity Essentials.

You can choose to always submit your batch files through one mode, or you can submit some batch files through one mode and some through the other mode. If you work with a vendor who has provided you with an EDI transactions system, such as a practice management system (PMS), hospital information system (HIS), or revenue cycle management system, consult with your vendor to determine how you'll submit batch files to Availity.

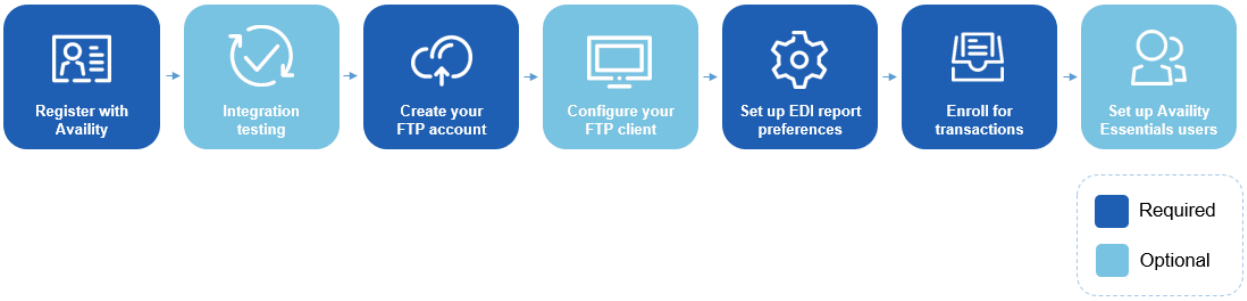
- Availity partners with many vendors. If you already work with a vendor, you can check their certification status from the Technology Company Partners List.
- If you work with a vendor, follow their instructions for building and submitting batch files.
- If you are a provider who has registered to send Medicare or Medicaid claims through Availity, you must configure your PMS, HIS, or other EDI system with the correct payer IDs and billing provider ID before you can send Medicare or Medicaid EDI claims through Availity. You might need to contact the vendor of your system for assistance with this process.
- Florida providers must register with Florida Medicaid prior to registering to send Medicaid claims through Availity.

Note: If you want to submit real-time (B2B) transactions through Availity's Simple Object Access Protocol (SOAP) Web service, you'll need to contact Availity Client Services to request a B2B setup.

EDI transactions through FTP

Setup steps for EDI through FTP

Getting set up to submit batch files of EDI transactions to Availity through FTP involves the following steps, some of which you might have already completed. The lighter-colored tasks, such as integration testing, might not be required for your particular implementation.



1. **Register with Availity** - If you haven't already registered your organization with Availity, go to www.availity.com and click **REGISTER**.

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Availity's payer list

Check out the Availity payer list for participating payers and payer IDs. You can also access the payer list from within Availity Essentials by typing **payer list** in the keyword search option.

- Transactions that are listed as **Available** in the payer list are sponsored by the associated payer and are provided at no charge.
- Transactions that are listed as **Contract Required** in the payer list are fee-based. For information about submitting transactions that require a contract, see the information about Comprehensive plans in EDI Clearinghouse plans.

  Note: If your organization already has a contractual agreement with Availity for submitting transactions that require a contract, no other action is required.

2. **Integration testing** - Availity gives you the option of doing integration testing in our QA environment before you submit any real transactions. See Integration testing through FTP on page 14 for details.
3. **Create your Availity FTP account** - See Create an Availity FTP account on page 16 for details.
4. **Configure your FTP client** - See Configure an FTP client on page 18 for details.
5. **Set up your EDI reporting preferences** - Availity's batch EDI processing generates response files for each batch file that you submit. The administrator for an organization can set reporting preferences that specify which response files are generated. See Set up EDI Reporting Preferences on page 32 for details.
6. **Enroll for transactions** - You might need to enroll for some transactions (such as claim submission) for particular health plans that you submit to. To determine if any of the health plans that you submit to require enrollments, see the Availity payer list. You can also enroll (if required) to have electronic remittance advice files (also known as ERAs and 835s) delivered to your Availity mailbox. Electronic

remittance advice files display payment information from all claims, whether submitted electronically or by paper. See the Availity payer list to determine if enrollment for ERAs is required for a particular health plan.

Note: If your ERAs are already delivered to Availity for the health plans that you submit claims to, you can skip the ERA transaction enrollment process.

7. **Set up your Availity Essentials users** - If other people in your organization need access to Availity Essentials, such as to view remittance advice information, you'll need to create an Availity Essentials account for each such person. Log in to Availity Essentials at https://apps.availity.com, click your name or the avatar icon in the Availity Essentials menu, and then click **Add User**.

   Tip: Have a lot of users? On the Add Users page, click the option to upload users in a spreadsheet in .csv format.

Integration testing through FTP

Integration testing is coordinated through Availity Client Services at no charge to the submitter. Once you've received the login credentials for your QA account from Availity Client Services, you'll need to complete the following two setup steps:

1. Create an Availity FTP account in QA on page 14
2. Configure an FTP client for QA on page 15

The process for uploading batches of transaction files to the Availity FTP site, viewing response files, and setting up which response files you receive is exactly the same in the QA environment as it is in the production environment.

Create an Availity FTP account in QA

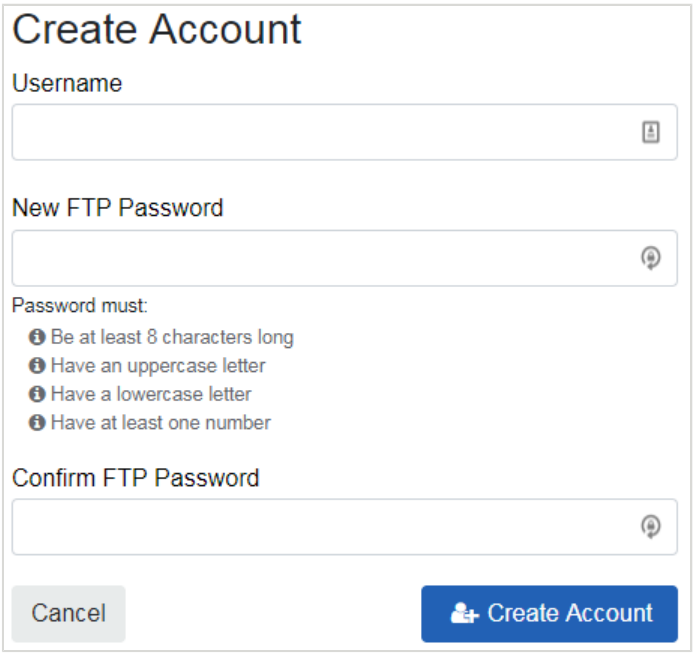
To do integration testing through FTP, you need to create an Availity FTP account in the Availity QA environment. Once you've created the FTP account, you'll be able to access your organization's mailbox in the QA environment, allowing you to submit test transactions and retrieve response files.

Important: Availity FTP account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, you'll be able to follow the steps below. If you don't have the appropriate permissions, look up your administrators by clicking your name or the avatar icon in the Availity Essentials menu, and then click **My Administrators**. Ask an administrator to follow the instructions below to create an FTP account for your organization.

To create an FTP account in the QA environment, follow these steps:

1. Log in to the Availity QA environment at https://qa-apps.availity.com.
2. In the Availity Essentials menu bar, click **Claims & Payments** | **FTP and EDI Connection Services**, and then click **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

   Note: You can also access the FTP and EDI Connection Services page from the **My Account Dashboard** tab on the Home page.
3. On the Manage Your FTP Mailbox page, select the **Organization**.
4. Enter a username and password for the new FTP account, confirm the password, and then click **Create Account**.



Configure an FTP client for QA

Once you've created your Availity FTP account in the QA environment, you'll need to configure your FTP client (software that allows you to send files through FTP) to connect to the Availity QA FTP site.

1. Launch or open your FTP client software.
2. Enter the following address in the server's host field: `qa-ftp.availity.com`
3. Enter your Availity QA FTP account username and password.
4. Enter the port number (Port 9922 is usually used for SFTP).
5. Select the appropriate option in your client software for Secure File Transfer Protocol (SFTP), if available and/or applicable. To ensure security, we recommend using the Secure File Transfer Protocol (SFTP).
6. Click **Connect** or press **Enter** to connect to the server.

   If you're prompted to enter a username and password, enter the same Availity QA FTP username and password that you entered in your FTP client.

Note: As an alternative to using an FTP client to connect to the Availity FTP site in the QA environment, you can access the QA FTP site by entering the following URL into a browser and then entering your FTP user name and password: https://qa-ftp.availity.com.

Set up FTP for the production environment

Once you've completed any testing you wanted to do in our QA environment, you're ready to create an FTP account in the production environment and start submitting real transactions through the Availity FTP site.

Create an Availity FTP account

To submit batch files of EDI transactions to Availity through FTP, you need to create an Availity FTP account (also referred to as your FTP or SFTP mailbox) in the production environment. Once you've created the FTP account, you'll be able to access your organization's mailbox in the production environment, allowing you to submit transactions and retrieve response files.

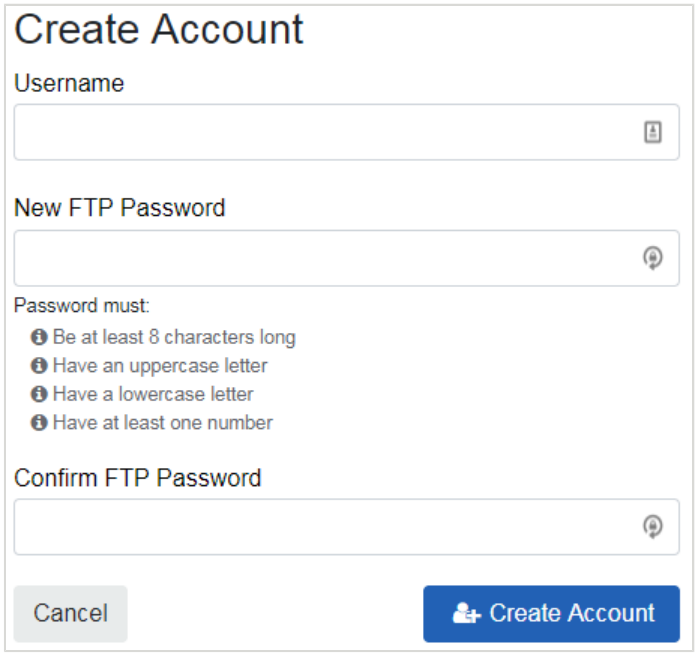
- If you requested an Availity SFTP mailbox during registration and completed the associated activation, then skip this task since you've already created your Availity FTP account. If you'd like to change the password you were given for your Availity FTP account, log in to Availity Essentials and navigate to **Claims & Payments** | **FTP and EDI Connection Services** | **Manage Your FTP Mailbox**.
- **Important:** Availity FTP account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, you'll be able to follow the steps below. If you don't have the appropriate permissions, look up your administrators by clicking your name or the avatar icon in the Availity Essentials menu, and then click **My Administrators**. Ask an administrator to follow the instructions below to create an FTP account for your organization.

To create an FTP account in the production environment, follow these steps:

1. Log in to Availity Essentials at https://apps.availity.com.
2. In the Availity Essentials menu bar, click **Claims & Payments** | **FTP and EDI Connection Services**, and then click **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

   Tip: You can also access the FTP and EDI Connection Services page from the **My Account Dashboard** tab on the Home page.
3. On the Manage Your FTP Mailbox page, select the **Organization**.
4. Enter a username and password for the new FTP account, confirm the password, and then click **Create Account**.

   Important: Make a note of these account credentials.



Once you've created your Availity FTP account, you'll want to configure your FTP client with your new account credentials.

Configure an FTP client

Once you've created your Availity FTP account in the production environment, you'll need to configure your FTP client (software that allows you to send files through FTP) to connect to the Availity FTP site.

Note: As an alternative to using an FTP client to connect to the Availity FTP site, you can access the FTP site by entering the following URL into a browser and then entering your FTP user name and password: https://ftp.availity.com. If you choose this alternative method, you can skip this task, but you'll have to enter your FTP user name and password each time you access the Availity FTP site.

1. Launch or open your FTP client software.
2. Create a new entry (in your FTP client) for accessing the Availity FTP site, and use the table below to specify the fields for the new entry.

FTP client settings

Field	Value
Host	ftp.availity.com
Port	9922 (typically used for SFTP)
Protocol or server type	Select the appropriate option in your FTP client software for Secure File Transfer Protocol (SFTP). For example, **SFTP - SSH File Transfer Protocol**.
Logon type	If there is an option for the logon type, select normal.
User	The user name for your Availity EDI account.
Password	The password for your Availity EDI account.

3. Click **Connect** or press **Enter** to connect to the server. If you're prompted to enter a user name and password, enter the same Availity FTP user name and password that you entered in your FTP client.

Change the password for an Availity FTP account

Important: Availity FTP account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, you'll be able to follow the steps below. If you don't have the appropriate permissions, look up your administrators by clicking your name or the avatar icon in the Availity Essentials menu, and then click **My Administrators**. Ask an administrator to follow the instructions below to create an FTP account for your organization.

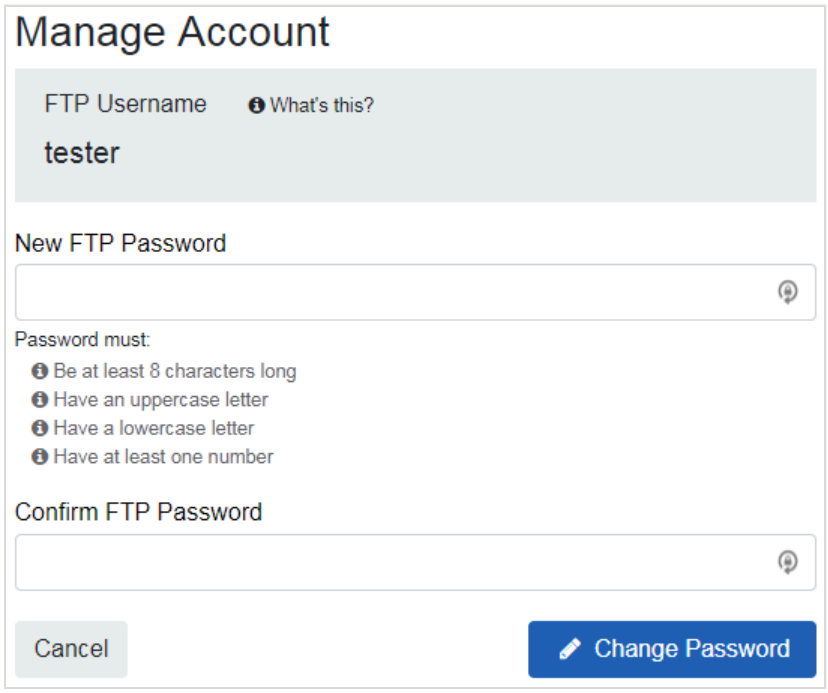
To change the password for an Availity FTP account, follow these steps:

1. Log in to Availity Essentials at https://apps.availity.com.

   Note: If you're changing the password for an FTP account in the QA environment, then log in to the QA environment at https://qa-apps.availity.com and complete the following steps.

2. In the Availity Essentials menu bar, click **Claims & Payments** | **FTP and EDI Connection Services**, and then click **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

3. Enter and confirm the new password, and then click **Change Password**.



Whenever you change the password on your Availity FTP account, you'll need to update your FTP client with the new password.

Submit transaction files via FTP

You can upload your batch files via an FTP client (software that allows you to send files through FTP), or by connecting to Availity's FTP site through a web browser.

Submit batch files via an FTP client

To submit batch files via an FTP client, follow these steps:

1. Connect to the Availity FTP site through your FTP client.
2. Once you're connected, click the **SendFiles** folder on the remote site (i.e., the Availity FTP site).
3. Add the files that you want to submit to the **SendFiles** folder. Availity will then process the files that you added.

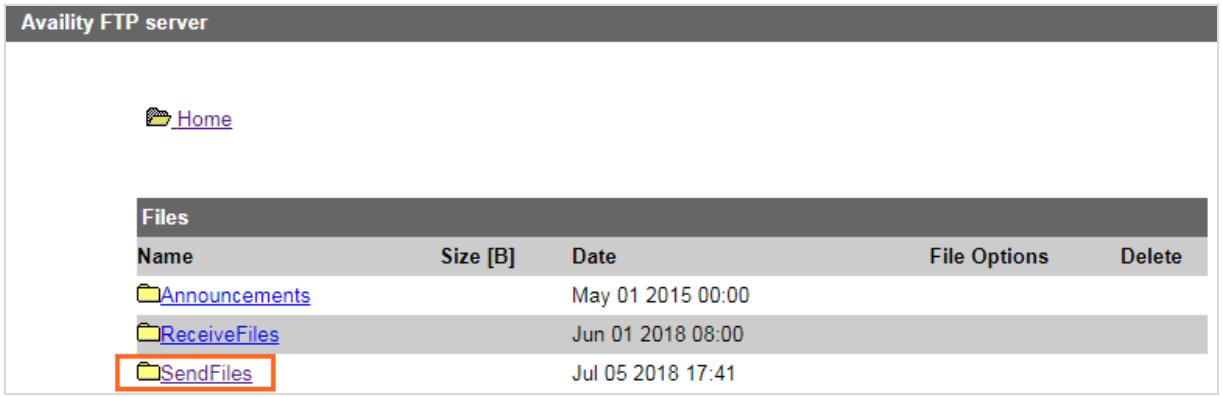
Submit batch files via FTP through a browser

To submit batch files by connecting to the Availity FTP site through a browser, follow these steps:

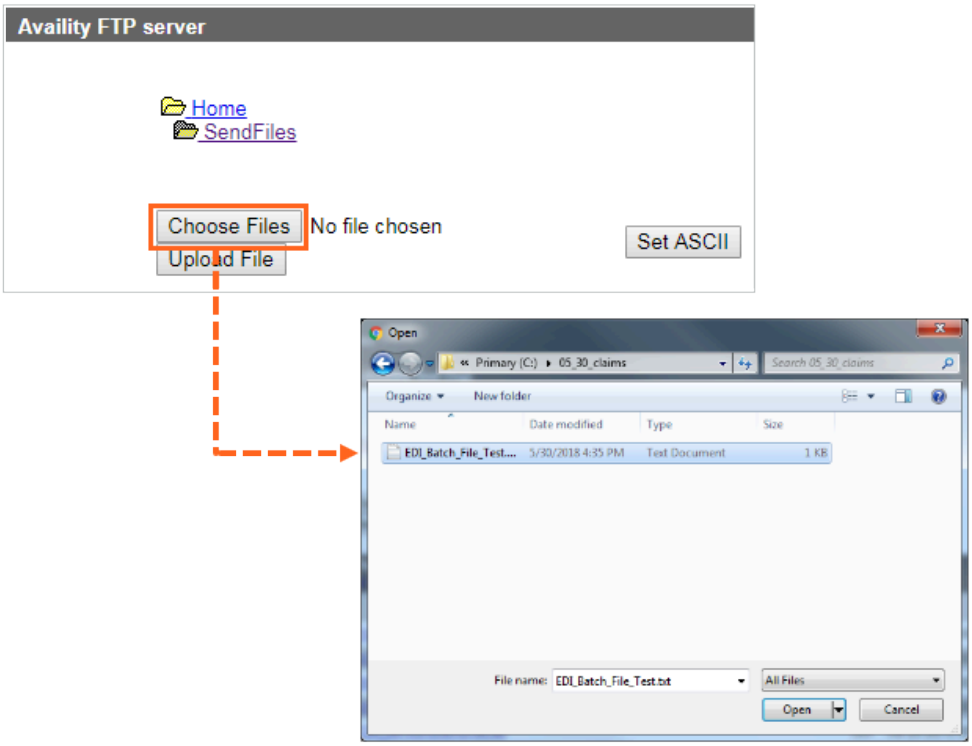
1. Enter the following URL in a browser, and then enter your FTP user name and password when prompted: https://ftp.availity.com.

   Note: If you're connecting to the Availity FTP site in the QA environment through a browser, use the following URL, and then enter your QA FTP user name and password: https://qa-ftp.availity.com.

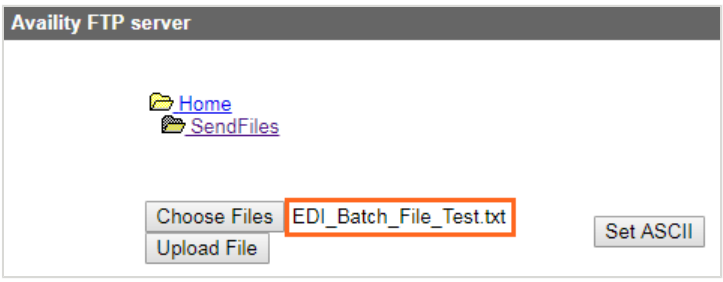
2. On the Availity FTP site, click **SendFiles**.



3. Click **Choose Files**, select the file that you want to submit (upload), and then click **Open**.



4. Verify that the file displayed to the right of the **Choose Files** button is the file you want, and then click **Upload File**. Availity will then process the file that you uploaded.



Results

Availity returns a notification file to your **SendFiles** folder indicating whether a batch file was accepted for processing. For details, see the topic on the Notification file on page 76.

Important: Availity removes and archives the notification files from the **SendFiles** folder each night, whether or not they've been downloaded.

Download response files via FTP

Availity's batch EDI processing generates response files for each batch file that you submit. When you're submitting batch files through the Availity FTP site, you'll want to download all response files on a regular basis to track the transactions that you submitted. Your administrator can specify which responses you receive.

Response files include Acknowledgements, Immediate Batch Reports, Immediate Batch Reports Plus, Electronic Batch Reports, and Delayed Payer Reports.

- Acknowledgements identify file-level issues.
- Immediate Batch Reports, Immediate Batch Reports Plus, Electronic Batch Reports, and Delayed Payer Reports identify claim-level issues. They contain the information needed to correct and resubmit transactions.

And if you elected to receive electronic remittance advice files (also known as ERAs and 835 files) through the Availity Health Information Network, you'll retrieve those files from the same location as your response files.

To download your response files, follow these steps:

1. Connect to the Availity FTP site through your FTP client or through a browser (by navigating to https://ftp.availity.com).

   Note: If you're connecting to the Availity FTP site in the QA environment through a browser, use the following URL, and then enter your QA FTP user name and password: https://qa-ftp.availity.com.

2. Once you're connected, click the **ReceiveFiles** folder on the remote site (i.e., the Availity FTP site).
3. Use the functions in your FTP client or browser (if that's how you connected) to download files from the **ReceiveFiles** folder. For descriptions of the types of response files, see Acknowledgements and/or reports on page 64.

   Tip: To download a response file from a browser, click the tools icon in the **File Options** column of the file you want, and then click a download option such as **text/plain**, under **Download and Delete Files**. You can also download the file directly through your browser.

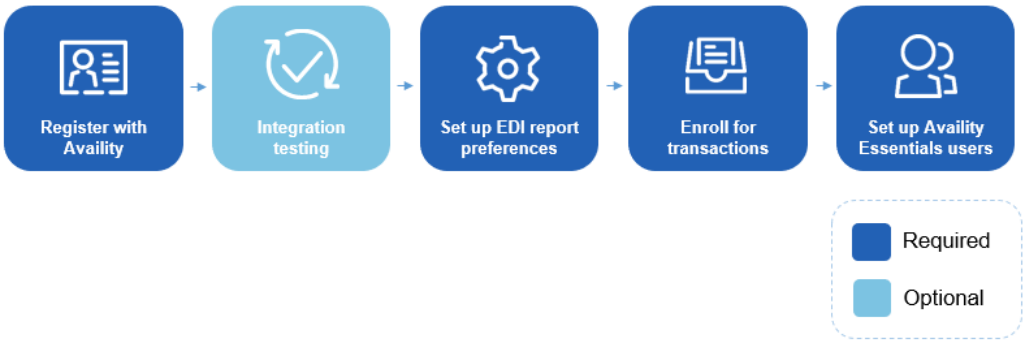
Note:

- Availity removes and archives response files remaining in the **ReceiveFiles** folder after 30 days, whether or not they've been downloaded. You can self-serve and restore archived response files for up to six months after the creation date. You can also request a copy of any archived response file from Availity Client Services regardless of the creation date.
- Availity removes and archives the notification files from the **SendFiles** folder each night, whether or not they've been downloaded.
- The **ReceiveFiles** folder includes response files received for the entire organization. If you send transmission files to a clearinghouse or payer representative other than Availity, the response files are sent to that clearinghouse or payer representative and you cannot access them. It is their responsibility to notify you of any issues identified in the response files. Contact the clearinghouse or payer representative directly for assistance.
- For UCare and Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are direct pass through without any mapping or editing by Availity.
- If an organization submits claims using Availity online claim forms and the payer processes claims in batches, the payer's response also displays in the **ReceiveFiles** folder in an EBR file. If the EDI reporting preferences are set up to receive EBRs together in a single file, the payer's responses for Web claims are mingled with payer responses for transmission files that were uploaded.

EDI transactions through Availity Essentials

Setup steps for EDI through Availity Essentials

Getting set up to submit batch files of EDI transactions to Availity through Availity Essentials involves the following steps, some of which you might have already completed. The integration testing step is optional.



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- Transactions that are listed as **Contract Required** in the payer list are fee-based. For information about submitting transactions that require a contract, see the information about Comprehensive plans in EDI Clearinghouse plans.

  Note: If your organization already has a contractual agreement with Availity for submitting transactions that require a contract, no other action is required.

2. **Integration testing** - Availity gives you the option of doing integration testing in our QA environment before you submit any real transactions. See Integration testing and submitting to the production environment on page 26 for details.
3. **Set up your EDI reporting preferences** - Availity's batch EDI processing generates response files for each batch file that you submit. The administrator for an organization can set reporting preferences that specify which response files are generated. See Set up EDI Reporting Preferences on page 32 for details.
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or by paper. See the Availity payer list to determine if enrollment for ERAs is required for a particular health plan.

Note: If your ERAs are already delivered to Availity for the health plans that you submit claims to, you can skip the ERA transaction enrollment process.

5. **Set up your Availity Essentials users** - If other people in your organization need access to Availity Essentials, such as to view remittance advice information, you'll need to create an Availity Essentials account for each such person. Log in to Availity Essentials at https://apps.availity.com, click your name or the avatar icon in the Availity Essentials menu, and then click **Add User**.

   Tip: Have a lot of users? On the Add Users page, click the option to upload users in a spreadsheet in .csv format.

Important: To manually upload transaction files through Availity Essentials, users will need the EDI Management role, which can be assigned by the administrator for your organization. Once the EDI Management role has been assigned to a user, it might take up to 24 hours before that user can upload files. Administrators automatically have the EDI Management role.

Integration testing and submitting to the production environment

Integration testing

Integration testing is coordinated through Availity Client Services at no charge to the submitter. Once you've received your user ID and password for your QA account from Availity Client Services, you'll be able to log in at https://qa-apps.availity.com. The process for uploading batches of transaction files, viewing response files, and setting up which response files you receive is exactly the same in the QA environment as it is in the production environment.

Submitting to the production environment

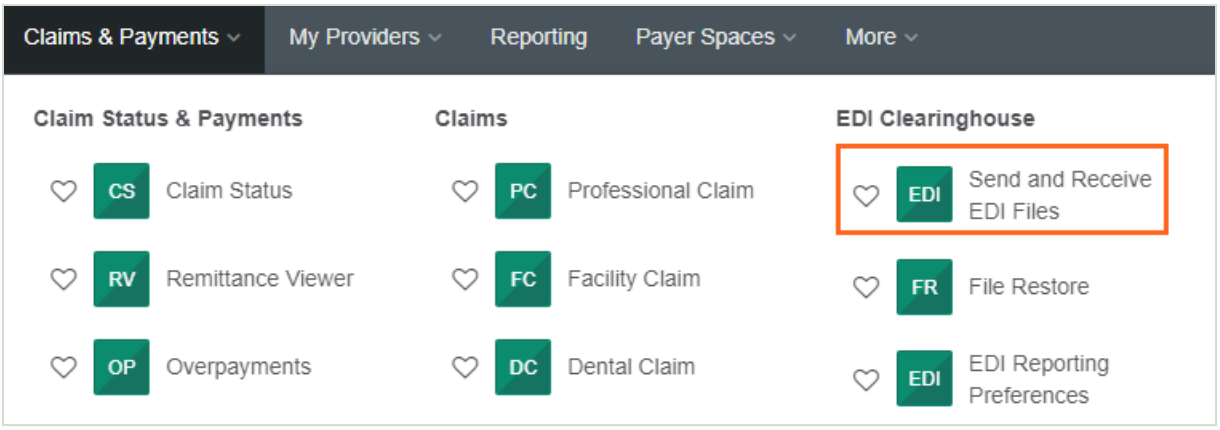
Once you've completed any testing you wanted to do in our QA environment, you're ready to start submitting transactions to our production environment through your Availity Essentials account. If you did any integration testing, then just remember to log in through our production URL at https://apps.availity.com to submit your real transactions to our production environment.

