Availity® Health Information Network

Batch Electronic Data Interchange (EDI) Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

November 2020
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.

The listing of an organization in this document does not imply any sort of endorsement, and Availity takes no responsibility for the third-party products, tools, and Internet sites listed. The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by Availity.
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:
This page is intentionally left blank.
# Table of contents

1 Introduction.................................................................................................................................................7
   Scope.........................................................................................................................................................7
   Overview....................................................................................................................................................7
   Benefits......................................................................................................................................................7
   Supported EDI transactions......................................................................................................................8

2 Getting started........................................................................................................................................... 9
   Trading Partner Registration.....................................................................................................................9

3 Availity trading partner QA testing.......................................................................................................... 10

4 Connectivity with the payer/communications.......................................................................................... 11
   EDI file submission methods..................................................................................................................11
   EDI transactions through FTP................................................................................................................ 12
   EDI transactions through Availity Portal................................................................................................. 23
   Set up EDI reporting preferences...........................................................................................................31
   Restore archived files............................................................................................................................. 42
   Tips for successful batch file submissions............................................................................................. 45
   System status, scheduled maintenance, and cut-off times....................................................................47
   Confidentiality and access, transaction platforms and deletion of transactions.................................48
   Transaction response aggregation..........................................................................................................49

5 Contact information..................................................................................................................................50
   Availity Client Services............................................................................................................................50

6 Control segments/envelopes................................................................................................................... 51
   Interchange Control Header (ISA) and Interchange Control Trailer (IEA) segments.........................51
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

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

1 Files over 12 megabytes with large checks might not be validated.

### Additional Availity EDI Companion Guides

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

---

© Availity, LLC, all rights reserved | Confidential and proprietary.
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 Portal registration

When we have processed the application, we send a confirmation by email to the administrator. The first time you log in to Availity Portal, 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 Portal, they can set up authorized personnel in the office as Availity Portal users. Each user must have a unique user ID and password. Availity does not allow users to share login credentials.
Availity trading partner QA testing

Availity gives you the option of setting up an account in our QA environment so that you can do integration testing with Availity before you submit any real transactions. Integration testing ensures that your translated HIPAA ASC X12N transactions can pass HIPAA standards validation and any applicable payer-specific edits that Availity performs on the payer's behalf.

Integration testing is coordinated through Availity Client Services (ACS) at no charge to the submitter. When you're ready to start testing, please call an Availity Client Services representative at 1.800.AVAILITY (282.4548) to set up a test account. ACS will send your request to our implementations area and an implementation analyst will contact you to facilitate your Availity implementation.

Note:

- End-to-end testing requires coordination with the payer, and not all payers support end to end testing. If you want end-to-end testing, contact Availity Client Services.
- Availity processes all transactions submitted to the QA environment as test transactions. Although Availity might forward test transactions to the payer's test environment, the payer does not process them for payment.
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 Portal

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 Portal.

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, are optional.

1. **Register with Availity** - If you haven’t already registered your organization with Availity, 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. **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 13 for details.

3. **Create your Availity FTP account** - See Create an Availity FTP account on page 15 for details.

4. **Configure your FTP client** - See Configure an FTP client on page 17 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 31 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 Portal users** - If other people in your organization need access to Availity Portal, such as to view remittance advice information, you'll need to create an Availity Portal account for each such person. Log in to Availity Portal at https://apps.availity.com, click your name or the avatar icon in the Availity Portal 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 13
2. **Configure an FTP client for QA** on page 14

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 Portal. 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 Portal 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:

2. In the Availity Portal menu, 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**.

![Create Account Form]

**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 Portal 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 Portal. 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 Portal 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:


2. In the Availity Portal menu, 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**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Host</td>
<td>ftp.availity.com</td>
</tr>
<tr>
<td>Port</td>
<td>9922 (typically used for SFTP)</td>
</tr>
<tr>
<td>Protocol or server type</td>
<td>Select the appropriate option in your FTP client software for Secure File Transfer Protocol (SFTP), if available and/or applicable. For example, <strong>SFTP - SSH File Transfer Protocol</strong>.</td>
</tr>
<tr>
<td>Logon type</td>
<td>If there is an option for the logon type, select normal.</td>
</tr>
<tr>
<td>User</td>
<td>The user name for your Availity FTP account.</td>
</tr>
<tr>
<td>Password</td>
<td>The password for your Availity FTP account.</td>
</tr>
</tbody>
</table>

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 Portal. 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 Portal 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:

   
   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 Portal menu, 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 73.

**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, Electronic Batch Reports, and Delayed Payer Reports.

- Acknowledgements identify file-level issues.
- Immediate Batch Reports, 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 61.

   **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 Portal

Setup steps for EDI through Availity Portal

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

1. **Register with Availity** - If you haven't already registered your organization with Availity, go to [www.availity.com](http://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. **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 25 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 31 for details.

4. **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.
5. **Set up your Availity Portal users** - If other people in your organization need access to Availity Portal, such as to view remittance advice information, you'll need to create an Availity Portal account for each such person. Log in to Availity Portal at [https://apps.availity.com](https://apps.availity.com), click your name or the avatar icon in the Availity Portal 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 Portal, 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 Portal 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 Portal

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

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

1. In the Availity Portal menu, 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 **Send Files** folder indicating whether a batch file was accepted for processing. For details, see the topic on the **Notification file** on page 73.

**Important:** Availity removes and archives the notification files from the **Send Files** folder each night, whether or not they've been downloaded.
Download EDI response files from Availity Portal

Availity's batch EDI processing generates response files for each batch file that you submit. When you're manually uploading batch files through Availity Portal, 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.

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

- Acknowledgements identify file-level issues.
- Immediate Batch Reports, 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 Portal you'll need to have both cookies and javascript enabled in your browser.

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

1. In the Availity Portal menu, 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**.

![Send And Receive EDI Files](image)
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 ![Tools Icon](image) 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 61.
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.

To set EDI reporting preferences, follow these steps:

1. In the Availity Portal 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.**

<table>
<thead>
<tr>
<th>Claims</th>
<th>Claim Payment / Advice</th>
<th>Non-Claim Transactions</th>
<th>Mail Box Options</th>
</tr>
</thead>
</table>

### File Acknowledgements

- **Type:** ?
  - Negative file acknowledgements (Required)

- **Format:** ?
  - Delimited (.ACK)
  - Text - Human readable (.ACT)

### Interchange Acknowledgements (TA1)

- **Type:** ?
  - Negative interchange acknowledgements (Required)

  **Note:** To receive a positive interchange acknowledgement, (TA1), you must set the value of the ISA14 to '1' in the batch file.

- **Format:** ?
  - X12 (.TA1)
  - Text - Human readable (.TAT)

  **Note:** Format selection applies to both Negative and Positive Interchange Acknowledgements.

### Options

- **Save**
- **Restore Default Settings**
- **Cancel**

- 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)
- 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 of the X12 file, particularly errors caused by duplicate interchange control numbers or an incorrect trading partner envelope.

