CSRA

a General Dynamics Information Technology, Inc. company

North Carolina Department of Health and Human Services (NC DHHS)

Division of Health Benefits (DHB)
Division of Mental Health (DMH)
Division of Public Health (DPH)

Standard Companion Guide Transaction Information Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010X220A1 Benefit Enrollment and Maintenance (834-O), for MMIS NCTracks starting July 1, 2013

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 31, 2022

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Preface

Companion Guides (CGs) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

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1. Transaction Instruction (TI) Introduction

1.1 BACKGROUND

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard. HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance According to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s)
- Change the meaning or intent of the standard’s implementation specification(s)

1.1.3 Compliance According to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide
- Modifying any requirement contained in the implementation guide

1.2 INTENDED USE

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

1.3 INTENDED AUDIENCE

This companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claims submissions to NCTracks. In addition, this information should be communicated to, and coordinated with, the provider’s billing office in order to ensure that the required billing information is provided to its billing agent/submitter.

1.4 PURPOSE OF COMPANION GUIDE

The companion guide is to be used with and to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guide is to provide trading partners with a guide to communicate NCTracks-specific information required to successfully exchange transactions.

The primary purpose of this document is to assist the trading partner with the appropriate use of the transactions; it is not intended to be a billing or policy guide.

1.5 ACKNOWLEDGMENTS

For all inbound transactions, a 999 Acknowledgment Report will be sent to the trading partner's 'OUTBOX' for retrieval. This report serves as the acknowledgment of the submission of a file. Typically, 999 Acknowledgment Reports are available within moments of submission.

1.6 TRADING PARTNER AGREEMENT SETUP

Refer to Section 2.2, Trading Partner Registration, of the NCTracks Trading Partner Connectivity Guide.

1.7 TESTING

North Carolina Department of Health and Human Services (NC DHHS) (DHB, DMH, and DPH) requires testing, or third-party certification, prior to approving a trading partner to submit claims in production. Once trading partner claims are in production, NC DHHS (DHB, DMH, and DPH) reserves the right to require re-testing if it is determined that the trading partner is receiving/generating an unacceptable volume of errors. Refer to Section 3, Testing and Certification Requirements, of the NCTracks Trading Partner Connectivity Guide.

2. Included ASC X12 Implementation Guides

The following table identifies the X12N Implementation Guides for all of the transactions supported by NCTracks. Companion guides are available for each of the transactions.

Section 3 of this document provides information specific to the 834 transaction, as defined in the 005010X220 Benefit Enrollment and Maintenance (834) Technical Report 3 (TR3) dated August 2006, and updated by:

- Errata 005010X220E1 Benefit Enrollment and Maintenance (834) dated January 2009
- Addenda 005010X220A1 Benefit Enrollment and Maintenance (834) dated June 2010

Unique ID	Name
005010X222	Health Care Claim: Professional (837P)
005010X223	Health Care Claim: Institutional (837I)
005010X224	Health Care Claim: Dental (837D)
005010X228	Health Care Claim Pending Status Information (277P)
005010X279	Health Care Eligibility Benefit Inquiry and Response (270/271)
005010X221	Health Care Claim Payment/Advice (835)
005010X212	Health Care Claim Status Request and Response (276/277)
005010X220	Benefit Enrollment and Maintenance (834)
005010X218	Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
005010X231	Implementation Acknowledgment for Health Care Insurance (999)

Pharmacy claims are submitted using the National Council for Prescription Drug Program's (NCPDP) D.0 format. Please refer to the D.0 Companion Guide for NCPDP D.0 claim formatting used by NCTracks.

3. Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend

Header rows: Midnight blue with white text
Subheader rows: Dandelion gold with black text
Table rows: Alternate row shading with Cornflower blue with black text

005010X220A1 Benefit Enrollment and Maintenance (Daily/Weekly/Monthly (EB) 834 Outbound)

