Upload File Format for HFS COVID-19 Portal

The portal provides two methods to request payment for COVID-19 testing services.

- **RIN only** - Providers who want to generate their own claims can request the Department to generate a Recipient Identification Number (RIN) **only** for the uninsured COVID-19 testing patients. To request a RIN **only** for the purpose of submitting claims, providers will only need to include **R**equired fields. Files containing RINs for the patients uploaded through the portal will be available for download by the provider after the RINs are generated.
- **RIN and Claim** - The full functionality of the portal will generate RINs and claims. Providers who use the portal's full functionality must include all **Required** and **Conditional** fields listed.
- **RIN found-** If a RIN exists and the participant is eligible for traditional Medicaid, a claim will be generated. If the participant is eligible through a Medicaid managed care plan, the claim will reject and providers must bill the plan.

Please note:

- The Department will be generating an 835 for claims processed through the portal.
- Instructions on how to download information will be forthcoming.

Note: Submit separate files for each submission type: records that need a **RIN only** and records that need a **RIN and Claim** generated. Providers will need to choose one selection before uploading.

File Type: XXXX.csv or XXXX.xlsx

Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Unique ID		O	Varchar(100)	If available, this is the unique ID that associates the lab claim with the Swab Site. If swab is done onsite, enter the Patient Reference Number if available.
Specimen Collection Date		R	Date	MM/DD/YYYY This is also the Date of Service

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Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
First Name		R	VARCHAR(100)	If the First Name is not on file, enter "Unknown"
Last Name		R	VARCHAR(100)	If the Last Name is not on file, enter "Unknown"
Gender	M – Male F - Female U – Unknown	R	VARCHAR(1)	
Date of Birth		R	Date	MM/DD/YYYY If Date of Birth is not on file enter 01/01/9999
Attestation Value	Y - I attest that the patient gave verbal approval to gather information for submission to HFS. N – I do not attest to being present when the patient consent was given to gather information for submission to HFS.	R	VARCHAR(100)	Copy the entire Text from the Allowable Values of either Y or N and enter into cell. The upload is expecting each character of the attestation statement *(including the **Y-I**…* or ***N-I**…*) on each row in the upload.
Attestation First Name		C	VARCHAR(100)	Enter the First Name of the provider employee present with the patient at the time of consent. Required if Attestation value was Y. Otherwise Leave Blank.

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Field	Allowable Values		R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Attestation Last Name			C	VARCHAR(100)	Enter the Last Name of the provider employee present with the patient at the time of consent. Required if Attestation value was Y. Otherwise leave blank.
RIN (Recipient Identification Number)			O	VARCHAR(9)	If known, enter the HFS RIN. If the patient is uninsured, a RIN will be assigned once the record is processed and updated in the system. HFS will provide further information regarding downloading options for retrieving RIN assignments.
SSN			R	Numeric(9)	If SSN is unknown, enter 000000000.
Address			O	VARCHAR(260)	
City			O	VARCHAR(100)	
State			O	VARCHAR(2)	
Zip			O	VARCHAR(5)	
Phone			O	VARCHAR(10)	000-000-0000
Race	A	Asian	R	VARCHAR(1)	
	B	Black			
	D	Did Not Answer/Unknown			
	M	Multi-Race			
	N	American Indian/Alaska			

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Field	Allowable Values		R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
	P	Hawaiian Native/Other Pacific Islander			
	W	White			
Ethnicity	HS - Hispanic NH -Non-Hispanic UK – Unknown		R	VARCHAR(2)	
Pregnancy	N – No Y - Yes U -Unknown		R	VARCHAR(1)	
Language Preference	English Spanish Other		R	VARCHAR(20)	If Language Preference is not on file, select “English”
Insurance Status	Medicare TriCare Medicaid Other Health Insurance No Health Insurance		R	VARCHAR(25)	For uninsured enter: No Health Insurance
Insurance Carrier Name			O	VARCHAR(100)	
Insurance Member ID			O	VARCHAR(100)	
Insurance Group Number			O	VARCHAR(100)	
Insurance Begin Date			O	Date	MM/DD/YYYY
Insurance End Date			O	Date	MM/DD/YYYY
Insurance Phone number			O	VARCHAR(10)	
Policy Holder Name			O	VARCHAR(200)	

Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Relationship to Policyholder		O	VARCHAR(100)	
Billing Provider Taxonomy Code		C	VARCHAR(10)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider NPI		C	VARCHAR(10)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider Name		C	VARCHAR(100)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider Address		C	VARCHAR(260)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider City		C	VARCHAR(100)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider State		C	VARCHAR(2)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider Zip		C	VARCHAR(5)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Billing Provider Tax ID		C	VARCHAR(9)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.

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Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Patient Account Number		C	VARCHAR(50)	**REQUIRED** if **RIN and Claim** was selected for upload. If blank, a claim will **NOT** be generated. Otherwise, leave blank.
Diagnosis Code		C	VARCHAR(7)	Enter a valid ICD-10 diagnosis code. Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Valid Covid-19 CPT/Procedure Code		C	VARCHAR(5)	COVID-19 Fee Schedule Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Provider Charge		C	INTEGER (9)	Required if **RIN and Claim** was selected for upload. Otherwise, leave blank.
Rendering Provider NPI		C	VARCHAR(10)	Required only if there was a Rendering Provider for the service. Otherwise, leave blank.
Rendering Provider Last Name		C	VARCHAR(100)	Required only if there was a Rendering Provider for the service. Otherwise, leave blank.
Rendering Provider First Name		C	VARCHAR(100)	Required only if there was a Rendering Provider for the service. Otherwise, leave blank.