Upload File Format for HFS COVID-19 Portal

The portal provides a method to request Patient Eligibility 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.

Please note:

- Instructions on how to download information will be forthcoming.

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)	
Last Name		R	VARCHAR(100)	
Gender	M – Male F - Female	R	VARCHAR(1)	
Date of Birth		R	Date	MM/DD/YYYY
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.

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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)	Providers are required to verify eligibility utilizing MEDI or the provider's usual verification method for each patient prior to utilizing the portal. If a RIN is found with "COVID 19 Testing Only" coverage, providers must bill/rebill any unpaid claims through normal claim submission methods outside the portal. If the patient is uninsured, leave this field blank. 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.

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Field	Allowable Values		R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
SSN			R	Numeric(9)	
Address			R	VARCHAR(260)	
City			R	VARCHAR(100)	
State			R	VARCHAR(2)	
Zip			R	VARCHAR(5)	
Phone			O	VARCHAR(10)	0000000000
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”

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Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
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)	
Relationship to Policyholder		O	VARCHAR(100)	
Billing Provider Taxonomy Code		O	VARCHAR(10)	Column with Heading required. No data should be submitted in this field
Billing Provider NPI		O	VARCHAR(10)	Column with Heading required. No data should be submitted in this field

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Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Billing Provider Name		O	VARCHAR(100)	Column with Heading required. No data should be submitted in this field
Billing Provider Address		O	VARCHAR(260)	Column with Heading required. No data should be submitted in this field
Billing Provider City		O	VARCHAR(100)	Column with Heading required. No data should be submitted in this field
Billing Provider State		O	VARCHAR(2)	Column with Heading required. No data should be submitted in this field
Billing Provider Zip		O	VARCHAR(5)	Column with Heading required. No data should be submitted in this field
Billing Provider Tax ID		O	VARCHAR(9)	Column with Heading required. No data should be submitted in this field
Patient Account Number		O	VARCHAR(50)	Column with Heading required. No data should be submitted in this field

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Field	Allowable Values	R - Required C - Conditional based on the previous answer O - Optional	Field Characteristics	Additional Information
Diagnosis Code		O	VARCHAR(7)	Column with Heading required. No data should be submitted in this field
Valid Covid-19 CPT/Procedure Code		O	VARCHAR(5)	Column with Heading required. No data should be submitted in this field
Provider Charge		O	INTEGER (9)	Column with Heading required. No data should be submitted in this field
Rendering Provider NPI		O	VARCHAR(10)	Column with Heading required. No data should be submitted in this field
Rendering Provider Last Name		O	VARCHAR(100)	Column with Heading required. No data should be submitted in this field
Rendering Provider First Name		O	VARCHAR(100)	Column with Heading required. No data should be submitted in this field