Upload transaction files through Availity Essentials

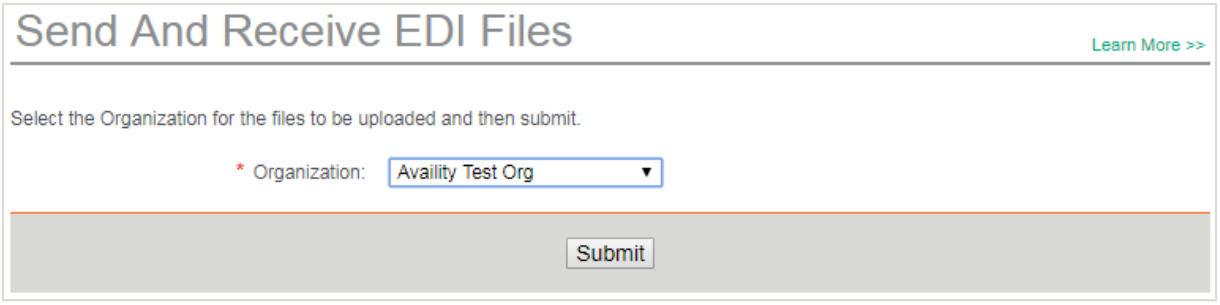
Note: In order to send and receive files through Availity Essentials you'll need to have both cookies and javascript enabled in your browser.

To upload an EDI batch file of transactions through Availity Essentials, follow these steps:

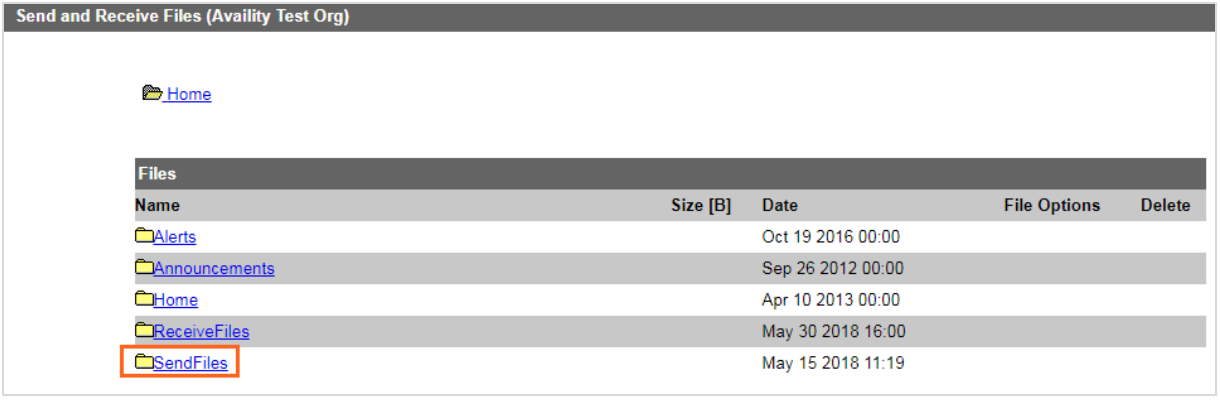
1. In the Availity Essentials menu bar, click **Claims & Payments** | **Send and Receive EDI Files**.



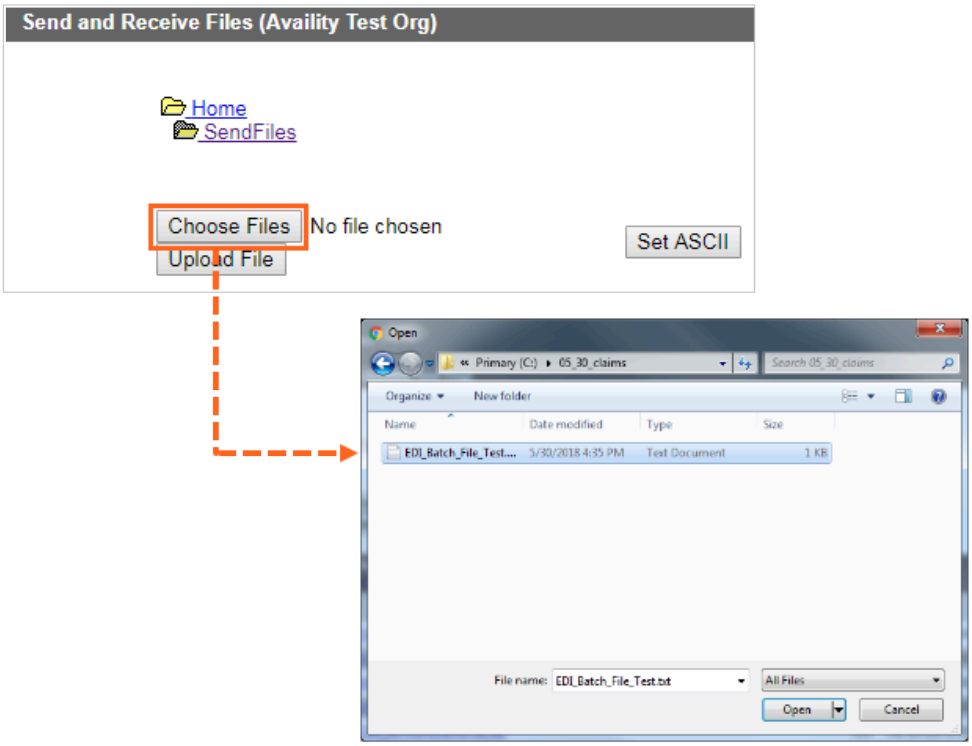
2. In the **Organization** field, on the Send and Receive EDI Files page, select the appropriate organization, and then click **Submit**.



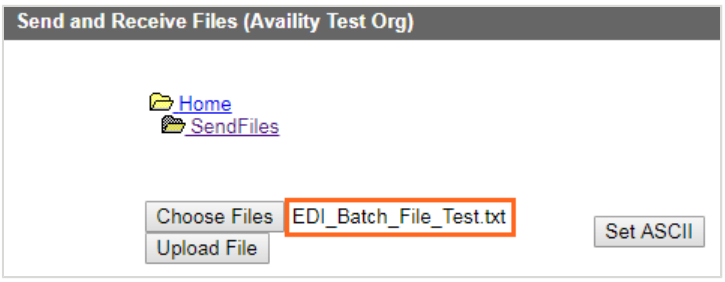
3. On the Send and Receive Files page, click **SendFiles** to upload files to Availity.



4. Click **Choose Files**, select the file that you want to upload, and then click **Open**.



5. Verify that the file displayed to the right of the **Choose Files** button is the file you want, and then click **Upload File**. Availity will then process the file that you uploaded.



Availity returns a notification file to your **SendFiles** folder indicating whether a batch file was accepted for processing. For details, see the topic on the Notification file on page 76.

Important: Availity removes and archives the notification files from the **SendFiles** folder each night, whether or not they've been downloaded.

Download EDI response files from Availity Essentials

Availity's batch EDI processing generates response files for each batch file that you submit. When you're manually uploading batch files through Availity Essentials, you'll want to retrieve all response files on a regular basis to track the transactions that you submitted. Your administrator can specify which responses you receive.

Note: You'll also want to retrieve response files if you're submitting claims from Availity online claim forms and the claim response page indicates that the health plan processes claims in batches.

Response files include Acknowledgements, Immediate Batch Reports, Immediate Batch Reports Plus, Electronic Batch Reports, and Delayed Payer Reports.

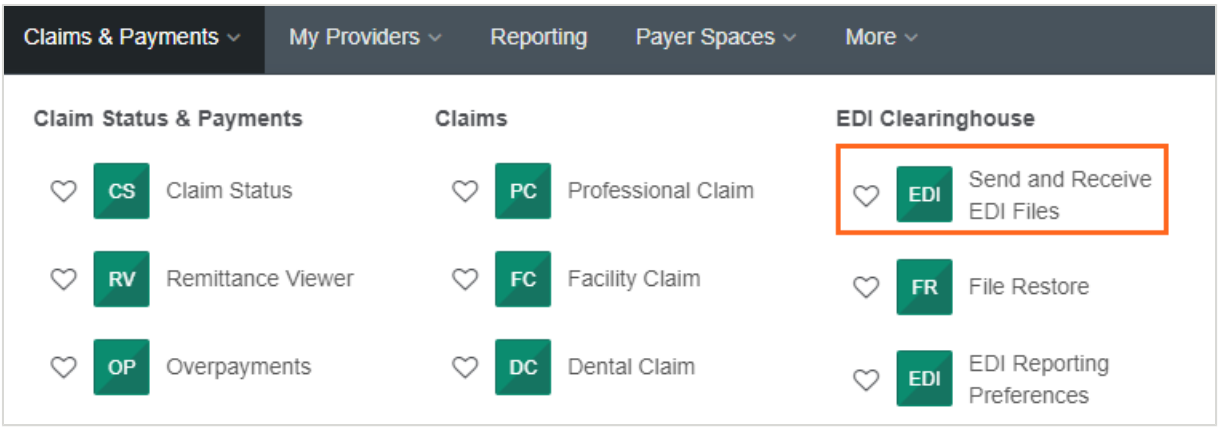
- Acknowledgements identify file-level issues.
- Immediate Batch Reports, Immediate Batch Reports Plus, Electronic Batch Reports, and Delayed Payer Reports identify claim-level issues. They contain the information needed to correct and resubmit transactions.

And if you elected to receive electronic remittance advice files (also known as ERAs and 835 files) through the Availity Health Information Network, you'll retrieve those files from the same location as your response files.

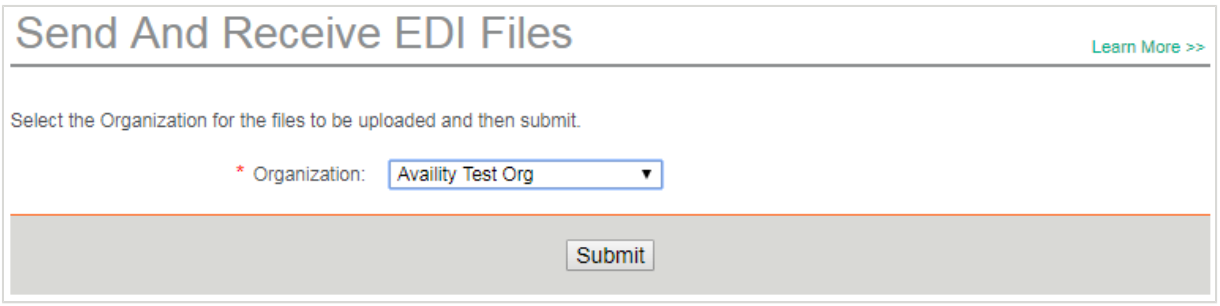
Note: In order to send and receive files through Availity Essentials you'll need to have both cookies and javascript enabled in your browser.

To download response files from Availity Essentials, follow these steps:

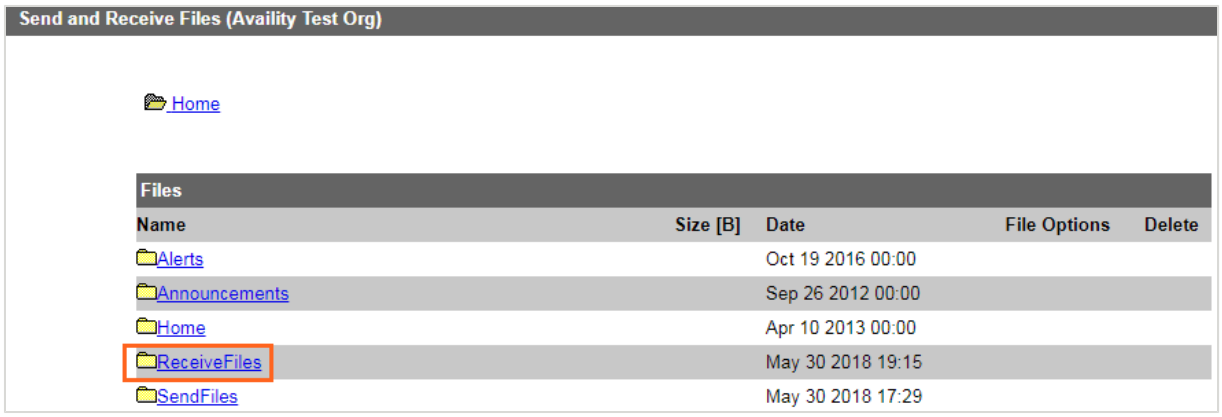
1. In the Availity Essentials menu bar, click **Claims & Payments** | **Send and Receive EDI Files**.



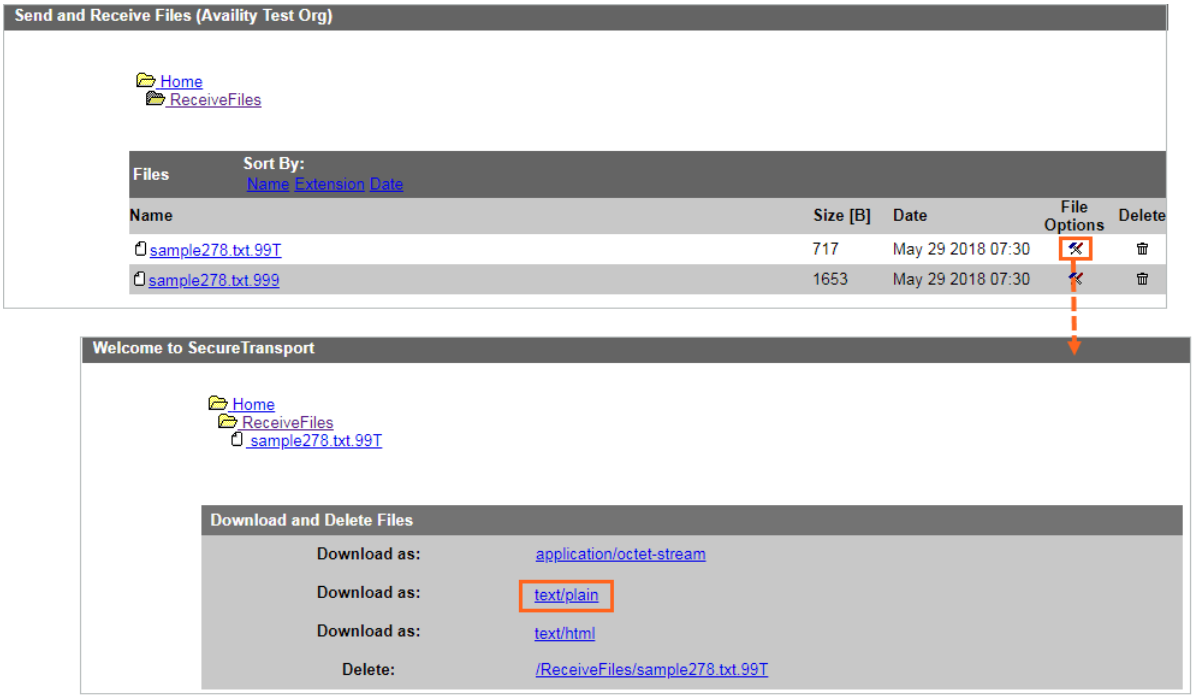
2. In the **Organization** field, on the Send and Receive EDI Files page, select the appropriate organization, and then click **Submit**.



3. On the Send and Receive Files page, click **ReceiveFiles** to retrieve files from Availity. The **ReceiveFiles** folder includes response files for all EDI batches submitted by your organization.



4. To download a response file, click the tools icon in the **File Options** column of the file you want, and then click a download option such as **text/plain**, under **Download and Delete Files**. You can also download the file directly through your browser. For descriptions of the types of response files, see Acknowledgements and/or reports on page 64.



Note:

- Availity removes and archives response files remaining in the **ReceiveFiles** folder after 30 days, whether or not they've been downloaded. You can self-serve and restore archived response files for up to six months after the creation date. You can also request a copy of any archived response file from Availity Client Services regardless of the creation date.
- Availity removes and archives the notification files from the **SendFiles** folder each night, whether or not they've been downloaded.
- The **ReceiveFiles** folder includes response files received for the entire organization. If you send transmission files to a clearinghouse or payer representative other than Availity, the response files are sent to that clearinghouse or payer representative and you cannot access them. It is their responsibility to notify you of any issues identified in the response files. Contact the clearinghouse or payer representative directly for assistance.
- For UCare and Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are direct pass through without any mapping or editing by Availity.
- If an organization submits claims using Availity online claim forms and the payer processes claims in batches, the payer's response also displays in the **ReceiveFiles** folder in an EBR file. If the EDI reporting preferences are set up to receive EBRs together in a single file, the payer's responses for Web claims are mingled with payer responses for transmission files that were uploaded.

Set up EDI Reporting Preferences

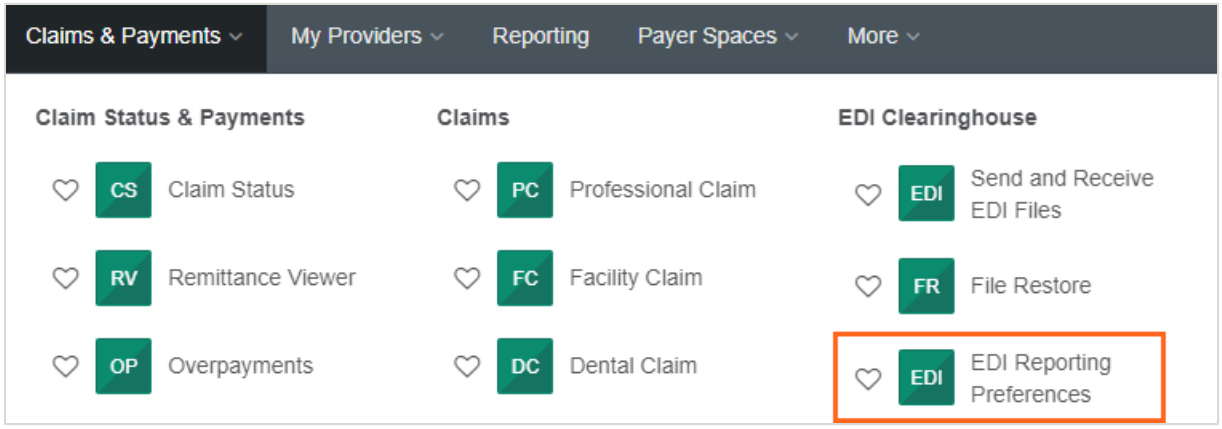
Availity's batch EDI processing generates response files (acknowledgements and reports) for each submitted batch file. Availity provides standard response files recommended in the official HIPAA implementation guides (called TR3s) and proprietary reports for end-to-end tracking and accountability of each submitted transaction.

The administrator for an organization can set up reporting preferences that specify which response files are generated. Response files are retrieved from your **ReceiveFiles** folder.

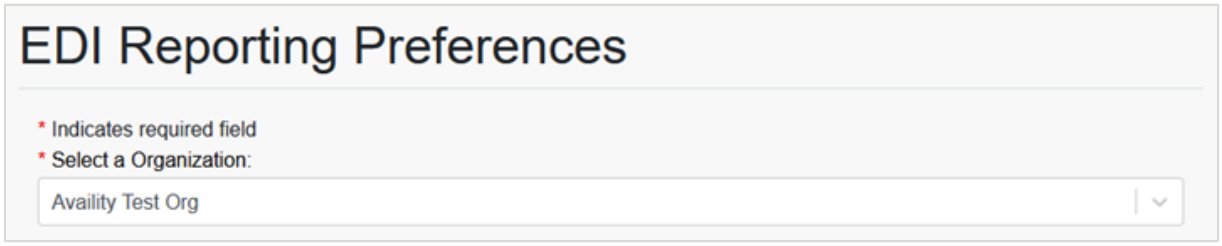
Note: Changes made to IBR, IBRPlus, EBR and DPR type EDI reporting preferences will now apply to claims received after the changes are made. Claims received before changes to the reporting preferences will continue to follow the preferences that were set at the time the claims were received.

To set EDI reporting preferences, follow these steps:

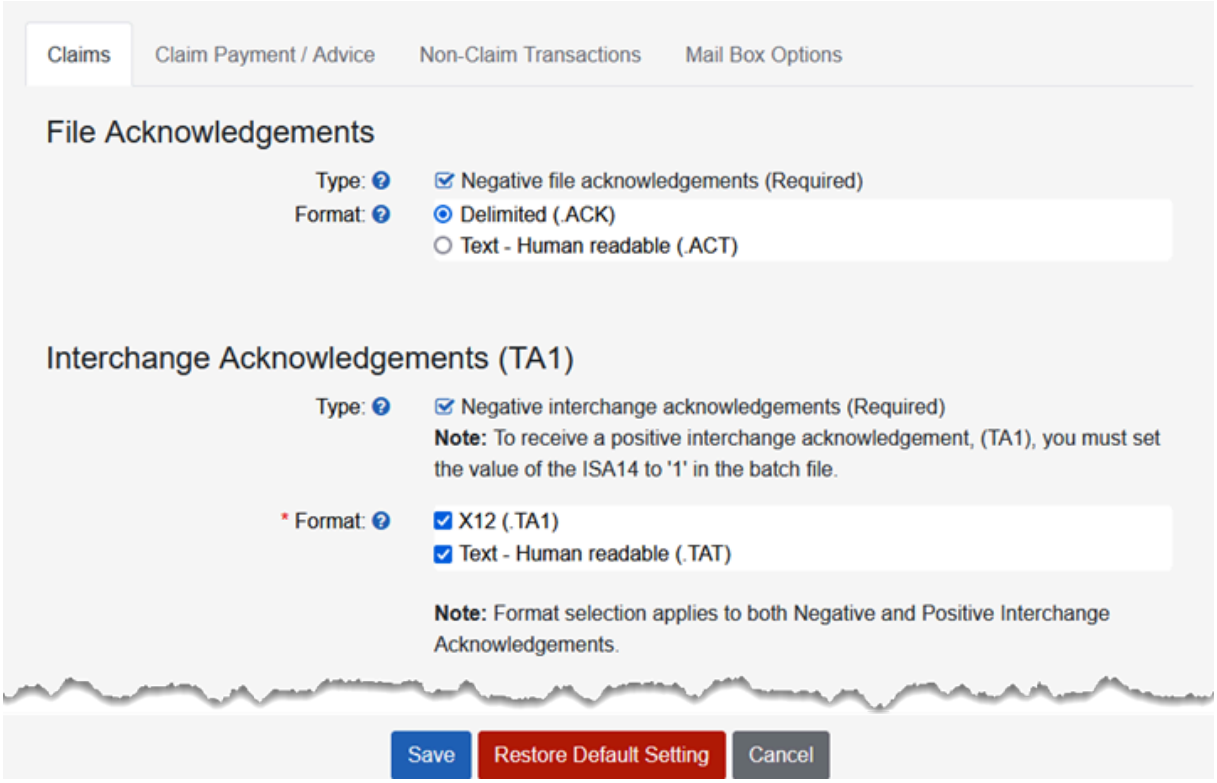
1. In the Availity Essentials menu, click **Claims & Payments** | **EDI Reporting Preferences**.



2. On the EDI Reporting Preferences page, select the organization that you're setting preferences for.



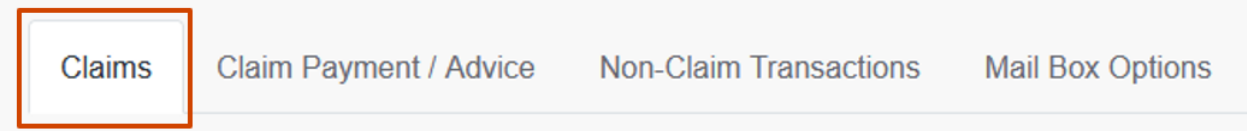
3. On each of the EDI Reporting Preferences tabs, for example the **Claims** tab (partial view) below, specify the preferences you want, and then click **Save** to save the preferences for that tab. **Changes are saved on a per tab basis**.



- Some responses, such as the **Negative interchange acknowledgement**, are required (per HIPAA guidelines) and are automatically generated. The associated check box is checked and grayed out to indicate that it can't be unchecked.
- You can view detailed information for a particular preference setting by clicking the blue question mark next to the label for the setting.
- File extensions for each report type are listed to the right of the report option, such as .ACK, .IBR, and others. The file extension consists of the characters that display after the period at the end of the file name for the report or response file. It indicates the type of file and can help you identify which report or response file types are listed in the **ReceiveFiles** folder.
- When you group EDI response files by payer on the EDI Reporting Preferences page, the response file returned to the **ReceiveFiles** folder will include the payer short name in the file name.
- Changing the file format (for example, from delimited to text-human readable) only affects response files that are created after you save the change to the file format. Response files that were created prior to the file format change will remain in their original format.

EDI reporting preferences for claims

The **Claims** tab of the EDI Reporting Preferences page is where you specify the types of responses that you want when you submit claims through Availity.



The following types of response files are associated with **Claims**:

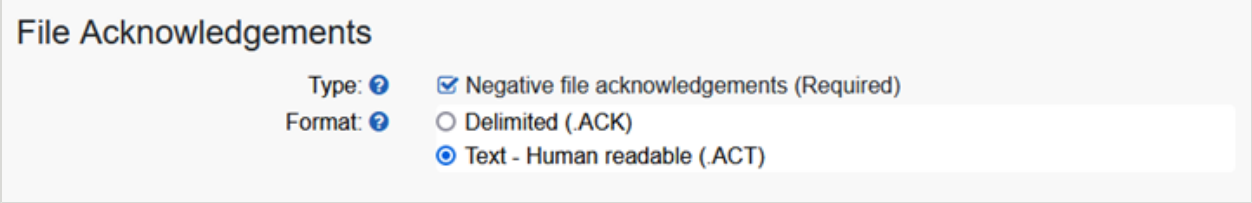
- File acknowledgements
- Interchange acknowledgements (TA1)
- Implementation acknowledgements (999)
- Immediate batch responses (IBR)
- Immediate batch responses Plus (IBRP)
- Electronic batch reports (EBR)
- Delayed payer reports (DPR)

We'll describe the preferences for each type of response file in a separate section below.

Important: When you're done making any changes on this tab, click **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

Preferences for File Acknowledgements

Availity automatically sends a negative file acknowledgement (ACK) to your organization's **ReceiveFiles** folder when a submitted batch file fails Availity's proprietary validation, most commonly when the file format is invalid.



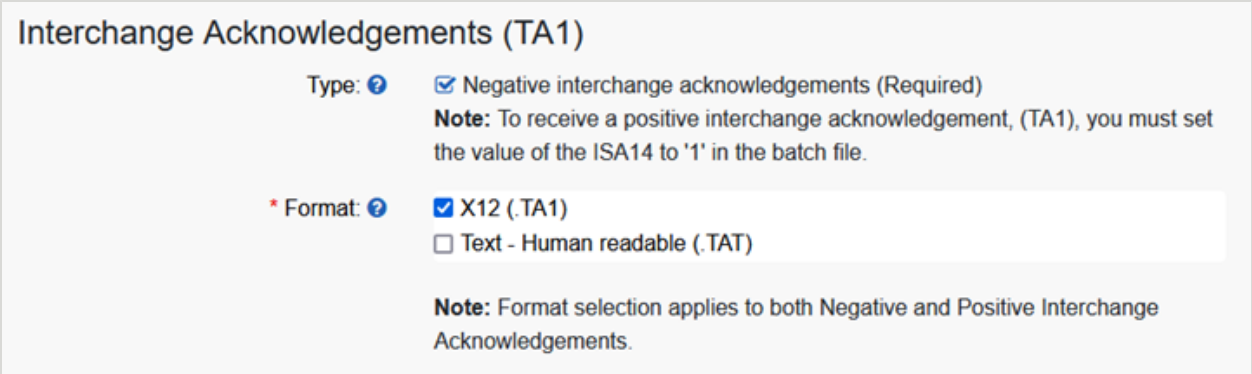
The **Negative file acknowledgements** check box is selected and grayed out, meaning that you always receive negative file acknowledgements.