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	‘00’ is sent
	ISA03	Security Information Qualifier	00	‘00’ is sent
	ISA05	Interchange ID Qualifier	ZZ	‘ZZ’ is sent
	ISA06	Interchange Sender ID		NCTRACKSBAT = Batch transaction
	ISA07	Interchange ID Qualifier	ZZ	‘ZZ’ is sent
	ISA08	Interchange Receiver ID		Receiver’s Electronic Transmitter Identifier Number (ETIN) is sent
Header	GS	Functional Group Header		
	GS01	Functional ID Code	BE	Benefit Enrollment and Maintenance (834)
	GS02	Application Sender’s Code		NCTRACKSBAT = Batch transaction
	GS03	Application Receiver’s Code		Receiver’s ETIN is sent
Header	BGN	Beginning Segment		
	BGN08	Action Code	2	‘2’ is sent
1000A	N1	Sponsor Name		
	N102	Name – Plan Sponsor Name		‘DHB’ is sent
	N103	Identification Code Qualifier	FI	‘FI’ is sent
	N104	Identification Code – Sponsor ID		Federal Taxpayer’s Identification Number is sent

Loop ID	Reference	Name	Codes	Notes/Comments
1000B	N1	Payer		
	N103	Identification Code Qualifier	FI	'FI' is sent
	N104	Identification Code – Insurer Identification Code		The Federal Taxpayer's identification of the receiver is sent. The Daily/Weekly/Monthly (EB) 834 Outbound sent to the Prepaid Health Plan (PHP) and the Enrollment Broker (EB) will include the current eligibility, future Eligibility, and past 24 months of eligibility. Refer to Section 4.3, Naming Standards for Outbound Transactions.
2000	INS	Member Level Detail		
	INS01	Yes/No Condition or Response Code	Y	'Y' is sent
	INS02	Individual Relationship Code	18	Self
	INS03	Maintenance Type Code	001 021 024	'001' is sent if there is a change or an update to the recipient record '021' is sent for new recipients '024' is sent when a recipient is terminated
	INS04	Maintenance Reason Code	20 22	'20' is sent if the recipient is Active '22' is sent if the recipient has a change
	INS06-1	Medicare Plan Code	D E	'D' is sent if the recipient has Medicare. Please see Loop 2320, COB segment for Medicare info. 'E' is sent if the recipient does not have Medicare
	INS08	Employment Status Code	AC	"AC" is sent for all records, as the enrollment is through a non-employment based program.
2000	REF	Subscriber Identifier		
	REF01	Reference Identification Qualifier	0F	'0F' is sent
	REF02	Reference Identification – Subscriber Identifier		The Recipient ID is sent in this segment
2000	REF	Member Policy Number		
	REF01	Reference Identification Qualifier	1L	'1L' is sent
	REF02	Reference Identification – Member Group or Policy Number		The recipient's System ID (NCTracks internal ID) is sent in this segment

Loop ID	Reference	Name	Codes	Notes/Comments
2000	REF	Member Supplemental Identifier		Loop 2000, REF segment, Member Supplemental Identifier, can repeat up to thirteen (13) times
	REF01	Reference Identification Qualifier	6O F6 ZZ	Cross Reference Number (there may be more than one(1) Cross Reference Number returned) Medicare MBI/HIC 'ZZ' is sent for the following values: • Tribal Code • Tribal Services Received Code • Authorized Representative Language • Case Head Language • Cost Sharing information
	REF02	Reference Identification		Tribal Code will have the label **TRIBE** Tribal Services Received Code will have the label **TRIBE SRV** and will return a 'Y' or 'N' response Authorized Representative Language will have the label **AUTHREPLANG** Case Head Language will have the label **CASEHDLANG** Cost Sharing will have the label **COST SHARING.** The first value will be the fiscal year of the Cost Sharing. The second value will return a 'Y' or 'N' value, indicating if the recipient is subject to Cost Sharing. If the recipient is subject to Cost Sharing, the third value will return a 'Y' or 'N' value, indicating if the recipient has met their maximum Cost Sharing. If the recipient has met their maximum Cost Sharing, the fourth value will contain the date the Cost Sharing was met. <u>Cost Sharing example:</u> REF*ZZ*COST SHARING FY2019-Y-Y-20190501~