<table>
<thead>
<tr>
<th>Interchange Acknowledgements (TA1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type:</strong> ?</td>
</tr>
<tr>
<td><strong>Format:</strong> ?</td>
</tr>
<tr>
<td>- Negative interchange acknowledgements (Required)</td>
</tr>
<tr>
<td>Note: To receive a positive interchange acknowledgement, (TA1), you must set the value of the ISA14 to '1' in the batch file.</td>
</tr>
<tr>
<td>- X12 (.TA1)</td>
</tr>
<tr>
<td>- Text - Human readable (.TAT)</td>
</tr>
<tr>
<td>Note: Format selection applies to both Negative and Positive Interchange Acknowledgements.</td>
</tr>
</tbody>
</table>

- 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.

- 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 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.

#### Delayed Payer Reports (DPR)

```
* Format: ?
  □ Data Report (.DPR)
  □ Text Report (.DPT)
  □ Summary Report (.DPT)
  □ Detail Report (.DPT)
  □ 277CA (.277DPR)

Grouped by: ?
All responses destined for an organization by payer ▼

Delivery: ?
  □ Immediate
  □ Scheduled Response
```

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 30 days, whether or not they've been downloaded. You can, however, restore any files archived from your ReceiveFiles folder within the past 6 months without having to contact Availity Client Services. And you can actually restore up to 2,000 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 Portal menu, click Claims & Payments > File Restore (under EDI Clearinghouse)

![Availity Portal menu with File Restore highlighted]

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

![File Restore page]

**Find files...**

- **Organization:** Availity Test Org
- **Batch Id:** Ex. 12345678901234

![File Restore page with search bar]

**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 30 days, whether or not they've been downloaded. You can, however, restore any files archived from your ReceiveFiles folder within the past 6 months without having to contact Availity Client Services. And you can actually restore up to 2,000 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 Portal menu, click Claims & Payments > File Restore (under EDI Clearinghouse)

![Availity Portal menu with File Restore highlighted]

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

![File Restore page]

**Find files...**

- **Organization:** Availity Test Org
- **Batch Id:** Ex. 12345678901234

![File Restore page with search bar]
3. By default, the Basic tab is selected on the File Restore page. As shown in the figure above, the Basic tab allows you to search for a single file by batch ID. To search for one or more files by date range, file type, and/or keywords, click the Advanced tab.
4. Whether you're searching from the **Basic** tab or from the **Advanced** tab, enter search criteria in the fields provided, and then click **Search**.

Consider the following guidelines when you're searching from the **Advanced** tab:

- **Selecting a date range** – Click the calendar button to select the date range.
  - Click one of the pre-defined date ranges, or click **Custom Range** to specify a custom date range.
  - For custom date ranges, click the start date and end date in the calendars provided, and then click **Apply**.

- **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 and case-sensitive.

- **Restoring as individual or zip files** – Click **Individual Files** to restore each file individually, or click **Zip File** to restore the files in a ZIP 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.

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

**Note:** Click **Back to Search** to change your search criteria.

The results page displays the EDI files that were restored. Click **Receive Files** on the results page to view the restored EDI files.
Tips for successful batch file submissions

• Need information about how electronic professional claims match up to paper CMS-1500 forms? See this quick reference guide.

• 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 (ICN). 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 Portal. 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 Response (IBR) (If you have chosen to receive the IBR) 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 Portal and submit an online support ticket (24/7) by navigating to Help & Training > Availity Support, at the top of Availity Portal. Or, contact an Availity Client Services representative at 1.800.AVAILITY (282.4548).

Hours of operation: Monday through Friday

<table>
<thead>
<tr>
<th>Eastern Time Zone</th>
<th>Central Time Zone</th>
<th>Mountain Time Zone</th>
<th>Pacific Time Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 a.m. to 8:00 p.m.</td>
<td>7:00 a.m. to 7:00 p.m.</td>
<td>6:00 a.m. to 6:00 p.m.</td>
<td>5:00 a.m. to 5:00 p.m.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Usage</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data element separator</td>
<td>* Asterisk</td>
</tr>
<tr>
<td>Sub-element separator</td>
<td>: Colon</td>
</tr>
<tr>
<td>Segment terminator</td>
<td>~ Tilde</td>
</tr>
<tr>
<td>Repetition separator (5010)</td>
<td>^ Caret</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Usage</th>
<th>Specifications</th>
<th>Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Information Qualifier</td>
<td>Code to ID the type of information in the authorization</td>
<td>• Required&lt;br&gt;• Length: 2/2&lt;br&gt;• Required Value: 00 = No Authorization Information Present&lt;br&gt;<strong>Note:</strong> For EDI batch mode, login credentials are not provided in the ISA header.</td>
<td>ISA01</td>
</tr>
<tr>
<td>Authorization Information</td>
<td>Info used for identification or authorization of the sender or the data interchange</td>
<td>• Required&lt;br&gt;• Length: 10/10&lt;br&gt;• Required Value: (10 blank spaces)</td>
<td>ISA02</td>
</tr>
<tr>
<td>Security Information Qualifier</td>
<td>Code to ID the type of information in the Security Info</td>
<td>• Required&lt;br&gt;• Length: 2/2&lt;br&gt;• Required Value: 00 = No Security Information Present&lt;br&gt;<strong>Note:</strong> For EDI batch mode, login credentials are not provided in the ISA header.</td>
<td>ISA03</td>
</tr>
<tr>
<td>Security Information</td>
<td>Info used for identifying security information about the sender or the data interchange</td>
<td>• Required&lt;br&gt;• Length: 10/10&lt;br&gt;• Required Value: (10 blank spaces)</td>
<td>ISA04</td>
</tr>
<tr>
<td>Interchange ID Qualifier</td>
<td>Qualifier to denote the system/method of code structure used to designate the sender</td>
<td>• Required&lt;br&gt;• Length: 2/2&lt;br&gt;• Required Value: ZZ = Mutually Defined</td>
<td>ISA05</td>
</tr>
<tr>
<td>Field</td>
<td>Usage</td>
<td>Specifications</td>
<td>Segment</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| 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   |
### Acknowledgement Requested
Code sent by the sender to request an interchange acknowledgement (TA1)

- Required
- Length: 1/1
- Recommended Value = 1

### 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)

### 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.

### 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]

#### 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

<table>
<thead>
<tr>
<th>Field</th>
<th>Usage</th>
<th>Specifications</th>
<th>Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Included</td>
<td>A count of the number of functional groups included in the interchange</td>
<td>• Required</td>
<td>IEA01</td>
</tr>
<tr>
<td>Functional Groups</td>
<td></td>
<td>• Field Length: 1/5</td>
<td></td>
</tr>
<tr>
<td>Interchange Control</td>
<td>A control number assigned by the sender</td>
<td>• Required</td>
<td>IEA02</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td>• Field Length: 9/9 (same as ISA13)</td>
<td></td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Usage</th>
<th>Specifications</th>
<th>Segment</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Field</th>
<th>Usage</th>
<th>Specifications</th>
<th>Segment</th>
</tr>
</thead>
</table>
| 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.