You can receive this file in a computer-readable or human-readable format.

- Select **Delimited (.ACK)** to receive a delimited file format that you can import into a computer system.
- Select **Text - Human readable (.ACT)** to receive a text file that you can read. This is the default.
- Delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view this file.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Preferences for Interchange Acknowledgements (TA1)

Availity automatically sends negative interchange acknowledgements to your organization's **ReceiveFiles** folder. This file reports errors encountered within the interchange header or trailer, or functional group header, of the X12 file, particularly errors caused by duplicate interchange control numbers or an incorrect trading partner envelope.



- The **Negative interchange acknowledgements** check box is selected and grayed out, meaning that you always receive negative interchange acknowledgements.
- To receive positive interchange acknowledgements, the value of ISA14 must be set to 1 in the submitted batch file. Positive interchange acknowledgements are returned with the implementation acknowledgement file (999).

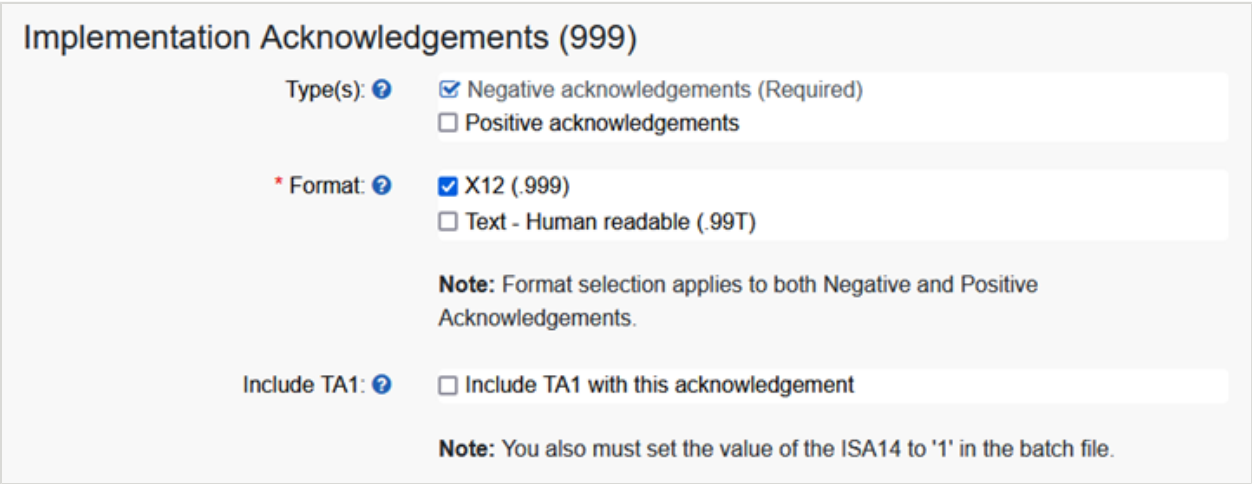
You can receive this file in a computer-readable or human-readable format.

- Select **X12 (.TA1)** to receive an X12 file that you can import into a computer system. This is the default.
- Select **Text - Human readable (.TAT)** to receive a text file that you can read.
- X12 files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view this file.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Note: The format selection applies to both negative and positive interchange acknowledgements.

Preferences for Implementation Acknowledgements (999)

Availity automatically sends negative implementation acknowledgements to your organization's **ReceiveFiles** folder. This file indicates that Availity received the transmission file and it had errors, particularly X12 and HIPAA syntax errors. Implementation acknowledgements are also referred to as 999 files.



- The **Negative acknowledgements** check box is selected and grayed out, meaning that you always receive negative implementation acknowledgements.
- To receive positive implementation acknowledgements that acknowledge the receipt and successful validation of each functional group within your batch files, select the **Positive acknowledgements** check box.

You can receive this file in a computer-readable or human-readable format.

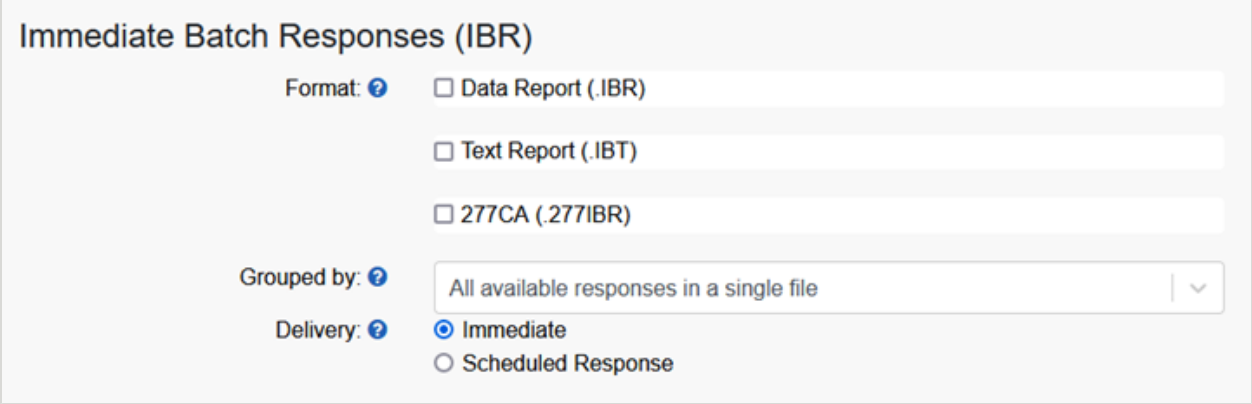
- Select **X12** to receive an X12 file format that you can import into a computer system. This is the default.
- Select **Text - Human readable** to receive a text file that you can read. These reports contain similar information as the data files, but are intended for viewing by non-technical users.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Note: The format selection applies to both negative and positive implementation acknowledgements.

Select **Include TA1** to include the positive TA1 with the acknowledgement. To generate a positive TA1, the value of ISA14 must be set to '1' in the submitted batch file.

Preferences for Immediate Batch Response (IBR)

The immediate batch response (also referred to as an IBR) is a proprietary report that acknowledges accepted claims and identifies rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.



The Immediate Batch Response (IBR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive immediate batch responses in the 277CA claim acknowledgement format. All of these reports are optional.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

- Select **Data Report (.IBR)** to receive IBRs in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.IBT)** to receive IBRs in a text format intended for viewing by non-technical users.

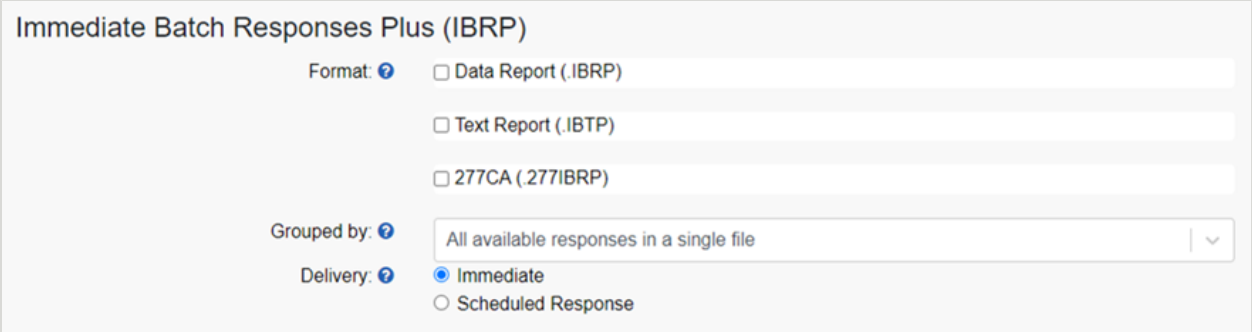
- Select **277CA (.277IBR)** to receive immediate batch responses in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Preferences for Immediate Batch Response Plus (IBRP)

The immediate batch response plus (also referred to as an IBRP) is a proprietary report that acknowledges accepted claims and identifies warning messages and rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note:

A warning on a claim is informational content from Availity on behalf of the payer and can be added to an accepted or rejected claim. Warnings are informational only and do not cause a claim to be rejected.



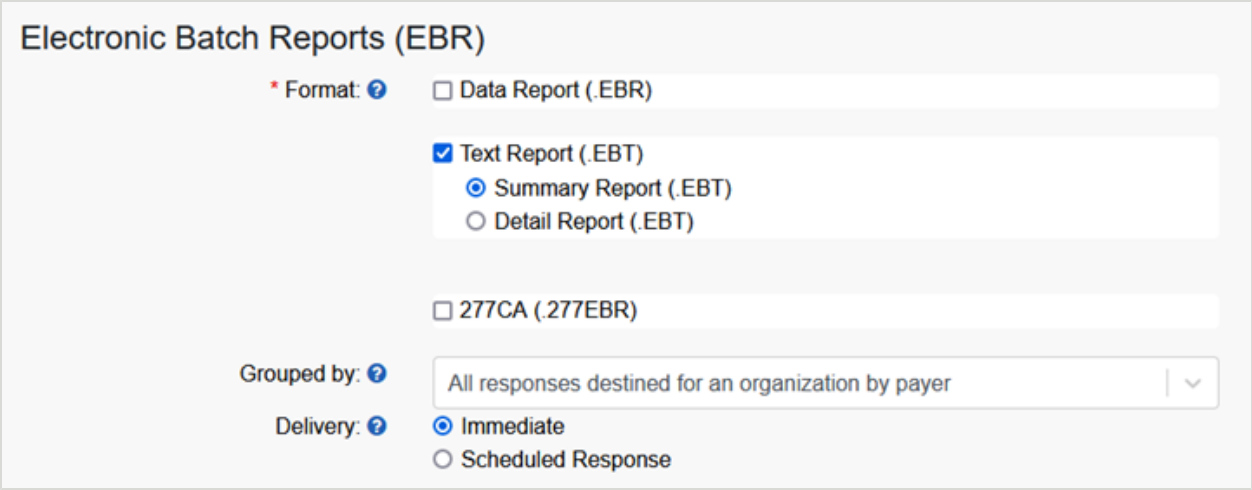
The Immediate Batch Response Plus (IBRP) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive immediate batch responses in the 277CA claim acknowledgement format. All of these reports are optional.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

- Select **Data Report (.IBRP)** to receive IBRPs in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.IBTP)** to receive IBRPs in a text format intended for viewing by non-technical users.
- Select **277CA (.277IBRP)** to receive immediate batch responses in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Preferences for Electronic Batch Reports (EBR)

The electronic batch report (also referred to as an EBR) is a proprietary report that provides the status (received from the payer) for each transaction in the original submission. The report contains summary counts of transactions received and accepted, and lists detailed information for rejected transactions, including payer specific edits (PSEs) and HIPAA edits. Only claims that passed file format and syntax validations are included in this report.



The Electronic Batch Report (EBR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive electronic batch reports in the 277CA claim acknowledgement format, in conjunction with the pipe-delimited or text report format. All of these reports are optional.

- Select **Data Report (.EBR)** to receive electronic batch reports in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
    - Select **Summary Data Report (.EBR)** to receive a summary which includes only prepayment details and errors for rejected claims. This report does not include accepted claims details.

      Note: The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
    - Select **Detail Data Report (.EBR)** to receive a report including acknowledgement of all claims in the transmission file. This option includes the results of edits at both Availity and the receiver or payer for accepted claims, prepayment details, and rejected claims and important messages from the health plan.

      Note: The detail report is recommended.
- Select **Text Report (.EBT)** to receive electronic batch reports in a text format intended for viewing by non-technical users.
    - Select **Summary Report (.EBT)** to receive a summary which includes only prepayment details and errors for rejected claims. This report does not include accepted claims details or rejection reasons. To receive rejection details, select the detail report.

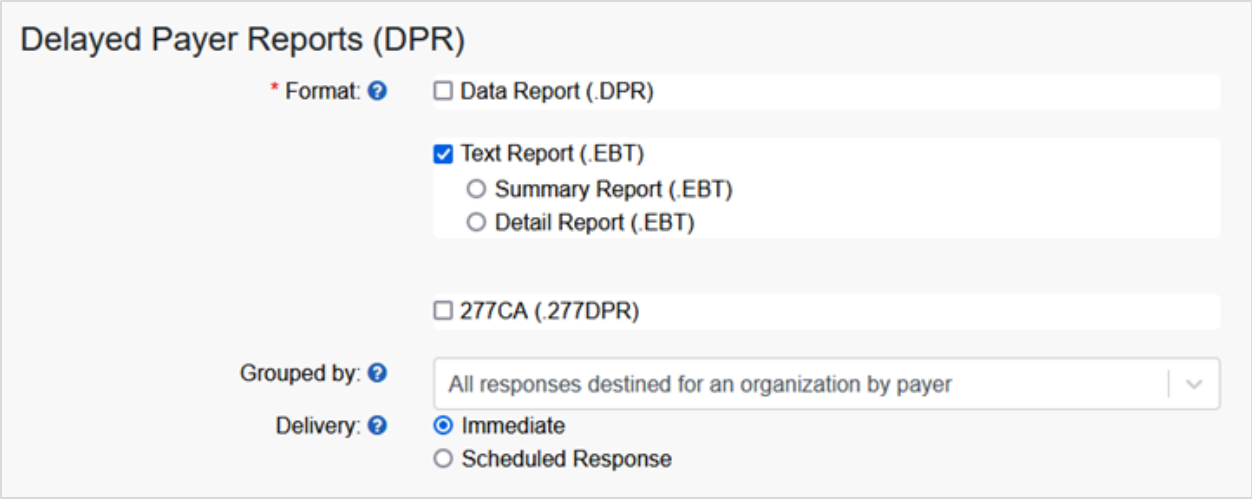
      Note: The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
    - Select **Detail Report (.EBT)** to receive a report including acknowledgement of all claims in the transmission file. This option includes the results of edits at both Availity and the receiver or payer for accepted claims, prepayment details, and rejected claims and important messages from the health plan.

      Note: The detail report is recommended.
- Select **277CA (.277EBR)** to receive electronic batch reports in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Note: The .277EBR can only be received in combination with the .EBR or .EBT. If you do not select the .EBR or .EBT, the .277EBR will not be sent.

Preferences for Delayed Payer Reports (DPR)

The delayed payer report (also referred to as a DPR) includes information from payers that utilize batch processing or other non-real-time adjudication processes. The report includes transaction receipt acknowledgement, transaction reject messaging, warning, and informational messages, as well as adjudication responses returned by the destination payer.



The Delayed Payer Report (DPR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive delayed payer reports in the 277CA claim acknowledgement format, in conjunction with the pipe-delimited or text report format. All of these reports are optional.

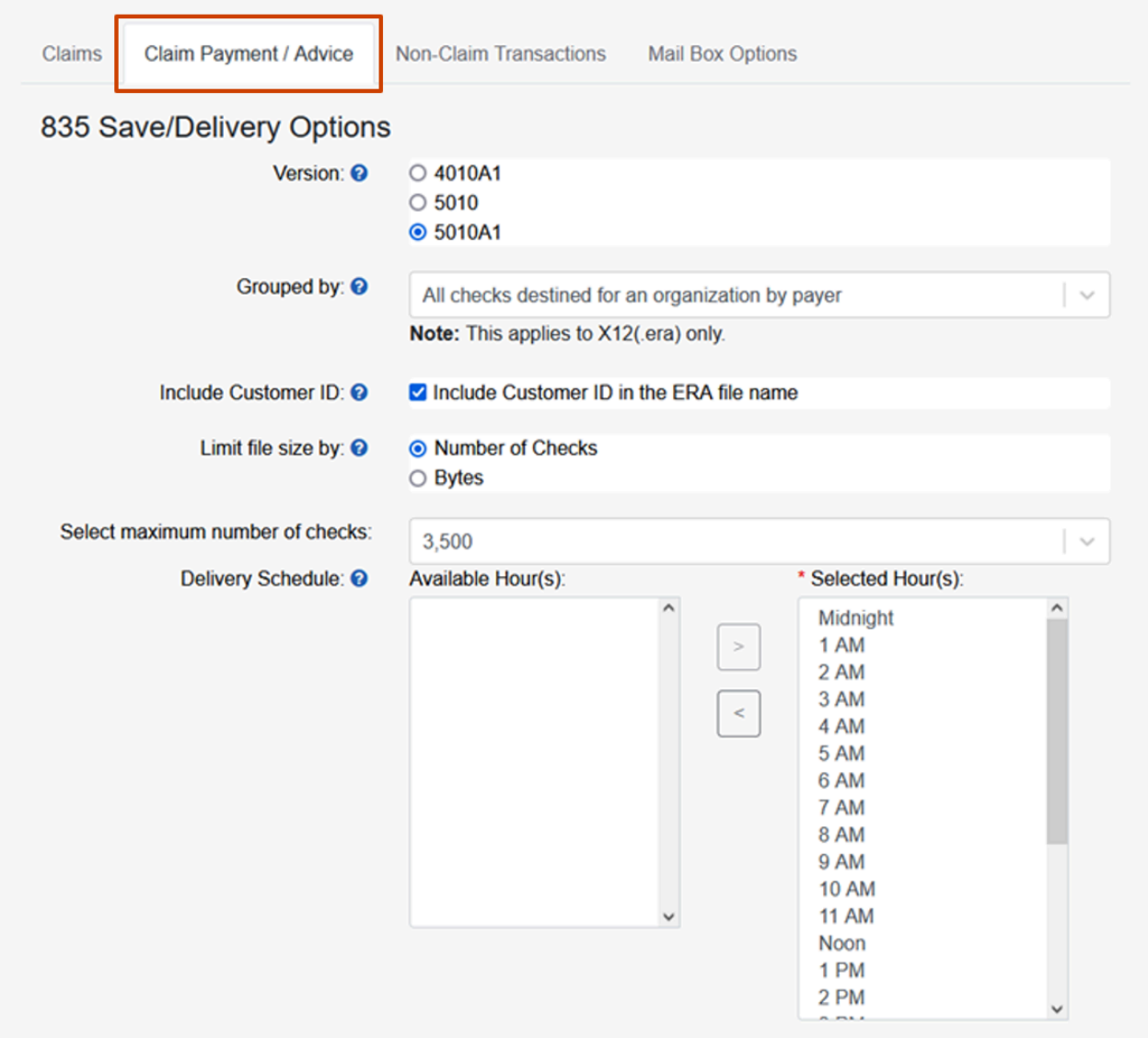
- Select **Data Report (.DPR)** to receive delayed payer reports in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.DPT)** to receive delayed payer reports in a text format intended for viewing by non-technical users.
  - Select **Summary Report (.DPT)** to receive a summary.
  - Select **Detail Report (.DPT)** to receive a detail report including acknowledgement of all claims in the payer's response and important messages from the health plan.

    Note: The detail report is recommended.
- Select **277CA (.277DPR)** to receive delayed payer reports in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

  Note: The .277DPR can only be received in combination with the .DPR or .DPT. If you do not select the .DPR or .DPT, the .277DPR will not be sent.

EDI reporting preferences for claim payment/advice

The **Claim Payment/Advice** tab of the EDI Reporting Preferences page is where you specify preferences for your claim payment/advice files. These files are referred to as electronic remittance advice (ERA) files or 835 files.



- You can select the HIPAA version (5010 or 5010A1) of your electronic remittance advice files. The default is 5010A1. If the payer sends a different version, Availity will convert the files for you.
- You can group your electronic remittance advice files by organization, provider, or payer.
- You can limit the maximum file size by number of checks or by number of bytes.
- You can schedule multiple deliveries of your electronic remittance advice files throughout the day.

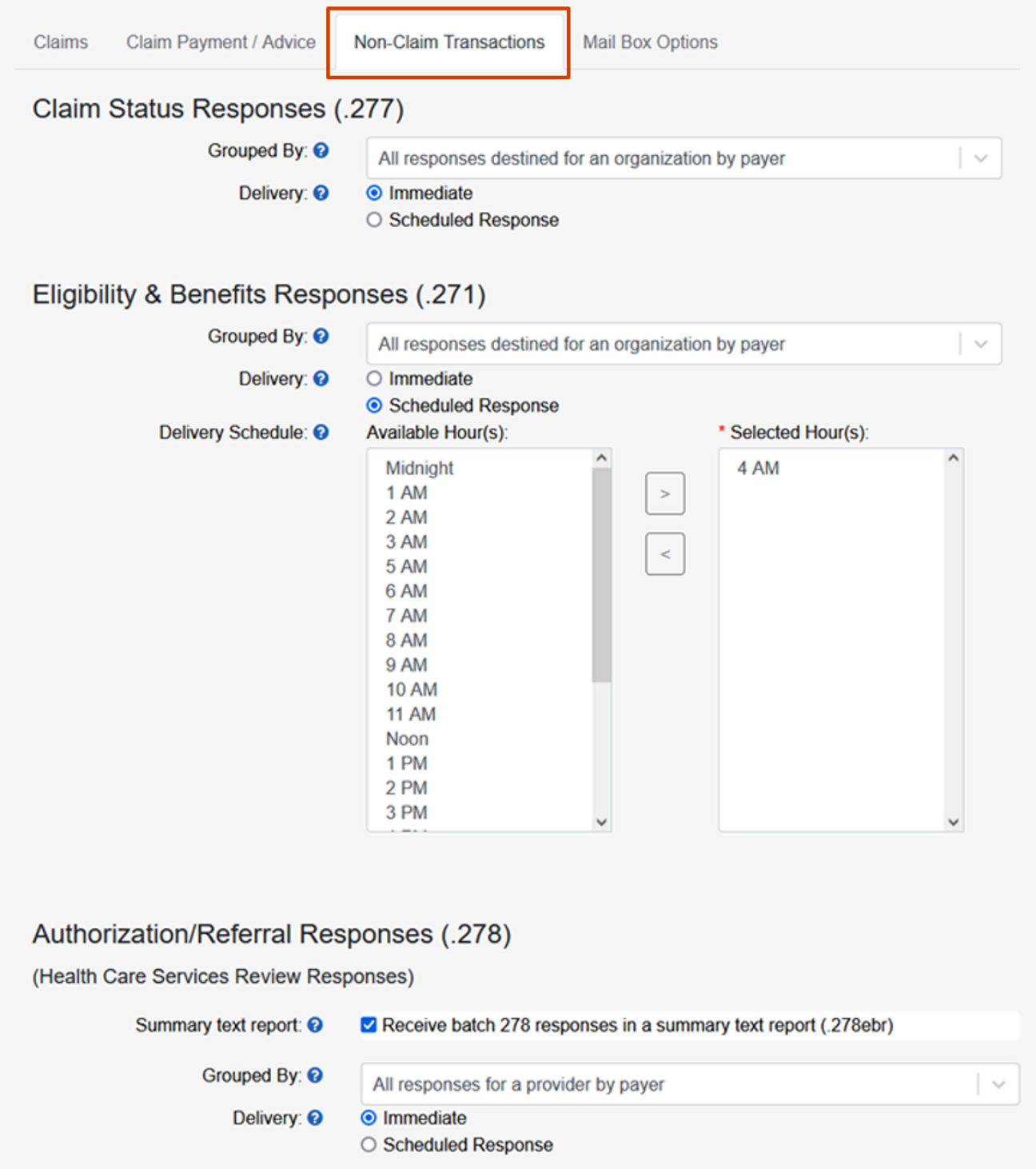
BCBSIL, BCBSNM, BCBSOK, BCBSTX

You cannot use the 835 Save/Delivery Options to convert (up or down-convert) the 835 version.

Important: When you're done making any changes on this tab, click **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

EDI reporting preferences for non-claim transactions

The **Non-Claim Transactions** tab of the EDI Reporting Preferences page is where you specify preferences for claim status responses, eligibility & benefits responses, and authorization/referral responses.

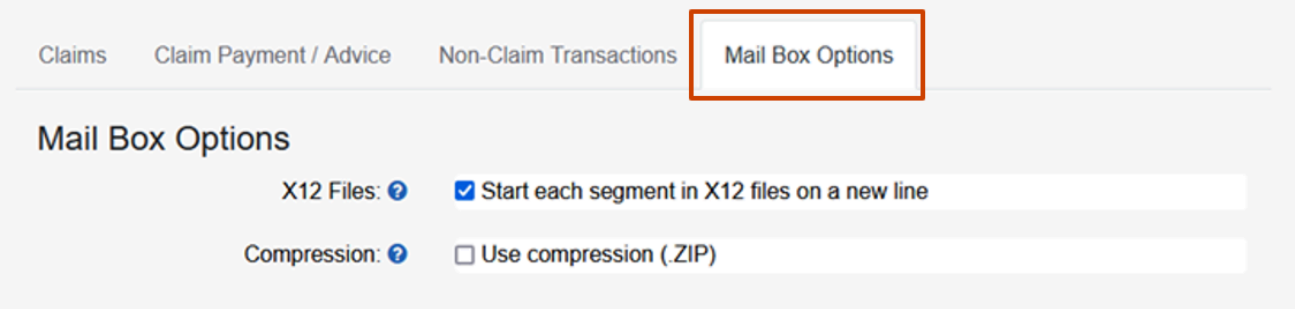


- You can group the response files for your non-claim transactions by organization and payer, or by provider and payer, or you can choose not to group the response files.
- You can choose to receive immediate responses or schedule multiple deliveries of your non-claim transaction response files throughout the day.
- For authorization and referral responses, you can receive a summary text report that displays the information in a form that's intended for non-technical users.

Important: When you're done making any changes on this tab, click **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

EDI reporting preferences for mail box options

The **Mail Box Options** tab of the EDI Reporting Preferences page is where you specify general preferences that apply to all response files.



- You can choose to receive all of your X12 response files with carriage returns after each line, which makes the files easier to read. If your system can't accept carriage returns and line feeds or you'd like to receive one stream of data, uncheck this option.
- You can choose to have your response files delivered together in a single ZIP file.

Important: When you're done making any changes on this tab, click **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

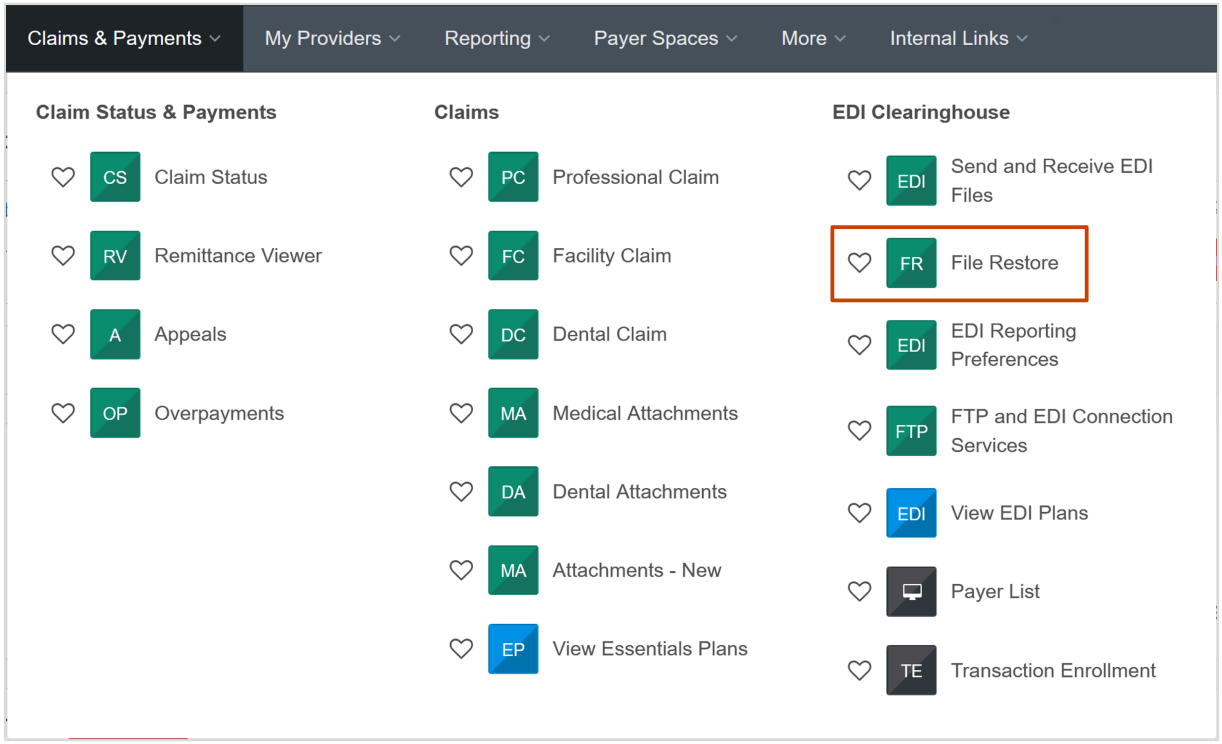
Restore archived files

If you're looking for a particular response file in your **ReceiveFiles** folder and can't find it, note that Availity archives response files remaining in the **ReceiveFiles** folder after 60 days, whether or not they've been downloaded. You can, however, restore any files archived from your **ReceiveFiles** folder within the past six months without having to contact Availity Client Services. You can restore up to 50 files per request.