Loop ID	Reference	Name	Codes	Notes/Comments
2000	DTP	Member Level Dates		Loop 2000, DTP segment, Member Level Dates, can repeat up to six (6) times
	DTP01	Date/Time Qualifier	473 474	'473' is sent for Medicaid Begin Date '474' is sent for Medicaid End Date Medicare Begin and End dates are sent in the 2320, DTP segment
2100A	NM1	Member Name		
	NM101	Entity Identifier Code	IL	Insured or Subscriber
	NM108	Identification Code Qualifier	34	'34' is sent
	NM109	Identification Code – Subscriber Identifier		When available, Social Security Number is sent
2100A	N3 and N4	Member Residence – Street Address, City, State, Zip Code		The recipient's address is sent. The Residential County is reported in Loop 2300, REF segment
2100A	DMG	Member Demographics		
	DMG05-1	Race or Ethnicity Code		NCTracks returns up to ten (10) occurrences of the ethnicity and race. The first byte is the ethnicity code, followed by up to nine (9) race codes
	DMG06	Citizenship Status Code		NCTracks returns the recipient's citizenship status code
2100A	LUI	Member Language		
	LUI01	Identification Code Qualifier	LE	'LE' is sent
2100G	NM1	Responsible Person		
	NM101	Entity Identifier Code	6Y 9K	The 'Eligibility Case Head' is returned 'Key Person' is returned when the Beneficiary has an authorized representative
	NM108	Identification Code Qualifier	ZZ	'ZZ' is sent
	NM109	Identification Code – Responsible Party Identifier		The CNDSID of the Case Head is sent

Loop ID	Reference	Name	Codes	Notes/Comments
2100G	N3 and N4	Responsible Person – Street Address, City, State, Zip Code		The Case Head address is sent
2300		HEALTH COVERAGE		The 2300 loop can occur up to 99 times. The loop occurrences will contain up to 10 years of health coverage data.
2300	HD	Health Coverage		
	HD03	Insurance Line Code		***See Appendix A for Insurance Line Code assignment***
	HD04	Plan Coverage Description		***See Appendix A for the Plan Coverage Description and the Benefit Plan to Health Plan crosswalk***
	HD05	Coverage Level Code	IND	'IND' is sent
2300	DTP	Health Coverage Dates		
	DTP01	Date/Time Qualifier	348 349	'348' is sent for Enrollment Begin date '349' is sent for Enrollment End date
	DTP02	Date /Time Period Format Qualifier	D8	'D8' is sent if Loop 2300, DTP01 equals qualifiers '348' or '349'
2300	AMT	Health Coverage Policy		Loop 2300, AMT, Health Coverage Policy, can repeat up to 9 times
	AMT01	Amount Qualifier Code	FK D2	'FK' is sent for Patient Monthly Liability (PML). Patient Monthly Liability is the monthly amount the beneficiary is expected to pay for their share of cost of care for certain Long Term Care living arrangements. 'D2' is sent for Deductible Balance. Deductible Balance applies to beneficiaries who have to meet a deductible/spenddown. The Deductible Balance is the amount remaining to meet the deductible on the date it is met and is only applicable to certain claims.
	AMT02	Monetary Amount – Contract Amount		The corresponding value is sent
2300	REF	Health Coverage Policy Number		Loop 2300, REF segment, Health Coverage Policy Number, can repeat up to fourteen (14) times
	REF01	Reference Identification Number	M7 ZX ZZ	'M7' is sent for the recipient's Category of Eligibility Code 'ZX' is sent for the Residential County Code 'ZZ' is sent for the following values: • Living Arrangement • Sub-Program Code 1, 2, 3, 4 • Eligibility Status Code • Administrative County • Managed Care Status

Loop ID	Reference	Name	Codes	Notes/Comments
				• Tailored Plan Eligibility Type • Indian Health Services (IHS)
	REF02	Reference Identification		• Residential County will have the label **RESCO** • Living Arrangement will have the label **LA** • Sub-Program Code 1, 2, 3, and/or 4 will have the labels: **SUBPGM1** **SUBPGM2** **SUBPGM3** **SUBPGM4** • Eligibility Status Code will have the label **ELIGSTAT** • Administrative County Code will have the label **ADMCO** • Managed Care Status will have the label **MCSTATUS** • Tailored Plan Eligibility Type will have the label **TLRD PLAN** • Indian Health Services (IHS) will have the label **IHS**
2310	LX	Provider Information		Loop 2310, LX segment, Provider Information, can repeat up to thirty (30) times. Loop 2310, LX segment, and the supporting segments will contain the following: • Pre-paid Health Plan-Standard Plan (PHP) Provider info • Primary Care Provider (PCP) Provider info • Managed Care AMH PCP Provider Info • Behavioral Health (LME MCO) • Tribal Option (TRIBAL OP) • Community Care of NC (CCNC) • Pre-paid Health Plan-Tailored Plan (PHPTP) • Tailored Care Manager (TCM)
2310	NM1	Provider Name		
	NM101	Entity Identifier Code	Y2 P3	'Y2' is returned for PHP, PHPTP, LME MCO, Tribal Option, and CCNC 'P3' is returned for PCP and Tailored Care Manager
	NM106	Name Prefix – Provider Name Prefix		• When the recipient is enrolled in a Pre-paid Health Plan-Standard Plan (PHP) Provider, 'PHP' is returned • When the recipient is assigned a Primary Care Provider (PCP) Provider, 'PCP' is returned • When the recipient is enrolled in Managed Care AMH PCP Provider, 'AMH PCP' is returned