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Segment</th>
<th>Element Name</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000A</td>
<td>NM1</td>
<td>Submitter Name and ID</td>
<td>To supply the full name of an individual or organizational entity</td>
<td>Senders must submit the submitter name (NM103) and submitter identifier (NM109) assigned by the destination payer</td>
</tr>
</tbody>
</table>
| 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 (UserName/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:

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

The following table displays the CORE Phase II services supported by Availity:
<table>
<thead>
<tr>
<th>Service name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>realTimeTransaction</td>
<td>Submit a real time transaction, synchronous call.</td>
</tr>
<tr>
<td>batchSubmitTransaction</td>
<td>Submit a file to Availity for processing as an MTOM request. The payload contains an attachment to the web service call.</td>
</tr>
<tr>
<td>batchSubmitAckRetrievalTransaction</td>
<td>Retrieve a list of file names available for retrieval. The list of files, separated by a comma, is in the Response object, Payload element.</td>
</tr>
<tr>
<td>batchResultsRetrievalTransaction</td>
<td>Retrieve a single file (provide the file name in the payloadID) and receive the file as an MTOM attachment in the response.</td>
</tr>
</tbody>
</table>

For more information on CAQH CORE Phase II Operating rules, see [CAQH CORE Phase II 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) or interchange control trailer (IEA) 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, 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 or payer-specific edits (PSEs) 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 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.

<table>
<thead>
<tr>
<th>File name</th>
<th>Extension</th>
<th>837</th>
<th>835</th>
<th>270/271</th>
<th>276/277</th>
<th>278/278</th>
<th>278N/278N</th>
<th>275</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Acknowledgement</td>
<td>.ACK</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>File Acknowledgement Readable</td>
<td>.ACT</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Interchange Acknowledgement (TA1)</td>
<td>.TA1</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Interchange Acknowledgement Readable (TA1)</td>
<td>.TAT</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Implementation Acknowledgement (999)</td>
<td>.999</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Implementation Acknowledgement-Readable (999)</td>
<td>.99T</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immediate Batch Response-Pipe Delimited Data</td>
<td>.ibr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immediate Batch Response-Readable Report</td>
<td>.ibt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Electronic Batch Report-Pipe Delimited Data</td>
<td>.ebr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Electronic Batch Report-Readable Report</td>
<td>.ebt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Delayed Payer Report ^</td>
<td>.dpr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

^ Received from selected payers only
<table>
<thead>
<tr>
<th>File name</th>
<th>Extension</th>
<th>837</th>
<th>835</th>
<th>270/271</th>
<th>276/277</th>
<th>278/278</th>
<th>278N/278N</th>
<th>275</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Payer Report</td>
<td>.dpt</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Services Review</td>
<td>.278ebr</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Text Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic Remittance Advice</td>
<td>.era</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>X12 Paired Response Transaction</td>
<td>.271</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X12 Paired Response Transaction</td>
<td>.277</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X12 Paired Response Transaction</td>
<td>.278</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>X12 Paired Response Transaction</td>
<td>.278N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Response file and ERA file naming conventions

Response file naming conventions

<table>
<thead>
<tr>
<th>File type</th>
<th>Naming convention</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Acknowledgement (ACK)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.ACK</td>
</tr>
<tr>
<td>File Acknowledgement-Readable (ACT)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.ACT</td>
</tr>
<tr>
<td>Interchange Acknowledgement (TA1)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.TA1</td>
</tr>
<tr>
<td>Interchange Acknowledgement-Readable (TAT)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.TAT</td>
</tr>
<tr>
<td>Implementation Acknowledgement (999)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.999</td>
</tr>
<tr>
<td>Implementation Acknowledgement-Readable (99T)</td>
<td>&lt;&lt;Availity Batch ID&gt;&gt;.99T</td>
</tr>
<tr>
<td>Immediate Batch Response (IBR)</td>
<td>IBR-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.ibr</td>
</tr>
<tr>
<td>Immediate Batch Response-Readable (IBT)</td>
<td>IBT-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.ibt</td>
</tr>
<tr>
<td>Health care claim acknowledgement - 277CA (277IBR)</td>
<td>277CA-&lt;&lt;CCYYMMDDHHMMSS&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.277ibr</td>
</tr>
<tr>
<td>File type</td>
<td>Naming convention</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Electronic Batch Report (EBR)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td>All responses for an organization by payer</td>
</tr>
<tr>
<td></td>
<td>Default: EBR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;&gt;.ebr</td>
</tr>
<tr>
<td></td>
<td>All responses for an organization, multiple payers</td>
</tr>
<tr>
<td></td>
<td>EBR-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;&gt;.ebr</td>
</tr>
<tr>
<td></td>
<td>All responses for a provider by payer</td>
</tr>
<tr>
<td></td>
<td>• EBR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;-&lt;&lt;Tax ID&gt;&gt;.ebr</td>
</tr>
<tr>
<td></td>
<td>• EBR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;-&lt;&lt;Tax ID&gt;-&lt;&lt;NPI&gt;&gt;.ebr</td>
</tr>
<tr>
<td></td>
<td>All responses for a provider, multiple payers</td>
</tr>
<tr>
<td></td>
<td>• EBR-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;-&lt;&lt;Tax ID&gt;&gt;.ebr</td>
</tr>
<tr>
<td></td>
<td>• EBR- MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;-&lt;&lt;seq#&gt;-&lt;&lt;Tax ID&gt;-&lt;&lt;NPI&gt;&gt;.ebr</td>
</tr>
<tr>
<td>File type</td>
<td>Naming convention</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Electronic Batch Report-Readable (EBT)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization by payer</strong></td>
</tr>
<tr>
<td></td>
<td>Default: EBT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;.ebt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>EBT-MULTIPAYER-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;.ebt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider by payer</strong></td>
</tr>
<tr>
<td></td>
<td>• EBT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.ebt</td>
</tr>
<tr>
<td></td>
<td>• EBT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.ebt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>• EBT-MULTIPAYER-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.ebt</td>
</tr>
<tr>
<td></td>
<td>• EBT- MULTIPAYER-&lt;&lt;CCYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.ebt</td>
</tr>
<tr>
<td>Health care claim acknowledgement - 277CA (277EBR)</td>
<td>277CA-&lt;&lt;CCYMMDDHHMMSS&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.277ebr</td>
</tr>
<tr>
<td>File type</td>
<td>Naming convention</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Delayed Payer Report (DPR)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization by payer</strong></td>
</tr>
<tr>
<td></td>
<td>Default: DPR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;.dpr</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>DPR-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;.dpr</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider by payer</strong></td>
</tr>
<tr>
<td></td>
<td>• DPR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.dpr</td>
</tr>
<tr>
<td></td>
<td>• DPR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.dpr</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>• DPR-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.dpr</td>
</tr>
<tr>
<td></td>
<td>• DPR- MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.dpr</td>
</tr>
<tr>
<td>File type</td>
<td>Naming convention</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Delayed Payer Report-Readable (DPT)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization by payer</strong></td>
</tr>
<tr>
<td></td>
<td>Default: DPT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;.dpt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for an organization, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>DPT-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq##&gt;.dpt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider by payer</strong></td>
</tr>
<tr>
<td></td>
<td>• DPT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.dpt</td>
</tr>
<tr>
<td></td>
<td>• DPT-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.dpt</td>
</tr>
<tr>
<td></td>
<td><strong>All responses for a provider, multiple payers</strong></td>
</tr>
<tr>
<td></td>
<td>• DPT-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq##&gt;-&lt;Tax ID&gt;&gt;.dpt</td>
</tr>
<tr>
<td></td>
<td>• DPT- MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;seq##&gt;-&lt;Tax ID&gt;-&lt;NPI&gt;&gt;.dpt</td>
</tr>
<tr>
<td>Health care claim acknowledgement - 277CA (277DPR)</td>
<td>277CA-&lt;&lt;CCYYMMDDHHMMSS&gt;&gt;-&lt;&lt;SEQ##&gt;.277dpr</td>
</tr>
<tr>
<td>Eligibility Benefit Response (271)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td>• Default: 271-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ##&gt;.271</td>
</tr>
<tr>
<td></td>
<td>• 271-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ##&gt;-2100B NM109&gt;.271</td>
</tr>
<tr>
<td>File type</td>
<td>Naming convention</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Claim Status Response (277)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td>• Default: 277-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.277</td>
</tr>
<tr>
<td></td>
<td>• 277-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;2100B NM109&gt;&gt;.277</td>
</tr>
<tr>
<td>Health Care Services Review Response (278)</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td></td>
<td>• Default: 278-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.278</td>
</tr>
<tr>
<td></td>
<td>• 278-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;2100B NM109&gt;&gt;.278</td>
</tr>
<tr>
<td>Health Care Services Review Notification and</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td>Acknowledgement (278N)</td>
<td>• Default: 278N-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.278N</td>
</tr>
<tr>
<td></td>
<td>• 278N-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;2100B NM109&gt;&gt;.278N</td>
</tr>
<tr>
<td>Health Care Services Review Summary Text</td>
<td>One of the following based on selected grouping option:</td>
</tr>
<tr>
<td>Report (278ebr)</td>
<td>• Default: 278EBR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.278ebr</td>
</tr>
<tr>
<td></td>
<td>• 278EBR-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;2100B NM109&gt;&gt;.278ebr</td>
</tr>
</tbody>
</table>

