Companion Document For

Batch Response File (BRF) Receipt From

Alabama Medicaid

The Health Insurance Portability and Accountability Act (HIPAA) requires that Alabama Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The Batch Response File is a proprietary fixed length text file created by Alabama Medicaid and is not subject to these standards.

The following information is intended to serve only as a companion document to this proprietary file, which communicates the pre final adjudication results. The proprietary response file will return error codes and error messages for claims that are suspended or denied.

There will be one standard proprietary batch response file for the 837 Dental, Professional and Institutional transactions. This batch response will only be returned to the trading partner that uploads a batch of claims.

Note: *The information in this document is subject to change. Please refer to the version number and effective date located in the footer of this document for the latest information available. Changes within the document will be in red type. A copy of the most current version of this companion document can be obtained from the internet at* *https://medicaid.alabama.gov/content/7.0_Providers/7.9_Vendor_Guides.aspx*

The layouts contain specific requirements to be used when processing data from the Alabama Medicaid Management Information System (AMMIS). The file will have a .BRF extension.

Field Name	Field Description	Attributes	Start Position	End Position
Trading Partner ID	The assigned 9 digit trading partner number used by the submitter to send a batch of claims.	Char(15)	1	15
File Tracking ID	The tracking number assigned to a batch of claims when uploaded to AMMIS.	Number(09)	16	24
Internal Control Number (ICN)	The internal control number that uniquely identifies a claim in the system.	Number(13)	25	37
Claim Status	The status of the claim after processing thru the system. Values can be either "P" (paid), "S" (suspended), or "D" (denied).	Char(01)	38	38
Total Detail Count	The total number of details associated to the claim.	Number(04)	39	42
Provider NPI ID	The National Provider ID used to process the claim.	Char(15)	43	57
Provider Medicaid ID	The Medicaid Provider ID used to process the claim. Identifies the service location.	Char(15)	58	72
Recipient ID	The Recipient or Subscriber ID submitted on the claim.	Char(12)	73	84
Recipient Check Digit	The Recipient or Subscriber check digit submitted on the claim.	Char(01)	85	85
Patient Account Number	The Patient Account Number submitted on the claim.	Char(38)	86	123
Medical Record Number	The Medical Record Number submitted on the claim.	Char(30)	124	153
First Date of Service	The date of the first date of service on the claim in CCYYMMDD format.	Number(08)	154	161

Billed Amount	The Billed Amount submitted on the claim.	Number(9,2)	162	170
Paid Amount	The paid amount that was calculated by the system for a paid claim. This field will be the end of the record for Paid claims.	Number(9,2)	171	179
Error Count	The number of errors set on the claim.	Number(04)	180	183
Detail Number	The detail number on which the error was set. 0 = header; 1 > = detail number.	Number(04)		
Error Code Status	Status code that represents the disposition of the specific error that has set on the claim. Values are deny(D) or suspend(S).	Char(01)		
Error Code	The Explanation Of Benefit (EOB) code set on the claim.	Number(04)		
Error Message	The text message that describes the error that was set on the claim.	Char(50)		

Note:
Error Count – For denied or suspended claims this field will be returned one time.

Detail Number, Error Code Status, Error Code, Error Message – For denied or suspended claims these fields will repeat according to the number returned in the Error Count field.