Loop ID	Reference	Name	Codes	Notes/Comments
				• When the recipient is assigned a Behavioral Health (LME MCO) Provider, 'LME MCO' is returned • When the recipient is assigned Tribal Options, 'TRIBAL OP' is returned • When the recipient is assigned to Community Care of NC (CCNC), 'CCNC' is returned • When the recipient is assigned to Pre-paid Health Plan-Tailored Plan, 'PHPTP' is returned • When the recipient is assigned to Tailored Care Manager (TCM), 'TCM' is returned
	NM107	Name Suffix – Provider Name Suffix		The PHP, PHPTP, PCP, TCM, or LME MCO Location Code is returned **Note**: CCNC and Tribal Option location code is not returned.
	NM108	Identification Code Qualifier	SV XX	'SV' is returned for Atypical IDs 'XX' is returned for NPIs
	NM109	Identification Code – Provider Identifier		The Atypical ID or NPI is returned
2320	COB	Coordination of Benefits		Loop 2320, COB segment, Coordination of Benefits, can repeat up to 5 times. NCTracks will send COB in the following order of the 2320 loop: • Medicare Part A • Medicare Part B • Medicare Part C • Medicare Part D • Other Insurance
	COB01	Payer Responsibility Sequence Number Code	U	'U' is sent
	COB02	Reference Identification – Member Group or Policy Number		Medicare Part A, B, C or D contract number or other insurance Policy Number is sent
	COB03	Coordination of Benefits Code	1	'1' is sent
	COB04	Service Type Code		'48' is sent for Medicare Part A '1' is sent for Medicare Part B and C '89' is sent for Medicare Part D All other Service Type Codes are sent according to the COB service provided
2320	REF	Additional Coordination of Benefits		Loop 2320, REF segment, Additional Coordination of Benefits, can repeat up to 4 times

Loop ID	Reference	Name	Codes	Notes/Comments
	REF01	Reference Identification Number	6P ZZ	'6P' is sent for Medicare Part C, Medicare Part D, and Other Insurance 'ZZ' is sent to identify all other COB information: • Insurance Type Code • COB Status
	REF02	Reference Identification – Member Group or Policy Number		Medicare Part C or D Plan number is sent. (Medicare Parts A and B will not receive Plan numbers) For other insurance, the Group number is sent. Third Party Liability (TPL) Insurance Type Code will have the label **INSTYPE** COB Status will have the label **STATUS**
2330	NM1	Coordination of Benefits Related Entity		
	NM101	Entity Identifier Code	IN	'IN' is sent
	NM103	Name Last or Organization Name – Coordination of Benefits Insurer Name		Medicare Part A, B, C plan name, Medicare D organization name, or other insurance carrier name is sent.
	NM108	Identification Code Qualifier	XV	'XV' is sent for Medicare Parts C and D, and TPL. Medicare Parts A and B do not have a Plan ID
	NM109	Identification Code – Coordination of Benefits Insurer Identification Code		For Medicare Part C, Part D, and TPL, the NCTracks Carrier ID is sent
2330	N3/N4	Coordination of Benefits Address, City, State, and Zip		The COB address will only be returned for TPL; Medicare Parts A, B, C, and D address info will not be returned.