Legend:

- **<<Availity Batch ID>>** – Availity assigned
- **<<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 same CCYYMMDDHHMM
### ERA file naming conventions

<table>
<thead>
<tr>
<th>Grouping option</th>
<th>Naming convention</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>One check per file</td>
<td>ERA-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.era</td>
<td>ERA-BCBS_OF_FL-200902201240-001.era</td>
</tr>
<tr>
<td>All checks destined for an organization by payer</td>
<td>ERA-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.era</td>
<td>ERA-BCBS_OF_FL-200902201240-001.era</td>
</tr>
<tr>
<td><strong>Note:</strong> This method is the default setting for all current 835 recipients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All checks for an organization from multiple payers</td>
<td>ERA-MULTIPAYER-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.era</td>
<td>ERA-MULTIPAYER-200902201240-001.era</td>
</tr>
<tr>
<td>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</td>
<td>ERA-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;.era</td>
<td>ERA-BCBS_OF_FL-200902201240-001-987654321.era</td>
</tr>
<tr>
<td>All checks for a provider by payer, and where every check in the file bears the same tax ID and same NPI</td>
<td>ERA-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;-&lt;&lt;Tax ID&gt;&gt;-&lt;&lt;NPI&gt;&gt;.era</td>
<td>ERA-BCBS_OF_FL-200902201240-001-987654321-1234567890.era</td>
</tr>
<tr>
<td>All checks for a provider by payer, and where at least two different tax IDs appear in the file</td>
<td>ERA-&lt;&lt;Payer Short Name&gt;&gt;-&lt;&lt;CCYYMMDDHHMM&gt;&gt;-&lt;&lt;SEQ#&gt;&gt;.era</td>
<td>ERA-BCBS_OF_FL-200902201240-001.era</td>
</tr>
<tr>
<td>Grouping option</td>
<td>Naming convention</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 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:
- ERA files from BCBSIL, BCBSNM, BCBSOK and BCBSTX are not aggregated with other ERAs, nor do they follow the naming convention described above. Rather, all of their ERA files include the .835 file extension, which may or may not be followed by additional characters, as in the following example: XXXXXXX.835.XX_XX_XXXXXXX_XXXX
- 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.

![Availity FTP server](image)

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 Portal 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 (ICN), 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 (ICN) 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 occurs 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 (ICN). 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.

**Example: File Acknowledgement**

```
1|2020-07-15|12.06.05.726||2009031511593700|300300557
1E|Availity does not recognize the interchange data starting at position 0 as valid.
```
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 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). 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.
## Interchange acknowledgement - format and examples

### Elements on the TA1 segment

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>HIPAA segment ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interchange Control Number</td>
<td>• Required</td>
<td>TA101</td>
</tr>
<tr>
<td></td>
<td>• Field Length: 9/9</td>
<td></td>
</tr>
<tr>
<td>Interchange Date</td>
<td>• Required</td>
<td>TA102</td>
</tr>
<tr>
<td></td>
<td>• Format: YYMMDD</td>
<td></td>
</tr>
<tr>
<td>Interchange Time</td>
<td>• Required</td>
<td>TA103</td>
</tr>
<tr>
<td></td>
<td>• Format: HHMM</td>
<td></td>
</tr>
<tr>
<td>Interchange Acknowledgement Code</td>
<td>• Required</td>
<td>TA104</td>
</tr>
<tr>
<td></td>
<td>• Field Length: 1/1</td>
<td></td>
</tr>
<tr>
<td>Interchange Note Code</td>
<td>• Required</td>
<td>TA105</td>
</tr>
<tr>
<td></td>
<td>• Field Length: 3/3</td>
<td></td>
</tr>
</tbody>
</table>

**Example: Interchange Acknowledgement (TA1)**

```
ISA*001*000*01*030240928*ZZ*AV09311993*190103*1440*^*00501*185486211*0*T*:~
TA1*219381897*181207*2204*R*025~
IEA*0*185486211~
```

**Example: Human readable Interchange Acknowledgement (TAT)**

```
AVAILITY TA1 INTERCHANGE ACKNOWLEDGEMENT

Customer ID: 0002176
Date Received: 2010-12-07
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
```
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, Availity 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. IK501 and AK901 = R.

