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 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 outside the portal, 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 **R**equired and **C**onditional 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

Upload File Format for HFS COVID-19 Portal

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(125)	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.

Upload File Format for HFS COVID-19 Portal

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

Upload File Format for HFS COVID-19 Portal

Field	Allowable Values		R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Race	A	Asian	R	VARCHAR(1)	
	B	Black			
	D	Did Not Answer/Unknown			
	M	Multi-Race			
	N	American Indian/Alaska			
	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)	

Upload File Format for HFS COVID-19 Portal

Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
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)	
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.

Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
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.
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.

Upload File Format for HFS COVID-19 Portal

Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
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.