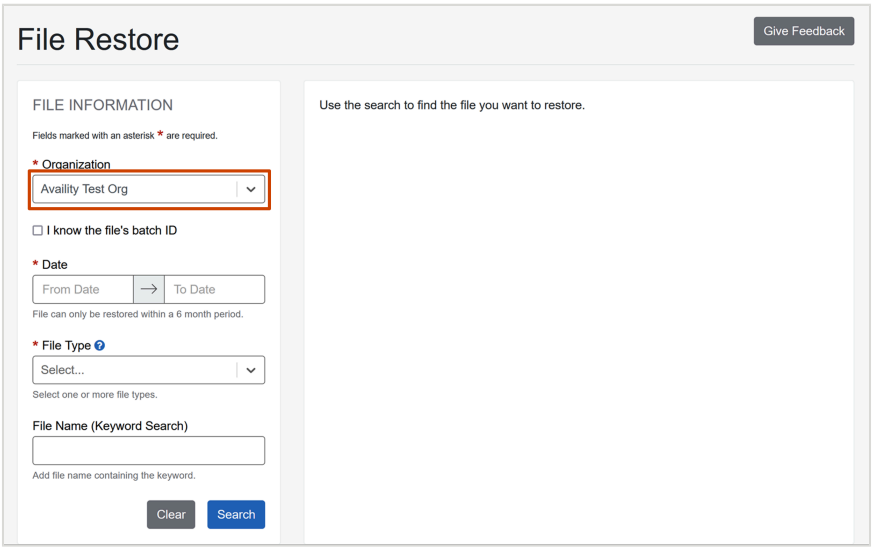
Note: To restore response files that are more than six months old, you'll need to contact Availity Client Services.

To restore archived files, follow these steps:

1. In the Availity Essentials menu, click **Claims & Payments** | **File Restore** (under **EDI Clearinghouse**).



2. In the **Organization** field, on the File Restore page, select the organization associated with the files you want to restore.



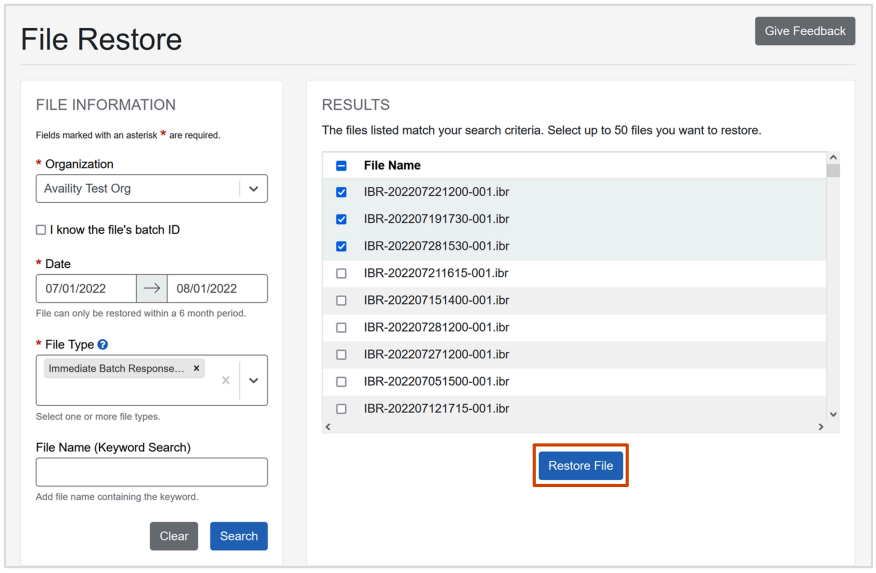
3. You can search for files by one of the following methods:

   - To search for one or more files by date range, file type, and/or keywords, enter search criteria in the fields provided, and then click **Search**.
   - To search for a single file by batch ID, select the **I know the file's batch ID**, enter the file's batch ID in the **Batch ID** field, and then click **Search**.

   Consider the following guidelines when you're searching:

   - **Selecting a date range** – Click the **Date** field to select the date range.
   - **Selecting file types** – Select one or more file types. You can remove a file type by clicking the ✖ icon next to the file type.
   - **Searching by keywords** – Enter one or more words contained in the names of the files you want to restore. Keywords are optional.

4. Select the check box next to each file you want to restore, and then click **Restore Selected Files**.



Note: Click **Cancel** to change your search criteria.

5. In the Restore Files dialog box, click **Restore** and then choose one of the following options:

   - To restore the files in a ZIP file, click **Restore as ZIP**.
   - To restore each file individually, click **Restore as File**.

   Note: ZIP file names begin with **RestoredFiles**, followed by the date range, and then the file extensions (e.g., DPT, EBT, ERA, IBT) of the files that were restored.

The selected files were restored. Click **Receive Files** on the results page to view the restored EDI files. You can also click **New Search** to search for and restore additional files.

Tips for successful batch file submissions

- Most errors occur due to data entry mistakes and accidentally skipped fields. To reduce errors, always verify the data you enter in your system before batching the claims, inquiries, and requests, and submitting them to Availity.
- If you are submitting a rebatched transaction file, be sure it contains a new interchange control number. Files with duplicate control numbers will be rejected.
- Verify you are using the most current procedure and diagnosis code lists available.
- Do not use decimals in procedure or diagnosis codes. For example, submit 525.25 as 52525.
- Do not use decimals in whole-dollar charge amounts. For example, submit $27.00 as 27.
- For charge amounts involving cents with more than two decimal places, round the amount to the nearest penny. HIPAA rejects amounts submitted with more than two decimal places. For example, submit $59.99223 as 59.99.
- Ensure all dates are valid date values using the correct format, YYYYMMDD.
- Do not enter dashes in zip codes.
- If you enter dashes in social security, federal tax ID, and employer ID numbers, Availity will remove them.
- Make sure the correct payer-assigned provider ID is in the **Provider ID** field, and the tax ID is in the **Tax ID** field.
- For Medicare claims, do not enter the subscriber's social security number.
- Do not use special characters, such as colons or asterisks (*). They might be confused with delimiters, which are special characters used to separate data in ANSI X12 files. Also, due to multiple conversions, the characters may translate differently.
- Do not enter trailing spaces in elements when it is not required for a minimum length.
- Submit up-to-date and specific ICD-10, CPT, and HCPCS codes. Availity applies the code set effective dates as established by code owners (administrators).
    - ICD-10 is updated annually on October 1 as directed by CMS
    - CPT and HCPCs are released on January 1 with quarterly updates
- Only bill claims for services that have already occurred. The claim dates of service must be prior to the transaction creation date. Other examples of dates that must be prior to the transaction creation date are:
    - Onset of Current Symptom/Illness
    - Subscriber Birth Date
    - X-ray Date
    - Date Last Seen
    - Initial Treatment Date
    - Last Certification Date

    - Service Date
    - Last Certification Date
- Always include the admission date on inpatient claims.
- Availity accepts up to 50 service lines per claim.
- Do not enter a value of `6` for Claim Frequency Codes.
- Do not enter e-codes for the primary diagnosis or the admitting or patient reason for visit.
- Do not use value `XV` for the National Plan ID.

For claims involving oxygen therapy

- The Service Line Date of Oxygen Saturation/Arterial Blood Gas Test is required on the initial oxygen therapy service line. Technically speaking, segment CR5 is used in loop 2400 and CR501 is I.
- Segment 2420E PER is required when services involving an oxygen therapy CMN are being billed/reported on this service line and segment DTP 'Date Oxygen Saturation/Arterial Blood Gas Test' in loop 2400 is used.

For authorization, referrals, and certifications

When the certification is for home health care, private duty nursing, or services by a nurses' agency, then the CR6 segment is required.

System status, scheduled maintenance, and cut-off times

System status

You can check the status of the Availity network by visiting the Availity Network Outage Notification page at https://www.availity.com/status/. The Availity Network Outage Notification page provides details about the following:

- Current outages
- Recently resolved outages
- Scheduled maintenance

Scheduled maintenance

So that we can keep the computer and network operations centers running smoothly, and provide you with new product features, Availity performs scheduled maintenance on the data center computers and network servers. Scheduled maintenance is posted on the **Scheduled Maintenance** tab on the Availity Network Outage Notification page at https://www.availity.com/status/.

- Availity makes every effort to complete all scheduled maintenance within the scheduled maintenance window.
- Major upgrades are scheduled during weekend hours. Major upgrades can include, but are not limited to, software upgrades, operating system upgrades, and reconfiguration of network routers.
- Upgrades requiring more than a day's work are scheduled for holiday periods.
- Some maintenance, either scheduled or emergency, might force interruptions to production services. In such cases, we'll post a notification in the **News and Announcements** section on the Home page of Availity Essentials. Outage details are also provided on the Availity Network Outage Notification page.
- Availity has a recovery plan for failed upgrades of software or hardware to ensure that services are unavailable for the least amount of time possible.

Cut-off times

Most payers and/or payer contractors have a designated cut-off time for transmission files to be processed in each day's cycle. To ensure that your files are processed in a particular day's cycle, you will need to contact the payer to determine their particular cut-off time, if any. For reference, Availity edits, bundles, and forwards accepted claims daily to each payer and/or payer contractor (receiver) and has no cut-off time for submissions.

Note: Payer responses reflect the date and time that Availity received the transactions.

Confidentiality and access, transaction platforms and deletion of transactions

- Availity treats all EDI submissions confidentially. The information is used for internal Availity business purposes only and always within the privacy and security guidelines established by HIPAA.
- Availity processes all transactions submitted to the Availity Health Information Network production environment/web site and forwards them to payers for adjudication and processing, regardless of the test/production indicator within the ISA segment of the transaction set.
- Availity does not delete any production transactions accepted through the Availity Health Information Network. If your office submits any transactions in error, your office must handle the issue with the payer.
- Availity rejects any transactions submitted with invalid payer identification and reports the transactions as invalid on the Availity Immediate Batch Reports (IBR or IBRP) (If you have chosen to receive the IBR or IBRP) unless the entire file is rejected for invalid payer identification. If the entire file is rejected, an Electronic Batch Report (EBR) is generated. You must review, correct, and resubmit these transactions in a new batch file containing a unique batch control number.

Transaction response aggregation

In support of the HIPAA-mandated EDI standard transactions, Availity accepts non-claim transactions (270/271, 276/277, and 278) in a batch file format, performs HIPAA compliance validation and forwards those that pass validation to the payers. Responses to these transactions and 835 remittance advice files are also received and processed by Availity for the payers supporting this functionality.

- Transactions submitted for real-time payers usually result in a response in your **ReceiveFiles** mailbox within 24 hours or less.
- Transactions for Blue plans outside of your home Blue plan can result in the following types of transaction responses: interim acknowledgement within 24 hours or less; payer benefit/rejection within 72 hours. The interim response is returned in the X12 standard paired response transaction format (i.e. 271, 277, 278).

Within the constraints of the hierarchy (HL) and loops defined in the ANSI ASC X12N HIPAA implementation standards, there can be a number of different ways of aggregating information for a given transaction. This is especially true in the paired transactions such as the 270/271 and the 276/277 and the 278. For example, inbound transaction sets (ST/SE) that have many business transactions can have a single business transaction in each ST/SE in the response transactions. This is compliant and any HIPAA-compliant PMS or system translator has no problem accepting the transactions in this format.

During processing, Availity breaks down inbound transactions to the smallest logical business transaction and sends that transaction content to the payer. For example, your inbound batch 837 EDI claims file contains a total of 100 claims for 60 unique patients for services rendered by 6 different providers in your provider group. Upon receipt and validation of the inbound EDI file, the Availity Health Information Network process creates 100 individual standalone ANSI ASC X12N 837 compliant transactions, each with their own ISA/IEA, to send to the designated payers.

Contact information

Availity Client Services

For questions, assistance, and support, log in to Availity Essentials and submit an online support ticket (24/7) by navigating to **Help & Training** | **Availity Support**, at the top of Availity Essentials. Or, contact an Availity Client Services representative at 800-282-4548 (800-AVAILITY).

Hours of operation: Monday through Friday

Eastern Time Zone	Central Time Zone	Mountain Time Zone	Pacific Time Zone
8:00 a.m. to 8:00 p.m.	7:00 a.m. to 7:00 p.m.	6:00 a.m. to 6:00 p.m.	5:00 a.m. to 5:00 p.m.

For issues with specific EDI transactions, please be prepared to provide the batch ID of the batch that contains your issue. The batch ID is a unique, 16-digit date-timestamp that Availity assigns to an EDI transmission file when you upload and submit it through Availity. The ID takes the format YYYYMMDDHHMMSSSS. For EDI transactions submitted through a third-party clearinghouse, contact that clearinghouse for the batch ID.

Control segments/envelopes

The Availity Health Information Network processing is operationally compliant with the Interchange and Application Control Structures standards defined in Appendix B of each 5010 HIPAA TR3. This section details the specific addressing and control values expected in the following segments of batch X12 files that are submitted to Availity:

- Interchange Control Header and Trailer (ISA/IEA)
- Functional Group Header and Trailer (GS/GE)
- Loop ID – 1000A Submitter Name (claims)
- Loop ID – 1000B Receiver Name (claims)

Adherence to these specifications is necessary to provide sufficient discrimination for the payer routing and acknowledgement process to function properly and to ensure that audit trails are accurate.

Note: The content in this section is intended for users who are setting up X12 files for submission to Availity. As such, it requires a detailed understanding of the structure and content of X12 files.

Interchange Control Header (ISA) and Interchange Control Trailer (IEA) segments

The ISA segment is the only EDI segment with a fixed length. A total of 105 positions are allowed in the ISA segment, including the letters ISA, the asterisk (*) or other value used as a data element separator (also known as an element delimiter), and the colon (:) or other sub-element separator (also known as a composite element delimiter). The value in position 106 is reserved for the tilde (~) or other segment terminator character used to denote the end of each segment.

Once specified in the interchange header, the delimiters and terminators cannot be used in a data element value elsewhere in the file. Availity can accept as a data element any value in the Basic and Extended Character Sets referenced in Appendix B.1.1.2 of 5010 ANSI X12N Implementation Guides, and accepted as X12 standard compliant.

When Availity processes your batch, we create a new ISA/IEA for each transaction we develop and send to the payer. Availity currently uses the following values for delimiters and terminators and requests that you not use these values in any element text.

Usage	Value
Data element separator	'*' Asterisk
Sub-element separator	':' Colon
Segment terminator	'~' Tilde
Repetition separator (5010)	'^' Caret

The following rules apply to multiple functional groups and multiple transaction sets:

- Multiple Functional Groups (GS/GE) within an Interchange (ISA/IEA) must be numbered uniquely, using the Group Control Number data element (GS06). It is recommended that the GS06 be unique within all transmissions over a period of time.

- Multiple Transaction Sets (ST/SE) within a Functional Group (GS/GE) must be numbered sequentially beginning with 1 in the first Transaction Set Control Number data element (ST02).

Interchange Control Header (ISA) segment

The following table defines the requirements for the Interchange Control Header (ISA) segment. When a value for a required field is specified in the **Specifications** column, the specified value is required in all files submitted to Availity.

ISA segments

Field	Usage	Specifications	Segment
Authorization Information Qualifier	Code to ID the type of information in the authorization	• Required • Length: 2/2 • Required Value: 00 = No Authorization Information Present **Note:** For EDI batch mode, login credentials are not provided in the ISA header.	ISA01
Authorization Information	Info used for identification or authorization of the sender or the data interchange	• Required • Length: 10/10 • Required Value: *(10 blank spaces)*	ISA02
Security Information Qualifier	Code to ID the type of information in the Security Info	• Required • Length: 2/2 • Required Value: 00 = No Security Information Present **Note:** For EDI batch mode, login credentials are not provided in the ISA header.	ISA03
Security Information	Info used for identifying security information about the sender or the data interchange	• Required • Length: 10/10 • Required Value: *(10 blank spaces)*	ISA04
Interchange ID Qualifier	Qualifier to denote the system/method of code structure used to designate the sender	• Required • Length: 2/2 • Required Value: ZZ = Mutually Defined	ISA05

Field	Usage	Specifications	Segment
Interchange Sender ID	ID code for sender, as defined by Availity. This ID is qualified by the value in ISA05	• Required • Length: 15/15 • Required Value: AV09311993 *(+5 blank spaces)*	ISA06
Interchange ID Qualifier	Qualifier to denote the system/method of code structure used to designate the receiver	• Required • Length: 2/2 • Required Value: 01 = Duns (Dun & Bradstreet)	ISA07
Interchange Receiver ID	ID code published by the receiver. This ID is qualified by the value in ISA07.	• Required • Length: 15/15 • Required Value: 030240928 *(+6 spaces)*	ISA08
Interchange Date	Date of the interchange	• Required • Format: YYMMDD	ISA09
Interchange Time	Time of the interchange	• Required • Format: HHMM	ISA10
Repetition Separator	Provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure	• Required • Length: 1/1 • Recommended Value = ^	ISA11
Interchange Control Version Number	This version number covers the interchange control segments	• Required • Length: 5/5 • Required Value: 00501	ISA12
Interchange Control Number	A unique control number assigned by the sender	• Required • Length: 9/9 • Recommended Value: Must be identical to the value in IEA02	ISA13

Field	Usage	Specifications	Segment
Acknowledgement Requested	Code sent by the sender to request an interchange acknowledgement (TA1)	• Required • Length: 1/1 • Recommended Value = 1	ISA14
Usage Indicator	Code to indicate whether data enclosed is test or production. Test until all Availity validation testing is complete then set to P for Production.	• Required • Length: 1/1 • Recommended Values = T (Testing) or P (Production)	ISA15
Component Element Separator	The sender identifies the element separator used as a delimiter to separate the data within a composite data structure. Must be different from the data element separator and segment terminator.	• Required • Length: 1/1 • Recommended Value: Any value from the Basic Character Set.	ISA16
Segment Terminator	Always use tilde as segment terminator. There will be no line feed in X12 code.	• Required • Position 106 1/1 • Required Value = "~" [Tilde]	ISA

Interchange Control Trailer (IEA) segment

The following table define the requirements for the Interchange Control Trailer (IEA) segment, which is paired with the Interchange Control Header (ISA) segment.

IEA segments

Field	Usage	Specifications	Segment
Number of Included Functional Groups	A count of the number of functional groups included in the interchange	• Required • Field Length: 1/5	IEA01
Interchange Control Number	A control number assigned by the sender	• Required • Field Length: 9/9 *(same as ISA13)*	IEA02

Functional Group Header (GS) and Functional Group Trailer (GE) segments

The Functional Group Header (GS) segment indicates the beginning of a functional group of transaction sets and provides control information for acknowledgements and other reporting. Availity can accept an interchange with multiple mixed transaction types GS/GE Functional Groups. Please review Appendices A & B in the HIPAA IGs and Appendices B & C in the HIPAA TR3s of the transaction being generated for additional details.

Functional Group Header (GS) segment

The following table defines the requirements for the Functional Group Header (GS) segment.

GS segments

Field	Usage	Specifications	Segment

Functional Identifier Code	Code identifying a group of application related transaction sets	• Required
		• Field Length: 2/2
		• Recommended Values: [vary based on transaction type]
		  • HI = Health Care Services Review Information (278)
		  • HR = Health Care Claim Status Request (276)
		  • HN = Health Care Claim Status Notification (277)
		  • HC = Heath Care Claim (837)
		  • HS = Eligibility, Coverage or Benefit Inquiry (270)
		  • HB = Eligibility, Coverage or Benefit Information (271)
		  • HP = Health Care Claim Payment/Advice (835)
		  • FA = 999 Implementation Acknowledgement (5010)
		  • PI = Additional information to support a health care claim or encounter (275)
			GS01

Field	Usage	Specifications	Segment
Application Sender's Code	Code Identifying party sending transmission. Code agreed to by trading partners.	• Required • Field Length: 2/15 • Recommended Value (5010): Vendor partners should enter the vendor's customer ID.	GS02
Application Receiver's Code	Code identifying party receiving transmission. Code agreed to by trading partner.	• Required • Field Length: 2/15 • Required Value: 030240928	GS03
Date	Creation Date	• Required • Field Length: 8/8 • Format: CCYYMMDD	GS04
Time	Creation Time	• Required • Field Length: 4/8 • Format: HHMM (*GMT/UTC Standard*)	GS05
Group Control Number	Assigned number originated and maintained by the sender	• Required • Field Length: 1/9 **Note:** Do not use leading zeroes • Must be unique within interchange • Recommended to be unique over a 6-month period • Must match GE02	GS06
Responsible Agency Code	Code used to identify the issuer of the standard	• Required • Field Length: 1/2 • Recommended Value: X = Accredited Standards Committee X12	GS07

Field	Usage	Specifications	Segment

Version / Release / Industry Identifier Code	Code indicating the version, release, sub release, and industry identifier of the EDI standard being used	• Required
		• Field Length: 1/12
		• Recommended Values: [vary based on transaction type]
		  • **835** – 005010X221A1
		  • **270/271** – 005010X279A1
		  • **276/277** – 005010X212
		  • **278** – 005010X217
		  • **278N** – 005010X216
		  • **837 Institutional** – 005010X223A2
		  • **837 Professional** – 005010X222A1
		  • **837 Dental** – 005010X224A2
		  • **275 Medical** – 005010X210
			GS08

Functional Group Trailer (GE) segment

The following table defines the requirements for the Functional Group Trailer (GE) segment, which is paired with the Functional Group Header (GS) segment.

GE segments

Field	Usage	Specifications	Segment
Number of Transaction Sets Included	Total number of transaction sets (ST/SE) included in the functional group or interchange	• Required • Field Length: 1/6	GE01
Group Control Number	Assigned number originated and maintained by the sender. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	• Required • Field Length: 1/9	GE02

Submitter (1000A) and Receiver (1000B) loops

The following table defines the requirements for the Submitter (1000A) and Receiver (1000B) loops.

Loop ID	Segment	Element Name	Description	Requirement
1000A	NM1	Submitter Name and ID	To supply the full name of an individual or organizational entity	Senders must submit the submitter name (NM103) and submitter identifier (NM109) assigned by the destination payer
1000B	NM1	Receiver Name and ID	To supply the full name of an individual or organizational entity	• Senders can submit the destination payer name (NM103) and payer ID (NM109) • For BCBSF (Florida Blue) use tax ID number 592015694. For Humana, use their Dun & Bradstreet number 049944143 • Other Payer IDs are available in Availity Health Plan Partners list • Senders can also submit with NM103 equal to Availity and the Availity Dun & Bradstreet number 030240928 in NM109

CAQH CORE Phase II connectivity

In support of the CAQH CORE Phase II mandate, Availity offers a fully compliant connectivity solution via the following URL:

https://gateway.availity.com:2021/core

Availity can receive batch files using either Envelope Standard A (HTTP MIME Multipart) or Envelope Standard B (SOAP+WSDL) and requires that Submitter Authentication Standard C (User name/ Password) use the UserName and Password fields for Envelope Standard A and WS-security for Envelope Standard B. For more information, see Phase I CORE 153: Eligibility and Benefits Connectivity Rule and Phase II CORE 270: Connectivity Rule

The following table displays the CORE Phase II field level requirements:

Field	Description
Payload Type	Specifies the type of payload included within the request. Must be one of the following: • `X12_270_Request_005010X279A1` • `X12_276_Request_005010X212` • `X12_278_Request_005010X215` • `X12_278_Request_005010X216` • `X12_278_Request_005010X217` • `X12_837_Request_005010X223A2` • `X12_837_Request_005010X222A1` • `X12_837_Request_005010X224A2`
ProcessingMode	RealTime or Batch
PayloadID	The unique payload identifier
TimeStamp	The following is an example of a valid timestamp: 20121130T22:30:06-5:00
SenderID	The submitting entity identifier
ReceiverID	The requested health plan identifier
CORERuleVersion	The CORE rule version that this envelope is using (not required)
Payload	Contains inline X12 transactions for real-time service or an attachment for batch

The following table displays the CORE Phase II services supported by Availity:

Service name	Description
realTimeTransaction	Submit a real time transaction, synchronous call.
batchSubmitTransaction	Submit a file to Availity for processing as an MTOM request. The payload contains an attachment to the web service call.
batchSubmitAckRetrievalTransaction	Retrieve a list of file names available for retrieval. The list of files, separated by a comma, is in the Response object, Payload element.
batchResultsRetrievalTransaction	Retrieve a single file (provide the file name in the payloadID) and receive the file as an MTOM attachment in the response.

For more information on CAQH CORE Phase II Operating rules, see CAQH CORE Phase II Operating Rules.

CAQH CORE Phase IV connectivity

In support of CAQH CORE Phase IV, Availity offers fully compliant connectivity support for the 278 and 837 transactions via the following URL:

https://gateway.availity.com/caqh

Availity can receive real-time 278 and batch 837 files using SOAP+WSDL with WS-security. For more information, see:

- https://www.caqh.org/sites/default/files/core/phase-iv/450_837-infrastructure-rule.pdf
- https://www.caqh.org/sites/default/files/core/phase-iv/452_278-infrastructure-rule.pdf
- https://www.caqh.org/sites/default/files/core/phase-iv/470-connectivity-rule.pdf

The following table displays the CORE Phase IV field level requirements:

Field	Description
Payload Type	Specifies the type of payload included within the request. Must be one of the following: • X12_837_Request_005010X222A1 • X12_837_Request_005010X223A1_2 • X12_837_Request_005010X224A1_2 • X12_278_Request_005010X217E1_2
ProcessingMode	RealTime or Batch
Payload ID	The unique payload identifier
Payload Length	The payload length
TimeStamp	The following is an example of a valid timestamp: 20121130T22:30:06-5:00
SenderID	The submitting entity identifier
ReceiverID	The requested health plan identifier
CORERuleVersion	V4.0.0
Payload	Contains inline X12 transactions for real-time service or an attachment for batch

The following table displays the CORE Phase IV services supported by Availity:

Service name	Description
realTimeTransaction	Submit a real time transaction, synchronous call.

Service name	Description
batchSubmitTransaction	Submit a file to Availity for processing as an MTOM request. The payload contains an attachment to the web service call.
batchSubmitAckRetrievalTransaction	Retrieve a list of file names available for retrieval. The list of files, separated by a comma, is in the Response object, Payload element.
batchResultsRetrievalTransaction	Retrieve a single file (provide the file name in the payloadID) and receive the file as an MTOM attachment in the response.

For more information on CAQH CORE Phase IV Operating rules, see CAQH CORE Phase IV Operating rules.

Acknowledgements and/or reports

Availity's batch EDI processing generates response files (acknowledgements and reports) for each submitted batch file. Availity provides standard response files recommended in the official HIPAA implementation guides (called TR3s) and proprietary reports for end-to-end tracking and accountability of each submitted transaction.