- **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. IK501=R and AK901 = P.

- **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. IK501 and AK901 = A.

- 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 (ICN). 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**

<table>
<thead>
<tr>
<th>837 claim</th>
<th>999 acknowledgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISA</td>
<td>ISA</td>
</tr>
<tr>
<td>GS - 837</td>
<td>GS - 999</td>
</tr>
<tr>
<td>ST</td>
<td>ST</td>
</tr>
<tr>
<td><em>837</em>0001</td>
<td>AK1 (AK102 equals GS06 in the functional group being acknowledged)</td>
</tr>
<tr>
<td>SE</td>
<td>AK2 (AK202 equals ST02 in the transaction set being acknowledged)</td>
</tr>
<tr>
<td>ST</td>
<td>IK5</td>
</tr>
<tr>
<td><em>837</em>0002</td>
<td>AK2 (AK202 equals ST02 ...)</td>
</tr>
<tr>
<td>SE</td>
<td>IK5</td>
</tr>
<tr>
<td>GE</td>
<td>AK9</td>
</tr>
<tr>
<td>GE</td>
<td>SE</td>
</tr>
<tr>
<td>IEA</td>
<td>IEA</td>
</tr>
</tbody>
</table>

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.

**Example: 999 file rejected**

<table>
<thead>
<tr>
<th>ISA<em>00</em></th>
<th><em>00</em></th>
<th><em>01</em>030240928</th>
<th><em>ZZ</em>AV09311993<em>031204</em>1109<em>U</em>00501<em>00090091</em>0<em>P</em>:*~</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA1<em>000001732</em>031204<em>1101</em>A*000~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GS<em>FA</em>030240928<em>AV01101957</em>20031204<em>1109</em>80180<em>X</em>005010X231A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST<em>999</em>0001*005010X231A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK1<em>HC</em>17321*005010X223A2~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AR2<em>837</em>00000001*005010X223A2~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IK3<em>CL1</em>24<em>2300</em>8~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTX*CIM01:393931D_1310~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IK4<em>Z</em>1314<em>5</em>AA~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IK5<em>R</em>5~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK9<em>R</em>1<em>1</em>0~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SE<em>8</em>0001~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GE<em>1</em>80180~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IEA<em>1</em>000090091~</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example: 999 file accepted**

<table>
<thead>
<tr>
<th>ISA<em>00</em></th>
<th><em>00</em></th>
<th><em>01</em>030240928</th>
<th><em>ZZ</em>AV09311993<em>030306</em>1356<em>U</em>00501<em>000000000</em>0<em>P</em>:*~</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS<em>FA</em>030240928<em>AV01101957</em>20030306<em>1356</em>000000000<em>X</em>005010X231A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST<em>999</em>000000000*005010X231A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK1<em>HC</em>103136*005010X222A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AR2<em>837</em>000003136*005010X222A1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IK5*A~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK9<em>A</em>1<em>1</em>1~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SE<em>6</em>000000000~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GE<em>1</em>000000000~</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IEA<em>1</em>000000000~</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
Group Control #: 1                           Submitter ID: 1234567893
Transaction Set #: 0001                      Submitter: AVAILITY TEST ORG
Batch ID: 10103560                            Receiver: BCBSX
Batch Status: ACCEPT                         Receiver ID: 84980
Trans Type: 005010X222A1