4. TI Additional Information

4.1 BUSINESS SCENARIOS

The 834 Outbound transaction is used to provide enrollment information concerning recipients enrolled in Medicaid HMO (Health Maintenance Organization) plans under Prepaid Inpatient Health Plan (PIHP). Payment information is also included to support what is reported on the 820, Payroll Deducted and Other Group Premium Payment for Insurance Products.

4.2 PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

An 834 Outbound will be generated once a month. The enrollment information is provided for each member. Retroactive activity since the last month is reported.

The 834 Outbound transaction is now separated based on the Provider ID assigned to the MCO that is affiliated with the Federal Tax ID returned in the 1000B, N104 segment. The Provider ID associated with each file will be defined in the name of the 834O file sent to the MCO. Refer to Section 4.3, Naming Standards for Outbound Transactions.

4.3 NAMING STANDARDS FOR OUTBOUND TRANSACTIONS

The following is the naming convention standard for outbound transactions:

[R/F]-[Mailbox ID]-[Timestamp]-[File ID]-[Provider Number]-[Transaction Type]-ISA-0001-.x12

ex: R-BXA12345-140628112722-1417900000000022FF-1234567890-5E-ISA-00001-.x12

Node Name	# of Characters	Description
R/F	1	R: Response F: File
Mailbox ID	8	Alphanumeric characters
Timestamp	12	The timestamp format is YYMMDDHHMMSS.
File ID	18	Alphanumeric characters. The last 2 characters are always FF.
Provider Number	Up to 10	NPI or Atypical ID
Transaction Type	2	01 = TA1 02 = F-File 03 = 999 5A = 820 5E = 834 Reconciliation 5D = 834 Daily 5W = 834 Weekly 5M = 834 Monthly 5R = 277P 5T = 835 09 = 277 10 = 271
ISA-0001	8	This is a static value that will be present for all transactions.

4.4 SCHEDULED MAINTENANCE

NCTracks maintenance will occur Sunday morning from 12:01 a.m. through 4:00 a.m. NCTracks will not be available to submit files during this time.

4.5 FREQUENTLY ASKED QUESTIONS

1. Compliance errors found when processing the 834.

   NCTracks validates up to Level 2 compliance checking. In order to provide all the information on the X12 834 that PHPs need for processing, NCTracks includes information in three segments on the X12 834 that may return compliance errors (2300 REF*ZZ**,** 2310 NM1, and 2330 NM1 segments). We ask that in these circumstances that you please relax your compliance so that you may receive all of the information needed for processing.

4.6 OTHER RESOURCES

- **Washington Publishing Company**

  WPC holds the copyright on the format of all X12 publications, which are available at https://x12.org/products.

- **X12 Code Sets**

  The X12N external code sets and other useful X12 forms are available at https://x12.org/reference.

- **United States Department of Health and Human Services (HHS)**

  This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA.

  https://www.hhs.gov/hipaa/index.html

- **Workgroup for Electronic Data Interchange (WEDI)**

  A workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative simplification provisions of HIPAA.

  www.wedi.org

- **North Carolina Department of Health and Human Services**

  www.ncdhhs.gov

- **North Carolina Division of Health Benefits**

  https://medicaid.ncdhhs.gov/

- **North Carolina Division of Mental Health/Development Disabilities/Substances Abuse Services**

  http://www.ncdhhs.gov/mhddsas/

- **North Carolina Division of Public Health**

  http://publichealth.nc.gov/

5. Contact Information

5.1 ELECTRONIC DATA INTERCHANGE (EDI) TECHNICAL ASSISTANCE

Phone: 1-800-688-6696, option #1

Email: NCMMIS_EDI_SUPPORT@gdit.com

Website: http://www.nctracks.nc.gov/provider/index.html

Companion Guides: http://www.nctracks.nc.gov/provider/guides/index.html

5.2 PROVIDER/TRADING PARTNER ENROLLMENT

Currently Enrolled Provider (CEP), Billing Agent Enrollment
Phone: 1-800-688-6696