The following types of response files are available:

Notification file

Indicates whether a batch file was successfully received by Availity and recognized as a batch file.

File acknowledgement (ACK)

Indicates that a batch file failed Availity proprietary validation, and usually means that the format of the batch file (which is expected to be X12) is invalid.

Interchange acknowledgement (TA1)

Indicates that the interchange control header (ISA), interchange control trailer (IEA), or functional group header (GS) segments of a batch file are invalid.

Implementation acknowledgement (999)

Reports the acceptance or rejection of each transaction set (ST/SE) in a batch file, and the transactions they contain, based on whether any X12 syntax errors were detected.

Immediate batch response (IBR)

Acknowledges claims accepted by Availity and identifies claims that were rejected due to HIPAA edits, payer-specific edits (e.g., duplicate transactions, member ID formatting issues), or clinical edits (e.g, billing or coding issues) conducted by Availity on behalf of payers. These response files are typically available within minutes after submitting a batch file, but can take up to 24 hours depending upon the volume of claims processing at that time.

Immediate batch response plus (IBRP)

Acknowledges claims accepted by Availity and identifies warning messages and claims that were rejected due to HIPAA edits, payer-specific edits (e.g., duplicate transactions, member ID formatting issues), or clinical edits (e.g, billing or coding issues) conducted by Availity on behalf of payers. These response files are typically available within minutes after submitting a batch file, but can take up to 24 hours depending upon the volume of claims processing at that time.

Electronic batch report (EBR)

Contains aggregated initial responses from payers and trading partners (such as other clearinghouses) about the status of submitted claims. The report is typically available 24-48 hours after claims accepted by Availity are submitted to a payer.

Delayed payer report (DPR)

Contains aggregated claim status information from payers that utilize batch processing or other non-real-time adjudication processes, or in cases where a payer response is received after Availity has already

sent an EBR to your organization. The report is typically available within 30 days after claims accepted by Availity are submitted to a payer. This report is not available for all payers.

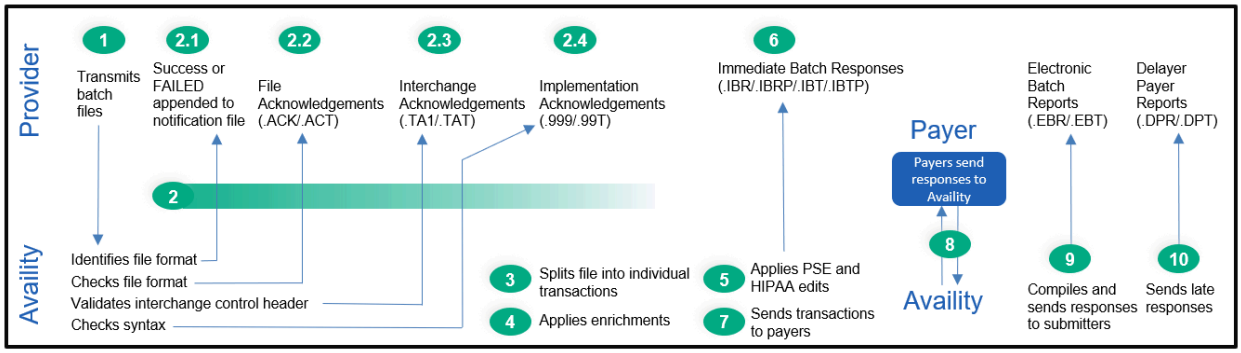
Payer responses for non-claim transactions

Response files for non-claim transactions include the following: eligibility & benefits responses (.271), claim status responses (.277), authorization/referral (.278), health care services review notification and acknowledgement (.278N), and health care services review (.278ebr) summary text report.

All response files, except notification files, are available from the **ReceiveFiles** folder for an organization. The administrator for an organization can set up reporting preferences that specify which response files are generated, the delivery schedule, and grouping options. Notification files are available from the **SendFiles** folder for an organization.

Note: If an organization registered to receive electronic remittance advice files (also known as ERAs and 835 files) through Availity, the ERA files are available from the **ReceiveFiles** folder for the organization.

The following figure shows the response files that can be generated as an EDI file is processed by Availity.



EDI response files by transaction

The type of response files generated depend on the transaction type and the edit level being reported. The following table lists each type of response file that an Availity non-payer submitter might receive, the file extension and applicable transactions.

File name	Extension	837	835	270/271	276/277	278/278	278N/278N	275
File Acknowledgement	.ACK	X		X	X	X	X	
File Acknowledgement Readable	.ACT	X		X	X	X	X	
Interchange Acknowledgement (TA1)	.TA1	X		X	X	X	X	
Interchange Acknowledgement -Readable (TA1)	.TAT	X		X	X	X	X	
Implementation Acknowledgement (999)	.999	X		X	X	X	X	X
Implementation Acknowledgement-Readable (999)	.99T	X		X	X	X	X	
Immediate Batch Response-Pipe Delimited Data	.ibr	X						
Immediate Batch Response Plus Pipe Delimited Data	.ibrp	X						
Immediate Batch Response-Readable Report	.ibt	X						
Immediate Batch Response Plus Readable Report	.ibtp	X						
Electronic Batch Report-Pipe Delimited Data	.ebr	X						

File name	Extension	837	835	270/271	276/277	278/278	278N/278N	275
Electronic Batch Report-Readable Report	.ebt	X						
Delayed Payer Report	.dpr	X						
Delayed Payer Report	.dpt	X						
Health Care Services Review Summary Text Report	.278ebr					X	X	
Electronic Remittance Advice	.era		X					
X12 Paired Response Transaction	.271			X				
X12 Paired Response Transaction	.277				X			
X12 Paired Response Transaction	.278					X		
X12 Paired Response Transaction	.278N						X	

Note: The delayed payer report is not received from all payers.

Response file and ERA file naming conventions

Response file naming conventions

File type	Naming convention
File Acknowledgement (ACK)	<<Availity Batch ID>>.ACK
File Acknowledgement-Readable (ACT)	<<Availity Batch ID>>.ACT
Interchange Acknowledgement (TA1)	<<Availity Batch ID>>.TA1
Interchange Acknowledgement-Readable (TAT)	<<Availity Batch ID>>.TAT
Implementation Acknowledgement (999)	<<Availity Batch ID>>.999
Implementation Acknowledgement-Readable (99T)	<<Availity Batch ID>>.99T
Immediate Batch Response (IBR)	IBR-<<CCYYMMDDHHMM>>-<<SEQ#>>.ibr
Immediate Batch Response-Readable (IBT)	IBT-<<CCYYMMDDHHMM>>-<<SEQ#>>.ibt
Health care claim acknowledgement - 277CA (277IBR)	277-<<CCYYMMDDHHMM>>-<<SEQ#>>.277ibr

File type	Naming convention
Electronic Batch Report (EBR)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.ebr **All responses for an organization, multiple payers** EBR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.ebr **All responses for a provider by payer** • EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebr • EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebr **All responses for a provider, multiple payers** • EBR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebr • EBR- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebr

File type	Naming convention
Electronic Batch Report-Readable (EBT)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.ebt **All responses for an organization, multiple payers** EBT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.ebt **All responses for a provider by payer** • EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebt • EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebt **All responses for a provider, multiple payers** • EBT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebt • EBT- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebt
Health care claim acknowledgement - 277CA (277EBR)	277-<<CCYYMMDDHHMMSS>>0<<SEQ#>>.277ebr

File type	Naming convention
Delayed Payer Report (DPR)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.dpr **All responses for an organization, multiple payers** DPR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.dpr **All responses for a provider by payer** • DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpr • DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpr **All responses for a provider, multiple payers** • DPR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpr • DPR- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpr

File type	Naming convention
Delayed Payer Report-Readable (DPT)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.dpt **All responses for an organization, multiple payers** DPT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.dpt **All responses for a provider by payer** • DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpt • DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpt **All responses for a provider, multiple payers** • DPT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpt • DPT- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpt
Health care claim acknowledgement - 277CA (277DPR)	277-<<CCYYMMDDHHMMSS>>0<<SEQ#>>.277dpr
Eligibility Benefit Response (271)	One of the following based on selected grouping option: • Default: 271-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.271 • 271-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2100B NM109>>.271

File type	Naming convention
Claim Status Response (277)	One of the following based on selected grouping option: • Default: 277-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.277 • 277-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2100B NM109>>.277
Health Care Services Review Response (278)	One of the following based on selected grouping option: • Default: 278-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278 • 278-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278
Health Care Services Review Notification and Acknowledgement (278N)	One of the following based on selected grouping option: • Default: 278N-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278N • 278N-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278N
Health Care Services Review Summary Text Report (278ebr)	One of the following based on selected grouping option: • Default: 278EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278ebr • 278EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278ebr

Legend:

- **<<Availity Batch ID>>** – Availity assigned
- **<<CCYYMMDDHHMM>>** – Date-time stamp to an accuracy of minutes
- **<<CCYYMMDDHHMMSS>>** – Date-time stamp to an accuracy of seconds
- **<<Payer Short Name>>** – Representation of payer full name, up to 10-bytes
- **<<SEQ#>>** – 3-byte sequence number starting at ‘001' and incrementing by 1 for each file within same CCYYMMDDHHMM
- **<<2100B NM109>>** – Information receiver identification number in 271 or 277

- **<<2010B NM109>>** – Information receiver identification number (requester identifier) in 278, 278N or 278EBR

ERA file naming conventions

Grouping option	Naming convention
One check per file	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL-200902201240-001.era
All checks destined for an organization by payer **Note:** This method is the default setting for all current 835 recipients.	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001.era
All checks for an organization from multiple payers	ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-MULTIPAYER-200902201240-001.era
All checks for a provider by payer, and where every check in the file bears the same tax ID, but not the same NPI or the NPI is missing	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001-987654321.era
All checks for a provider by payer, and where every check in the file bears the same tax ID and same NPI	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>-<<NPI>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001-987654321-1234567890.era
All checks for a provider by payer, and where at least two different tax IDs appear in the file	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL-200902201240-001.era

Grouping option	Naming convention
All checks for a provider from multiple payers	• If there is a Tax ID in the file, the convention is as follows: ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>.era **Example:** ERA-MULTIPAYER- 200902201240-001-987654321.era • If there isn't a Tax ID in the file, the NPI is used in place of the Tax ID, and the convention is as follows: ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<NPI>>.era

Legend:

- **<<CCYYMMDDHHMM>>** – Date-time stamp
- **<<Payer Short Name>>** – Representation of payer full name, up to 10-bytes
- **<<SEQ#>>** – 3-byte sequence number starting at ‘001' and incrementing by 1 for each file within a set of files that otherwise would have the same name. Sequence numbers are generated for ERA files under the following conditions:
  - When the system creates additional ERA files to accommodate checks that exceed the user-defined file size limit.
  - When the user selects the 'one check per file' aggregation method and the date-time stamp on the resulting files is the same.
  - When the user selects the 'all checks for a provider by payer' aggregation method and the same date-time stamp, payer short name, and ID combination occurs for multiple files.
- **<<Tax ID>>** – The federal tax ID for the pay-to provider named in the checks.
- **<<NPI>>** – The NPI for the pay-to provider.

Note: If you choose to receive compressed files, the ERAs are contained in a ZIP file with file extension `.zip`.

Notification file

When a submitted batch file is received, Availity attempts to recognize the file by validating the following criteria:

- File contains content
- Acceptable file type
- Acceptable file format, identified by ISA in first three bytes

Batch file accepted by Availity

If an error does not occur at this point, the next step in validation begins and a notification file, indicating success, is delivered to the **SendFiles** folder. The name of the notification file is the name of the original batch file, concatenated with the Availity batch ID that was assigned to the file, and the suffix `-success`. The batch ID is simply the date/time that the file was submitted.

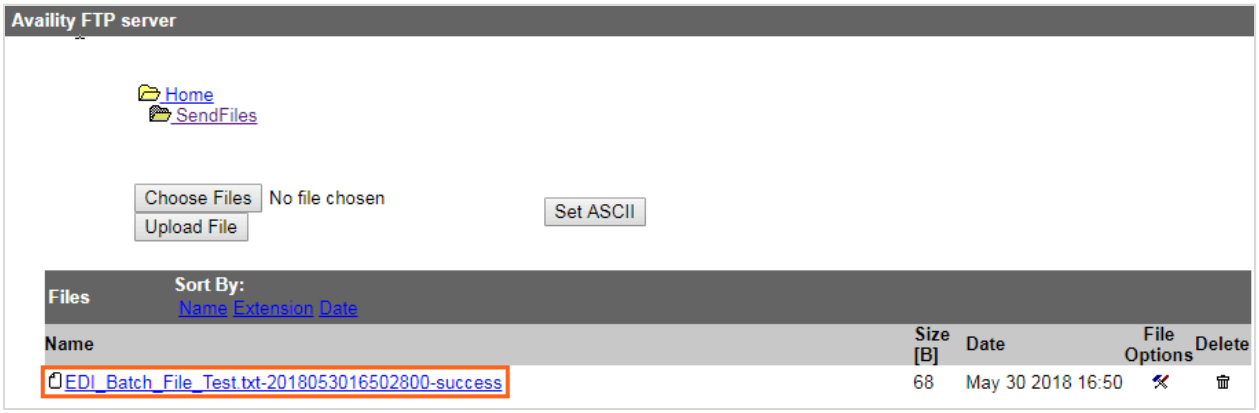


Figure 1: Example: -success file (batch file submitted through browser)

Tip: If you submitted the batch file through a browser, you can delete the notification file from the **SendFiles** folder by clicking the trash can icon in the **Delete** column of the file you want.

Batch file rejected by Availity

If an error occurs at this point, Availity does not process the batch file any further. A notification file, containing an error message, is delivered to the **SendFiles** folder. The name of the notification file is the name of the original batch file, concatenated with the Availity batch ID that was assigned to the file, and the suffix `-FAILED`. The batch ID is simply the date/time that the file was submitted.

To view the reason for the failure, do one of the following:

- If you submitted the batch file through an FTP client, use the tools in your software to open the `-FAILED` file, to view the errors.

- If you submitted the batch file through Availity Essentials or via FTP through a browser, click the tools icon in the **File Options** column of the file you want, and then click a download option such as **text/plain**, under **Download and Delete Files**. You can also download the file directly through your browser.

When a failed file upload occurs, one of the following error messages displays in the `-FAILED` file:

Empty file received - please review and resubmit

- **Cause** – This error occurs when the transmission file has zero bytes (is empty).
- **Troubleshooting** – Rebatch the file in your PMS, HIS, or other system using a new interchange control number, and then resubmit it, ensuring the file contains data. If the problem occurs again with the rebatched transmission file, contact your vendor. Your system may be creating files incorrectly.

Invalid file type received - please review and resubmit

- **Cause** – This error occurs when the transmission file is not a text (.txt) file. It may contain one of these incorrect file extensions instead: .exe, .jpg, .tif, .tiff, .emf, .jpeg, .jff, .jpe, .png, .bmp, .bid, .rle, .bmz, .gif, .gfa, .wpg.
- **Troubleshooting** – Rebatch the transmission file in your PMS, HIS, or other system using a new interchange control number and the extension .txt. If you are certain the file is a text file, but merely contains the wrong extension, you can change the file extension manually to .txt without rebatching it. Then resubmit the file. If the problem occurs again with the rebatched file, contact your vendor. Your system may be applying an incorrect file extension.

Invalid file format received - please correct and resubmit

- **Cause** – This error can occur when the first three bytes in a transmission file are not ISA.
- **Troubleshooting** – Rebatch the transmission file in your PMS, HIS, or other system using a new interchange control number. Ensure the first three bytes contain ISA, and then resubmit it. If the problem occurs again with the rebatched file, contact your vendor. Your file may contain control characters that are not viewable in text format or your system may be creating files incorrectly.

File acknowledgement (ACK)

Availity automatically sends a negative file acknowledgement (ACK) to your organization's **ReceiveFiles** folder when a submitted batch file fails Availity's proprietary validation, most commonly when the file format is invalid.

File extensions

- `.ACK` (delimited file)
- `.ACT` (human readable text file) – This is the default format.

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative file acknowledgements are not optional.
- Positive file acknowledgements are not sent.

If you do not receive the acknowledgement, please contact Availity Client Services.

Additional details

This response file reports errors in acceptable file format. The following criteria are validated:

- The first three characters in the file are ISA.
- The ISA segment is valid.

Next steps

When a file acknowledgement (ACK) is generated, processing of the batch file terminates. You must correct and resubmit the entire batch, using a new interchange control number.

File Acknowledgement (ACT)

```
------------------------------------------------------------------------------
                      AVAILITY PROPRIETARY ACKNOWLEDGEMENT
------------------------------------------------------------------------------
Customer ID: 0012345                    File Status: REJECTED
Date Received: 2020-01-01               Time Received: 10:58:01.101
Filename: 837_202001011058.txt
File Control Number: 000000000
******************************************************************************
1E - Availity does not recognize the interchange data starting at position 0 as valid.
------------------------------------------------------------------------------
                                END OF REPORT
------------------------------------------------------------------------------
```

File Acknowledgement (ACK) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|Availity Customer ID|CCYYMMDDXXXXXXXX
 - Batch ID|000000000
1E|Error message
```

File Acknowledgement (ACK)

```
1|2020-07-15|12.06.05.726|0012345|2009031511593700|000000000
1E|Availity does not recognize the interchange data starting at position 0 as valid.
```

Interpret file acknowledgements ACK

File acknowledgements are available in a formatted text version that is easy to read. The data file version of this file is intended to be imported into computers, although technical personnel may be able to view and interpret them.

File acknowledgements are delivered only when Availity rejected the transmission file in the first step of validation, usually due to an unacceptable file format.

1. Open the negative file acknowledgement and look at line 1E for the error.
2. See below for troubleshooting the error displayed in 1E.
3. After successfully troubleshooting and correcting the problem, rebatch the entire transmission file in your PMS, HIS, or other system and resubmit it to Availity, using a new interchange control number. Be sure that all control segments adhere to Availity's requirements for X12 files, as specified in the section on Control segments/envelopes.
4. If the error is not covered below or you are unable to resolve the problem, contact Availity Client Services for assistance.

Availity does not recognize the interchange data starting at position 0 as valid

Cause

This error is usually caused by one of the following conditions:

- File does not begin with ISA.
- Invalid ISA segment due to invalid numbers of spaces or characters in one or more data elements.

  Note: The ISA segment is the only fixed-length record in the X12 transaction. The total length of the ISA segment must be 106 characters, and all elements must have exactly the specified number of spaces or characters.
- Incorrect control segment identifier; for example, specifying a GE segment where an SE segment is expected.
- Missing control segments; for example, missing a trailer segment for an ISA, GS or ST segment.
- Invalid paragraph returns inserted into the transaction file, particularly in the control segments.

Interchange acknowledgement

Availity automatically sends negative interchange acknowledgements to your organization's **ReceiveFiles** folder. This file reports errors encountered within the interchange header or trailer, or functional group header, of the X12 file, particularly errors caused by duplicate interchange control numbers or an incorrect trading partner envelope.

File extensions

- `.TA1` (X12 file) – This is the default format.
- `.TAT` (human readable text file)

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative interchange acknowledgements are not optional.
- To receive positive interchange acknowledgements, the value of ISA14 must be set to 1 in the submitted batch file. Positive interchange acknowledgements are returned with the implementation acknowledgement file (999).

Additional details

This response file reports errors (TA104) in the interchange control header (ISA) or trailer (IEA), or functional group header (GS). The following criteria are validated:

- Duplicate interchange control number (ISA13).
- Incorrect trading partner envelope, signified by an invalid value in either the interchange control header (ISA) or functional group header (GS) segments.

Next steps

When an interchange acknowledgement is generated, processing of the batch file terminates. You must correct and resubmit the entire batch, using a new interchange control number.

Interchange acknowledgement - format and examples

The following table specifies the elements on the TA1 segment.

Field	Description	HIPAA segment ID
Interchange Control Number (File Control Number)	• Required • Field Length: 9/9	TA101
Interchange Date	• Required • Format: YYMMDD	TA102
Interchange Time	• Required • Format: HHMM	TA103
Interchange Acknowledgement Code	• Required • Field Length: 1/1	TA104
Interchange Note Code	• Required • Field Length: 3/3	TA105

Interchange Acknowledgement (TA1) example

```
ISA*00* *00* *01*030240928 *ZZ*AV09311993 *190103*1440*^*00501*185486211*0*T*:~
TA1*219381897*181207*2204*R*025~
IEA*0*185486211~
```

Human readable Interchange Acknowledgement (TAT) example

```
                        AVAILITY TA1 INTERCHANGE ACKNOWLEDGEMENT


Customer ID: 0002176                                              File  Status: ACCEPTED
Date Received: 2010-12-07                                    Time Received: 11:58:26.137
Filename: RespReport_test3.TXT
File Control Number: 000164875
*************************************************************************************************************
Interchange acknowledged: TA101
*************************************************************************************************************
********************Interchange Date: 101201                                        Interchange Time:
 0933
Interchange Status: A
Interchange Note: 000
-------------------------------------------------------------------------------------------------------------
                                          END OF REPORT
-------------------------------------------------------------------------------------------------------------
```

Interpret interchange acknowledgement files TA1

Tip: Availity offers a text version of this file, which is easier to read than the data file. To receive this text report, ask your Availity Essentials administrator to select the **Text – Human Readable (.TAT)** check box in your organization's EDI reporting preferences.

Interchange acknowledgements are delivered only when Availity rejected the transmission file in the first step of validation, usually due to one of these issues:

- Duplicate interchange control number (ISA13).
- Incorrect trading partner envelope, signified by an invalid value in either the interchange control header (ISA) or functional group header (GS) segments.

1. Follow these steps:

1. Open the negative interchange acknowledgement and look for the error.

   Tip: You'll know you're viewing a TA1 data file if it contains only the segments ISA, TA1 and IEA. If the date file includes an ST*999 segment, it is an implementation acknowledgement (999), which is a different type of acknowledgement. In that case, see Interpret implementation acknowledgement data files 999 on page 88 instead of the procedure described here.

2. See the appropriate section below for common errors.
3. After successfully troubleshooting and correcting the problem, rebatch the entire transmission file in your PMS, HIS, or other system and resubmit it to Availity, using a new interchange control number.
4. If the error is not covered below or you are unable to resolve the problem, contact Availity Client Services for assistance.

The trading partner agreement for interchange level could not be found

Cause

The transmission file has a trading partner identifier that we do not recognize or is not registered with Availity. This value may occur in either the interchange control header (ISA) or functional group header (GS) segments.

Troubleshooting

- See the related topics on interchange control segments and functional group segments, which explain the requirements for these segments in the file.
- If your knowledge about EDI is limited, see the related topic on understanding EDI X12 batch file structure for a brief explanation of these segments.
- You might also see the related topic on loops and segments in EDI claims (X12 837P Files).
- If necessary, contact the vendor for your EDI transactions system to discuss Availity's specifications for EDI files and how they apply to your system.

Duplicate file: The same control number has already been received

Cause

This error usually occurs when a transmission file is submitted using the same interchange control number. In other words, the interchange control number (ISA13) was used in a previous file submitted to Availity.

Troubleshooting

Rebatch the transmission file in your PMS, HIS, or other system, ensuring a new, unique interchange control number is assigned, and then resubmit it. If the problem occurs again with the rebatched file, contact your vendor. Your system may be reusing the same interchange control number.

Implementation acknowledgement

Availity automatically sends negative implementation acknowledgements to your organization's **ReceiveFiles** folder. This file indicates that Availity received the transmission file and it had errors, particularly X12 and HIPAA syntax errors. Implementation acknowledgements are also referred to as 999 files.

File extensions

- `.999` (X12 file) – This is the default format.
- `.99T` (human readable text file)

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative implementation acknowledgements are not optional.

Additional details

The X12N EDI standard 999 Implementation Acknowledgement transaction (.999) is used to report the acceptance or rejection of each transaction set (ST/SE) within each functional group (GS/GE) contained in the inbound file of ASC X12N 5010 EDI transactions.

- **Negative implementation acknowledgement** - If the entire file does not pass the validation, AvailityAvaility rejects it entirely and sends a negative implementation acknowledgement (999) to your organization's **ReceiveFiles** mail box. The file is not processed further, and the transactions are not routed to the payer.
- **Partial implementation acknowledgement** - If the file contains multiple transaction sets and some of them pass validation and others do not, Availity partially rejects the file. This means that Availity rejects or accepts the file at the transaction-set level. For partially rejected files, Availity sends an implementation acknowledgement (999) to your organization's **ReceiveFiles** mail box. Rejected transaction sets are not processed further, and they are not routed to the payer. Accepted transaction sets continue through processing.
- **Positive implementation acknowledgement** - If the entire file passes validation in this step and you set up your EDI reporting preferences to receive positive implementation acknowledgements (999), Availity sends a positive acknowledgement file to your organization's **ReceiveFiles** mail box. The accepted transaction sets proceed to the next step in processing.
- If the file contains multiple ISA/IEA segments, Availity sends an acknowledgement for each ISA/IEA pairing.

Next steps

If Availity rejects or partially rejects any or all transaction sets, you must correct the errors in your EDI billing system, rebatch all transactions in the rejected transaction sets, and upload the new file to Availity again.

Important: You must rebatch even those transactions in the rejected transaction set that do not need correction, because as part of the rejected transaction set, they have not been routed to the payer yet. Also, you must upload the corrected transaction sets using a new interchange control number. If you attempt to upload them using the previous interchange control number, Availity rejects the file as a duplicate.

Implementation acknowledgement 999 - format and examples

Implementation acknowledgement 999 format

837 claim	999 acknowledgement
ISA GS - 837 ST *837*0001 SE ST *837*0002 SE GE GS - 837 ST *837*0001 SE GE IEA	ISA GS - 999 ST AK1(AK102 equals GS06 in the functional group being acknowledged) AK2 (AK202 equals ST02 in the transaction set being acknowledged) IK5 AK2 (AK202 equals ST02 . . .) IK5 AK9 SE GE GS ST AK1 (AK102 equals GS06 . . .) AK2 (AK202 equals ST02 . . .) IK5 AK9 SE GE IEA

The most important segments, for troubleshooting purposes, in an implementation acknowledgement file are the following:

IK3

Segment IK3 in 999 implementation acknowledgement files identifies the location of errors in the transaction segment. Multiple IK3 segments can display if the transaction set contains multiple errors.

CTX

Segment CTX in 999 implementation acknowledgement files is used for the following:

- When a syntax error occurs within a business unit, the CTX segment identifies the business unit (such as the patient control number for a claim) that generated the error.
- When a syntax error is triggered by a situational requirement, the CTX segment identifies the data element that triggered the situational requirement.

IK4

Segment IK4 in 999 implementation acknowledgement files identifies the data element, or field, in the transaction set that is in error. Multiple IK4 segments can display if multiple transaction sets have data elements in error.

IK5

Segment IK5 in 999 implementation acknowledgement files identifies the status of a in the transmission file whether or not it contains errors. Multiple IK5 segments are associated with a single AK9 segment if the transmission file contains more than one transaction set in the associated functional group.

AK9

Segment AK9 in 999 acknowledgement files identifies the status of the in the transmission file. A single AK9 segment has multiple IK5 segments associated with it if the functional group in the transmission file includes more than one transaction set.

More information about how to interpret these segments is available in the topics that follow. Detail implementation specifications for the 999 Implementation Acknowledgement can also be found in the Implementation Acknowledgment For Health Care Insurance.

As shown in the following examples, the 999 transaction is intended to be imported into an automated system such as an EDI X12N compatible practice management system, and therefore is not formatted for human readability. A human-readable version is provided by the 99T format.

999 file rejected

```
ISA*00*     *00*     *01*030240928   *ZZ*AV09311993*031204*1109*U*00501*000090091*0*P*:~
TA1*000001732*031204*1101*A*000~
GS*FA*030240928*AV01101957*20031204*1109*80180*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*17321*005010X223A2~
AK2*837*000000001*005010X223A2~
IK3*CL1*24*2300*8~
CTX*CLM01:393931D_1310~
IK4*2*1314*5*AA~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*80180~
IEA*1*000090091~
```

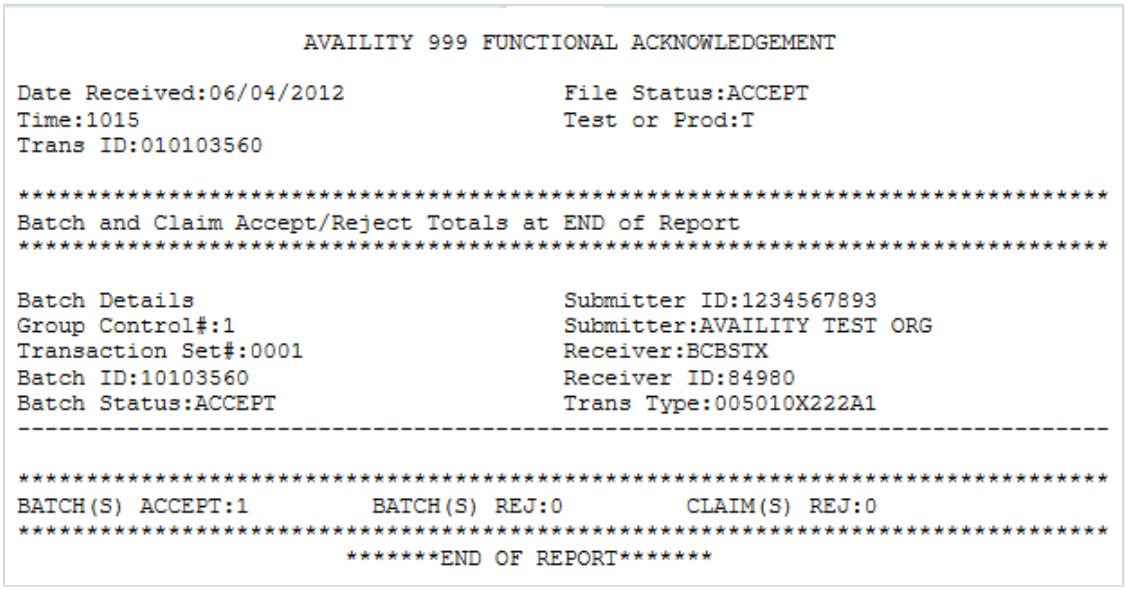
999 file accepted

```
ISA*00*     *00*     *01*030240928   *ZZ*AV09311993*030306*1356*U*00501*000000000*0*P*:~
GS*FA*030240928*AV01101957*20030306*1356*000000000*X*005010X231A1~
ST*999*000000000*005010X231A1~
AK1*HC*103136*005010X222A1~
AK2*837*000003136*005010X222A1~
IK5*A~
AK9*A*1*1*1~
SE*6*000000000~
GE*1*000000000~
IEA*1*000000000~
```

Implementation acknowledgement 99T - readable format

The 99T format of the 999 Implementation Acknowledgement provides the same information as the X12 format of the 999 acknowledgement, but in a readable format. Like the X12 version, it reports the acceptance or rejection of each transaction set (ST/SE) within each functional group (GS/GE) contained in the inbound file of ASC X12N 5010 EDI transactions.

The following figure shows an example of the Availity 999 Implementation Acknowledgement in its readable format.