*****************************************************************************

BATCH(S) ACCEPT: 1                          BATCH(S) REJ: 0
CLAIM(S) REJ: 0                              *

***** END OF REPORT *****
```
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.

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 (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||CCYYMMDDXXXXXXX - Availity Batch ID (assigned by Availity)|Inbound ISA13 value - File
Control Number|99999 - Total Submitted Claims|000000.00 - Total Submitted 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|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 # (will be NA in the IBR)|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

<table>
<thead>
<tr>
<th>Line 1 (ISA Level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 2 (Payer 1 Level Claim Rejects/Accepts) Repeat &gt; 1</td>
</tr>
<tr>
<td>Rejects =&gt; Line 3 (Claim Level) Repeat &gt; 1</td>
</tr>
<tr>
<td>Line 3e (Claim Level Error) Repeat &gt; 1</td>
</tr>
<tr>
<td>Accepts =&gt; Line 3 (Claim Level) Repeat &gt; 1</td>
</tr>
</tbody>
</table>

Immediate Batch Response (IBR)

1|2010-08-17|15.26.05.222|NA|2017029718498200|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|01||5010|
2|CIGNA|NA|NA|NA|NA|NA|NA|87726|
3|STAR, RINGO|20170927|20170927|888|230.00|1760438840|NA|NA|128799450_1|1464|A|
3|KEYS, PIANO|20170927|20170927|856301|230.00|1760438840|NA|NA|128799450_2|1464|A|
3|CHILDS, JULIA|20170927|20170927|856320|337.00|1760438840|NA|NA|NA|1464|R|
3e|HIPAA|R|3939612|HCPCS Procedure Code is invalid in Professional Service. Invalid data:
97072|2400|SV|01||1|5010|
2|HUMANA|NA|NA|NA|NA|NA|NA|87726|
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|
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).

**Immediate Batch Response (IBT) layout**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received:</td>
<td>Date the file was received</td>
</tr>
<tr>
<td>Time Received:</td>
<td>Time the file was received</td>
</tr>
<tr>
<td>Availity Batch ID:</td>
<td>Batch identifier for the file</td>
</tr>
<tr>
<td>File Control Number:</td>
<td>Control number for the file</td>
</tr>
<tr>
<td>Availity File ID:</td>
<td>File identifier for the file</td>
</tr>
<tr>
<td>File Name:</td>
<td>Name of the file</td>
</tr>
<tr>
<td>Submitted Claims:</td>
<td>Number of claims submitted</td>
</tr>
<tr>
<td>Accepted Claims:</td>
<td>Number of accepted claims</td>
</tr>
<tr>
<td>Rejected Claims:</td>
<td>Number of rejected claims</td>
</tr>
<tr>
<td>Payer Name: Payer #1:</td>
<td>Name of the payer</td>
</tr>
<tr>
<td>Payer ID:</td>
<td>Identification number for the payer</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>Name of the patient</td>
</tr>
<tr>
<td>Patient Control Number:</td>
<td>Control number for the patient</td>
</tr>
<tr>
<td>From Date:</td>
<td>Start date for the claims</td>
</tr>
<tr>
<td>To Date:</td>
<td>End date for the claims</td>
</tr>
<tr>
<td>Charge:</td>
<td>Amount billed</td>
</tr>
<tr>
<td>Provider Billing ID:</td>
<td>Identification number for the billing provider</td>
</tr>
<tr>
<td>Clearinghouse Trace #: Claim #1:</td>
<td>Trace identifier for the clearinghouse and claim number</td>
</tr>
<tr>
<td>Availity Trace #:</td>
<td>Trace identifier for the Availity</td>
</tr>
<tr>
<td>Error Initiator:</td>
<td>Initiator for the error</td>
</tr>
<tr>
<td>Segment ID:</td>
<td>Segment identifier for the error</td>
</tr>
<tr>
<td>Element #:</td>
<td>Element identifier for the error</td>
</tr>
<tr>
<td>Error Message:</td>
<td>Error message for the error</td>
</tr>
<tr>
<td>Version:</td>
<td>Version of the IBT format</td>
</tr>
<tr>
<td>Status:</td>
<td>Status of the batch response</td>
</tr>
</tbody>
</table>

---

November 2020 005010 | Page 84 of 105
© Availity, LLC, all rights reserved | Confidential and proprietary.
BATCH SUMMARY

Date Received: <<2>>  
Availity Batch ID: <<4>>  
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>>  
Provider Billing ID: <<23>>

From Date: <<20>>  
To Date: <<21>>

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>>  
Provider Billing ID: <<23>>

From Date: <<20>>  
To Date: <<21>>

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

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Availity Customer ID</td>
<td>Entity customer ID</td>
</tr>
<tr>
<td>1</td>
<td>Availity Messages</td>
<td>NA - at this time</td>
</tr>
<tr>
<td>2</td>
<td>Date Received</td>
<td>CCYY-MM-DD</td>
</tr>
<tr>
<td>3</td>
<td>Time Received</td>
<td>HH.MM.SS.SSS</td>
</tr>
<tr>
<td>4</td>
<td>Availity Batch ID</td>
<td>File name assigned by Availity: INTERNAL_FILENAME</td>
</tr>
<tr>
<td>5</td>
<td>File Control Number</td>
<td>ISA13:</td>
</tr>
<tr>
<td>6</td>
<td>Availity File ID</td>
<td>Availity assigned - DB_INSTANCE_NUM&lt;-&gt;DOCUMENT_SEQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example: 1-123456789</td>
</tr>
<tr>
<td>7</td>
<td>File Name</td>
<td>Original incoming file name: EXCHANGE_FILENAME</td>
</tr>
<tr>
<td>Field number</td>
<td>Field</td>
<td>Note</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>Submitted Claims</td>
<td>Count of 2300 CLM per ISA</td>
</tr>
<tr>
<td>9</td>
<td>Total Submitter Charges</td>
<td>Sum of all 2300 CLM02; 9,999.99 format</td>
</tr>
<tr>
<td>10</td>
<td>Accepted Claims</td>
<td>Count of 2300 CLM accepted per ISA</td>
</tr>
<tr>
<td>11</td>
<td>Total Accepted Charges</td>
<td>Sum of accepted 2300 CLM02; 9,999.99 format</td>
</tr>
<tr>
<td>12</td>
<td>Rejected Claims</td>
<td>Count of 2300 CLM rejected</td>
</tr>
<tr>
<td>13</td>
<td>Total Rejected Charges</td>
<td>Sum of rejected 2300 CLM02, 9,999.99</td>
</tr>
<tr>
<td>14</td>
<td>Payer Name</td>
<td>Availity payer name</td>
</tr>
<tr>
<td>15</td>
<td>Payer ID</td>
<td>2010BB NM109 (professional)</td>
</tr>
<tr>
<td>16</td>
<td>Submitter Batch ID</td>
<td>BHT03</td>
</tr>
<tr>
<td>17</td>
<td>Status</td>
<td>A</td>
</tr>
<tr>
<td>18</td>
<td>Patient Name</td>
<td>2010BA/CA NM103, NM104</td>
</tr>
<tr>
<td>19</td>
<td>Patient Control Number</td>
<td>2300 CLM01</td>
</tr>
<tr>
<td>20</td>
<td>From Date</td>
<td>2400 DTP03</td>
</tr>
<tr>
<td>21</td>
<td>To Date</td>
<td>2400 DTP03</td>
</tr>
<tr>
<td>22</td>
<td>Charge</td>
<td>2300 CLM02; 9,999.99 format</td>
</tr>
<tr>
<td>23</td>
<td>Provider Billing ID</td>
<td>2010AA NM109</td>
</tr>
<tr>
<td>24</td>
<td>Clearinghouse Trace #</td>
<td>2300 REF02 from inbound submitter REF*D9</td>
</tr>
<tr>
<td>25</td>
<td>Availity Trace #</td>
<td>Outbound REF*D9</td>
</tr>
<tr>
<td>Field number</td>
<td>Field</td>
<td>Note</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>Error Initiator</td>
<td>Availity</td>
</tr>
<tr>
<td>27</td>
<td>Loop</td>
<td>Loop ID</td>
</tr>
<tr>
<td>28</td>
<td>Segment ID</td>
<td>Segment ID</td>
</tr>
<tr>
<td>29</td>
<td>Element #</td>
<td>Element number</td>
</tr>
<tr>
<td>30</td>
<td>Error Message</td>
<td>Detailed claim error message</td>
</tr>
<tr>
<td>31</td>
<td>Version</td>
<td>5010</td>
</tr>
</tbody>
</table>

**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.

**Example: Immediate Batch Response (IBT)**

```plaintext
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```
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*AV010110957*20110517*1305*356254*X*005010X214~
ST*277*1001*05010X214~
BHT*0085*08*356255*20110517*130522*TH~
HL*1*2*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*09*239097104_16~
DTP*472*RD8*201100831~
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*05010X214~
BHT*0085*08*448850*20110524*164536*TH~
HL*1*2*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*QA*1~
AMT*YY*75~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*W1234567890~
TRN*2*20110549~
STC*A3:448*20110524*U*75********TRANSACTION SET HEADER IS INVALID. INVALID DATA 005010X222~
REF*D9*239745576_0~
DTP*472*RD8*201001001~
SE*26*1001~
GE*1*356254~
IEA*1*000356253~
```
**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 (ICN), 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 |
| 3a | Error Initiator | R | Error Code – if available, otherwise NA | Error Message | Loop | Segment ID | Element # | Version |
| 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|
```

**Example 2: Electronic Batch Report (EBR)**

```
1|2010-08-31|12.56.06.182|NA|20100831122541900|3699988180|0018155555|
2|Arkansas BCBS|1|0|75.00|0.00|1|75.00|00520|
3|DOE, JOHN|20101019|20101019|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|||
```
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.