Email: NCTracksprovider@nctracks.com

Website: https://www.nctracks.nc.gov/provider/providerEnrollment/

NCTracks Enrollment
Phone: 1-800-688-6696

Email: NCTracksprovider@nctracks.com

Website: https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html

6. Change Summary

Date	Change	Responsible Party
August 31, 2022	Added PHHC Benefit Plan and updated INS08 description	GDIT under the direction of NC DHHS
April 19, 2022	Updated the CAP Benefit Plan Short Description in Appendix A	GDIT under the direction of NC DHHS
October 11, 2021	Removed a valid value from 2300, REF02 and added Tailored Plan information	GDIT under the direction of NC DHHS
July 8, 2021	Update to Cost Sharing and 2100A segment	GDIT under the direction of NC DHHS
June 09, 2021	Updates for Managed Care Transformation	CSRA under the direction of NC DHHS
May 31, 2021	Updates for Managed Care Transformation	CSRA under the direction of NC DHHS
November 19, 2018	MCT Changes – Draft Daily/Weekly/Monthly(EB) 834 Outbound version	GDIT under the direction of NC DHHS

Appendix A. Benefit Plan to Health Plan Crosswalk

HD04 Benefit Plan Short Description	Benefit Plan Long Description	HD03 Insurance Line Code	Insurance Line Code – Definition	Health Plan
CAPAI	CAPAI – Obsolete 2006	HLT	HEALTH	1 – NCXIX
CAPCD	CAP CHILDREN	HLT	HEALTH	1 – NCXIX
CAPCH	CAP CHOICE	HLT	HEALTH	1 – NCXIX
CAPDA	CAP DISABLED ADULT	HLT	HEALTH	1 – NCXIX
CAPMR	CAP MENTALLY RETARDED/DEVELOPMENTALLY DISABLED	HLT	HEALTH	1 – NCXIX
EHDI	EARLY HEARING DETECTION AND INTERVENTION	HLT	HEALTH	6 – PUBLIC HEALTH
HCCRV	HEALTH CHOICE MANAGED CARE – CARVE OUT	HLT	HEALTH	2 – NCXXI
HCSTD	HEALTH CHOICE MANAGED CARE – STANDARD PLAN	HMO	HEALTH MAINTENANCE ORGANIZATION	2 – NCXXI
ITP	INFANT/TODDLER PROGRAM	HLT	HEALTH	6 – PUBLIC HEALTH
MAFDN	MEDICAID FAMILY PLANNING	HLT	HEALTH	1 – NCXIX
MCAID	MEDICAID	HLT	HEALTH	1 – NCXIX
MCCRV	MEDICAID MANAGED CARE – CARVE OUT	HLT	HEALTH	1 – NCXIX
MCSTD	MEDICAID MANAGED CARE – STANDARD PLAN	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
MFP	MONEY FOLLOWS THE PERSON	HLT	HEALTH	1 – NCXIX
MQBB	QUALIFIED MEDICARE BENEFICIARY PART B PREMIUM ONLY	HLT	HEALTH	1 – NCXIX
MQBE	QUALIFIED MEDICARE BENEFICIARY PART B PREMIUM ONLY	HLT	HEALTH	1 – NCXIX
MQBQ	QUALIFIED MEDICARE BENEFICIARY	HLT	HEALTH	1 – NCXIX
NCHC	NORTH CAROLINA HEALTH CHOICE	HLT	HEALTH	2 – NCXXI
PACE	PLAN OF ALL-INCLUSIVE CARE FOR THE ELDERLY	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
PHPB	MANAGED CARE FOR BEHAVIORAL HEALTH SERVICES	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
PHPC	INNOVATIONS WAIVER – CAP SERVICES	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
PHHC	BEHAVIORAL HEALTH SERVICES FOR NORTH CAROLINA HEALTH CHOICE	HMO	HEALTH MAINTENANCE ORGANIZATION	2 – NCXXI
SC	SICKLE CELL PROGRAM	HLT	HEALTH	6 – PUBLIC HEALTH

HD04 Benefit Plan Short Description	Benefit Plan Long Description	HD03 Insurance Line Code	Insurance Line Code – Definition	Health Plan
TBI	TRAUMATIC BRAIN INJURY	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
TPMC	Tailored Plan Medicaid Managed Care	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
TPHC	Tailored Plan Health Choice Managed Care	HMO	HEALTH MAINTENANCE ORGANIZATION	2 – NCXXI
TPINV	Tailored Plan Innovations Waiver Managed Care	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX
TPTBI	Tailored Plan Traumatic Brain Injury Managed Care	HMO	HEALTH MAINTENANCE ORGANIZATION	1 – NCXIX

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