```
                    AVAILITY 999 FUNCTIONAL ACKNOWLEDGEMENT

Date Received:06/04/2012                File Status:ACCEPT
Time:1015                               Test or Prod:T
Trans ID:010103560

*******************************************************************************
Batch and Claim Accept/Reject Totals at END of Report
*******************************************************************************

Batch Details                           Submitter ID:1234567893
Group Control#:1                        Submitter:AVAILITY TEST ORG
Transaction Set#:0001                   Receiver:BCBSTX
Batch ID:10103560                       Receiver ID:84980
Batch Status:ACCEPT                     Trans Type:005010X222A1
-------------------------------------------------------------------------------

*******************************************************************************
BATCH(S) ACCEPT:1         BATCH(S) REJ:0         CLAIM(S) REJ:0
*******************************************************************************
                        *******END OF REPORT*******
```

Interpret implementation acknowledgement data files 999

The most common acknowledgement file is the implementation acknowledgement (999). You might find interpreting implementation acknowledgement data files difficult unless you understand their basic structure. If you already understand acknowledgement data files, proceed with this topic, which explains how to interpret them as implemented at Availity.

Tip:

- Availity offers a text version of this file, which is easier to read than the data file. To receive this text report, ask your Availity Essentials administrator to select the **Text – Human Readable** check box in your organization's EDI reporting preferences.
- If the implementation acknowledgement (999) file contains a TA1 segment, you can use the value of TA101 to tie the 999 file back to the transmission file, because TA101 is set to the interchange control number (ISA13) of the associated transmission file. To set up your 999 files to always include a TA1 segment, set ISA14 to '1' in the transmission file and select **Include TA1 with this acknowledgement**, in the **Implementation Acknowledgements (999)** section of the **Claims** tab on the EDI Reporting Preferences page.

Each functional group from the initial transmission file is represented by one sequence of segments that starts with AK1 and ends with AK9. To determine the type of error (if any) and the cause, you'll need to look at the values of the AK1 through AK9 segments. The following sections describe the general types of errors that you can encounter, including the case where no errors occurred.

No errors occurred

If AK901=A, Availity has accepted all transaction sets in the associated functional group. No other action is required.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a functional group that was accepted by Availity:

```
AK1*HC*3456*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK9*A*1*1*1~
```

Functional group level errors

If AK901=R and there are no IK5 segments, an error occurred at the functional group level (i.e., in the GS and/or GE segments in the transmission file).

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a functional group that has an error at the functional group level in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK9*R*1*1*0*<<AK905 code>>~
```

- The presence of the AK905 element (indicated by the <<AK905 code>> placeholder in the example) indicates a functional group error, and its value specifies the cause of the error. For a list of AK905 values and their meaning, see Interpret AK9 in implementation acknowledgement files 999 on page 98.
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.

Transaction set level errors

If AK901=R or P and there are no IK3 segments, the error either occurred at the transaction set level (i.e., in the ST and/or SE segments in the transmission file), or in the functional group header (but not detected until later).

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a transaction level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK5*R*<<IK502 code>>~
AK9*<<R or P>>*1*1*0~
```

- Use the value of IK502 (indicated by the <<IK502 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK502 values and their meaning, see Interpret IK5 in implementation acknowledgement files 999 on page 96.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).

- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Segment level errors

If AK901=R or P and there are IK3 segments but no IK4 segments, the error occurred at the segment level. Examples of segment level errors include missing segments or missing segment identifiers.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a segment level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK3*<<segment ID>>*<<position>>*<<loop>>*<<IK304 code>>~
CTX*<<business unit element ID>>:<<business unit value>>~
IK5*R*5~
AK9*<<R or P>>*1*1*0~
```

- Use the value of IK304 (indicated by the <<IK304 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK304 values and their meaning, see Interpret IK3 in implementation acknowledgement files 999 on page 92.
- If the error occurred within a business unit (e.g., a claim), a CTX segment will be present, as in the above example.
- Use the value of IK301 and CTX01 (if present) to locate the segment that has the error. And use other IK3 elements, if necessary, to help locate the error.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Data element level errors

If AK901=R or P and IK4 segments are present, the error occurred at the data element level. Examples of data level errors include missing elements or invalid values.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a data element level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK3*<<segment ID>>*<<position>>*<<loop>>*<<IK304 code>>~
CTX*<<business unit element ID>>:<<business unit value>>~
IK4*<<element ID>>*<<element ref number>>*<<IK403 code>>*<<bad value>>~
IK5*R*5~
AK9*<<R or P>>*1*1*0~
```

- The value of IK304 (indicated by the <<IK304 code>> placeholder in the example) is often 8, which simply indicates that the associated segment has data element errors. For other values of IK304, see Interpret IK3 in implementation acknowledgement files 999 on page 92.
- Use the value of IK403 (indicated by the <<IK403 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK403 values and their meaning, see Interpret IK4 in implementation acknowledgement files 999 on page 94.
- If the error occurred within a business unit (e.g., a claim), a CTX segment will be present, as in the above example.
- Use the value of IK301 and CTX01 (if present) to locate the data element that has the error. And use other IK3 and IK4 elements, if necessary, to help locate the error.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Note:

- If AK901=E, Availity accepted the associated functional group but noted some minor errors. An example of a minor error might be a leading zero in front of an amount, such as the zero in front of the decimal in the amount 0.10. You do not need to correct these types of errors.
- If you have problems interpreting the implementation acknowledgement (999) file, contact Availity Client Services for assistance. To expedite the process, please obtain the batch ID before contacting Availity Client Services.

Interpret IK3 in implementation acknowledgement files 999

Segment IK3 in 999 implementation acknowledgement files identifies the location of errors in the transaction segment. Multiple IK3 segments can display if the transaction set contains multiple errors.

Each value in IK3 represents specific information, as follows:

IK301 (First Value)

Identifies the segment in the transaction containing the error. Use this value with IK302 to identify the location of the error. Example, in bold: `IK3*N4*10*2300*8~`

IK302 (Second Value)

Identifies the line number in the transaction set containing the error. Use this value with IK301 to identify the location of the error. Example, in bold: `IK3*N4*10*2300*8~`

IK303 (Third Value)

Identifies the loop number containing the segment in error. The loop number corresponds to a section of the transaction. Example, in bold: `IK3*N4*10*2300*8~`

Note: If you contact the vendor for your EDI transactions system, knowing the meaning of the loop number can help you communicate with the vendor. For more information, see the topic on loops and segments in EDI claims (X12 837P Files).

IK304 (Fourth Value)

Identifies the type of error at the segment level. Example, in bold: `IK3*N4*10*2300*8~`

Note: An IK304 value of 8 is the most common. For other values, contact your technical resource or vendor for assistance.

IK304 values

Value	Definition
1	Unrecognized segment ID, often indicating a typographical error in the segment ID.
2	Unexpected segment, indicating the segment is not normally used for the transaction set.
3	Mandatory segment missing, meaning the transaction set is missing a required or expected segment.
4	Loop occurs over maximum times, meaning the transaction set contains too many instances of the loop.
5	Segment exceeds maximum use, meaning the transaction set contains too many instances of the segment.

Value	Definition
6	Segment not in defined transaction set, meaning the segment is not used for the type of transaction.
7	Segment not in proper sequence. In other words, the segment occurs out of the expected order.
8	Segment has field errors, meaning the fields within the segment contain errors.
I4	Implementation "Not Used" segment present
I6	Implementation dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation dependent "Not used" segment present

Example

```
IK3*N4*10*2300*8~
```

- The IK301 is N4, indicating the error is located in the N4 segment.
- The IK302 is 10, identifying the line in the transaction set in which the error is located. The error occurs in the tenth line from the beginning of the transaction set, counting the ST segment as line 1.
- The IK303 is 2300, indicating the error is located in loop 2300. The HIPAA Implementation Guide indicates this is the claim-level information.
- The IK304 is 8, indicating the segment identified in IK301 has field errors.

In other words, the tenth line in the transaction set is the N4, or address, segment, which contains field errors related to the claim-level information loop.

Note: An IK4 segment may follow the IK3 segment and specifically identifies the data element in error. Interpret the IK4 segment to help you further pinpoint the error.

Interpret CTX in implementation acknowledgement files 999

Segment CTX in 999 implementation acknowledgement files is used for the following:

- When a syntax error occurs within a business unit, the CTX segment identifies the business unit (such as the patient control number for a claim) that generated the error.
- When a syntax error is triggered by a situational requirement, the CTX segment identifies the data element that triggered the situational requirement.

CTX for business unit identifier

In the case that the CTX segment specifies a business unit identifier, the segment contains only the CTX01 element.

- For claims, CTX01 consists of the context name CLM01, followed by a colon (:) and then followed by the patient control control. The patient control number can be either the patient account number or the claim control number. The following is an example of a CTX segment for a claim with a patient control number of 1234567:

  ```
  CTX*CLM01:1234567~
  ```

- For eligibility and benefits inquiries, CTX01 consists of the context name TRN02, followed by a colon (:) and then followed by the trace number (TRN02). The following is an example of a CTX segment for an eligibility and benefits inquiry with a trace number of 1234567:

  ```
  CTX*TRN02:1234567~
  ```

- For authorization and referral transactions, CTX01 consists of the context name NM109, followed by a colon (:) and then followed by the subscriber ID (NM109). The following is an example of a CTX segment for an authorization or referral transaction with a subscriber ID of ABC123456789:

  ```
  CTX*NM109:ABC123456789~
  ```

CTX for situational trigger

In the case that the CTX segment specifies a data element that triggered a situational requirement, the CTX01 element always has the value SITUATIONAL TRIGGER. The remaining elements in the CTX segment identify the data element that triggered the situational requirement causing the error. In the following example, the trigger is the composite data element CLM05-3, which is the forty-third segment in the transaction set, as counted from the ST segment:

```
CTX*SITUATIONAL TRIGGER*CLM*43**5:3~
```

Interpret IK4 in implementation acknowledgement files 999

Segment IK4 in 999 implementation acknowledgement files identifies the data element, or field, in the transaction set that is in error. Multiple IK4 segments can display if multiple transaction sets have data elements in error.

Each value in IK4 represents specific information, as follows:

IK401 (First Value)

Identifies the location, or position, of the erroneous value in the transaction segment identified in IK301 and IK302. Example, in bold: `IK4*`**`1`**`*1069*7*00~`

Note: In rare cases, IK401 includes two or more numbers separated by colons, indicating the transaction segment is a composite data element. The extra value(s) identifies the component of the data element containing the error. For example, if IK401 is `1:2`, the error is located in the second component of the first data element in the transaction segment.

IK402 (Second Value)

Identifies the data element number. Example, in bold: `IK4*1*`**`1069`**`*7*00~`. For more information, see the topic on loops and segments in EDI claims (X12 837P files).

IK403 (Third Value)

Identifies the cause of the error Availity found during syntax validations. Example, in bold: `IK4*1*1069*`**`7`**`*00~`

IK403 values

Value	Definition
1	Mandatory field missing.
2	Conditional required field missing.
3	Too many fields.
4	Field too short.
5	Field too long.
6	Invalid character in field.
7	Invalid code value.
8	Invalid date.
9	Invalid time.
10	Exclusion condition violated. In other words, the segment includes two values that should not occur together. Only one of them can be present. See the appropriate HIPAA Implementation Guides or contact the vendor of your PMS, HIS, or other system for more information. For more information, see the topic on loops and segments in EDI claims (X12 837P files).
12	Too many repetitions
13	Too many components
I10	Implementation "Not Used" data element present
I11	Implementation too few repetitions
I12	Implementation pattern match failure

Value	Definition
I13	Implementation dependent "Not Used" data element present
I6	Code value not used in implementation
I9	Implementation dependent data element missing

IK404 (Fourth Value)

Displays a copy of the erroneous value. It displays only if the IK403 is 6, 7, 8, or 9. Example, in bold: `IK4*1*1069*7*`**`00`**`~`

Example

```
IK4*1*1069*7*00~
```

- The IK401 is 1, indicating the data element is located in the first position of the transaction segment identified in IK301 and IK302.
- The IK402 is 1069, which the X12N Data Element Dictionary defines as the individual relationship code.
- The IK403 is 7, indicating the individual relationship code is an invalid code value.
- The IK404 is 00, which is a copy of the erroneous value in the claim segment.

In other words, the IK4 segment indicates that 00, found in the first position of the transaction segment identified in IK301 and IK302, is an invalid value for the individual relationship.

Interpret IK5 in implementation acknowledgement files 999

Segment IK5 in 999 implementation acknowledgement files identifies the status of a in the transmission file whether or not it contains errors. Multiple IK5 segments are associated with a single AK9 segment if the transmission file contains more than one transaction set in the associated functional group.

Each value in the IK5 represents specific information, as follows:

IK501 (First Value)

Identifies whether Availity accepted or rejected the transaction set. This value can help you determine if a problem exists in the transaction set. Example, in bold: `IK5*`**`R`**`*5~`.

Value	Definition
A	Accepted advised, meaning Availity accepted the transaction set.
E	Accepted, but errors were noted. This code means minor errors occurred that did not cause Availity to reject the transaction set. Instead, Availity has continued processing the transaction set and routed the transactions to the payer.
R	Rejected advised, meaning Availity rejected the transaction set. Availity rejects the entire transaction set, even if most of the transactions in the set passed validation.

IK502 - IK506 (Second through Sixth Values)

The IK5 segment can display up to five additional values to identify the syntax errors in the transaction set. The segment does not display these values if the IK501 is A, indicating the transmission file is accepted. Example, in bold: `IK5*R*`**`5`**`~`

Note: The most common value is 5, indicating one or more segments are in error. If a different value is present, you might need to contact the vendor for your PMS, HIS, or other system for assistance.

Value	Definition
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available

Value	Definition
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
18	Transaction Set not in Functional Group
19	Invalid Transaction Set Implementation Convention Reference
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment
I5	Implementation One or More Segments in Error
I6	Implementation Convention Not Supported

Example

```
IK5*R*5~
```

- The IK501 is R, indicating Availity rejected the transaction set.
- The IK502 is 5, indicating one or more segments in the transaction set are in error.

Interpret AK9 in implementation acknowledgement files 999

Segment AK9 in 999 acknowledgement files identifies the status of the in the transmission file. A single AK9 segment has multiple IK5 segments associated with it if the functional group in the transmission file includes more than one transaction set.

Each value in AK9 represents specific information, as follows:

AK901 (First Value)

Identifies whether Availity accepted or rejected the transaction sets in the functional group. Example, in bold: `AK9*R*8*8*0*3~`

Value	Definition
A	Accepted advised, meaning Availity accepted all transaction sets in the functional group.
E	Accepted, but errors were noted. Minor errors occurred that did not cause Availity to reject the transaction sets in the functional group. Instead, Availity has continued processing the transactions and routed them to the payer.
M	Rejected, message authentication code (MAC) failed. Because Availity does not perform this type of validation at this stage in processing, this code never displays.
P	Partially accepted, meaning at least one transaction set, but not all of them, in the functional group was rejected. Rejected transaction sets are indicated by an R in IK501.
R	Rejected advised, meaning that Availity rejected all transaction sets in the functional group. All IK501s associated with the AK9 segment display R.
W	Rejected, assurance failed validity tests. Because Availity does not perform this type of validation at this stage in processing, this code never displays.
X	Rejected, content after decryption could not be analyzed. Because Availity does not perform this type of validation at this stage in processing, this code never displays.

AK902 (Second Value)

Identifies the number of transaction sets in the functional group, as specified in the transmission file. Example, in bold: `AK9*R*`**`8`**`*8*0*3~`

AK903 (Third Value)

Identifies the number of transaction sets in the functional group, as identified by Availity upon receiving the transmission file. Example, in bold: `AK9*R*8*`**`8`**`*0*3~`

AK904 (Fourth Value)

Identifies the number of transaction sets in the functional group that Availity accepted. Example, in bold: `AK9*R*8*8*`**`0`**`*3~`

AK905 (Fifth Value)

Identifies the syntax errors in the functional group header or trailer in the transmission file. If the group header or trailer does not contain syntax errors, this value is missing. Example, in bold: `AK9*R*8*8*0*`**`3`**`~`

Value	Definition
1	Functional Group Not Supported
2	Functional Group Version Not Supported
3	Functional Group Trailer Missing
4	Group Control Number in the Functional Group Header and Trailer Do Not Agree
5	Number of Included Transaction Sets Does Not Match Actual Count
6	Group Control Number Violates Syntax
10	Authentication Key Name Unknown
11	Encryption Key Name Unknown
12	Requested Service (Authentication or Encryption) Not Available
13	Unknown Security Recipient
14	Unknown Security Originator
15	Syntax Error in Decrypted Text
16	Security Not Supported

Value	Definition
17	Incorrect Message Length (Encryption Only)
18	Message Authentication Code Failed
19	Functional Group Control Number not Unique within Interchange
23	S3E Security End Segment Missing for S3S Security Start Segment
24	S3S Security Start Segment Missing for S3E End Segment
25	S4E Security End Segment Missing for S4S Security Start Segment
26	S4S Security Start Segment Missing for S4E Security End Segment

Example

```
AK9*R*8*8*0*3~
```

- The AK901 is R, indicating all transaction sets in the functional group are rejected.
- The AK902 is 8, indicating the functional group includes eight transaction sets, as specified in the transmission file.
- The AK903 is 8, indicating the functional group includes eight transaction sets, as received by Availity.
- The AK904 is 0, indicating Availity accepted no transaction sets for the functional group.
- The AK905 is 3, indicating the functional group trailer is missing.

In other words, Availity rejected all of the eight transaction sets it received. If the entire acknowledgement file were shown in this example, you would see eight IK5 segments preceding the AK9 segment to identify each of the transaction sets in error. Finally, the AK905 indicates that the trailer for the functional group is missing from the transmission file.

Immediate batch responses

Immediate Batch Response

The immediate batch response (also referred to as an IBR) is a proprietary report that acknowledges accepted claims and identifies rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

File extensions

- `.IBR` (delimited file) – This is the default format.
- `.IBT` (human readable text file)
- `.277IBR` – 277CA claim acknowledgement format.

When is this response file sent?

Within minutes after transmission or up to 24 hours depending upon the volume of claims processing at that time.

- Immediate batch responses are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Availity generates the IBR after an accepted (A), accepted with errors (E), or a partial accepted (P) Implementation Acknowledgement (999) has been posted to your **ReceiveFiles** mailbox.
- If any errors display in this report, you can correct the claims, rebatch them, and resubmit them. This response file benefits you because it allows you to correct problems without having to wait for the payer to finish processing the rest of the transmission file.
- Unless your administrator selected grouping options, each IBR represents one ISA – IEA. If a file contains multiple ISA – IEA, Availity generates an IBR for each ISA – IEA.
- Rejected claims on the IBR also appear as rejected claims on the electronic batch report (EBR).
- Availity does not generate or return an IBR in the following situations:
  - If the complete batch file rejected on a negative ACK, TA1 or 999 file.
  - If the batch file contained non-claims transactions (27x.).

Next steps

For every claim identified as rejected in the IBR, you must correct the errors in your EDI transactions system or practice management system, rebatch the claims with a new interchange control number, and

upload the new file to Availity again. Claims that contain no HIPAA-compliance errors or payer-specific errors are routed to the payer.

Immediate Batch Response Plus

The immediate batch response plus (also referred to as an IBRP) is a proprietary report that acknowledges accepted claims and identifies warning messages and rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

File extensions

- `.IBRP` (delimited file) – This is the default format.
- `.IBTP` (human readable text file)
- `.277IBRP` – 277CA claim acknowledgement format.

When is this response file sent?

Within minutes after transmission or up to 24 hours depending upon the volume of claims processing at that time.

- Immediate batch responses are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Availity generates the IBRP after an accepted (A), accepted with errors (E), or a partial accepted (P) Implementation Acknowledgement (999) has been posted to your **ReceiveFiles** mailbox.
- If any errors display in this report, you can correct the claims, rebatch them, and resubmit them. This response file benefits you because it allows you to correct problems without having to wait for the payer to finish processing the rest of the transmission file.
- Unless your administrator selected grouping options, each IBRP represents one ISA – IEA. If a file contains multiple ISA – IEA, Availity generates an IBRP for each ISA – IEA.
- Rejected claims on the IBRP also appear as rejected claims on the electronic batch report (EBR).
- A warning on a claim is informational content from Availity on behalf of the payer and can be added to an accepted or rejected claim. Warnings are informational only and do not cause a claim to be rejected.
- Warnings are only available on the IBRP and not IBR.
- Availity does not generate or return an IBRP in the following situations:
  - If the complete batch file rejected on a negative ACK, TA1 or 999 file.

- If the batch file contained non-claims transactions (27x.).

Next steps

For every claim identified as rejected in the IBRP, you must correct the errors in your EDI transactions system or practice management system, rebatch the claims with a new interchange control number, and upload the new file to Availity again. Claims that contain no HIPAA-compliance errors or payer-specific errors are routed to the payer.

Immediate Batch Response (IBR) - pipe delimited format

The pipe-delimited IBR file provides claim detail for all claims within the file (accepted and rejected) and is intended to be imported into an automated system.

Immediate Batch Response (IBR) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|blank - Internal Use
 Only|CCYYMMDDXXXXXXXX - Availity Batch ID (assigned by Availity)|Inbound ISA13 value - File
 Control Number|99999 - Total Submitted Claims|000000.00 - Total Submitted Charges|00000
 - Total Accepted Claims| 000000.00 - Total Accepted Charges |00000 - Total Rejected
 Claims|0000.00 Total Rejected Charges|Availity Messages|Availity Customer ID| Availity File ID
 | Original File Name |
2|Payer Name|NA| NA|NA| NA| NA|NA|Payer ID|
3|Patient Last Name, First Name|CCYYMMDD - From Date |CCYYMMDD - To Date|Echo inbound CLM01 -
 Patient Control Number|00000.00 - Echo inbound CLM02 Total Claim Charge |Provider Billing ID
 - 2010AA, NM109| Clearinghouse Trace # |NA|Availity Trace #|Submitter Batch ID|"I", "W, "A" or
 "R" - Status |
3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |
```

Note:

- Line 1 will occur once per ISA.
- Line 2 will occur for every payer within the ISA.
- Line 3 will occur once per claim for a payer.
- Line 3e will occur if the claim is rejected by an Availity, HIPAA or Payer Specific Edit (PSE). Multiple 3e lines per claim can occur.
- If no error message number is available, field 3 will equal NA.

Sample report structure

```
Line 1 (ISA Level)
   Line 2 (Payer 1 Level Claim Rejects/Accepts) Repeat > 1
           Rejects = > Line 3 (Claim Level) Repeat > 1
                       Line 3e (Claim Level Error) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
   Line 2 (Payer 2 Level Claim Rejects/Accepts) Repeat > 1
           Rejects => Line 3 (Claim Level) Repeat > 1
                      Line 3e (Claim Level Error) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
   Repeat by payer…..
```

Immediate Batch Response (IBR)

```
1|2010-08-17|15.26.05.222|NA|2017092718492800|000001869|18|3829.00|15|2954.00|3|875.00|NA|
0001815|1-41025630|UHCtext.txt|
2|UNITED HEALTHCARE (UHC)|NA|NA|NA|NA|NA|NA|87726|
3|DUCK, DON|20170927|20170927|123456|336.00|1760438840|NA|NA|NA|1464|R|
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '336.00' does not
 equal sum of line charge amounts (SV102) '337.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 336|2300|CLM|02||||5010|
2|UNICARE|NA|NA|NA|NA|NA|NA|80314|
3|STAR, RINGO|20170927|20170927|888|230.00|1760438840|NA|NA|128799450_1|1464|A|
3|KEYS, PIANO|20170927|20170927|856301|210.00|1760438840|NA|NA|128799450_2|1464|A|
3|CHILDS, JULIA|20170927|20170927|856320|337.00|1760438840|1234567|NA|12345678901|1464|R|
3e|HIPAA|R|3939612|HCPCS Procedure Code is invalid in Professional Service. Invalid data:
 90772|2400|SV1|01||||5010|
2|HUMANA|NA|NA|NA|NA|NA|NA|61101|
3|SMART, PHONE|20170927|20170927|850043|174.00|1760438840|NA|NA|128799450_4|1464|A|
3|JUNGLE, JIM|20170927|20170927|899935|117.00|1760438840|NA|NA|128799450_5|1464|A|
3|POP, MUSIC|20170927|20170927|8594|202.00|1760438840|NA|NA|128799450_6|1464|A|
```

Immediate Batch Response Plus (IBRP) - pipe delimited format

The pipe-delimited IBRP file provides claim detail for all claims within the file (accepted and rejected) and is intended to be imported into an automated system.