Electronic Batch Report (EBT) layout

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Availity Customer ID</td>
<td>Entity customer ID</td>
</tr>
<tr>
<td>1</td>
<td>Date Received</td>
<td>CCYY-MM-DD</td>
</tr>
<tr>
<td>2</td>
<td>Time Received</td>
<td>HH.MM.SS.SSS</td>
</tr>
<tr>
<td>3</td>
<td>Availity Batch ID</td>
<td>File name assigned by Availity or Batch of One: INTERNAL_FILENAME</td>
</tr>
<tr>
<td>4</td>
<td>File Control Number</td>
<td>ISA13 on submitted file</td>
</tr>
<tr>
<td>5</td>
<td>Availity File ID</td>
<td>Availity assigned - DB_INSTANCE_NUM&lt;-&gt;DOCUMENT_SEQ Example: 1-123456789</td>
</tr>
<tr>
<td>6</td>
<td>File Name</td>
<td>Original incoming file name: EXCHANGE_FILENAME</td>
</tr>
<tr>
<td>7</td>
<td>Payer Name</td>
<td>Availity payer name</td>
</tr>
</tbody>
</table>

Descriptions of fields in the EBT layout
<table>
<thead>
<tr>
<th>Field number</th>
<th>Field</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Payer ID</td>
<td>2010BB NM109 (professional)</td>
</tr>
<tr>
<td>9</td>
<td>Claim Responses Returned</td>
<td>Count of responses for this payer breakdown</td>
</tr>
<tr>
<td>10</td>
<td>Charges</td>
<td>Total of related charges for this payer breakdown: 9,999.99 format</td>
</tr>
<tr>
<td>11</td>
<td>Accepted Claims</td>
<td>Count of accepted claims for this payer breakdown</td>
</tr>
<tr>
<td>12</td>
<td>Charges</td>
<td>Total of accepted charges for this payer breakdown: 9,999.99 format</td>
</tr>
<tr>
<td>13</td>
<td>Rejected Claims</td>
<td>Count of rejected claims for this payer breakdown</td>
</tr>
<tr>
<td>14</td>
<td>Charges</td>
<td>Total of rejected charges for this payer breakdown: 9,999.99 format</td>
</tr>
<tr>
<td>15</td>
<td>Patient Name</td>
<td>2010BA/CA NM103, NM104</td>
</tr>
<tr>
<td>16</td>
<td>From Date</td>
<td>2400 DTP03</td>
</tr>
<tr>
<td>17</td>
<td>To Date</td>
<td>2400 DTP03</td>
</tr>
<tr>
<td>18</td>
<td>Patient Control Number</td>
<td>2300 CLM01</td>
</tr>
<tr>
<td>19</td>
<td>Charge</td>
<td>2300 CLM02; 9,999.99 format</td>
</tr>
<tr>
<td>20</td>
<td>Provider Billing ID</td>
<td>2010AA NM109</td>
</tr>
<tr>
<td>21</td>
<td>Clearinghouse Trace #</td>
<td>2300 REF02 from inbound submitter REF*D9</td>
</tr>
<tr>
<td>22</td>
<td>Payer Claim #</td>
<td>If provided in payer response, else NA</td>
</tr>
<tr>
<td>23</td>
<td>Availity Trace #</td>
<td>Outbound REF*D9</td>
</tr>
<tr>
<td>Field number</td>
<td>Field</td>
<td>Note</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>24</td>
<td>Error Initiator</td>
<td>Availity</td>
</tr>
<tr>
<td>25</td>
<td>Message Type</td>
<td>A</td>
</tr>
<tr>
<td>26</td>
<td>Error Code</td>
<td>If provided, else NA</td>
</tr>
<tr>
<td>27</td>
<td>Loop</td>
<td>Loop</td>
</tr>
<tr>
<td>28</td>
<td>Segment ID</td>
<td>Segment ID</td>
</tr>
<tr>
<td>29</td>
<td>Element #</td>
<td>Element number</td>
</tr>
<tr>
<td>30</td>
<td>Error Message</td>
<td>Detailed claim error message</td>
</tr>
<tr>
<td>31</td>
<td>Version</td>
<td>5010</td>
</tr>
<tr>
<td>32</td>
<td>Bill Type</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>33</td>
<td>Allowed Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>34</td>
<td>Non-Covered Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>35</td>
<td>Deductible Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>36</td>
<td>Co-Pay Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>37</td>
<td>Co-Insurance Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
<tr>
<td>38</td>
<td>Withhold Amount</td>
<td>Adjudicated claim information returned by some real time payers.</td>
</tr>
</tbody>
</table>
### 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.

**Example: Electronic Batch Report (EBT)**

```plaintext
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
---------------------------------------------------------------------------------
```

November 2020 005010 | Page 95 of 105
© Availity, LLC, all rights reserved | Confidential and proprietary.
**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*PR*2*AVAILITY LLC*****46*030240928~
TRN*2*293907104~
STC*AI:120*20110517*WQ*259.5~
QTY*90*1~
AMT*YY*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME*****MI*K11111~
TRN*1*20110517150014602~
DTP*050*D8*20110526~
DTP*009*D8*20110526~
HL*2*1*21*1~
NM1*PR*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*AI:120*20110517*WQ*259.5~
QTY*90*1~
AMT*YY*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME*****MI*K11111~
```

**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*PR*2*AVAILITY LLC*****46*UB924010THIN~
TRN*1*0~
DTP*009*D8*20110526~
DTP*009*D8*20110526~
HL*2*1*21*1~
NM1*PR*2*AVAILITY LLC*****46*030240928~
TRN*2*85371405~
STC*AI:120*20110526*WQ*11591.49~
QTY*AA*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~
```

November 2020 005010 | Page 96 of 105
© Availity, LLC, all rights reserved | Confidential and proprietary.
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.

Example: 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.

