BLUE CROSS BLUE SHIELD OF FLORIDA
AUTOMATED ENROLLMENT
CORPORATE REQUIREMENTS

The purpose of this document is to outline the Blue Cross Blue Shield of Florida corporate requirements for transmitting enrollment electronically. This includes the standard HIPAA-AS compliant format as well as non-standard formats.

Accepted File Formats

- Standard - Group Health Plans must use the standard HIPAA-AS compliant format - ANSI X 12 Version 5010A1 834. This is the Blue Cross Blue Shield of Florida preferred file format and provides portability to the client.
- Non-Standard - Employer/plan sponsors and non-qualifying ERISA health plans can use a HIPAA-AS non-standard format (BCBSF proprietary or client specific) provided they meet the BCBSF enrolled contracts/size requirements. By 2014 this option will no longer be available. (See below for detailed information.)

Enrolled Contracts/Size Requirements

- Standard Format – any size group may use the standard HIPAA-AS 834 5010A1 compliant format to transmit enrollment electronically.
- Non-Standard Format – Minimum group size of 1500 enrolled contracts is required.

Minimum Required Data Elements

- Elements required: record type, contract number, first and last names, sex, birth date, address, group division and/or benefit option code, coverage tier code, effective date, employment status.
- Elements recommended: middle initial, primary physician provider number (for HMO), current patient indicator, telephone number, hire date, preexisting to and from dates, dependent SSN.
- Dependent Data is required: record type, contract number, first and last names, sex, birth date, relationship to subscriber, effective date, SSN required for dependents 45+.

When utilizing the Standard HIPAA-AS format, clients will need to comply with the requirements as outlined in the Benefit Enrollment and Maintenance (834) ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, the Blue Cross Blue Shield of Florida 834 Companion Guide and Accepted Code Value Document.

Full file processing is preferred. However, transaction processing will be accepted if the client provides termination dates and agrees to provide a quarterly full file for audit purposes.

When using a non-standard/proprietary format, only one record per member, with the most current information, should be sent for each subscriber and dependent.

The client must be able to provide a coverage effective date and be able to send a new date when group division, benefits or coverage tiers change. The BCBSF group division number and/or a benefit option code for each subscriber are required.

The client must be able to provide all product data housed in BCBSF billing system (Health, Life, etc.) for each subscriber on the file.