Immediate Batch Response Plus (IBRP) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|blank - Internal Use
 Only|CCYYMMDDXXXXXXXX - Availity Batch ID (assigned by Availity)|Inbound ISA13 value - File
 Control Number|99999 - Total Submitted Claims|000000.00 - Total Submitted Charges|00000
 - Total Accepted Claims| 000000.00 - Total Accepted Charges |00000 - Total Rejected
 Claims|0000.00 Total Rejected Charges|Availity Messages|Availity Customer ID| Availity File ID
 | Original File Name |
2|Payer Name|NA| NA|NA| NA| NA|NA|Payer ID|
3|Patient Last Name, First Name|CCYYMMDD - From Date |CCYYMMDD - To Date|Echo inbound CLM01 -
 Patient Control Number|00000.00 - Echo inbound CLM02 Total Claim Charge |Provider Billing ID
 - 2010AA, NM109| Clearinghouse Trace # |NA|Availity Trace #|Submitter Batch ID|"I", "W, "A" or
 "R" - Status |
3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |
3w|Warning Initiator|W|Warning Code - if available, otherwise NA|Warning Message | NA|NA|NA
 |||| Version |
```

Note:

- Line 1 will occur once per ISA.
- Line 2 will occur for every payer within the ISA.
- Line 3 will occur once per claim for a payer.
- Line 3e will occur if the claim is rejected by an Availity, HIPAA, or Payer Specific Edit (PSE). Multiple 3e lines per claim can occur.
- Line 3w will occur if the claim has an informational warning message. Warnings do not cause a claim to be rejected. Multiple 3w lines per claim can occur.
- Lines 3e and 3w can occur for the same claim if the claim was rejected for an error and an informational warning also occurred.
- If no error or warning message number is available, field 3 will equal NA.

Sample report structure

```
Line 1 (ISA Level)
   Line 2 (Payer 1 Level Claim Rejects/Accepts) Repeat > 1
           Rejects = > Line 3 (Claim Level) Repeat > 1
                       Line 3e (Claim Level Error) Repeat > 1
                       Line 3w (Claim Level Warning) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
   Line 2 (Payer 2 Level Claim Rejects/Accepts) Repeat > 1
           Rejects => Line 3 (Claim Level) Repeat > 1
                      Line 3e (Claim Level Error) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
   Repeat by payer…..
```

Immediate Batch Response Plus (IBRP)

```
1|2010-08-17|15.26.05.222|NA|2017092718492800|000001869|18|3829.00|15|2954.00|3|875.00|NA|
0001815|1-41025630|UHCtext.txt|
2|UNITED HEALTHCARE (UHC)|NA|NA|NA|NA|NA|NA|87726|
3|DUCK, DON|20170927|20170927|123456|336.00|1760438840|NA|NA|NA|1464|R|
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '336.00' does not
 equal sum of line charge amounts (SV102) '337.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 336|2300|CLM|02||||5010|
2|UNICARE|NA|NA|NA|NA|NA|NA|80314|
3|STARFISH, SALLY|20170927|20170927|888|230.00|1760438840|NA|NA|128799450_1|1464|A|
3|KEYS, PIANO|20170927|20170927|856301|210.00|1760438840|NA|NA|128799450_2|1464|A|
3|BEACH, SANDY|20170927|20170927|856320|337.00|1760438840|1234567|NA|12345678901|1464|R|
3e|HIPAA|R|3939612|HCPCS Procedure Code is invalid in Professional Service. Invalid data:
 90772|2400|SV1|01||||5010|
3w|PSW|W|AP9999|59 modifier requires additional information|NA|NA|NA||||5010A1|
2|HUMANA|NA|NA|NA|NA|NA|NA|61101|
3|SMART, PHONE|20170927|20170927|850043|174.00|1760438840|NA|NA|128799450_4|1464|W|
3w|PSW|W|AP9999|59 modifier requires additional information|NA|NA|NA||||5010A1|
3|JUNGLE, JIM|20170927|20170927|899935|117.00|1760438840|NA|NA|128799450_5|1464|A|
3|POP, MUSIC|20170927|20170927|8594|202.00|1760438840|NA|NA|128799450_6|1464|A|
```

Immediate Batch Response (IBT) - readable format

The IBT format of the Immediate Batch Response report provides the same information as the pipe-delimited format, but in a readable format. Like the pipe-delimited version, it provides claim detail for all claims within the file (accepted and rejected). The layout of the report is as follows:

```
                            Availity Customer ID: <<0>>
                          Immediate Batch Text Response
Availity Messages: <<1>>
-------------------------------------------------------------------------------------
                                   BATCH SUMMARY
Date Received:          <<2>>                 Time Received:           <<3>>
Availity Batch ID:      <<4>>                 File Control Number:     <<5>> ISA #1
Availity File ID:       <<6>>
File Name:              <<7>>
Submitted Claims:       <<8>>                 Total Submitted Charges: <<9>>
Accepted Claims:        <<10>>                Total Accepted Charges:  <<11>>
Rejected Claims:        <<12>>                Total Rejected Charges:  <<13>>
-------------------------------------------------------------------------------------
Payer Name: Payer #1    <<14>>                Payer ID: <<15>>
-------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                Status:                  <<17>>
Patient Name:           <<18>>                Patient Control Number: <<19>>
From Date:              <<20>>                To Date:                 <<21>>
Charge:                 <<22>>                Provider Billing ID:     <<23>>
Clearinghouse Trace #: Claim #1               Availity Trace #:        <<25>>
Error Initiator:        <<26>>                Loop:                    <<27>>
Segment ID:             <<28>>                Element #:               <<29>>
Error Message:          <<30>>                Version:                 <<31>>
-------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                Status:                  <<17>>
Patient Name:           <<18>>                Patient Control Number: <<19>>
From Date:              <<20>>                To Date:                 <<21>>
Charge:                 <<22>>                Provider Billing ID:     <<23>>
Clearinghouse Trace #: Claim #2               Availity Trace #:        <<25>>
Error Initiator:        <<26>>                Loop:                    <<27>>
Segment ID:             <<28>>                Element #:               <<29>>
Error Message:          <<30>>                Version:                 <<31>>
```

```
--------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                  Payer ID: <<15>>
--------------------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                 Status:                 <<17>>
Patient Name:          <<18>>                 Patient Control Number: <<19>>
From Date:             <<20>>                 To Date:                <<21>>
Charge:                <<22>>                 Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #3               Availity Trace #:       <<25>>
Error Initiator:       <<26>>                 Loop:                   <<27>>
Segment ID:            <<28>>                 Element #:              <<29>>
Error Message:         <<30>>                 Version:                <<31>>
--------------------------------------------------------------------------------------------
--------------------------------------------------------------------------------------------
                                    BATCH SUMMARY

Date Received:         <<2>>                  Time Received:          <<3>>
Availity Batch ID:     <<4>>                  File Control Number:    ISA #2
Availity File ID:      <<6>>
File Name:             <<7>>
Submitted Claims:      <<8>>                  Total Submitted Charges: <<9>>
Accepted Claims:       <<10>>                 Total Accepted Charges:  <<11>>
Rejected Claims:       <<12>>                 Total Rejected Charges:  <<13>>
--------------------------------------------------------------------------------------------
Payer Name: Payer #1 <<14>>                   Payer ID: <<15>>
--------------------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                 Status:                 <<17>>
Patient Name:          <<18>>                 Patient Control Number: <<19>>
From Date:             <<20>>                 To Date:                <<21>>
Charge:                <<22>>                 Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #4               Availity Trace #:       <<25>>
Error Initiator:       <<26>>                 Loop:                   <<27>>
Segment ID:            <<28>>                 Element #:              <<29>>
Error Message:         <<30>>                 Version:                <<31>>
--------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                 Payer ID: <<15>>
--------------------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                 Status:                 <<17>>
Patient Name:          <<18>>                 Patient Control Number: <<19>>
From Date:             <<20>>                 To Date:                <<21>>
Charge:                <<22>>                 Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #5               Availity Trace #:       <<25>>
Error Initiator:       <<26>>                 Loop:                   <<27>>
Segment ID:            <<28>>                 Element #:              <<29>>
Error Message:         <<30>>                 Version:                <<31>>
--------------------------------------------------------------------------------------------
                                    END OF REPORT
     ------------------------------------------------------------------
```

Descriptions of fields in the IBT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Availity Messages	NA - at this time
2	Date Received	CCYY-MM-DD
3	Time Received	HH.MM.SS.SSS
4	Availity Batch ID	File name assigned by Availity: INTERNAL_FILENAME
5	File Control Number (Interchange Control Number)	ISA13

Field number	Field	Note
6	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
7	File Name	Original incoming file name: EXCHANGE_FILENAME
8	Submitted Claims	Count of 2300 CLM per ISA
9	Total Submitter Charges	Sum of all 2300 CLM02; 9,999.99 format
10	Accepted Claims	Count of 2300 CLM accepted per ISA
11	Total Accepted Charges	Sum of accepted 2300 CLM02; 9,999.99 format
12	Rejected Claims	Count of 2300 CLM rejected
13	Total Rejected Charges	Sum of rejected 2300 CLM02, 9,999.99
14	Payer Name	Availity payer name | UNKNOWN
15	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
16	Submitter Batch ID	BHT03
17	Status	A | R | W | I
18	Patient Name	2010BA/CA NM103, NM104
19	Patient Control Number	2300 CLM01
20	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
21	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
22	Charge	2300 CLM02; 9,999.99 format
23	Provider Billing ID	2010AA NM109

Field number	Field	Note
24	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
25	Availity Trace #	Outbound REF*D9 | NA – For the rejected claims, this will always be NA in the IBT/IBR.
26	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
27	Loop	Loop ID
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow U.S. currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Immediate Batch Response (IBT) example

```
                        Availity Customer ID:  0002176
                         Immediate Batch Text Response
Availity Messages:     NA
--------------------------------------------------------------------------------
                             BATCH SUMMARY
Date Received:         2010-12-08          Time Received:           15.20.18.018
Availity Batch ID:     2010120815201500    File Control Number:     000100495
Availity File ID:      1-41025630
File Name:             UHCtest.TXT
Submitted Claims:      1                   Total Submitted Charges: 251.00
Accepted Claims:       1                   Total Accepted Charges:  251.00
Rejected Claims:                           Total Rejected Charges:  0.00
--------------------------------------------------------------------------------
Payer Name:            UNITED HEALTHCARE (UHC)     Payer ID:               87726
--------------------------------------------------------------------------------
Submitter Batch ID:    AAS100494           Status:                  A
Patient Name:          DOE, JOHN           Patient Control Number:  AAS0000068
From Date:             2010-05-21          To Date:                 2010-05-21
Charge:                251.00              Provider Billing ID:     1164748786
Clearinghouse Trace #: AAS100494           Availity Trace #:        27254
--------------------------------------------------------------------------------
                                  END OF REPORT
--------------------------------------------------------------------------------
```

Immediate batch response plus (IBTP) - readable format

The IBTP format of the Immediate Batch Response plus report provides the same information as the pipe-delimited format, but in a readable format. Like the pipe-delimited version, it provides claim detail for all claims within the file (accepted and rejected). The layout of the report is as follows:

```
Availity Customer ID: <<0>>
                        Immediate Batch Text Plus Response
Availity Messages: <<1>>
--------------------------------------------------------------------------------
                                BATCH SUMMARY
Date Received:         <<2>>               Time Received:          <<3>>
Availity Batch ID:     <<4>>               File Control Number:    <<5>> ISA #1
Availity File ID:      <<6>>
File Name:             <<7>>
Submitted Claims:      <<8>>               Total Submitted Charges: <<9>>
Accepted Claims:       <<10>>              Total Accepted Charges:  <<11>>
Rejected Claims:       <<12>>              Total Rejected Charges:  <<13>>
--------------------------------------------------------------------------------
Payer Name: Payer #1   <<14>>              Payer ID: <<15>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>              Status:                 <<17>>
Patient Name:          <<18>>              Patient Control Number: <<19>>
From Date:             <<20>>              To Date:                <<21>>
Charge:                <<22>>              Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #1            Availity Trace #:       <<25>>
Error Initiator:       <<26>>              Loop:                   <<27>>
Segment ID:            <<28>>              Element #:              <<29>>
Error Message:         <<30>>              Version:                <<31>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>              Status:                 <<17>>
Patient Name:          <<18>>              Patient Control Number: <<19>>
From Date:             <<20>>              To Date:                <<21>>
Charge:                <<22>>              Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #2            Availity Trace #:       <<25>>
Error Initiator:       <<26>>              Loop:                   <<27>>
Segment ID:            <<28>>              Element #:              <<29>>
Error Message:         <<30>>              Version:                <<31>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>              Status:                 <<17>>
Patient Name:          <<18>>              Patient Control Number: <<19>>
From Date:             <<20>>              To Date:                <<21>>
```

```
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #2                 Availity Trace #:       <<25>>
Warning Initiator:      <<32>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Warning Message:        <<33>>                  Version:                <<31>>

-------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                    Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #3                 Availity Trace #:       <<25>>
Error Initiator:        <<26>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Error Message:          <<30>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------
                                  BATCH SUMMARY

Date Received:          <<2>>                   Time Received:          <<3>>
Availity Batch ID:      <<4>>                   File Control Number:    ISA #2
Availity File ID:       <<6>>
File Name:              <<7>>
Submitted Claims:       <<8>>                   Total Submitted Charges: <<9>>
Accepted Claims:        <<10>>                  Total Accepted Charges:  <<11>>
Rejected Claims:        <<12>>                  Total Rejected Charges:  <<13>>
-------------------------------------------------------------------------------------------
Payer Name: Payer #1 <<14>>                     Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #4                 Availity Trace #:       <<25>>
Error Initiator:        <<26>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Error Message:          <<30>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                   Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #5                 Availity Trace #:       <<25>>
Warning Initiator:      <<32>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Warning Message:        <<33>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
                                  END OF REPORT
     ---------------------------------------------------------------------
```

Descriptions of fields in the IBTP layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Availity Messages	NA - at this time
2	Date Received	CCYY-MM-DD
3	Time Received	HH.MM.SS.SSS
4	Availity Batch ID	File name assigned by Availity: INTERNAL_FILENAME

Field number	Field	Note
5	File Control Number (Interchange Control Number)	ISA13
6	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
7	File Name	Original incoming file name: EXCHANGE_FILENAME
8	Submitted Claims	Count of 2300 CLM per ISA
9	Total Submitter Charges	Sum of all 2300 CLM02; 9,999.99 format
10	Accepted Claims	Count of 2300 CLM accepted per ISA
11	Total Accepted Charges	Sum of accepted 2300 CLM02; 9,999.99 format
12	Rejected Claims	Count of 2300 CLM rejected
13	Total Rejected Charges	Sum of rejected 2300 CLM02, 9,999.99
14	Payer Name	Availity payer name | UNKNOWN
15	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
16	Submitter Batch ID	BHT03
17	Status	A | R | W | I
18	Patient Name	2010BA/CA NM103, NM104
19	Patient Control Number	2300 CLM01
20	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
21	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
22	Charge	2300 CLM02; 9,999.99 format

Field number	Field	Note
23	Provider Billing ID	2010AA NM109
24	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
25	Availity Trace #	Outbound REF*D9 | NA – For the rejected claims, this will always be NA in the IBT/IBR.
26	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
27	Loop	Loop ID
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010
32	Warning Initiator	PSW – Used when there is a payer-specific warning that Availity relays on behalf of the payer.
33	Warning Message	Detailed claim warning message

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow U.S. currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Immediate Batch Text Plus Response (IBTP) example

```
Availity Customer ID:  0001194
                        Immediate Batch Text Plus Response
Availity Messages:     NA
--------------------------------------------------------------------------------
                            BATCH SUMMARY
Date Received:          2021-11-16                  Time Received:           15.42.07.007
Availity Batch ID:      mp2611-16-warn              File Control Number:     267551429
Availity File ID:       1-266501
File Name:              mp2611-16-warn
Submitted Claims:       1                           Total Submitted Charges: 59.00
Accepted Claims:        1                           Total Accepted Charges:  59.00
Rejected Claims:        0                           Total Rejected Charges:  0.00
--------------------------------------------------------------------------------
Payer Name:             WELLMARK BCBS (IOWA, SOUTH DAKOTA)Payer ID:          88848
--------------------------------------------------------------------------------
Submitter Batch ID:     67459                       Status:                  W
Patient Name:           LNAME, FNAME                Patient Control Number:  RXA000687484
33
From Date:              2021-11-04                  To Date:                 2021-11-04
Charge:                 59.00                       Provider Billing ID:     1053680678
Clearinghouse Trace #:  ARSF0011211706              Availity Trace #:        117963
Warning Initiator:      PSW                         Loop:                    NA
Segment ID:             NA                          Element #:               NA
Version #:              5010A1                      Warning Message          59 modifier
requires additional information
--------------------------------------------------------------------------------
                                  END OF REPORT
--------------------------------------------------------------------------------
```

277IBR Examples

Example: 277CA Positive Immediate Batch Response (IBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1305*^*00501*000356253*0*T*:~
GS*HN*030240928*AV01101957*20110517*1305*356254*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356255*20110517*130522*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20110517130522167~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356254~
IEA*1*000356253~
```

Example: 277CA Negative Immediate Batch Response (IBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110524*1645*^*00501*000448848*0*T*:~
GS*HN*030240928*AV01101957*20110524*1645*448849*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*448850*20110524*164536*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*2011052416453672~
DTP*050*D8*20110524~
DTP*009*D8*20110524~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239745576~
STC*A1:20*20110524*WQ*75~
QTY*AA*1~
AMT*YY*75~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1154374825~
TRN*1*0~
REF*TJ*561853990~
QTY*QC*1~
AMT*YY*75~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*W1234567890~
TRN*2*110549~
STC*A3:448*20110524*U*75********TRANSACTION SET HEADER IS INVALID. INVALID DATA  005010X222~
REF*D9*239745576_0~
DTP*472*RD8*20101001-20101001~
SE*26*1001~
GE*1*448849~
IEA*1*000448848~
```

277IBRP Examples

Example: 277CA Positive Immediate Batch Response Plus (IBRP)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1305*^*00501*000356253*0*T*:~
GS*HN*030240928*AV01101957*20110517*1305*356254*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356255*20110517*130522*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20110517130522167~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356254~
IEA*1*000356253~
```

Example: 277CA Positive Immediate Batch Response Plus (IBRP) with a warning

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *211221*0001*^*00501*123456789*0*P*:~
GS*HN*030240928*AV01101957*20211221*0001*234234234*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*234234234*20211221*000100*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20211221000100000~
DTP*050*D8*20211221~
DTP*009*D8*20211221~
HL*2*1*21*1~
NM1*41*2*ABC CLINIC*****46*AV09311993~
TRN*2*000654321~
STC*A1:20*20211221*WQ*500~
QTY*90*1~
AMT*YU*500~
HL*3*2*19*1~
NM1*85*1*PROVIDER****XX*1234567890~
TRN*1*0~
REF*TJ*111223333~
QTY*QA*1~
AMT*YU*500~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*ABC12345678~
TRN*2*22222~
STC*A1:20*20211221*WQ*500********59 modifier requires additional information~
REF*D9*AB123D12341234~
DTP*472*RD8*20211221-20211221~
SE*26*1001~
GE*1*234234234~
IEA*1*123456789~
```

Example: 277CA Negative Immediate Batch Response Plus (IBRP)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110524*1645*^*00501*000448848*0*T*:~
GS*HN*030240928*AV01101957*20110524*1645*448849*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*448850*20110524*164536*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*2011052416453672~
DTP*050*D8*20110524~
DTP*009*D8*20110524~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239745576~
STC*A1:20*20110524*WQ*75~
QTY*AA*1~
AMT*YY*75~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1154374825~
TRN*1*0~
REF*TJ*561853990~
QTY*QC*1~
AMT*YY*75~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*W1234567890~
TRN*2*110549~
STC*A3:448*20110524*U*75********TRANSACTION SET HEADER IS INVALID. INVALID DATA  005010X222~
REF*D9*239745576_0~
DTP*472*RD8*20101001-20101001~
SE*26*1001~
GE*1*448849~
IEA*1*000448848~
```

Interpret IBR files

After each file transmission, check your **ReceiveFiles** mail box for an immediate batch response (IBR) file and interpret it to determine if errors occurred in the transmission file at Availity.

Note: If you don't receive this report now, contact your administrator, who can set your organization's EDI reporting preferences to receive IBR files in text format (for viewing) or data file format (for importing into a PMS, HIS, or other system).

The file immediately provides information about the initial validation of your file and the claims it includes, enabling you to correct and resubmit erroneous claims and avoid payment delays. This report, which you can download to your computer or print, includes the following information:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer
- Accepted claims
- Claim counts and charges for submitted and rejected claims at the claim level and transmission file level. If you received a partial negative implementation acknowledgement because some transaction sets in the file were rejected during file format, structure, and syntax validations, the count of total claims submitted excludes the claims in those rejected transaction sets.
- Both accepted and rejected claims are itemized and included in this report

Header Information

- If an IBR with a .ibt extension is present, open that file. It's a readable text report. The IBR file ending in .ibr is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ibr and it is intended to be imported into your PMS or HIS system.

- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data response file, and the payer, coinciding with line 2 in a data file.
- The following two fields display in the first section (coinciding with line 1 in a data file):
    - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
    - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- In the header information of the IBR text file at the claim level, the **Submitted Claims**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.

Claim Information

- Information about the claims display below the header and coincide with line 3 in the data file.
- Some fields, such as the **Availity Trace #** field and some payer-specific fields, may display NA (not applicable).

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the data file: **Error Initiator**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as <payer ID>-PSE (for a payer-specific error detected at Availity), HIPAA (for a HIPAA-compliance edit), or Availity (for an invalid payer ID error).
- The **Version** field displays the X12 version the claim was in when the error occurred.
- If you must contact the vendor of your EDI transactions system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.
- If Availity rejects any claims at this stage, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been routed to the payer. See the sections below for more information on these errors.
- If you encounter any problems while interpreting errors in the IBR and cannot resolve them yourself, contact Availity for assistance.

Legacy identifier may not be used error

Error message

The legacy identifier, <identifier in REF01 is shown>, may not be used for this payer after the National Provider ID (NPI) is mandated for use. Please correct and resubmit.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The payer's legacy identifier is not allowed for payers following NPI Mandate guidelines. Remove the legacy identifier from REF01 and resubmit the transaction.

Note: State license numbers (0B) continue to be accepted.

NPI format not valid error

Error message

The National Provider ID (NPI) submitted is not in the valid NPI format. Please correct and resubmit. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

A transaction in the transmission file contains an NPI that is not in the proper format. The NPI must be a 10-digit number consisting of nine numeric digits followed by one numeric check digit. This error occurs if the ‘XX' qualifier displays in NM108 and an improperly formatted NPI displays in NM109. Correct the identifier in NM109 and resubmit the transaction.

NPI is required for payer error

Error message

The National Provider ID (NPI) is required for this payer. Expected value for NM108 is 'XX.' Please add the Provider's NPI to this claim and resubmit the claim(s) for processing. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The valid qualifier sent for an NPI in NM108 is ‘XX.' This message occurs if you send any qualifier other than ‘XX' when NPI is mandated for use. Change the qualifier in NM108 to XX and be sure the identifier in NM109 is a valid NPI. Then resubmit the transaction.

Segment REF (Billing/Pay-To Provider Secondary ID) is missing

Error message

Segment REF (Billing/Pay-To Provider Secondary Identification) is missing. Either EIN or SSN of Provider must be carried in this REF segment when NM108 is 'XX'.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing professional or facility claims.

Toubleshooting

This error applies to professional and facility claims only. If the NPI is sent in the NM1 loop for the Billing Provider (2010AA) or Pay-to Provider (2010AB), then either the provider's Employer Identification Number (EIN) or Social Security Number (SSN) must be sent in the REF segment of the same loop.

Interpret IBRP files

After each file transmission, check your **ReceiveFiles** mail box for an immediate batch response plus (IBRP) file and interpret it to determine if errors occurred in the transmission file at Availity.

Note: If you don't receive this report now, contact your administrator, who can set your organization's EDI reporting preferences to receive IBRP files in text format (for viewing) or data file format (for importing into a PMS, HIS, or other system).

The file immediately provides information about the initial validation of your file and the claims it includes, enabling you to correct and resubmit erroneous claims and avoid payment delays. This report, which you can download to your computer or print, includes the following information:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer

- Payer-specific warnings that Availity relays on behalf of the payer
- Accepted claims
- Claim counts and charges for submitted and rejected claims at the claim level and transmission file level. If you received a partial negative implementation acknowledgement because some transaction sets in the file were rejected during file format, structure, and syntax validations, the count of total claims submitted excludes the claims in those rejected transaction sets.
- Both accepted and rejected claims are itemized and included in this report

Header Information

- If an IBRP with a .ibtp extension is present, open that file. It's a readable text report. The IBRP file ending in .ibrp is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ibrp and it is intended to be imported into your PMS or HIS system.
- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data response file, and the payer, coinciding with line 2 in a data file.
- The following two fields display in the first section (coinciding with line 1 in a data file):
    - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
    - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- In the header information of the IBRP text file at the claim level, the **Submitted Claims**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.

Claim Information

- Information about the claims display below the header and coincide with line 3 in the data file.
- Some fields, such as the **Availity Trace #** field and some payer-specific fields, may display NA (not applicable).

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the data file: **Error Initiator**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as <payer ID>-PSE (for a payer-specific error detected at Availity), HIPAA (for a HIPAA-compliance edit), or Availity (for an invalid payer ID error).
- The **Version** field displays the X12 version the claim was in when the error occurred.
- The **Warning Initiator** field displays PSW, which means payer specific warning.
- The **Warning Message** field displays informational payer messages to the submitter.
- If you must contact the vendor of your EDI transactions system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.

- If Availity rejects any claims at this stage, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been routed to the payer. See the sections below for more information on these errors.
- If you encounter any problems while interpreting errors in the IBRP and cannot resolve them yourself, contact Availity for assistance.

Legacy identifier may not be used error

Error message

The legacy identifier, <identifier in REF01 is shown>, may not be used for this payer after the National Provider ID (NPI) is mandated for use. Please correct and resubmit.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The payer's legacy identifier is not allowed for payers following NPI Mandate guidelines. Remove the legacy identifier from REF01 and resubmit the transaction.

Note: State license numbers (0B) continue to be accepted.

NPI format not valid error

Error message

The National Provider ID (NPI) submitted is not in the valid NPI format. Please correct and resubmit. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

A transaction in the transmission file contains an NPI that is not in the proper format. The NPI must be a 10-digit number consisting of nine numeric digits followed by one numeric check digit. This error occurs if the ‘XX' qualifier displays in NM108 and an improperly formatted NPI displays in NM109. Correct the identifier in NM109 and resubmit the transaction.

NPI is required for payer error

Error message

The National Provider ID (NPI) is required for this payer. Expected value for NM108 is 'XX.' Please add the Provider's NPI to this claim and resubmit the claim(s) for processing. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The valid qualifier sent for an NPI in NM108 is ‘XX.' This message occurs if you send any qualifier other than ‘XX' when NPI is mandated for use. Change the qualifier in NM108 to XX and be sure the identifier in NM109 is a valid NPI. Then resubmit the transaction.

Segment REF (Billing/Pay-To Provider Secondary ID) is missing

Error message

Segment REF (Billing/Pay-To Provider Secondary Identification) is missing. Either EIN or SSN of Provider must be carried in this REF segment when NM108 is 'XX'.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing professional or facility claims.

Toubleshooting

This error applies to professional and facility claims only. If the NPI is sent in the NM1 loop for the Billing Provider (2010AA) or Pay-to Provider (2010AB), then either the provider's Employer Identification Number (EIN) or Social Security Number (SSN) must be sent in the REF segment of the same loop.

Electronic batch report

The electronic batch report (also referred to as an EBR) is a proprietary report that provides the status (received from the payer) for each transaction in the original submission. The report contains summary counts of transactions received and accepted, and lists detailed information for rejected transactions, including payer specific edits (PSEs) and HIPAA edits. Only claims that passed file format and syntax validations are included in this report.

File extensions

- `.EBR` (delimited file)
- `.EBT` (human readable text file) – This is the default format.
  - Summary report (errors and prepayment responses) – This is the default report.
  - Detail report (all claims acknowledged)
- `.277EBR` – 277CA claim acknowledgement format.

  Note: The .277EBR can only be received in combination with the .EBR or .EBT.

When is this response file sent?

When all expected responses are received from the payer; typically within 24-48 hours. If a payer fails to send any response within five business days, Availity contacts the payer to obtain a status on the transaction set.