Delayed Payer Report (DPT) layout

```
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>>
----------------------------------------------------------
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

<table>
<thead>
<tr>
<th>Field number</th>
<th>Field</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Availity Customer ID</td>
<td>Entity customer ID</td>
</tr>
<tr>
<td>1</td>
<td>Date Received</td>
<td>Date response received: CCYY-MM-DD</td>
</tr>
<tr>
<td>2</td>
<td>Time Received</td>
<td>Time response received: HH.MM.SS.SSS</td>
</tr>
<tr>
<td>3</td>
<td>Availity Batch ID</td>
<td>File name assigned by Availity or Batch of One: INTERNAL_FILENAME</td>
</tr>
<tr>
<td>4</td>
<td>File Control Number</td>
<td>ISA13 on submitted file</td>
</tr>
<tr>
<td>5</td>
<td>Availity File ID</td>
<td>Availity assigned - DB_INSTANCE_NUM-&gt;DOCUMENT_SEQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example: 1-123456789</td>
</tr>
<tr>
<td>6</td>
<td>File Name</td>
<td>Original incoming file name: EXCHANGE_FILENAME</td>
</tr>
<tr>
<td>7</td>
<td>Patient Account Number</td>
<td>2300 CLM01</td>
</tr>
<tr>
<td>8</td>
<td>Total Charges</td>
<td>2300 CLM02; 9,999.99 format</td>
</tr>
<tr>
<td>9</td>
<td>Patient Name</td>
<td>2010BA/CA NM103, NM104</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max length = 25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>10</td>
<td>Process Date</td>
<td>Date response was processed by Availity: CCYY-MM-DD</td>
</tr>
<tr>
<td>11</td>
<td>From Date</td>
<td>2400 DTP03</td>
</tr>
<tr>
<td>12</td>
<td>Status</td>
<td>ACK</td>
</tr>
<tr>
<td>13</td>
<td>Billing Provider Name</td>
<td>2010BB, NM103</td>
</tr>
<tr>
<td>14</td>
<td>Billing Provider ID</td>
<td>2010BB, NM109</td>
</tr>
<tr>
<td>Field number</td>
<td>Field</td>
<td>Note</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Billing Provider NPI</td>
<td>NA (it is provided in the above field or is absent for nontraditional providers)</td>
</tr>
<tr>
<td>16</td>
<td>Submitter Name</td>
<td>1000A, NM103</td>
</tr>
<tr>
<td>17</td>
<td>Payer Name</td>
<td>Availity database payer name associated with payer ID</td>
</tr>
<tr>
<td>18</td>
<td>Payer Claim Number</td>
<td>If provided in payer response, else NA</td>
</tr>
<tr>
<td>19</td>
<td>Payer ID</td>
<td>2010BB- NM109 - Professional</td>
</tr>
<tr>
<td>20</td>
<td>Payer Seq Number</td>
<td>NA – Availity does not create this sequence</td>
</tr>
<tr>
<td>21</td>
<td>Availity Batch ID</td>
<td>File name assigned by Availity or Batch of One: INTERNAL_FILENAME</td>
</tr>
<tr>
<td>22</td>
<td>Clearinghouse Trace #</td>
<td>2300 REF02 from inbound submitter REF*D9</td>
</tr>
<tr>
<td>23</td>
<td>Claim Sequence #</td>
<td>NA – Availity doesn't create a claim sequence number</td>
</tr>
<tr>
<td>24</td>
<td>Message Type</td>
<td>A</td>
</tr>
<tr>
<td>25</td>
<td>Message Code</td>
<td>If provided, else NA</td>
</tr>
<tr>
<td>26</td>
<td>Message Loop</td>
<td>Loop</td>
</tr>
<tr>
<td>27</td>
<td>Message Segment</td>
<td>Segment ID</td>
</tr>
<tr>
<td>28</td>
<td>Message Element</td>
<td>Element number</td>
</tr>
<tr>
<td>29</td>
<td>Message Text</td>
<td>Claim error message</td>
</tr>
</tbody>
</table>

**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.
Example: Delayed Payer Report (DPT)

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
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.

<table>
<thead>
<tr>
<th>Health care services review (278ebr) summary text report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received:</td>
</tr>
<tr>
<td>Time Received:</td>
</tr>
<tr>
<td>Availity Batch ID:</td>
</tr>
<tr>
<td>File Control Number:</td>
</tr>
<tr>
<td>Payer:</td>
</tr>
<tr>
<td>Type of Request:</td>
</tr>
<tr>
<td>2010A – NM103 (NM1_0200)</td>
</tr>
<tr>
<td>2000F – UM01 (UM_1690)</td>
</tr>
<tr>
<td>Patient Tracking Number:</td>
</tr>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Sub: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820)</td>
</tr>
<tr>
<td>Dep: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)</td>
</tr>
<tr>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Sub: 2010CA – DMG02 (DMG_0960)</td>
</tr>
<tr>
<td>Dep: 2010DA – DMG02 (DMG_1320)</td>
</tr>
<tr>
<td>Member ID:</td>
</tr>
<tr>
<td>Sub: 2010CA – NM109 (NM1_0820)</td>
</tr>
<tr>
<td>Dep: 2010DA – NM109 (NM1_1190)</td>
</tr>
<tr>
<td>Patient Gender:</td>
</tr>
<tr>
<td>Sub: 2010CA – DMG03 (DMG_0960)</td>
</tr>
<tr>
<td>Dep: 2010DA – DMG03 (DMG_1320)</td>
</tr>
<tr>
<td>Subscriber Name:</td>
</tr>
<tr>
<td>2010CA – NM103, NM104, NM105, NM107 (NM1_0820)</td>
</tr>
<tr>
<td>Supplemental ID:</td>
</tr>
<tr>
<td>Sub: 2010CA – REF02 (REF_0830)</td>
</tr>
<tr>
<td>Dep: 2010DA – REF02 (REF_1200)</td>
</tr>
<tr>
<td>Error Message:</td>
</tr>
<tr>
<td>Error Code</td>
</tr>
<tr>
<td>Loop:</td>
</tr>
<tr>
<td>Message: 2000E – MSG01 (MSG_1510)</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Message</th>
<th>2000E – MSG01 (MSG_1510)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer:</td>
<td>2010A – NM103 (NM1_0200)</td>
</tr>
<tr>
<td>Type of Request:</td>
<td>2000F – UM01 (UM_1690)</td>
</tr>
<tr>
<td>Payer:</td>
<td>2010A – NM103 (NM1_0200)</td>
</tr>
<tr>
<td>Type of Request:</td>
<td>2000F – UM01 (UM_1690)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Tracking Number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Sub: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820)</td>
</tr>
<tr>
<td></td>
<td>Dep: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)</td>
</tr>
<tr>
<td>Patient Date of Birth:</td>
<td>Sub: 2010CA – DMG02 (DMG_0960)</td>
</tr>
<tr>
<td></td>
<td>Dep: 2010DA – DMG02 (DMG_1320)</td>
</tr>
</tbody>
</table>

| 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 |
# Health care services review (278ebr) summary text report

<table>
<thead>
<tr>
<th>Type of Service #3:</th>
<th>2000F – UM03 (UM_1690) – 3rd loop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Service #4:</td>
<td>2000F – UM03 (UM_1690) – 4th loop</td>
</tr>
<tr>
<td>Admission Date:</td>
<td>2000F – DTP03 (DTP_1730)</td>
</tr>
<tr>
<td>Service Date:</td>
<td>2000F – DTP03 (DTP_1720)</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>2000F – DTP03 (DTP_1780)</td>
</tr>
<tr>
<td>Expiration Date:</td>
<td>2000F – DTP03 (DTP_1770)</td>
</tr>
<tr>
<td>Certification Date:</td>
<td>2000F – DTP03 (DTP_1760)</td>
</tr>
</tbody>
</table>

## Referred by Provider

<table>
<thead>
<tr>
<th>Name:</th>
<th>2010B - NM103, NM104, NM105, NM107 (NM1_0480)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID:</td>
<td>2010B – NM109 (NM1_0480)</td>
</tr>
<tr>
<td>Payer Assigned ID:</td>
<td>2010B - REF02 (REF_0490)</td>
</tr>
</tbody>
</table>

## Referred to Provider/Facility

(This loop can repeat up to 10 times.)

<table>
<thead>
<tr>
<th>Name:</th>
<th>2010E - NM103, NM104, NM105, NM107 (NM1_1520)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID:</td>
<td>2010E – NM109 (NM1_1520)</td>
</tr>
<tr>
<td>Payer Assigned ID:</td>
<td>2010E - REF02 (REF_1530)</td>
</tr>
</tbody>
</table>

## 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.