- Electronic batch reports are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Batches and/or claims received with an invalid or unrecognized payer will generate the standard EBR report. The impacted claims display in the rejected claims section of the EBR.
- Information returned on accepted claims includes the following: patient name, claim service dates, patient control number, charge, provider billing id, clearinghouse trace number, payer claim number, Availity trace number, the message source (usually the payer name), and any message codes and message text.
- If the payer does NOT normally send a claim response, but sends a positive acknowledgement, indicating it has received the claims and found no errors during any file processing performed by this point, Availity sends the EBR containing the Availity validation information to your organization's **ReceiveFiles** mail box. Payers unable to return a claim response, such as some small payers, fall into this category and are referred to as "999-only payers."
- If the payer normally sends a claim response, Availity waits for the claim response for all claims in the file from the payer, and then compiles the information into the EBR with the Availity validation information and sends it to your **ReceiveFiles** mail box.
- Uncommonly, a payer may send a negative acknowledgement, meaning it has found errors in the transaction sets during validation. In this case, Availity contacts the payer to determine the cause of the error. If the error requires you to fix and resubmit the transaction sets, Availity contacts you (the provider) to discuss the issue.

- Because Availity generates a response file for each payer in each transaction set, you might receive multiple response files for a single file, and you probably won't receive them all at the same time. If you need to change the delivery times of the response files, contact your administrator to adjust the delivery options for electronic batch reports.
- Sometimes claims are routed to the payer through other clearinghouses or intermediaries, who also perform validations on the claims. These additional validations are the reason you might receive an error in the EBR stating a claim was rejected at another clearinghouse even though you submitted it through Availity.
- If an organization submits claims using Availity online claim forms and the payer processes claims in batches, the payer's response also displays in the **ReceiveFiles** folder in an EBR file. If the EDI reporting preferences are set up to receive EBRs together in a single file, the payer's responses for Web claims are mingled with payer responses for transmission files that were uploaded.
- For UCare and Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are direct pass through without any mapping or editing by Availity.

Next steps

Monitor status of transactions, correct and resubmit transactions with errors.

If the payer rejects any transactions (claims) at this stage (identified by the payer's name in the **Error Initiator** field), you must correct and rebatch the rejected claims in your system using a new interchange control number, and then upload and resubmit a new file.

Note: You do not need to include accepted claims in the new file, since those claims have already been processed and accepted at the payer level. Also, if you already corrected and rebatched any rejected claims identified in the IBR, you do not need to do it again, although those errors may display in the EBR with either HIPAA or Availity in the **Error Initiator** field.

Electronic Batch Report (EBR) - pipe delimited format

The pipe-delimited EBR file is intended to be imported into an automated system.

Electronic Batch Report (EBR) layout

```
1|Date of Batch Receipt - CCYY-MM-DD|Time of Batch Receipt- HH.MM.SS.SSS|Internal
 Usage|Availity Batch ID|File Control Number|Availity Customer ID|Availity File ID |Original
 File Name|||

2|Payer Name - from Availity Payer File|Claim Responses Returned| Total Accepted Claim
 Count|Total Claim Responses Returned Charges|Total Accepted Claim Charges|Total Rejected Claim
 Count|Total Rejected Claim Charges|Payer ID|

3|Patient Last Name, First Name|From Service Date - CCYYMMDD|To Service Date - CCYYMMDD|Patient
 Control Number|Total Claim Charges |Billing Provider ID| Clearinghouse Trace Number |Payer
 Claim Number or NA |Availity Trace Number||

3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |

3a|Bill Type|Allowed Amount|Non-Covered Amount |Deductible Amount |Co-Pay Amount |Co-insurance
 Amount |Withhold Amount |Estimated Payment Amount |Patient Liability|Message Code|Message
 Text|

3c|Error Initiator | Message Type| Error Code |Error Message | Loop|Segment ID | Element # |
```

Note:

- Line 1 is the file/ISA level.
- Line 2 is the payer level.
- Line 3 will occur once per claim. Line 3 will always have a line 3e, 3a, or 3c following. All 3/3e lines will occur first followed by all 3/3a lines, followed by all 3/3c lines.
- Line 3e will occur minimum of once for each Availity, HIPAA or PSE reject. Multiple 3e lines per claim can occur.
- Line 3a will occur if a claim is accepted by both Availity and the Receiver and the payer returns adjudication information in their response file.
- Line 3c indicates a clean claim without adjudication information. Line 3c will occur if a claim is accepted by both Availity and the receiver and there is no adjudication information.

Example 1: Electronic Batch Report (EBR)

```
1|2010-08-27|14.05.33.434|NA|2010082713594600-UPL|008271053|0060000|||
2|MEDICARE B - TEXAS|2|2|200.00|200.00|0|0.00|04402|
3|DUCK, DONALD|20100728|20100728|1218|100.00|1457382525|NA|NA|230038742_0||
3c|TRAILBLAZER|NA|NA|This claim has been accepted for further processing|NA|NA|NA|
3|MOUSE, MINNIE|20100707|20100707|1262|100.00|1457382525|NA|NA|230038742_1||
3c|TRAILBLAZER|NA|NA|This claim has been accepted for further processing|NA|NA|NA|

1|2010-08-31|12.56.06.182|NA|2010083112541900|369998138|0001815|||
2|Arkansas BCBS|1|0|75.00|0.00|1|75.00|00520|
3|DOE, JOHN|20091019|20091019|GOOKA000|75.00|1225057391|155835019_0|NA|NA||
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '75.00' does not
 equal sum of line charge amounts (SV102) '76.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 75|2300|CLM|02||||
```

Example 2: Electronic Batch Report (EBR)

```
1|2010-12-07|11.58.23.023|NA|2010120711582200|000164875|0002176|2010120711582200|
RespReport_test3.TXT|||
2|HUMANA|2|0|290.00|0.00|2|290.00|61101|
3|SMITH, JADA|20101105|20101105|16386|165.00|9876543213|467484130|NA|27080||
3e|HUMANA|R|42|Invalid use of Null|NA|NA|NA||||5010|
3|WOMAN, WONDER|20101107|20101107|16386|125.00|9876543213|467484132|NA|27081||
3e|HUMANA|R|42|Invalid use of Null|NA|NA|NA||||5010|
```

Electronic batch report (EBT) - readable format

The EBT format of the Electronic Batch Report provides the same information as the pipe-delimited format, but in a readable format. The layout of the report is as follows:

```
                    Availity Customer ID: <<0>>
                  Availity Electronic Batch Report
--------------------------------------------------------------------------------
Date Received:            <<1>>                Time Received:          <<2>>
Availity Batch ID:        <<3>>                File Control Number:    <<4>>
Availity File ID:         <<5>>
File Name:                <<6>>
--------------------------------------------------------------------------------
Payer:                    <<7>>                Payer ID:               <<8>>
Claim Responses Returned: <<9>>                Charges:                <<10>>
Accepted Claims:          <<11>>               Charges:                <<12>>
Rejected Claims:          <<13>>               Charges:                <<14>>
--------------------------------------------------------------------------------
Patient Name:             <15>>
From Date:                <<16>>               To Date:                <<17>>
Patient Control Number:   <<18>>               Charge:                 <<19>>
Provider Billing ID:      <<20>>               Clearinghouse Trace #:  <<21>>
Payer Claim #:            <<22>>               Availity Trace #:       <<23>>

Error Initiator:          <<24>>               Message Type: <<25>> Error Code: <<26>>
Error Message:            <<27>>
Loop:                     <<28>>               Segment ID: <<29>>   Element #:  <<30>>
Version:                  <<31>>
```

Descriptions of fields in the EBT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Date Received	CCYY-MM-DD
2	Time Received	HH.MM.SS.SSS
3	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
4	File Control Number (Interchange Control Number)	ISA13 on submitted file
5	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
6	File Name	Original incoming file name: EXCHANGE_FILENAME
7	Payer Name	Availity payer name | UNKNOWN

Field number	Field	Note
8	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
9	Claim Responses Returned	Count of responses for this payer breakdown
10	Charges	Total of related charges for this payer breakdown: 9,999.99 format
11	Accepted Claims	Count of accepted claims for this payer breakdown
12	Charges	Total of accepted charges for this payer breakdown: 9,999.99 format
13	Rejected Claims	Count of rejected claims for this payer breakdown
14	Charges	Total of rejected charges for this payer breakdown: 9,999.99 format
15	Patient Name	2010BA/CA NM103, NM104
16	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
17	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
18	Patient Control Number	2300 CLM01
19	Charge	2300 CLM02; 9,999.99 format
20	Provider Billing ID	2010AA NM109
21	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
22	Payer Claim #	If provided in payer response, else NA
23	Availity Trace #	Outbound REF*D9

Field number	Field	Note
24	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
25	Message Type	A | R | W | I
26	Error Code	If provided, else NA
27	Loop	Loop
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010
32	Bill Type	Adjudicated claim information returned by some real time payers.
33	Allowed Amount	Adjudicated claim information returned by some real time payers.
34	Non-Covered Amount	Adjudicated claim information returned by some real time payers.
35	Deductible Amount	Adjudicated claim information returned by some real time payers.
36	Co-Pay Amount	Adjudicated claim information returned by some real time payers.
37	Co-Insurance Amount	Adjudicated claim information returned by some real time payers.
38	Withhold Amount	Adjudicated claim information returned by some real time payers.

Field number	Field	Note
39	Estimated Payment Amount	Adjudicated claim information returned by some real time payers.
40	Patient Liability Amount	Adjudicated claim information returned by some real time payers.

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow U.S. currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Electronic Batch Report (EBT) example

```
Availity Customer ID:  0002176
                              Availity Electronic Batch Report
--------------------------------------------------------------------------------
Date Received:          2010-12-07          Time Received:          11.58.23.023
Availity Batch ID:      2010120711582200    File Control Number:    000164875
Availity File ID:       2010120711582200
File Name:              RespReport_test3.TXT
--------------------------------------------------------------------------------
Payer:                  HUMANA              Payer ID:               61101
Claim Responses Returned:2                  Charges:                290.00
Accepted Claims:        0                   Charges:                0.00
Rejected Claims:        2                   Charges:                290.00
--------------------------------------------------------------------------------
Patient Name:           SMITH, JADA
From Date:              20101105            To Date:                20101105
Patient Control Number:16386                Charge:                 165.00
Provider Billing ID:    9876543213          Clearinghouse Trace #:  467484130
Payer Claim #:          NA                  Availity Trace #:       27080

Error Initiator:        HUMANA              Message Type:           R
Error Code:             42
Error Message:          Invalid use of Null
Version:                5010                Loop:                   NA
Segment ID:             NA                  Element #:              NA
--------------------------------------------------------------------------------
Patient Name:           WOMAN, WONDER
From Date:              20101107            To Date:                20101107
Patient Control Number:16386                Charge:                 125.00
Provider Billing ID:    9876543213          Clearinghouse Trace #:  467484132
Payer Claim #:          NA                  Availity Trace #:       27081

Error Initiator:        HUMANA              Message Type:           R
Error Code:             42
Error Message:          Invalid use of Null
Version:                5010                Loop:                   NA
Segment ID:             NA                  Element #:              NA
--------------------------------------------------------------------------------
--------------------------------------------------------------------------------
                                  END OF REPORT
--------------------------------------------------------------------------------
```

277EBR Examples

Example: 277CA Positive Electronic Batch Report (EBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1345*^*00501*000356276*0*T*:~
GS*HN*030240928*AV01101957*20110517*1345*356277*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356278*20110517*134514*TH~
HL*1**20*1~
NM1*PR*2*CORRECTCARE*****PI*CCIH~
TRN*1*20110517134514367~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356277~
IEA*1*000356276~
```

Example: 277CA Negative Electronic Batch Report (EBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110526*1500*^*00501*000465756*0*T*:~
GS*HN*030240928*AV01101957*20110526*1500*465757*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*465758*20110526*150014*TH~
HL*1**20*1~
NM1*PR*2*ADVOCATE HEALTH PARTNERS*****PI*65093~
TRN*1*20110526150014602~
DTP*050*D8*20110526~
DTP*009*D8*20110526~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*UB924010THIN~
TRN*2*85371405~
STC*A1:20*20110526*WQ*11591.49~
QTY*AA*1~
AMT*YY*11591.49~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
REF*TJ*363695814~
QTY*QC*1~
AMT*YY*11591.49~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*123456-000~
TRN*2*008990~
STC*A3:448*20110526*U*11591.49********MISSING OR INVALID DATA PREVENTS CARRIER FROM PROCESSING
 THIS CLAIM~
REF*D9*85371405~
REF*BLT*214~
DTP*472*RD8*20100801-20100824~
SE*27*1001~
GE*1*465757~
IEA*1*000465756~
```

Interpret EBR files

Periodically check your **ReceiveFiles** mail box for new electronic batch report (EBR) file items and interpret them to determine if errors occurred in the transmission file at the payer or payer intermediary.

Note: If you receive only EBR data files, you can contact your administrator, who can set your organization's EDI reporting preferences to receive EBR files also in text format, which are easier to read. Data files are intended to be imported into a PMS, HIS, or other system, while EBR text files can be viewed by people.

An EBR file includes any of the following information, which you can download to your computer or print:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer
- Errors that the payer or payer intermediary detects
- Any warning and informational messages that the payer sends
- Possibly pre-adjudication information, depending on the payer
- Possibly information for accepted claims, if your organization's reporting preferences are set up to receive EBRs with all claims acknowledged

Header Information

- If an EBR with a .ebt extension is present, open that file. It's a readable text report. The EBR file ending in .ebr is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ebr and it is intended to be imported into your PMS or HIS system.
- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data file, and the payer, coinciding with line 2 in a data file.
    - The following two fields display in the first section (coinciding with line 1 in a data file):
        - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
        - **File Name** – The name the submitter assigned to the file being submitted to Availity.
    - In the second section (coinciding with line 2 in a data file), the **Claim Responses Returned**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.
- If you receive EBRs only for claims with errors, and the payer or payer intermediary accepted all claims in the transmission file and returned no pre-adjudication information, the file contains only the header information.

Claim Information

- If errors occurred for any claims, or if you receive EBRs for both accepted and rejected claims, information about the claims display below the header, coinciding with line 3 in the data file. The section for each claim is separated from subsequent claims by a dashed line.
- For some payers, the payer's internal reference number for the claim displays in the **Payer Claim #** field. This field is empty if the payer did not pass the information in the file.

- For some payers, the **Availity Trace #** field displays the transaction ID, the internal Availity control number that identifies the claim. This field may also display NA (not applicable). Refer to this number, if available, when calling Availity Client Services for assistance.

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the response data file: **Error Initiator**, **Message Type**, **Error Code**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as the payer, Availity, or a payer-specific edit or HIPAA-compliance edit performed at Availity. If you already corrected errors identified in the IBR, you only need to correct errors initiated by the payer.
- The **Version** field displays the X12 version the claim was in when the error occurred.
- If you must contact the vendor of your EDI billing system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.
- Some payers may also return warnings and informational messages.
- If the payer returns multiple messages, they all display together in the message field.

Adjudication information (on EBRs with All Claims Acknowledged)

- If the payer can pre-adjudicate claims and determined it will probably accept and pay the claim, the following fields indicating the status display in the lower part of the information section, coinciding with line 3a in the data file: **Allowed Amt**, **Co-Pay Amt**, **Co-Insurance Amt**, **Without Amt**, **Estimated Payment Amt**, and **Patient Liability Amt**.
- The EBR indicates processing status for claims with no errors that have not been pre-adjudicated. The following fields display in the lower part of the claim section: **Message Initiator**, **Message Code**, and **Message**.
- The **Message Code** and **Message** fields indicate claim-level adjudication messages from the payer and display data only for payers who pass this information in the file.
- If the payer rejects a claim at this stage, you must correct and rebatch the rejected claims in your billing system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been processed and accepted at the payer.
- If you encounter any problems while interpreting errors in the EBR and cannot resolve them yourself, contact the payer for assistance.

Sender code is invalid error

Error message

Sender Code is Invalid

Scenario

This error might display in the EBR file after you submit a transmission file to Florida Blue.

Toubleshooting

A transaction in the transmission file either contains a sender code not beginning with "G" or "H" or contains no sender code. Follow these guidelines to troubleshoot the problem:

- **Is the sender code present?** – Open the transmission file and look for the segment containing the sender code: Loop 1000A, NM1*41, NM109. The sender code must be present.
- **Does the sender code begin with "G" or "H"?** – If the sender code is present, verify that it begins with "G" or "H."
- **Need assistance?** – If you are having further problems, contact the vendor of your EDI transactions system for assistance. When explaining the problem, communicate the loop and segment information: Loop 1000A, NM1*41, NM109.

Note: If you are not able to complete these troubleshooting steps because you do not know how to open and view transmission files, contactAvaility Client Services for assistance.

Delayed payer report

The delayed payer report (also referred to as a DPR) includes information from payers that utilize batch processing or other non-real-time adjudication processes. The report includes transaction receipt acknowledgement, transaction reject messaging, warning, and informational messages, as well as adjudication responses returned by the destination payer.

File extensions

- `.DPR` (delimited file)
- `.DPT` (human readable text file) – This is the default format.
  - Summary report (errors and responses) – This is the default report.
  - Detail report (all claims acknowledged)
- `.277DPR` – 277CA claim acknowledgement format.

  Note: The .277DPR can only be received in combination with the .DPR or .DPT.

When is this response file sent?

If late responses are received from the payer; typically within 30 days.

- Delayed payer reports are sent only for claims, not non-claim transactions.
- This is an optional response file.

Humana

Delayed payer reports are not generated for claims submitted to Humana.

Florida Blue

Delayed payer reports are not generated for claims submitted to Florida Blue.

Additional details

- If Availity does not receive delayed payer responses, we do not generate a report.
- If the payer processes claims on a batch schedule, rather than in real-time, or sends information after Availity has sent the EBR to your organization, Availity generates a delayed payer report. This may occur with small payers, non-direct payers, or payers who accept claims through another clearinghouse.

Next steps

Monitor status of transactions, correct and resubmit transactions with errors. If a delayed payer report indicates the payer has rejected claims (line 2), you must correct and rebatch the rejected claims in your system, and then upload and resubmit the file. Do not include accepted claims in the file.

Delayed payer report (DPR) - pipe delimited format

The pipe-delimited DPR file is intended to be imported into an automated system.

Delayed Payer Report (DPR) layout

```
DPR|Report Creation Date & Time|Availity Customer ID-Availity Batch ID|File Control
 Number|Customer ID| Availity File ID |Original File Name|
CST|Availity Batch ID|Patient Account Number|Payer ID| Billing Provider ID|Patient
Last Name, First Name| From Date|Total Charges|Process Date|Message Text|NA|Status|Payer Claim
 Number|Submitter
Name|Billing Provider Name| Payer Name|Trace ID||
```

Note:

- Line 1 is the file/interchange level.
- Line 2 will occur for each patient loop in the file.

Delayed Payer Report (DPR)

```
DPR|20101123133022000|0015515-2010112313302000|101019034|0015515|2010112313302000|
PhysiciansHC_837P.txt|||
CST|2010112313302000|CN1975-10|PHCS1|1234567893|LOCKLEAR, HEATHER|20100930|410.00|2010-11-23|
A^^This claim has been accepted for further processing^^^|NA|ACK|CLM_001|AVAILITY LLC|DOCTOR,
 INDIVIDUAL|PHC TEXAS|240076456_0||
```

Delayed payer report (DPT) - readable format

The DPT format of the Delayed Payer Report provides the same information as the pipe-delimited format, but in a readable format. The layout of the report is as follows:

```
Availity Customer ID: <<0>>
                          Availity Delayed Payer Report
------------------------------------------------------------------------
Date Received:          <<1>>            Time Received:       <<2>>
Availity Batch ID:      <<3>>            File Control Number: <<4>>
Availity File ID:       <<5>>
File Name:              <<6>>
------------------------------------------------------------------------
----5----10---15---20---25---30---35---40---45---50---55---60---65---70---75---8
Patient Account Number: <<7>>            Total Charges:       <<8>>
Patient Name:           <<9>>            Process Date:        <<10>>
From Date:              <<11>>           Status:              <<12>>
Billing Provider Name:  <<13>>           Billing Provider ID: <<14>>
Billing Provider NPI:   <<15>>           Submitter Name:      <<16>>
Payer Name:             <<17>>           Payer Claim Number:  <<18>>
Payer ID:               <<19>>           Payer Seq Number:    <<20>>
Availity Batch ID:      <<21>>           Trace ID:            <<22>>
Claim Sequence #:       <<23>>
Message Type:           <<24>>           Message Code:        <<25>>
Message Loop:           <<26>>           Message Segment:     <<27>>
Message Element:        <<28>>
Message Text:           <<29>>
```

Descriptions of fields in the DPT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Date Received	Date response received: CCYY-MM-DD
2	Time Received	Time response received: HH.MM.SS.SSS
3	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
4	File Control Number (Interchange Control Number)	ISA13 on submitted file
5	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
6	File Name	Original incoming file name: EXCHANGE_FILENAME
7	Patient Account Number	2300 CLM01
8	Total Charges	2300 CLM02; 9,999.99 format
9	Patient Name	2010BA/CA NM103, NM104 Max length = 25 If Patient Loop 2010CA is present and different from the Subscriber loop, the Patient NM103, NM104 is displayed. The last name will be included in its entirety then the remaining bytes will reflect the first name.
10	Process Date	Date response was processed by Availity: CCYY-MM-DD
11	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
12	Status	ACK | REJ
13	Billing Provider Name	2010BB, NM103

Field number	Field	Note
14	Billing Provider ID	2010BB, NM109
15	Billing Provider NPI	NA (it is provided in the above field or is absent for nontraditional providers)
16	Submitter Name	1000A, NM103
17	Payer Name	Availity database payer name associated with payer ID
18	Payer Claim Number	If provided in payer response, else NA
19	Payer ID	2010BB- NM109 - Professional 2010BC – NM109 - Institutional
20	Payer Seq Number	NA – Availity does not create this sequence
21	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
22	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
23	Claim Sequence #	NA – Availity doesn't create a claim sequence number
24	Message Type	A | R | W | I
25	Message Code	If provided, else NA
26	Message Loop	Loop
27	Message Segment	Segment ID
28	Message Element	Element number
29	Message Text	Claim error message

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow U.S. currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Delayed Payer Report (DPT) example

```
Availity Customer ID:  0015515
                            Availity Delayed Payer Report
--------------------------------------------------------------------------------
Date Received:          2010-11-23          Time Received:          13.30.22.022
Availity Batch ID:      2010112313302000    File Control Number:    101019034
Availity File ID:       2010112313302000
File Name:              PhysiciansHC_837P.txt
--------------------------------------------------------------------------------
Patient Account Number:CN1975-10            Total Charges:          410.00
Patient Name:           LOCKLEAR, HEATHER   Process Date:           2010-11-23
From Date:              20100930            Status:                 ACK
Billing Provider Name: DOCTOR, INDIVIDUAL   Billing Provider ID:    1234567893
Billing Provider NPI:  NA                   Submitter Name:         Availity LLC
Payer Name:             PHC TEXAS           Payer Claim Number:     NA
Payer ID:               PHCS1               Payer Seq Number:       NA
Availity Batch ID:      2010112313302000    Trace ID:               240076456_0
Claim Sequence #:       NA
Message Type:           A                   Message Code:           NA
Message Loop:           NA                  Message Segment:        NA
Message Element:        NA
Message Text:           This claim has been accepted for further processing
--------------------------------------------------------------------------------
                                  END OF REPORT
--------------------------------------------------------------------------------
```

Interpret DPR files

Periodically check your **ReceiveFiles** mail box for new delayed payer report (DPR) file items and interpret them to determine if delayed errors occurred at the payer level.

- If a DPR with a .dpt extension is present, open that file. It's a readable text report. The DPR file ending in .dpr is the data file, intended to be imported into your system.
- The following two fields display in the first section (coinciding with line 1 in a data file):
  - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
  - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- The DPR may include multiple messages for rejects, warnings, and informational messages.
- If a DPR indicates the payer rejects any claims, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims or claims with warning or informational messages in the file.
- You can download the text file to your computer or print it.

  Note: The administrator can select to receive the text file in a summary or detail format. The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
- If you encounter problems interpreting errors in the DPR and cannot resolve them yourself, contact the payer for assistance.

Health care services review (278ebr) summary text report

In addition to the 278 ANSI ASC X12N response transactions, Availity also produces the Health Care Services Review (278ebr) summary text report.

278 summary text report layout, with errors, with HIPAA segment information

When errors are received as the response to the 278 request batch transaction, the layout of the report is as shown in the following table.

Date Received:		**Time Received:**	
Availity Batch ID:		**File Control Number:**	
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Patient Tracking Number:			
Patient Name:	**Sub**: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820) **Dep**: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)	**Patient Date of Birth:**	**Sub**: 2010CA – DMG02 (DMG_0960) **Dep**: 2010DA – DMG02 (DMG_1320)
Member ID:	**Sub**: 2010CA – NM109 (NM1_0820) **Dep**: 2010DA – NM109 (NM1_1190)	**Patient Gender:**	**Sub**: 2010CA – DMG03 (DMG_0960) **Dep**: 2010DA – DMG03 (DMG_1320)
Subscriber Name:	2010CA – NM103, NM104, NM105, NM107 (NM1_0820)	**Supplemental ID:**	**Sub:** 2010CA – REF02 (REF_0830) **Dep:** 2010DA – REF02 (REF_1200)
Error Message:			
Error Code			
Loop:			
Message: 2000E – MSG01 (MSG_1510)			

278 summary text report layout, no errors, with HIPAA segment information

When the 278 request transaction has passed all HIPAA validation, it is sent to the payer. The payer responds with the 278 Health Care Services Review response transactions. The layout of the report is as shown in the following table.

Date Received:		**Time Received:**	
Availity Batch ID:		**File Control Number:**	
HCSR(s) Received:		**HCSR(s) Accepted:**	
Message 2000E – MSG01 (MSG_1510)			
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Patient Tracking Number:			
Patient Name:	**Sub**: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820) **Dep**: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)	**Patient Date of Birth:**	**Sub**: 2010CA – DMG02 (DMG_0960) **Dep**: 2010DA – DMG02 (DMG_1320)
Member ID:	**Sub**: 2010CA – NM109 (NM1_0820) **Dep**: 2010DA – NM109 (NM1_1190)	**Patient Gender:**	**Sub**: 2010CA – DMG03 (DMG_0960) **Dep**: 2010DA – DMG03 (DMG_1320)
Subscriber Name:	2010CA – NM103, NM104, NM105, NM107 (NM1_0820)	**Supplemental ID:**	**Sub:** 2010CA – REF02 (REF_0830) **Dep:** 2010DA – REF02 (REF_1200)
Certification #:	2000F – HCR02 (HCR_1700)	**Status:**	2000F – HCR01 (HCR_1700)
Type of Service #1:	2000F – UM03 (UM_1690) – 1st loop		
Type of Service #2:	2000F – UM03 (UM_1690) – 2nd loop		
Type of Service #3:	2000F – UM03 (UM_1690) – 3rd loop		

Type of Service #4:	2000F – UM03 (UM_1690) – 4th loop		
Admission Date:	2000F – DTP03 (DTP_1730)	**Service Date:**	2000F – DTP03 (DTP_1720)
Effective Date:	2000F – DTP03 (DTP_1780)		
Expiration Date:	2000F – DTP03 (DTP_1770)	**Certification Date:**	2000F – DTP03 (DTP_1760)
Referred by Provider			
Name:	2010B - NM103, NM104, NM105, NM107 (NM1_0480)		
Tax ID:	2010B – NM109 (NM1_0480)		
Payer Assigned ID:	2010B - REF02 (REF_0490)		
Referred to Provider/ Facility	(This loop can repeat up to 10 times.)		
Name:	2010E - NM103, NM104, NM105, NM107 (NM1_1520)		
Tax ID:	2010E – NM109 (NM1_1520)		
Payer Assigned ID:	2010E - REF02 (REF_1530)		
Lab & Clinical Information:	2000F – MSG01 (MSG_1910)		

Proprietary payer report

For UCare and Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are direct pass through without any mapping or editing by Availity.